



Practice Guidelines For Psychology Professionals  
**Working With Sexually And  
Gender-Diverse People**

Psychological Society of South Africa. (2017). *Practice Guidelines For Psychology Professionals Working With Sexually And Gender-Diverse People*. Johannesburg: Psychological Society of South Africa.

This document can be accessed from <http://www.psyssa.com>

Copyright © Psychological Society of South Africa.



# CONTENTS

<b>INTRODUCTION: Diversity Competence in a Multicultural Society: Practice Guidelines For Psychology Professionals</b> .....	5
<b>SUMMARY OF PRACTICE GUIDELINES</b> .....	12
<b>GUIDELINE 1: Non-discrimination</b>	
Rationale .....	14
Application .....	15
<b>GUIDELINE 2: Individual Self-Determination</b>	
Rationale .....	18
Application .....	19
<b>GUIDELINE 3: Enhancing Professional Understanding</b>	
Rationale .....	22
Application .....	26
<b>GUIDELINE 4: Awareness Of Normative Social Contexts</b>	
Rationale .....	29
Application .....	30
<b>GUIDELINE 5: Intersecting Discriminations</b>	
Rationale .....	32
Application .....	33
<b>GUIDELINE 6: Counteracting Stigma And Violence</b>	
Rationale .....	36
Application .....	37

<b>GUIDELINE 7: Recognising Multiple Developmental Pathways</b>	
Rationale .....	41
Application .....	43
<b>GUIDELINE 8: Non-Conforming Family Structures And Relationships</b>	
Rationale .....	45
Application .....	47
<b>GUIDELINE 9: The Necessity Of An Affirmative Stance</b>	
Rationale .....	49
Application .....	50
<b>GUIDELINE 10: Foregrounding Global Best Practice Care</b>	
Rationale .....	51
Application .....	53
<b>GUIDELINE 11: Disclosing And Rectifying Of Personal Biases</b>	
Rationale .....	55
Application .....	55
<b>GUIDELINE 12: Continued Professional Development</b>	
Rationale .....	57
Application .....	57
<b>IN CLOSING</b> .....	58
<b>GLOSSARY</b> .....	59
<b>REFERENCES</b> .....	64
<b>APPENDIX I: Collaborating Organisations</b> .....	76
<b>APPENDIX II: IPsyNet Policy Statement And Commitment On LGBTI Issues</b> .....	77
<b>APPENDIX III: PsySSA Sexuality and Gender Division</b> .....	79
<b>APPENDIX IV: Example Of General Practitioner Consent Form</b> .....	82
<b>ACKNOWLEDGEMENTS</b> .....	84

# Diversity Competence in a Multicultural Society:

## *Practice Guidelines For Psychology Professionals*

---

In recent years, and in line with international trends in the profession, efforts are also underway in South Africa to identify competencies for psychology professionals. Given our country's history, our diverse society, and the significant issues around gender, race, culture, sexual orientation, and health status – including gender violence, hate crime and hate speech, and stigmatisation and prejudice around HIV status – it goes without saying that competencies in working with diversity, which include multicultural or cultural competence, are all important.

The 'International Declaration on Core Competencies in Professional Psychology' of the International Union of Psychological Science (IUPsyS) clearly outlines work with diversity, including cultural competence, as key for psychology professionals. This set of competencies includes:

- knowledge and understanding of the historical, political, social and cultural context of clients, colleagues, and relevant others;
- cultural humility;
- respecting diversity in relevant others;
- realising the impact of one's own values, beliefs, and experiences on one's professional behaviour, clients, and relevant others;
- working and communicating effectively with all forms of diversity in clients, colleagues, and relevant others; and
- inclusivity of all forms of diversity in working with clients, colleagues, and relevant others (IUPsyS, 2016).

Being competent may be viewed as “doing something successfully and satisfactorily, though not outstandingly well; being ‘good enough’ or simply

adequate” (Naidu & Ramlall, 2016, p.83). IUPsyS defines competence as a “combination of practical and theoretical knowledge, cognitive skills, behaviour, and values used to perform a specific behaviour or set of behaviours to a standard, in professional practice settings associated with a professional role” (IUPsyS, 2016, p.4).

The term ‘diversity’ includes working with sexual and gender diversity, the specific area of application dealt with in the *PsySSA practice guidelines for psychology professionals working with sexually and gender-diverse people*. These are one of several sets of practice guidelines that will be developed by the Psychological Society of South Africa (PsySSA). Each set of guidelines in the series will address separate, but sometimes also intersectional<sup>1</sup> target groups (including, but not limited to, diversity based on race, ethnicity, culture, language, religion and/or spirituality; nationality, internally and externally displaced people and asylum seekers; socio-economic status, poverty and unemployment; physical, sensory and cognitive-emotional disabilities; etc.).

---

<sup>1</sup> Intersectionality in psychology, as a concept, acknowledges diversity and focuses on attending to all the different forms of oppressions that occur in society – the different ‘-isms’ – racism, ableism, heterosexism, sexism, classism, etc. and the ways they overlap and often reinforce a power that could potentially subjugate one cultural group. Being a minority within a minority (for example, being intersex and an immigrant) could deepen one's sense of isolation and disconnection from the statistical and cultural majority. The American Psychological Association [2012] notes that the cumulative effects of heterosexism, sexism, and racism, for instance, may put a person at special risk of stress, which adds to the vast range of contextual factors that worsen the effects of stigma. Multiple layers of discrimination that a person could potentially experience may create multiple and intersecting levels of stress.



# Practice Guidelines For Psychology Professionals Working With Sexually And Gender-Diverse People

## Introduction

These practice guidelines aim to increase psychological knowledge of human diversity in sexual orientations, gender identities, gender expressions and sex characteristics. They aim to facilitate the *application* of this knowledge in support of the well-being and human rights of all sexually and gender-diverse people. This constitutes the first version of the Psychological Society of South Africa (PsySSA) practice guidelines and, as such, is a pilot of what is very much deemed a 'living document': if and when revisions are indicated, they will be made at set intervals.

This project is a collaboration between PsySSA's Sexuality and Gender Division, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and the PsySSA African LGBTI Human Rights Project. Please see Appendix I for details about each organisation/structure/project. The collaborative project that informs this document seeks to contribute to developing, disseminating and implementing standards of care for sexually and gender-diverse people. The overall goal of this project is to build PsySSA's capacity in South Africa and Africa, more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics. (Although some abridged definitions are provided throughout the document, please see the Glossary where more terms are defined).

## From Position Statement to Practice Guidelines

These practice guidelines draw on the PsySSA sexual and gender diversity position statement (PsySSA, 2013; Victor, Nel, Lynch, & Mbatha, 2014).

The position statement communicates an affirmative stance on sexual and gender diversity, including Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual (hereafter LGBTIQ+). The + indicates, as per current practice, an openness to additional categorisation and self-claimed descriptors. The position statement was and is aimed primarily at psychology professionals in South Africa, though it is applicable to all mental health professionals on the continent of Africa. It supplements

**SEXUAL ORIENTATION:** A person's lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual/same-sex sexual orientation, bisexual or asexual).

**GENDER IDENTITY:** A person's private sense of being male, female or another gender. This may or may not match the biological sex that a person was assigned at birth.

**SEX(UAL) CHARACTERISTICS:** A sex organ (also called a reproductive organ, primary sex organ, or primary sexual characteristic) is any anatomical part of the body in a complex organism that is involved in sexual reproduction and constitutes part of the reproductive system. The external and visible organs, in males and females, are the primary sex organs known as the 'genitals' or 'genitalia'. The internal organs are known as the 'secondary sex organs' and are sometimes referred to as the 'internal genitalia'. The characteristics that begin to appear during puberty, such as, in humans, pubic hair on both sexes and facial hair on the male, are known as 'secondary sex characteristics'.

the harm-avoidance approach in the South African Health Professions Act (Department of Health, 2006) by outlining specific themes to consider in assuming an affirmative stance in psychological research and practice.

The PsySSA position statement acknowledges that, regardless of sexual or gender identification, individuals seeking psychological services may experience various difficulties in life, including the negative impact of prejudice, stigmatisation and victimisation associated with patriarchal and heteronormative societies (PsySSA, 2013; Victor et al., 2014). It proposes that as health professionals, we acknowledge how these difficulties have cultural, class, race and gender components that often overlap. The position statement suggests ways for thinking about addressing both past and ongoing harms and present contexts.

In a similar fashion, the PsySSA practice guidelines embrace an affirmative stance and intersectionality and are consistent with the South African Constitution and its Bill of Rights (Republic of South Africa [RSA], 1996), the South African Health Professions Act and associated general ethical rules for health professionals (Department of Health, 2006), as well as the PsySSA Constitution (PsySSA, 2012).

## Purpose of Practice Guidelines

The purpose of these practice guidelines is to provide a guide and reference for psychology professionals to deal more sensitively and effectively with matters of sexual and gender diversity.<sup>2</sup> Whereas the position statement outlines PsySSA's stance on sexual and gender diversity, the practice guidelines are aspirational in nature – and will hopefully provide all psychology professionals

---

<sup>2</sup> As will become evident from this guidelines document, 'biological variance' (which includes intersex) is subsumed in the term 'sexual and gender diversity', even though not, in fact, part of sexual diversity nor gender diversity, as defined in the glossary. There are several reasons for this inclusion in the guidelines, even though biological variance receives little direct attention, given the paucity in research to draw from. Most importantly, it serves to acknowledge the similarities in experiences [see the definition of LGBTIQ+ in the glossary]. This also highlights the need for psychology professionals to engage more actively in related work.

**LGBTIQ+:** An abbreviation referring to lesbian, gay, bisexual, transgender and intersex persons. 'LGB' refers to sexual orientations, while 'T' indicates a gender identity, 'I' a biological variant, 'Q' a queer identified person, 'A' for asexual, and '+' indicating other non-conforming minorities. These groups are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination and victimisation in a heteronormative and heterosexist society, in an effort to ensure equality before the law and equal protection by the law. However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences and needs of these people may in fact differ significantly and in several respects. In solidarity with the activist position regarding this matter, however, in this document, reference is made to LGBTIQ+, and distinctions among the diversity of identities that exist are minimised.

**PSYCHOLOGY PROFESSIONAL:** Inclusive of Health Professions Council of South Africa- (HPCSA-) registered psychologists, regardless of registration category (Clinical, Counselling, Educational, Industrial, Research), registered counsellors and psychometrists, as well as non-registered professionals with a qualification in psychology.

**POSITION STATEMENT:** Refers to a document outlining the stance of a professional body on a specified area.

**HETERONORMATIVITY:** Related to 'heterosexism', it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person's biological sex as assigned at birth, and that only sexual attraction between these 'opposite' genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities also, i.e. it serves to regulate not only sexuality but also gender.

**PRACTICE GUIDELINES:** Related to 'position statement', this term refers to recommendations regarding professional practice in a specified area. The function of practice guidelines in the field of psychology is to provide psychology professionals with applied tools to develop and maintain competencies and learn about new practice areas.

with recommendations and applied tools to develop and maintain a basic level of competency in the area of sexual and gender diversity. These guidelines are based on the most up-to-date research and our most in-depth current understanding, globally and particularly locally.

These practice guidelines should be distinguished from treatment guidelines. Whereas treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition, practice guidelines provide a general framework that can be used across different registration categories and scopes of practice (Reed, McLaughlin, & Newman, 2002).

The intended audience for these practice guidelines is thus primarily all South African psychology professionals dealing with matters of sexual and gender diversity. In addition, as with the PsySSA position statement, the guidelines may apply across mental health service provision and may well apply across the broader African continent.

The document contains 12 practice guidelines, each providing a review of current knowledge followed by potential application in psychological practice. Some content is applicable across more than one guideline. The research and writing team has tried to avoid unnecessary duplication and where possible, readers are directed to content that might be covered in other guidelines. This document contains a glossary of terms currently in use. A resource guide for professionals will additionally be added when the practice guidelines document is revised in the foreseeable future.

## Need for Practice Guidelines

While the need for affirmative guidelines for psychotherapeutic practice in Africa has been highlighted repeatedly in recent years (Coetzee, 2009; Nel, 2007; Nel, Mitchell, & Lubbe-De Beer, 2010), some might question why psychology practitioners working with sexually and gender-diverse individuals need a *specialised set* of guidelines. Of course, respect, empathy and competence are professionally required from practitioners working with all people. How is working with sexually and gender-diverse individuals any different? Similarly, competent practitioners are expected to maintain an attitude of openness and curiosity, to

be willing to learn, and to set aside personal biases and prejudices – even if they have had no targeted education or training in working with sexually and gender-diverse individuals. This is also true if they find themselves working in other contexts that involve sexual and gender diversity matters, such as policy or curriculum development.

In addition, in the South African context, sexual orientation and gender are protected by the Constitution and related constitutional and other legal challenges brought before South African courts, among other outcomes, have resulted in the legalisation of same-sex marriages, as well as the right to alter one's sex description on identity documents (IDs). This has also had a positive influence on legal rights of the sexually and gender diverse to adopt children. Global diagnostic systems such as the 5<sup>th</sup> edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association [APA], 2013) are increasingly moving away from pathologising sexual and gender diversity. There is a growing awareness of the indivisible human rights of sexually and gender-diverse individuals (International Commission of Jurists, 2007; UN Office of the High Commissioner for Human Rights [OHCHR], 2012). Sexual orientation and gender are grounds for non-discrimination and equality, according to the Constitution and its Bill of Rights (RSA, 1996). For this reason, health professionals are guided by the South African Health Professions

**SEXUAL DIVERSITY:** The range of different expressions of sexual orientation and sexual behaviour that span across the historically imposed heterosexual-homosexual binary.

**GENDER DIVERSITY:** The range of different gender expressions that spans across the historically imposed male-female binary. Referring to 'gender diversity' is generally preferred to 'gender variance' as 'variance' implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals.



Act (56 of 1974) to do no harm in their interactions with service users/clients/participants or patients (Department of Health, 2006).

Regrettably, and despite these protections and laws, severe human rights violations have occurred in psychological practice regardless of specific practitioner guidelines on ethics. In South Africa, many sexual and other minority groups have been oppressed by psychology due to silences or support for mainstream political discourses (July, 2009; Yen, 2007). On a global scale, psychology has also failed sexually and gender-diverse people through unethical and unscientific practices. For example, homosexuality was listed in the DSM as a mental illness until 1978, and differences in gender expression were treated as social deviance. Today, reparative therapies and efforts to change sexual orientation and gender identity to conform to normative societal standards of heterosexuality and cisgender, continue despite empirical evidence that such approaches are unethical and can be harmful (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Reports of attempts by practitioners to change people's sexual orientation or gender identity, either subtly or openly, continue to surface.

These practices take place despite the reality that psychological services may be the last safe space that sexually and gender-diverse people seek out away from persistent prejudice, violence and hate crimes that regularly occur.

Guidelines such as these are also necessary because, in South Africa, healthcare practices are still shaped by dominant heteronormative positions, which negatively affects the quality and access to healthcare services for sexually and gender-diverse individuals. Discrimination and negative encounters with healthcare providers have emerged in a number of studies (Graziano, 2005; A.C. Meyer, 2003; Müller, 2013; Rich, 2006; Stephens, 2010; Wells, 2005; Wells & Polders, 2003). Ignorance of matters related to sexual orientation and gender identity or the lack of adequate services is the norm for the majority of healthcare service providers (Klein, 2013; Nel, 2007; Nel & Judge, 2008; Nkoana & Nduna, 2012; Stevens, 2012).

How service providers deal with service users/clients/participants or patients' sexual orientation was identified in a recent study as a main cause of negative encounters with psychotherapists and

counsellors (Victor, 2013; Victor & Nel, 2016). Such practices include:

- a heterosexist attitude that could suggest that the client's sexual orientation is abnormal;
- supporting negative lesbian, gay and bisexual lifestyle myths;
- regarding sexual orientation as fixed instead of fluid;
- ignoring the often-internalised homophobia of the client;
- ignorance of the particular negative societal experiences of LGBTIQ+ people; and
- focusing mainly or only on the client's sexual orientation, regardless of whether this is indicated (Victor, 2013; Victor & Nel, 2016).

The lack of training on healthcare matters related to sexually and gender-diverse people is a factor that contributes to practitioners' insufficient understanding of such groups (Coetzee, 2009; Müller, 2014; Nel, 2007). The absence of specific guidelines to help trainers and practitioners provide relevant and supportive services to sexually and gender-diverse people may be contributing to these training gaps.

**REPARATIVE THERAPY:** Also known as 'conversion therapy' or 'sexual orientation change efforts' (SOCE), it refers to psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change his or her sexual orientation.

**CISGENDER:** Often abbreviated to simply 'cis', a term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth.

These practice guidelines are aimed at filling some of these gaps and are based on local and international research that sexually and gender-diverse individuals require additional expertise and skills from psychology professionals in serving them. By creating these practice guidelines, it is acknowledged that the necessary foundational skills are already in place to enable practitioners to serve sexually and gender-diverse people efficiently, but that ongoing professional growth in this area will make us aware of the subtle diversities that can be overlooked, misread, accepted as a matter of fact, or simply be paid less attention to. Such introspection will enable practitioners to assess their own beliefs and prejudices about how they make sense of their work – in form and content – on an ongoing basis.

These practice guidelines will generally direct practitioners who may encounter sexual and gender diversity but they will not be able to address every exceptional situation, just as a roadmap does not indicate every pothole and speed bump. Hence, our work processes require reflexivity as an essential tool to hone our wisdom, humility and knowledge, and our understanding of what we do not know. With these practice guidelines, we hope to spur learning and unlearning: to acquire the ability to see new ways, to acknowledge our blind spots, our biases, our beliefs and conventions of how the world is, our knowledge gaps, our prejudices shaped by how we were taught, socialised and supervised, together with our norms and values that inhibit curiosity, respect and acceptance of diversity.

## Selection of evidence

South Africa has a burgeoning but still relatively limited academic research output in the field of sexual and gender diversity. Nevertheless, the team has tried to use South African research from multiple disciplines, both published and unpublished, as well as local expert opinion. This body of work was supported by African literature where available, and international work in the absence of any local or regional material.

These practice guidelines have taken various international guidelines into account in the development process, but for this guide the authors have drawn strongly on local knowledge and

understandings to better empower practitioners working in South Africa and in Africa more broadly.

A number of guidelines have been developed in other countries. These include:

- The American Psychological Association’s (APA) “Practice guidelines for lesbian, gay and bisexual clients”, which was originally adopted in 2000 and updated in 2011 (APA, 2011);
- The APA’s “Guidelines for psychological practice with transgender and gender non-conforming people” (APA, 2015);
- The Australian Psychological Society’s “Guidelines for psychological practice with lesbian, gay and bisexual clients” (Australian Psychological Society, 2010);
- The British Psychological Society’s “Guidelines and literature review for psychologists working therapeutically with sexual and gender minority patients” (British Psychological Society, 2012);
- The “Competencies for counsellors working with gay, lesbian, bisexual and transgender clients” (Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2003);
- The World Professional Association for Transgender Health’s [WPATH] “Standards of care for the health of transsexual, transgender, and gender non-conforming people” (WPATH, 2011);
- The “Statement of the Psychological Association of the Philippines on non-discrimination based on sexual orientation, gender identity and expression” (Psychological Association of the Philippines, 2012); and
- The “Position Paper for Psychologists working with Lesbians, Gays, and Bisexual Individuals” (Hong Kong Psychological Society, 2012).

## Development process

The development process for the PsySSA sexual and gender diversity position statement is outlined

in detail in Victor and Nel (2017). Following the ratification of the position statement by the PsySSA Council in 2013 and subsequent dissemination, a larger working group was established in September 2014, consisting of six core members and fourteen expert contributors/critical readers who are all listed in the Acknowledgement section. The core group, each with expertise in different areas of sexual and gender diversity practice, was tasked with the drafting of different sections of the guidelines document. Over a two-year period, the group had several meetings to consider literature and initial drafts of the practice guidelines. A final draft of the guidelines was sent to the extended group for feedback on iterations of the guidelines, including specific input from experts in particular areas (such as intersex matters). The draft practice guidelines were finalised in July 2017, after which the document was professionally edited before presenting it to the PsySSA Council for discussion and approval. The final practice guidelines were approved in September 2017.

To assist professionals in utilising the guidelines, it is envisaged that a resource directory will be included through a full mapping exercise, case material will be developed, curricula will be outlined and training courses developed and presented over the next period.

## **A final introductory note on how to engage with this document**

- This is a 'living document' and subject to revisions when indicated
- Each guideline/section has been written as stand-alone, and, in fact, by different lead authors with unique styles. For the same reason, the guidelines/sections do not have a standard format across the document
- Importantly, all the guidelines/sections also cross-reference
- Therefore, skim-read the document, as a whole, before focusing on the guideline(s)/section(s) most relevant to your specific case/enquiry/concern
- Remember to consult the glossary when in doubt of the meaning of a specific term.

## SUMMARY OF PRACTICE GUIDELINES<sup>3</sup>

Recognising the harm that has been done in the past to individuals and groups by the prejudice against sexual and gender diversity in South African society as well as in the profession of psychology, PsySSA hereby affirms:

### GUIDELINE 1: Non-discrimination

Psychology professionals respect the human rights of sexually and gender-diverse people, and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity and biological variance

### GUIDELINE 2: Individual self-determination

Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as ‘coming out’) of sexual orientation, or of gender diversity, or of biological variance

### GUIDELINE 3: Enhancing professional understanding

Psychology professionals acknowledge and endeavour to understand sexual and gender diversity and fluidity, including biological variance

### GUIDELINE 4: Awareness of normative social contexts

Psychology professionals are aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative and cisgender contexts

### GUIDELINE 5: Intersecting discriminations

Psychology professionals are sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive-emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality

### GUIDELINE 6: Counteracting stigma and violence

Psychology professionals have an understanding of stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals

### GUIDELINE 7: Recognising multiple developmental pathways

Psychology professionals recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age

---

<sup>3</sup> The guideline statements derive from the PsySSA sexual and gender diversity position statement [2013]. Minor edits have been made to those original statements, where such changes were strongly indicated.

## GUIDELINE 8: **Non-conforming family structures and relationships**

Psychology professionals understand the diversity and complexities of relationships that sexually and gender-diverse people have, which include the potential challenges:

- of sexually and gender-diverse parents and their children, including adoption and eligibility assessment;
- within families of origin and families of choice, such as those faced by parental figures, caregivers, friends, and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant others; and
- for people in different relationship configurations, including polyamorous relationships

## GUIDELINE 9: **The necessity of an affirmative stance**

Psychology professionals adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training and education (including curriculum development, assessment and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions)

## GUIDELINE 10: **Foregrounding global best practice care**

Psychology professionals support best practice care in relation to sexually and gender-diverse service users/clients/participants by:

- cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy;
- opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by

the World Professional Association for Transgender Health (WPATH); and

- encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons

## GUIDELINE 11: **Disclosing and rectifying of personal biases**

Psychology professionals are, if it be the case, aware of their own cultural, moral or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist her or him in finding an alternative psychology professional should the client so wish

## GUIDELINE 12: **Continued professional development**

Psychology professionals seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals



# Practice Guidelines For Psychology Professionals:

## *Working With Sexually And Gender-Diverse People*

---

### **GUIDELINE 1: Non-discrimination**

Psychology professionals respect the human rights of sexually and gender-diverse people, and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity and biological variance

#### Rationale

South Africa has seen significant legal and social change with regard to the protection of the human rights of all people in the country. These laws and policies propagate respect for diversity and a concomitant commitment to non-discrimination based on, amongst others, gender and sexual orientation. The South African Constitution and the Bill of Rights within the Constitution inform these developments specifically (RSA, 1996).

The National Action Plan for the Protection and Promotion of Human Rights provides the tangible policy and legislative programme for the realisation of the fundamental human rights and freedoms outlined in the Constitution and Bill of Rights (Ally, Madonsela, Parsley, Thipanyan, & Lambert, 1998). Human rights are not special rights, and should rather be viewed as a set of checks and balances to ensure equal and equitable access and experiences for all citizens, including sexually and gender-diverse people (International Commission of Jurists, 2007; OHCHR, 2012).

These developments have brought about changes at institutional and disciplinary level with, for instance, the ethical rules of conduct for health practitioners, including a focus on human rights, diversity and non-discrimination within a general do-no-harm framework (Department of Health, 2006).

The African Commission on Human and Peoples' Rights (ACHPR) in its 55<sup>th</sup> Ordinary Session in Luanda, Angola in May 2014 passed a resolution noting that the Commission was alarmed that "acts of violence, discrimination and other human rights violations continue to be committed on individuals in many parts of Africa because of their actual or imputed sexual orientation or gender identity" (ACHPR, 2014, para 4). The resolution specifically condemns "the situation of systematic attacks by State and non-state actors against persons on the basis of their imputed or real sexual orientation or gender identity" and calls for states to "end all [such] acts of violence and abuse, whether committed by State or non-state actors" (ACHPR, 2014, para 11). In the context that could be construed as broadly applying to healthcare practitioners, the resolution also "calls on State Parties to ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities" (ACHPR, 2014, para 10).

Upholding human rights in our area of work as psychology professionals includes:

- conducting what we do without discrimination;

- respecting the autonomy and dignity of service users/participants;
- obtaining informed consent before action;
- providing all information necessary for decision-making by service users/participants;
- respecting service users'/participants' confidentiality;
- taking the service users'/participants' backgrounds into account; and
- maintaining professional competence at the highest possible level (International Federation of Health and Human Rights Organisations [IFHHRO], 2012).

