

**LESBIAN, GAY AND BISEXUAL CLIENTS' EXPERIENCE OF
PSYCHOTHERAPY AND COUNSELLING: THE SEARCH FOR
LGBTI-AFFIRMATIVE PRACTICE**

by

CORNELIUS JOHANNES VICTOR

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SUPERVISOR: PROF JA NEL

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ABSTRACT

Despite legal and policy advancements in South Africa, prejudice, discrimination and victimisation are still a reality for many lesbian, gay and bisexual (LGB) people in the country. The Psychological Society of South Africa (PsySSA) has embarked on a process to develop lesbian, gay, bisexual, transgender and intersex (LGBTI) affirmative practice guidelines for psychology professionals, when working with these client populations. As a part of the larger objective, this research study highlights LGB people's experiences of psychotherapy and counselling in South Africa as possible inputs for the mentioned practice guidelines. Qualitative in-depth interviews were conducted with selected participants. The results indicate that some aspects of LGB people's experiences are similar to those of anyone in psychotherapy or counselling, but also that there are distinct differences. Negative experiences were almost exclusively due to the counsellor being disaffirming of the client's sexual orientation. Self-acceptance and the development of alternative perspectives of sexuality were more prominent outcomes of counselling compared to studies among broader populations. The participants' feedback on a list of affirmative statements provides a potential basis for future affirmative practice guidelines.

Keywords: Lesbian; gay; bisexual; LGB; sexual minorities; sexual orientation; client experiences; experience of psychotherapy; experience of counselling; affirmative practice; LGBTI-affirmative; Community Psychology; social intervention.

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DECLARATION

I declare that “Lesbian, gay and bisexual clients’ experience of psychotherapy and counselling: The search for LGBTI-affirmative practice” is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

.....

Cornelius Johannes Victor

Student number: 3339 3702

.....

Date

GLOSSARY¹

Affirmative approach: An approach to psychological practice that recognises lesbian, gay, bisexual, transgender and intersex (LGBTI) sexualities and gender identities as normal variations of human sexuality and not as psychopathological. It emphasises the importance of contextual awareness, including an understanding of how factors such as homophobia, transphobia, heterosexism, prejudice and stigma impact on mental health and well-being.

Bisexual: A person who is capable of having sexual, romantic and intimate feelings for or a love relationship with someone of the same gender and with someone of other genders. Such an attraction to different genders is not necessarily simultaneous or equal in intensity.

Coming out: A term describing the process of disclosing one's sexual orientation. In heteronormative contexts the expectation to disclose one's sexual orientation is typically associated with non-heterosexual orientations, while heterosexuality is generally assumed unless indicated otherwise. Coming out is a process of how one wants to be identified in relation to others. When an individual chooses not to come out (which is their right), the colloquial term used is "to be in the closet".

Gay: A man who has sexual, romantic and intimate feelings for or a love relationship with another man (or men).

Gay-affirmative therapy: A term possibly coined by Weinberg in 1972 to refer to a therapeutic approach to LGBTI individual and group therapy and counselling with one of its basic premises that same-sex sexuality is a normal variation of human sexuality, thereby rejecting any pathologising based on sexual orientation.

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

¹ Sources used in compiling this glossary include Clarke, Ellis, Peel, and Riggs (2010), Lalla-Edward (2010), Nel (2007), PsySSA (2013), and Wells and Polders (2003).

Gender non-conformity: 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.

Hate crime: Any incident that may or may not constitute a criminal offence, perceived as being motivated by prejudice or hate. Perpetrators seek to demean and dehumanise their victims, whom they consider different from them based on their actual or perceived race, ethnicity, gender, age, sexual orientation, disability, health status, nationality, social origin, religious convictions, culture, language or other characteristic.

Healthcare providers: People who provide care, services and supplies related to the promotion, maintenance and restoration of the health of an individual. This includes preventative, diagnostic, therapeutic, rehabilitative, maintenance and palliative care as well as counselling. Healthcare providers include nurses, doctors, social workers, psychologists and counsellors, other mental health professionals and traditional healers.

Hegemony: An ideology which dominates in a society and exerts power over other rival ideologies. Central to the notion of hegemony is that it dominates in taken-for-granted ways, where the dominant ideology elicits the support of the oppressed by being seen as legitimate and accepted. In this manner the power relations stipulated by the hegemonic ideology are regarded as normal, inevitable and beneficial to everyone.

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 also determine what is regarded as viable or socially valued masculine and feminine identities, *i.e.* it serves to regulate not only sexuality but also gender.

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.

Heterosexual: Having sexual, romantic and intimate feelings for or a love relationship with a person or persons of a gender other than your own.

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

Homophobia: Also termed “homoprejudice”, it refers to an irrational fear of and/or hostility towards lesbian women and gay men, or same-sex sexuality more generally.

Homosexual: A term used to refer to people whose primary emotional and sexual attraction is to people of their own sex. It is often considered by LGBTI people to be a negative, clinical or derogatory term.

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 impacting on a person in interrelated ways.

Intersex: 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”.

Lesbian: A woman who has sexual, romantic and intimate feelings for or a love relationship with another woman (or women).

LGB/LGBT/LGBT(I)/LGBTI/LGBQ: Abbreviations referring to lesbian, gay, bisexual, transgender, intersex and queer persons. “LGB” are sexual orientations, while “T” is a gender identity and “I” is a biological variant. They 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 or to whom these labels may be assigned ought not to be trivialised. Their respective issues, experiences and needs may in fact differ significantly and in several respects.

MSM/Men who have sex with men: A term that first appeared in the 1990s in reference to men engaging in sexual activity with other men. This is a behavioural concept and does not

indicate sexual orientation, nor does it specify a minimum number of sexual acts, a minimum number of male partners, or a minimum period of time a man engages in sexual activities with another man.

Position statement: Refers to a document outlining a professional body's stance 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.

Queer: An inclusive term that refers not only to lesbian and gay persons, but also to any person who feels marginalised because of her or his sexual practices, or who resists the heteronormative sex/gender/sexual identity system.

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.

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

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

Significant other(s): Person(s) who have an important influence on an individual's life and well-being. These could include their romantic partner(s), friends, and biological or social family.

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 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 a polarised, dichotomous construct. This broad term encompasses cross-dressers, gender benders, transsexuals, genderqueers, people who are androgynous, and those who defy what society tells them is appropriate for their gender. Transgender people can be heterosexual, bisexual, homosexual or asexual.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 THE SOUTH AFRICAN CONTEXT

Given its history of colonial and racial politics of oppression, South Africa faces unique challenges. These politics have led to the continued intellectual dominance by minority Western thought to the exclusion of a more inclusive, broad-based thinking that gives equal voice to the diversity in the country (Baloyi, 2008). Similarly, the discourses on sexual orientation have been polarised. Sexual orientation was part of the anti-discrimination struggle for human rights, and remains a part of human rights debates, while at the same time discourses have raged on homosexuality as un-African and a continuation of the colonialism by the West (Leatt & Hendricks, 2005).

The advent of democracy in South Africa brought with it an era of significant development of the legal rights of lesbian, gay and bisexual (LGB) people. The new constitution of the country enshrined the right to non-discrimination on the basis of sexual orientation, making South Africa the first country in the world to do so. This led to significant strides in relevant legislation, which since 1998 includes protection against labour discrimination on the basis of sexual orientation, and more recently, in 2006, allows same-sex marriages (Brouard & Pieterse, 2012). The inclusion of sexual orientation in the general struggle for human rights is testament to the involvement of LGB people in this struggle (Gevisser & Cameron, 1994).

The significant advancements in the legal protection of LBG people have, however, not necessarily filtered through to the general public. Quantitative studies among lesbian, gay, bisexual and transgender (LGBT) individuals living in metropolitan areas of South Africa have indicated high levels of homophobic discrimination (Rich, 2006; Stephens, 2010; Wells, 2005; Wells & Polders, 2004). A nationally representative study conducted in 2007 indicated that 88% of the South Africa population believed that it is always or almost always wrong for two adults of the same sex to have sexual relations (Roberts & Reddy, 2008). A small study among undergraduate students at the University of the Western Cape indicated that 71% viewed same-sex marriages as strange, 40% supported discrimination against homosexuals, and 46% indicated that homosexuals should be denied the right to adopt children (Mwaba, 2009).

In their more extreme forms, prejudice, discrimination and victimisation have given rise to gruesome and extreme hate crimes, including the murder of people because of their sexual orientation, and so-called “corrective rape” – the rape of lesbian women to supposedly “correct” their sexual orientation (Brouard & Pieterse, 2012; Mbele & Ndabeni, 2013; Nel & Judge, 2008).

Our society is heavily influenced by a resurgent post-apartheid patriarchal hegemony that contributes to high levels of both sexual- and gender-based violence as well as increased risky sexual behaviour among many South African men. Poverty, violence, unemployment, poor education, poor service delivery and familial reliance further place sexual minorities in difficult and potentially dangerous positions, which can also threaten the very human rights LGB people fought for (Dartnall & Jewkes, 2013; Lynch, Brouard, & Visser, 2010; Swarr, 2009). In commenting on this state of affairs, Brouard and Pieterse (2012, p. 60) concluded that “to foster acceptance and ensure equality, societal attitudes will need to be shifted, and this implies mobilisation and transformation, not just reformation”.

1.2 MENTAL HEALTHCARE PROVISION FOR SEXUAL MINORITIES IN SOUTH AFRICA

The impact of prejudice and discrimination on the mental health of LGB people has been well-documented (Harper, 2005). In South Africa, this includes an increased risk of post-traumatic stress disorder (PTSD) (Theuninck, 2000), vulnerability to depression (Polders, Nel, Kruger, & Wells, 2008) and the risk of suicidal ideation (Wells, 2006). Current healthcare practices in South Africa often assume heterosexuality in service delivery, which negatively impacts the quality of the support rendered to LGB people and serves as a barrier to access healthcare services. The majority of the providers appear ignorant of sexual orientation issues or have difficulty providing adequate services (Nel, 2007; Nel & Judge, 2008). Their lack of understanding is partially due to their lack of training on sexual minority issues in healthcare (Coetzee, 2009; Nel, 2007).

Psychology, either by remaining silent or being actively supportive of the political mainstream of the day, has been an oppressive force for many minorities, including sexual minorities, in South Africa (July, 2009; Yen, 2007). This included human rights abuses against gay male conscripts in the then South African Defence Force, such as compulsory reparative psychotherapy with electroconvulsive shock treatment, and arguments in court by

psychologists that same-sex sexuality was a sickness and a sin that could be cured psychologically or spiritually (Nel, 2007).

In recent years, progress has been made in establishing more sexual orientation-affirming practices, as evidenced by the position statement on homosexuality by the South African Society of Psychiatrists (SASOP) (2005) and the strong LGB-affirmative stream of presentations at the more recent PsySSA conferences (Nel, Mitchell, & Lubbe-De Beer, 2010).

1.3 LESBIAN-, GAY- AND BISEXUAL-AFFIRMATIVE PRACTICE

Affirmative health services for LGB people developed in North America and northern Europe from the early 1960s with the move away from viewing homosexuality as a pathology to an understanding of different orientations as normal variants of human sexuality. This move coincided with mounting evidence of the poor success rates of conversion therapies (Nel, 2007). By the 1990s, individual authors and local mental health organisations and associations started developing position statements, standards of care and practice guidelines to assist providers when working with LGB people. The individual authors include Davies in the UK (1996) and Schippers in the Netherlands (1997), and the associations include the American Psychological Association (2000, 2011), the Australian Psychological Society (2010) and the British Psychological Society (2012), to name but a few.

The international practice guidelines, however, might not provide for the potentially unique situation in South Africa and also the rest of Africa. There have been increasing calls in recent years for the development of affirmative guidelines for psychotherapeutic practice in Africa (Nel, 2007; Nel, 2010; Nel *et al.*, 2010). Consequently, PsySSA, the only member of the International Network on Lesbian, Gay & Bisexual Concerns & Transgender Issues in Psychology (INET) in Africa, has embarked on a process to develop guidelines for lesbian, gay, bisexual, transgender and intersex (LGBTI) affirmative psychological practice specifically for the African context. Such guidelines could be a significant step in the drive to normalise LGBTI people and their lives on our continent. In the words of the previous president of PsySSA, Prof Kopano Ratele, “each of us should be taking a lead in developing Psychology and deploying its insights for the enhancement of human well-being in this society and beyond the borders of South Africa” (University of South Africa Centre for Applied Psychology, 2011, p. 5).

As a precursor to the guidelines, the PsySSA Executive Committee recently approved a position statement for psychology professionals working with sexual and gender diversity (PsySSA, 2013). The guidelines will provide a framework for research, debate and the development of an LGBTI-affirmative stance in, among other things, training, education and policy frameworks. These guidelines could potentially have a systemic change effect within psychology as a discipline and the mental health environment, have interdisciplinary impact, as well as serve as comment on broader societal and contextual issues, such as heteronormativity, prejudice, discrimination and victimisation.

1.4 PURPOSE OF THE STUDY

Given the unique South African context and mental health provision in the country, PsySSA reached the decision to first develop LGBTI-affirmative practice guidelines for use in South Africa before embarking on the task of developing similar guidelines for broader application in the rest of Africa. Against this background, the need was identified to explore LGBTI people's experiences of psychotherapy and counselling as potentially unique South African characteristics that need to be taken into account, thereby providing an LGBTI client voice to guide the structure and content of the guidelines. As the literature review will show, very little research is available on LGBTI-affirmative practice as well as on LGBTI people's experiences of psychological and mental health services in the South African context.

Taking cognisance of the potential complexity of research among LGBTI people within the confines of a dissertation of limited scope, as well as the researcher's lack of financial resources, the decision was made to focus this study on sexual orientation, and more specifically researching LGB people's experiences of psychotherapy and counselling.

The research was undertaken as a form of social intervention (Nelson & Prilleltensky, 2005) in the hope that it will (a) provide LGB people with the experience of their stories being listened to, (b) become a tool to create awareness of the relevant issues, (c) assist in challenging assumptions and stereotypes, (d) assist in an improved understanding of the unique perspectives and experiences of LGB people, and (e) that this knowledge be used by therapists and counsellors to improve their practice (Clarke, Ellis, Peel, & Riggs, 2010).

1.5 OUTLINE OF THE DISSERTATION

Chapter 2 offers a literature review. A discussion of Community Psychology, the ecological metaphor and ideas of social intervention as theoretical framework for the study is followed by an introduction to sexual orientation and the debates on sexual orientation. More specifically, prejudice, discrimination and victimisation on the basis of sexual orientation, as well as the potential impact of these on mental health are outlined. This leads to an exposition of healthcare provision for sexual minorities, specifically psychological services in South Africa, which opens the way for an outline of LGB-affirmative practice. The chapter concludes with a discussion of research on client experiences of psychotherapy and counselling with reference to South African research among LGB people.

For the purposes of this research, qualitative in-depth interviews were conducted with 15 selected participants. The research design is discussed in Chapter 3, followed by the research findings in Chapter 4. The final chapter, Chapter 5, summarises the key findings, highlighting potential statements for inclusion in affirmative guidelines for working with LGB people in South Africa.

1.6 THE USE OF TERMINOLOGY

The glossary (on p. ix) elucidates certain terms used in this dissertation as it relates to the area of study. Unless otherwise indicated, the term “counsellor” refers to either a psychotherapist or counsellor. Similarly, “counselling” refers to either psychotherapy or counselling. Where participants or other authors used the term “therapy” to refer to psychotherapy and/or counselling, it was retained.

The research studies discussed in this dissertation might have defined the population and sample of interest in different terms. These studies might have focused on either lesbian or gay or bisexual people, or else have included broader definitions of people, such as LGBT individuals, which include transgender people. Different terms might also have been used, for example “homosexual” when referring to lesbian or gay people, or both. These original definitions used by these authors have been retained in the discussion in the current study, even though this study focuses on LGB people only.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Community Psychology as a discipline, and specifically the ideas of the ecological metaphor and social intervention, provide a theoretical framework for this study. In this chapter, a discussion of sexual orientation is followed by a review of literature on prejudice, discrimination and victimisation, which provides important concepts within which LGB mental health is situated. This is followed by a short discussion of the issues dealt with by LGB people, including interpersonal relationships; diversity; religion and spirituality; age; physical, sensory and cognitive-emotional disabilities; physical and sexual health; and workplace issues.

Having created a context, mental health provision for LGB people, with specific reference to South Africa, is discussed. Using the Community Psychology ecological metaphor, the areas covered include legal, policy and strategic developments, mental health provision in communities, and psychological services in South Africa. At this point, the reader is introduced to views on affirmative practice and work done in this area in South Africa.

The chapter concludes with an overview of research on client experiences of psychotherapy and counselling, moving from the broad service user or the client globally to the specifics of LGB people in South Africa.

2.2 COMMUNITY PSYCHOLOGY AND THE ECOLOGICAL METAPHOR

2.2.1 What is Community Psychology?

Moving from the traditional psychology paradigm, which focuses on the individual and her or his deficits, Community Psychology endeavours to understand people in their context or ecology through a holistic analysis of the person within the multiple social systems within which they are embedded (Nelson & Prilleltensky, 2005). The focus therefore becomes the strengths of the individual or community living in difficult conditions with the understanding that people adapt as well as they can to oppressive and stressful situations, thereby enabling them to build on existing resources, capacities and strengths. The goal becomes the promotion of well-being and competence through self-help, community development, and social and political action.

The emphasis within Community Psychology is therefore on the active participation, choice and self-determination of the participants in an intervention. This makes it clear why it would be important to talk to LGB people about their experiences of psychotherapy and counselling and giving them feedback on the findings of their inputs as part of continued feedback in a recursive learning loop, as well as ensuring that LGB people's inputs are used as a basis for developing future practice (Kilgore, Sideman, Amin, Baca, & Bohanske, 2005). This way, the psychologist becomes a resource collaborator who brings science and social activism to community work, while the community stakeholders participate fully, providing fertile ground for the creation of knowledge and change of social conditions.

A further step is to realise that psychotherapy and counselling services could be provided by a broader array of providers than just psychologists, and that their inputs become important for affirmative practice guidelines. More specifically, psychology needs to be sensitised to the role that community-based organisations (CBOs) play, and can play, in the provision of mental health services to the LGB community. These practice guidelines could become a useful tool for CBOs and a broader range of providers in delivering services to LGB people – emphasising the circular and recursive nature of the ecology (Nelson & Prilleltensky, 2005).

In South Africa, Community Psychology developed against the backdrop of oppression and segregation under apartheid. Mainstream psychology did not challenge the *status quo* of racism in the country; the focus of Community Psychology was placed on social change and mental health issues (Yen, 2007). Within this environment of oppression and segregation, some issues have come to the fore, including that psychotherapeutic services were mainly available to the affluent or middle classes (predominantly white, even today), and that treatment approaches predominantly reflect Western values and are negotiated within a Western language – English (Baloyi, 2008). Health services are still underutilised by LGB people and other minorities due to discrimination and stigmatisation, or, if used, significant drop-out occurs after initial contact (Anova Health Institute, 2011a).

2.2.2 The area of concern for Community Psychology

Highly relevant to the struggle of LGB people, “the central problem with which CP [Community Psychology] is concerned is that of oppression, and ... the central goals of CP are to work in solidarity with disadvantaged people and to accompany them in their quest for liberation and well-being” (Nelson & Prilleltensky, 2005, p. 24). Community Psychology is

therefore concerned with liberation from oppression, as well as the achievement of personal, relational and collective well-being. This can be considered a refinement of the World Health Organisation's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organisation, 1946, p. 100).

Prilleltensky and Nelson (2002, p. 12) see oppression as "a state of domination where the oppressed suffer the consequences of deprivation, exclusion, discrimination, exploitation, control of culture, and sometimes even violence". The core of oppression is viewed as the power inequality in the system as indicated at various levels of analysis. On an individual level, the person internalises the dominant discourses on themselves – also referred to as internalised oppression – which can be psychologically damaging, leading to self-blame, personal worthlessness, or even more serious mental health issues such as depression, anxiety and substance abuse. The oppressed people are seen as inferior in relation to others and treated as such by those in power, which is reflected in, among other things, the use of derogatory terms such as "istabane" in Zulu and "moffie" in Afrikaans (Gevisser & Cameron, 1994; Nkabinde, 2008). Collectively, or at a societal level, inequality is embedded in larger structural arrangements which manifest in social policies and community settings, such as the lack of specialist provision for LGB people at mental health institutions and clinics (Lalla-Edward, 2010).

Within such a context, or ecology, it becomes important for disadvantaged people to reclaim their voices and power in their struggle to liberate themselves from oppression. This includes individual awareness and an understanding of the unjust psychological and sociopolitical circumstances oppressing them, as well as connecting with others in mutually supportive relationships in which power is shared, such as potentially found in self-help groups as exemplified by the OUT Psychotherapy Group in Pretoria (Nel, Rich, & Joubert, 2007) and the Triangle Project work in Cape Town (Clayton, 2001), as well as in social movement organisations which can also serve as vehicles for collective resistance and social action (Gevisser & Cameron, 1994; Nel, 2007).

