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PsySSA
Psychological Society of South Africa

Article

The Psychological Society of South Africa's guidelines for psychology professionals working with sexually and gender-diverse people: towards inclusive and affirmative practice

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Abstract

In this article, we outline the practice guidelines for psychology professionals working with sexually and gender-diverse people, ratified by the Psychological Society of South Africa's Council in 2017. The guidelines are an augmentation of the Psychological Society of South Africa's position statement of 2013 providing a framework for understanding the challenges that sexually and gender-diverse people face in patriarchal and hetero- and cis-normative societies. An affirmative stance towards sexual and gender diversity enables psychology practitioners to work ethically, effectively, and sensitively in this field. The guidelines – a first for Africa – are aspirational in nature and call on psychology professionals to become aware of their own biases, conscientise themselves of the best practices in the field by continued professional development, and to utilise the guidelines as a resource in their related work. Brief mention is made of the development process, before the rationale and possible applications of the 12 guidelines are explored.

Keywords

Affirmative practice, LGBTIQA+, practice guidelines, Psychological Society of South Africa, psychology professionals, sexual and gender diversity, sexuality, transgender

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South Africa is a country with a diverse and vibrant society, although clouded by a troubled history, with acts of dominance and violence, colonialism, and Apartheid. It is a country in which challenges and opportunities arrive with all the complexities that enable communities to develop and grow. This is moreover reflected in the field of psychology. Psychology professionals work in a diverse society permeated with issues around race, culture, gender, sexual orientation, class, and health status. They deal, for example, with people experiencing stigmatisation, prejudice, gender-based violence, and hate crimes.

Internationally, efforts are underway to identify competencies for psychology professionals in working with diversity and intersectionality (International Union of Psychological Science [IUPsyS], 2016). Accordingly, the practice guidelines that the Psychological Society of South Africa (PsySSA) developed, focuses on the key competencies that psychology professionals need within a general diversity competence framework, to work ethically and effectively with people who are sexually and/or gender-diverse. This article focuses on the development, as well as the purpose of the guidelines. Furthermore, it explores the content of the 12 guidelines and reflects on some limitations.

The development of the guidelines

Since the mid-2000s, there have been increasing calls for the development of affirmative practice guidelines in Africa (Nel, 2007; Victor & Nel, 2016). These calls were inspired by similar initiatives of several member organisations of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet). IPsyNet facilitates and supports the contributions of psychological organisations to the improved health, well-being, and enjoyment of human rights by promoting policy, education, and advocacy for sexually and gender-diverse people globally (IPsyNet, 2016). The American Psychological Association (APA) – Secretariat of IPsyNet, was the first to develop such guidelines in 2001 and revised these in 2011. The Association for Lesbian, Gay, Bisexual and Transgender Issues in Counselling developed guidelines in 2003, followed by the Australian Psychological Society in 2010, the British Psychological Society (BPS) in 2012, and others. Consequently, PsySSA, the only member in Africa of IPsyNet at that time, embarked on a process to develop affirmative guidelines for psychology professionals working with sexually and gender-diverse people specifically for South Africa, with potential application to the rest of Africa (Victor, Nel, Lynch, & Mbatha, 2014). The work was conducted under the auspices of the Arcus Foundation-funded PsySSA African LGBTI Human Rights Project, initiated in 2012, with significant support from IPsyNet.

PsySSA is the representative body for psychology professionals in South Africa and is committed to the transformation of psychology by redressing historical injustices and biases, be it racial, cultural, gender, or sexual orientation-based, or due to other variables (Psychological Society of South Africa [PsySSA], 2017a). Psychology has historically had a hetero-cis-normative focus which influenced practice and research (PsySSA, 2013). This focus often led to victimisation, persecution, and pathologisation of sexually and gender-diverse persons (Victor et al., 2014). PsySSA first developed a position statement (PsySSA, 2013; Victor et al., 2014), informed by an affirmative stance of openness, acceptance, and affirmation of sexual and gender diversity and respect for the unique and fluid lived experience of others. Although the position statement – a first in Africa – was aimed at South Africa's psychology professionals, it could also be applied to other health professionals in Africa. This statement is consistent with the South African Constitution and its Bill of Rights (Republic of South Africa, 1996), the harm avoidance approach of the Health Professions Act (Department of Health, 2006) and PsySSA's constitution (PsySSA, 2017a). The position statement led to the development of guidelines that aim to provide a general framework that can be used across different psychology registration categories and scopes of practice when working with/treating marginalised people/

groups (PsySSA, 2017b). Furthermore, the guidelines aspires to build PsySSA's capacity to engage with issues related to sexual orientation, attraction, and behaviours; gender identity and gender expression; as well as diversity of sex development. It was critical for the authors of the guidelines 'to develop a document that is specific to the South African context, rather than adopting guidelines developed for other countries' (PsySSA, 2017b, p. 58). These guidelines incorporate South African research and local knowledge from multiple disciplines, academic articles, other written material, and local expert opinion. Knowledge was also drawn from the African literature and only in the absence of information was international work consulted.