Of particular relevance when working in the field of sexual and gender diversity, is sexual rights. Sexual rights are human rights applied to sexuality and reproduction. These include the right to enjoy, regardless of sex, sexuality or gender, the following:

- equality and freedom of all forms of discrimination;
- the right to free and meaningful participation;
- the right to life, liberty, security and bodily integrity;
- the right to privacy;
- the right to recognition before the law and autonomy over decisions related to sexuality;
- the right to exercise freedom of thought, opinion and expression around sexuality;
- the right to health and benefits of scientific progress;
- the right to comprehensive sexuality education;
- the right to choose whether or not to marry and found and plan a family, including decisions over how and when to have children; and
- the right to hold those responsible for protecting these rights accountable

(International Planned Parenthood Federation [IPPF], 2008; World Association for Sexual Health [WAS], 2014).

PsySSA is a signatory to the IPsyNet policy statement and commitment on LGBTI matters, which provides a good introduction to some of the important considerations when dealing with sexual orientation and gender identity within the sexual and gender diversity area. This document is included as Appendix II for easy reference.

The onus is on every professional, individually, to ensure she or he practices within the confines of the law and ethically. A human rights framework not only represents the legal responsibility of psychology professionals, but also provides a strong basis for practitioners when thinking about providing affirmative practice for sexually and gender-diverse people, as reflected in these practice guidelines.

## Application

Psychology professionals consider and ensure the application of human and sexual rights within their area of work

All registered psychology professionals in South Africa are legally and ethically bound to uphold the human rights of the people with whom they work. As outlined in Guideline 12, continued professional development (CPD) also requires a minimum level of ethical training on an ongoing basis. There are at least three levels where the human and sexual rights of service users/clients/participants need to be upheld and respected by psychology professionals:

- personal/individual level;
- institutional environment – the place where you and/or your work are situated; and
- larger contextual system (community, society, country, global) within which you operate.

When thinking about working with sexually and gender-diverse people, a potentially useful question at each level would be 'How does what I do uphold the human and sexual rights of sexually and gender-diverse service users/participants and

colleagues? And in which ways does what I do not uphold these rights?

A psychology professional could influence the application of a human and sexual rights approach at each of these levels. Professionals should endeavour to exert their influence at all times in all three of these levels of their conduct and their provision of care.

In the continual process of ensuring the realisation of the human and sexual rights of sexually and gender-diverse service users/participants/colleagues, the following can be considered on each level:

In personal practice:

- Understanding and applying an affirmative stance in practice, as outlined in the PsySSA sexual and gender diversity position statement (2013) and in these guidelines (see Guideline 9 in particular)
- Continued adherence to, and professional development on, ethical practice within a human rights framework (see Guideline 12)
- Developing self-awareness of how psychology professionals' attitudes and knowledge regarding sexual and gender diversity is relevant to their practice
- Training, CPD and knowledge acquisition, including diversity appreciation and reduction of prejudice
- Reading and referring to key declarations pertaining to sexual rights, in general, including those of the IPPF (2008) and WAS (2014)
- Reading relevant professional policy documents relating to sexual and gender diversity matters, specifically the PsySSA sexual and gender diversity position statement (2013) and the IPsyNet policy statement and commitment on LGBTI issues (see Appendix II)
- Developing a reflexive practice to distinguish between personal opinions and professional best practice, to enhance the human and sexual rights of sexually and gender-diverse people

- Becoming a member of the PsySSA Sexuality and Gender Division, which embraces an affirmative stance (see Appendix III and <http://www.psytssa.com/divisions/sexuality-and-gender-division-sgd>).

In institutional/work environment:

- Arranging for sexual and gender diversity sensitisation training at your workplace
- Supporting the work of non-governmental organisations (NGOs) in this field, i.e. through corporate sponsorship and/or listings in workplace resource lists
- Assisting colleagues and service users/clients/participants in accessing resources as necessary, including legal resources when dealing with discriminatory practices, such as the barring of same-sex partners from work functions and/or refusal to address a transgender colleague with their preferred pronoun (he/she/him/her)
- Promoting access to resources within the area of sexual and gender diversity, i.e. through related listings in workplace directories.

In society more broadly:

- Exploring ways to advocate for human and sexual rights, in general, as outlined by the IPPF (2008) and WAS (2014) and those same rights for sexually and gender-diverse people specifically. This might include supporting trans and gender-diverse service users, among others, in:
  - » Accessing legal recognition to alter their sex description on their ID. The professional service provider might be engaged in various steps of the process,

**TRANS:** Commonly accepted shorthand for the terms transgender, transsexual, and/or gender non-conforming.

for example, writing a support letter that could be provided to the Department of Home Affairs by the transgender person

- » Approaching their medical aid and/or health insurer (if they are in this position) to apply or appeal for certain health-related services that could be supported by medical aids in South Africa

- » Raising awareness of avenues to report breaches of human rights and discriminatory practice in order to advise service users/clients/participants accordingly, including Chapter 9 institutions, such as the South African Human Rights Commission and Commission for Gender Equality, and the Equality Courts, as established by the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA).

## GUIDELINE 2: Individual self-determination

Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as ‘coming out’) of sexual orientation, or of gender diversity, or of biological variance

### Rationale

The South African Professional Conduct Guidelines in Psychology (PsySSA, 2007) encourage psychology professionals to respect the right to self-determination of service users/clients/participants/patients. This entails a process by which a person controls or determines the course of her or his own life. Self-determination includes the ability to seek treatment, consent to treatment, or refuse treatment. The informed consent process is one of the ways by which self-determination is maximised in psychotherapy (Glassgold et al., 2009).

The principle of self-determination has become controversial, as some have cautioned against providing interventions that have very limited evidence of effectiveness, run counter to current scientific knowledge, and have the potential for harm, despite client requests (Glassgold et al., 2009). Furthermore, research suggests prioritising and privileging individual self-determination are sometimes complex when dealing with sexually and gender-diverse service users/clients/participants (Beckstead & Israel, 2007).

Affirmative psychological support may be beneficial in the identity development and decision-making of transgender and gender non-conforming individuals regarding their social (and medical) transition. Closely aligned to some of the principles highlighted in Guideline 10 (Foregrounding global best practice care), this affirmative and transition-related healthcare support should be offered irrespective of whether the person has a binary or non-binary gender identity and whether they seek access to social or medical transition or one, several, or all treatments available.

In prioritising and privileging individual self-determination, it may serve psychology professionals well to remember that in accordance with the

standards of care for the health of transgender and gender non-conforming individuals (Coleman et al., 2012; WPATH, 2011), these individuals have the right to define their identities, live according to their gender identity, as well as to decide on and to access medical, psychotherapeutic, and social support as needed. The full autonomy of transgender and gender nonconforming individuals in affirming their gender identities ought to be supported.

Trans people should be supported to make informed decisions about their bodies and gender expression without the gatekeeping of health-care practitioners. In Appendix IV, an example is provided of a consent form that is available on the website of Gender DynamiX, a South African NGO that endeavours to advance transgender human rights. The consent form outlines risks associated with hormone treatment towards enabling informed decisions.

**SOCIAL TRANSITION:** The social portion of a transition, in which a transgender person makes others aware of her or his gender identity. Some parts of social transition could include telling people about your gender identity whether or not they are aware of your assigned gender/sex and/or transgender status.

**TRANSITIONING:** (Including social and medical transition) refers to the (permanent) adoption of the outward or physical characteristics of the gender with which one identifies, as opposed to those associated with one’s gender/sex assigned at birth.



Psychology professionals, especially in contexts of psychotherapy and counselling, may at times experience difficulty reconciling their ethical obligations to do no harm; to be congruent by promoting accurate, honest and truthful engagement in their practice; and honouring the client's unique individuality, culture and roles and right to self-determination according to her or his own principles, values and needs. According to Beckstead and Israel (2007), a case in point is whether it can be expected of a sexual and gender diversity-affirming therapist/counsellor to embrace a specific client/patient's initial treatment goal calling for gender identity or sexual orientation change efforts (SOCE), knowing that internalised stigma and heteronormativity may, indeed, be at play. Accordingly, self-determination should rather be viewed together with other ethical principles, such as the provision of services that are likely to provide benefit and avoidance of services that are not effective or have the potential for harm.

Local and international evidence suggests that self-disclosure of sexual orientation, or any form of diversity or difference – while often very challenging – can be beneficial to individual mental health, including improved self-esteem (Matthews, 2007) and lower stress levels (Matthews, 2007). However, a number of factors need to be considered carefully by both the health professional and service users/clients/participants/patients. These include:

- Sexually and gender-diverse people are vulnerable to stigma, prejudice, discrimination and violence (Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008; Nel, 2014);
- 'Coming out' could have an influence on work, family, social standing and intimate relationships (Pachankis & Goldfried, 2013);
- External stigma and persistent discrimination could lead to internalised stigma, low self-esteem and impaired mental health (Matthews, 2007; Pachankis & Goldfried, 2013); and
- This could lead, for example, to some seeking professional help to change their sexual orientation (Greene, 2007).

Different sexual identity management strategies include 'passing', 'covering', 'implicitly out' and 'explicitly out'. Appropriate strategies are a function of both internal belief as well as external

environmental factors. Different life contexts might, indeed, require different adaptive strategies (Lidderdale, Croteau, Anderson, Tovar-Murray, & Davis, 2003). In addition, in many societies, notions of 'the individual' are bound up with notions of family, community and context. Possible tensions between individual agency and a sense of belonging to a community/family need to be managed carefully (Mkhize, 2003).

Despite these challenges, numerous studies acknowledge that sexually and gender-diverse people are deeply resilient and are often able to negotiate hostile environments creatively (Freese, Ott, Rood, Reisner, & Pantalone, 2017).

## Application

With regard to self-determination, psychology professionals are encouraged to consider and refine their practice to ensure –

A focus on resilience and agency

- Psychology professionals should assist in exploring issues of both external and internal stigma with service users/clients/participants, and how this potentially affects their thoughts, feelings and behaviours

### **SEXUAL ORIENTATION CHANGE EFFORTS (SOCE):**

Also known as 'reparative therapy' or 'conversion therapy' is psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change her or his sexual orientation.

**INTERNALISED STIGMA/OPPRESSION:** Also known as 'internalised homo-/transphobia' or 'internalised negativity', it refers to the internalisation or absorption of negative attitudes (a personal acceptance of such stigma as part of one's value system and self-concept).

- Psychology professionals should strive to help service users/clients/participants develop a positive sexual and gender identity and have them analyse, explain and deal with internalised stigma regarding their sense of self, sexual orientation, gender identity, biological variance and sexual practices that may be deemed 'safe, sane and consensual'
- Consideration should be given to placing an emphasis on developing the client's sense of agency, including the broadening of options and strategies for dealing with their contexts, and the confidence to explore these
- Psychology professionals respect the right of service users/clients/participants to be called by the name of their choice and relevant pronouns and accept individual choices as to the extent to which they wish to transition (i.e. in the case of a transgender person, either/or both hormones and surgery)
- Psychology professionals ensure that they and those they work with understand that 'coming out' is a process, and about much more than letting others know about their sexual orientation, gender identity and/or biological variance and sexual practices. It should be based on developing a positive sexual and/or gender identity and dealing with internalised stigma
- Coming out is not an all or nothing 'event' – it can start (and stop) with one person
- Coming out and developing positive stories to share with others is a process the individuals themselves control and direct
- Service users/clients/participants should be prepared for both positive and negative reactions to the affirmation of themselves, as well as their choice to share information about their sexuality, gender identity and expressions with selected others
- Coming out should be a decision that the service users/clients/participants make for themselves, taking into consideration the context of their individual situation. For instance, with regard to trans disclosure, individuals should be able to live 'stealth' if they want to
- Service users/clients/participants or patients should be guided to understand that 'coming out' is a lifelong process as there will be situations and times when further disclosure or discussions will be needed in the ongoing heteronormative context in South Africa
- Under no circumstances should psychology professionals attempt to pressurise service users/clients/participants to come out in the belief that this will be 'better' for them.

#### The duty of care

- Psychology professionals should strive to help service users/clients/participants assess their physical safety and should explore ways to mitigate negative reactions at the workplace, at home and in faith, health and education contexts.
- Psychology professionals should strive to ensure that service users/clients/participants have a network of support, including helping people to connect with non-governmental organisations (NGOs), online social networks and other supportive platforms.

#### Ethics and confidentiality

- Ethical matters, as it applies to communicating with the client's family, consulting with

**STEALTH:** For a trans person going stealth is generally the goal of transition. It means to live completely as her or his gender identity and to pass into the public sphere being sure most people are unaware of their transgender status. This does not mean their status is a secret to every single person; family and close friends may know. Some transsexuals and most genderqueer and bigender people purposely do not go stealth because they want the people around them to know they are trans. Some desire to go stealth, but are unable to pass convincingly enough. Historically, going stealth is a very recent phenomenon since, for many people, hormones are necessary to pass.

other professionals, as well as in providing assessment or evaluation reports, should be given careful consideration, as is general practice

- Psychology professionals are ethically bound to keep all information shared by service users/clients/participants confidential at all times, except if compelled to disclose such information by law, or to avoid immediate harm to the client or others
- Other than under these rare circumstances, no confidential information should ever

be disclosed to other people without the informed consent of the client. Such consent should ideally be obtained in writing

- Service users/clients/participants should be aware of these conditions of utmost confidentiality and be reassured of them when necessary
- Thus, regardless of how significant a psychology professional might feel other people are in the client's life, no disclosure is made unless the informed consent of the client is obtained.

## GUIDELINE 3: Enhancing professional understanding

Psychology professionals acknowledge and endeavour to understand sexual and gender diversity and fluidity, including biological variance

### Rationale

For both psychology professionals and individuals seeking assistance, the language and concepts of sex, gender, identity and orientation can be complex and confusing. What does it mean to be gay or straight, a woman or a man? Or none of these social constructs? Meanings matter. The consequences of imprecision of language, lack of understanding and misunderstanding may be profound, particularly in terms of a reduced sense of agency and options for service users/clients/participants. The real-life experiences of individuals often do not conform to the academic categorisations that professionals use, and this might cause additional challenges (Niels, 2001).

In the English language, the distinction between 'sex' and 'gender' was only emphasised in the 1950s and 1960s by British and American psychiatrists and other medical professionals working with intersex and transsexual people (Esplen & Jolly, 2006). Professionals need to recognise how profoundly sex and gender are conflated in popular discourse. In reality, what it *means* to be a woman and what it *means* to be a man or neither differ among societies, and change over time even within societies. But many social forces, and socialising agents in society, including many religions and cultural systems, strive to make people believe that there are only two gender categories and that these gender categories – i.e. 'men' and 'women' – have fixed meanings, which are natural, eternally enduring and universal. An affirmative stance challenges these myths: for some persons, identity issues are not necessarily linear, moving in a 'forward' direction to an end point or on an inevitable journey from A to B. Trans persons, for instance, may seek to reverse certain processes or may arrive at a different understanding of who they are (now) as they age.

Psychology professionals should help service users/clients/participants understand that, although concepts of biological sex, sexuality and gender are interrelated, they are not necessarily dependent on each other. Towards enhanced professional understanding, these concepts are now analysed and evaluated.

### *Biological sex and variance*

The biological sex of a person is the biological and physiological characteristics that are socially agreed upon as informing the classification of a person as male or female or intersex (Victor et al., 2014). Even these supposedly 'scientific' categories can differ from society to society. While the determination of 'sex at birth' ought to entail an assessment of complex biological components, including genitalia (internal and external reproductive organs), sex hormones and sex chromosomes, more often only external genitalia are considered. Other investigations often only occur in the event of ambiguity. Importantly, the biological sex assigned at the birth of a person is not an indication of the person's gender identity and/or expression, sexual orientation or sexual behaviour.

Intersex, as classification, is often insufficiently understood and under-recognised and therefore receives specific mention in this section about [biological sex and variance](#). [Intersex](#) refers to the variations (genetic, physiological or anatomical)

**BIOLOGICAL VARIANCE:** A term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals.

in which a person's sexual and/or reproductive features and organs do not conform to the dominant and typical definitions of 'female' or 'male' (Fausto-Sterling, 2012; Harper, 2007). There are many different forms of intersex, including external genitals that cannot be easily classified as male or female; incomplete or unusual development of the internal reproductive organs; inconsistency between the external genitals and the internal reproductive organs; non-typical sex chromosomes; non-typical development of the testes or ovaries; over- or underproduction of sex-related hormones; and inability of the body to respond typically to sex-related hormones (Kemp, 2013; Rebello, Szabo, & Pitcher, 2008; Wiersma, 2004).

Early surgery, framed as normalising the genitalia of an intersex child, might lead to gender dysphoria and more generalised distress in later life (Rebello et al., 2008). The disclosure of an intersex diagnosis could be challenging for parents. In contexts where the family and the social environment are not supportive of sex markers outside the male–female binary, early determinacy of sex might be to the emotional benefit of the child, as experienced by two paediatric surgery units in Gauteng and KwaZulu-Natal (Rebello et al., 2008; Wiersma, 2004). Also, in some contexts where ignorance and prejudice are rife, a child presenting with externally visible differences may be at risk of harm by others.

Lev (2006, p.26) suggests withholding unnecessary surgeries until children are old enough to be involved in decisions regarding their medical treatment, to prevent psychological challenges, i.e. body image challenges associated with ambiguous genitalia, questions about sexual orientation, gender insecurity or doubts about correct gender assignment. Physical trauma from the surgery itself could create physical health problems, impaired fertility, physical scarring, cosmetic challenges, and decreased sexual response. Since intersex variations in families are often hidden, psychological support is often not requested or known to be available (see Guideline 10 for international best practice considerations).

### *Gender and how it is 'made'*

The term 'gender' refers to the behaviour, activities, and attributes that a particular society claim men and women should have. 'Gender' is a specific social construct – every society teaches children

and adults what it means 'to be a man' or 'to be a woman' in that society (Anova Health Institute, 2016). And, although most societies distinguish between two genders, corresponding to the understanding by those societies and their construction of biological sex, some societies recognise other gender possibilities (World Health Organization [WHO], 2015).

In many societies, deeply entrenched practices and systems of patriarchy have developed prescribing that certain behaviours, roles, tasks and even jobs are associated with a person's biological sex. These power systems are based on notions that men are considered 'superior' to women and their roles in society are elevated and privileged (Wilchins, 2014). In these societies, 'masculine' characteristics – such as rationality and competitiveness – are considered superior and valued above 'feminine' characteristics – such as emotionality, cooperativeness and nurturing – which are undervalued

**INTERSEXUALITY:** A term referring to a variety of conditions (genetic, physiological or anatomical) in which a person's sexual and/or reproductive features and organs do not conform to dominant and typical definitions of 'female' or 'male'. Such diversity in sex characteristics is also referred to as 'biological variance' – a term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals.

**GENDER DYSPHORIA:** Also known as gender identity disorder (GID), is the dysphoria (distress) a person experiences as a result of the sex and gender assigned to her or him at birth. In these cases, the assigned sex and gender do not match the person's gender identity, and the person is transgender. There is evidence suggesting that twins who identify with a gender different from their assigned sex may do so not only due to psychological or behavioural causes, but also biological ones related to their genetics or exposure to hormones before birth.



and sometimes even derided. In many societies, women perform the bulk of domestic labour in terms of cooking, cleaning and child rearing, despite also being part of the modern workforce (Wilchins, 2014).

These conventions have been challenged throughout history and in every society and are always being challenged or defended in different ways. More and more people realise that, despite these imposed social expectations, most people in reality have a combination of what are conventionally described as ‘masculine’ and ‘feminine’ characteristics and expressions. There is no task, or job, such as security that belongs to men, or nursing that belongs to women. Gender is more accurately viewed as a spectrum, rather than as binary ‘opposites’ and/or fixed positions (Wilchins, 2014).

In South African society, this kind of ‘gender binary’ approach and other key ideas of patriarchy are strongly upheld (Vipond, 2015). It is important to note that many of the key ideas – to cite just one example, that women should do all, or almost all housework, regardless of having other employment – are often reinforced with violence. South Africa has some of the highest levels of domestic violence in the world (Abrahams, Jewkes, Hoffman, & Laubscher, 2004; Abrahams, Jewkes, Martin, Matthews, Vetten, & Lombard, 2009). In addition, such a rigid and oppressive model of gender and sexuality limits the course of action available to men in that a normative male identity is associated with expectations of invulnerability and self-reliance (Lynch, Brouard, & Visser, 2010).

In addition to high levels of violence, and despite the progressive nature of South Africa’s Constitution and some laws, there are still a number of areas which conflate biology and gender and segment gender in particular ways, or which reinforce narrow and often oppressive stereotypes. For example, there are now laws allowing a person to apply for a legal adjustment of their sex description without genital surgery (Klein, 2008). However, while intersex people are recognised by law, sex classifications do not reflect this and still only provide for two sexes (male and female), excluding intersex and so forth. This kind of conflation and confusion often underpin heterosexist assumptions and prejudice.

This broad term, ‘gender’, also encompasses transgender, queer, gender diverse, trans diverse,

bigender, people who are androgynous, gender non-conforming, gender questioning and those who choose to defy what society ‘tells them’ is appropriate for their gender (APA, 2015). For example, a genderqueer person’s gender identity falls outside of the gender binary (i.e. such a person identifies with neither or both genders). A genderqueer person may also identify as genderfluid, but may be uncomfortable or even reject self-identification as trans binary (APA, 2015).

‘Queer’, is a word that has been re-appropriated or reclaimed since the late 1980s with multiple, interlinked meanings. This includes using it as an expansive term covering the spectrum of sex, sexual, and gender differences, or of the term being used socio-politically by people who strongly reject traditional gender identities, reject distinct sexual orientation labels, or who actively reject heteronormativity and homonormativity.

Gender identity is also an important concept. It is a person’s internal sense of being female, male or another gender (Müller, 2013). Gender identity is internal, and refers to how people *feel about themselves* in the world, that is, ‘feminine’ or ‘masculine’. A person will use a word that describes her or his gender that makes sense to her or him. It is deeply rooted and a significant part of a person’s being.

For cisgender people, this sense of being a woman or a man is congruent with their sex assigned at

**GENDER ASSIGNED AT BIRTH:** Gender assignment (sometimes known as sex assignment) is the determination of an infant’s sex at birth. In the majority of births, a relative, midwife, nurse or physician inspects the genitalia when the baby is delivered, and sex and gender are assigned, without the expectation of ambiguity. Assignment may also be done prior to birth through prenatal sex discernment. AFAB (assigned female at birth) and AMAB (assigned male at birth) are commonly used terms to refer to gender/sex assigned at birth. While many people use the terms ‘sex’ and ‘gender’ interchangeably, they are, in fact, two separate characteristics.

birth (Müller, 2013; Wilson, Marais, De Villiers, Addinall, & Campbell, 2014). Transgender people experience themselves as being different from their natal sex and/or gender assigned at birth. Their gender identity and mental body image thus do not correlate with their physique and/or sex and/or gender assigned at birth (McLachlan, 2010) and they experience an incongruity between their birth gender and their self-identified gender (Sanchez, Sanchez, & Danoff, 2009). For instance, someone may be assigned male at birth (MAB), yet have a female or feminine gender identity.

An affirmative stance suggests that psychology professionals have a deep appreciation for the reality that gender and gender roles are not fixed. Society, social norms and culture are also forever changing. Gender is a spectrum, and there are people whose gender identity differs from the typical binary (Wilson et al., 2014).

### ***Sexuality and sexual orientation***

Attraction, emotional expressions of love, intimacy and desire differ greatly from one person to another. Sexuality, also, is a spectrum and some may move constantly along this spectrum. Sexual orientation refers to a person's enduring emotional, romantic, sexual or affectionate attraction to others and, although 'heterosexual' is the dominant and expected norm for sexual orientation, various other orientations including lesbian, gay, bisexual and many others are as valid, deeply felt and enduring (APA, 2012; Victor et al., 2014). It is very important to note that people may have sex with other people for a variety of reasons other than as an expression of their sexual orientation (Anova Health Institute, 2010). They may regularly have sex with others of the same gender, without seeing themselves as lesbian or gay (Brown, Duby, & Van Dyk, 2013). In the public health context, especially in relation to the prevention of human immunodeficiency virus (HIV) infection and other sexually transmitted infection (STI), the terms MSM (men who have sex with men) or WSW (women who have sex with women) are typically used, and refer to sexual behaviour, not sexual orientation.

Bisexuality is often misunderstood by both members of sexually and gender-diverse communities and heterosexual communities. Often which community is supportive of one's sexuality is dependent on the sex of your partner. Depending on

the sex of your partner one may have to 'come out' and/or explain that a heterosexual pairing does not mean you are heterosexual. Such assumptions could often prevent clients from feeling safe (sexual identity should not be tied to sexual activity).

'Asexuality' is a sexual orientation that is often neglected and misunderstood. It is important to note that some people strongly assert no attraction to any sex, maintaining asexuality as their

**MSM (MEN WHO HAVE SEX WITH MEN):** Used in public health contexts to refer to men who engage in sexual activity with other men, including those who do not identify themselves as gay or bisexual, to avoid excluding men who identify as heterosexual. Note, trans men may also be included in such a description.

**WSW (WOMEN WHO HAVE SEX WITH WOMEN):** Used in public health contexts to refer to women who engage in sexual activity with other women, including those who do not identify themselves as lesbian or bisexual, to avoid excluding women who identify as heterosexual. Note, transwomen may also be included in such a description.

**SEXUAL BEHAVIOUR:** 'Sexual behaviour' is distinguished from 'sexual orientation' because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour. Individuals may engage in a wide range of behaviours and practices often associated with sexuality. These can include bondage and discipline and sadomasochism (BDSM), which have nothing to do with sexual orientation and/or gender identity. BDSM may also refer to a specific lifestyle or subculture comprising participants who regularly engage in such practices. Although some individuals are likely to participate in BDSM practices in various ways, many psychology professionals may be unfamiliar with the diversity, terminology, possible motivations and matters surrounding their service user/client/participant's lifestyle. BDSM potentially may be enriching and beneficial to many who safely participate (in this regard, the operative terms are 'safe, sane and consensual'), or it sometimes may be considered pathological and destructive.

sexual orientation (Academy of Science of South Africa [ASSAf], 2015).