Psychology's perceived or potential role within this struggle for liberation is twofold (and not necessarily complementary), namely (a) offering to assist disadvantaged individuals in order for them to better adjust to their social conditions, and (b) working with them towards social action and change. In so doing, the practitioner therefore becomes involved in challenging

generally held (heteronormative) assumptions, as well as raising people's awareness of the sources of problems (Nelson & Prilleltensky, 2005). Practice guidelines that are affirming of the minority, for instance, then represent potential social change at the level of policy to create a new vision of justice, well-being and empowerment for LGB people.

Well-being, as with liberation, has analytical implications at several systemic levels. At an individual level, it implies taking personal control, having and making choices, developing self-esteem, competence, independence and a positive identity, as well as achieving visible and actionable political rights. Relationally, well-being is when a person is rooted in a network of positive and supportive relationships, as well as being an active member of a community (Heller, 1989; Rappaport, 1981). At a societal or communal level, well-being implies the ability to acquire basic resources such as employment, income, education and housing (Nelson & Prilleltensky, 2005).

Community Psychology includes the areas of prevention and promotion in addition to treatment. Prevention refers to the reduction of contextual stress and resistance building in a system, whereas health promotion involves the proactive development of well-being and health in target populations (Cowen, 1994). In this sense, affirmative practice guidelines can be seen as a macro-level intervention to prevent the continuation of discrimination and social injustice in all their forms, as well as promote LGB mental well-being when psychotherapists and providers work with LGB people. The limitations of this concept are that prevention is often only associated with medical intervention, and can be focused on deficits rather than strengths of community members, such as resilience in the face of discrimination (Nelson & Prilleltensky, 2005).

2.2.3 The ecological metaphor in Community Psychology

The ecological metaphor refers to the interaction between individuals and the multiple social systems in which they are situated. Communities are viewed as open systems with many different levels and connections (D'Augelli, 2003). Human problems and competencies are perceived within the ecology of individual, micro-, meso- and macro-level systems. Competencies when dealing with the issue of bullying, for example, would include coping and negotiation skills in dealing with bullies at an individual level, family and peer support at a micro-level, the provision of structures to deal with bullies at school level (meso-level), and national educational policies dealing with the issue at a macro-level. Following the

Developmental Psychology ideas of Bronfenbrenner (1979), smaller systems are nested within the larger systems and the various levels are interdependent. The value of the ecological metaphor lies in its ability to conceptualise issues faced by oppressed people over time and across different levels of analysis.

Linney (2000) outlined three ways of thinking about and assessing environments, which would be relevant when evaluating LGB people's experiences of psychotherapy and counselling. These are

- the participants' perceptions of the environment, which could include
 - interpersonal perception – how caring and compassionate is a psychotherapist?
 - perception of personal development – is the need for self-determination addressed?
 - perception of systems maintenance and/or change – the balance between predictability and flexibility, such as openness to sexual orientation without it becoming the single focus;
- setting characteristics independent of the behaviour of the participants, such as ergonomics; and
- transactional analyses of the dynamic relationship between behaviour and context.

One limitation of this perspective is that it does not take into account the power differences within ecosystems (Becvar & Becvar, 2009). In the context of psychotherapy and counselling, it would therefore not address the power held by psychotherapists to stigmatise their clients and sustain negative perceptions – stigma and perceptions that could lead to (further) mental health challenges.

2.2.4 Liberation, well-being and social interventions in the LGB community

Nelson and Prilleltensky (2005) consider social interventions important as a basis for the promotion of well-being and liberation. Individual and organisational approaches are not sufficient to address the range of problems collectively faced. Social interventions address the power differences and impact on health and well-being as well as being the main vehicle for promoting larger transformational change. In line with the idea of prevention and promotion, Nelson and Prilleltensky (2005) discuss the idea of psychologists getting involved in social interventions. These authors are of the opinion that there is a need to change the social environment in which people live to give them a chance of improving their health and well-

being, for example change the way people think about psychotherapy and counselling with LGB clients. Such an intervention needs to go beyond social service provision to changing the systemic oppression at the root of the problem. According to Nelson & Prilleltensky (2005, pp. 162-3), social interventions are “intentional processes designed to affect the well-being of the population through changes in values, policies, programs, distribution of resources, power differentials and cultural norms”.

In the quest for the liberation and well-being of the LGB community or collective, Harper (2005) outlined a variety of social interventions at different levels within society, staying true to the ecological metaphor. South African and international examples of these are the following:

- LGB (mental) health promotion and prevention:
 - increased understanding that LGB people experience unique societal circumstances that may differentially impact their health and well-being, for example the Health 2020 blueprint by the US Federal Government (Baker, 2010; United States Department of Health and Human Services, 2010);
 - a brochure by OUT LGBT Well-being, a CBO in Pretoria, entitled “Understanding the challenges facing gay and lesbian South Africans: Some guidelines for service providers”, which supports their work on health promotion and prevention in the LGBT community (OUT LGBT Well-being, 2010);
 - best practice guidelines for healthcare providers developed by organisations within the HIV/AIDS and sexual health arena, such as “From top to bottom: A sex-positive approach for men who have sex with men – A manual for healthcare providers” by Health4Men, a project of the Anova Health Institute providing health services for men who have sex with men in South Africa (Anova Health Institute, 2011b);
- Building Community: LGB people and families unite:
 - CBOs, collective networks such as the Joint Working Group, and self-help groups who share a common concern, for example the youth group run by OUT LGBT Well-being in Pretoria;
- Collective Power: Gay rights liberation movement and community partnerships:

- the history of liberation in the United States and the four steps community psychologists can use to translate empowerment into action were discussed by Garnets and D'Augelli (1994);
- collaboration between universities and CBOs, such as the University of South Africa (Unisa) Centre for Applied Psychology and OUT LGBT Well-being in Pretoria (Nel, 2007);
- LGB legal issues and public policy: Towards inclusion and equity:
 - recent developments in South Africa in human rights, criminal justice and health (Nel, 2007); and
- LGB-related research:
 - well-publicised research on LGBT issues, such as those from large-scale quantitative studies by the Joint Working Group (JWG), a collective network of LGBTI organisations in South Africa (Baird, 2010; Rich, 2006; Wells, 2005; Wells & Polders, 2004).

2.3 SEXUAL ORIENTATION

2.3.1 Defining sexual orientation

One of the parameters of the study population is sexual orientation. Ritter and Terndrup (2002) believe that it is critical to provide clients with an understanding of the history and different definitions of sexual orientation as this could assist in their self-examination of their personal meaning of being an LGB person.

Sexual orientation is defined by the identity of the person whom an individual is physically and emotionally attracted to. Individuals who experience varying degrees of same-gender desire and attraction and engage in same-gender sexual behaviour are typically referred to with the terms “lesbians”, “gay men” and “bisexual women or men” (Harper, 2005). Increasingly, academics are moving away from using the term “homosexual” as this reflects the heterosexual bias in language, has negative connotations with psychopathology, and also a focus on only the sexual aspect of a person’s identity (Harper, 2005).

Bisexual participation in the LGB sector, and therefore knowledge of issues specific to this group, has been limited. The lack of accounts of bisexual life is possibly due to the fear of

disclosure and also of the potential impact of disclosure within both LGB and heterosexual circles (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 differences in South Africa appear to play an important part in defining one's sexual orientation. For most white South Africans, sexual orientation is considered basic to identity. In rural or poorer black and Coloured communities, however, sexual practices might not develop into identity formation. Sexual identities in these communities are more often based on traditional gender roles for men and women, whereby a "gay" man might see himself in the receptive role and refer to his sexual partner as "straight" (Nel, 2007; Rabie & Lesch, 2009; Reid, 2013).

Sexual orientation appears to be at least a multidimensional construct with a lack of precise and agreed upon definitions, but often narrowly defined only in terms of sexual behaviour and activity, sexual desire and arousal or sexual identity (Michaels, 1996). Several models have been developed to understand and assess sexual orientation, ranging from

- the traditional psychoanalytic dichotomy of homo- versus heterosexuality, linked to the unsuccessful resolution of the Oedipal conflict, to
- various models that allow for the measurement of bisexuality as an equal entity in the homo- versus heterosexual continuum, such as:
 - Kinsey and associates' idea of sexual orientation as a continuous variable that moved away from the homo- versus heterosexual dichotomy (De Cecco, 1990; McWhirter, Sanders, & Reinisch, 1990);
 - Klein's Sexual Orientation Grid (Klein, 1990), measuring sexual orientation as a multivariate and dynamic process;
 - Coleman's Assessment of Sexual Orientation (Coleman, 1990) as a tool to assist in clinical interviews, with the use of pie charts to represent an individual's sexual orientation rather than using a continuum;
 - the Multidimensional Sexuality Scale (Berkey, Perelman-Hall, & Kurdek, 1990); and
 - Weinberg, Williams and Pryor's work (1994) on bisexuality, which looked at sexual orientation on three dimensions, namely sexual feelings, sexual behaviours and romantic feelings.

By the mid 1990s, models that were designed included an increased number of variables, patterns and temporal dimensions. A key limitation of these models is that not all people label themselves in this way, nor do they attach the same meanings to some of the terms used. There is a need to be sensitive to the way in which people identify themselves rather than forcing them, almost linearly, in one or the other category (Page, 2007). The idea of “gay” identity development might require certain economic and social conditions, namely an urban environment where people have a higher level of voluntary mobility and find themselves in loosened family relations (Leatt & Hendricks, 2005). The incorporation of a more fluid understanding of sexual orientation in research poses significant challenges, but needs to be addressed through researchers being sensitive to how people call themselves and the meaning they attach to these words, as well as being clear on how they define who they want to speak to, and by implication who they exclude (Sandfort & Dodge, 2009).

2.3.2 Essentialism and social constructionism

According to essentialist theories, sexual orientation is either biologically determined or acquired early in life, and is fixed and unchanged. Numerous attempts have been made to discover the “cause” of an LGB orientation, and various different theories have been proposed regarding the origins of an LGB orientation. These include (a) the “gay gene” theory, which claims a genetic basis for the development of an LGB orientation; (b) the “gay brain” or neuroendocrine theory, which states that the brains of gay men have something in common with the brains of heterosexual women, and that the brains of lesbians and those of heterosexual men have something in common; and (c) early developmental theories, which view a gay identity as the product of a “close-binding intimate mother” and a “detached and hostile father”, implying that a gay identity is a pathological reaction to poor parenting. Essentialism is still the dominant discourse in our society and has been useful to human rights campaigns for LGB rights due to its position that sexual orientation is biologically determined and LGB sexual orientations therefore as natural as a heterosexual orientation (Clarke *et al.*, 2010).

Criticism of these theories has included that (a) they focus on being lesbian or gay rather than sexual orientation as a whole, including ignoring bisexuality or treating it as a variant of a lesbian or gay orientation; (b) essentialist research relies on models of sexuality based only on contemporary Western culture; (c) sexuality is a lot more fluid than the theories suggest; and (d) essentialist theories ignore the meanings people give to their sexualities and attempt

to classify them within the bipolar hetero- versus homosexual model, thereby excluding, for instance, men who do not identify as gay but have regular sex with other men (Clarke *et al.*, 2010).

In the mid 1980s, social constructionists began challenging essentialist conceptualisations of sexuality, arguing that “lesbian”, “gay”, “bisexual” and “heterosexual” are products or labels of particular historical, cultural and political contexts. Research within this area has focused on how people construct their identities, how sexual and gender identity categories are made “real” through social processes and interaction, and conceptualisations of sexuality across time and culture (Leatt & Hendricks, 2005). To some authors, sexuality is a choice or social process, therefore people could be empowered to reject heterosexual relationships in favour of same-sex relationships.

Social constructionism therefore creates the possibility of choice and agency in sexuality versus the biological determinism espoused by essentialist theories (Clarke *et al.* 2010). Politically, this position implies a move away from the fight against discrimination against LGB people to a fight against intolerance of differences based on any sexuality (Leatt & Hendricks, 2005).

2.3.3 Liberalism and radicalism

Liberal humanism is the dominant ideology in late modern Western cultures and emphasises the uniqueness and rights of individuals. The focus is on the essential humanness of LGB people and the small contribution of sexuality to overall humanness. Within this ideology, equal rights for LGB people have been campaigned for by way of social reform rather than social revolution, for example partnership, parenting and employment rights that is on a par with those of heterosexual people (Clarke *et al.*, 2010).

Radical theorists and activists, on the other hand, see the liberal political movements as normalising and ignorant of the ways in which LGB people are socially marginalised and therefore different from heterosexual people. Gay liberation, lesbian feminism and queer activism have more radical goals, namely that LGB people should not seek to fit in, and that heterosexual norms should not be the baseline for equality and social justice. They demand social transformation rather than equality (Clarke *et al.*, 2010). The liberal solution to heterosexism is education based on empirical data with the aim of changing attitudes and countering stereotypes. For radicals, the problem requires major social change.

Within the area of radical theory, queer theory requires a more detailed discussion. Queer theory developed as a critique of heteronormativity in the 1990s and is rooted in the work of Judith Butler (1990), amongst others. These theorists have been heavily influenced by the work of Michel Foucault, notably *The history of sexuality: An introduction, Volume 1* (Foucault, 1978). Foucault discusses power as relational and productive – power produces knowledge rather than simply repressing it. The goal of the queer theorist is working against power and not seeking freedom from power. Queer theory also builds on feminist critiques of essentialism. For instance, Butler (1990) theorised gender as something that people do rather than something they have or are. She used the concept of “performativity” to signal that gender is something outside our conscious control, and that society is organised around a belief of two genders and that gendered practices are shaped through these lenses.

A key element of queer theory is the rejection of sexual identity categories, for example “gay” and “lesbian”, as it views these as limiting self-expression. Butler (1990) viewed these categories as part of societal regulation. Rejecting these categories becomes important as meaningful resistance against power. Queer theorists define themselves as being in opposition to heteronormativity rather than in terms of defined sexual identities. This movement is therefore more inclusive than lesbian and gay movements, as it includes all those who reject heteronormativity in society, regardless of their sexual orientation (Steyn & Van Zyl, 2009).

2.4 PREJUDICE, DISCRIMINATION AND VICTIMISATION

2.4.1 Introduction

The following section comprises a discussion of general concepts relating to prejudice, discrimination and victimisation and the potential impact thereof on LGB people’s mental health in order to provide a context within which LGB people receive psychotherapy and counselling in South Africa. It is important to distinguish between the surface manifestations of problems, such as mental health problems, and the root causes of those problems. Disadvantaged people experience a multitude of health issues and psychosocial problems in everyday life. They are often isolated from a support network and experience powerlessness in relationships with others, such as work or intimate personal relationships. Powerlessness is related to discrimination, of which heterosexism is a form, and discrimination leads to exclusion and segregation from a range of social and community settings, such as the “pink ceiling” experienced in career advancement (Nelson & Prilleltensky, 2005).

2.4.2 Homophobia

The term “homophobia” was coined in the late 1960s by George Weinberg to describe heterosexual people’s fear, contempt and hatred of LGB people (Harper, 2005). Research on homophobia consistently reports that it is more common in men who hold conservative views and who lack personal contact with lesbians or gay men (D’Augelli, 1989). A local study among university students confirmed this pattern in attitudes towards lesbians and gay men: More negative views of lesbians and gay men were held by students who identified as heterosexual, men, more religious, and those who had had no previous contact with lesbian or gay people (Arndt & De Bruin, 2006). Findings on attitudes towards bisexual men and women were similar among a student sample (De Bruin & Arndt, 2010).

The purpose of identifying correlates of homophobia is to identify the people who are more at risk of perpetrating homophobia. Educational programmes could then be developed to target these groups. Such diversity training provides a tested strategy for use in workplaces and schools to combat homophobia. In a recent study, Coetzee (2009) evaluated a programme to change attitudes that focused on facts about LGB people, contact with LGB people and parallels between LGB people and other marginalised groups. The evaluation of this programme showed that it was an effective tool in changing attitudes (Coetzee, 2009).

2.4.3 Internalised homophobia

Internalised homophobia, also referred to as internalised oppression, internalised homophobia or internalised homonegativity, refers to the internalisation of and participation in prevailing negative societal stereotypes, attitudes and feelings towards being an LGB person (Nel, 2007). Research on internalised homophobia has looked at the effect of homophobia on substance use among LGB people (Amadio & Chung, 2004), as well as the experience of depression and anxiety, and suicide (Polders, 2006; Polders *et al.*, 2008; Theuninck, 2000; Wells, 2006). One of the key themes arising from a psychotherapeutic support group in Pretoria was self-devaluation. All the members had faced or were facing devaluation of who they were. The members often felt that their only worth was to serve others (Nel, 2007). In their evaluation of this theme, Nel and Joubert (1996) pointed out that self-denial and self-disgust develop in response to a homophobic context. Hiding one’s sexual orientation and not addressing homophobic attitudes and comments increase a sense of guilt and decrease self-worth. In a small qualitative study among five self-identified gay men in South Africa, Fourie (2002) explored stories of fears and dislikes about themselves and

fears and dislikes about them they felt others had had or had. Their dislikes centred around stereotypical gay behaviour, pressure to prove oneself, the lack of action around gay rights and lifestyles, and certain own personality traits, such as “bitchiness”.

A point of criticism about the concept of internalised homophobia is that it pathologises the distress experienced as a private issue that requires individual adjustment, rather than identifying the related social and cultural issues requiring social change (Clarke *et al.*, 2010). Similarly, criticism of the term from feminist and queer perspectives is that it too easily places oppression back onto the individual, taking the focus away from the source of the oppression. In other words, dealing with the bullying of LGBTI learners in schools, for example, should be through changing the school system rather than just dealing with the effects of the bullying on these individuals (Clarke *et al.* 2010).

2.4.4 Heterosexism

“Heterosexism” as a term was popularised by Gregory Herek in the late 1980s to mirror others’ words describing systemic marginalisation, such as racism and sexism, where the focus is on multiple levels of prejudice and oppression experienced by a group of people (Herek, 1990). It is defined as “the ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behaviour, identity, relationships or community” (Herek, 1995, p. 321).

Herek (1990) outlined two types of heterosexism. The first is cultural or institutional heterosexism, which includes pervasive cultural rituals, customs and beliefs that might not even be noticed, as well as macro-systemic and meso-systemic institutions such as government, medical and psychiatric centres, schools, businesses, mass media, legal system and religion that create policies and codes of conduct to strengthen and uphold heterosexist attitudes, values and behaviours and discriminate or stigmatise LGBTI people. The second type, psychological heterosexism, includes prejudice and stereotypes, harassment and violence. The perpetuation of negative stereotypes and myths represents one way in which people in the majority can use their position of power to influence others who have never come into contact with LGB people and rationalise their role in oppressing LGBTI people – what Rappaport (2000, p. 8) calls “culturally inspired hate crimes to which gay and lesbian people have been subjugated”. Harassment of and violence towards LGB people in South

Africa and the negative impact on the people who experience it have been well documented (Nel, 2007; Reid & Dirsuweit, 2002).

LGB people who are members of one or more other marginalised groups may experience multiple layers of oppression, for example oppression also based on race. They are therefore marginalised because of both their race and being LGB. The interaction between race or ethnicity and sexual orientation is further complicated by issues of power, as switching and concealing an LGB identity may result in varying degrees of social power and opportunities (Harper, 2005).

Studies of heterosexism are typically based on the social constructionist framework. Researchers explore how people “do” prejudice, *i.e.* how prejudices are produced and reproduced in discourse and social interaction and through cultural artefacts such as official documents, institutional norms and images (Van Zyl, 2005). Kitzinger (1995) argued that the concept of a lesbian does not exist beyond its social construction, which is based on the subordination of women through existing ideas of what “femininity” is, including that “feminine” women are heterosexual. Her analysis can be broadened to include LGB people across many contexts, such as the underrepresentation of LGB identities and lives in Life Orientation text books in South Africa (Potgieter & Reygan, 2012).

2.4.5 Heteronormativity

The term “heteronormativity” was coined by Michael Warner in 1991 and has its roots in queer theory. It refers to the institutionalisation in a society of exclusive heterosexuality based on a strong male-female binary model, which is drawn to other binaries, such as the hetero- versus homosexual binary. It also speaks to the rules of punishment versus support or reinforcement that is entrenched within this concept of privileged normative heterosexuality (Steyn & Van Zyl, 2009). Given this concept, LGB people who conform to heterosexual lifestyles, for example by adopting a gender-conventional appearance, are more likely to be accepted in society. The focus is therefore not on heterosexist practices *per se*, but rather on the ways in which gendered norms are reinforced in society. Research on heteronormativity would, for example, look at ways in which LGB people present themselves as heterosexual in ordinary conversations or look at the use of language to put people down, for example “moffie” and “istabane” (Steyn & Van Zyl, 2009).