Purpose and structure of the guidelines

In recognition of the harm that has been done in the past to individuals and groups by related prejudices in South African society, as well as in the profession of psychology, '[t]he purpose of these practice guidelines is to provide a guide and reference for psychology professionals to deal more sensitively and effectively with matters of sexual and gender diversity' (PsySSA, 2017b, p. 6). The practice guidelines, consisting of 12 guidelines, is a 'living document' that speaks to psychology professionals. Each guideline is written as a stand-alone section by different lead authors who are experts in their respective fields. As is evident from what follows, the guidelines elucidate current knowledge and to avoid duplication, also cross-reference each other, followed by potential applications in the field of psychology.

Guideline 1: non-discrimination

Sexually and gender-diverse people's human rights are protected in South Africa. Laws and policies exist that propagate respect for diversity and non-discrimination. Human rights should be viewed as a set of checks and balances to ensure equality, equitable and fair access, as well as equal opportunities for all community members (International Commission of Jurists, 2007). This guideline implores psychology professionals to respect clients/patients' human rights as their professional stance should be a commitment to non-discrimination.

These developments have an impact at the institutional level, for example, on ethical rules of conduct for health practitioners, where the focus is on human rights, non-discrimination, benevolence, non-malevolence, and general do-no-harm principles (Department of Health, 2006). The psychology professional is responsible to practise ethically, in the confines of the law and within a human rights framework.

Guideline 2: individual self-determination

The South African Professional Conduct Guidelines in Psychology (PsySSA, 2007) upholds the right to self-determination of clients/patients. This entails a process by which a person determines the course of her or his/their own life. 'Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as "coming out") of sexual orientation, or of gender diversity, or of biological variance' (PsySSA, 2017b, p. 18). This is so, regardless of research evidence suggesting that self-disclosure is beneficial to a person's mental health, improved self-esteem, and lower stress levels. The professional needs to explore internal and external stigma, homophobia and transphobia, and manage tensions between individual agency and community values and expectations (Mkhize, 2003). Gender-diverse people should be assisted through an informed consent or participatory process to make decisions regarding their bodies and the possibility of medical transitioning (McLachlan, 2019).

Guideline 3: enhancing professional understanding

It is important to consider the consequences of imprecision of language, misunderstanding, and/or lack of understanding, among others, in terms of a reduced sense of agency and options for sexually and gender-diverse service users/clients/participants. Additional challenges are also posed by the fact that the real-life experiences of individuals often do not conform to the academic categorisations that professionals use in respect of social constructs, such as sex, gender, identity, and orientation. Similarly, it needs to be recognised how profoundly 'sex' and 'gender' are conflated in popular discourse and that what it means to be a woman or a man, both or neither, differs among societies, and changes over time even within societies.

Gender and gender roles are not fixed. An affirmative stance suggests that psychology professionals recognise the influence of deeply entrenched practices and systems of patriarchy in many societies in the prescription of certain behaviours, roles, tasks, and even jobs. Although the concepts of biological sex, sexuality, and gender are interrelated, they are not necessarily dependent on each other. For instance, the biological sex assigned at birth is not an indication of the person's gender identity and/or expression, sexual orientation, or sexual behaviour. Also, 'for some persons, identity issues are not necessarily linear, moving in a "forward" direction to an end point or on an inevitable journey from A to B. Trans persons, for instance, may seek to reverse certain processes or may arrive at a different understanding of who they are (now) as they age' (PsySSA, 2017b, p. 22). Accordingly, this guideline implores psychology professionals to acknowledge and endeavour to enhance their understanding of sexual and gender diversity and fluidity, including biological variance.

Guideline 4: awareness of normative social contexts

This guideline impresses on psychology professionals to be aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative, and cisgender contexts. The shame and misunderstanding that often accompany being same-sex attracted, transgender, or a person with diversity of sex development/intersex are important in making sense of notions of 'automatic rights' and 'privileges' that go with being born heterosexual and/or cisgender. Cis-normativity includes the assumption that there are only two fixed genders, and that gender always reflects the person's sex as assigned at birth. Associated 'heteronormative' assumptions are that only sexual attraction between the 'opposite' genders can be considered normal or natural, that all people should be in a single committed relationship with one other person, preferably for life, and all people wish to (and should) procreate. Accordingly, societies are constructed to reward behaviours that conform to heterosexuality, and punish those that do not. Importantly, the influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities; that is, it serves to regulate not only sexuality but also gender.