A word of caution: The terms androphilia and gynaephilia may be useful in describing trans people's sexual orientation, which might be confusing and easily offensive (e.g. defining one's sexual orientation based on one's gender assigned at birth): it generally is less problematic to refer to who someone is attracted to without having to define that person's gender or sex.

### **Relationships**

Although there are many types of intimate relationships and sexual partnerships in all societies, monogamy is often assumed to be the default relationship identity or orientation. But many people are in more than one relationship at the same time. Some of these might be publically known but many are kept secret because of a particular society's norms and expectations. In many societies, for example, 'polyamory' – where more than two people are in a relationship with each other at the same time – is fairly common. Polyamory is often based on openness, i.e. everyone involved has consented. Sometimes referred to as "multiple concurrent romantic relationships with the permission of their partners" polyamory is under-recognised and under-researched (McCoy, Stinson, Ross, & Hjelmstad, 2015, p.134).

Professionals need to be sensitive and open to challenging the heteronormative assumptions that the only legitimate relationships are those that occur between a single man and a single woman. Often such assumptions could prevent clients from feeling safe enough to speak about their relationship orientations with their psychology professionals, out of fear of judgment and a lack of understanding that people could have meaningful relationships outside of monogamy.

ASSAf affirms that the concepts 'sexuality', 'sexual orientation', and categories such as 'homosexuality', 'heterosexuality', 'bisexuality' and 'asexual', mean different things in different societies at different times (ASSAf, 2015). In South Africa, an understanding of these different concepts is important for a psychology professional.

## Application

Psychology professionals are encouraged to be aware of the intricacies and complexities of human lived experience by:

- Recognising and understanding sexual and gender diversity from an affirmative stance, one that is consciously inclusive of the broad sexual and gender diversity spectrum
- Actively exploring and challenging one's own values and assumptions, and reflecting on the influence of socialisation on one's sexuality
- Striving for openness and acceptance of such diversity and respect for the unique and fluid lived experience of others
- Understanding that sexual orientations and

**ASEXUAL:** A person who has low or no sexual desire, little or no sexual behaviour, and a concomitant lack of subjective distress. Identifying as asexual does not preclude the ability for the person to have a romantic or love relationship with someone of the same and/or different gender.

**ANDROPHILIA:** 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation, as an alternative to a gender binary same-sex and heterosexual conceptualisation. Androphilia describes sexual attraction to men or masculinity.

**GYNAEPHILIA:** 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation as an alternative to a gender binary same-sex and heterosexual conceptualisation. Gynaephilia describes the sexual attraction to women or femininity.

**POLYAMORY:** A relationship configuration where a person has more than one intimate or sexual partner with the knowledge and consent of all partners involved, and with an emphasis on honesty and transparency within relationships. Polyamory is considered a minority relationship orientation, where monogamy is the dominant orientation. What makes polyamory seem deviant is the openness and honesty of being involved with multiple concurrent relationships, as opposed to cheating (hidden concurrent relationships), which is almost anticipated. It is also described as 'consensual non-monogamy'.

gender identities outside of the normative are not mental illnesses but are variants of human sexuality and gender identity and expression. These orientations are in no way abnormal, except in a strictly statistical or legalistic sense of 'not being the norm' in a given society at a given time

- Not assuming that mental health challenges are due to the individual's sexual orientation, sexuality, gender identity or expression. In this regard, being mindful of the therapeutic goals and what the person is consenting to focus on in the professional contact is important (For example, a trans person could present for bereavement and have no need or desire to focus on her or his gender identity)
- Taking into account the negative mental health effects of stigma-related stress and processes and how resilience could be developed to deal with negative effects of stress, as proposed in Meyer's minority stress model (I.H. Meyer, 2003) (see Guideline 6)
- Aiming for a deeper understanding of all the variations in the meaning of sexual and gender identity and relationship identity
- Being aware that some medical interventions at times required in intersex and transgender-affirming care, such as hormonal treatments, may affect emotional states and appropriate coping strategies for new emotional experiences
- Becoming familiar with alternative expressions of eroticism, creative sexual stimulation, and intimacy (see for instance <https://fetlife.com/>).

Psychology professionals are encouraged to understand sexual and gender diversity and fluidity in a non-binary and a non-heteronormative way by:

- Continuously exploring and questioning their own personal and professional knowledge and experiences, and how these could affect the individual seeking psychological assistance related to her or his sexuality or gender (Victor & Nel, 2017)
- Understanding that individuals could have a

range of gender identities and expressions and their gender identity might not be aligned to sex and/or gender assigned at birth

- Ensuring that identity and orientation are not imposed or forced, whether overtly or covertly
- Understanding that the journey of identity development could be highly complex and bewildering for the client/patient/participant
- Assisting people to differentiate between gender identity, sexual orientation and sexual behaviour, also understanding that these might be intertwined yet separate journeys for the person, for example a transgender man could have any sexual orientation or a lesbian might have sex with a man, and still identify as lesbian
- Taking into account the person's cultural and social context, with an emphasis on the potential implications for violence and other forms of stigmatisation and discrimination with which the non-conforming person has to deal
- Keeping in mind how the resilience of individuals could be further affirmed, including engaging with the potential experience of ambiguity of feelings around assigned sex, gender identity and expression, sexual orientation and sexual behaviour.

The way the psychology professional uses sexual and gender diversity language should encourage acceptance. Psychology professionals are encouraged to consider carefully the use of language in all areas of practice. To do this, they should:

- Be mindful that the terms which the individual chooses to use to describe her- or himself, might not be academically or ethically acknowledged. Allow for self-identification and self-labelling
- Enquire which pronoun the client prefers to use, i.e. 'he', 'she', 'they' or 'them'
- Enquire which titles are preferred, including but not limited to the titles Mx, and not just Mr, Ms and Mrs
- Ensure that the ways in which questions are phrased and how they respond should be

inclusive rather than exclusive of the ways people express themselves. Here suggestions include providing a range of options for capturing demographic information to ensure inclusivity, for example:

- » when taking a history, allow for identities other than male/female;
- » be mindful of separating sex assigned at birth from gender identity and gender expression;
- » measure sexual orientation using more complex methods by including self-

identification, sexual and emotional attraction and not just sexual behaviour. This implies the need for questions about 'how do you think/feel about ...', and not just questions such as 'what do you do sexually'; and

- » be mindful that some service users/clients/participants may orientate to polyamorous relationships more than to monogamous relationship identities.

It is important to acknowledge that the client is best placed in guiding which identity options and pronouns to use.



## GUIDELINE 4: Awareness of normative social contexts

Psychology professionals strive to be aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative and cisnormative contexts

### Rationale

Many assumptions accompany 'heterosexuality' and 'heteronormativity'. One such assumption is that there are only two fixed genders, and that gender always reflects the person's sex as assigned at birth. Most critically, an associated assumption is that only sexual attraction between the 'opposite' genders can be considered normal or natural. 'Heteronormativity' also refers to the privileged position associated with heterosexuality: societies are constructed to reward behaviours that conform to heterosexuality, and punish those that do not. As outlined in Guideline 3, the influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities as well, that is, it serves to regulate not only sexuality but also gender (Chambers, 2007; Rubin, 2011; Steyn & Van Zyl, 2009; Victor et al., 2014; Warner, 1999). For example, a key heteronormative assumption is that all people are attracted to the opposite sex, all people identify with their sex assigned at birth, all people should be in a single committed relationship with one other person, preferably for life, and all people wish to (and should) procreate.

Regardless of progressive laws, the prevailing culture and religious beliefs may be conservative and unsupportive of sexual and gender diversity. Sometimes there is a disjoint between policy and how it is actioned. Where normative beliefs are imposed on everyone, sexually and gender-diverse people are often seen as something 'lesser', and less deserving of social goods and affirmation. Marginalisation from the mainstream could undermine mental health and is often internalised by the person, who may not be aware that these are normative assumptions, and neither universal nor eternal 'truths'.

There are many examples of how heteronormativity is maintained and extended by South

African society, also in health systems (Müller, 2015). These include the type of questions that are asked in a first interview, and subsequent sessions, and the way services are advertised (for example, many advertisements for health services might only feature images of heterosexual couples and 'nuclear families'). Heterosexuality is also reflected in curricula, school and tertiary education (Blake 2016; Müller & Crawford-Browne, 2013) and is usually strongly promoted. For example, from an early age, most children are exposed to cultural bias, which gives preference not only to men relative to women, but also to opposite-sex sexual relationships relative to same-gender sexual relationships. A heteronormative model suggests the traditional family unit consisting of a stereotypical mother-father with their own biological offspring as the only viable and affirmed model. When a construct like 'family' or 'marriage' is used, it is usually implied that these unions are heterosexual in nature. Often when referring to same-sex families, the phrases are given different and marginalising names, for example, a 'lesbian family' or a 'gay family' (Breshears & Lubbe-De Beer, 2016).

Furthermore, heteronormativity adversely affects sexually and gender-diverse people within their families, schools, legal systems, places of work, religious and cultural traditions and communities.

It is important to note that conversely, the notion of homonormativity also needs to be

**HOMONORMATIVITY:** The system of regulatory norms and practices that emerges within homosexual communities and which serves a normative and disciplining function. These regulatory norms and practices need not necessarily be modelled on heteronormative assumptions, but they often are.



understood. This refers to ways in which some gender non-conforming communities create and make their own norms and practices. These are not necessarily modelled on heteronormative assumptions, but they often are (Rabie & Lesch, 2009; Reygan & Lynette, 2014). For instance, Moodie (1987, p.16) refers to mine “wives”, where younger men (*umfaan*) took on the behaviour of women in their relationships with their “spouses”, the miners, thus mimicking the expected gender roles, the heteronormative ideal. Homonormative assumptions could create negative experiences for genderqueer people as they often misrepresent/dismiss their identity.

This is problematic because homonormativity not only often copies or mimics heteronormative characteristics, but often also privileges those whose identities match dominant ‘socio-homo’ norms more closely (Chappell, 2015). For example, many mainstream ‘homosexual cultures’ continue to privilege identities that mirror constructs of (Western-centric) hegemonic (hetero) masculinity, i.e. young, muscular, athletic, rich, white (Oswin, 2007). In doing so, older, poor, black, disabled queers and certain queer cultures are often excluded from homonormative spaces.

Furthermore, homonormative and heteronormative assumptions place trans-cisgender couples in a difficult position. For example, in a trans-cisgender relationship, the trans masculine person could view themselves (note, ‘himself’ is not used as not all masculine off-centre people use he/him pronouns) as heterosexual, whereas the cisgender female partner may view themselves as lesbian or queer. It would therefore be quite detrimental for this couple if the therapist assumed they are a heterosexual couple or a queer couple, per se. As previously established, identity-related definitions should be driven by the service user/client/participant, rather than the therapist. In addition, each individual in the couple’s counselling session may well experience the appropriateness of psychotherapy considerably differently.

### ***An issue of privilege***

In most societies, heterosexuals are granted a form of automatic rights and privileges just by being born and living in a heteronormative society. For example, heterosexual and cisgender people are almost never confronted and asked to share intimate details about their sexual and gender

identity. This is not the case for sexually and gender-diverse individuals. In a heteronormative, cisnormative society, being same-sex attracted, transgender or intersex is mostly shamed or misunderstood. Because of external stigma, for example, sexually and gender-diverse individuals may have negative self-beliefs, especially initially in the first stages of coming out. As explored in Guideline 2 (and later in Guideline 6), the negative self-hating and self-shaming views often manifest as internalised stigma and/or oppression, also called ‘internalised homo-/transphobia’. Often this internalised shame is amplified by ongoing non-acceptance from significant people in the life of the sexually and gender-diverse individual (Vu, Tun, Sheehy, & Nel, 2011). As is further explored in Guideline 5, various privileges of orientation also intersect with privileges that derive from race, class, ethnicity and gender.

## Application

Psychology professionals are encouraged to recognise that there is privilege embedded in being heterosexual, cisgender and typically sexed by:

- Understanding that affirmative practice could become a powerful tool in establishing rapport and a more trusting relationship
- Understanding that initially, a same-sex attracted person could present with severe ego-dystonic feelings related to her or his sexual orientation. The self-loathing and self-hatred could present in a desperate wish not to be attracted to members of the same sex. It is imperative for the psychology professional to understand the deeply entrenched conflict, fed by a heteronormative society, which the individual is experiencing
- Being mindful that same-sex attracted people often have to justify, rationalise and defend their love for another or their sexual attractions and desires to a person of the same sex or gender
- Being mindful that constructed norms about reproduction and family often present obstacles for the sexually and gender-diverse service user/client/participant, which they have to navigate carefully

- Being aware of the effect of homonormativity on individuals not fulfilling, for example, the hegemonic masculine ideal (for example, a middle-aged, disabled gay man)
- Evaluating the ways in which institutions enforce heteronormativity in areas such as recruitment, career assessment and promotion
- Assisting sexually and gender-diverse people in navigating the workplace, dealing with both the internalised stereotypes of the service user/client/participant, as well as their strategies for dealing with matters such as prejudice
- Being mindful that sexually and gender-diverse people might be distrustful of psychology professionals based on their previous experience of being pathologised or marginalised
- Considering the ways in which work settings may reflect a heteronormative or cisgender ideal that may be perceived as alienating, for example, portraits and paintings, facilities, or standard forms, reflecting exclusivity of sexual and gender diversity
- Understanding that, given the challenges faced by sexually and gender-diverse service users/clients/participants, the psychology professional might have to become an advocate for her or his client beyond the normal scope of individual practice. This could include training the broader institutional setting around sexual and gender diversity, as well as negotiating with institutions and contexts on behalf of the service user/client/participant
- Understanding that trans–cis couples might each have different expectations in a couple’s counselling session/psychotherapy.

## GUIDELINE 5: Intersecting discriminations

Psychology professionals are sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive-emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality

### Rationale

People – including psychology professionals and their service users/clients/participants – have many different sides to their identity, and it is useful to think about everyone having a shifting *matrix of identities* that constitutes a whole person. The ‘matrix of identities’ is really about structural positions, not ‘an inner sense of who people are’, although people might express these as ‘who they are’. These include gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory, cognitive and emotional disabilities; health status, including HIV and AIDS status; being internally or externally displaced, including seeking asylum, geographical differences such as urban/rural dynamics, and matters of faith, religion and spirituality. Furthermore, identities operate in different ways – they are not all the same: ‘life stage’ and ‘race’ are not the same, and, of course, race is also a structural imposition.

Psychology professionals need to think about their own but also the identities of service users/clients/participants in a more subtle and nuanced way. Practitioners should strive to achieve a heightened sensitivity and empathy when these diverse identities intersect with a sexually or gender-diverse person.

Intersectionality in psychology, as a concept, acknowledges this diversity and focuses on attending to all the different forms of oppressions that occur in society – the different ‘-isms’ – racism, ableism, heterosexism, sexism, classism, etc. and the ways they overlap and often reinforce a power that could potentially subjugate one cultural group in terms of another. Being a minority within a minority (for example, being intersex and an immigrant) could deepen one’s sense of isolation and disconnection from the statistical and

cultural majority. The APA (2012, p.12) notes, “the cumulative effects of heterosexism, sexism, and racism may put lesbian, gay, and bisexual racial/ethnic minorities at special risk for stress”, which adds to the vast range of contextual factors that worsen the effects of stigma (Greene, 1994). This is often described as ‘minority stress’ (I.H. Meyer, 2003). Multiple layers of discrimination that a person might potentially experience could create multiple and intersecting levels of stress.

These potential sources of distress and conflict could present in countless, complex ways. Practitioners are therefore advised to remain aware of the challenges that sexually and gender-diverse individuals face having to negotiate multiple identities in a number of contexts. In some contexts, certain identities are advantageous and normative, and are therefore foregrounded, while in other contexts, those identities might be distressing or dangerous, and therefore downplayed. For example, being black in South Africa means being part of the numerical majority, despite ongoing structural racism; however, being black and gender non-conforming displaces one from this group. Additionally, being black, gender non-conforming and a refugee, living in an area where one is forced to speak a language with which one is unfamiliar, while looking for work add to the multiple intersecting identities the person must negotiate.

**INTERSECTIONALITY:** The interaction of different axes of identity, such as gender, race, sexual orientation, ability and socio-economic status, in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways.

People live very different lives, and an ‘intersectional lens’ could help psychology professionals to appreciate the complexities of these lives better. In the case of religion, for example, there are significant cultural differences in South Africa between being a gay Indian man who is Hindu and being a gay Indian man who is Muslim. There is a strong sense of Hinduism being generally neutral about sexually and gender-diverse people, and Islam being sternly disapproving, although collective Indian ‘culture’ in South Africa is generally critical of sexual and gender diversity (Pillay, 2014).

Researchers may often conflate religion and race and ignore the differences amongst groups that appear to share many similarities, e.g. ignoring the diverse religious affiliations amongst South African Indians, or among South African Africans, and among other groups, or underplaying the implications of these differences. Or, consider the negotiation of identities for openly lesbian black women who live and work in cosmopolitan urban areas and speak English in their multi-racial circle of middle-class friends – but who have to conceal numerous aspects of identity when visiting family in rural villages. In another context, for example, think of a transwoman, engaging in sex work, having to take HIV and tuberculosis (TB) treatment by accessing services at the local clinic where there are employees who live in her community. What are the consequences of this difficult negotiation on the well-being of the person? How are globalised and localised aspects of oneself, specifically with regard to gender and sexuality, internally and externally negotiated in different contexts?

It may serve us well to remember that both race and culture are dynamic constructs. Critical race theory tells us race is not a biological truth – and of course culture is made and remade every day – and so at an application level, white practitioners might impose essentialist ideas of race and culture and indeed within, say, African cultures and communities, both racial and cultural pride (or policing) might be used to exclude those who are ‘un-’.

When using or producing research, psychology professionals should be aware of the intersectionalities reflected in the research. For instance, until recently, research in South Africa tended to reflect the experiences of white middle-class, urban men and, sometimes, white women (Gevisser & Cameron, 1995; Potgieter, 1997). Some academics

have started expanding the research focus to explore the specific dynamics of intersecting identities and how these identities play out in diverse contexts. These new studies are now foregrounding and making race, class, geography and other previously marginalised dimensions of identity visible (see, for instance, Diesel, 2011; Graziano, 2004; Henderson & Shefer, 2008; Hoad, 2007; Livermon, 2012; Muholi, 2012; Pillay, 2014; Rankohta, 2005).

Despite sexual orientation change efforts (SOCE) being scientifically unsupported (whether psychological and/or those approaches that use a more religious frame), the effects of SOCE are poorly researched amongst minority groups in particular (APA, 2009). Given the pluralistic society within which they find themselves working, South African practitioners are likely to come across a multitude of traditional, indigenous, religious, ‘tribal’ and even quasi-scientific methods that sexually and gender-diverse people have to endure at the hands of people who want to change the sexual orientation, identity and/or behaviour of these sexually and gender-diverse people. These SOCE may appear in the guise of harmless religious or spiritual interventions, but could have longstanding negative consequences for the person. This is one example of many where cultural significance and meaning are often ignored in attempts to understand sexually and gender-diverse people (Murray & Roscoe, 1998).

## Application

### ***Practitioners are urged to remain aware of the multiple intersecting identities of sexually and gender-diverse individuals***

Practitioners should not assume that sexual and gender diversity is necessarily the most prominent aspect of identity for sexually and gender-diverse people. Identity is influenced by many combinations of factors, which could be biological, psychological, social, economic, cultural, geographical and religious or spiritual. Practitioners must therefore always assess the relative influences of all these factors when attempting to understand or empathise with a client, student or research participant. At different points in one’s lifespan, different factors might be foregrounded and be of particular significance to the person. During an initial interview for psychotherapy, for instance, a

psychotherapist should not assume that sexuality or gender is going to be the focus of discussion, point of departure, or therapeutic concern for a sexually and gender-diverse client. Instead, as Rothblum (2012: p.268) urges, “we must view our users/clients/participants, research participants, friends, neighbours, co-workers – as well as ourselves – as forming multiple, interlocking dimensions, each one adding colours, shades and hues to a rainbow tapestry”.

***Practitioners are urged to remain aware of the diversity of experiences amongst sexually and gender-diverse individuals***

Practitioners must acknowledge the vastly different experiences of being sexually and gender diverse based on other contextual issues facing the sexually and gender-diverse individual. In a group context, for example, it is quite possible that individuals have as many differences as they have similarities; and one should not assume that all sexually and gender-diverse individuals' life experiences reflect similar processes, matters or events. In fact, given the high levels of inequality in South African society, different segments of society have substantially different lifestyles – dependent especially on race, class, health status and geographical location.

As explored in Guideline 2, coming out and disclosing one's sexual orientation to friends and family is often considered to be a healthy aspect of the process of accepting one's sexuality, but may not be an option for a gay individual who is at risk of being isolated from her or his community. For example, Bonthuys and Erlank's (2012, p.269) study of attitudes of Muslim people in Johannesburg revealed that community attitudes to homosexuality “usually involve denial and secrecy in order to maintain the social fabric of daily life and relationships between community members”.

***Practitioners should remain cognisant of the enduring effects of colonialism, apartheid and postcolonialism on the lives of sexually and gender-diverse individuals***

Since 1652, when the first Dutch settlers arrived in South Africa, the lives of black South Africans have been consistently destabilised and dehumanised. Centuries of racial prejudice and discrimination, rooted in a worldview of white racial supremacy, manifested itself as slavery, apartheid,

and more recently, neo-liberalism. Despite more than two decades of democracy since 1994, the enduring effects of apartheid's social engineering has left centuries of this inequality intact. As a result, heteronormativity operates within an equally problematic ideology of white supremacy, ordering and reinforcing normative values, attitudes, beliefs, behaviours, and cultural activities in society. These value systems sometimes filter into 'gay-friendly' spaces that mirror the racial dynamics of the broader society. For example, Tucker (2009) demonstrates how Cape Town's gay-tourism district contains nightclubs that admit to having informal policies to exclude coloured and black patrons. See in this regard also Matebeni (2017).

This places black sexually and gender-diverse people in a precarious and isolated place. Where black individuals might hope to find solidarity in a social community of sexually and gender-diverse people, this might not occur if the space is predominantly white or biased toward whiteness in its value systems, practices and expectations. And where black individuals find solidarity amongst their black peers and community in the fight against racism, they might experience alienation and discrimination in the fight against homophobia or transphobia. Caught between two communities where their sense of belonging is conditional and premised on impossible demands, black sexually and gender-diverse individuals may experience significant distress.

Pride marches are global events to celebrate sexual and gender diversity. Yet, in South Africa, Pride events are sometimes marred by how different LGBTIQ+ groups stigmatise and exclude others: often such events are more LGB-focused, excluding the 'TIQA+'. Pride events in South Africa have often become sites of contestation by black activists who feel that Pride is racially exclusionary, had lost its political agenda and is unable to represent their needs (Soldati-Kahimbaara & Sibeko, 2012). Sometimes these exclusions are articulated as being classed, not only raced. Responses from black queer communities to the white dominance (materially and symbolically) in gay venues and during Pride events have brought about the rise of township and inner-city spaces which are affirming of black queerness, and the proliferation of various Pride events as a response to white-dominated Prides (Matebeni, 2017).



Additionally, despite the historical documentation of fluid sexual practices in pre-colonial Africa and a greater acceptance for gender diversity in traditional African tribes (Epprecht, 2004; Murray & Roscoe, 1998), negative beliefs about sexually and gender-diverse people continue to exist. Practitioners must therefore be aware of the nuanced ways in which sources of support could also become sources of oppression.

***Practitioners use cultural humility as a tool when working with cultures different from their own***

Cultural humility is a lifelong commitment to self-evaluation and self-criticism to address the potential power imbalances between practitioners and the culturally diverse people with whom they work (Tervalon & Murray-Garcia, 1998).

The process of working with culturally diverse individuals or groups requires a multicultural orientation that includes an ongoing, active, aspirational process of assessing one's attitudes, knowledge and skills to improve one's ability to work with diverse groups of people (Sue & Sue, 2013; Tervalon & Murray-Garcia, 1998). Although CPD activities in this area will improve multi-

cultural competence, a commitment to cultural humility ensures that expertise in this area is never finite or complete, and that ongoing reflective practice is what is mostly expected. This is what DasGupta (2008, p.980) similarly calls "narrative humility". For example, a client tells you that they chose you as their psychotherapist because of a similar cultural background and that you will understand them easily. Nevertheless, one should still be willing to have some cultural assumptions broken, by maintaining an attitude of openness and curiosity, by for instance, joining reading groups, supervision groups, and CPD activities which explore the ethical dimensions of working across differences.

For example, a black transwoman researcher from an affluent middle-class background in Durban, KwaZulu-Natal, is researching coloured transwomen's experiences in a working-class neighbourhood in the Northern Cape. While there may be some shared experiences in being a transwoman, differences in class, geography, race and language would implore the researcher to remain committed to cultural humility and not go into the process with an assumed expertise.



## GUIDELINE 6: Counteracting stigma and violence

Psychology practitioners have an understanding of stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals

### Rationale

Sexually and gender-diverse people experience substantial discrimination and victimisation (Nel, 2014) or the fear of discrimination and ill treatment. This in turn is linked to a range of mental health issues, including greater vulnerability to depression, anxiety and substance use (Polders, Nel, Kruger, & Wells, 2008; Victor & Nel, 2017).