2.4.6 Victimization and anti-LGB hate crimes

Crime and violence are major issues in South Africa, and include prejudice-motivated hate speech and victimisation. LGB individuals are frequently targeted due to their supposed deviance, and this has increasingly received attention in the press, such as the rape and murder of Noxolo Nogwasa and Eudy Simelane in KwaThema on the East Rand in Gauteng. It has also resulted in increased protest action due to the perceived lack of police action on these murders (Nkosi, 2011; Wikipedia, 2013). The National Policy Guidelines for Victim Empowerment (Department of Social Development, 2009) and the South African Victims' Charter (Department of Justice and Constitutional Development, 2008) provide frameworks to address such hate crimes. There are, however, gaps in legislative and policy frameworks, for example anti-LGB hate crimes are not recognised as a separate crime category in legislation in South Africa and there are therefore also no national statistics on its prevalence and incidence (Nel & Judge, 2008).

Hate crimes are criminal offences motivated by prejudice and hate, and include rape, assault and damage to property. These crimes can lead to physical injury or even death, as well as psychological trauma, including symptoms of depression, traumatic stress, anxiety and anger (Herek, Gillis, Cogan, & Glunt, 1997; Nel & Judge, 2008). It mostly occurs in the form of hate speech, bullying or conflict in specific settings. Verbal harassment in a community that is accepting of such narratives provides a breeding ground for more insidious emotional and physical hate crimes. Sexual orientation-based hate crimes represent extreme expressions of homophobia and are part of the larger heterosexist hegemony existing in the country (Nel & Judge, 2008).

A crime against an LGB person is not necessarily prejudice-motivated. Herek *et al.* (1997) identified three criteria for identifying homophobic hate crimes, namely verbal cues, such as demeaning jokes and name-calling; visibility cues, such as visiting a gay bar or known gay location; and contextual inferences, such as when it is known that a person was at a gay event.

Significant quantitative studies in South Africa that highlighted the high levels of homophobic discrimination in metropolitan areas included a study among 487 LGBT respondents in Gauteng conducted in 2003 (Wells & Polders, 2004), a study among 410 LGBT people in KwaZulu-Natal conducted in 2004-2005 (Wells, 2005), a study among 958 LGBT respondents in the Western Cape conducted in 2006 (Rich, 2006), and a study among

134 respondents in Pietermaritzburg (Stephens, 2010). A study among 319 LGB respondents in the North-West Province, representing the first non-metropolitan sample, suggested much lower perceived discrimination and abuse than in urban areas (Baird, 2010).

Colonialism and apartheid shaped the masculinities of the past. The transition to democracy brought about the unsettling of entrenched masculinities. This included changes in the existing gender order and the visibility of sexual matters, including the relation between sexuality, secrecy and HIV/AIDS (Reid & Walker, 2005). In addition, poverty, violence, unemployment and familial reliance place many sexual and gender minorities in difficult positions, including potentially dangerous tensions over sex and sexuality. This becomes more pronounced in situations where masculinity or maleness is in crisis, and is visible in the increase in reported homophobic and gender-based hate crimes in South Africa (Swarr, 2009). In their discussion of homophobic attacks, Reid and Dirsuweit (2002) noted that heterosexual people experienced the more public homosexual discourse in South Africa as subversive, leading to an increase in victimisation such as rape as a reinforcement of masculine dominance. Consequently, despite substantial legal strides, LGB people continue to experience high levels of homophobia and violence.

2.4.7 Lifespan and context issues LGB people deal with

Due to the heteronormative environment LGB people find themselves in, they have to deal with situations of prejudice and stigmatisation. In addition, they face unique lifespan issues which heterosexual people do not, such as elderly LGB individuals negotiating a heteronormative elderly or frail care environment. Increasingly, work is being done on the lifespan and context experiences and challenges of LGB people living in South Africa. This includes work on the dynamics in LGB relationships, such as power and abuse (Henderson, 2012); LGB parenting and the experience of children growing up in LGB-headed families (Annandale, 2008; Lubbe, 2007a; Lubbe, 2007b; Lubbe, 2008a; Lubbe, 2008b); the experience of same-sex marriage (Leventhal, 2010; Reddy, 2009; Van Zyl, 2011); religion and spirituality, such as prejudice in the Christian faith community (Dreyer, 2006; Vosloo, 2005); identity development and coming out in South Africa (Isaacs & McKendrick, 1992; Leatt & Hendricks, 2005); homophobic attitudes and bullying in schools (Mostert, Myburgh, & Poggenpoel, 2012; Watson & Vally, 2011); attitudes towards LGB people in different work contexts, including the South African Defence Force in the period 1969-1994 (Schaap, 2011); and physical and sexual health, including HIV/AIDS (Anova Health Institute, 2011b;

Bodibe, 2011b; Brouard, 2009; Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008; Jonsson, 2011; Knox, Huso, Reddy, Maimane, & Sandfort, 2010; Lalla-Edward, 2010; Lane, Raymond, Dladla, Rasethe, Struthers, McFarland, & McIntyre, 2011; MenEngage Alliance, 2009).

2.4.8 The impact of prejudice and discrimination on mental health

Prejudice and discrimination can lead to various threats to LGB people's well-being and liberation. As a result, LGB people experience a range of mental health issues, including internalised oppression, fragmented identity and living a double life, poor mental health, psychosocial problems, social isolation and rejection, powerlessness and discrimination, harassment and violence. These issues are interrelated and impact on LGB people in multiple recursive ways (Harper, 2005). Widespread social stigma leaves LGB people at a greater risk of mental illness. The stress caused by prejudice, stigma and discrimination has been correlated with depression, anxiety and substance use disorders. This is aggravated if LGB people face additional discrimination based on other variables, such as gender, race, culture and socio-economic status (Clarke *et al.*, 2010). A study among a sample of 329 self-identified homosexual and bisexual males found that nearly a third of the respondents qualified for a post-traumatic stress disorder (PTSD) diagnosis (Theuninck, 2000). Minority stressors (internalised homonegativity, sexual identity uncertainty, stigmatic stress and gay-related victimisation) were found to significantly correlate with both PTSD and negative beliefs around such issues as esteem, control, safety, trust and intimacy (Theuninck, 2000). Polders *et al.* (2008) reported that lowered self-esteem and frequent hate speech experiences were significant predictors of vulnerability to depression among a quantitative sample of gay men and lesbian women in Gauteng. A study by Wells (2006) among 385 gay and lesbian individuals in Gauteng also found that gay-related stressors increased their risk of suicide ideation.

2.5 MENTAL HEALTH PROVISION FOR LGB PEOPLE

In this section, the ecological metaphor of Community Psychology is used to provide an understanding of mental health provision for LGB people in South Africa, starting with the macro-level through to provision of services within the meso-level of psychology.

2.5.1 General legal framework

The South African Constitution has been claimed to be one of the most progressive in the world (Beresford, Schneider, & Sember, 2007). Since 1995, the rights to freedom of expression and assembly juxtaposed with the gender and sexual equal rights outlined in the Constitution has proven a powerful force in the defence against conservative moral claims from religious, political, cultural and other voices. The inclusion in the Constitution of the right to non-discrimination on the basis of sexual orientation and gender marked the beginning of remarkable political and legal development (Nel, 2007). The legal battles for equal rights included striking down the criminal prohibition on sodomy between consenting adults and protection against labour discrimination on the basis of sexual orientation in 1998, the 1999 declaration of sections of the Alien Control Act of 1991 as unconstitutional because it omitted to give same-sex life partners the benefits it extended to spouses, a 2002 ruling that gay couples could adopt children, a 2003 ruling in favour of Judge Kathy Satchwell arguing for the same benefits for her lesbian partner as the married partners of other judges, and a 2005 case that found that the common law definition of marriage was inconsistent with the Constitution and invalid as it did not permit same-sex couples to enjoy the status, benefits and responsibilities given to heterosexual couples, effectively legalising same-sex marriages (Beresford *et al.*, 2007; Brouard & Pieterse, 2012).

The realisation of these rights, however, is hampered and even threatened in day-to-day living. As stated earlier, our society is heavily influenced by a resurgent post-apartheid patriarchal hegemony that contributes to high levels of both sexual- and gender-based violence. Poverty, unemployment, poor education, poor service delivery and familial reliance further place sexual minorities in difficult and potentially dangerous positions, which can also threaten the very human rights LGB people fought for (Dartnall & Jewkes, 2013; Lynch *et al.*, 2010; Swarr, 2009). This is exacerbated by popular intolerance, ranging from government opposition to changes in laws and mechanisms of enforcement and remedy, to active public and community opposition and violence against LGB people (Nel, 2007). Legal rights do not necessarily translate into public acceptance, as illustrated by a study indicating that 88% of a nationally representative sample of South Africa's adults feel that it is always or almost always wrong for two adults of the same sex to have sexual relations (Roberts & Reddy, 2008).

2.5.2 Healthcare provision for sexual minorities

South Africa's health system encompasses a large public sector and a small, fast-growing private sector. Care varies from basic primary healthcare, offered free of charge by the state, to highly specialised private care. The landscape might change significantly with the introduction of a universal medical insurance requirement which the government plans to develop and implement. In addition, the field of sexology in South Africa is poorly developed, and sex psychotherapy is only available to a minority in private healthcare facilities in urban centres (Nel, 2007).

South Africa has committed to achieving the United Nation's Millennium Development Plan and its goals, which include sexual and reproductive health. The country is also a signatory to the Sexual Health Charter, which aims to ensure that the sexual rights of people are respected, protected and fulfilled. Together with the South African Constitution, these represent an important framework for sexual rights (Nel, 2007). However, despite these positive developments, people engaging in consensual same-sex behaviour, such as men who have sex with men (MSM), face significant problems in accessing healthcare services in South Africa, particularly in the mainstream public sector health service (Desmond Tutu HIV Foundation, 2011).

When sexuality issues are addressed, it is often from a heterosexist position. Research has indicated that gay men and MSM are less likely to seek healthcare in the public sector due to previous experiences of homophobia and discrimination by public health workers. Given the lack of support services, these people might be more likely to be depressed and abuse substances, placing them at a greater risk of HIV infection and illness. Some studies suggest that the HIV infection among MSM is as high as that among young women, whereas young men in general have a much lower HIV incidence (Bodibe, 2011a; Cloete *et al.*, 2008; Lalla-Edward, 2010).

Mental health provision for LGB people faces similar challenges. In a 240-page report on decreasing the burden of mental illness in the Western Cape, reference was made to homosexuality only in one paragraph in the appendix, stating that homosexual individuals have higher rates of mental illness than heterosexual individuals and that this may in part be due to minority stress, internalised homophobia, and expected and actual discrimination (Corrigal, Ward, Stinson, Struthers, Frantz, Lund, Flisher, & Joska, 2007). The

heteronormative nature and extent of the report is pervasive to the exclusion of dealing with issues of the LGB community in the Western Cape.

It has been found that lay counsellors at victim support centres are not always affirming in their counselling of LGB victims. There is often the assumption of heterosexuality in public service facilities such as clinics, which can negatively impact on the quality of support rendered to LGB people and serve as a barrier to access (Nel & Judge, 2008). Nel, Yi, Sandfort and Rich (2013) recently analysed data of people who identified as MSM in a sample of LGBT individuals. The results indicated that the fear of being tested for HIV is associated with feminine gender expression, sexual orientation-based victimisation at school or in the workplace, and unequal services in the healthcare environment. The study highlighted the need for the health service sector to be more LGBTI-friendly.

This lack of sensitivity and commitment is also visible in the lack of training in sexual minority issues in healthcare and related service provider training, such as in human rights awareness and diversity sensitisation. The vast majority of providers appear ignorant of sexual orientation issues or have difficulty in providing adequate service, potentially due to unfamiliarity, lack of understanding or skills, low prioritising of sexual orientation-related issues, unwillingness or prejudice (Nel, 2007).

Mainstream neglect of LGB issues has led to the provision by CBOs of health and psychosocial services, such as OUT LGBT Well-being in Pretoria and the Triangle Project in Cape Town (Brouard & Pieterse, 2012; Letsike, 2009). Nel (2005) highlighted the importance of LGB community-based service organisations in service provision to empower people at grassroots level by giving them a voice and providing a networking function to ensure communication between the diverse elements of the community, as well as touchpoints for mainstream press, legislators and other people wanting to explore LGB community views.

2.5.3 Psychological services in South Africa

Historically, LGB people were seen as being mentally ill as they did not conform to heterosexual or gender norms. “Homosexuality” was removed as a diagnostic category from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973, followed by the removal of the category “Ego-dystonic homosexuality” in 1987. In 1993, “homosexuality” was also removed from the World Health Organisation’s International Classification of

Diseases. Locally, the South African Society of Psychiatrists only published a position statement agreeing with these developments in 2005. Aversion psychotherapy, which is psychiatric treatment in which a patient is exposed to stimuli while subjected to extreme discomfort such as electrical shock or chemical castration, is still a reality in our society (Clarke *et al.*, 2010; Nel, 2007; South African Society of Psychiatrists, 2005).

In the same way that psychology was either silent or actively supportive of the *status quo* on race and racism in South Africa, it was also an oppressive force for many minorities in South Africa and contributed significantly to the pathologising of LGB individuals (July, 2009; Yen, 2007). This included human rights abuses by South African Defence Force psychiatrists against gay male conscripts, which included compulsory reparative psychotherapy with electroconvulsive shock treatment. In addition, psychologists argued in court that same-sex sexuality is a sickness and a sin and could be cured psychologically or spiritually. Psychology therefore did not only *not* oppose the persecution of LGB people – it actively contributed to the victimisation and persecution of this group (Nel, 2007; Schaap, 2011).

Substantial progress has been made in the field, as evidenced by a strong LGB-affirmative stream of presentations at the recent PsySSA conferences as well as statements condemning the potential introduction of anti-LGB legislation in Uganda (Nel *et al.*, 2010). The lack of inclusion of LGB issues in the curriculum for psychologists, including the lack of mention in textbooks, remains an issue (Coetzee, 2009). Some local work is being done to address this, including work by Coetzee (2009) and Nel (2009), as well as short courses offered by the Unisa Centre for Applied Psychology (UCAP) and the North-West University.

It has been argued that psychology can make a significant contribution to empowering the LGB community. This includes more traditional tertiary services, such as individual psychotherapy, group and couples psychotherapy. It is critical, though, to be sensitive to issues around the culture-specific construction of psychology, *i.e.* Western and individualistic, as well as the heteronormativity that is prevalent in the discipline (Nel, 2005).

2.6 LGB-AFFIRMATIVE PRACTICE

In this section, LGB-affirmative practice is defined and discussed with reference to international guidelines and local work that is leading the way for guidelines for affirmative practice in South Africa. This provided a framework to assist in defining relevant areas to

investigate in the research study and also informed some of the suggestions flowing from the study.

There appears to be substantial debate both within and outside counselling and psychotherapy circles about the focus of mental health services on the individual and her or his intrapsychic world to the exclusion of the impact of the social, economic and cultural environments in which people live. The debates have ranged from a critique of psychotherapists' lack of social awareness to stances that clients' distress is located and maintained within the social environment. It has also been highlighted that these professions are dominated by middle-class values and generally only accessible to a privileged few (Feltham & Horton, 2000). There has been a strong call for anti-discriminatory and anti-oppressive practice that at the very least respects the client and her or his position – a challenge posed to the psychotherapist and counsellor (Lago & Smith, 2003).

There is a lack of general consensus on what constitutes LGB-affirmative practice. One viewpoint is that it is a general, non-discriminatory and contextually aware attitude when working with LGB people, and advocates incorporation of this attitude into mainstream psychology theories. Others, such as Davies (1996) and Milton and Coyle (1999), view it as a distinct way of operating and taking a specific stance, rather than a more general view. Ritter and Terndrup (2002) feel that a neutral therapeutic posture advocated by psychoanalytic theory may be problematic and insufficient for LGB clients who require an affirmative approach that communicates the belief that homosexuality is a natural developmental outcome for numerous individuals. Falco (1996) believes that the self of most LGB clients is constricted due to numerous acts of non-disclosure and self-censoring. A practical appreciation of the similarities, differences and contexts of clients can be seen as a starting point of a lesbian- and gay-affirmative perspective (Kowszun, 2000). "Affirmative" implies an attitude where being gay, lesbian or bisexual is viewed as a "viable, constructive way of life, compatible with psychological well-being" (Perlman, 2003, p. 50). For Crisp (2006), affirmative practice focuses on the person in her or his environment; the psychotherapist's cultural competency, including knowledge, attitude and skills as well as a strength-perspective focusing on self-determination; health rather than pathology; and raising consciousness of rights and relevant issues. Kowszun (2000) argued that this social appreciation should be supported by four aspects: (1) an open and accepting attitude; (2) self-awareness, particularly as it relates to one's own sexuality and view of others practising alternatives to this; (3) reading sexual diversity literature as well as theories challenging

heterosexist notions of health and perversity; and (4) utilisation of lesbian- and gay-affirmative resources, both in continuing professional development and accessing lesbian and gay resources – in the words of Marmor (1996, p. 543), knowing the “specific subcultural network systems” of sexual minority groups.

Schippers (1997) sees a general accepting attitude as a starting point, but highlights that the psychotherapist also needs to realise that different presenting problems may require different approaches. His view contains principles that are important in LGB-affirmative practice and include viewing an LGB orientation as one sexual and emotional preference that is to a greater or lesser extent present in all individuals and of equal value to heterosexual norms. Schippers (1997) further feels that it should be acknowledged that LGB clients, and the subculture as a whole, have the same potential creativity and internal resources to deal with their difficulties and problems – thereby taking a strength rather than deficit viewpoint. He also deems it important to deal with and explore the societal impact on LGB clients, including actively taking a positive view of LGB life and accepting the detrimental effects of anti-gay sentiment, research and therapeutic endeavours.

There appears to be a number of shared characteristics of affirmative psychotherapy in the literature, namely that the practitioner

- views LGB sexualities and gender identity as normal and natural;
- does not see sexuality as the cause of psychological difficulties or pathology;
- has a contextual awareness, including an understanding of how factors such as homophobia, heterosexism, prejudice and stigma impact on mental health;
- is able to empathise with the experiences of LGB clients, which includes being knowledgeable about LGB sexuality and lifestyles; and
- is comfortable with and open about her or his own sexuality to avoid her/his own biases impacting on the psychotherapy or counselling (Milton, Coyle, & Legg, 2002).

In comparing the attitudes of psychologists in the United States over a 15-year period, it was found that they were increasingly viewing an active LGB lifestyle as acceptable and not pathological. They were also more likely to support gay-affirmative therapies at the expense of endeavours to change sexual orientation (Kilgore *et al.*, 2005).

A number of international guidelines for affirmative practice have been developed, including the American Psychological Association’s “Practice guidelines for lesbian, gay and bisexual

clients” (American Psychological Association, 2001; American Psychological Association, 2011), 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 clients” (British Psychological Society, 2012), and the “Competencies for counsellors working with gay, lesbian, bisexual and transgender clients” (Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2003).

In designing an affirmative intake schedule when working with LGB clients, Schippers (1997) suggests that the practitioner should obtain general intake information, such as history, problem development, actions taken to deal with difficulties, current life situation, the personality of the client, and clear problem definition. In addition, attention should be paid to psychosocial development, including sexuality in the family of origin; the development of LGB feelings as well as current experiences, context and body perceptions; an estimate of the client’s acceptance of her/his sexual orientation; history of “coming out”; quality and extent of the client’s gay network; lifestyle and details of relational context (not just, for example, a 10-year relationship, but understanding some of the intricacies of how the relationship is defined); issues around sexual history and dealing with HIV/AIDS; experiences of victimisation; presence of pathology; and understanding that homosexuality does not cause pathology, but that LGB people are exposed to additional stressors in a society where they are marginalised that may contribute to the presence of pathology.

A number of policy statements of various types have seen the light in South Africa since 1996, all of which have possibly contributed to the liberalisation of South African Psychology and the potential adoption of a more affirmative stance by psychotherapists and counsellors. The Health Professions Council of South Africa (HPCSA) has ethical rules governing the conduct of health professionals as mandated by the Health Professions Act, 1974 (Department of Health, 2006). Annexure 12 of these rules pertains to the profession of psychology and contains at least three sections that are directly relevant to general practice with LGB individuals, whether as client, employee, research participant, student, supervisee, trainee or any other person over which a psychologist has authority, namely:

- respect for human rights, which specifies that a psychologist should “respect the dignity and human worth of a client and shall strive to preserve and protect the

client's fundamental human rights" as well as "respect the right of a client to hold values, attitudes, beliefs and opinions that differ from his or her own" (Department of Health, 2006, p. 18);

- a section on unfair discrimination, which specifies that a psychologist shall not impose on nor unfairly discriminate against someone based on their sexual orientation, among other things; and
- specific responsibility to be aware of the potential non-applicability of assessment tools due to a person's sexual orientation.