'Where normative beliefs are imposed on everyone, sexually and gender-diverse people are often seen as something "lesser", and less deserving of social goods and affirmation. Marginalisation from the mainstream could undermine mental health and is often internalised by the person, who may not be aware that these are normative assumptions, and neither universal nor eternal "truths"' (PsySSA, 2017b, p. 29). This equally has bearing on 'homonormativity': the manner in which older, poor, Black, disabled queers, and certain queer cultures are often excluded from mainstream 'homosexual cultures'. Homonormativity refers to a tendency to privilege identities that mirror constructs of (Western-centric) hegemonic (hetero) masculinity, that is, young, muscular, athletic, rich, White (Oswin, 2007). Normative assumptions, in general, are maintained and extended in health systems, for instance, by the type of questions that are asked in a first interview and the way services are advertised.

Guideline 5: intersecting discriminations

This guideline sensitises psychology professionals to intersectionality, defined as the 'interaction of different axes of identity . . . in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways' (PsySSA 2017b, p .61). An intersectional lens is important in the diverse South African context, due to the complex heterogeneity of the population, in terms of 'gender; sexual orientation; biological variance; socioeconomic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive – emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality' (PsySSA, 2017b, p. 32). If we formulate the impact of these multiple factors on a person's development, self-concept, mental health, life opportunities, and overall well-being, it becomes obvious that such a matrix of positionings necessarily complicates simplified notions of what it means to be 'a South African'.

For example, consider a 41-year-old Black lesbian who has always lived in rural Nongoma in KwaZulu-Natal and is unemployed, depressed, and relies on sex work with men to generate an income. Her experiences will be vastly different from a 21-year-old Black lesbian who lives in Rosebank in Johannesburg, works at a corporate firm, and is in a relationship with a White transwoman. These contextual variables affect our social constructions of a 'Black lesbian' in such inequitable settings. Practitioners are therefore urged to work with cultural humility (IUPsyS, 2016; Tervalon & Murray-Garcia, 1998), which is a lifelong commitment to self-evaluation and self-criticism that highlights power imbalances.

Guideline 6: counteracting stigma and violence

This guideline aims to enhance the understanding of psychology professionals of 'stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals' (PsySSA, 2017b, p. 36). Evidence suggests that sexually and gender-diverse people, indeed, experience substantial discrimination and victimisation (Nel, 2014). They may have been subjected to varying forms of systemic prejudice, discrimination, and violence.

An affirmative stance strongly urges practitioners to develop contextual awareness of homophobia, transphobia, heterosexism, cis-normativity, prejudice, and stigma and encourages practitioners to recognise hate speech and hate crimes. Awareness leads to developing counteracting measures in relation to the mental health effects of stigma and discrimination.

Furthermore, an oppressive social environment increases minority stress. Consider the extent to which the health and criminal justice systems are themselves steeped in heteronormative assumptions, most evident in the extent that active discrimination in the provision of services and/or treatment occurs, negatively affecting the quality of support to which sexually and gender-diverse persons gain access (Victor et al., 2014). An example of institutionalised discrimination is when sexually and gender-diverse people report a hate crime to the police and are subjected to further prejudice and/or trauma.

For sexually and gender-diverse individuals, fear of poor treatment, discrimination, and judgmental attitudes present significant barriers to access services (Academy of Science of South Africa [ASSAf], 2015). 'Such violence and discrimination could also exacerbate negative feelings within sexually and gender-diverse persons towards their own sexual orientation or gender non-conformity. In this way, discrimination may lead to internalised stigma and/or oppression' (PsySSA, 2017b, p. 37).

Guideline 7: recognising multiple developmental pathways

This guideline urges psychology professionals to recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age.

Self-chosen identities have become the norm in many countries. Psychology professionals are encouraged to explore the fluid developmental pathways to sexual orientation and gender identity. These variations are seen as normal developmental variation (ASSAf, 2015). A client may similarly choose to live a public and private identity (McLachlan, 2010). Sexual orientations and gender identities may also shift through the various life stages. Regardless of their sexual orientation, some people reject gender binaries entirely, as cultural and social contexts change over time. A person's needs will also change and people face different challenges over their lifespans. Heteronormative and cis-normative expectations may also influence related developmental pathways. Sexual orientation and gender identity as categories are often conflated and sexually and gender-diverse people may have tried to conform to cultural and societal expectations. Sexual orientation could also be more complex to articulate if a person is not identifying as cisgender. Accordingly, "[p]sychology professionals need to create the space for hearing how service users/clients/participants refer to themselves and to help them assess meanings they attach to these words" (PsySSA, 2017b, p.41).