There is significant evidence that oppressive social environments increase minority stress, having severe negative consequences on the health of sexually and gender-diverse people. Alongside this, the health system is itself steeped in heteronormative assumptions, and often actively discriminates in the provision of treatment. This can negatively affect the quality of support to which sexually and gender-diverse persons gain access (Victor et al., 2014). Fear of poor treatment and judgmental attitudes often makes sexually and gender-diverse individuals less likely to access healthcare (ASSAf, 2015).

Practitioners need to be aware that stigma and discrimination on the basis of sexual and gender diversity are more deep-seated and pervasive, in Africa and elsewhere, than is acknowledged in the public domain. Thirty-four countries in Africa – out of a total of 53 sovereign states and territories – impose some kind of legal restrictions on certain sexual desires and practices (International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA], 2015). In much of sub-Saharan Africa, same-sex sexuality is held to be ‘foreign’, and is portrayed as ‘un-African’ and a product of colonialism. Some traditional beliefs suggest those of a same-sex sexual orientation are cursed or bewitched (Murray & Roscoe, 1998). In primarily Christian and Muslim African countries, gay men and lesbian women are confronted with religious condemnation.

Recent developments suggest that, instead of abating, negative attitudes in some African countries may, in fact, be intensifying against LGBTIQ+ persons. In January 2014, Nigeria enacted stringent anti-homosexual legislation, and in February 2014, Uganda passed its Anti-Homosexuality Bill into law, but this was subsequently struck down by the constitutional court on technical grounds. Both these 2014 laws facilitate the active persecution of LGB persons and their supporters and friends. This intensifying of attitudes, and the promulgation of new laws, are often fanned by right-wing religious organisations from the United States who are exporting Western ‘culture wars’ to Africa and are helping repressive governments to use “... out-dated colonial era laws, scapegoating during political conflicts, religiosity, rigid beliefs in cultural and family values, and a patriarchal mind-set”, to keep their grips on power (Nel, 2014, p.145).

A great deal of evidence points to this stigmatisation, leading to deep-seated and widespread prejudice, discrimination and anti-homosexual harassment and violence, both state-sanctioned and extrajudicial. This includes increased rates of verbal and other forms of harassment, teasing, bullying at school or in the workplace, threats of violence and actual violence. Furthermore, criminalisation on the basis of sexual orientation has been found to exacerbate social discrimination and, in particular, to lead some health service providers to discount, ignore and neglect the needs of sexually and gender-diverse people, thus compounding their vulnerability (Dramé et al., 2013). The stigmatisation and criminalisation of same-sex sexuality has also made it difficult to implement public health interventions, such as HIV prevention programmes for MSM, effectively (ASSAf, 2015).

Even in South Africa, where such discrimination is prohibited by the Constitution, negative attitudes

towards sexually and gender-diverse people persist (Nel, 2014). South Africa has higher levels of violence than most countries, including violence against sexually and gender-diverse individuals (Peacock, 2013).

Examples of related institutionalised discrimination include the difficulties many sexually and gender-diverse people experience reporting hate crimes to the police without being subjected to further prejudice and/or trauma (Human Rights Watch [HRW], 2011; Nel & Judge, 2008). Problems are experienced with the Department of Home Affairs when trans people try to change their gender on their ID and are discriminated against by individual Home Affairs officers who hold the belief that this goes against the law. In some instances, the law falls short and this could lead to further prejudice and discrimination. Examples include the law not providing for non-binary gender categories, as well as trans–cis couples who are already married having problems with staying married legally, but still being able to change the gender of one of the spouses (Gender DynamiX & Legal Resource Centre, 2014).

An affirmative stance strongly urges practitioners to take steps to develop their contextual awareness of how prevalent homo- and transphobia, heterosexism, prejudice and stigma are, and which effect these have on mental health and well-being. Recent research on minority stress, as applied to LGBTIQ+ communities, is particularly useful in exposing how deeply such stress could affect overall mental health. The Academy of Science of South Africa (ASSAf), in accordance with its mandate to provide evidence-based science advice to government and other stakeholders, recommends that to promote well-being and social justice, the psychology profession and other disciplines in Africa should engage more actively in research to reduce stigma. Practitioners should seek ways actively to promote access to healthcare and educational materials for sexually and gender-diverse communities (ASSAf, 2015).

Recognising the nature and extent of the harm caused by stigma, prejudice, discrimination and prejudice-motivated speech is crucial. Many jurisdictions, including Canada, Germany and the European Union, have provisions similar to those in South Africa, limiting the dissemination of hate speech. Provisions of this kind remind society of the value of diversity and the worth and dignity of

every human being. Hate speech restrictions seek to combat the grave psychological and social consequences to individual members of the targeted group in terms of their psychological integrity and well-being, which result from the humiliation and degradation caused by hate speech. They also seek to prevent the harmful and polarising effect which hate speech has on society at large as it subtly and unconsciously absorbs the message that the targeted group is inferior and is to be detested and disparaged (Breen, Lynch, Nel, & Matthews, 2016; Nel & Breen, 2013).

## Application

***Psychology professionals are aware that all sexually and gender-diverse people, regardless of race and/or socio-economic status or culture, may have been subjected to systemic prejudice, discrimination and violence, albeit in varying forms and at different levels of intensity***

South Africa's past is characterised by a state which categorised, discriminated and promoted prejudice. This history of institutionalised discrimination under apartheid and colonialism still forms the backdrop of hate-based discrimination and victimisation in South Africa (Nel & Judge, 2008). Nel and Judge (2008) argue that a key long-term effect of the structural discrimination of apartheid was to entrench social division actively on constructed notions of difference on the basis of, amongst others, race, gender and sexuality. In addition, hate speech played a central role in entrenching social values and practices that justified social division and associated discrimination.

It should be noted that hate speech has social and community consequences. It builds on and perpetuates 'us–them' divisions. Even where hate speech is directed at a particular person, the whole community of which that person is a member is affected, because hate speech targets key identity characteristics of a person with whom the rest of the community is associated. This could lead to decreased feelings of safety and security in the community generally (Nel & Breen, 2013).

Such violence and discrimination could also exacerbate negative feelings within sexually and gender-diverse persons towards their own sexual orientation or gender non-conformity. In this way, discrimination may lead to internalised stigma

and/or oppression. Research indicates that hate speech directed at lesbians and gay men makes victims significantly more vulnerable to a range of psychological harms, particularly a heightened risk of depression (Polders et al., 2008). Because hate speech targets a person's identity, it has an influence on self-esteem and self-worth. The perpetuation of negative images of sexually and gender-diverse individuals and experiences of discrimination may have a particularly detrimental effect on the psychological development of children and young adults (ASSAf, 2015; Sanger, 2013).

Dominant gender norms in any society shape the extent to which sexually and gender-diverse people can live out their genders and sexualities. Research shows, for example, that there is a close relationship between 'gender presentation' and vulnerability to victimisation (HRW, 2011; Nel & Judge, 2008). Sexually and gender-diverse people who present in gender non-conforming ways are more susceptible to both overt and covert discrimination than those who do not. People who present differently are sometimes punished or threatened, because they are perceived to disrupt the normative gender and sexual order (Nel & Judge, 2008). Furthermore, a person does not actually have to be gay or lesbian to experience discrimination, but may be victimised for having a non-conforming way of expressing gender. In other words, in South Africa, gay and lesbian people are discriminated against on the basis of *both* their sexuality and gender (Nel & Judge, 2008).

***Practitioners are encouraged to recognise the nature and extent of bullying, hate speech and hate crime sexually and gender-diverse people endure***

South African schools have been found to be homophobic (Bhana, 2012), with disturbingly high rates of verbal and physical harassment (Rich, 2006; Wells, 2005). Many learners do not feel safe in schools (Lee, 2014). At the same time, young people often are or feel alienated from their families who deprive them of emotional support which could otherwise offset the harmful effects of discrimination at school. Relentless bullying could affect both cognitive and non-cognitive skills development and influence long-term educational achievement and professional success (Lee, 2014).

Sexually and gender-diverse people are subject to bullying at three times the rate of the general population (ASSAf, 2015). A number of studies referenced in the ASSAf report have shown that in the United States, even with relatively high levels of acceptance of LGBTIQ+ rights and individuals, more than 80% of LGBT individuals experience verbal harassment at school; about 40% experience 'milder' forms of physical bullying, such as being pushed around. More than 20% report more serious physical assault related to their gender expression. Of particular concern is that very few victims felt able to report the assaults and those who did report the matter were more often than not disappointed with the support received (ASSAf, 2015; Nel & Breen, 2013).

Research has found that approximately 62% of the respondents in a study<sup>4</sup> had experienced negative jokes regarding their sexual orientation during their schooling (Nel & Judge, 2008). During the two-year period that the study was conducted, 37.1% of all respondents had experienced verbal abuse. This was the most prevalent form of victimisation across both sexes and all race groups. Actual physical abuse and assault was experienced by 15.6% of respondents, with almost 8% of respondents reporting sexual abuse (prevalence levels were similar between men and women). Sexual abuse levels in particular experienced by black women and men were much higher compared to their white counterparts. In addition, the findings confirmed that higher levels of 'outness' and integration into LGBTIQ+ communities and the adoption of gender roles associated with the opposite sex (i.e. increased visibility as gay or lesbian) led to increased rates in some forms of homophobic discrimination.

Other studies confirm the extent of discrimination and violence sexually and gender-diverse people endure in South Africa. Of the 121 black lesbians, transgender men and gender non-conforming women Human Rights Watch interviewed, almost all reported they had been verbally abused, ridiculed or harassed at some point in their life. A significant number of respondents reported such abuse *throughout* their lives (HRW, 2011).

---

4 The study was based on a representative quantitative study commissioned by the South African Joint Working Group [a national network of several LGBTIQ+-focused community organisations] of which the data was collected in Gauteng over a 24-month period between 2002 and 2003.

There is a strong correlation between hate speech and hate crimes perpetrated against vulnerable groups (Breen et al., 2016; Nel & Breen, 2013). Hate crimes mostly occur in contexts of sustained prejudice-motivated victimisation, including ongoing taunting (or hate speech), bullying or conflicts between people known to each other within specific settings, such as a school or a community. As such, hate speech (such as harassment, slurring, name-calling and other forms of verbal abuse) creates the breeding ground for hate-based attacks. Hate crimes – any incident that may or may not constitute a criminal offence, perceived as being motivated by prejudice or hate – can be seen as the extreme side of a continuum that starts off with verbal abuse, and the social acceptability of such abuse (Nel & Judge, 2008).

Practitioners should be aware that verbal abuse and harassment contribute to sexually and gender-diverse people becoming fearful and cautious, and heighten their vulnerability to depression (Polders et al., 2008). Left unchecked, such antipathy circulates and reinforces prejudices among and within communities. Verbal abuse and harassment that people face due to their gender expression and/or sexual orientation could create or enhance negative self-image, shape public opinion, instil fear and shame in people, and inhibit the victim's ability to access public space and seek redress or justice. It also creates and reinforces a climate of impunity within which violence could escalate from verbal harassment and abuse to physical and sexual attacks.

Practitioners can counteract this by paying attention to previous experiences of anti-LGBTIQ+ violence and by exploring the possible relationship between the presenting problem and such previous experiences.

***Practitioners recognise and counteract the psychological effect of stigma, prejudice, discrimination and violence on the individual and targeted group/community***

During an overview of related literature, it was found that the ASSAf report (2015) confirms that sexually and gender-diverse individuals fare poorly on most measures of health, from physical well-being to rates of STI prevalence, rates of mental illness and risk of suicide. Studies cited in the ASSAf report have confirmed this is a worldwide trend (Goldbach, Tanner-Smith, Bagwell, &

Dunlap, 2014; Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). However, there is substantial evidence that such health disparities are not caused by individual sexual orientation or gender identity per se, but arise because of discrimination and prejudice and the inability of sexually and gender-diverse populations to live openly, access health information and access health and other state facilities freely (ASSAf, 2015; Nel, 2007).

Moreover, in many African countries, sexually and gender-diverse populations often suffer socio-economic discrimination of various kinds. They are also affected by other factors that affect their life choices and opportunities. These challenges can be particularly acute for adolescents and young adults, who often face intense pressure to conform to gender roles and identities in multiple domains – for example, in school, at home, in faith structures and from peers. The key reasons for these poor outcomes are the stress caused by high levels of social alienation, potential and substantive rejection by family and the community, bullying and violence, as well as state-supported violence and potential incarceration. These factors interact with a lack of health services or fear of using health services, a lack of educational material, and absence of any of the 'usual' channels of community support that are open to heterosexuals (ASSAf, 2015).

The central tenet of the minority stress model, as outlined previously, is that rejection, alienation, absence of social support, bullying and violence perniciously affect the self-image, educational attainment, economic integration and sense of belonging for sexually and gender-diverse individuals and communities. This causes a wide range of mental health disorders, including depression. This stress is then often 'self-medicated' by those who experience it through substance use and abuse, including a high prevalence of alcohol abuse (L.H. Meyer, 2003).

Homo- and transphobic violence and discrimination target a person as a result of her or his perceived sexual orientation and/or gender identity. It acts as a constant reminder that sexually and gender-diverse individuals face risks in making their minority status publically known, as this aspect of their identity may expose them to further discrimination, maltreatment or even violence. Such fears could have a chilling effect on the ways they present themselves in public. It often



encourages them to play down or conceal their sexual orientation or gender non-conformity, with a number of detrimental psychological effects. Not only do these strategies of self-preservation force sexually and gender-diverse individuals to choose between their safety and their identity, but they often also reduce the visibility and participation of the sexually and gender diverse, as an integral part of South African society (Nel & Judge, 2008). These types of effects are likely to be felt by other groups where there is victimisation based on other markers of identity, such as race or nationality, for example.

Practitioners could consider focusing on:

- Foregrounding internalised oppression, as core to psychological problems with self-image and social functioning in adolescence and adulthood. Building self-esteem, reducing internalised oppression and increasing visibility of positive sexually and gender-diverse role models are some of the vital interventions.
- Exploring, as outlined in Guideline 2, how self-determined disclosure could be beneficial to mental health, including improved self-esteem. Despite these possible benefits, practitioners should note that the potential for violence and threat could outweigh these potential benefits, and become an ethical issue around the protection of the individual and related advice given.
- Alleviating the significant distress due to external stigma, should this present, and helping negotiate what might be requests for help in changing of sexual orientation. Evidence of both the ineffectiveness of such approaches – there is no credible evidence that sexual orientation can be changed, even if there is some fluidity over a lifetime with some individuals along a continuum of attraction – and of possible kinds of harm should be shared candidly with clients.
- More importantly, service users/clients/participants should be helped to access their deepest appreciation of their own desires and innate orientation, and ways found to express those safely even in very oppressive social contexts.

***Practitioners remain cognisant of the effect stigma, prejudice, discrimination and violence have on society in general***

Given that hate speech stigmatises certain forms of identity, practice and expression, it reduces the space within which all members of society are free to express themselves as they choose. Hate speech clearly aims at sending a message that certain forms of identity and practice are to be socially excluded, detested and condemned. It increases intolerance in society at large and disparages non-conformist behaviours, identities and expressions (Nel & Breen, 2013).

Homo- and transphobic hate speech – just like other forms of hate speech – may therefore have detrimental implications for the pillars of human dignity, i.e. equality and freedom, which are meant to support South Africa’s constitutional democracy. Fear, distrust, prejudice and renewed conflicts and previous areas of division in society may result in further polarisation and destabilisation, and restrict the full and unhindered participation of sexually and gender-diverse people in public and political life (Nel, 2007).

To promote human welfare, psychology professionals should advance well-being and social justice in their work. Accordingly, the UN High Commissioner for Human Rights, the President of the International Union of Psychological Science (IUPsyS), and others, drew definite links between human rights and health and well-being during the International Congress of Psychology in 2012, which was held for the first time on African soil (Nel, 2014). Practitioners should consider evidence that policies and practices that protect the human rights of sexually and gender-diverse individuals and communities are beneficial across entire societies. Such policies and practices protect these individuals against violence and discrimination, improve their health and well-being, increase their contribution to the economy, society, and culture, and promote inter-group contact that reduces prejudice against all minority groups in society.

## GUIDELINE 7: Recognising multiple developmental pathways

Psychology professionals recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age

### Rationale

There has been a movement away from imposed identities, to self-chosen identities, in many areas of life and in many countries. People are insisting on their own agency and ability to define who they are, and to refine and adapt that in different contexts. In terms of sexuality, there are multiple, and often fluid, pathways in the development of sexual orientation. These are a normal aspect of human developmental variation (ASSAf, 2015). The same is true for gender and social identity. How people think about and talk about the people to whom they feel attracted, might be substantially different from what they claim as their identity or how they talk about their orientation, depending on various factors, for example, levels of stigma in their society and their own sense of personal agency (ASSAf, 2015). It is also possible to live with two identities – one public and one private (McLachlan, 2010).

Orientations, how we understand our attractions to others and identities evolve too, over a lifetime. Some people find their sexual orientations and sexual preferences evolve through different life stages. Less well understood is that some people's gender identities shift too, and not always in any obvious alignment to their orientations or sexual practices. Increasingly, globally, some people opt to reject gender binaries entirely, regardless of their sexual orientation.

Cultural and social contexts change over time, including expectations of people at different stages of life. The needs of individuals might also differ across their lifespans. Older sexually and gender-diverse people might, for instance, also face additional issues around health, retirement, finances and social support that are aggravated by the heteronormative expectations for older people. Practitioners need to be open to these life shifts.

Because identity and orientation are not the same, although these categories are often conflated, it is important to include sexual orientation and gender identity in the process of identity exploration. In this context, it should be recognised that the articulation of sexual orientation is made more complex when sex assigned at birth is not aligned with gender identity. Practitioners need to be sensitive that a person's gender identity cannot be determined by simply examining external appearance, expression or behaviour, but must incorporate a person's identity and self-identification (Broido, 2000).

In addition, many gender-diverse adults have disguised or rejected their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimise their fear of difference (Bockting, Milner, Swinburne Romine, Hamilton, & Coleman, 2012).

Psychology professionals need to create the space for hearing how service users/clients/participants refer to themselves and to help them assess meanings they attach to these words. Practitioners and researchers also need to be clear on how they define with whom they want to engage, and by implication whom they want to exclude from an intervention and/or programme, i.e. interviewing lesbian and gay people, per se, will exclude those people who may be same-sex attracted, but do not identify with the labels 'lesbian' and/or 'gay' (Sandfort & Dodge, 2009).

### *Sexual orientation development*

Research indicates a significant potential biological basis for the development of sexual orientation. Sexual orientation may develop by different biological pathways for male- and female-identified people, but this always occurs in particular social and cultural ways (ASSAf, 2015). For many, sexual orientation is



mostly 'fixed' fairly early in life, but there are some indications that sexual orientation is more fixed for men and more fluid and changeable for women, which might reflect on socialisation to gender norms (Diamond, 2008, 2015; Dillon, Worthington, & Moradi, 2011; Farr, Diamond, & Baker, 2014; Savin-Williams & Diamond, 2000; Worthington, Savoy, Dillon, & Vernaglia, 2002). For most people, their sexual orientation is not experienced as being chosen and is generally not experienced as changeable at will, or at all (ASSAf, 2015).

There appears to be no significant evidence that the nature of parenting or early childhood experiences play any role in the formation of a person's basic sexual orientation (ASSAf, 2015). There is no empirical evidence indicating that sexual orientation may be acquired through contact with sexually and gender-diverse people, including the otherwise powerful mechanism of peer pressure (ASSAf, 2015). As explored in the ASSAf report, peer pressure has a significant influence on much social behaviour and on many cultural and political attitudes, but does not appear to have any influence on sexual orientation.

The expression of sexual orientation, on the other hand, is significantly influenced by social and cultural systems – sexual orientations may be defined in relatively distinctive ways in different societies, and over different times. In addition, personal agency also plays a role in the expression of sexual orientation.

Sexually diverse people face similar developmental tasks that accompany adolescence for all youth, including sexual identity development. However, they must also navigate awareness and acceptance of a socially marginalised sexual identity, potentially without family, community or societal support. This could increase their risk for psychological distress and substance use behaviours. On the other hand, supportive families, peers, school and community environments could improve psychosocial outcomes (SAMHSA, 2015).

For example, educational institutions could potentially be both an obstacle as well as opportunity for young sexually and gender-diverse people during their development (Francis, 2017). Heteronormativity and homophobia in the school system and the experience of sexually and gender-diverse learners, including bullying, have

been investigated (Francis & Msibi, 2011; Msibi, 2012). Educational institutions have a social responsibility to manage possible discrimination and improve safety for all learners (Watson & Vally, 2011). Increasingly, localised resources are available to assist professionals in providing sexual and gender diversity-affirming education and environments (Reygan, 2016).

Recent models and research suggest same-sex attraction sexual identity development as a circular, dynamic process that entails the acquisition of an individual as well as a group identity. These two parallel paths – individual sexual identity and group identity development – influence each other, but not necessarily simultaneously (Coetzee, 2009). A key limitation of these models is that not all people label themselves in particular ways, nor do they attach the same meanings to some of the terms used. There is thus a need to be sensitive to the way in which people identify themselves rather than forcing them, almost linearly, into one or the other category (Page, 2007). For example, the idea of 'gay' identity development might require particular economic and social conditions, such as an urban environment where people have a high level of voluntary mobility or find themselves in loosened family relations (Leatt & Hendricks, 2005). Such concepts as 'gay' might feel alien and inappropriate in different cultural contexts.

Positive same-sex attraction sexual identity is related to healthy psychological adjustment (Nel, 2007). Without endeavouring to essentialise race and culture, and also keeping in mind potential significant variation within communities, research has indicated that racial and cultural intersectionalities currently also play an important part in defining one's sexual orientation. For example, for many white South Africans, sexual orientation is considered integral to identity. But in rural or poor black and coloured communities, sexual practices might not influence identity formation. For example, a 'gay' man who sees himself in a receptive role might refer to his sexual partners as 'straight' (Nel, 2007; Rabie & Lesch, 2009; Reid, 2013).

### ***Gender Identity Development***

Gender development begins in infancy and continues progressively through childhood. The child's gender role development is influenced by biological, cognitive and social factors (Alanko et

al., 2008). Although gender identity is usually established in childhood, individuals might become aware in childhood, adolescence, or adulthood that their gender identity is not in full alignment with sex assigned at birth. Some people also experience their gender identity as fluid to a more or lesser extent over time (Lev, 2004; McLachlan, 2010).

The experience of questioning one's gender could create significant confusion for some gender-diverse people and their significant others, especially for those who are unfamiliar with the range of possible gender identities that exist. This includes the lack of more nuanced terminology. For example, to explain any discordance that might be experienced between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, and/or gender role non-conformity and gender identity, some gender-diverse people may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009).

For many, gender dysphoria before puberty will not persist and they will develop a cisgender identity in adolescence or adulthood (WPATH, 2011). For some though, gender dysphoria in childhood will persist and usually worsen with the physical changes of adolescence. For others, gender dysphoria will only emerge after puberty with no history of gender non-conformity.

Different terminology is used by health practitioners when referring to children who present outside the gender norm. Some use more pathologising descriptors such as Gender Identity Disorder in Childhood (GIDC), Gender Incongruence in Childhood, or Gender Dysphoria. Others may view the child's behaviour as very possibly transient in nature and part of the development process in childhood, and use terms such as 'gender variance', 'gender atypical behaviour' or 'gender questioning' (McLachlan & Nel, 2015). Gender diversity in childhood is thus not seen as pathological.

Some gender questioning children and adolescents might have increased risk of depression, anxiety and behavioural matters. This might be related to negative social attitudes or rejection. Conversely, a supportive social network improves psychosocial outcomes (SAMHSA, 2015).

Puberty blockers/suppression may become a treatment option for the gender-diverse adolescent. These blockers, which are reversible, prevent the development of secondary sex characteristics which, in turn, could alleviate gender dysphoria (WPATH, 2011). Others find that to transition socially creates enough space to live out and explore their gender identity.

## Application

Psychology professionals could:

- Assist people to differentiate between gender identity and sexual orientation including how social expectations to conform to strict gender norms could be harmful
- Normalise each individual's unique pathway in the development of her or his gender identity and sexual orientation, including highlighting the possibility that these identities are not necessarily fixed but might change over time
- Consider particular historical contexts of the life stage to which the client belongs. In addition, to consider the current social and cultural environment within which the person finds her- or himself in, e.g. media representations
- Discuss the potential phases of gender identity and sexual orientation development, making it clear that these are not fixed but are merely useful to assist in understanding and providing clarity. A number of models are available, and equally, there are some criticism of these models, which needs to be taken into account. See, for example, Robertson and Louw (2013) for a useful summary
- Provide information about both sexual orientation and gender identity, including the narratives of other sexually and gender-diverse people
- Be open and informed that the potential exists that individuals in relationships might identify their orientations differently (i.e. one partner might identify as heterosexual and the other partner as gay or bisexual)
- Be sensitised to the effect of stigma, prejudice, discrimination and violence on the

developmental health of sexually and gender-diverse people

- Consider matters of parental, partner and other social support and how to facilitate the provision of a strong social support network, including psycho-education
- Seek up-to-date information and resources for own learning and to assist clients.

## GUIDELINE 8: Non-conforming family structures and relationships

Psychology professionals understand the diversity and complexities of relationships that sexually and gender-diverse people have, which include potential challenges –

- of sexually and gender-diverse parents and their children, including adoption and eligibility assessment;
- within families of origin and families of choice, such as those faced by parental figures, caregivers, friends, and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant other; and
- for people in different relationship configurations, including polyamorous relationships

### Rationale

#### ***Potential challenges of sexually and gender-diverse parents and their children, including adoption and eligibility assessments***

Many sexually and gender-diverse people are parents or want to have children. Some sexually and gender-diverse people have their own biological children, others choose to adopt, foster or pursue surrogacy. Sexually and gender-diverse people sometimes become parents before coming out. Sometimes their sexual and gender diversity becomes part of custody proceedings or other kinds of settlements. More and more countries allow sexual and gender-diverse persons to raise biological, foster and adopted children (ASSAf, 2015).