In addition, a position statement by the South African Society of Psychiatrists states that it distances itself from previous discriminatory practice against homosexuality and supports the equality clause in the present constitution. The mentioned position statement continues with the following stances:

- support for the American Psychiatric Association's view that homosexuality in itself does not imply impairment in judgement and capability or psychopathology, including a commitment to decrease stigma where this may occur;
- opposition to any psychotherapy aimed at changing a person's sexual orientation, *i.a.* "reparative" or "conversion" psychotherapy, including a statement of the potential harming effects of such therapeutic techniques;
- recognition of the potential therapeutic need with the stressful event of the development of a gay identity, while at the same time expressing an understanding that not all therapeutic needs are based on a person's sexual orientation; and
- recognition of the widespread nature of prejudice and stigma, the potential resultant actions of violence or harassment, and the emotional and physical trauma suffered by individuals due to this. The organisation strongly pronounces against such incidents and encourages their members to take action to prevent as well as actively respond to treat victims of such events (South African Society of Psychiatrists, 2005).

In her study to provide guidelines for educational psychologists when dealing with homosexual clients in South Africa, Meyer (2003) outlined the following:

- Keep abreast of issues relating to homosexuality, including regular contact with homosexual people and their lifestyle, literature studies and attending seminars and congresses.

- Practise continued self-evaluation around heterosexism and homophobia, and if this remains a problem, refer the client to someone else.
- Avoid reducing the homosexual client to a sex object and relating all her or his problems to her/his sexuality.
- Provide a warm atmosphere.
- Trying to change a client's sexual orientation is a taboo.
- Have the view that a homosexual relationship is equal to a heterosexual relationship.
- As with heterosexual clients, do not cross sexual borders.
- Use and interpret assessment tools, such as projective techniques, sensitively.
- Be honest about your sexual orientation if you are homosexual.

This was a valiant step in formalising guidelines for a professional group who might not have been exposed to an alternative way of dealing with their LGB clients, even though they might have seen them often in their own practice. However, the use of the term “homosexual” leaves the reader with the sense that the “homosexual client” is still viewed as “the other” while trying to “normalise them”, and that it suggests how the psychologist is supposed to react and deal with “them”.

Most recently, PsySSA developed a position statement for psychology professionals regarding sexually and gender diverse clients. This statement deals with human rights and self-determination; sexual diversity and fluidity; challenges faced by sexually and gender diverse people; complications of multiple intersectional challenges; the impact of stigma, prejudice and discrimination on mental health; multiple and fluid developmental pathways; complexities of relationships within a sexually and gender diverse context and the importance of the professional taking an affirmative stance; following best practice care; committing to continuing professional development; and promoting social awareness (PsySSA, 2013). The position statement is a precursor to the development of fully fledged practice guidelines, with the current research study hopefully providing a client perspective that can assist in this process.

2.7 RESEARCH ON CLIENT EXPERIENCES OF PSYCHOTHERAPY AND COUNSELLING

2.7.1 Introduction

This chapter has thus far provided an understanding of the context within which the current research can be placed, namely the area of Community Psychology, with reference to sexual orientation, challenges faced by LGB people and mental health provision for LGB people. A discussion of affirmative practice was offered to delineate the ultimate aim of the research – to provide inputs for the development of practice guidelines for psychology professionals working with sexually and gender diverse clients in South Africa. The attention is now turned to research on client experiences of psychotherapy and counselling, with specific reference to research conducted among LGB people. This informed the design of and analysis method used in the current study.

2.7.2 General international research

Elliot and James (1989, p. 444) define clients' experiences of psychotherapy as their "sensations, perceptions, thoughts, and feelings during, and with reference to, psychotherapy sessions". Studying client experiences is considered important as it assists in honing psychotherapeutic skills through sensitising psychotherapists to the varieties of client expectations, thoughts and feelings. Understanding the psychotherapeutic processes that lead to change could advance theoretical understandings as well as lead to more effective interventions (Elliott, 2008).

The types of research on client experiences of psychotherapy cover a very broad scope and include event-based studies looking at clients' moment-to-moment experiences, such as the meta-analysis of seven studies on the impact of significant and helpful events in psychotherapy identified by clients by Timulak (2007); qualitative mental health service evaluation, which generally focuses on helpful and useful aspects as opposed to hindering or problematic aspects of a psychotherapeutic experience and clients' perceptions of change over the course of psychotherapy, such as the current study; and quantitative survey predictor studies driven by specific hypotheses (Elliott, 2008).

When planning a project about clients' experiences of psychotherapy, Elliot (2008) suggests consideration of at least five aspects of the psychotherapy process:

- From which perspective will the research be done – the client’s, psychotherapist’s or observer’s?
- Which person or people involved in the interaction will be the focus – the client or group members, the psychotherapist or the psychotherapeutic relationship?
- Which units of the psychotherapy process are of interest in the study? This could range from sub-episode units to episodes, situations or difficulties, and psychotherapy process units such as the psychotherapeutic relationship as a whole or the global experiences over the whole psychotherapeutic course.
- The temporal phase covered, which refers to whether the focus is on the process itself, the context or its effects.
- Which of the four aspects of the process would be important: content, dealing with the “what”; action, dealing with the goal of the psychotherapy; style or state, such as emotional experiences or interpersonal stances; or quality, which would include the skill of the psychotherapist’s responses and how hard or deeply the client is working?

Elliott and James (1989) conducted an extensive review of literature on clients’ experiences of psychotherapy from 1948 to the mid 1980s. Following Orlinsky, Grawe and Parks’ (1994) Generic Model of Psychotherapy, they identified three main domains of research, namely clients’ experiences of self, the psychotherapist, and psychotherapy as treatment. Clients’ experiences of self included the intentions or tasks they bring to psychotherapy, their in-session moods or feeling states, self-attitudes, their style of relating to psychotherapists, as well as the issues or concerns they bring to psychotherapy. Perceptions of the psychotherapist’s intentions or actions as well as perceptions of the psychotherapist’s characteristics were covered in the domain of clients’ experiences of the psychotherapist (Elliott & James, 1989). Potential overlapping continuums here include psychotherapists imposing their views on the client versus being affirming of alternative ways of looking at the world; the psychotherapist being validating and affirming versus judgemental or invalidating (Elliott, 2008). In looking at clients’ experiences of psychotherapy, Timulak’s (2007) meta-analysis of helpful impacts identified nine categories of impact, which, as could be expected, overlap to an extent:

- self-awareness, insight into self and others and self-understanding;

- an interpersonal dimension, including reassurance, support, acceptance and safety, which in a group context includes aspects of identification with other group members and the experience of universality;
- behavioural change, problem solution or symptom relief, which would include the psychotherapist offering specific techniques for dealing with problems;
- exploring feelings and emotions;
- feeling understood;
- empowerment, which is experienced as a sense that one has the strength to cope with problems and difficulties;
- experiential relief, unburdening or relaxation due to a sense of safety and affirmation provided by the psychotherapist, which possibly includes the experience of hope Elliot and James (1989) referred to;
- client involvement that provides the client with a platform for expression and development of confidence and self-esteem; and
- the client experiencing the psychotherapist as a fellow human being.

The numerous studies provide a broad, consistent baseline that can be incorporated in mediational models of the change process in psychotherapy, but there still is a need to pay attention to the unique issues faced by specific populations, such as the LGB community, as well as cultural differences (Elliott, 2008). However, in focusing on these populations, care should be taken to understand that there would be substantial heterogeneity within any group (Jim & Pistrang, 2007). There appears to be a growing focus in the literature on clients' individualised perspectives, such as hermeneutic single-case efficacy design research, as opposed to the emphasis on broad-based quantitative work on psychotherapeutic impact and outcome (Elliott, 2002). Over the past 20 years, there has been an increased amount of research on clients as active change agents, *i.e.* how clients deal with issues in the relationship with the psychotherapist, communicational difficulties with the psychotherapist, and analysis of client-identified process difficulties using the in-session moments as units of analysis (Greenberg, 2007).

2.7.3 International research among LGB people

An understanding of the elements contributing to LGB people's experiences is important if mental health professionals are to serve this population effectively (Israel, Gorcheva, Burnes,

& Walther, 2008). A number of research studies have focused on the experiences of self-identified lesbian and gay people, and to a lesser extent bisexual people, in psychotherapy and counselling. Most of the studies have been from the United States, which might reflect easier accessibility of this material rather than actual research output, and some of these are now discussed.

In a study by Garnets, Hancock, Cochran, Goodchilds and Peplau (1991), 1 481 psychologists from the United States were asked to describe examples or practices of harmful as well as beneficial care for gay and lesbian clients. The harmful practices included assuming a client is heterosexual; focusing on sexual orientation when it is not relevant, or urging a client to change his or her sexual orientation; a lack of knowledge of lesbian and gay identity development and the impact of coming out; a lack of understanding of the importance and variety of gay and lesbian relationships; unfamiliarity with the unique family issues and parenting difficulties faced by gay and lesbian clients; and a general lack of knowledge of gay and lesbian issues. The beneficial practices included recognition that homosexuality is not pathological; interventions that included an understanding of the prejudice and discrimination faced by gay and lesbian people and helping clients overcome internalised homophobia; assisting in the development of positive identities; possessing knowledge of the diversity of relationships and recognising the importance of alternative families; and the psychotherapists' own expertise and education, which included countering biased views of other professionals.

Moving the focus from psychotherapists to clients, Liddle (1996, 1997, 1999) conducted a survey among 392 gay and lesbian individuals looking for a client-psychotherapist match, and an evaluation of 13 psychotherapist approaches, taken from the Garnets *et al.* (1991) study, as they relate to clients' rating of helpfulness and the failure to return for a second session, *i.e.* early termination. The results indicated a preference for gay or lesbian psychotherapists or heterosexual psychotherapists who are knowledgeable about and accepting of homosexuality and therefore whom clients find helpful – *i.e.* gay-affirmative psychotherapists. In addition, the results provided some data to support the assumption that unhelpful practices are related to the early termination of sessions, and helpful practices to positive helpfulness ratings.

The topic of matching client and counsellor sexual orientation has received some attention, including a study by Bernstein (2000) that suggested that, presumably heterosexual,

psychotherapists can work successfully with lesbian and gay people and their families as long as they are accepting of their clients' sexuality and reasonably free of heterosexist bias and homophobic prejudice. The author highlighted the importance of disclosure, trust and collaborative meaning-making in creating a therapeutic relationship that is sensitive to the unique issues of lesbian and gay people, clinically effective, and ethically responsible.

A study by Moran (1992) indicated that a counsellor's sexual orientation was less important when the therapeutic issue was not sexual in nature. A 1997 study among 609 LGB individuals found that there was a tendency to prefer a psychotherapist with the same sexual orientation, and that this was rated as most important if the problem was sex-related (Kaufman, Carlozzi, Boswell, Barnes, Wheeler-Scruggs, & Levy, 1997). In their discussion, the authors felt that the longer term trend was that the level of openness about sexual orientation was becoming less important, potentially due to LGB people's confidence that they would find affirming psychotherapists. This confidence might have been driven by the increased emphasis on non-discrimination and affirmation of human diversity in the ethical codes and training of mental health professionals in the US. This appears to suggest that affirmative guidelines could contribute to the general effectiveness of the therapeutic relationship.

A quantitative study among 126 self-identified LGB people in the United States indicated that psychotherapists' use of bias-free language had strong effects on the clients' rating of the counsellor, the likelihood of returning to see the counsellor, and their willingness to disclose personal information as well as sexual orientation (Dorland & Fischer, 2001). A UK-based qualitative study in 2001 on 14 gay men's experiences of psychotherapy and counselling found that, in contrast to most studies from the United States at the time, the overall experience of psychotherapy was considered helpful by the respondents, but that their experience of discussions around their sexuality was not and that they felt this area was not sufficiently explored (Mair & Izzard, 2001).

In a United States-based study in 2006 by Burckell and Goldfried (2006), 42 "non-heterosexual adults" between 18 and 29 years of age were asked to rank 63 psychotherapist characteristics when seeking treatment. The characteristics were ranked for situations in which they considered their sexual orientation to be relevant and situations in which it was not. The respondents valued psychotherapists with LGB-specific knowledge who exhibited affirming behaviours as well as general therapeutic skills in forming and maintaining a

therapeutic relationship, and avoided psychotherapists who held “heterocentric” views. The authors concluded that psychotherapists should not just increase their awareness of LGB issues, but also adopt a stance of openness about LGB issues rather than making assumptions about the connection between the client’s concerns and her or his sexual identity or orientation (Burckell & Goldfried, 2006).

In a fairly large-scale US-based qualitative study by Israel *et al.* (2008), 42 LGBT individuals were interviewed about helpful and unhelpful therapeutic situations. This included exploring client and psychotherapist characteristics; environmental and contextual factors such as setting; psychotherapy interventions; relationship, such as the response to the client’s sexual orientation or gender identity; and descriptions of helpful and unhelpful situations as well as the consequences of each. The study found that the participants did not necessarily focus on sexual orientation in their narratives, and suggested that researchers expand their enquiry beyond just sexual orientation to broader therapeutic aspects. Also, given the different stages of identity formation and orientation identification, it was mentioned that psychotherapists need to take the fluidity of sexuality into account in practice. It was further highlighted that transgender issues appeared to be distinctly unique from LGB issues and required a special set of skills and knowledge to address. The authors felt that an understanding of LGBT clients’ lives outside the therapeutic situation was important and that the effectiveness of psychotherapy could be increased by working with the larger LGBT community. This finding resonates with local author Nel’s (2005) call for community-based organisational involvement in empowering LGBT communities.

Although a United States study in 2005 indicated a greater acceptance of gay-affirmative practice among practitioners, it also highlighted that overt forms of heterosexism could be replaced by more subtle forms (Bowers, Plummer, & Minichiello, 2005). In line with this, a recent qualitative study among 16 self-identified lesbian, gay, bisexual and queer psychotherapy clients in the United States explored sexual orientation micro-aggressions. Taking a cue from race studies, the authors defined micro-aggressions as “communications of prejudice and discrimination expressed through seemingly meaningless and unharmed tactics” (Shelton & Delgado-Romero, 2011, p. 210). The seven themes of micro-aggression found were the assumption that sexual orientation is the cause of the presenting problem; avoidance of sexual orientation; attempts to over-identify with LGBQ clients; making stereotypical assumptions about LGBQ clients; expressions of heteronormative bias; the

assumption that LGBQ individuals need treatment; and warnings about the dangers of identifying as LGBQ (Shelton & Delgado-Romero, 2011).

Some of the gaps in relevant international research identified by Clarke *et al.* (2010) include a lack of robust public health statistics about incidence of illness and disease among the LGB group; the lack of inclusion of sexual and gender identity as routine demographic information in population-based health surveys; little critical health psychology research among LGB people; a lack of research on trans and bisexual health and illness, mental health service use patterns or the experiences of LGB people suffering from psychiatric disorders; and the lack of application of “mainstream” health psychology models to LGB people and their health issues.

2.7.4 South African research among LGB people

In South Africa, very little research has been conducted on LGB individuals’ experiences of psychotherapy and counselling. The Unisa Centre for Applied Psychology (UCAP), under the auspices of the Joint Working Group (a group of community-based LGBT organisations), conducted a number of quantitative surveys in the period 2002-2006 in the major metropolitan areas of South Africa. Three studies were conducted in Gauteng (2002/2003), KwaZulu-Natal (2005) and the Western Cape (2006) respectively on the levels of empowerment of LGBT people in these areas, including an understanding of the healthcare interface from the perspective of LGBT people.

In the Gauteng survey, 55% of the respondents were male, 64% black and 36% white (Wells & Polders, 2003, 2004). In the KwaZulu-Natal survey, 54% of respondents were male, 66% black, 21% white and 13% Indian (Wells, 2005). In the Western Cape survey, 51% of respondents were male, 51% white, 26% Coloured and 22% black (Rich, 2006). The relevant key results from these studies are indicated in the following tables:

Table 2.1: Health practitioners consulted in past two years

%	Gauteng (n=481)	KwaZulu-Natal (n=410)	Western Cape (n=955)
Private doctor	42	68	75
Government doctor	23	47	22
Nurses/Clinics	31	52	31
Psychologists	13	26	26
Social workers	11	13	8
Traditional healers	13	11	4

Table 2.2: Agreement with statements about healthcare professionals

%	Gauteng (n=481)	KwaZulu-Natal (n=410)	Western Cape (n=955)
Aware of my sexual orientation	64	50	56
Asks about my sexual orientation	49	42	32
Openly discusses concerns related to my sexual orientation	49	42	43
Makes me feel comfortable	68	70	62
Asks questions which make it seem that being heterosexual is the only way to be	37	23	21
Assume I am heterosexual	41	37	42
Uphold confidentiality	63	55	71

Particularly significant are the high levels for the statements “Asks questions which make it seem that being heterosexual is the only way to be” and “Assume I am heterosexual”.

Table 2.3: Treatment interactions

%	Gauteng (n=481)	KwaZulu-Natal (n=410)	Western Cape (n=955)
Refused (providing) treatment based on sexual orientation	6	5	2
Delayed seeking treatment for fear of discrimination based on sexual orientation	12	13	8
Did not seek treatment for fear of sexual orientation being discovered	12	16	8

In a small qualitative study at the Stellenbosch University, the respondents reported negative experiences with the on-campus counselling centre, ranging from counsellors avoiding discussion of sexual orientation, possibly due to a lack of knowledge, to framing non-heterosexual sexuality as promiscuous (Graziano, 2005). In 1995, Nel and Joubert (1996) started a psychotherapeutic support group for lesbian and gay people under the auspices of a community-based LGBT organisation in Pretoria, now called OUT LGBT Well-being. The group dealt with issues relating to gay life, such as coming out, identity and relationships. Longitudinal work done over the period 1995-2003 showed the positive therapeutic value of such a group, as evidenced by the changes reported by participants, including increases in self-acceptance, self-confidence, sense of identity, tolerance of others, honesty around the disclosure of their sexual orientation, and social integration (Nel *et al.*, 2007). The stark contrast with the study by Graziano (2005) is obvious and illustrates the therapeutic potential not only of the self-help group therapy tool and the role of CBOs in providing such services, but also of affirmative therapeutic practice.

Finally, Meyer (2003) conducted seven focus group discussions to explore lesbian and gay experiences of a visit to a psychologist. Based on the results as well as her literature study, she suggested guidelines for educational psychologists (as listed in 2.6) working with “homosexual clients”. Her study indicated that the majority of the respondents’ experiences of psychologists were negative. These included psychologists’ lack of knowledge and insight; reducing the client to a sex object; a lack of empathy; avoiding discussion of sexual orientation; a lack of appropriate dealing with relationships; inappropriate use of assessment and psychometric tests; endeavours to change the respondents’ sexual orientation; gay or

lesbian psychotherapists presenting as heterosexual; and perceived inappropriate sexual advances. Positive experiences included a relaxing, positive atmosphere where the client felt accepted without being judged. The majority of the respondents preferred a psychotherapist with the same sexual orientation as themselves.

2.8 CONCLUSION

The discipline of Community Psychology provides an ideal meta-framework within which the current study on LGB clients' experiences of psychotherapy and counselling can be positioned. Some of the perspectives and debates around sexual orientation as a concept were discussed with reference to the discourse in South Africa. This was followed by an exposition of the prejudice, discrimination and victimisation experienced by LGB people and the potential impact thereof on their mental health, which led to a discussion of mental health provision for LGB people in South Africa and the challenges they face in accessing these services. Following on this outline, LGB-affirmative practice was discussed as one tool for psychology in liberating itself from the web of heteronormativity. In focusing on the topic of the study, a discussion was offered of research on client experiences of psychotherapy and counselling, including highlighting the very few South African studies that have touched on the topic.

In the next chapter, the design of the current research study as well as the data collection method and sample used are discussed.

CHAPTER 3: RESEARCH DESIGN

3.1 INTRODUCTION

Chapter 2 outlined the contextual background that informed the current study. A discussion of Community Psychology provided a framework for the study. The discussion of sexual orientation included highlighting some of the issues that might be experienced by LGB people, with specific reference to mental health services in South Africa. LGB-affirmative practice was discussed as a framework within which psychotherapists and counsellors can work with LGB people. Previous research on people's experiences of psychotherapy and counselling, with specific reference to LGB people in South Africa, concluded the review.

In this chapter, the research design of the study is discussed, including the data collection method, sample definition and sampling method, sample achieved, data collection instrument, how the data were analysed, and ethical considerations.

3.2 QUALITATIVE RESEARCH

3.2.1 Using a qualitative research approach

Given the exploratory nature of this study, a qualitative approach to data collection and analysis was followed. It is well-suited to obtaining cultural-specific information, which a predesigned quantitative questionnaire might not, thereby allowing for a uniquely South African perspective to emerge.