Guideline 8: non-conforming family structures and relationships

Guideline 8 sensitises psychology professionals to the variety and complexities of sexually and gender-diverse people's relationships. Many sexually and gender-diverse people already have children or want to be parents through giving birth, adoption, foster care, or surrogacy. Since 2002, gay and lesbian people may adopt children in South Africa (Klein, 2013).

Homophobia and transphobia can impact parenthood. It can add challenges to finding non-discriminatory adoption agencies or practitioners that can assist with reproductive treatment. For example, the psychology professional could assist in eligibility assessments for sexually and gender-diverse clients during the adoption process. The choice of wanting to have children can also impact the trans and gender-diverse person's gender-affirming treatment, for example, hormones can influence fertility (American Psychological Association [APA], 2015). The children, as well as parents, may be impacted by their family not conforming to the stereotypes that society upholds. International studies have found that children from diverse families do not experience more psychopathology than other children (Breshears & Lubbe-De Beer, 2016), as the quality of relationships is more import than the structure of the family (Lubbe-De Beer, 2013). The psychology professional could assist by helping to engage with schools to be more inclusive when they represent different family constructions.

Challenges could similarly be experienced by sexually and gender-diverse people within their families of origin. For example, families subscribing to patriarchal, heteronormative, and cis-normative family constructions may be inclined to negative social responses and even violent rejection (APA, 2015). For them, it can become very important to create a supportive family of choice. Research has found that supportive family environments reduce minority stress and its negative impact on sexually and gender-diverse persons' mental health (ASSAf, 2015). Families could benefit from validation in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant other. For example, parents of a non-binary and/or transgender adolescent may require education on the construction of gender, gender identity, and gender roles.

Married couples may experience difficulties when a gender-diverse person decides to legally change their gender marker on their identity document (Gender DynamiX and Legal Resource Centre, 2014). The couple will most likely be perceived, and related to differently by the community as the trans person transitions. For example, a transman that was perceived to be in a lesbian relationship before transitioning could now be perceived as heterosexual after transitioning. This could affect not only the relationship, but also how the individuals self-identify and impact the decision on accessing gender-affirming treatment or not, and/or renegotiating relationship configurations.

Within the sexually and gender-diverse community different monogamous, and for others non-monogamous, relationship configurations exist (British Psychological Society [BPS], 2012). In South Africa, it is legal for same-sex couples to be married. However, couples living in polyamorous and polygamous relationships often experience more criticism as they do not subscribe to dominant societal ideas of relationships (Lynch & Maree, 2013). Couples can experience their relationships as fluid and changing. Even the dating scene can be daunting for many sexually and gender-diverse people as they need to 'come out' to prospective partners. Practitioners could explore with clients power imbalances, roles, and ways to build healthy and respectful relationships.

Guideline 9: the necessity of an affirmative stance

This guideline sensitises psychology professionals to why an affirmative stance is always necessary in all work and organisational contexts. Consider the wide variety of practices we are called upon to contribute towards: research and academia, training, teaching, supervision, curriculum design, psychometric test development, policy writing and analysis, programme designs and implementation, monitoring and evaluation, management, and of course, assessments, counselling, and psychotherapy. An affirmative lens 'implies specific positive assumptions about sexual and gender diversity, which informs all areas of professional practice' (PsySSA, 2017b, p. 49). This means respectfully taking into account how issues of sexual and gender diversity are accommodated and incorporated into one's specific area of work, and/or the type of psychosocial interventions being designed.

For example, psychology professionals are often involved in suicide prevention efforts, which may include formulating policies, writing operational procedures, conducting individual risk assessments, designing public health programmes, conducting research, or facilitating therapy groups. An affirmative lens means being aware that globally, research shows that sexually and gender-diverse people are at increased risk of depression and suicide due to minority stress, lack of familial support, social isolation, hate crimes, homophobia, and transphobia (Human Rights Watch, 2011). Yet, Meer, Lunau, Oberth, Daskilewicz, and Müller (2017) note that there is a significant knowledge gap on suicide and self-harm among sexually and gender-diverse people in Southern Africa. An affirmative lens would bring these specific issues of sexual and gender diversity to bear on the development of suicide prevention efforts. Other examples include being sensitive to how curricula are designed, whether the theories being taught are affirmative or hetero- and/or cis-normative; and whether or not the voices of sexually and gender-diverse people are included in the design of relevant research projects.