Since 2002, South Africa has been the only African country where gay and lesbian people have been able to adopt children (Klein, 2013). But, for many sexually and gender-diverse people adopting or fostering a child is fraught with difficulties. This includes having to find a non-discriminatory organisation/agency or social worker to facilitate the adoption or foster process. This is not only a South African issue; these problems are common around the world (APA, 2015).

Practitioners should be aware of and sensitive to the stress of the adoption process, and to any additional stressors that might be causing distress due to homophobia and transphobia.

Some lesbian people, gender non-conforming people and trans men choose to fall pregnant. Many choosing this require reproductive treatment. There are sometimes issues finding medical professionals willing to assist (Swain & Frizelle, 2013). In addition, the hormonal treatment received by some transgender and gender non-conforming people could limit their reproductive choices (APA, 2015; De Villiers & De Vries, 2013). For other gender-diverse people, their future plans of parenthood and conceiving naturally could influence their choice of starting with hormonal therapy and undergoing gender-affirming surgery. So, for example, gender-diverse people could be counselled to consider choosing to store their eggs/sperm.

Transgender and gender non-conforming people who choose to change their gender marker at the Department of Home Affairs might be burdened by their marriage status. As the Marriage Act (25 of 1961) as well as the Recognition of Customary

#### **GENDER-AFFIRMING SURGERY/TREATMENT/**

**PROCEDURE:** Also sometimes referred to as 'sex-reassignment surgery', this refers to medical treatment and other procedures, such as cross-gender hormones and gender-affirming surgeries, which transgender persons could choose to undergo in order to make their bodies more congruent with their gender identity, thus affirming their gender.

Marriage Act (120 of 1998) do not recognise same-sex marriages, the married couple has to divorce in order to remarry in terms of the Civil Union Act (17 of 2006) (Gender Dynamix & Legal Resource Centre, 2014). This puts additional strain on the couple as well as on the family and could even have an effect regarding custody issues of children during this process.

A variety of global studies have shown that children from sexually and gender-diverse parents do not experience more psychopathology than children from other families (see, for instance, Breshears & Lubbe-De Beer, 2016 and Breshears & Le Roux, 2013). In South Africa, there are some signs that societal acceptance of non-normative families is increasing. While this is leading to a more supportive environment for the children from these families (Breshears & Le Roux, 2013), many families still face complex and often discriminatory social environments.

Although research is limited, there is no indication that children of gender-diverse parents suffer any long-term negative effects due to transitioning by a parent (APA, 2015). In terms of the well-being of members of a family, the structure and form of the family are less important than the quality of the relationships within that family (Lubbe-De Beer, 2013).

#### ***Potential challenges of family of origin and family of choice***

There is considerable evidence that a more repressive environment increases minority stress and this could have a negative effect on a gender and sexually diverse person's health (ASSAf, 2015). The reverse is also true: several studies have indicated that gender-diverse adults and adolescents who experience acceptance from their family of origin have significantly decreased rates of negative outcomes such as depression and suicide (APA, 2015).

Some sexually and gender-diverse people have experienced abuse and violence in their family of origin (APA, 2015; Nuttbrock et al., 2014). Due to the high prevalence of stigma, rejection and negative social responses (Meier, Pardo, Labuski, & Babcock, 2013), they often experience a lack of affirmation and belonging (Benestad, 2002). This creates additional stressors, which could contribute to mental health challenges and problems (APA, 2012; ASSAf, 2015; Meier et al.,

2013; Wolf & Dew, 2012). Many sexually and gender-diverse people experience rejection or a feeling of not belonging to their family of origin. For some of them, it becomes important to form a new family of choice.

Families of sexually and gender-diverse people often also require support when dealing with sexual and gender diversity.

In the face of weakened family of origin ties, sexually and gender-diverse people often form extended networks of friends who could provide role models and become the family the person feels she or he might not have in her or his family of origin, partially as her or his family of origin might consist solely of cis-gender and heterosexual individuals. Some research has indicated that these extended circles might also include previous romantic and sexual partners as close friends. Both the family of origin and the family of choice could provide strong support systems on which the person could rely as she or he navigates the road to making sense of societal rejection and discrimination, dealing with her or his own sense of shame and loss, to developing a strong connected identity (Pachankis & Goldfried, 2013).

#### ***Potential challenges of different relationship configurations***

Following on from the discussion initiated in Guideline 3, different relationship configurations exist within the sexually and gender-diverse community with some being in monogamous relationships and others in non-monogamous relationships (British Psychological Society, 2012). Furthermore, as a person goes through different life stages and/or as relationships develop, the fluidity of monogamy/non-monogamy could come to the forefront.

Regardless of sexual orientation, couples might negotiate different forms of monogamy or non-monogamy as a potential process through the course of their relationship. The notion that bisexual people are often non-monogamous is as fallacious as making this assumption about any other orientation (Lynch, 2013). The term 'couple' here should not imply two people only, as couples could have relationships in multiple configurations, such as found in polyamorous and polygamous relationships.



In South Africa, even though same-sex marriage is legal and diverse family structures, for example polygamous formations, are considered acceptable (Breshears & Le Roux, 2013), heterosexual, monogamous marriage is privileged as part of broader social patterns of heteronormativity (Lynch & Maree, 2013). Many people in relationship configurations that do not uphold these heterosexual expressions and relationships experience hostility, even to the point of violent opposition (Marnell, 2013). Sexually diverse people take different and shifting positions regarding the heteronormative discourse regarding relationships, at times being restricted by it, at other times in opposition to it and/or challenging it (Lynch & Maree, 2013) and at yet other times, attempting to redefine their relationships to reflect this dominant discourse.

Gender-diverse people may also experience stressors as they negotiate their relationships with their significant other. Disclosure of a gender-diverse identity early in a relationship correlates with a better relationship outcome, as a later disclosure could be perceived and experienced by the partner as a betrayal (APA, 2015). In an existing relationship, the couple often both need to be involved in the decision-making process regarding the use of resources for gender-affirming treatment as well as sharing the news with family members, the community of care, other support structures and within the community (APA, 2015).

Couples often need to renegotiate relationship roles, interrogate the meaning of being a partner and understanding of the roles, and at times even grieve the loss of aspects of their partner and/or relationship (APA, 2015). For the intimate partner, being in a relationship with a person who transitioned may entail questioning her or his own sexuality and sexual identity. Furthermore, some partners of transgender persons experience transphobia and transphobic violence (Theron, 2009). For some couples, the stressors, new roles and identities become too challenging and the couple may separate or divorce. Some trans-gender couples renegotiate the 'new identities' and relationship roles through introducing structures such as negotiated open relationships or polygamy. This is particularly in relation to couples who want to remain staying together; however, the trans person's sexual orientation might have shifted after or during transition.

For gender-diverse persons, it can also be very stressful as they engage in the dating scene, especially when they present differently from their sex assigned at birth. Some gender-diverse people experience a shift in their sexuality or question their sexuality as they transition (APA, 2015; Meier et al., 2013). Others may identify as gay although living their preferred gender while dating a person with the same natal sex as them, whereas another may identify as straight/heterosexual (Meier et al., 2013). Some gender-diverse people who have transitioned and are living the opposite gender as their sex assigned at birth, dating the same sex as their preferred gender may identify as gay/lesbian or as heterosexual/bisexual/asexual and so forth (Meier et al., 2013). Furthermore, after transitioning, some gender-diverse people experience a shift in their sexuality and sexual identity. The gender-diverse person navigates the world of relationships as she or he also explores her or his own understanding of sexuality – the process of making sense and finding a new identity within communities should be supported with empathy and care.

As in any other relational configuration, power inequalities also exist in sexually and gender-diverse relationships and this could lead to intimate partner violence (Henderson, 2012; Khan & Moodley, 2013; Müller, 2013). In this sense, the results of intimate partner violence on partners become an important area of work for psychology professionals.

## Application

Psychology professionals work with sexually and gender-diverse persons across the lifespan to address family, relationship and parenting issues (APA, 2015).

### ***Sexually and gender-diverse parents and their children, including adoption and eligibility assessment***

Practitioners could provide support and guidance to the sexually and gender-diverse parent and person who wants to become a parent. The professional could support and guide the person/couple/people in the relationship as they navigate their quest of becoming parents. As a psychology professional, the person needs to aspire to create a safe space where the person/people could explore the different options available to them.



The psychology professional could also provide affirmative therapy as the sexually and gender-diverse persons negotiate their status as an 'alternative family' within the community.

Psychological screening and assessment as part of the adoption process:

The psychology professional could assess the client's psychological well-being as part of the screening for adoption. Furthermore, the professional could also assess the relationship structure and dynamics as part of the screening process.

Eligibility assessment:

The psychology professional could furthermore be involved in the eligibility assessment during divorce and separation proceedings. The professional needs to be cognisant of her or his own internalised homophobia/transphobia and her or his own inherent beliefs of what an ideal family constellation entails. The psychology professional needs to forefront the best interest of the child and work within the ethical guidelines of the profession.

***Families of origin and families of choice (such as those faced by parental figures, caregivers, friends and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant other)***

Practitioners could help sexually and gender-diverse people to negotiate family dynamics (APA, 2015). This might mean individual work as well as family therapy as the person explores and establishes her or his sexual and gender identity (APA, 2015) to assist in negotiation and

renegotiation of relationships and the roles and rules of those relationships. At times, this could also involve dealing with the loss of a daughter or son as the person transitions and relationships change.

The disclosure (or non-disclosure) of sexual and gender-diverse identities could also be supported by the professional as the gender-diverse person negotiates her or his relationships as well as intimate relationships. In the case of gender diversities, the psychology professional could also focus on fostering resilience in the relationships and could provide support to the intimate partners of gender-diverse clients, whether on individual level or through partner/peer support groups (APA, 2015). Psychology professionals may also need to explore the fluidity in sexual orientation that might occur during the transitioning period of the gender-diverse client (Meier et al., 2013).

***People in different relationship configurations, including polyamorous relationships***

Regardless of sexual orientations, some people feel monogamy is unsuitable, and the expectations affiliated with a monogamous relationship model 'set them up for failure' as the commitment required to agree to it is too restrictive. Practitioners could help those in polyamorous or 'open' relationships establish ethical boundaries and informed consent. As with any relationship configuration, an absence of coercion and high levels of trust are important baselines to establish.

The psychology professional could assist the gender and sexually diverse client exploring and embracing a variety of relationship configurations. Practitioners could also work with the relationship unit as they explore their roles and understanding of their relationship configuration.

## GUIDELINE 9: The necessity of an affirmative stance

Psychology professionals adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training and education (including curriculum development, assessment and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions)

### Rationale

What does it mean to take an affirmative stance? Psychology practitioners recognise that previous therapeutic approaches often pathologised and caused harm to sexually and gender-diverse individuals. Past approaches were not neutral: psychology as a social science and as a service was 'part of the problem'. In the 21<sup>st</sup> century, it is not enough for practitioners and the profession to just stop doing harm. Psychology professionals need to be and could be part of a set of solutions and approaches that provide responsible, affirming and comprehensive mental health care for sexually and gender-diverse individuals. This is the essence of an affirmation stance – going out of our way to redress past imbalances and prejudices, with the aim of providing optimal mental health systems.

An affirmative stance implies specific positive assumptions about sexual and gender diversity, which informs all areas of professional practice (PsySSA, 2013). These assumptions include the core premise that sexual and gender diversity are recognised as normal and natural variances of the human experience, and are not per se the cause of psychological difficulties. There is considerable and up-to-date multinational research to support this view. This also demands a broader contextual awareness of how minority stress in the form of homophobia, transphobia, heterosexism, prejudice and stigma affect the mental health and well-being of sexually and gender-diverse people (PsySSA 2013).

As a member of IPsyNet, PsySSA advocates that sexually and gender-diverse people be included as experts and active, equal partners in research and policy development for research and policy initiatives that concern them (see policy statement attached as Appendix II). PsySSA, furthermore, supports the development of psychological research and education that is not hetero- or cisnormative.

This research and education must be based on scientifically grounded knowledge. Where possible, researchers should actively advocate for greater awareness of the health and well-being needs of sexually and gender-diverse people in order to improve public policy and sexually and gender-diverse communities (IPsyNet, 2016). This affirmative stance is particularly important because of the widespread failure to incorporate sexual and gender diversity into professional psychology practice and training. An affirmative stance is also needed to counteract the frequent downplaying of sexual and gender diversity concerns when designing, implementing or evaluating a range of interventions, such as national or organisational policies, psychometric tests, teaching methods, curricula, psychotherapies, research agendas and tools or public health programmes. These interventions are usually seeped in heteronormative assumptions.

An affirmative approach respectfully recognises diversity, including the expertise found in sexually and gender-diverse people's own lived experiences. It seeks to use this knowledge to inform interventions and practice. Psychotherapy and counselling, as one of the hallmark activities of the psychology profession, requires a radical sensitisation towards sexual and gender diversity matters in order for the process to be conducive to developing and maintaining a therapeutic alliance, which research shows to be the core facet of enduring healing processes.

Beyond psychotherapy, research practitioners should strive to be sensitive to the ways in which data is collected and whether the tools and forms they use are sensitive and inclusive of sexual and gender diversity (Davies, 1996; Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Harrison, 2000; Johnson 2012; Korell & Lorah, 2007; Milton, Coyle, & Legg, 2002; Pachankis & Goldfried, 2013; Ritter & Terndrup, 2002).

## Application

***Practitioners are urged to remain aware of heteronormative biases when planning interventions, and to take an active affirmative and inclusive stance in their implementation***

As a general rule of thumb, it is, for instance, better to err on the side of being overly inclusive rather than being conservative or exclusionary. Practical ways of evaluating whether an intervention is affirmative and inclusive is to read it or imagine its implementation while keeping sexually and gender-diverse populations in mind, or allowing a few sexually and gender-diverse individuals to assess the intervention to see whether it is experienced as exclusionary, or to have it assessed by a known expert in the area of affirmative interventions. For example, LGBTI Cultural Competency Framework of Australia's LGBTI Health Alliance specifically includes LGBTI people working in mental health and suicide prevention organisations (Walker & Mars, 2013).

***Practitioners involved in policy development and planning must ensure that the policy is written in an affirmative manner, sensitive to sexually and gender-diverse experiences, and is planned in such a way that it would not be exclusionary in its implementation***

LGBTIQ+ people must be included as experts and as active, equal partners in research and policy development for research and policy initiatives that concern them to ensure the development of psychology research and education that is not hetero- or cis-normative (e.g. Clarke, Ellis, Peel, & Riggs, 2010; Doan, 2011; McNulty, Richardson, & Monro, 2010).

***Practitioners involved in all forms of training, education, teaching, examinations, interviews and selections, assessments, and curriculum development and appraisal must remain aware of the effect of those processes and its content on sexually and gender-diverse students or participants, and should strive to ensure that those processes and content are affirmative and inclusive***

Practitioners who are progressively involved in the current processes of 'decolonisation' of psychology curricula, for example, acknowledge that psychology is taught from a predominantly

North American and European vantage point. Such knowledge is often steeped in patriarchal and heteronormative assumptions and values. Decolonising curricula, therefore, is as much about the changing content and pedagogy, as it is about actively endorsing, for example, a feminist and queer lens to the content and teaching practices. Such revisions to curricula and teaching practice need to include sexual and gender-diverse frameworks in the process.

Educational psychologists working in schools must, for instance, be aware of how schools could become sites that (re)produce heterosexism and homophobia. Teachers' personal viewpoints on sexual and gender diversity could often become official school policies on what is appropriate behaviour, leading to victimisation and marginalisation of students who do not fit into the pre-determined, expected norms of behaviour and interaction (Bhana, 2012; Deacon, Morrell, & Prinsloo, 1999; Msibi, 2012).

***Practitioners practice affirmative forms of psychotherapy and counselling, and if their client's sexual orientation has not been revealed, the practitioner must not assume that the client is heterosexual***

Practitioners should draw on the wide variety of useful and pragmatic case studies detailing how a practitioner would go about using an affirmative orientation when counselling or treating a sexually and gender-diverse client (e.g. the case of 'Felix' by Glassgold [2009] and 'Adam' by Mandel [2014]).

After a systematic review of the literature assessing the effectiveness of affirmative psychotherapy on LGBTI service users/clients/participants, the British Association for Counselling and Psychotherapy (BACP) (2007, p.33) for instance recommended "all psychotherapy training institutes regard knowledge of LGBTI development and lifestyles as part of *core training*" (emphasis added). The onus therefore is on training centres to ensure that appropriate sexual and gender diversity content be incorporated into the curricula.

## GUIDELINE 10: Foregrounding global best practice care

Psychology professionals support best practice care in relation to sexually and gender-diverse service users/clients/participants by:

- cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy;
- opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the WPATH; and
- encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons

### Rationale

To supplement the guidelines, it is advised that psychology professionals keep abreast of global and local best practice care. Of particular importance here are three areas of work, namely:

- conversion therapy, which includes scientific and ethical views on conversion therapy and requests to change sexual orientation;
- best practice care for transgender persons embarking on a journey of gender-affirming surgery and treatment; and
- surgical interventions in the case of intersex infants.

In discussing each of these areas, the citations for the current state-of-the-science best practice reference material are provided and listed in the References.

#### ***Cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy***

Sexual orientation change efforts (SOCE) and gender identity/expression change efforts are based on the idea that sexual and gender diversity are maladies that require treatment (ASSAf, 2015; British Psychological Society, 2012; SAMHSA,

2015). Evidence for considering non-heterosexual sexuality as an abnormality or some kind of disorder has been systematically debunked in the past few decades. Many high-quality studies indicate that the higher prevalence of certain psychological problems in some sexually and gender-diverse individuals stem not from inherent pathology, but from prejudice and discrimination. Living in hostile environments creates the conditions for what has been theorised and studied as 'minority stress' (ASSAf, 2015) and the symptoms of this stress have often been confused and wrongly attributed to distress related to sexual orientation.

Many studies, and overviews of current knowledge, such as the ASSAf (2015) study also show that same-sex orientation cannot be changed by reparative or conversion therapy. The APA (2012, p.17) states, "Reviews of the literature, spanning several decades, have consistently found that efforts to change sexual orientation were ineffective." In the United States, some people have successfully sued organisations offering such change therapies on the grounds of their deceptive advertising, as evidence of lack of efficacy has been strengthened by recent research (American Counselling Association, 2010; British Psychological Society, 2012).

Furthermore, studies note that SOCE in all its various forms is dangerous and in conflict with medical ethics. SOCE could result in real harm (American Counselling Association, 2010; APA,

2012; ASSAf, 2015). Some of the negative consequences of SOCE, conversion and reparative therapy include:

- increased levels of self-hatred;
- decreased self-esteem;
- increased anxiety and aggression;
- social isolation;
- depression;
- ‘self-medication’, such as substance abuse; and
- an increase in suicidal ideation (American Counselling Association, 2010; ASSAf, 2015).

Although SOCE does not work (APA, 2012) and could cause harm, some organisations and therapists continue to offer these treatments (ASSAf, 2015). An affirmative stance, as proposed in these guidelines, strongly encourages practitioners to develop and offer culturally responsive and appropriate care. Training for how to engage in ‘best practice care’ inclusive of sexual and gender diversity should be part of all mental health curricula across the training continuum. Such care could help practitioners recognise the gaps in scientific knowledge that perpetuate mental health disparities among the sexually and gender diverse, and should incorporate an understanding of harmful practices to avoid, such as SOCE, which have been shown to affect mental health adversely.

SOCE ‘reparative therapy’ is harmful for adults, but it is particularly harmful when offered to or forced onto children and adolescents. Children displaying any kind of gender-atypical behaviour could be subject to such therapy by parents, schools or religious organisations. Besides the harm such efforts could cause to the individual, it could also put family ties and bonds under pressure, and could lead to alienation from close relatives at the very time when families should be young people’s primary sources of emotional support. Young people whose families do not accept their gender and sexual diversity are at heightened risk of depression and suicide and other mental health and substance abuse problems (Nell & Shapiro, 2011; Sanger, 2013).

### ***Opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the WPATH (2011)***

Even with the improvement in South Africa’s legal approach, most gender-diverse service users/clients/participants struggle to access trans and gender-affirming healthcare, particularly in less-resourced contexts (Klein, 2013; Meier et al., 2013; Nkoana & Nduna, 2012). For many gender-diverse people, gender-affirming treatment is not a choice but a necessity in order to live authentically (McLachlan, 2010). Research studies have found that most gender-diverse service users/clients/participants receiving gender-affirming medical and psychological treatment have positive treatment outcomes, an improved quality of life and a reduction in negative psychological symptoms, as well as decreased gender dysphoria (APA, 2015).

However, it is important for practitioners to note that not all gender-diverse service users/clients/participants wish or require medical interventions (Müller, 2012). As the Standards of Care (SOC-7) developed by WPATH states, “The SOC articulate standards of care while acknowledging the role of making informed choices and the value of harm reduction approaches” (WPATH, 2011, p.1).

In South Africa, transgender and gender non-conforming people often find it hard to access appropriate surgery and hormone therapy, and many are unable to transition physically (Jobson, Theron, Kaggwa, & Kim, 2012; Klein, 2009; Morgan, Marais, & Wellbeloved, 2009; Nkoana & Nduna, 2012; Prinsloo, 2011). Most medical aids do not cover gender-affirming treatment (Bateman, 2011) and only a few government hospitals provide gender-affirming surgery and hormone treatment (Wilson et al., 2014). Due to the economic divide that exists within South Africa, people from lower socio-economic classes struggle even more to access appropriate healthcare (Klein, 2009; Klein, 2013). Gender-affirming treatment is not easily accessible within public health (Klein, 2013; Müller, 2012; Wilson et al., 2014). This lack of affirmative practices and support structures could lead to secondary victimisation and minority stress (APA, 2012; ASSAf, 2015; Nel, 2014).

For the gender-diverse adolescent, the onset of irreversible and possibly unwanted physiological



changes can be a cause of much distress (Bateman, 2011; McLachlan, 2010). According to Wilson et al. (2014), non-intervention could cause much harm and the possibility to delay puberty needs to be explored. Refer to Guideline 2 for a discussion around models of informed consent.

***Encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons***

Intersexuality has unfortunately long been regarded as a ‘treatable medical condition’ in South Africa. Where children were born with sexually ambiguous genitalia, urgent surgical treatment had been the preferred option (Swarr, 2009). But recent South African research has strongly suggested that surgery, when not urgently medically required, should only be performed when a child is able to participate in the decision (Wiersma, 2011).

This could cause a great deal of tension. Intense professional and community support may be needed for parents who decide to defer ‘corrective surgery’ until their child is able to give consent (British Psychological Society, 2012). In South Africa, intersex children as well as their parents are faced with discrimination, marginalisation and rejection within their respective communities. In some cultures, intersex children can even be regarded as ‘bewitched’ (Rebelo et al., 2008). See related discussion in Guideline 3.

In South Africa, a person can only identify legally as female or male (Klein, 2013). For many intersex people, the notion that their body is different and even viewed as unacceptable within the ‘norm’ stated by society creates high levels of distress as their body is viewed as requiring ‘corrective’ surgery (Husakouskaya, 2013).

## Application

***Conversion or reparative therapy***

A person requesting SOCE should be counselled with accurate and up-to-date information regarding sexual diversity and the scientific evidence around conversion or reparative therapy (APA, 2012; ASSAf, 2015). Perspectives and overviews, such as the ASSAf report, or other resources that show that sexual and gender diversity are no

longer regarded as conditions to be treated, but as normal and natural variations of human sexuality, could be shared with service users. The psychology professional might be faced with clients who experience significant and acute stress and conflict around their sexual orientation, beyond what might be expected as people deal with issues of developing a non-normative identity. Sources of conflict could include cultural or religious conflicts. The ethical conundrum for the therapist or counsellor might be in negotiating the line between doing no harm and respecting client values and needs. The issue of self-determination has been dealt with in Guideline 2. A client’s autonomy and choice may be restricted as a result of her or his belief in heterosexist ideals and as a result of internalised stigma. The professional will need to explore these biases about sexuality in an affirming, empathic manner, thus balancing how to act both affirmatively and ethically. For further reading, see Haldeman (2004).

***The practitioner aspires to be primarily evaluative and supportive in trans healthcare***

The gender-diverse individual is no longer required to undergo mandatory psychotherapy to access gender-affirming treatment, and the mental health practitioner’s role is primarily evaluative and supportive (Wilson et al., 2014; WPATH, 2011). Although psychology professionals are no longer ‘gatekeepers’ in terms of this decision-making, they could provide and facilitate access to trans- and gender-affirming care (APA, 2015). Indeed, most intersex and transgender service users/clients/participants are not referred to psychology professionals before surgery, even though research indicates many intersex service users/clients/participants wished for psychological support (Husakouskaya, 2013).

It should be noted that reports are often required from the psychology professional to access trans- and gender-affirming care in South Africa. Practitioners should work at all times from an informed consent model (WPATH, 2011). Informed consent is a process which occurs between a client/patient and a provider (such as an endocrinologist or general practitioner [GP] who prescribes hormones). Increasingly, there is a move in certain areas in South Africa towards a more participatory model, rather than only a medical or rights-based approach. The process should include an individualised discussion of the

risks, benefits, unknowns and alternatives, against the risk of no treatment. While Appendix III provides an example of a consent form for hormone therapy, a related discussion and shared decision-making between client/patient and provider is strongly recommended.