Clarke *et al.* (2010) outlined a number of advantages of qualitative approaches with LGB groups, namely that they

- place participants' experiences and the meanings they attach to these at the centre,
- are ideal to give marginalised and invisible groups a voice, and
- are useful for exploratory work on underresearched topics.

The aim of the qualitative endeavour within the social sciences is to obtain an in-depth description and understanding of human experience, *i.e.* making sense thereof. It is about determining or elucidating the meaning of gathered material in relation to the purpose of the study (Babbie & Mouton, 2001). According to Kelly (2006), a good qualitative project would in the first instance develop an understanding of the subjective experience and secondly

provide an interpretation of this experience. Qualitative research can provide rich descriptions of how people make sense of the topic and the meanings they attach to it. This can assist in interpreting and an increased understanding of the complex realities of a specific topic. Qualitative research can provide the richness and depth of people's experiences, highlighting nuances that quantitative research might miss (Brouard, 2009).

3.2.2 Qualitative method of data collection

For this particular study, a semi-structured interviewing technique was used to collect information, with one researcher in conversation with one participant. With semi-structured interviews, the researcher has a set of questions on an interview schedule that guides the interviews rather than dictates them. This technique allowed for the participants' stories and experiences to emerge, while at the same time giving the researcher some prompts to ensure that certain broad themes of particular interest, such as cross-cultural issues, are covered. The advantages of a semi-structured interview are that it facilitates rapport, allows flexibility of coverage, and tends to produce richer data than structured interviews (Smith, 1995).

Focus groups are useful when the researcher feels that responses from one individual in the group might elicit or trigger information from other individuals that they might not recall in an individual interview. One limitation of this technique could be that the participants might, for various reasons, not feel comfortable enough to discuss very unique, individualised and personal information with people they have never met before (Babbie & Mouton, 2001). In addition to this technique potentially providing less depth, dominant members may shape the discussion, and the consensus arrived at by the group therefore reflect these dominant members' opinions (Brouard, 2009). Furthermore, there are logistical challenges to conducting focus group discussions with minority groups that are often not visible, including difficulties in recruiting multiple participants to a venue, and participants' fears that the gathering might have a different, potentially more nefarious purpose than that stated (Meyer, 2003).

3.3 SAMPLING DESIGN AND METHOD

Having established the method of data collection, this section summarises the criteria used for including participants in the sample and the sampling method and design used, and offers a brief discussion of the interview schedule and sorting technique utilised during the interviews.

3.3.1 Inclusion criteria

3.3.1.1 *Sexual orientation*

Following Clarke *et al.* (2010), for the purposes of the current study, participants were recruited based on their self-identification as gay, lesbian or bisexual. Given the complexities involved in desire, behaviour and identity, particularly as many people do not identify as exclusively gay or lesbian, the following question was asked: “How would you describe your sexual orientation?” Appendix B contains the biographical questionnaire used in the recruitment.

This definition excluded men who have sex with men and women who have sex with women and who do not identify with an LGB sexual orientation. In addition, given the fluidity of sexuality as discussed in the literature survey, the broad phrasing of the question could be open to debate around current versus past sexual orientation. The intention was to gain an answer within each individual’s own current perceptual frame rather than forcing a further theoretical refinement upon the participants.

3.3.1.2 *Psychological services*

All the participants had to have had experienced (in one or more sessions) psychotherapy or counselling with a psychologist, psychiatrist or other counsellor, including lay counsellors, in South Africa in the previous five years. The psychotherapy or counselling could have been individual, family or group-based counselling.

As indicated in Chapter 2, a significant section of the LGB population, particularly from disadvantaged communities, would not be able to afford or otherwise access private practice psychologists. The definition was therefore somewhat broader to ensure the inclusion of psychological services offered by other agencies such as CBOs and other mental health facilities.

3.3.1.3 *Demographic variables*

The major metropolitan areas of Johannesburg and Pretoria and the larger Cape Town area were included to obtain a regional view. The exclusion of the rest of the country was due to financial constraints.

Participants across different life stages and age groups were selected as the expectations and experiences of these groups may differ significantly (Ritter & Terndrup, 2002). Given the

ethical considerations when interviewing children, all the participants had to be at least 18 years of age. The age groupings used were based on the classification used by the South African Audience Research Foundation's AMPS study (SAARF, 2013). The groupings identified young adults as 18-24 years old, adults as 25-35 years old, mature adults as 36-49 years old, and older adults as 50 years or older. In the final sample breakdown, the first two groups were combined and the second two groups were combined to give an idea of the spread of ages.

Different race groups were included to ensure representation across the population. A detailed discussion of the area of race classification is beyond the scope of this study. This classification system is a remnant of the apartheid years, but given the significant, often institutionalised and systemic differences in the socio-economic experiences of most people, it remains a more or less useful classification tool to ensure diversity and spread in a sample. Classification on the basis of race in this day and age is considered relevant to achieve transformation and measure the effectiveness of racial redress (Centre for Critical Research on Race and Identity, 2010).

3.3.2 Sampling design and method

A convenience or snowball sampling technique was used to recruit individuals. The participants were recruited from a variety of accessible sources, including personal and professional networks, LGBT community groups such as OUT LGBT Well-being, and social media such as Facebook. Interested individuals were provided with an introduction letter explaining the research, a biographical recruitment questionnaire for their completion, as well as a consent form they were required to sign. Two people were excluded from the interviews as their experiences of psychotherapy and counselling were from longer ago than five years. No person who was approached refused to be interviewed. Copies of the introduction letter and consent form are attached as Appendix A and C.

3.3.3 Interview schedule

The interview schedule, contained in Appendix D, began by requesting the participants to relate or describe a recent experience of psychological counselling or psychotherapy. Probes to expand on the story followed the chronological flow outlined in Orlinsky *et al.*'s (1994) Generic Model of Psychotherapy, covering what they term "input" for before the actual psychotherapy or counselling, "process" for the therapeutic relationship, and "output" for the

impact or outcome of the psychotherapy or counselling. Probes around the “input” included what led to the experience, the process followed in selecting a counsellor, and how the participant felt at this point. “Process” probes included a description of the counsellor and the counselling, and “output” probes included whether some resolution or goal was reached, as well as their thoughts and feelings about the outcome of the counselling. In addition, the participants were specifically prompted on how the topic of their sexual orientation was dealt with, and what was affirming or disaffirming about the experience.

Finally, the participants were given 30 cards, each with an affirming statement gleaned from the literature, such as: “Understanding that lesbian, gay and bisexual orientations are not mental illnesses”, and: “Assists in developing a positive lesbian, gay and bisexual identity”. They were asked to sort these into at least three groups – important/relevant, not important/relevant and unsure. If the important/relevant group was too big, they were requested to sort this group into a further two groups – more important and less important. The group of most important statements and those the respondents were unsure of were discussed.

Kerlinger (1986) considers the ranking of items as a useful form of a scale. Items can be ranked according to some criterion, such as importance. Each of the ranked items, or groups of items, can be assigned a value, providing rank-order or ordinal values of unspecified size. Thus a ranked item can be considered “greater than” or “less than” another ranked item (Guy, Edgley, Arafat, & Allen, 1987). Key benefits of this method over, for instance, Likert scales are that it provides variability to data when all items are considered important or relevant, and escapes the tendency for participants to agree with socially desirable items (Kerlinger, 1986).

The ranking exercise is similar to Q sort, a part of Q methodology developed by Stephenson in 1935. This research method is useful in understanding the subjective experience of people in a structured fashion (Du Plessis, 2005). This focus on subjectivity has made this method appealing to qualitative researchers interested in the lived experience of participants (Brown, 1996). In the Q-sort procedure judges (participants) sort a set of cards into pre-ordered categories. These categories are given a numerical value that then allows further statistical analysis. The number of items or cards, as well as the shape of the distribution of item scores are determined in advance (Ozer, 1993). The ranking exercise used in the study does not subscribe to the same rigour as explained above as neither the values nor the shape of

distribution of items were pre-determined. In addition, the analysis was based on the items and not on the participants as is usually the case with Q methodology.

3.4 FIELDWORK AND SAMPLE ACHIEVED

A total of 15 in-depth interviews were conducted between April and June 2012. The interviews were conducted in English. All the interviews were conducted in venues that the participants felt comfortable with, mainly their homes. The interviews were audio recorded, with the exception of one, during which only notes were taken due to the participant's concerns about confidentiality. The interviews lasted about 60 minutes each. The participants were not incentivised. The researcher agreed to provide them with a summary copy of the dissertation for their own interest.

The following table outlines the demographics of the sample:

Table 3.1: Sample achieved

	N
Male	10
Female	5
Gay	8
Lesbian	4
Bisexual	3
White	11
Black	2
Mixed race/Coloured	2
18-35	7
36-65	8
Pretoria	6
Johannesburg	3
Cape Town	6

3.5 DATA ANALYSIS

According to Knight (2002), qualitative data analysis involves a two-stage process, namely

- the coding of data into similar topics, themes or units of meaning; and
- continuous data interpretation, involving reflection and repetition of the process, *i.e.* going back to the raw data, potentially recoding and reinterpreting it.

Terre Blanche, Kelly and Durrheim (2006, pp. 271-274) stressed two key principles of qualitative research that are important in data analysis. The first is “the commitment to understanding human phenomena in context, as they are lived, using context-derived terms and categories”. The second is the principle of the researcher (or “self”) as instrument, specifically as instrument of analysis – *i.e.* as central to attaching meaning – but also as part of the context itself. Qualitative research generally gives recognition to the role of the researcher and his/her theoretical frame, or the pre-understanding brought to the research process, in forming meaning and creating the “reality” of those researched.

Knight (2002) provided suggestions to broaden the researcher’s scope of interpretation, which include the following:

- Gain awareness of the broad range of theories, positions or views that could be utilised in the field of study.
- Discuss the results with someone who knows a little about the research to gain a different perspective.
- Analyse data in different ways, for example analyse whole stories versus only parts of stories, such as the beginnings.
- Obtain feedback from experts in the field (such as a supervisor) or let them analyse a subset of the data to provide an indication of possible interrater reliability.
- Look for the opposite of the finding in the data – the “counter-example” (Knight, 2002, p.183).
- Analyse the same data at different times.
- Provide enough time for data analysis to avoid rushing completion and missing vital messages.

The recorded audio tapes were transcribed and the transcriptions formed the core of the data that were analysed. The latest version of AtlasTI software was used to aid analysis (Atlas.ti Scientific Software Development GmbH, 2012). A general thematic analysis method, as described in, among others, Terre Blanche *et al.* (2006) and Smith (1995), was used to identify patterns and themes within subsections of the interviews. Verbatim comments as appropriate were included to elucidate and ground these themes and elements (Elliott, Fischer, & Rennie, 1999).

3.6 ETHICAL CONSIDERATIONS

The ethical principles summarised in the Belmont Report provided the basis for considering ethics in this research study and include respect for persons, beneficence and non-maleficence, and justice (Maritz & Visagie, 2011).

In line with the respect for persons, individuals were only invited to participate in the research if they indicated their readiness and willingness to do so. The participants were provided with and signed an informed consent form that stipulated the nature of the study, the voluntary nature of participation and freedom to withdraw at any time during the process, an overview of the research process, the protection of privacy and confidentiality, an outline of how the results would be used, a commitment to provide them with a summary copy of the study, and contact details of the supervisor involved in the study should the participants have any issues or difficulties with the researcher. The researcher will retain copies of the primary documentation for a period of at least two years, but this information will not be made available to anyone for any reason unless prior permission is obtained from the participants. The transcriber of the audio tapes signed a confidentiality agreement regarding the study as a whole, including the content of the audio tapes and personal or identifying information of participants.

Beneficence implies that the study was designed in such a way as to minimise the risk and maximise the potential benefit to the participants (Maritz & Visagie, 2011). The interviews were conducted at a time and place that were convenient for the participants. One participant was uncomfortable with allowing any recording of personal information, in which case the researcher made notes of the session, using a pseudonym for archival purposes. The other participants found the initial explanation and rapport-building sufficient to confidentially share intimate information. The inputs of the participants are acknowledged in this document,

including by way of using direct quotations. The quality of the research was ensured by following a well-planned process in accordance with best practice. The researcher has been involved in previous qualitative research studies, and this study was supervised by Prof Juan Nel, a well-known expert and academic in the field.

In the context of ethical principles, justice refers to the equal distribution of risks and potential benefits among those who may benefit from the research, as well as the reasonable and non-discriminatory treatment of participants (Maritz & Visagie, 2011). Outside of the inclusion criteria, potential participants were not systematically excluded and potentially vulnerable populations not targeted for convenience. The interviews were conducted in an accepting and non-judgemental fashion with an underlying affirmative stance on the experiences of the participants.

3.7 IN CONCLUSION

This chapter summarised the research design of the current study. A qualitative semi-structured interviewing technique was used to collect information. The inclusion criteria for the participants were an LGB sexual orientation; experience of psychotherapy or counselling in the previous five years, being at least 18 years of age and living in the major metropolitan areas of Gauteng or Cape Town and surrounds. The interview schedule contained general discussion topics and specific probes into the participants' experience of psychotherapy or counselling. A discussion of how the topic of their sexual orientation was dealt with was followed by a card-sorting exercise and a discussion of the most important affirmative practice statements. The transcripts of the audio recordings of the achieved sample of 15 participants were analysed. The chapter concluded with a discussion of the ethical principles employed in the study.

The next chapter offers the research findings with verbatim comments as supportive evidence where relevant.

CHAPTER 4: RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the research findings are discussed. The identified themes within each broad section of the interview schedule are examined and illustrated with direct quotations from the participants. The results of the card-sorting of the LGB-affirmative practice statements are then discussed and also illustrated with quotations where relevant.

4.2 BEFORE GOING TO COUNSELLING/THE “INPUT” PHASE

4.2.1 Reasons for going to psychotherapy or counselling

The participants went to counselling for a variety of reasons, ranging from longer term personal issues to help after experiencing trauma and relational issues. The reasons included the following, in no particular order:

- relationship issues, including difficulties with making long-term commitments, intimacy and sexual functioning; dysfunctional interactional patterns; cheating; abuse; and dealing with break-ups;
- family of origin issues, including dealing with coming out to parents, siblings and other family members and the reactions to coming out;
- trauma, such as car accidents and sexual abuse;
- dealing with the death of a loved one;
- personal issues, including lack of self-esteem, lack of self-control, and feelings of vulnerability and fragility;
- depression and following a suicide attempt;
- anxiety following significant stressors, such as moving cities, general anxiety and obsessive-compulsive behaviour patterns;
- stress and burn-out due to work or more general frustrations, a “nervous breakdown” and/or lack of concentration;
- sexual orientation issues, including the coming out process and self-acceptance;
- sexual problems, such as using sex as an escape and dealing with HIV; and
- substance abuse.

Keeping in mind that the participants had to relate an experience from the previous five years, a number of them started seeing counsellors during their teenage years as a result of an intervention by significant systems, such as a school or parents. The other participants mostly made the decision to go themselves due to one of the mentioned reasons.

The reason for continuing with counselling can also change and develop with time and might or might not be directly related to the original task or concern:

- “I went with day-to-day things I was facing then and then realised what the deeper issues were” (Gay, 18-35, black)².

4.2.2 The decision process

The participants were to a greater or lesser extent involved in the decision process to select a counsellor. There was no single pattern in the process of choosing the counsellor they saw. On the one end of the spectrum, the process involved little informed decision-making and was based on one of the following:

- someone else chose the counsellor, such as a caregiver or parent;
- the counsellor was assigned by the hospital or clinic the participant was in;
- previous experience with the counsellor, for example a counsellor seen at a remedial school;
- the counsellor was referred by another professional, such as a psychiatrist or medical doctor; or
- the counsellor was an allocated counsellor at one of the gay or gay-friendly CBOs, such as the Triangle Project (Cape Town) and OUT LGBT Well-being (Pretoria).

The participants who followed a more comprehensive approach utilised a combination of sources to inform their decision, including:

- word-of-mouth recommendations by friends and family members, whether from one or more persons;
- research on the internet;
- referral from another professional or colleague; and

² Quotations are denoted by the participants’ sexual orientation, age group and race, as this was used as inclusion criteria in the sample. It is used simply as descriptors to indicate that all participants' stories were included.

- meeting a person in another context, such as a psychodrama group.

These participants also had one or more of the following criteria in mind:

- a specific type of counselling modality, for example Jungian;
- a gay or gay-friendly counsellor;
- convenience, such as distance from home or work;
- after-hours availability; or
- rates and payment system.

In some cases, the participant and counsellor met for an initial session to decide whether they could work together.

4.2.3 Expectations

In general, the period after making the appointment and waiting for the first session was filled with apprehension or dread. For some it evoked feelings of ambiguity, and for a few, feelings of excitement:

- Some participants said they were scared or nervous as they had not opened up to someone before and were daunted by the thought of allowing someone to ask personal questions, did not know what to expect, or were afraid that they would have nothing to say to the psychotherapist or counsellor or that they had not chosen the right counsellor.
- Some participants were excited or hopeful that their issues would be addressed and knew that they were doing the right thing, but on the other hand felt a bit scared, daunted and nervous because they did not know how counselling worked, were meeting a stranger, or were generally uncomfortable opening up to another person.
- A few were excited, had a sense of relief or felt empowered by the decision to initiate change and were looking forward to the session.

Some participants were sceptical, given their lack of clear understanding of what counselling could do for them, or because they came from an environment where a person would be viewed as “crazy” or “weak” if they went to psychotherapy or counselling.

One participant was concerned that they would not be able to express themselves in their home language and would struggle to make their meaning clear in a second language.

4.3 DURING COUNSELLING/THE “PROCESS”

4.3.1 Duration and frequency

The duration of the participants' counselling ranged from one session to continuous counselling with the same counsellor over a period of ten years. The frequency of the sessions the participants attended ranged from *ad hoc* sessions from time to time, as they felt they needed it or could afford it, to weekly sessions and daily sessions. Weekly sessions, with the exception of holidays, seemed to be the more popular option. The frequency of the sessions tended to change as time progressed, driven either by what the counsellor felt was necessary or practical factors such as the availability of funds. The participants tended to go more frequently during times of crises, which included the beginning of their counselling due to trauma or a crisis such as a suicide attempt. In a few cases, the counsellor was available for contact at all hours should a crisis erupt.

4.3.2 Setting

A popular setting for counselling appeared to be a home office, whether an office adjacent to a house, a study or even a lounge in a house. This was followed by an office either in an office block or a converted residential building, such as a block of apartments. There were very few mentions of seeing a counsellor in a clinic or hospital setting.

In some cases there was a waiting area for clients. If there was a receptionist, important attributes included friendliness and efficiency (“being organised”): “The receptionist is the first person you see and the last person you see at a session’ (Gay, 36-65, white). The facilities had separate toilets or bathrooms. The counselling rooms differed in size and mostly did not seem to influence the participants' experience too much. A few participants mentioned that the rooms were too small for them and that it became an issue not having enough personal space or being able to move around and change seats, for example. Refreshments such as coffee, tea, juice and water were sometimes offered, and sometimes available to clients to help themselves.

A wide variety of styles were encountered, ranging from old, renovated areas with Persian carpets and dark wooden furniture to more domestic, lounge-type settings and more modern and sophisticated styles with expensive furniture. For at least one participant the latter indicated that the counsellor was very successful. Other elements included

- chairs, armchairs, with the counsellor's chair higher than the other chairs in one case;

- couches, with the choice of sitting on a chair or couch (a two-seater or lie-down couch);
- bookcases with books and desks with or without a personal computer; and
- "... a few trinkets one could play with" (Lesbian, 36-65, white), implying some decorations or toys that could be handled during sessions.

The ambiance was generally quiet, calm and peaceful and sometimes included music playing in the background in the waiting area (such as a classical radio channel). In one case, kids could sometimes be heard playing in the background at a home office: "It's comfortable and very different to the way I live" (Gay, 18-35, black). A number of comments related to the presence or absence of light and air in the venue. Some venues had a lot of natural light and were described as "sunny, which is important to me" (Lesbian, 36-65, white). Some had windows overlooking a garden, and the windows were opened in summer and closed in winter. Some rooms had no windows and were only air-conditioned, or the office had windows but looked out on other buildings.

It would seem that personal preference played a significant role in how the setting was experienced. A comparison was also sometimes made with what was expected from a counsellor's office, such as depictions in mass media: "It looks like Freud could have strolled out of it. It's an old renovated Victorian house" (Gay, 18-35, white).

For some participants, the space reflected the personality of the counsellor. This ranged from more cold and clinical, which might not have been enjoyed and might be related to the client not relating to the counsellor: "I think it was more an aura thing. Our auras clashed or something" (Gay, 36-65, white), and: "I've walked into a place before, where it was definitely a straight person's practice and it freaks me out" (Gay, 18-35, white). A counsellor could also have a positive effect on a less than ideal setting: "Once I'm inside and talk to her, the climate that she creates helps me ease off" (Bisexual female, 18-35, white).