Guideline 10: foregrounding global best practice care

Guideline 10 advises psychology professionals to keep abreast of not only local, but also international best practice care. It cautions psychology professionals against gender identity/expression change efforts and sexual orientation change efforts (SOCE), as these interventions are based on the notion that sexual and gender diversity are disorders/illnesses that require treatment

(BPS, 2012). This guideline acknowledges that sexually and gender-diverse people often live in hostile environments that could lead to the person experiencing 'minority stress' (McLachlan, 2019). The practitioner is warned against SOCE as it could result in harm, and thus conflict with medical ethics.

Guideline 10 also proposes that psychology professionals support the World Association of Transgender Health's (WPATH) Standards of Care 7's (SOC7) notion that trans and gender-diverse people are not required to undergo psychotherapy before accessing gender-affirming healthcare. The mental health provider should avoid stepping into a 'gatekeeper' position, but rather use the participatory or informed consent model, for example, facilitating access to gender-affirming healthcare, playing a supportive role and collaborating with the client where an assessment is required (McLachlan, 2019; World Professional Association for Transgender Health [WPATH], 2012).

The affirming psychology practitioner aims to support the parents of children with diversity of sex development and intersex clients and to encourage alternatives to surgical intervention, unless for pertinent physical health reasons

Guideline 11: disclosing and rectifying of personal biases

The professional needs to be aware of their own religious, cultural, and moral bias, prejudice and dilemmas regarding sexual and gender diversity, and should rather refer appropriately if they are unable to assist the client/patient. Mental health providers should not, like previously, be complicit in causing harm by pathologisation. Accordingly, the guideline provides a range of tools that psychology professionals would find useful in cultivating ongoing sensitivity around their own biases.

Research indicates that healthcare providers who lack knowledge and skills regarding sexual and gender diversity can cause more harm (Victor & Nel, 2016). Psychology professionals should practice within the boundaries of their competence, engage in training, and acquire knowledge before working in this field. It also becomes important to disclose and rectify personal biases.

'Utilising a sexual and gender-neutral model has at times been proposed for use by psychology professionals. Unfortunately, this approach – similar to a race-neutral approach – ignores or even denies the particular life experiences of sexually and gender-diverse people, and potentially perpetuates a heteronormative model that might be unhelpful to service users/clients/participants' (PsySSA, 2017b, p. 55).

Guideline 12: continued professional development

The Health Professions Council of South Africa (HPCSA; (2017) mandates psychology professionals to maintain and update professional competencies and to commit to lifelong learning. Ethical practice, as well as the beneficence principle, ask of psychology practitioners to 'actively develop a scientifically grounded resource base on which they can draw, and to keep updating this. In order to advocate and meet the mental health needs of sexually and gender-diverse people better, an affirmative stance requires keeping current with a variety of academic and popular culture trends' (PsySSA, 2017b, p. 57).

Sexual and gender diversity are usually not taught in under- and postgraduate curricula in South African universities. Accordingly, this guideline encourages psychology professionals to 'seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals' (PsySSA, 2017b, p. 13).

Limitations

The practice guidelines is a living document and the authors are aware that even at the time of going to print, some terms are already being contested in the literature, such as ‘biological variance’ used in the guidelines in reference to diversity of sex development. The authors acknowledge that more research needs to be conducted and incorporated regarding diversity of sex development, in general. The conspicuous absence of related material, also in relation to bisexuality, is an indictment that information is being privileged, also within the field of sexual and gender diversity. New terms have also been incorporated into the field since publication, for example, MSMW (men who have sex with men and women, but do not identify with a bisexual identity). Finally, although the practice guidelines are informed by a comprehensive literature review, a systematic review of all sexual and gender diversity issues in South African psychology was not undertaken.

Conclusion and way forward

The guidelines reflect an overview of the current research in the field of sexual and gender diversity, are challenging, illuminating, and an enriching experience that contributes to ethical and responsive ways of practise. The guidelines form a basis for psychology professionals when working with service users/clients/participants and can contribute to the development of curricula, research agendas, and policy work. To increase dissemination, the team that developed the guidelines plans to train various stakeholders working with sexually and gender-diverse people.

Although primarily aimed at South African qualified professionals, as with the sexual and gender diversity position statement, its applicability may be broader, namely in areas outside South Africa, as well as other health professions, including social workers. Potentially, collaboration with colleagues from other African countries can be initiated to develop their own localised statements and guidelines (Victor & Nel, 2017).

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