Awareness of transphobic social pressures, prejudice and discrimination could broaden the psychology professional's understanding and assist in assessing, treating, supporting and advocating for the gender-diverse client (APA, 2015; Wilson et al., 2014). The psychology professional could play a valuable role in the gender-diverse client's right to autonomy and self-identification (Wilson et al., 2014). Psychology professionals, furthermore, have a role to play in the empowerment and enabling of service users/clients/participants to recognise and resist prejudice, oppression and marginalisation (Wolf & Dew, 2012) by identifying possible courses of action, navigating public spaces and healthcare, developing self-advocacy strategies and identifying supportive resources (APA, 2015). Another role that WPATH (2011) advocates for is that healthcare providers need to advocate for their service users/clients/participants to receive gender-affirming

healthcare if need be. The psychology professional could play a critical role in validating and empowering the gender-diverse person (APA, 2015).

Gender-diverse service users/clients/participants who have been traumatised by emotional and physical violence and/or hate crimes may need therapeutic support (APA, 2015; Müller, 2012). The psychology professional could also play an advocacy role in this regard. Advocating for gender-neutral bathrooms and better human resource (HR) practices are affirming examples.

### ***Counselling parents of intersex infants***

In counselling parents of intersex infants, the affirming practitioner would be supportive in exploring the fears that parents might have about their child. Exploring heterosexist assumptions and highlighting the resilience of people in dealing with diversity would be important, whilst recognising and being empathetic towards the difficulties parents face. Examples and role models, such as found with the South African athlete and world champion, Caster Semenya, who is an intersex person, are often useful in creating an alternative and positive future vision for their child.

## GUIDELINE 11: Disclosing and rectifying of personal biases

Psychology professionals are, if it be the case, aware of their own cultural, moral or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist her or him in finding an alternative psychology professional should the client so wish

### Rationale

Whereas mental health professions have previously been complicit in causing harm to sexually and gender-diverse individuals by pathologising them, there is now broad consensus that mental health care has a significant role to play to promote optimal mental health and resilience for sexually and gender-diverse individuals (IPsyNet, 2016; PsySSA, 2013; World Psychiatric Association, 2016). However, psychology professionals' own explicit or implicit heterosexist biases, attitudes and assumptions could affect the quality of service they provide. Psychology professionals who themselves identify as sexually and gender diverse may also hold attitudes and assumptions that could affect the quality of service they provide. Bias can take the form of language used, and the choice and framing of interventions. The lack of training and knowledge of the particular issues dealt with by sexually and gender-diverse people could limit the ability of psychology professionals to provide appropriate services. Sexually and gender-diverse people have indicated that the healthcare provider's lack of knowledge and skills had a significant negative influence on their experience/outcome (Victor & Nel, 2016).

Utilising a sexual and gender-neutral model has at times been proposed for use by psychology professionals. Unfortunately, this approach – similar to a race-neutral approach – ignores or even denies the particular life experiences of sexually and gender-diverse people, and potentially perpetuates a heteronormative model that might be unhelpful to service users/clients/participants.

Disclosing and rectifying personal biases are important. It is also important that psychology professionals practice within the boundaries of their competence, as well as established professional and scientific knowledge. In this regard, but also in terms of referrals, the South African ethical

rules for psychology professionals are clear:

#### Competency limits

- A psychologist shall limit her or his practice to areas within the boundaries of her or his competency based on her or his formal education, training, supervised experience and/or appropriate professional experience.
- A psychologist shall ensure that her or his work is based on established scientific and professional knowledge of the discipline of psychology (Department of Health, 2006, pp.16–17).

#### Interruption of psychological services

- A psychologist shall not abandon a client by terminating the professional relationship prematurely or abruptly, but shall –
  - » make appropriate arrangements for another psychologist to deal with the needs of the client in the event of an emergency during periods of foreseeable absence when the psychologist will not be available; and
  - » make every reasonable effort to plan for continuity of service in the event that such service is interrupted by factors such as the psychologist's illness, death, unavailability or relocation or by the client's relocation or financial limitations (Department of Health, 2006, p.22).

### Application

Psychology professionals may be working with sexually and gender-diverse people in various

ways. The level of knowledge and competency required differs depending on the type of service offered. Regardless, psychology professionals ought to demonstrate insight and understanding about stigma, power dynamics, emotions, and human responses to emotions and the way implicit bias and assumptions about sexual and gender diversity may affect client care negatively.

Psychology professionals are urged to:

- Develop cultural humility, which includes avoiding making assumptions about the client. In the view of the International Union of Psychological Sciences (IUPsyS), cultural humility requires that psychologists strive to achieve humbleness in their interactions with clients; recognize that they are not the expert, and that they actively commit to being self-reflective and self-critiquing. Cultural humility entails the active inclusion of others' cultural worldviews to develop authentic and respectful relationships; reflection on one's thoughts, feelings and behaviour about their client's cultural worldview, and commitment to engaging in a life-long learning process towards humility and respect for others (IUPsyS, 2016, p.5)
- Use self-exploration, self-reflection and self-education, including exploration of own sexuality, gender identification and expression, to ensure an affirmative stance to sexual and gender diversity. This includes being aware of their own biases (explicit and implicit), background and values and how these might affect their work
- Be upfront during the initial intake/telephonic screening with potential service users/clients/participants regarding their own limitations/related expertise/(un)availability
- Facilitate referral processes, especially when a therapeutic relationship has already been established with the client. Psychology professionals have an ethical duty to refer clients appropriately in cases where their own values and worldview (for instance their religious beliefs) are discordant with the needs and diversities of the client. In accordance with Guideline 12, psychology professionals may similarly require engaging in appropriate self-reflection and introspection in such instances
- If in a position of leadership, confront stigma, minority stress and implicit bias in mental health settings with trainees and colleagues and engage in systems-based improvements to eliminate related adverse effects
- Seek additional training and supervision to ensure competence based on evidence-based practice on a continuous basis. This might also include first-hand accounts of the lived experiences of sexually and gender-diverse people
- Seek collaboration with service users/clients/participants or groups representing service users/clients/participants to enable their active decision-making in their own processes
- As affirmative practitioners, advocate for sexually and gender-diverse clients when working or dealing with colleagues. This would include highlighting issues around heterosexist biases and the effect of this in working with sexually and gender-diverse people
- Realise that psychology professionals who, themselves, identify as sexually and gender diverse are not above holding heterosexist biases, particularly given the lack of training in affirmative practice in South Africa. Thus, all psychology professionals need to cultivate cultural humility in their practice, and explore their own biases and the potential negative outcome on sexually and gender-diverse individuals.

## GUIDELINE 12: Continued professional development

Psychology professionals seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals

### Rationale

The rules of conduct for the profession of psychology, as outlined in the Health Profession Act (56 of 1974) are clear that psychology professionals must not only develop, but also maintain a high standard of professional competence (Department of Health, 2006). Continued professional development (CPD) is key to this. The Health Professions Council of South Africa (HPCSA) strongly encourages and mandates professions to maintain and update professional competencies in the interest of service users and participants (HPCSA, 2017).

Ethical practice requires commitment to lifelong learning as a part of the beneficence principle. This is all the more important in terms of affirmative practice for the sexually and gender diverse, given that related content is mostly absent from undergraduate and postgraduate curricula in South Africa.

However, while CPD points are important, and the regulations provide good incentives, it is important for practitioners to actively develop a scientifically grounded resource base on which they can draw, and to keep updating this. In order to advocate and meet the mental health needs of sexually and gender-diverse people better, an affirmative stance requires keeping current with a variety of academic and popular culture trends.

These areas are and will remain contentious, and there will be public and professional debates. There are a number of areas where good local research is urgently needed, and some areas where even globally there is a lack of well-designed credible studies. It is important to know what we do not know, and to think about how we can be part of shaping local and international research agendas. An essence of an affirmative stance is sharing knowledge and speaking up when gaps in the

knowledge are inhibiting the treatment, care and counselling of service users/clients/participants.

### Application

Psychology professionals could consider the following:

- Doing more CPD activities to improve, in particular self-reflection, skills and knowledge about matters of sexuality and gender. This can include attending specialised training workshops
- Using the substantial online resources available for trainers and trainees, including these guidelines, to provide both more generalised information as well as to assist in developing more advanced expertise
- Having an updated list of relevant local community and potential referral sources. Research has indicated that access to community resources improves psychological well-being (D'Augelli & Garnets, 1995). Sometimes, sexually and gender-diverse individuals are not familiar with resources available to assist them. Awareness and ability to access and refer to community resources could then become important.



## IN CLOSING

The authors felt it was critical to develop a document that is specific to the South African context, rather than adopting guidelines developed for other countries. Although this was challenging, it was also highly enriching.

The final document reflects a relatively comprehensive overview of current understanding in this field. As such, we believe that it forms the basis to support all psychology practitioners in their work, including researchers, trainers and professionals working in specific contexts such as education and industry. The guidelines represent a foundation for further work in this area, including developing research agendas, supporting policy work and development of curricula, both for new professionals as well as for CPD.

While the guidelines are primarily aimed at South African qualified professionals, our experience in the utilisation of the PsySSA sexual and gender diversity position statement has indicated that its applicability might well be broader, namely to include health professions in areas outside South Africa as well.

In addition, the guidelines and the process of development provide useful frameworks for the development of guidelines in other areas of work, and assisting those tasked with this development in planning and execution.

Finally, it is our sincere hope that you found the document useful, at times challenging, illuminating and an enriching experience. As mentioned in the introduction to the document, there are several streams of work already planned around the guidelines. Given this, we would really appreciate feedback on your experience with using the guidelines in your area of work.

## GLOSSARY

This section outlines and explains a number of key terms, which psychology professionals might find useful in practice. These explanations and definitions are mostly taken from PsySSA (2013), APA (2015) and Queer (2016). Some of these terms have been discussed in the guidelines. As mentioned in the guidelines, care should be taken when using language in this area of work. These terms could potentially mean different things in different cultural and social contexts. People might attribute different meanings to the terms when they define their own identities and journeys. Within academic circles, terminology is also developing quickly to take into account our improved understanding of this area of work within the broader affirmative framework.

**ANDROPHILIA:** Androphilia and gynaephilia are terms used in behavioural science to describe sexual orientation, as an alternative to a gender binary same-sex and heterosexual conceptualisation. Androphilia describes sexual attraction to men or masculinity; gynaephilia describes the sexual attraction to women or femininity (also see Gynaephilia and Sexual orientation).

**ASEXUAL:** A person who has low or no sexual desire, little or no sexual behaviour, and a concomitant lack of subjective distress. Identifying as asexual does not preclude the ability for the person to have a romantic or love relationship with someone of the same and/or different gender.

**BIOLOGICAL SEX:** The biological and physiological characteristics that are socially agreed upon as informing the classification of a person as male or female.

**BIOLOGICAL VARIANCE:** A term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals (see Intersexuality).

**BISEXUAL:** A person who is capable of having sexual, romantic and intimate feelings for or a love relationship with someone of the same gen-

der and/or with someone of other genders. Such an attraction to different genders is not necessarily simultaneous or equal in intensity.

**CISGENDER:** Often abbreviated to simply 'cis', a term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth.

**CISNORMATIVITY:** Also referred to as 'cissexism' and 'cisgenderism', a placing of more emphasis on societal norms that enforce the gender binary, but which are occasionally used synonymously with transphobia.

**GAY:** A man who has sexual, romantic and intimate feelings for or a love relationship with another man (or men). In the South African context, some lesbians also identify as 'gay' which, again, emphasises the importance of enquiring about self-naming and honouring such naming.

**GENDER:** The socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for either men or women.

**GENDER-AFFIRMING SURGERY/TREATMENT/PROCEDURE:** Also sometimes referred to as 'sex-reassignment surgery', this refers to medical treatment and other procedures, such as

cross-gender hormones and gender-affirming surgeries, which transgender persons could choose to undergo in order to make their bodies more congruent with their gender identity, thus affirming their gender.

**GENDER ASSIGNED AT BIRTH:** Gender assignment (sometimes known as sex assignment) is the determination of an infant's sex at birth. In the majority of births, a relative, midwife, nurse or physician inspects the genitalia when the baby is delivered, and sex and gender are assigned, without the expectation of ambiguity. Assignment may also be done prior to birth through prenatal sex discernment. AFAB (assigned female at birth) and AMAB (assigned male at birth) are commonly used terms to refer to gender/sex assigned at birth. While many people use the terms 'sex' and 'gender' interchangeably, they are, in fact, two separate characteristics (see Sex assigned at birth).

**GENDER DIVERSITY:** The range of different gender expressions that spans across the historically imposed male–female binary. Referring to 'gender diversity' is generally preferred to 'gender variance' as 'variance' implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals (also see Sexual diversity and Gender non-conformity).

**GENDER DYSPHORIA:** Also known as 'gender identity disorder' (GID), is the dysphoria (distress) a person experiences as a result of the sex and gender assigned to her or him at birth. In these cases, the assigned sex and gender do not match the person's gender identity, and the person is transgender. There is evidence suggesting that twins who identify with a gender different from their assigned sex may do so not only due to psychological or behavioural causes, but also biological ones related to their genetics or exposure to hormones before birth.

**GENDER IDENTITY:** A person's private sense of being male, female or another gender. This may or may not match the biological sex that a person was assigned at birth.

**GENDER NON-CONFORMITY:** Also referred to by some as 'gender variance', 'gender atypical' or 'genderqueer', is displaying gender traits that are not normatively associated with a person's biological sex. 'Feminine' behaviour or appearance in a

male is considered gender non-conforming, as is 'masculine' behaviour or appearance in a female. In the case of transgender people, they may be perceived, or they perceive themselves as, gender non-conforming before transitioning, but might not be perceived as such after transitioning. Some intersex people may also exhibit gender non-conformity (also see Gender diverse and genderqueer).

**GENDERQUEER:** Also termed 'non-binary', is a catch-all category for gender identities that are not exclusively masculine or feminine, i.e. identities, which are thus outside of the gender binary and cisnormativity. 'Androgynous' (also 'androgynous') is frequently used as a descriptive term for people in this category. However, not all persons identify as androgynous. Genderqueer people may identify as either having an overlap of or indefinite lines between gender identity; having two or more genders (being bigender, trigender or pangender); having no gender (being agender, non-gendered, genderless, or genderfree); moving between genders or having a fluctuating gender identity (genderfluid); or being third gender or other-gendered, a category which includes those who do not place a name to their gender.

**GYNAEPHILIA:** 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation as an alternative to a gender binary same-sex and heterosexual conceptualisation. 'Gynaephilia' describes the sexual attraction to women or femininity (also see Androphilia and Sexual orientation).

**HETERONORMATIVITY:** Related to 'heterosexism', it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person's biological sex as assigned at birth, and that only sexual attraction between these 'opposite' genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities also, i.e. it serves to regulate not only sexuality but also gender (see Homonormativity).

**HETEROSEXISM:** A system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. It assumes that heterosexuality is the only normal or natural option for human relationships, and posits that all

other sexual relationships are either subordinate to or perversions of heterosexual relationships. In everyday life, this manifests as the assumption that everyone is heterosexual until proven otherwise (see Heteronormativity).

**HETEROSEXUAL:** Having sexual, romantic and intimate feelings for or a love relationship with a person or persons of a gender other than one's own.

**HOMONORMATIVITY:** The system of regulatory norms and practices that emerges within homosexual communities and which serves a normative and disciplining function. These regulatory norms and practices need not necessarily be modelled on heteronormative assumptions, but they often are (see Heteronormativity).

**HOMOPHOBIA:** Also termed 'homoprejudice', it refers to an emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards lesbian women and gay men (or women), or same-sex sexuality more generally. Homophobia is a type of prejudice and discrimination similar to racism and sexism, and lesbian and gay black, coloured or Indian people are often subjected to all three forms of discrimination at once (also see Transphobia).

**INTERNALISED STIGMA/OPPRESSION:** Also known as 'internalised homo-/transphobia' or 'internalised negativity', it refers to the internalisation or absorption of negative attitudes (a personal acceptance of such stigma as part of one's value system and self-concept).

**INTERSECTIONALITY:** The interaction of different axes of identity, such as gender, race, sexual orientation, ability and socio-economic status, in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways.

**INTERSEXUALITY:** A term referring to a variety of conditions (genetic, physiological or anatomical) in which a person's sexual and/or reproductive features and organs do not conform to dominant and typical definitions of 'female' or 'male'. Such diversity in sex characteristics is also referred to as 'biological variance' – a term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping

of diversity in sex characteristics, including, but not limited to, intersex individuals.

**LESBIAN:** A woman who has sexual, romantic and intimate feelings for or a love relationship with another woman (or women). Note, some lesbians prefer referring to themselves as 'gay'.

**LGBTIQA+:** An abbreviation referring to lesbian, gay, bisexual, transgender and intersex persons. 'LGB' refers to sexual orientations, while 'T' indicates a gender identity, 'I' a biological variant, 'Q' a queer identified person, 'A' for asexual, and '+' indicating other non-conforming minorities. These groups are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination and victimisation in a heteronormative and heterosexist society, in an effort to ensure equality before the law and equal protection by the law. However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences and needs of these people may in fact differ significantly and in several respects. In solidarity with the activist position regarding this matter, however, in this document, reference is made to LGBTIQA+, and distinctions among the diversity of identities that exist are minimised.

**MSM (MEN WHO HAVE SEX WITH MEN):** Used in public health contexts to refer to men who engage in sexual activity with other men, including those who do not identify themselves as gay or bisexual, to avoid excluding men who identify as heterosexual. Note, trans men may also be included in such a description (also see WSW and Sexual behaviour).

**POSITION STATEMENT:** Refers to a document outlining the stance of a professional body on a specified area.

**PRACTICE GUIDELINES:** Related to 'position statement', this term refers to recommendations regarding professional practice in a specified area. The function of practice guidelines in the field of psychology is to provide psychology professionals with applied tools to develop and maintain competencies and learn about new practice areas.

**PSYCHOLOGY PROFESSIONAL:** Inclusive of Health Professions Council of South Africa- (HPCSA-) registered psychologists, regardless of

registration category (Clinical, Counselling, Educational, Industrial, Research), registered counsellors and psychometrists, as well as non-registered professionals with a qualification in psychology.

**POLYAMORY:** A relationship configuration where a person has more than one intimate or sexual partner with the knowledge and consent of all partners involved, and with an emphasis on honesty and transparency within relationships. Polyamory is considered a minority relationship orientation, where monogamy is the dominant orientation. What makes polyamory seem deviant is the openness and honesty of being involved with multiple concurrent relationships, as opposed to cheating (hidden concurrent relationships), which is almost anticipated. It is also described as ‘consensual non-monogamy’.

**QUEER:** An inclusive term that refers not only to lesbian and gay persons, but also to trans and gender non-conforming persons, or anyone else who feels marginalised because of her or his sexual practices, or who resists the heteronormative system regarding sex/gender/sexual identity. Historically, a word meaning ‘odd’, ‘curious’ or ‘peculiar’ and later used as a derogatory term for LGB persons.

**REPARATIVE THERAPY:** Also known as ‘conversion therapy’ or ‘sexual orientation change efforts’ (SOCE), it refers to psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change his or her sexual orientation (see Sexual orientation change efforts).

**SEX ASSIGNED AT BIRTH:** At birth, a child is usually assigned a sex according to the body parts with which that child is born (Also see Gender assigned at birth).

**SEX(UAL) CHARACTERISTICS:** A sex organ (also called a reproductive organ, primary sex organ, or primary sexual characteristic) is any anatomical part of the body in a complex organism that is involved in sexual reproduction and constitutes part of the reproductive system. The external and visible organs, in males and females, are the primary sex organs known as the ‘genitals’ or ‘genitalia’. The internal organs are known as the ‘secondary sex organs’ and are sometimes referred to as the ‘internal genitalia’. The characteristics

that begin to appear during puberty, such as, in humans, pubic hair on both sexes and facial hair on the male, are known as ‘secondary sex characteristics’.

**SEXUAL BEHAVIOUR:** ‘Sexual behaviour’ is distinguished from ‘sexual orientation’ because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour. Individuals may engage in a wide range of behaviours and practices often associated with sexuality. These can include bondage and discipline and sadomasochism (BDSM), which have nothing to do with sexual orientation and/or gender identity. BDSM may also refer to a specific lifestyle or subculture comprising participants who regularly engage in such practices. Although some individuals are likely to participate in BDSM practices in various ways, many psychology professionals may be unfamiliar with the diversity, terminology, possible motivations and matters surrounding their service user/client/participant’s lifestyle. BDSM potentially may be enriching and beneficial to many who safely participate (in this regard, the operative terms are ‘safe, sane and consensual’), or it sometimes may be considered pathological and destructive (see the DSM V; see also MSM and WSW).

**SEXUAL DIVERSITY:** The range of different expressions of sexual orientation and sexual behaviour that span across the historically imposed heterosexual–homosexual binary (also see Gender diversity).

**SEXUAL ORIENTATION:** A person’s lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual/same-sex sexual orientation, bisexual or asexual).

**SEXUAL ORIENTATION CHANGE EFFORTS (SOCE):** Also known as ‘reparative therapy’ or ‘conversion therapy’ is psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change her or his sexual orientation (see Reparative therapy).

**SOCIAL TRANSITION:** The social portion of a transition, in which a transgender person makes others aware of her or his gender identity. Some parts of social transition could include telling



people about your gender identity whether or not they are aware of your assigned gender/sex and/or transgender status (see Transitioning).

**STEALTH:** For a trans person going stealth is generally the goal of transition. It means to live completely as her or his gender identity and to pass into the public sphere being sure most people are unaware of their transgender status. This does not mean their status is a secret to every single person; family and close friends may know. Some transsexuals and most genderqueer and bigender people purposely do not go stealth because they want the people around them to know they are trans. Some desire to go stealth, but are unable to pass convincingly enough. Historically, going stealth is a very recent phenomenon since, for many people, hormones are necessary to pass.

**TRANS:** Commonly accepted shorthand for the terms transgender, transsexual, and/or gender non-conforming.

**TRANSGENDER:** A term for people who have a gender identity, and often a gender expression that is different to the sex they were assigned at birth by default on account of their primary sexual characteristics. It is also used to refer to people who challenge society's view of gender as fixed, unmoving, dichotomous and inextricably linked to one's biological sex. Gender is more accurately viewed as a spectrum, rather than as a polarised, dichotomous construct. This broad term encompasses transsexuals, genderqueers, people who are androgynous, and those who defy what society tells them is appropriate for their gender. Transgender people could be heterosexual, bisexual, same-sex attracted or asexual.

**TRANS(GENDER) MAN:** A person who was assigned 'female' at birth, but identifies as male. Such a person is also referred to as a 'female-to-male (FtM) trans person'. Note, the term 'FtM' has become somewhat controversial as many in the trans community feel that they were never female to begin with. Instead, 'masculine presenting' is preferred.

**TRANS(GENDER) WOMAN:** A person who was assigned 'male' at birth, but identifies as female. Such a person is also referred to as a 'male-to-female (MtF) trans person'. Note, the term 'MtF' has become somewhat controversial as many in the trans community feel that they were never

male to begin with. Instead, 'feminine presenting' is preferred.

**TRANSPHOBIA:** Emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards people who do not conform to the gender expectations of society. It is often expressed alongside homophobic views and hence is often considered an aspect of homophobia. Transphobia is a type of prejudice and discrimination similar to racism and sexism, and transgender black, coloured or Indian people are often subjected to all three forms of discrimination at once (see Homophobia).

**TRANSITIONING:** (Including social and medical transition) refers to the (permanent) adoption of the outward or physical characteristics of the gender with which one identifies, as opposed to those associated with one's gender/sex assigned at birth (see Social transition).

**TRANSSEXUAL:** A medical term used to describe transgender persons who may or may not opt to undergo gender-affirming treatment to align their body with their self-identified sex and gender identity. Not commonly used anymore and considered offensive by some.

**WSW (WOMEN WHO HAVE SEX WITH WOMEN):** Used in public health contexts to refer to women who engage in sexual activity with other women, including those who do not identify themselves as lesbian or bisexual, to avoid excluding women who identify as heterosexual. Note, transwomen may also be included in such a description (also see MSM and Sexual behaviour).