Home office settings were often described as

- a more relaxed, chatty environment;
- a nice, warm and welcoming setting: "... as if I was just chatting to a friend" (Gay, 18-35, mixed);
- a quiet, peaceful place, homely; and
- a place where the client felt safe and comfortable.

A formal office could be experienced as too clinical, but could also be made to be warm and inviting. With the exception of one, the sense of comfort and warmth was important to all the participants: "... one needs to be physically comfortable to be more free to express emotion" (Lesbian, 36-65, white), and: "I got so comfortable that I would take my shoes off in there" (Gay, 18-35, white).

4.3.3 Therapeutic operations

The majority of the participants had only experienced individual psychotherapy or counselling. Some of the participants had experienced couples counselling, group therapy or family therapy. A few participants were clear on what theoretical view the counsellor held, for example Jungian or Buddhist psychoanalysis. Very few had a specific preference for a therapeutic modality.

In all cases, the psychotherapy or counselling was predominantly driven by mutual verbal communication. In some instances, this was augmented by other elements such as assessment, hypnotherapy, physical exercises such as breathing exercises, soft background music during sessions, providing materials such as a CD with a man talking in a calming voice as part of an exercise the participant had to do at home, astrology charts, and providing some directive around the participant journaling or diarising events, dreams, stories, thoughts and feelings. In most cases where the latter was provided, the participants complied and found the experience enriching. Sometimes what they wrote was discussed, sometimes they just read what they wrote, and other times the counsellor only enquired about their feelings and reactions to writing:

- "She made me write a lot and within time I started magically doing it" (Bisexual female, 18-35, white).
- "I wrote a short story about being sexually abused by my uncle" (Gay, 36-65, white).
- "It was sometimes things to think about and make notes of" (Gay, 36-65, white).
- "... he's been encouraging me to journal, which I haven't found the time to do" (Gay, 18-35, black).

Some counsellors were experienced as more directive and others as more non-directive, ranging from times when advice was provided and times when the counsellor was very direct with the client in highlighting problematic patterns, to situations of long silences with the counsellor providing no guidance or not asking questions. The participants responded

differentially to this. One felt that the lack of questioning and long silences were a waste of time, whereas another felt that it provided her with the space to explore issues that she would otherwise not even have thought of mentioning. Another participant had a both/and view: “I would prefer someone who is a good listener, but who also helps steering me in the right direction, but doesn’t tell me what to do” (Gay, 36-65, mixed).

Some counsellors were perceived as more talkative than others. In a few cases it was highlighted that the counsellor shared some of their own experiences and that this was appreciated and assisted in creating a rapport between participant and counsellor. Some responded more positively to a more conversationalist style, whereas others did not want a conversation but rather a clear focus on their concern or issue.

Some counsellors took notes, while others did not. In turn, some participants appreciated it when the counsellor made notes and referred back to them as the sessions progressed, whereas others found it distracting:

- “She would make notes and refer back to them, so I really enjoyed that” (Gay, 18-35, mixed).
- “The first guy ... was writing all the time, so it didn’t feel that he was listening to me” (Gay, 18-35, white).
- “So when he wrote something down I thought I might have said something interesting” (Gay, 18-35, white).

An area of ambivalence for some participants was the issue of dependency on the counsellor. Some felt it was what they needed at the time of a crisis, but for others this either highlighted a pattern of interaction they had difficulty with to start with or became an issue:

- “I think this becomes a dependency, so I can go and misbehave and then go to her and say sorry, rather than relying on my own resources to grow and strengthen” (Bisexual male, 36-65, white).
- “The time when I started seeing her was a very bad time for me, so she was my lifeline. I was so dependent on the time I had with her” (Bisexual female, 18-35, white).

4.3.4 Positive experiences with and aspects of the counsellor

Most participants experienced their more recent counselling as positive, useful and helpful. For some, previous experiences when they were younger were more negative and disaffirming. An important dimension that contributed to the positive experiences was the counsellor's self. The positive experiences almost always included mention of receiving unconditional regard, total acceptance and the counsellor being non-judgemental:

- “That unconditional love and acceptance, whilst still caring enough to be honest with me” (Bisexual female, 18-35, white).
- “I think I felt that I was not going to be judged by her, whereas the others were the typical Afrikaner – can hit you with the Bible if you say the wrong thing” (Gay, 36-65, white).
- “When I came here, I felt so welcome and I said: ‘Where were you my whole life?’” (Lesbian, 18-35, black).

This went hand in hand with the counsellor being

- compassionate, warm and caring:
 - “She cares enough for me to be real with me” (Bisexual female, 18-35, white).
 - “She was warm, yet remained professional” (Lesbian, 36-65, white).
- honest:
 - “She will never let me get away with any form of denial if she thinks I’m strong enough to handle it” (Bisexual female, 18-35, white).
- congruent:
 - “... honest about the way that she sees the world” (Bisexual female, 18-35, white).
- and calm and gentle:
 - “He was totally non-threatening” (Gay, 18-35, white).
 - “She had a very gentle way about her” (Bisexual female, 18-35, white).

For some, this was underpinned by the level of life experience, or similar experiences the counsellor had gone through:

- “It feels like he’s been through it all” (Gay, 18-35, white).
- “It feels safer if they have been there” (Gay, 36-65, mixed).

For some it was apparent that the counsellor had their best interests at heart: "... her biggest agenda is that she has my best interests at heart and she wants me to face me and things about me that I was never ready to face before" (Bisexual female, 18-35, white). This was enhanced by the level of joining or rapport established by the counsellor, and a sense of sharing similar values:

- "I feel he is with me as well" (Gay, 18-35, white).
- "... she communicated with me on a level that was understood by me" (Gay, 36-65, white).
- "I felt a very strong connection with her" (Bisexual female, 18-35, white).

The counsellor was often experienced as being

- a good listener:
 - "I talk most of the time and he doesn't say much, but it's good to talk. I think he helps me more by just listening" (Bisexual male, 36-65, white).
- sensitive, emotionally in touch, containing and empathetic:
 - "... she's sensitive enough to know when to let something go" (Bisexual female, 18-35, white).
 - "... he was a very deeply emotional person, so I realised that everything in his office had a deep meaning" (Gay, 18-35, white).
- present and observant:
 - "He's very here and now" (Gay, 18-35, white).
 - "He focuses on what is said" (Gay, 18-35, black).
 - "... how perceptive she was and that's kind of what made me going back" (Bisexual male, 36-65, white).
- and prepared for sessions, on time, and flexible, for example being understanding of the difficulties in arriving on time at sessions.

For some it was important that the counsellor dealt with them as people and not as "patients":

- "She never made me feel that she's the therapist and I'm the patient" (Lesbian, 36-65, white).
- "She greeted me as a friend and started talking to me as a friend" (Bisexual male, 36-65, white).

This was enhanced by the counsellor sharing their own experiences when appropriate:

- “Another thing I absolutely love and it didn’t often happen ... she would say that she’d also had that feeling in her relationships” (Lesbian, 36-65, white).
- “He was prepared to share his own experiences” (Gay, 36-65, mixed).

It was also relevant at times, or for some of the participants, that the therapeutic boundaries were kept strong:

- “I actually know very little about him, because of what I’m going through” (Gay, 18-35, black).

Sometimes the boundaries became blurred as part of the therapeutic process:

- “... she was starting to feel like my mother ... I was duplicating a dependency syndrome with [the counsellor]” (Bisexual male, 36-65, white).

This also speaks to the ethical issue of dealing with multiple roles:

- “He removed me from Facebook as soon as he became my therapist” (Gay, 18-35, white).
- “... we did have mutual friends. It came up now and then and we handled it beautifully” (Lesbian, 36-65, white).

What stood out for some participants was that the counsellor appeared balanced, looked happy and had a positive attitude, was physically attractive and had an authentic smile: “She really had a smile that was genuine” (Gay, 36-65, white). This was underpinned by having a good sense of humour.

In two cases the participants appreciated that the counsellor came across as more academic. For one participant, the counsellor’s spirituality was an outstanding factor: “He had universally acceptable spiritual pictures on the walls, so one would immediately realise that any person with any religion would have been able to relate to it” (Gay, 18-35, white).

4.3.5 Positive affirmation of sexual orientation by the counsellor

Positive affirmation of one’s sexual orientation by a counsellor is at least part of having unconditional regard and being totally accepting and non-judgemental, and was specifically

probed in the interviews. Themes that the participants highlighted as evidence of their experience being affirming were:

- viewing same-sex attractions, feelings and behaviour as normal variants of human sexuality:
 - “She was working with lots of gay students and couples and that it’s just a normal part of life” (Gay, 18-35, mixed).
 - “She never said to me that being gay is wrong. It was always about how can we take this and how it could work for me best” (Gay, 36-65, white).
- accepting of sexual fluidity:
 - “Yes, initially I was completely gay and over the years I became completely bi. No, he had no issues about it and didn’t force me into anything” (Bisexual male, 36-65, white).
- acceptance of sexual orientation as potentially only one aspect of the therapeutic experience:
 - “... we did discuss my sexual orientation, because that was one of the biggest reasons I was there. It played a big part at the start, but then we moved on to other issues” (Gay, 18-35, mixed).
 - “My sexual orientation wasn’t discussed as such, but it was almost always integrated into the session” (Gay, 36-65, white).
 - “... if you focus on sexual orientation too much, it makes you feel that you are completely different from the rest of the world” (Gay, 18-35, mixed).
- dealing with internalised homophobia:
 - “Yes, because my biggest fear was admitting it up to that point” (Gay, 36-65, white).
 - “I worked through that whole thing of wishing I wasn’t gay. You want everything to be normal” (Gay, 18-35, white).
- sensitivity to and respect for same-sex relationships:
 - “The emotions of two women together can be something else – it can be too intense” (Lesbian, 36-65, white).
 - “[A discussion of sexual orientation] was always present because of the relationship issue that was part of the therapy” (Gay, 18-35, white).
 - “Yes, what I fear most about it is having my relationships trivialised and that doesn’t happen” (Gay, 18-35, black).

- using context-appropriate language:
 - “He reflects my words. If I say gay, he doesn’t say homosexual” (Gay, 18-35, white).
- and the counsellor adopting a curious stance:
 - “... she was interested anyway, even though she was heterosexual and happily married and children and all of that” (Lesbian, 36-65, white).

4.3.6 Negative experiences with the counsellor

With very little exception, the participants’ negative experiences with a counsellor related to how the counsellor dealt with their sexual orientation. The themes that emerged were:

- viewing a client’s sexual orientation as abnormal:
 - “... she then referred me to a horrible woman ... who told me that I was absolutely sick” (Bisexual male, 36-65, white).
 - “He wasn’t open to accept it or to work around it. He immediately made value judgements” (Lesbian, 36-65, white).
- heterosexism and negative myths:
 - “... he suggested that I should go to the first adult site and get laid as quickly as possible by a guy” (Lesbian, 36-65, white).
 - “I felt completely misunderstood. I could go and have sex with five guys, but how is that going to help me?” (Lesbian, 36-65, white).
 - “She tried to set me up with her daughter, which sounds horrific now, but when you’re fourteen you don’t know that it’s weird” (Gay, 18-35, white).
- viewing sexual orientation as an either/or dichotomy rather than affirming the fluidity of a client’s sexual feelings:
 - “One of the reasons why I wanted to leave is because I felt that she was pushing me in a particular direction that I didn’t want to go ... there’s gay and there’s straight and you’re either in the one or in the other” (Bisexual male, 36-65, white).
- not dealing with a client’s internalised homophobia:
 - “... it brought up all those fears again of my own fears and judgement of myself, saying yes, gay is wrong” (Bisexual male, 36-65, white).
- not realising that LGB youth face different challenges than heterosexual youth:

- “She was comparing me to others my age and said that this was just part of growing up. I hated that and now that I can compare it, I’d safely say that I’ll never go back to a straight counsellor” (Lesbian, 18-35, black).
- meeting in a different context (for example a nightclub) and the consequent concern about confidentiality; and
- viewing a client only through their sexual orientation:
 - “I felt as if she was sexualising or interpreting it through a prism that said it’s just about the sex” (Bisexual male, 36-65, white).

4.3.7 Sexual orientation of the counsellor

A slight majority of the participants preferred, wanted or liked their counsellor to be lesbian, gay or bisexual. They felt that a lesbian, gay or bisexual counsellor would be more understanding of their own life experiences and challenges, as they might have experienced the same:

- “I don't think any other therapist would ever have managed to get me to a point where I embrace my sexuality” (Bisexual female, 18-35, white).
- “They can understand what you’re talking about and where you’re coming from” (Lesbian, 18-35, black).

There was substantial concern that a heterosexual counsellor could be uncomfortable with alternative sexualities, have difficulty relating to the client, be judgemental and biased rather than affirming or even actively discriminatory:

- “... with a straight person I ask in the back of my mind whether they’re judging me” (Gay, 18-35, white).

One participant felt that they would prefer a lesbian, gay or bisexual counsellor if they were dealing with sexual orientation issues, but did not feel that their presenting problem was of such a nature. Another participant felt that it was important that the counsellor be gay-friendly and be known for working with LGB people regardless of their own sexual orientation.

Those to whom this was not important mentioned a variety of reasons:

- “If you’re gay and it’s an attractive guy, it’s maybe not a good idea” (Bisexual male, 18-35, white).
- “I’m not one of those people who would prefer to see a gay doctor” (Gay, 18-35, white).
- One participant felt that the gay counsellor he saw did not clearly distinguish his role within a therapeutic context from that when meeting or seeing each other at a social event.
- “... it was interesting having a straight therapist, because I think that was something that made her think a little bit. It’s lovely when you’re in therapy when you’re not the only one needing to be stimulated or inspired” (Lesbian, 36-65, white).

4.3.8 Termination

The decision to stop going to psychotherapy or counselling can be driven by

- the client, because of a negative experience with the counsellor, they feel they have resolved their issue or concern, or due to a lack of funds; or
- mutual decision, which can either be initiated by the counsellor with agreement by the client, or initiated by the client with agreement by the counsellor.

In one case, the counsellor terminated while the participant did not want to. In retrospect, the participant realised that the counsellor did this as a way of helping the participant to deal with dependency issues – both the dependency on the counsellor and a pattern of dysfunctional dependency on others.

4.4 OUTCOME OR “IMPACT” OF THE COUNSELLING

The following themes were identified as the outcome or impact the counselling had on the participants:

- being more comfortable to express their own feelings and issues, and honest with self and others:
 - “It has made me an extremely direct and honest person” (Gay, 36-65, white).
 - “It was to reinforce the idea that it’s okay to say no” (Gay, 18-35, white).

- At least two participants said that they tried to control the counsellor's perception of them or tried to show a certain image. In one case the counsellor assisted the participant in feeling that they were more honest; in the other: "I realised I didn't get to or dealt with the really hard stuff" (Bisexual male, 36-65, white).
- self-understanding, self-awareness and insight:
 - "It's been interesting getting to know myself in a different way" (Gay, 18-35, black).
 - "I was able to process a lot of my history" (Lesbian, 36-65, white).
- dealing with issues and symptoms, such as anxiety or fear:
 - "He helped me to calm myself down" (Gay, 18-35, white).
 - "... at that stage I felt I kind of resolved things" (Gay, 36-65, white).
 - "It led me to get treatment for depression" (Gay, 18-35, white).
- increased self-confidence and self-esteem:
 - "It made me not doubt myself so much" (Gay, 18-35, mixed).
 - "The first one gave me a lot of confidence, because I knew exactly who I was and what I stood for" (Gay, 18-35, white).
- a sense of control and empowerment:
 - "It started helping me to take control and realising that I am the creator and writer of my own destiny" (Gay, 36-65, white).
 - "... my psychotherapist was able to keep me kind of on track and focused on what I personally needed to do to move through this whole situation" (Lesbian, 36-65, white).
- self-acceptance:
 - "I am who I am and I don't really care about what people say ..." (Lesbian, 18-35, black).
 - "The therapist played a huge role ... to accept myself for who I am" (Gay, 36-65, white).
 - "Either I accept who I am and carry on with my life, or face being unhappy for the rest of my life" (Gay, 36-65, white).
- the ability to view things from a different perspective:
 - "... changing my own perceptions and long-held beliefs about behaviour and sexuality" (Bisexual male, 36-65, white).
 - "... and see things from a different perspective" (Gay, 18-35, mixed).

- relief and unburdening:
 - “It’s a good investment once a week just to get stuff off your chest” (Gay, 18-35, white).
 - “The best thing you can do is talk – don’t build things up inside you” (Gay, 18-35, mixed).
 - “I felt so much better, as if a weight was lifted off my shoulders” (Gay, 36-65, white).
- hopeful and optimistic:
 - “The major impact is that I’m happy” (Bisexual male, 18-35, white).
- improvement in interpersonal relationships:
 - “It makes a massive difference, especially around my friends. They’re all opening up more” (Bisexual male, 18-35, white).
- and feeling contained and supported:
 - “He’s very containing ... for about six months there, it was supportive therapy” (Gay, 18-35, white).
 - “It was incredibly supportive during my breakdown ...” (Lesbian, 36-65, white).

4.5 AFFIRMATIVE PRACTICE STATEMENTS

As mentioned in the previous chapter, the participants were provided with a list of 30 LGB-affirmative statements gleaned from the literature. Initially they had to sort these statements into three groups, namely those statements that were important and relevant; those that were not important or relevant, and those they were unsure about or omitted from the sorting. In most cases, the important and relevant group contained a large proportion of the statements. To provide a clearer idea of which of these were more important than others, the participants were subsequently requested to sort this group into two more groups based on their relative importance. The most important group as well as the statements they were unsure about were discussed further.

Given that this card-sorting exercise provided a ranking of importance and relevance, weights were applied in calculating the final importance/relevance score:

- Important/Relevant – 2
- Less important/relevant – 1
- Not important/relevant – 0

- Unsure – Omitted

The following table contains the scores calculated across the sample of 15 participants. If every participant gave a statement a score of 2 (important/relevant), the total would be 30 and the percentage 100%. The percentages therefore provide an indicator of importance or relevance.

Table 4.1: Results of the affirmative practice statements sorting

	TOTAL	%
Understanding that lesbian, gay and bisexual orientations are not mental illnesses	28	93
Understanding that same-sex attractions, feelings and behaviour are normal variants of human sexuality	28	93
Knowledgeable about and respects importance of lesbian, gay and bisexual relationships	28	93
Provides a safe, trusting environment or setting	27	90
Comes across as being accepting of a lesbian, gay and bisexual lifestyle	27	90
Assists in developing a positive lesbian, gay or bisexual identity	25	83
Does not use sexist, homophobic or stereotypical language	25	83
Does not try to change sexual orientation	25	83
Understands that not all needs are based on your sexual orientation – some needs are the same as any other person’s, regardless of sexual orientation	25	83
The psychotherapist or counsellor is aware of his/her own attitudes and knowledge about lesbian, gay and bisexual issues	22	73
The psychotherapist or counsellor is comfortable with his/her own sexual orientation	22	73
Understanding of the effects of prejudice, discrimination and hate crimes on your life	18	60
Respects my confidentiality around my sexual orientation	18	60
Explores the area of sexuality sufficiently – not too much and not too little	17	57
Continually increases his/her knowledge and understanding of lesbian, gay and bisexual lives and issues	15	50

Table 4.1: Results of the affirmative practice statements sorting (continued)

	TOTAL	%
Counters biased views held by others, including other professionals	15	50
Has the same sexual orientation as I do	15	50
Understands the unique developmental or life issues that lesbian, gay and bisexual people face, such as the “coming out” process	15	50
Understands the unique problems and risks faced by lesbian, gay and bisexual youth	15	50
Considers the influences of religion and spirituality in the lives of lesbian, gay and bisexual people	15	50
Strives to understand the ways in which sexual orientation impacts on the family of origin and relationships within the family of origin	14	47
Provides relationship information that you can relate to, for example positive lesbian, gay and bisexual role models	12	40
Recognises age group and life stage differences among lesbian, gay and bisexual people	12	40
Strives to understand the impact of HIV/AIDS on the lives of lesbian, gay and bisexual people	11	37
Distinguishes between sexual orientation issues and issues of gender identity	10	33
Shares information on a lesbian, gay and bisexual lifestyle	10	33
Recognises the challenges faced by lesbian, gay and bisexual people with physical, sensory or cognitive-emotional disabilities	8	27
Recognises that the families of lesbian, gay and bisexual people may include people who are not legally or biologically related	7	23
Strives to understand the experiences and challenges faced by lesbian, gay and bisexual parents	6	20
Recognises the challenges faced by lesbian, gay and bisexual people of different population, language and cultural groups	5	17

The following analysis is based on a combination of the ranking and content of the statements. The discussion provides quotations from the participants to support the ratings they gave.