## REFERENCES

- Abrahams, N., Jewkes, R., Hoffman, M., & Laubsher, R. (2004). Sexual violence against intimate partners in Cape Town: Prevalence and risk factors reported by men. *Bulletin of the World Health Organization*, 82(5), 330–337.
- Abrahams, N., Jewkes, R., Martin, L. J., Mathews, S., Vetten, L., & Lombard, C. (2009). Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and Victims*, 24(4), 546–556.
- African Commission on Human and Peoples' Rights. (2014). *Resolution on protection against violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity*. Retrieved from <http://www.achpr.org/sessions/55th/resolutions/275/>
- Alanko, K., Santtila, P., Harlaar, N., Witting, K., Varjonen, M., Jern, P., ... Sandnabba, N. K. (2008). The association between childhood gender atypical behavior and adult psychiatric symptoms is moderated by parenting style. *Sex Roles*, 58, 837–847.
- Ally, R., Madonsela, T., Parsley, J., Thipanyane, T., Yigen, K., & Lambert, P. (1998). *The national action plan for the protection and promotion of human rights*. Retrieved from [http://www.dhnet.org.br/dados/pp/nacionais/pndh\\_africa\\_do\\_sul\\_1998.pdf](http://www.dhnet.org.br/dados/pp/nacionais/pndh_africa_do_sul_1998.pdf)
- American Counseling Association. (2010). American Counseling Association competencies for counselling with transgender clients. *Journal of LGBT Issues in Counseling*, 4, 135–159.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2009). *Report of the APA task force on appropriate therapeutic responses to sexual orientation*. Washington, DC: Task force on appropriate therapeutic responses to sexual orientation. Retrieved from <http://www.apa.org/pi/lgbcpublications/therapeutic-resp.html>.
- American Psychological Association. (2011). *Practice guidelines for LGB clients*. Washington, DC: American Psychological Association. Retrieved from <http://www.apa.org/pi/lgbt/resources/guidelines.aspx>.
- American Psychological Association. (2012). Guidelines for psychotherapy practice with lesbian, gay, and bisexual clients. *American Psychologist*, 67, 10–42.
- American Psychological Association. (2015). *Guidelines for psychological practice with transgender and gender nonconforming people*. Washington, DC: Author. Retrieved from <https://www.apa.org/practice/guidelines/transgender.pdf>
- Anova Health Institute. (2010). *From top to bottom: A sex-positive approach for men who have sex with men – a manual for healthcare providers*. Johannesburg: Author.
- Anova Health Institute. (2016). *Transgender health training for facilitators/trainers*. Johannesburg: Author.
- Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling. (2003). *Competencies for counseling gay, lesbian, bisexual, and transgender (LGBT) clients*. Retrieved from <http://www.algbtic.org/resources/competencies.html>

- Australian Psychological Society. (2010). *Guidelines for psychological practice with lesbian, gay and bisexual clients*. Melbourne: Australian Psychological Society.
- Bateman, C. (2011). Transgender patients sidelined by attitudes and labelling. *South African Medical Journal*, 101(2), 91–93.
- Beckstead, L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 221–244). Washington, DC: American Psychological Association.
- Benestad, E. E. P. (2002). Gender belonging: Children, adolescents, adults and the role of the therapist. In D. Denborough (Ed.), *Queer counselling and narrative practice* (pp. 204–225). Adelaide: Dulwich Centre Publications.
- Bhana, D. (2012). Understanding and addressing homophobia in schools: A view from teachers. *South African Journal of Education*, 32, 307–318.
- Blake, C. (2016). *The value of sexual health education in South Africa: A retrospective evaluation by recent matriculants* (Unpublished master's thesis). University of Witwatersrand, Johannesburg.
- Bockting, W. O., Benner, A., & Coleman, E. (2009). Gay and bisexual identity development among female-to-male transsexuals in North America: Emergence of a transgender sexuality. *Archives of Sexual Behaviour*, 38(5), 688–701.
- Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming-out process. In R. Ettner, S. Monstrey, & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York, NY: Haworth.
- Bockting, W. O., Milner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health and the resilience in an online sample of the US transgender population. *American Journal of Public Health*, 103, 943–951.
- Bonthuys, E., & Erlank, N. (2012). Modes of (in) tolerance: South African Muslims and same-sex relationships. *Culture, Health and Sexuality*, 14(3/4), 269–283.
- Breen, D., Lynch, I., Nel, J. A., & Matthews, I. (2016). Hate crime in transitional societies: The case of South Africa. In J. Schweppe & M. A. Walters (Eds.), *The globalisation of hate: Internationalizing hate crime?* (pp. 126–141). Oxford: Oxford University Press.
- Breshears, D., & Le Roux, A. (2013). Outsider discourse surrounding children's experience of familial identity in same-sex-parented families. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 1–20). Johannesburg: Jacana Media.
- Breshears, D., & Lubbe-De Beer, C. L. (2016). Same-sex parented families' negotiation of minority social identity in South Africa. *Journal of GLBT Family Studies*, 12(4), 346–364.
- British Association for Counselling and Psychotherapy. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people*. Leicestershire: Author.
- British Psychological Society. (2012). *Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients*. Retrieved from [http://www.bps.org.uk/sites/default/files/images/rep\\_92.pdf](http://www.bps.org.uk/sites/default/files/images/rep_92.pdf)
- Broido, E. M. (2000). Constructing identity: The nature and meaning of lesbian, gay, and bisexual lives. In R. Perez, K. DeBord, & K. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 13–33). Washington, DC: American Psychological Association.
- Brown, B., Duby, Z., & Van Dyk, D. (2013). *Health care provision for men who have sex with men, sex workers and people who use drugs: An introductory manual for health care workers in South Africa*. Cape Town: The Desmond Tutu HIV Foundation.

- Chambers, S. A. (2007). 'An incalculable effect': Subversions of heteronormativity. *Political Studies*, 55(3), 656–679.
- Chappell, P. (2015). Queering the social emergence of disabled sexual identities: Linking queer theory with disability studies in the South African context. *Agenda*, 29(1), 54–62.
- Clarke, V., Ellis, S. J., Peel, E., & Riggs, D. W. (2010). *Lesbian, gay, bisexual, trans and queer psychology: An introduction*. Cambridge: Cambridge University Press.
- Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., & Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20(9), 1105–1110.
- Coetzee, C. A. (2009). *The development and evaluation of a programme to promote sensitive psychotherapeutic practice with gay men and lesbians* (Unpublished doctoral thesis). Rhodes University, Grahamstown.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7th version). *International Journal of Transgenderism*, 13, 165–232.
- DasGupta, S. (2008). The art of medicine: Narrative humility. *The Lancet*, 371, 980–981.
- D'Augelli, A. R., & Garnets, L. D. (1995). Lesbian, gay, and bisexual communities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities over the lifespan* (pp. 293–320). New York, NY: Oxford University Press.
- Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay and bisexual clients*. (pp. 24–40). Philadelphia, PA: Open University Press.
- Deacon, R., Morrell, R., & Prinsloo, J. (1999). Discipline and homophobia in South African schools: The limits of legislated transformation. In D. Epstein & J. Sears (Eds.), *A dangerous knowing: sexuality, pedagogy and popular culture* (pp. 164–180). London: Cassell.
- Department of Health. (2006). *Ethical rules of conduct for practitioners registered under the Health Professions Act, 1974*. Retrieved from <http://www.hpcsa.co.za/Conduct/Ethics>
- De Villiers, A., & De Vries, E. (2013). *The adult transgender patient. A guide for general practice: Hormone transition therapy*. Cape Town: SATHRI project.
- Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, 44, 5–14.
- Diamond, L. M. (2015). Sexual fluidity. In P. Whelehan & A. Bolin (Eds.), *The International Encyclopedia of Human Sexuality*. (pp. 1115–1354). San Francisco, CA: Wiley.
- Diesel, A. (Ed.). (2011). *Reclaiming the L-word: Sappho's daughters out in Africa*. Athlone: Modjaji Books.
- Dillon, F. R., Worthington, R. L., & Moradi, B. (2011). Sexual identity as a universal process. In S. J. Schwartz & E. Al (Eds.), *Handbook of identity theory and research* (pp. 649–670). New York, NY: Springer.
- Doan, P. L. (Ed.). (2011). *Queering planning: Challenging heteronormative assumptions and reframing planning practice*. Farnham: Ashgate.
- Dramé, F. M., Peitzmeier, S., Lopes, M., Ndaw, M., Sow, A., Diouf, D., & Baral, S. (2013). Gay men and other men who have sex with men in West Africa: Evidence from the field. *Culture, Health and Sexuality*, 15, Suppl. 7–21. doi:10.1080/13691058.2012.748935
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*, 3(2), 165–172.



- Epprecht, M. (2004). *Hungochani: The history of a dissident sexuality in Southern Africa*. London: McGill-Queens University Press.
- Espen, E., & Jolly, S. (2006). *Gender and sex: A sample of definition*. Retrieved from [http://www.iwtc.org/ideas/15\\_definitions.pdf](http://www.iwtc.org/ideas/15_definitions.pdf)
- Farr, R. H., Diamond, L. M., & Baker, S. M. (2014). Female same-sex sexuality from a dynamical systems perspective: Sexual desire, motivation, and behaviour. *Archives of Sexual Behaviour*, 43(8), 1477–1490.
- Fausto-Sterling, A. (2012). *Sex/ Gender: Biology in a social world*. New York, NY: Routledge.
- Francis, D., & Msibi, T. (2011). Teaching about heterosexism: Challenging homophobia in South Africa. *Journal of LGBT Youth*, 8(2), 157–173. doi:10.1080/19361653.2011.553713
- Francis, D. A. (2017). “I think we had one or two of those, but they weren’t really”: Teacher and learner talk on bisexuality in South African schools. *Journal of Bisexuality*, 17(2), 206–224.
- Freese, R., Ott, M. Q., Rood, B. A., Reisner, S. L., & Pantalone, D. W. (2017). Distinct coping profiles are associated with mental health differences in transgender and gender nonconforming adults. *Journal of Clinical Psychology*. Advance online publication. doi:10.1002/jclp.22490
- Gender DynamiX and Legal Resource Centre. (2014). *Alteration of sex description and sex status act, No. 49 of 2003*. Cape Town: Authors.
- Gevisser, M., & Cameron, E. (Eds.). (1995). *Defiant desire: Gay and lesbian lives in South Africa*. Abingdon-on-Thames: Routledge.
- Glassgold, J. M. (2009). The case of Felix: An example of gay-affirmative, cognitive-behavioral therapy. *Pragmatic Case Studies in Psychotherapy*, 5(4), 1–21.
- Glassgold, J. M., Beckstead, L., Drescher, J., Greene, B., Lin Miller, R., & Worthington, R. L. (2009). *Appropriate therapeutic responses to sexual orientation*. Washington, DC: American Psychological Association Task Force. doi:10.1037/e548572011-001
- Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: A meta-analysis. *Prevention Science*, 15(3), 350–363. doi:10.1007/s11121-013-0393-7
- Graziano, K. J. (2004). Oppression and resiliency in a post-apartheid South Africa: Unheard voices of black gay men and lesbians. *Cultural Diversity and Ethnic Minority Psychology*, 10(3), 302–316.
- Graziano, K. J. (2005). Reflections from university students in a South African gay and lesbian society. *International Journal for the Advancement of Counselling*, 27(2), 299–310.
- Greene, B. (1994). Ethnic minority lesbians and gay men: Mental health and treatment issues. *Journal of Consulting and Clinical Psychology*, 62, 243–251.
- Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 181–199). Washington, DC: American Psychological Association.
- Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist*, 32, 691–715.
- Harper, C. (2007). *Intersex*. Oxford: Berg.
- Harrison, N. (2000). Gay affirmative therapy: A critical analysis of the literature. *British Journal of Guidance & Counseling*, 28, 37–53.
- Health Professions Council of South Africa. (2017). *Continued professional development*. Retrieved from <http://www.hpcs.co.za/CPD>
- Henderson, N. (2012). Narratives of power and abuse in gay relationships in the Cape Metropole. *South African Journal of Psychology*, 42(3), 323–332.



- Henderson, N., & Shefer, T. (2008). Practices of power and abuse in gay male relationships. *South African Journal of Psychology*, 38(1), 1–20.
- Hoad, N. (2007). *African intimacies: Race, homosexuality and globalisation*. Minneapolis, MN: University of Minnesota Press.
- Hong Kong Psychological Society. (2012). *Position paper for psychologists working with lesbians, gays, and bisexual individuals*. Hong Kong: Author.
- Human Rights Watch. (2011). *World report 2011: The events of 2010*. Geneva: Author.
- Husakouskaya, N. (2013). Rethinking gender and human rights through transgender and intersex experiences in South Africa. *Agenda: Empowering Women for Gender Equity*, 27(4), 10–24.
- International Commission of Jurists. (2007). *Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity*. Retrieved from <http://www.refworld.org/docid/48244e602.html>
- International Federation of Health and Human Rights Organisations. (2012). *Step for change: A human rights action guide for health workers*. Retrieved from [https://www.ifhhro.org/images/stories/ifhhro/manuals\\_and\\_guidelines/ifhhro\\_steps\\_for\\_change\\_en.pdf](https://www.ifhhro.org/images/stories/ifhhro/manuals_and_guidelines/ifhhro_steps_for_change_en.pdf)
- International Lesbian, Gay, Bisexual, Trans and Intersex Association. (2015). *State sponsored homophobia*. Retrieved from [http://old.ilga.org/Statehomophobia/ILGA\\_State\\_Sponsored\\_Homophobia\\_2015.pdf](http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2015.pdf)
- International Planned Parenthood Federation. (2008). *Sexual rights: An IPPF declaration*. Retrieved from <http://www.ippf.org/resource/sexual-rights-ippf-declaration>
- International Union of Psychological Sciences. (2016). *International Declaration on Core Competences in Professional Psychology*. Retrieved from <http://www.iupsys.net/dotAsset/1fd6486e-b3d5-4185-97d0-71f512c42c8f.pdf>
- IPsyNet. (2016). *The International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues*. Retrieved from <http://www.apa.org/ipsynet/>
- Jobson, G. A., Theron, L. B., Kaggwa, J. K., & Kim, H. (2012). Transgender in Africa: Invisible, inaccessible, or ignored? *Journal of Social Aspects of HIV/AIDS*, 9(3), 160–163.
- Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry*, 82(4), 516–522.
- July, E. (2009). *Awareness, attitudes and referral practices of health care providers to psychological services in Botswana* (Unpublished master's dissertation). Nelson Mandela Metropolitan University, Port Elizabeth.
- Kemp, T. (2013). Three siblings with complete androgen insensitivity syndrome. *Journal of Endocrinology, Metabolism and Diabetes of South Africa*, 18(3), 159–163.
- Khan, G., & Moodley, Y. (2013). Breaking the silence: A discussion on intimate partner violence in gay-male relationships. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 237–258). Auckland Park: Fanele.
- Klein, T. (2008). Querying medical and legal discourses of queer sexes and genders in South Africa. *Anthropology Matters Journal*, 10(2), 1–17.
- Klein, T. (2009). Intersex and transgender activism in South Africa. *LIMINALIS*, 3, 15–41.
- Klein, T. (2013). Necessity is the mother of invention: Access inequalities to medical technologies faced by transgender South Africans. *Technology and Innovation*, 15, 165–179.

- Korell, S. C., & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender clients. In K. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 271–288). Washington, DC: American Psychological Association.
- Leatt, A., & Hendricks, G. (2005). Beyond identity politics: Homosexuality and gayness in South Africa. In M. van Zyl & M. Steyn (Eds.), *Performing queer: Shaping sexualities* (pp. 303–322). Cape Town: Kwela Books.
- Lee, J. (2014). Too cruel for school: LGBT bullying, noncognitive skill development, and the educational rights of students. *Harvard Civil Rights-Civil Liberties Law Review*, 49(1), 261–290.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York, NY: Haworth Clinical Practice.
- Lev, A. I. (2006). Intersexuality in the family: An unacknowledged trauma. *Journal of Gay & Lesbian Psychotherapy*, 10(2), 27–56.
- Lidderdale, M. A., Croteau, J. M., Anderson, M. Z., Tovar-Murray, D., & Davis, J. M. (2003). Building lesbian, gay, and bisexual vocational psychology: A theoretical model of workplace identity management. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 245–270). Washington, DC: American Psychological Association.
- Livermon, X. (2012). Queer(y)ing freedom: Black queer visibilities in postapartheid South Africa. *GLQ: A Journal of Lesbian and Gay Studies*, 18, 2–3.
- Lubbe-De Beer, C. (2013). Planned lesbian parenting in South Africa: Reflections on the process of clinically assisted donor insemination. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 159–184). Auckland Park: Fanele.
- Lynch, I. (2013). Erased, elided and made invisible? A critical analysis of research on bisexual parenthood and families. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 68–86). Auckland Park: Fanele.
- Lynch, I., Brouard, P. W., & Visser, M. J. (2010). Constructions of masculinity among a group of South African men living with HIV/AIDS: Reflections on resistance and change. *Culture Health and Sexuality*, 12(1), 15–27.
- Lynch, I., & Maree, D. J. F. (2013). Negotiating heteronormativity: Exploring South African bisexual women's constructions of marriage and family. *Feminism & Psychology*, 23(4), 459–477.
- Mandel, S. H. (2014). Targeting sexual stigma: The hybrid case study of “Adam”. *Pragmatic Case Studies in Psychotherapy*, 10(2), 48–105.
- Marnell, J. (2013). Home affairs: A photographic essay celebrating family diversity. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 89–92). Auckland Park: Fanele.
- Matebeni, Z. (Ed.). (2017). *Queering Cape Town: Queer in Africa III*. Heinrich Boell Foundation. Retrieved from [https://za.boell.org/sites/default/files/queering\\_cape\\_town\\_web.pdf](https://za.boell.org/sites/default/files/queering_cape_town_web.pdf)
- Matthews, C. R. (2007). Affirmative lesbian, gay and bisexual counseling with all clients. In R. M. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients* (pp. 201–219). Washington DC: American Psychological Association.
- McCoy, M. A., Stinson, M. A., Ross, D. B., & Hjelmstad, L. R. (2015). Who's in our clients' bed? A case illustration of sex therapy with a polyamorous couple. *Journal of Sex & Marital Therapy*, 41(2), 134–144.

- McLachlan, C. (2010). *Queering gender: An exploration of the subjective experience of the development of a transgender identity* (Unpublished master's dissertation). University of KwaZulu-Natal, Pietermaritzburg.
- McLachlan, C., & Nel, J. (2015, September). *Queering 'trans' children: Is psychology's treatment of gender non-conforming children benevolent?* Paper presented at the 21st annual South African Psychology Congress, Johannesburg.
- McNulty, A., Richardson, D., & Monro, S. (2010). *Lesbian, gay, bisexual and trans (LGBT) equalities and local governance research report for practitioners and policy makers*. (Research report). Retrieved from University of Huddersfield Repository: <http://eprints.hud.ac.uk/id/eprint/14271/1/selgreportmarch2010.pdf>
- Meier, S. C., Pardo, S. T., Labuski, C., & Babcock, J. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archive of Sexual Behaviour*, 42, 463–474.
- Meyer, A. C. (2003). *Riglyne aan opvoedkundige sielkundiges vir die hantering van die homoseksuele kliënt* (Unpublished master's dissertation). University of South Africa, Pretoria.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697.
- Milton, M., Coyle, A., & Legg, C. (2002). Lesbian and gay affirmative psychotherapy: Defining the domain. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and gay psychology* (pp. 175–197). Oxford: Blackwell.
- Mkhize, N. J. (2003). *Culture and the self in moral and ethical decision-making: A dialogical approach* (Unpublished doctoral dissertation). University of Natal, Pietermaritzburg.
- Moodie, T. D. (1987). *Migrancy and male sexuality on South African gold mines*. Retrieved from [http://wiredspace.wits.ac.za/bitstream/handle/10539/8008/HWS-289.pdf?sequence=1&origin=publication\\_detail](http://wiredspace.wits.ac.za/bitstream/handle/10539/8008/HWS-289.pdf?sequence=1&origin=publication_detail)
- Morgan, R., Marais, C., & Wellbeloved, R. J. (2009). *Trans: Transgender life stories from South Africa*. Auckland Park: Fanele.
- Msibi, T. (2012). 'I'm used to it now': Experiences of homophobia among queer youth in South African township schools. *Gender and Education*, 24(5), 515–533. doi:10.1080/09540253.2011.645021
- Muholi, Z. (2012). *Faces and phases*. Johannesburg: Prestel.
- Müller, A. (2012). *Sexual and reproductive health for transgender and gender non-conforming people: Guidelines for healthcare workers in primary care*. Cape Town: Gender DynamiX.
- Müller, A. (2013). Teaching lesbian, gay, bisexual and transgender health in South African health sciences faculty: Addressing the gap. *BMC Medical Education*, 13, 174.
- Müller, A. (2014). Professionalism is key in providing services to lesbian, gay, bisexual, transgender and intersex South Africans. *South African Medical Journal*, 104(8), 558–559.
- Müller, A. (2015). Strategies to include sexual orientation and gender identity in health professions education. *African Journal of Health Professions Education* 7(1), 4–7.
- Müller, A., & Crawford-Browne, S. (2013). Challenging medical knowledge at the source: Attempting critical teaching in the health sciences. *Agenda: Empowering Women for Gender Equity*, 27(4), 25–34.
- Murray, S., & Roscoe, W. (Eds.). (1998). *Boy-wives and female husbands: Studies of African homosexualities*. New York, NY: St. Martin's Press.

- Naidu, T., & Ramlall, S. (2016). Establishing competence in talk therapy. In T. Naidu & S. Ramlall (Eds.), *Talk therapy toolkit: Theory and practice of counselling and psychotherapy* (pp. 80–101). Pretoria: Van Schaik.
- Nel, J. A. (2007). *Towards the 'good society': Healthcare provision for victims of hate crime from periphery to centre stage* (Unpublished doctoral thesis). University of South Africa, Pretoria.
- Nel, J. A. (2014). Editorial: South African psychology can and should provide leadership in advancing understanding of sexual and gender diversity on the African continent. *South African Journal of Psychology*, 44(2), 145–148. doi:10.1177/0081246314530834
- Nel, J. A., & Breen, D. (2013). Victims of hate crime. In R. Peacock (Ed.), *Victimology in South Africa* (2nd ed., pp. 239–253). Pretoria: Van Schaik.
- Nel, J. A., & Judge, M. (2008). Exploring homophobic victimisation in Gauteng, South Africa: Issues, impacts and responses. *Acta Criminologica*, 21(3), 19–36.
- Nel, J. A., Mitchell, Y., & Lubbe-De Beer, C. (2010, August). *Advocacy in working with LGBTI health and well-being issues*. Presentation at the Round Table Discussion at the PsySSA Congress, Durban.
- Nell, M., & Shapiro, J. (2011). *Out of the box: Queer youth in South Africa today*. The Atlantic Philanthropies. Retrieved from <http://www.atlanticphilanthropies.org/news/out-box-queer-youth-south-africa-today>
- Niels, T. (2001). Same-sex sexuality in Africa: A case study from Senegal. *AIDS and Behavior*, 5(2), 173–182.
- Nkoana, T., & Nduna, M. (2012). Engaging primary health care providers in transgender community health care: Observations from the field. *New Voices in Psychology*, 8(2), 120–129.
- Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014). Gender abuse and major depression among transgender women: A prospective study of vulnerability and resilience. *American Journal of Public Health*, 104(11), 2191–2198.
- Oswin, N. (2007). Producing homonormativity in Neoliberal South Africa: Recognition, redistribution, and the equality project. *Signs*, 32(3), 649–669.
- Pachankis, J. E., & Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity*, 1(s), 45–58.
- Page, E. (2007). Bisexual women's and men's experiences of psychotherapy. In B. A. Firestein (Ed.), *Becoming visible: Counselling bisexuals across the lifespan* (pp. 52–71). New York, NY: Columbia University Press.
- Peacock, R. (Ed.). (2013). *Victimology in South Africa* (2nd ed.). Pretoria: Van Schaik.
- Pillay, S. R. (2014, September). *The absence of gay Indians in the post-apartheid research agenda*. Paper presented at 20th National Psychology Congress of the Psychological Society of South Africa, Durban International Convention Centre, Durban.
- Polders, L. A., Nel, J. A., Kruger, P., & Wells, H. L. (2008). Factors affecting vulnerability to depression among gay men and lesbian women in Gauteng, South Africa. *South African Journal of Psychology*, 38(4), 673–687. doi:10.1177/008124630803800407
- Potgieter, C. (1997). From apartheid to Mandela's constitution: Black South African lesbians in South Africa. In B. Greene (Ed.), *Psychological perspectives on lesbian and gay issues: Ethnic and Cultural diversity among lesbians and gay men* (Vol. 3, pp. 88–116). Thousand Oaks, CA: Sage.
- Prinsloo, J. (2011). Negotiating transgender identities on the internet a South African study. *Agenda: Empowering Women for Gender Equity*, 25(4), 30–41.



- Psychological Association of the Philippines. (2012). Statement of the Psychological Association of the Philippines on non-discrimination based on sexual orientation. *Gender Identity and Expression*, 44(2), 229–230.
- Psychological Society of South Africa. (2007). *South African professional guidelines in psychology*. Johannesburg: Author.
- Psychological Society of South Africa. (2012). *Psychological Society of South Africa*. Retrieved from <http://www.psyssa.com/about-us/what-is-psyssa>
- Psychological Society of South Africa. (2013). *Sexual and gender diversity position statement*. Johannesburg: Author.
- Queer. (2016). In *Wikipedia*. Retrieved from <https://en.wikipedia.org/w/index.php?title=Queer&oldid=741155160>
- Rabie, F., & Lesch, E. (2009). 'I am like a woman': Constructions of sexuality among gay men in a low-income South African community. *Culture, Health & Sexuality*, 11(7), 717–729.
- Rankotha, S. (2005). How black men involved in same-sex relationships construct their masculinities. In M. van Zyl & M. Steyn (Eds.), *Performing queer: Shaping sexualities in 1994–2004* (Vol. 1, pp. 165–175). Cape Town: Kwela Books.
- Rebello, E., Szabo, C. P., & Pitcher, G. (2008). Gender assignment surgery on children with disorders of sex development: A case report and discussion from South Africa. *Journal of Child Health Care*, 12(1), 49–59.
- Reed, G. M., McLaughlin, C. J., & Newman, R. (2002). American Psychological Association policy in context: The development and evaluation of guidelines for professional practice. *American Psychologist*, 57, 1041–1047. doi:10.1037/0003-066X.57.12.1041
- Reid, G. (2013). *How to be a real gay: Gay identities in small-town South Africa*. Scottsville: University of KwaZulu-Natal Press.
- Republic of South Africa. (1996). Constitution of the Republic of South Africa (Act 108 of 1996). *Government Gazette*, 38. Pretoria: Government Printers.
- Reygan, F. (2016). Making schools safer in South Africa: An antihomophobic bullying educational resource. *Journal of LGBT Youth*, 13(1/2), 173–191.
- Reygan, F., & Lynette, A. (2014). Heteronormativity, homophobia and “culture” arguments in KwaZulu-Natal, South Africa. *Sexualities*, 17(5/6), 707–723.
- Rich, E. (2006). *Overall research findings on levels of empowerment among LGBT people in Western Cape, South Africa* (Unpublished report). University of South Africa, Pretoria.
- Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: The Guilford Press.
- Robertson, V., & Louw, C. (2013). Coming out to families: Adolescent disclosure practices in the Western Cape. In C. Lubbe-De Beer & J. Marnell, J. (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 259–286). Johannesburg: Jacana Media.
- Rothblum, E. D. (2012). From invert to intersectionality: Understanding the past and future of sexuality. In R. Das Nair & E. D. Butler (Eds.), *Intersectionality, sexuality and psychological therapies: Working with lesbian, gay and bisexual diversity* (pp. 263–268). West Sussex: Wiley.
- Rubin, G. (2011). *Blood under the bridge: Reflections on “thinking sex”*. London: Duke University Press.
- Sanchez, J. P., Sanchez, M. P. H., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health*, 99(4), 713–719.