The statements that can be considered important by most to all of the participants, *i.e.* achieved a score of above 70%, included:

- Understanding that lesbian, gay and bisexual orientations are not mental illnesses:
 - “They won’t help you if they think it’s a disease” (Gay, 18-35, white).
 - “If there is not understanding, the person will be damaged and feel like a reject” (Bisexual male, 36-65, white).
- Understanding that same-sex attractions, feelings and behaviour are normal variants of human sexuality:
 - “You are normal, so there’s nothing wrong with you” (Gay, 18-35, white).
 - “He has to respect you for who you are” (Bisexual male, 36-65, white).
- Knowledgeable about and respects importance of lesbian, gay and bisexual relationships:
 - “They need to recognise that these relationships rule our lives. It’s an integral part of who we are” (Lesbian, 36-65, white).
 - “When I talk about my relationship I want that person to realise that it’s important to me” (Gay, 18-35, white).
 - “The therapist and patient should have respect for each other’s attitudes and values” (Gay, 36-65, white).
- Provides a safe, trusting environment or setting:
 - “If the setting’s not right, I won’t open up” (Gay, 18-35, white).
- Comes across as being accepting of a lesbian, gay and bisexual lifestyle:
 - “I don’t want someone choking when I tell them I have a boyfriend” (Gay, 18-35, white).
- Assists in developing a positive lesbian, gay or bisexual identity:
 - “I think that has a lot to do with helping you to improve your own self-image as a gay person and to help you to realise that you are unique” (Gay, 36-65, white).
 - “I’ve had quite a good experience with that because of how he is about it and what I’ve talked about, so I think that is important” (Gay, 18-35, white).
- Does not use sexist, homophobic or stereotypical language:

- “It would be a problem if it’s indicative of her prejudices, such as all gay men are promiscuous” (Bisexual male, 36-65, white).
- “Homophobic things are complicated, because I also have gay friends whom I think are sometimes homophobic and have internal homophobia” (Gay, 36-65, white).
- “I don’t mind that if the person is gay, because then it’s a joke. A faggot can call himself a faggot. If you’re straight, don’t do it in a derogatory way” (Lesbian, 36-65, white).
- Does not try to change sexual orientation:
 - “I remember when I went to a youth centre at the Dutch Reformed Church ... I went there and spoke to a very well-known ‘dominee’ [minister] and it was a situation of going on our knees, pray and when you open your eyes, you are now heterosexual. It just doesn’t work like that ... it’s not something that I can change” (Gay, 36-65, white).
- Understands that not all needs are based on your sexual orientation – some needs are the same as any other person’s, regardless of sexual orientation:
 - “It’s very important, because you get psychiatrists who hammer on that your problems are because you’re gay ... He can still make you feel like a loser because you’re gay. There are many other issues causing problems” (Bisexual male, 36-65, white).
 - “Yes, they didn’t break into your car because you’re a lesbian. They did it, because it’s a crime” (Lesbian, 18-35, black).
- The psychotherapist or counsellor is aware of his/her own attitudes and knowledge about lesbian, gay and bisexual issues – a statement that also has the implication that a self-aware and knowledgeable counsellor would be respectful of a client, which was a generally important aspect for the participants:
 - “You don’t want to go to a counsellor and explain to them what it means to be gay” (Gay, 36-65, white).
- The psychotherapist or counsellor is comfortable with his/her own sexual orientation:
 - “They need to have worked through all their issues in order to show me the way” (Lesbian, 36-65, white).
 - “I think it would be very difficult if you go to a therapist that is for example homophobic or is unsure of their own sexuality” (Gay, 36-65, white).

In some cases, there appeared to be a more ambivalent opinion among the participants, but skewed towards more important:

- Understanding of the effects of prejudice, discrimination and hate crimes on your life:
 - “Last week my partner had a fight with a guy and punching was involved. People discriminate against us every day” (Lesbian, 18-35, black).
 - “It’s my opinion that gay people understand the struggle of black people better than heterosexual people, because gay people also understand discrimination, repression and the dominance of the heterosexual society” (Lesbian, 18-35, black).
 - For some participants, a counsellor who understands the effect of prejudice and discrimination would also counter biased views held by others, including other professionals, which would appear to give the affirmative counsellor an activist agenda as well.
- Respects my confidentiality around my sexual orientation:
 - Some participants felt that this statement questioned how comfortable they were with their own coming out process and acceptance of their orientation in counselling rather than reflecting an ethical issue. A rewording could be: “What you talk about with the counsellor stays confidential.”
- Explores the area of sexuality sufficiently – not too much and not too little:
 - “I suppose if you have issues with sexuality and going for help, it’s important ... There would then be a very fine line of what to touch and what not to touch on the sex issue” (Bisexual male, 18-36, white).

In some cases, the ambivalence was more equally spread:

- Continually increases his/her knowledge and understanding of lesbian, gay and bisexual lives and issues:
 - In contrast with the statement about a counsellor being aware of his/her own attitudes and knowledge regarding LGB issues, this statement might not be something that a client is necessarily aware of. The participants might have experienced the impact of such activities through the attitudes of the counsellor: “What I like about her is that she’s open to ideas. She likes to explore, because she’s open-minded” (Lesbian, 18-35, black).
- Has the same sexual orientation as I do:

- This was more important if the presenting problem was directly related to the participant's sexual orientation, as discussed in the section on the experience with the counsellor.
- The three statements that appear to share the theme of life stage and developmental differences, namely: "Understands the unique developmental or life issues that lesbian, gay and bisexual people face, such as the 'coming out' process"; "Understands the unique problems and risks faced by lesbian, gay and bisexual youth"; and: "Recognises age group and life stage differences among lesbian, gay and bisexual people":
 - "As I said, I came out in my early twenties. I had girlfriends and it was quite traumatic for the people in my life and for me. It's been good to do that with somebody who seems to not be freaked out by the fact that I claimed to be heterosexual for a long time before I realised I was gay" (Gay, 18-35, white).
 - "I have a friend now who is 68 and he's looking into a retirement village. He's single and it's not easy for him, because he had to give up many of his things and move into a smaller place" (Gay, 36-65, white).
- Considers the influences of religion and spirituality in the lives of lesbian, gay and bisexual people:
 - "That's not important to me in therapy" (Gay, 36-65, white).
 - "I think a lot of gay people are very spiritual. Some of the most spiritual people in the world are gay" (Lesbian, 36-65, white).
 - "I've been able to grow spiritually and gain a better understanding of who I perceive my God to be and I could increase my acceptance of my sexuality in the same sense with her" (Bisexual female, 18-35, white).
- Strives to understand the ways in which sexual orientation impacts on the family of origin and relationships within the family of origin:
 - The term "family of origin" created some confusion among the participants: "I don't understand what that's saying" (Gay, 36-65, white).
 - In addition, the statement "Recognises that the families of lesbian, gay and bisexual people may include people who are not legally or biologically related" seemed to be in a similar theme group as sexual orientation impacting on a person's broader interpersonal worlds, which include family of origin, family of choice and other friends: "Yes, it's friends as well" (Lesbian, 18-35, black).

- Provides relationship information that you can relate to, for example positive lesbian, gay and bisexual role models:
 - This statement was interpreted as dealing with both relationship issues and the establishment of positive role models.
 - “It would be nice if the therapist can refer the patient to a centre or if they can refer literature to the person” (Gay, 36-65, white).
 - “I don’t think my therapist has to do that. It’s my responsibility” (Gay, 18-35, white).

Some of the statements were ranked as relatively less important or relevant to the participants:

- Strives to understand the impact of HIV/AIDS on the lives of lesbian, gay and bisexual people.
- Distinguishes between sexual orientation issues and issues of gender identity
- Recognises the challenges faced by lesbian, gay and bisexual people with physical, sensory or cognitive-emotional disabilities.
- Strives to understand the experiences and challenges faced by lesbian, gay and bisexual parents.
- Recognises the challenges faced by lesbian, gay and bisexual people of different population, language and cultural groups.

To many participants, the following statement was not relevant or appropriate for a therapeutic or counselling context:

- Shares information on a lesbian, gay and bisexual lifestyle: “I know why it would be relevant to a very young gay person, but you don’t want your therapist telling you what the gay lifestyle is all about” (Gay, 18-35, mixed).

4.6 IN CONCLUSION

This chapter offered the analysed data from the semi-structured interviews conducted. The following and final chapter discusses the findings in more detail to lead to conclusions and recommendations.

CHAPTER 5: SUMMARY AND CONCLUSIONS

5.1 INTRODUCTION

In this, the final chapter, the key findings of the study are summarised. The participants' qualitative feedback on different aspects of their experiences of counselling is discussed. The feedback is structured according to the process of counselling, using the model of psychotherapy outlined by Orlinsky *et al.* (1994) – starting with the input phase before going to counselling, then moving on to the process phase during counselling, and ending with the output phase, or the outcomes achieved. Comments relative to other work in this area are also offered.

As set out in the previous chapter, the participants were provided with a set of affirmative practice statements. These were ranked according to how important and relevant they were considered to be by the participants. The participants then discussed each of the more important statements. These responses are discussed in this chapter, with recommendations for the inclusion of certain statements in affirmative practice guidelines for psychology professionals and counsellors working with LGB people and communities. The current research study is then positioned within the area of Community Psychology, with the focus on the potential benefits this study could provide to LGB people who receive psychotherapy and counselling, LGB communities, as well as the psychotherapists and counsellors providing these services. Finally, consideration is given to further research, as well as the limitations of the study.

5.2 DISCUSSION OF THE RESEARCH FINDINGS

Following is a summary and brief discussion of the research findings, including supporting evidence from other sources for the findings. The participants' experiences before going to counselling are followed by their experiences during the process, the termination process, and the outcomes achieved. The section concludes with a discussion of the participants' ranking of and commentary on the set of affirmative practice statements they were provided with.

5.2.1 Before going to counselling/The “input” phase

5.2.1.1 *Reasons for going to psychotherapy or counselling*

This research highlighted that LGB people seek counselling for a broad range of reasons – from longer term personal issues and help after experiencing trauma to relational issues. In many cases, the presenting problem was not directly related to sexual orientation. The presenting problem might well have been impacted by the prejudice and discrimination the participants faced due to their sexual orientation, which contribute to lower self-esteem and self-worth and increased vulnerability to substance abuse and depression (American Psychological Association, 2011). However, in some cases, issues around sexual orientation were at the core of the counselling, including help in the coming out process. The American Psychological Association (2011) highlights a number of factors, such as different patterns of sexual behaviour, gender role socialisation, stigma and hostility towards same-sex relationships, that might also lead to a higher proportion of relationship difficulties in this group.

5.2.1.2 *The decision process*

There was no single pattern in the process of choosing the counsellor the participants saw. On the one end, the process involved little informed decision-making and constituted simply seeing the counsellor chosen by someone else, such as a caregiver, one appointed by a hospital or clinic, or one referred to by another professional. At the other end, some participants spent a good deal of time and effort in searching for and deciding on an appropriate counsellor. This included using word-of-mouth recommendations, research on the internet, referrals, and even first meeting the counsellor. These participants then made an informed decision based on such elements as counselling modality, whether the counsellor was LGB or LGB-friendly, distance or accessibility from home or work, after-hours availability, rates and payment structure, and perceived compatible personality. As stated by Nel (2005), CBOs such as OUT LGBT Well-being and the Triangle Project have also become important as conduits for providing therapeutic referrals or services within this population.

5.2.1.3 *Expectations*

The period after making an appointment and waiting for the first session was often filled with apprehension and dread, mainly because of the potentially intimate nature of psychotherapy

or counselling with a person the participants did not know. Some of the participants had a sense of excitement or relief that their issues might be addressed or that they were proactively doing something to initiate change.

5.2.2 During counselling/The “process” phase

5.2.2.1 Duration of counselling and frequency of sessions

The duration of the counselling ranged from one session to continuous counselling over a period of ten years. Weekly sessions seemed to be the most popular. The frequency of the sessions did at times become more or less frequent, depending on what the counsellor recommended, the availability of funds, or if the participant experienced a crisis.

5.2.2.2 Setting

Therapists practise in a variety of settings with different styles of furnishings. A popular setting for counselling appeared to be a home office with separate toilet facilities. Most participants found a quiet, calm and peaceful ambiance with a lot of natural light to be the most comfortable and facilitative of discussion and openness. For some participants, the setting reflected the personality of the counsellor; others commented on how the counsellor contributed to making a less than ideal setting more acceptable. There did not appear to be a preference for particular settings that might be different from that expected by most people going for counselling. A substantial body of international research has been published on the impact of settings, such as room design on mental health and emotional state (Anthes, 2009), but this is beyond the scope of this study.

5.2.2.3 Therapeutic operations

Most of the participants had experienced individual counselling with mutual verbal communication as the main tool of counselling. This was sometimes augmented by one or more of a wide variety of elements, including assessments, physical exercises, hypnotherapy, astrology charts, and directives around journaling or homework. Where counsellors took notes, some participants liked it as it made them feel they were saying important things, whereas others found it to be intrusive. Some counsellors were experienced as more directive and others as more non-directive, with some participants preferring the one or the other approach. Some appreciated that the counsellor shared her or his own experiences, while

participants who mentioned it experienced the development of a dependency on the counsellor as more ambivalent.

Different therapeutic frameworks provide evidence or recommendations for different operational elements, including the duration of the counselling and the frequency of the sessions (De Shazer, Dolan, Korman, Trepper, McCollum, & Berg, 2007; McWilliams, 1994). These are not necessarily specific to counselling with LGB people. LGB-affirmative practice is not prescriptive about the actual tools of counselling; it provides more of a framework, stance and position when working with LGB people. In addition, Schippers (1997) highlighted a focus on individual strengths and creativity, and exploring the societal impact on the LGB client in therapy. He further provided recommendations for expanding an intake schedule to be more affirmative, as discussed in Chapter 2.

5.2.2.4 Positive experiences with and aspects of the counsellor

Most of the participants experienced their more recent counselling as positive, useful and helpful. In some cases, previous experiences some years back were more negative and disaffirming. This might indicate that counsellors are more affirming today than before. Given that this is a qualitative sample, the findings should be interpreted with care as a number of other studies have indicated more negative, discriminatory or negative experiences with healthcare providers (Graziano, 2005; Meyer, 2003; Rich, 2006; Wells, 2005; Wells & Polders, 2003).

Israel *et al.* (2008) found that the most commonly described helpful situation was where counsellors were warm, trustworthy and caring, followed by counsellors being affirming in dealing with their clients' sexual orientation or gender identity. Similarly, this study firstly highlighted that positive experiences almost always included mention of receiving unconditional positive regard, total acceptance and the counsellor being non-judgemental. This went hand in hand with the counsellor being compassionate, warm and caring; honest; congruent; and calm and gentle. In addition, good experiences were related to the counsellor appearing to have the participants' best interests at heart, being a good listener, empathetic, present, observant, and prepared for the sessions, as well as dealing with the participant as a person and not a "patient". For some it was important that the counsellor reflected having experienced something similar to themselves, or had the life experience to understand what

the participant was experiencing. Sharing their own stories provided evidence of this, but it was still important for the counsellors to keep the therapeutic boundaries.

Secondly, it appeared important to most of the participants that the counsellor was affirming of their sexual orientation. This included viewing same-sex attractions, feelings and behaviour as normal variants of sexuality; being accepting of sexual fluidity; seeing sexual orientation as one aspect of the person, not the only aspect; helping the participant deal with internalised homonegativity; having sensitivity and respect for same-sex relationships; using context-appropriate language; and the counsellor adopting a curious stance.

5.2.2.5 Negative experiences with the counsellor

With very little exception, the participants' negative experiences with a counsellor related to how the counsellor dealt with sexual orientation. Themes that emerged included the counsellor viewing the participant's sexual orientation as abnormal; evidence of heterosexism and negative myths and stereotypes; viewing sexual orientation as an either/or dichotomy within which the participant had to "choose" or "decide" where they belonged; not dealing with the participant's internal homonegativity; not realising that LGB youth might face different challenges than heterosexual youth; a lack of comfort in meeting the counsellor in social contexts; and the counsellor viewing the participant only through their sexual orientation.

Elliott (2008) elucidated two overlapping continuums in his discussion of clients' experiences of psychotherapists, namely (a) psychotherapists being affirming of alternative ways of looking at the world versus imposing their views on the client, and (b) psychotherapists being validating and affirming versus being invalidating and judgemental. These continuums were also present in this study. Firstly, some participants experienced the counsellor as being affirming of another way of looking at the world, while others felt that the counsellor was imposing her or his views on the participant – mainly a heterosexual view. In the second continuum, counsellors, or aspects of their attitudes and behaviour, were experienced as either validating and affirming or judgemental and invalidating, the latter almost exclusively due to a participant's sexual orientation. This would suggest that, although the overall experiences of the participants in this sample were more positive than those in other studies, such as by Graziano (2005) and Meyer (2003), there remains a need for counsellors to be

sensitised to the specific issues and unique circumstances faced by LGB people, and to be aware of their own reactions to LGB people's sexual orientation.

5.2.2.6 Sexual orientation of the counsellor

A slight majority of the participants in the sample preferred, wanted or liked their counsellor to be LGB themselves, as the counsellor would be more understanding of their life experiences and challenges. This is in line with research by Kaufman *et al.* (1997), which indicated a slight preference for a counsellor with the same sexual orientation, especially if the problem was sex-related.

5.2.2.7 Termination

In the current sample, the termination process was generally initiated by joint agreement or by the participant. In the latter instance, this could be because the participant felt that the reason for being in counselling was resolved, because of a lack of funds, or because the counsellor was perceived as judgemental and non-affirming of the participant's sexual orientation. Termination due to feeling disaffirmed or prejudiced is similar to the reasons found in other research, such as by Bodibe (2011a), Cloete *et al.* (2008) and Lalla-Edward (2011), which suggested that stigma, intolerance and discrimination were reasons for a low uptake of treatment services by HIV-positive men who have sex with men, as well as for early termination.

5.2.3 Outcome of the counselling

The outcomes included participants being more comfortable to express their feelings and issues and to be honest with themselves and others; having gained new self-understanding, self-awareness and insight; being able to deal with issues and symptoms such as anxiety and fear; having increased self-confidence and self-esteem; having gained a sense of control and empowerment; being more self-accepting; having developed the ability to view things from a different perspective; feeling relieved, unburdened, hopeful, optimistic, contained and supported; and experiencing an improvement in interpersonal relationships.

Most of these outcomes were also discussed in the meta-analysis of helpful impacts for clients in psychotherapy by Timulak (2007). The two exceptions are that self-acceptance and the ability to view things from a different perspective, particularly relating to clients' own beliefs and perceptions about sexuality, are more prominent among the participants in the

current study. Self-acceptance was also reported by participants in Nel *et al.*'s (2007) work among LGB group members on the benefits of group therapy at OUT LGBT Well-being.

5.2.4 Affirmative practice statements

The participants in the current study were provided with a list of 30 affirmative statements gleaned from the literature. Initially they had to sort these statements into three groups, namely those that were important and relevant, those that were not important and relevant, and those they were unsure about or that were omitted from the sorting. In most cases, the important and relevant group contained a large proportion of the statements. To provide a clearer idea of which of these were more important than others, the participants were subsequently requested to sort this group into two further groups based on their relative importance. The most important group as well as the statements they were unsure about were discussed.

One key finding was that most of the participants placed nearly half of the statements in the most important and relevant group. This, together with the double sorting required, indicated that taking an LGB-affirmative stance in general was considered to be important by the participants. More specifically, these statements could be considered to be perceived as core to any therapeutic encounter by clients.

Following is a discussion of each of these statements in relative order of importance:

- “Understanding that lesbian, gay and bisexual orientations are not mental illnesses”. The participants viewed this statement as a basic for counsellors to, at the very least, do no harm to their clients. Pathologising LGB people’s sexual orientation amounts to stigmatisation, which could further impact on their psychological well-being and contribute to low self-esteem (Theuninck, 2000), vulnerability to depression (Polders *et al.*, 2008) and suicidal ideation (Wells, 2006).
- “Understanding that same-sex attractions, feelings and behaviour are normal variants of human sexuality”. The participants felt that it was important for a counsellor to accept who you are, which would include your sexual orientation, considered by Milton *et al.* (2002) to be fundamental to affirmative practice.
- “Knowledgeable about and respects importance of lesbian, gay and bisexual relationships”, which implied respect from a counsellor for the relational issues LGB people have to deal with. In the absence of positive role models, LGB people develop

their own relational support structures (American Psychological Association, 2011). In addition, the heteronormative model of a mother, father and two children is restrictive to all people, and counsellors should challenge their own belief systems around this (Steyn & Van Zyl, 2009). A statement dealing with relationship issues that was rated as less important was: “Provides relationship information that you can relate to, for example positive lesbian, gay and bisexual role models”. A number of the participants felt that it was not so much the task of a counsellor to provide them with information as providing an accepting and non-judgemental space that allowed for their own insight development.