- Sandfort, T. G. M., & Dodge, B. (2009). Homosexual and bisexual labels and behaviors among men: The need for clear conceptualizations, accurate operationalizations, and appropriate methodological designs. In V. Reddy, T. G. M. Sandfort, & R. Rispel (Eds.), *Perspectives on same-sex sexuality, gender and HIV/AIDS in South Africa: From social silence to social science* (pp. 51–57). Pretoria: Human Sciences Research Council.
- Sanger, N. (2013). *Safely queer on the urban peripheries of Cape Town*. Retrieved from [http://www.hsrc.ac.za/Research\\_Publication-22769.phtml](http://www.hsrc.ac.za/Research_Publication-22769.phtml)
- Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual identity trajectories among sexual-minority youths: Gender comparisons. *Archives of Sexual Behavior, 29*, 607–627. Doi:10.1023/A:100205850513
- Smith, A. D., Tapsoba, P., Peshu, N., Sanders, E. J., & Jaffe, H. W. (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet, 374*(9687), 416–422. doi:10.1016/S0140-6736(09)61118-1
- Soldati-Kahimbaara, K., & Sibeko, B. (2012). Gay Pride 2012. *New Voices in Psychology, 8*(2), 163–168.
- Stephens, A. V. (2010). *An exploration of hate crime and homophobia in Pietermaritzburg, KwaZulu-Natal: A research report commissioned by the Gay and Lesbian Network*. Pietermaritzburg: Gay & Lesbian Network.
- Stevens, M. (2012). *Transgender access to sexual health services in South Africa: Findings from a key informant survey*. Gender Dynamix. Retrieved from <http://www.genderdynamix.org.za/wp-content/uploads/2012/10/Transgender-access-to-sexual-health-services-in-South-Africa.pdf>
- Steyn, M., & Van Zyl, M. (2009). *The prize and the price: Shaping sexualities in South Africa*. Cape Town: HSRC Press.
- Substance Abuse and Mental Health Services Administration. (2015). *Ending conversion therapy: Supporting and affirming LGBTQ youth*. HHS publication no. (SMA) 15-4928. Rockville, MD: SAMHSA.
- Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.
- Swain, K., & Frizelle, K. (2013). Resistance and re(production): Becoming lesbian parents through assisted reproductive technologies. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 185–207). Auckland Park: Fanele.
- Swarr, A. L. (2009). “Stabane”, intersexuality, and same-sex relationships in South Africa. *Feminist Studies, 35*(3), 524–548.
- Tervalon, M., & Murray-Garcia, J. M. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.
- The Academy of Science of South Africa. (2015). *Diversity in human sexuality: Implications for policy in Africa*. Retrieved from <http://dx.doi.org/10.17159/assaf/0022>
- Theron, L. (2009). Trans-hate at the core of gender based violence? *Concerned Africa Scholars, 83*, 36–38.
- Tucker, A. (2009). Framing exclusion in Cape Town’s gay village: The discursive and material perpetration of inequitable queer subjects. *Area, 41*(2), 186–197.
- UN Office of the High Commissioner for Human Rights. (2012, September). *Born free and equal: Sexual orientation and gender identity in international human rights law*. HR/PUB/12/06. Retrieved from <http://www.refworld.org/docid/5065a43f2.html>

- Victor, C. J. (2013). *Lesbian, gay and bisexual clients' experience of psychotherapy and counselling: The search for LGBTI-affirmative practice* (Unpublished master's dissertation). University of South Africa, Pretoria.
- Victor, C. J., & Nel, J. A. (2016). Lesbian, gay, and bisexual clients' experience with counselling and psychotherapy in South Africa: Implications for affirmative practice. *South African Journal of Psychology, 46*(3), 351–363.
- Victor, C. J., & Nel, J. A. (2017). Developing an affirmative position statement on sexual and gender diversity for psychology professionals in South Africa. *Psychology in Russia: State of the Art, 10*(2), 87–102.
- Victor, C. J., Nel, J. A., Lynch, I., & Mbatha, K. (2014). The Psychological Society of South Africa sexual and gender diversity position statement: Contributing towards a just society. *South African Journal of Psychology, 44*(3), 292–302. doi:10.1177/0081246314533635
- Vipond, E. (2015). Resisting transnormativity: Challenging the medicalization and regulation of trans bodies. *Theory in Action, 8*(2), 21–44.
- Vu, L., Tun, W., Sheehy, M., & Nel, D. (2011). Levels and correlates of internalized homophobia among men who have sex with men in Pretoria, South Africa. *AIDS Behaviour, 16*, 717–723.
- Walker, B., & Mars, M. (2013). *LGBTI Cultural Competency Framework: Including LGBTI people in mental health and suicide prevention organisations*. Newtown: National LGBTI Health Alliance.
- Warner, M. (1999). *The trouble with normal: Sex, ethics and the politics of queer life*. Cambridge, MA: Harvard University Press.
- Watson, P., & Vally, S. (2011). *Sexual orientation and gender identity rights in education*. Johannesburg: Education Rights Project/GALA.
- Wells, H. (2005). *Overall research findings on levels of empowerment among LGBT people in KwaZulu-Natal*. Pretoria: OUT LGBT Well-being.
- Wells, H., & Polders, L. (2003). *Gay and lesbian people's experience of the healthcare sector in Gauteng*. Retrieved from file:///C:/Users/psych/Downloads/healthcare\_in\_gauteng\_research\_findings%20(1).pdf
- Wiersma, R. (2004). True hermaphroditism in southern Africa: The clinical picture. *Paediatric Surgery International, 20*(5), 363–368.
- Wiersma, R. (2011). The clinical spectrum and treatment of ovotesticular disorder of sexual development. In M. I. New & J. L. Simpson (Eds.), *Hormonal and genetic basis of sexual differentiation disorders and hot topics in endocrinology* (pp. 101–103). New York, NY: Springer.
- Wilchins, R. (2014). *Queer theory, gender theory: An instant primer*. Los Angeles, CA: Riverdale.
- Wilson, D., Marais, A., De Villiers, A., Addinall, R., & Campbell, M. M. (2014). Transgender issues in South Africa, with particular reference to the Groote Schuur Hospital Transgender Unit. *South African Medical Journal, 104*(6), 449–451.
- Wolf, E. C. M., & Dew, B. J. (2012). Understanding risk factors contributing to substance use among MTF transgender persons. *Journal of LGBT Issues in Counselling, 6*, 237–256.
- World Association for Sexual Health. (2014). *Declaration of sexual rights*. Retrieved from [http://www.worldsexology.org/wp-content/uploads/2013/08/declaration\\_of\\_sexual\\_rights\\_sep03\\_2014.pdf](http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf)
- World Health Organization. (2015). *Policy brief: Transgender people and HIV*. Geneva: Author.
- World Professional Association for Transgender Health. (2011). *Standards of care for the health of transsexual, transgender and gender non-conforming people*. Retrieved from <http://www.wpath.org/documents/SOC%20V7%2003-17-12.pdf>
- World Psychiatric Association. (2016). *Working group on sex, sexual and gender diversity: Medical education in psychiatry* (Unpublished manuscript).

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30*(4), 498–531. doi:10.1177/00100002030004002

Yen, J. (2007). A history of 'community' and community psychology in South Africa. In N. Duncan, B. Bowman, A. Naidoo, J. Pillay, & V. Roos (Eds.), *Community psychology: Analysis, context and action* (pp. 67–83). Cape Town: UCT Press.

## APPENDIX I:

### Collaborating Organisations

As indicated in the introductory section, the project that informs this guidelines document is a collaboration between PsySSA's Sexuality and Gender Division, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and the PsySSA African LGBTI Human Rights Project.

#### **Psychological Society of South Africa (PsySSA)**

PsySSA is a non-profit association of psychology practitioners and persons involved in the academic research and practical application of the discipline of psychology. Established in 1994, it is the nationally representative professional body for psychology in South Africa. PsySSA is committed to the transformation and development of South African psychology to serve the needs and interests of all South Africa's people. PsySSA advances psychology as a science, a profession and a means of promoting human well-being (see [www.psyssa.com](http://www.psyssa.com)).

#### **PsySSA's Sexuality and Gender Division**

As a division of the Psychological Society of South Africa (PsySSA), the mission of the Sexuality and Gender Division (SGD) is to promote a psychological understanding of the fields of sexuality and gender. The goal is to support PsySSA in its endeavour to ensure human well-being and social justice for all people. This is realised through SGD member participation in research, clinical practice, education and training, connectivity within and across disciplines, and advocacy that promotes understanding and inclusivity of all sexual and gender identities and expressions, and biological sex variances (see <http://www.psyssa.com/divisions/sexuality-and-gender-division-sgd/>).

#### **International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet)**

PsySSA is a member of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world working together to increase understanding of sexual orientation and gender-diverse people and to promote their human rights and well-being (see [www.ipsynet.org](http://www.ipsynet.org)).

#### **PsySSA African LGBTI Human Rights Project**

A significant innovation for PsySSA as a professional voluntary association has been the international and local donor-funded PsySSA African LGBTI Human Rights Project within the SGD. The overall goal of this project is to build PsySSA capacity in South Africa, and sub-Saharan Africa more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics.

## APPENDIX II:

### IPsyNet Policy Statement And Commitment On LGBTI Issues

1. We acknowledge, as subscribers to the principle that human rights are universal, and that all human beings are worthy of dignity and respect, including respect for diversity on the basis of sexual orientation, gender identity and gender expression, or differences in sex development. We believe that discrimination and psychological maltreatment are not consistent with international human rights aspirations (Universal Declaration of Ethical Principles for Psychologists, 2008). We actively support the development of and support for LGBTIQ+ affirmative and inclusive treatment as well as service provision.
2. We concur that psychology as a science and a profession has expertise based upon decades of research demonstrating that LGBTIQ+ identities and expressions are normal and healthy variations of human functioning and relationships. For example, as set out in the World Health Organization's ICD-10 (p. 11) homosexuality is not a diagnosable mental disorder. We actively challenge claims made by political, scientific, religious or other groups that claim or profess that LGBTIQ+ identities, expressions, and sex characteristics are abnormal or unhealthy.
3. As LGBTIQ+ identities and orientations are normative variations of human experience and are not diagnosable mental disorders, they do not require therapeutic interventions to change them.  
  
We support affirmative approaches to therapy for LGBTIQ+ people and reject sexual orientation and gender identity change efforts that stigmatise same-sex orientations and transgender identities, because they encourage prejudice and discrimination and have the potential for harm.
4. Transgender and gender nonconforming individuals have the right to live according to their gender identity and to access medical, psychotherapeutic, and social support as needed. This support should be offered irrespective of whether the person has a binary or nonbinary gender identity and whether they seek access to social or medical transition or one, several, or all treatments available. We furthermore support the full autonomy of transgender and gender nonconforming individuals in affirming their gender identities. Affirmative psychological support may be beneficial in their identity development and decision-making regarding social and medical transition (Coleman et al., 2012). We strongly oppose regulations forcing transgender and gender nonconforming individuals to undergo sterilization, divorce, or other procedures that might have stigmatizing or mentally, physically, or socially harmful effects in order to access desired transition supports. We affirm that transgender and gender nonconforming individuals have the right to define their identities as well as to decide on and access affirmative and transition-related health care as desired (Yogyakarta Principles, International Panel of Experts, 2007).
5. Some LGBTIQ+ people may experience psychological distress because of the impact of social stigma and prejudice against LGBTIQ+ people in general or their individual identity within the LGBTIQ+ spectrum. LGBTIQ+ individuals with non-monosexual (e.g., bisexual, pansexual) and non-cis identities (e.g., trans, nonbinary, agender), as well as LGBTIQ+ individuals with inter'sectional minority identities (e.g., based on race, ethnicity, disability, religion, gender, social class) may be especially at risk for minority stress, discrimination, both within and outside the LGBTIQ+ population, and resultant



- psychological difficulties. We condemn discrimination on the basis of intersecting minority identities within and beyond the LGBTIQ+ population. We furthermore actively support psychological research and practice that fully considers the intersectionality of LGBTIQ+ identities with others' identities such as ethnicity, social class, and religion.
6. Efforts to re-pathologise LGBTIQ+ orientations, identities or people by linking them to poor mental health misconstrue the effects of stigmatization and environmental hostility as inherent to LGBTIQ+ sexual orientations, gender identities and expressions, or biological variance. We advocate for the removal of the stigma of psychopathology from LGBTIQ+ identities and expressions, and oppose the misuse of research on health inequalities faced by LGBTIQ+ people that seek to misinform the public and attempt to re-pathologise LGBTIQ+ people.
  7. Psychologists' lack of information and misinformation about LGBTIQ+ people and identities can perpetuate discrimination, stereotyping, and the potential for physical and mental health abuse. We advocate that LGBTIQ+ people are included as experts and active, equal partners in research and policy development for research and policy initiatives that concern them. We support the development of psychological research and education that is not hetero- or cis-normative (e.g., Clarke et al., 2010). Moreover, we provide psychological knowledge to psychological networks, organizations, policymakers, the media and the public. Finally, based on scientifically-grounded knowledge we advocate for greater awareness of the health and well-being needs of LGBTIQ+ people in order to improve public policy and LGBTIQ+ communities.

## **APPENDIX III:**

### **PsySSA Sexuality and Gender Division**

## OUR MISSION

As a division of the Psychological Society of South Africa (PsySSA), the mission of the Sexuality and Gender Division (SGD) is to promote a psychological understanding of the fields of sexuality and gender. The goal is to support PsySSA in its endeavour to ensure human well-being and social justice for all people. This is realised through SGD member participation in research, clinical practice, education and training, connectivity within and across disciplines, and advocacy that promotes understanding and inclusivity of all sexual and gender identities and expressions, and biological sex variances.

The SGD focuses its efforts within the unique South African context, but also cultivates continental and international networks for mutual interest in the fields of sexuality and gender in Psychology. Within the area of sexuality and gender, we are committed to cooperative relationships across disciplines - within PsySSA, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and other professional organisations, including relevant civil society organisations; research, training and education institutions; applied entities and individuals, and the general public - in achieving our objectives.



## OUR MEMBERS

Our membership consists of a diverse group of psychology professionals including clinicians, researchers, teachers, community practitioners, health workers and students from a variety of disciplines across South Africa and the rest of the continent. To all mental health professionals who are interested in the social and mental well-being of all South Africans.



**"A division in a voluntary professional association is the sum of its active members, no more, no less. A division only shines through in its potential to provide a sense of belonging. This sense is made possible by the professional and collegial mutual efforts of the individuals, groups and organisations involved in the division - only the strength of the engaged 'we' can realise this potential to the benefit of all stakeholders."**

Niel Victor, 2016



To join, or find out more:

[www.psyssa.com/divisions/sexuality-and-gender-division-sgd/](http://www.psyssa.com/divisions/sexuality-and-gender-division-sgd/)

The website contains useful additional information and resources, as well as the contact details for the current SGD Executive. Visit regularly for updates.



[www.facebook.com/sgdpsyssa](http://www.facebook.com/sgdpsyssa)

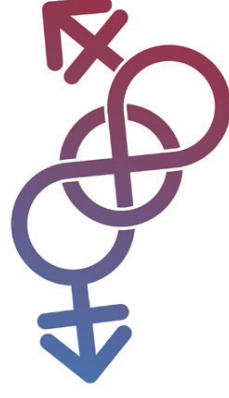


[@SGDPsySSA](https://twitter.com/SGDPsySSA)

Contact the PsySSA office:

+27 11 486 3322 / [info@psyssa.com](mailto:info@psyssa.com)

IPsyNet [www.ipsynet.org](http://www.ipsynet.org)



# SEXUALITY AND GENDER DIVISION



## OUR WORK

The SGD is active in a range of activities across diverse contexts towards the achievement of our goals:



### Research

Our members are continuously involved in empirical and theoretical work on sexual orientation, gender identity and biological sex, as well as work on gender-based violence, intersectionality and social justice, and sexual and reproductive health. Much of this is reflected in the strong sexuality and gender focused stream at PsySSA congresses as well as academic and general publications.



### Education

We provide training and workshops for students, clinicians, health workers and academics, informed by the PsySSA Sexual and Gender Diversity Position Statement (2013), amongst others, on the provision of sexual and gender-affirming and inclusive practices. This includes both general training offered as well as customised programmes based on specific requests and needs.



### Advocacy and Expert Opinion

We engage in advocacy efforts and policy development on issues concerning sexual and gender rights, both in South Africa and elsewhere. Through our network, we are also able to provide expert opinions related to this field of interest.



### Practice

We are committed to the development and dissemination of sexual and gender-affirmative practice across the spectrum of mental health providers in South Africa. This includes PsySSA's first position statement, namely on sexual and gender diversity, that was approved in 2013.



PsySSA is a member of the **International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet)**, and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world working together to increase understanding of sexual orientation and gender-diverse people and promote their human rights and well-being.



**Sexual diversity:** The range of different expressions of sexual orientation and sexual behaviour that spans across the historically imposed heterosexual-homosexual binary.



(PsySSA Sexual and Gender Diversity Position Statement, 2013)\*

## PsySSA African LGBTI Human Rights Project

A significant innovation for PsySSA as a professional voluntary association, has been the international and local donor funded 'PsySSA African LGBTI Human Rights Project' within the SGD. The overall goal of this project is to build PsySSA capacity in South Africa, and Sub-Saharan Africa more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics. A fantastic opportunity for researchers, practitioners and activists to get involved in this area of work!



\* Psychological Society of South Africa (PsySSA). (2013). Sexual and gender diversity position statement. Retrieved from [http://www.psyssa.com/wp-content/uploads/2015/12/PsySSA\\_position\\_statement\\_sexual\\_gender-1.pdf](http://www.psyssa.com/wp-content/uploads/2015/12/PsySSA_position_statement_sexual_gender-1.pdf)

## SOME OF OUR MILESTONES

- 2007** PsySSA joins IPsyNET (International Psychology Network for LGBTI Issues)
- 2009** First focused LGBTI programming at a PsySSA Congress, which has grown to be a premier annual event bringing together the best scholarly and applied work around sexuality and gender in Psychology in South Africa
- 2010** Statement to the Ugandan government offering a science-based assessment of the proposed "Anti-Homosexuality Bill of 2009" and calling upon them to abandon or defeat it
- 2010** Open statement to the United Nations (UN) following and condemning the South African vote to remove a reference to sexual orientation from the UN resolution condemning extrajudicial, summary and arbitrary executions and other killings
- 2011** Recipient of substantial international funding to support the activities of the Division – the first PsySSA Division/ Interest Group to do so
- 2013** Development and adoption of the PsySSA Sexual and Gender Diversity Position Statement– a first for the Society, which promotes an affirmative stance in working with sexually and gender diverse South Africans in the mental health context
- 2014** Official launch of the Division at the 20th PsySSA Congress
- 2014** Receive an award at the PsySSA AGM for Most Improved Division
- 2015** SGD Executive Member Prof Juan Nel contributes to the publication of Diversity in Human Sexuality: Implications for Policy in Africa, by the Academy of Science of South Africa (ASSAF)
- 2016** Endorsement by PsySSA Presidency of IPsyNet Statement and Commitment to LGBTIQ+ Affirmative Psychological & Psychotherapeutic Practice and Research



## APPENDIX IV:

### Example Of General Practitioner Consent Form

#### Informed Consent Form:<sup>5</sup>

##### Feminising Hormone Therapy

Hormone therapy changes your body so that it becomes more like that of a woman.

It can take many months before the changes become obvious and some changes can take years before being complete. Patients respond in different ways to hormones, and changes do not happen at the same time or in the same way for everyone. Patients do not all take the same hormones or at the same dose.

Taking more hormones than prescribed will not make your body change faster and may even slow down or stop these changes.

##### The changes:

###### **Breasts:**

If you are taking oestrogen, you will probably develop breasts. It may take a couple or more years to develop to their full size. The changes may be permanent even after stopping therapy.

###### **Skin and hair:**

Your skin may become softer. Facial hair may grow more slowly but will not disappear.

If you have already started to develop baldness on your head, the hair will probably not grow back naturally.

###### **Body shape:**

Your muscles will become smaller and lose some strength.

Body fat will gather in new parts of the body, which should give the body a female shape.

###### **Genitals, sexual function and fertility:**

You may become permanently infertile.

In the meantime, however, you might still be able to make someone pregnant and should consider using condoms or other methods if necessary.

If you wish to have children, you should discuss fertility options with your doctor before you start taking hormones.

The testicles will become smaller and make less testosterone.

There may be a lower sex drive and fewer – and weaker – erections.

###### **Voice:**

Your natural voice will not change and the Adam's apple will not get smaller.

###### **Mood:**

Your mood may change and you may feel more emotional.

##### Risks and side effects:

The risks of taking feminising therapy for many years are not yet fully known. The more common or serious known side-effects of therapy are mentioned here:

###### **Liver inflammation or liver damage**

- Thrombosis or blood clots: Oestrogen increases the risk of blood clots, which could result in a stroke, heart attack and sometimes death. Oestrogen may increase the risk of diabetes, high blood pressure and heart disease.

<sup>5</sup> Based on the Callen Lorde consent form, adapted by Dr Arnaud de Villiers as part of the Gender Dynamix [2013] hormone guidelines [see <https://genderdynamix.org.za>].



**Tumours:**

- Oestrogen may increase the risk of tumours of the pituitary, a gland in the brain. It is not common, is not cancerous and can be treated. It could affect eyesight and cause severe headaches.
- Hormones may put you at higher risk of breast cancer.

**Other effects:**

- Spironolactone may cause low blood pressure and changes to the heart rhythm, which could be life-threatening.
- Feminising medication could interact with some other drugs. Always check with your doctor or pharmacist.

**Extra risk:**

- There is a greater risk of the dangerous side effects from oestrogen if you smoke, are overweight, over 40 years old, or have a history of

blood clots, high blood pressure, or a family history of breast cancer.

- You are strongly advised to stop smoking completely before starting oestrogen.
- Too much alcohol puts an extra strain on your liver.
- To help reduce or identify any possible complications of therapy, you should have regular check-ups as part of your treatment plan. Breasts and prostates should be checked regularly according to the cancer-prevention programme.
- You should not change or stop your hormone treatment without consulting your doctor.

---

Patient's declaration:

I confirm that I have read and understand the information above.

I confirm that my doctor has told me about the effects of feminising hormone treatment, including the more common or serious risks and side-effects as mentioned above. I understand that some of these effects may be permanent. I understand that, as part of my treatment plan, I shall take my medication as prescribed and have check-ups, including blood tests, as required.

I hereby agree that my doctor start/continue treating me with feminising hormone therapy.

---

Patient Signature

Date

Place

---

Prescribing clinician Signature

Date

Place

For official use:

This form is for use within an informed consent healthcare model. It is not intended to substitute any aspect of clinical interaction between the clinician and the patient including, but not limited to, health education, behaviour modification and counselling.

## ACKNOWLEDGEMENTS

The members<sup>6</sup> of the PsySSA African LGBTI Human Rights Project who gave their time, commitment and enthusiasm to compile these guidelines are:



(From left to right): Delene van Dyk, Chris McLachlan, Liesl Theron, Cornelius Victor, Suntosh Pillay, Juan Nel

### Core team members:

Co-project leaders: Mr Cornelius J Victor and Prof. Juan A Nel

Assisted by Mr Suntosh Pillay, Revd Chris McLachlan, Ms Delene van Dyk and Ms Liesl Theron

Extended team of critical readers and subject specialists:

Mr Pierre Brouard, Dr Peace Kiguwa, Prof. Melanie Judge, Ms Ella Kotze, Mr Jonathan Bosworth, Ms Angeline Stephens, Ms Lusajo Kajula (Tanzania), Dr Elma de Vries, Ms Casey Blake, Ms Letitia Rambally Greener, Mr Joachim Ntetmen (Cameroon), Ms Carol Musikanth, Dr Yaseen Alley and Mr Graeme Hendricks

The project team gratefully acknowledges the following individuals and organisations for their valuable contributions and collaborative efforts that have led to the successful production of this document:

Professor Harry Dugmore for his relentless hard work in further researching, handling and incorporating comments into the document, as well as sound advice regarding packaging the materials.

Ms Jackie Viljoen for editing the document.

Mr Nantes Pieterse for assistance in finalising the reference list.

Kim Mathurine for the design and layout of the document.

Our gratitude goes to the Arcus Foundation for generous funding of the project; Dr Clinton Anderson and Mr Ron Schlittler from the American Psychological Association's Lesbian, Gay, Bisexual and Transgender Concerns Office; Ms Fatima Seedat (Executive Director of PsySSA), the Executive Committee of PsySSA and the PsySSA Council (in particular, the Ethics Standing Committee and Equity and Transformation Standing Committee); as well as each and every individual and organisation who provided their voice in the creation of these guidelines.

<sup>6</sup> Unless indicated, otherwise, all members of the team are from South Africa