- “Provides a safe, trusting environment or setting”. As discussed earlier, this statement may well be relevant to all people entering into a therapeutic space. For the participants, this statement also reflected an affirmative setting, *i.e.* speaking to the attitude of the counsellor.
- “Comes across as being accepting of a lesbian, gay and bisexual lifestyle”. The participants were wary of counsellors who would potentially be shocked by discussions of their lifestyle. This confirms that an actively affirming approach, as suggested by Ritter and Terndrup (2002), would be experienced more positively than simply a neutral position.
- “Assists in developing a positive lesbian, gay or bisexual identity”. The participants connected a positive LGB identity with an improved self-image and a realisation and acceptance of one’s own uniqueness. The link between identity and self-image was discussed by Isaacs and McKendrick (1992). For Van Zyl (2005), highlighting the multiple and unique paths of identity formation is critical in creating the potential for transformative living in a changing environment.
- “Does not use sexist, homophobic or stereotypical language”. For the participants, this statement not only spoke to heterosexual therapists’ views as evidenced by their language, but could also reflect the internalised homonegativity that some LGB people might have, including LGB counsellors. In addition, the counsellor’s ability to reflect the client’s language, or reflect on the client’s use of language, is potentially also an aspect to consider.
- “Does not try to change sexual orientation”. The American Psychological Association (2009) has published a report on the lack of evidence supporting sexual orientation change efforts. A response by PsySSA to a letter in the *Jewish Report* (a national

Jewish newspaper in SA) promoting reparative therapy highlights that practitioners should assist clients in working towards the acceptance of their sexual orientation, and further states that PsySSA does not support the use of reparative therapy (Nel, 2008).

- “Understands that not all needs are based on your sexual orientation – some needs are the same as any other person’s, regardless of sexual orientation”. This statement was important as the participants felt that the focus on sexual orientation would again potentially stigmatise and victimise them and make them feel that their orientation is the cause of their problems. Garnets *et al.* (1991) indicated that one of the harmful psychological practices is to focus on a person’s sexual orientation when it is not relevant. An allied statement is that the counsellor “[e]xplores the area of sexuality sufficiently – not too much and not too little”. This statement takes on particular importance if the presenting problem relates to sex and sexuality.
- “The psychotherapist or counsellor is aware of his/her own attitudes and knowledge about lesbian, gay and bisexual issues”. For the participants, this statement also had the implication that a self-aware and knowledgeable counsellor would be respectful of a client. Kowszun (2000) discussed the need for self-awareness, including awareness of heteronormative and homonormative attitudes, as an important aspect leading to the social appreciation of sexual orientation.
- “The psychotherapist or counsellor is comfortable with his/her own sexual orientation”. The participants felt that a counsellor needed to have worked through his/her own issues around sexuality to be able to assist them with their problems. Milton *et al.* (2002) highlighted that a characteristic of affirmative practice is that practitioners are comfortable with their own sexuality and avoid biases impacting on their practice.
- “Understanding of the effects of prejudice, discrimination and hate crimes on your life”. The first statement in the American Psychological Association’s (2011) relevant practice guidelines covers this point. The recent PsySSA Sexual and Gender Diversity Position Statement (PsySSA, 2013) also includes this as one of its statements, again highlighting how crucial this understanding is in practice.
- “Respects my confidentiality around my sexual orientation”. Some participants felt that this statement enquired about how comfortable they were with their own coming out process and acceptance of their orientation in counselling, rather than reflecting an

ethical issue. A rewording going forward could be: “What you talk about with the counsellor stays confidential”.

It would appear that three of the statements are similar in that they share the theme of life stage and developmental differences. These statements are: “Understands the unique developmental or life issues that lesbian, gay and bisexual people face, such as the ‘coming out’ process”; “Understands the unique problems and risks faced by lesbian, gay and bisexual youth”; and: “Recognises age group and life stage differences among lesbian, gay and bisexual people”. Going forward, a statement incorporating these three could be: “Understands the developmental and life stage issues that lesbian, gay and bisexual people face, such as the ‘coming out’ process”. This statement deals with the different and sometimes unique experiences of LGB people at different life stages, ranging from dealing with heterosexual experiences and the reasons for this during adolescence to the elderly potentially having to negotiate a heteronormative frail care environment.

The term “family of origin” in the statement: “Strives to understand the ways in which sexual orientation impacts on the family of origin and relationships within the family of origin” was unclear to some participants. The statement: “Recognises that the families of lesbian, gay and bisexual people may include people who are not legally or biologically related” also seemed to address the issue of significant others. It is proposed that these statements be combined and revised to read: “Strives to understand the ways in which sexual orientation impacts on families and significant others”.

The ranking exercise itself might have impacted on the rating of the above statements in that a participant might have felt she or he needed to choose one of the above three statements as most important and relevant. In view of this, it is suggested that the above revised statements would be given a higher ranking if the exercise was repeated and should therefore be considered for inclusion in affirmative guidelines.

A number of statements were considered to be somewhat less important by the participants as these might address particular sectionalities faced by specific LGB people. These statements include: “Considers the influences of religion and spirituality in the lives of lesbian, gay and bisexual people”; “Strives to understand the impact of HIV/AIDS on the lives of lesbian, gay and bisexual people”; “Recognises the challenges faced by lesbian, gay and bisexual people with physical, sensory or cognitive-emotional disabilities”; “Strives to understand the experiences and challenges faced by lesbian, gay and bisexual parents”; “Recognises the

challenges faced by lesbian, gay and bisexual people of different population, language and cultural groups”; and: “Distinguish between sexual orientation issues and issues of gender identity”. Each of these intersections would be relevant to at least some LGB people. It could be useful to combine them in a statement such as: “Strives to understand the role of aspects such as religion and spirituality; HIV/AIDS; physical, sensory or cognitive-emotional disabilities; parenthood; and different population, language and cultural groupings as additional sources of stress, prejudice and discrimination for lesbian, gay and bisexual people”.

Finally, statements that were of little importance to the participants were:

- “Continually increases his/her knowledge and understanding of lesbian, gay and bisexual lives and issues”, which might rather refer to continuing professional development.
- “Has the same sexual orientation as I do”. As discussed earlier, only a slight majority of the participants felt that a counsellor should have the same sexual orientation as they do. This appears to become more important when the client is dealing with specific sexual orientation issues, such as “coming out”.
- “Shares information on a lesbian, gay and bisexual lifestyle”, which was generally not seen as the responsibility of the counsellor.

5.3 POSITIONING THE RESEARCH WITHIN COMMUNITY PSYCHOLOGY

Within the Community Psychology framework, it is important to involve the community in the enquiry or research – the community in this case being the individuals receiving psychotherapy and counselling – in addition to other stakeholders, such as practitioners and LGB CBOs. Nelson and Prilleltensky (2005) rightly said that it is important to work directly with disadvantaged people in their quest for liberation and well-being. This is in line with the recommendation by Linney (2000) that the community psychologist talk to participants in their context or environment.

The findings of this study, in addition to those obtained from other stakeholders, could become the basis for the development of hopefully more suitable interventions, such as guidelines, programmes and training courses, aimed at the LGB group. This research was focused on talking to LGB clients of psychology professionals and counsellors with the aim

to provide a localised basis from a client perspective as input for the development of practice guidelines. This way, clients (and other LGB-focused stakeholders) become co-creators of the interventions aimed at them – a basic tenet of Community Psychology. A part of this feedback process is to provide the relevant stakeholders with the findings and interpretations of the research, and the participants in the study with a copy of the research findings.

According to Nelson and Prilleltensky (2005), social interventions are an important basis for the promotion of well-being and liberation. In endeavouring to understand the benefits or potential benefits of a social intervention, the ecological metaphor challenges the researcher to analyse the potential or actual interaction between individuals and multiple social systems. This research study was not just about collecting information for academic purposes; the act of conducting the research and providing the participants with the findings might create an awareness in them of potentially oppressive practices that they might experience in future therapeutic encounters. The research findings, representing feedback from both themselves and others who have been in counselling, might also provide them with a sense of empowerment that will enable them to be aware of, make decisions around and comment on different forms of oppression. This could include their own internalised oppression, interpersonal repression, particularly as it relates to their counselling, and larger systemic oppression, such as heteronormative expectations of the therapeutic process.

This study furthermore provides practitioners with feedback from potential clients to enable them to improve their service delivery and interest them in continuing professional development. Another potential reader group is trainers of potential, novice and experienced practitioners. Insight into feedback from users of psychotherapeutic and counselling services could impact on the design and content of such training. Finally, as is indicated in the title of this study, this research will provide inputs for the development of affirmative practice guidelines that could assist in preventing the continuation of discrimination and social injustice when working with LGB clients.

5.4 IMPLICATIONS FOR FURTHER RESEARCH

The focus on client experiences of psychotherapy and counselling provides a rich narrative and foundation for work in this area in South Africa. Within the client stakeholder group, a more robust, representative, quantitative survey of specific client experiences, helpful

impacts and potential affirmative statements could provide a basis for informing the development of guidelines that would be acceptable across the discipline as a whole. Such work might also provide a baseline for measuring how experiences and satisfaction regarding psychotherapy and counselling change over time. This could identify practise areas that improve and areas requiring more attention in professional development. This baseline could also be applied in different countries and regions in Africa to provide a global African perspective, as well as robust intercountry or interregion comparisons. Within the area of LGB client experiences and satisfaction, research can be undertaken among different LGB subpopulations to compare and highlight similarities and differences. This could include particular LGB subpopulations, such as the youth, LGB parents and LGB people with physical or other disabilities. Further comparisons can focus on the experiences with private versus public health providers, as well as private practice versus inpatient settings. Regarding the latter, in a study by Israel *et al.* (2008), LGBT people reported more helpful situations in private practice settings than inpatient settings.

More in-depth research can be done on specific aspects of psychotherapy and counselling with LGB people. Comparing the impact of different presenting problems on the perception of what is helpful or not in counselling and the outcomes of different types of therapeutic interventions could be one potential area for further studies. There is also a paucity of research on the attitudes of psychotherapists and counsellors towards LGB people, as well as of work that endeavours to present this important group's view of affirmative practice, and elements that could potentially be included in affirmative practice guidelines. The same foci could be researched among other stakeholders, such as trainers, community-based agencies and policy-makers.

As mentioned in the first chapter, transgender and intersex people were not included in this dissertation of limited scope. In addressing the objective of PsySSA, similar research needs to be conducted amongst transgender and intersex populations to ensure that the planned affirmative guidelines are representative of their voices as well.

5.5 LIMITATIONS OF THE RESEARCH

This study has a number of methodological constraints that should be kept in mind. Although the study provides the opportunity for LGB clients of psychotherapists and counsellors to

voice their experiences, the use of a convenience sampling method and the size of the sample mean that the findings of this study may not be transferable to contexts outside the study population or even the population of LGB clients in South Africa.

A further weakness of the sample size is that it does not allow for detailed comparative analysis between different subgroups, for example younger versus older LGB people. In addition, the diversity found within the LGB community might be underrepresented. More specifically, the sample was not selected with a broader range of sectionalities in mind, such as people with sensory-motor disabilities or LGB parents. The study could have benefited from obtaining the perspectives of more public health clients. It excluded other demographics that might provide a different view to the more resourced individuals interviewed. This includes LGB people living in other areas, particularly semi-rural or rural areas; consideration of socio-economic class as a variable in the selection; and adolescents, who might be dealing with issues of identity and “coming out”.

Some criticism can be raised about the use of lesbian, gay and bisexual categories in the study. Brouard (2009) has indicated that such identity labels may be Western constructs that do not reflect the lived experience of most people in Africa.

Finally, the semi-structured in-depth interview method does not allow for a detailed description of an individual’s lived experience, such as would be found in a single-case study. The participants have less ability to influence the researcher’s interpretation of their experiences and the conclusions reached than would be the case if a participative action-orientated approach was followed.

5.6 CONCLUSION

The dramatic advancements in legal protection in South Africa have not necessarily meant changes in either public attitudes or attitudes experienced by LGB people accessing healthcare services. Prejudice, discrimination and victimisation are still a reality for many LGB people in the country. However, progress is being made within psychology. PsySSA has embarked on a process to develop relevant affirmative practise guidelines for psychology professionals. A first step in the process was the PsySSA position statement that provides psychology professionals with an affirmative view of sexual and gender diversity (PsySSA, 2013). Against this background, a need was identified to explore LGBTI people’s experiences of psychological practice as possible inputs for the guidelines. This research

study takes a step in this direction by highlighting LGB people's experiences of psychotherapy and counselling in South Africa.

LGB people go to counselling for many of the same reasons numerous other people do. However, prejudice and discrimination could contribute to or increase the vulnerability of LGB people. In addition, aspects of sexual orientation are also one of the presenting problems. This study confirms the findings of international studies that have indicated that a therapeutic relationship characterised by unconditional positive regard, acceptance, non-judgement and warmth is important, regardless of sexual orientation (Israel *et al.*, 2008). Positive experiences further included the counsellor being affirming of the person's sexual orientation, and negative experiences were almost exclusively due to being disaffirming of the client's sexual orientation. A slight majority of the respondents in this study preferred the counsellor to be LGB themselves. The outcomes of the counselling were similar to those found in other studies among broader populations, with more prominence being expressed of self-acceptance and the development of alternative perspectives of sexuality.

The participants highlighted a number of key statements that were important to them in experiencing counselling as affirming. These statements are:

1. Understanding that lesbian, gay and bisexual orientations are not mental illnesses.
2. Understanding that same-sex attractions, feelings and behaviour are normal variants of human sexuality.
3. Knowledgeable about and respects the importance of lesbian, gay and bisexual relationships.
4. Provides a safe, trusting environment or setting.
5. Comes across as being accepting of a lesbian, gay and bisexual lifestyle.
6. Assists in developing a positive lesbian, gay or bisexual identity.
7. Does not use sexist, homophobic or stereotypical language.
8. Does not try to change sexual orientation.
9. Understands that not all needs are based on your sexual orientation – some needs are the same as any other person's, regardless of sexual orientation.
10. The psychotherapist or counsellor is aware of his/her own attitudes and knowledge about lesbian, gay and bisexual issues.
11. The psychotherapist or counsellor is comfortable with his/her sexual orientation.
12. Understanding of the effects of prejudice, discrimination and hate crimes on your life.

13. What you talk about with the counsellor stays confidential.
14. Understands the developmental and life stage issues that lesbian, gay and bisexual people face, such as the “coming out” process.
15. Strives to understand the ways in which sexual orientation impacts on families and significant others.
16. Strives to understand the role of aspects such as religion and spirituality; HIV/AIDS; physical, sensory or cognitive-emotional disabilities; parenthood; and different population, language and cultural groupings as additional sources of stress, prejudice and discrimination for lesbian, gay and bisexual people.

Community Psychology concerns itself with the well-being and liberation of disadvantaged groups, with a strong belief in the underlying creative potential and resources of people. This, in essence, implies a general affirmative stance. The current research study has the potential to become a social intervention, in the sense meant by Harper (2005), that could influence participants, practitioners, policy-makers and other readers, and create an informed awareness of the potential oppressions in working with LGB people in psychotherapy and counselling. The title of this study provides for one aspect of the intervention, namely as input for the PsySSA-driven process to develop relevant affirmative practice guidelines in South Africa. It is finally the hope of the researcher that this study will inspire readers to become more aware of their own attitudes and biases, and proactively work to become more affirmative in their practices.

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APPENDIX A: INTRODUCTION LETTER TO PARTICIPANTS

My name is Niel Victor and I am currently doing my Masters degree in Clinical Psychology at the University of South Africa (Unisa). As part of my studies I am busy with a research project around lesbian, gay, and bisexual clients' experience of psychotherapy and counselling with Psychologists, Psychiatrists and other Counsellors, including lay counsellors, supervised by Prof. Juan Nel.

To this end I want to interview self-identified lesbian, gay, and bisexual individuals. The discussion will be about their experiences with psychotherapy or counselling in the past 5 years, across the broad spectrum of possible reasons for their visit or interaction. Participants need to live in Gauteng or Cape Town, be at least 18 years old, from across different population groups.

It is estimated that the interview will last around 60 minutes, and will be conducted at a private location convenient for each participant.

Participation is completely voluntary, and participants can withdraw at any time during the research process. The Ethical Rules of Conduct as described in the Health Professions Act (No. 56 of 1974) will be followed, including ensuring the confidentiality and anonymity of individual participants. A summary report outlining the key findings and themes will be shared with each participant.

Your participation and input would be greatly appreciated. Please contact Niel on 078 297 8102 or willgold9@gmail.com for more information or if you would be willing to participate. If you have other concerns e.g. around ethics you can also contact my supervisor Prof. Juan Nel on nelja@unisa.ac.za.

APPENDIX B: BIOGRAPHICAL QUESTIONNAIRE FOR PARTICIPANTS

RESEARCH PROJECT: 'Lesbian, gay, and bisexual clients' experience with psychotherapy and counselling.'

Please complete the following biographical information form.

Name: _____

Physical address: _____

Tel (h): _____

Tel (w): _____

Tel (cell): _____

E-mail address: _____

Age: _____

Race: _____

Gender: _____

How would you describe your sexual orientation? _____

REMEMBER THAT ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL IN ACCORDANCE WITH THE CODE OF ETHICS OF THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

APPENDIX C: INFORMED CONSENT FORM FOR PARTICIPANTS

INFORMED CONSENT FORM

Thank you for agreeing to be part of the research project: 'Lesbian, gay, and bisexual clients' experience with psychotherapy and counselling.'

1. Nature of the study

This study is being conducted as part of the requirement for a Masters Degree in Clinical Psychology at the University of South Africa (Unisa).

2. Participation

Participation is completely voluntary, and you can withdraw at any time during the research process without giving a reason.

3. Research process

Individual in-depth personal interviews will be conducted in a convenient private location. Interviews will be audio-taped and transcribed for thematic analysis. The interviews will be between 60-90 minutes long.

4. Confidentiality

This study will adhere to the Ethical Rules of Conduct as described in the Health Professions Act (No. 56 of 1974) ensuring confidentiality. A copy of the Ethical Rules of Conduct is available on request or on www.hpcs.co.za. The transcribed interviews will be anonymous and will not reflect your name or link back to you. All data will be strictly confidential.

5. Use of results

The results will be published as a dissertation, as well as used in appropriate articles and presentations. All participants will receive a copy of the summary report containing key findings and themes, and we would appreciate feedback on whether this accurately reflects some of the experiences you spoke about.

6. Contact Information

Niel Victor can be contacted on 078 297 8102 or willgold9@gmail.com. If you have concerns around the research that is not dealt with, you can contact his Supervisor, Professor Juan Nel on nelja@unisa.ac.za.

7. Consent

I have read the above information before signing this consent form. The content and meaning has been adequately explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered. I hereby volunteer to take part in this study and agree to the recording of the interview.

Name: _____

Signature: _____ Date: _____

APPENDIX D: INTERVIEW SCHEDULE

Request the participant to relate or describe a recent experience (whether one or more sessions) with psychological counselling or therapy. Probe the following:

[30-40 minutes]

- Before:
 - What led to the experience? Who decided and on what basis which psychologist/counsellor? What was the process followed? How did respondent go about selecting therapist? Any 'pre-screening'?
 - How did the respondent feel at different points before the experience? What were they looking forward to? What were they dreading?
 - How often/frequently have they visited someone for psychological/counselling services? How would they rate the general experience with these versus the more recent experience? What is for the same or a different reason and describe those?
- During:
 - How long ago was the experience/last session? How many sessions does the experience entail?
 - Describe the therapist in detail. What stood out? What appealed to you? What bothered you?
 - During sessions therapist can do many things, including talking, using activities, giving homework and so on. What did the therapist do?
 - Describe the setting in which the sessions happened
 - Anyone else involved in session? Who else was involved (family, colleagues, friends, lovers/partners)? What made them an important part of the sessions?
 - Thoughts, feelings, impressions during the experience
 - What impact did the sessions have on his/her life outside the sessions? In what way?
 - Elements that stood out, elements that were missing
 - Evaluation of the experience and what about it gave them this evaluation?
 - What could have been done/said differently?
- After:
 - What happened? When and how?
 - Thoughts, feelings?

- Resolution of problems/goals reached? What made them feel/think this happened or not i.e. how do they evaluate 'success' or not of the session(s)?

[20 minutes]

- Sexual orientation: (Probed after broader experience discussed)
 - What your sexual orientation discussed? How did this unfold or happen? How did it make you feel?
 - Do you feel sexual orientation was relevant in the sessions? Why?
 - What about experience found affirming/disaffirming of your sexual orientation?
 - *Affirming = view your sexuality as normal and natural + not the cause of your problems*

[20 minutes]

- Here are a number of things other people have mentioned that they found as a positive or negative experience in their own sessions. For each I would like you to tell me:
 - Sort into 3 groups – relevant/important to session, not relevant/important, unsure what this is about
 - For relevant/important:
 - whether it was dealt with by the therapist or counsellor
 - whether the experience was positive or negative
 - and in what way
 - For unsure explore how better to state it