SOUTH AFRICAN CLINICAL AND COUNSELLING PSYCHOLOGISTS' TRAINING, EXPERIENCE, PERCEIVED COMPETENCE, AND CONFIDENCE IN PRACTISING AFFIRMATIVELY WITH SEXUALLY DIVERSE PEOPLE

by

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I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

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ABSTRACT

Following the launch of the Psychological Society of South Africa (PsySSA) practice guidelines for psychological professionals working with sexually and gender-diverse people (PsySSA, 2017), a need was identified to benchmark and track the progress of affirmative practices. My study focused on assessing the training, experience, confidence, and perceived competence of clinical and counselling psychologists working with sexually diverse people. Data were collected as part of a larger transnational project, of which I am a member, focusing on the role of psychology guidelines regarding mental health access and the treatment of sexually and gender-diverse individuals. One phase of the transnational project comprised an online internet survey with mental health professionals. My final sample of 201 clinical and counselling psychologists working with sexually diverse people was skewed to larger urban areas, white, female, cisgender, and heterosexual respondents in their mid-forties, working in the private health sector, whilst over a fifth of the respondents identified as sexually diverse. The sample's confidence and perceived competence scored higher relative to similar samples in the USA. Confidence and perceived competence were correlated with personal and professional experience, involvement in continued professional development activities, and familiarity with the PsySSA practice guidelines. Although increasing in recent years, half of the respondents indicated that they had not been exposed to LGBT+-focused activities during their graduate studies. With 15% of their case load being LGBT+ clients or patients, practitioners have engaged in substantial professional development activities and showed great interest in continued learning in the field. Sexually diverse respondents reported being significantly more confident and competent; had more contact, professional experience, and familiarity with the PsySSA guidelines; and had engaged in more professional development activities than their heterosexual counterparts. Based on the research results, a total of 16 recommendations were made to inform education, training, research, advocacy,

and policy development efforts to continue improving competence in affirmative practice with sexually diverse people. This included increased training and supervision, to have more focus on advocacy skills, certain themes from the PsySSA guidelines, and the application of knowledge when working with sexually diverse clients or patients.

Key terms: confidence, contact, continued professional development, perceived competence, professional training, psychologist, self-efficacy, sexual diversity, sexual orientation, South Africa

OPSOMMING

Ná die bekendstelling van die Sielkundige Vereniging van Suid-Afrika (PsySSA) se praktykriglyne vir sielkundige professionele persone wat met seksueel- en geslagsdiverse mense werk (PsySSA, 2017), is ’n behoefte geïdentifiseer om die vordering van regstellende praktyke te meet en na te gaan. My studie het gefokus op die assessering van die opleiding, ervaring, selfvertroue en waargenome bevoegdheid van kliniese en voorligtingsielkundiges wat met seksueel diverse mense werk. Data is ingesamel as deel van ’n groter transnasionale projek waarvan ek ’n lid is, wat fokus op die rol van sielkunderiglyne rakende toegang tot geestesgesondheid en die behandeling van seksueel- en geslagsdiverse individue. Een fase van die transnasionale projek het ’n aanlyn internetopname met geestesgesondheidswerkers behels. My finale steekproef van 201 kliniese en voorligtingsielkundiges wat met seksueel diverse mense werk, was skeefgetrek ten opsigte van groter stedelike gebiede, wit, vroulik, cisgender en heteroseksuele respondente in hulle middel-veertigs, wat in die private gesondheidsektor werk, terwyl meer as ’n vyfde van die respondente as seksueel divers geïdentifiseer het. Die steekproef se vertroue en waargenome bevoegdheid het ’n hoër telling behaal in vergelyking met soortgelyke steekproewe in die VSA. Vertroue en waargenome bevoegdheid is gekorreleer met persoonlike en professionele ervaring, betrokkenheid by voortgesette professionele ontwikkelingsaktiwiteite, en vertroudheid met die PsySSA-praktykriglyne. Alhoewel dit die afgelope jare toegeneem het, het die helfte van die respondente aangedui dat hulle nie tydens hulle nagraadse studies aan aktiwiteite gefokus op LGBT+ blootgestel is nie. Met 15% van hulle gevallelading wat LGBT+ kliënte of pasiënte is, het praktisyns by beduidende professionele ontwikkelingsaktiwiteite betrokke geraak en groot belangstelling in voortgesette leer in die veld getoon. Seksueel diverse respondente het gerapporteer dat hulle aansienlik meer selfversekerd en bekwaam was; meer kontak, professionele ervaring en vertroudheid met die PsySSA-riglyne gehad het; en meer betrokke

geraak het by professionele ontwikkelingsaktiwiteite as hulle heteroseksuele eweknieë. Gegrond op die navorsingsresultate, is ’n totaal van 16 aanbevelings gemaak om onderwys, opleiding, navorsing, voorspraak en beleidsontwikkelingspogings in te lig om voort te gaan om bevoegdheid in regstellende praktyk met seksueel diverse mense te verbeter. Dit het toenemende opleiding en toesig ingesluit, asook meer fokus op voorspraakvaardighede, sekere temas uit die PsySSA-riglyne, en die toepassing van kennis wanneer daar met seksueel diverse kliënte of pasiënte gewerk word.

Sleutelterme: vertroue, voortgesette professionele ontwikkeling, waargenome bevoegdheid, professionele opleiding, sielkundige, selfdoeltreffendheid, seksuele diversiteit, seksuele oriëntasie, Suid-Afrika

ISIFINQO

Ngemuva kokuqaliswa kokwethulwa kwemihlahlandlela yokuzijwayeza ye-Psychological Society of South Africa (PsySSA) yochwepheshe bezengqondo abasebenza nabantu abahlukene ngokocansi nobulili (i-PsySSA, 2017), kuhlonzwe isidingo sokulinganisa kanye nokulandelelwa kwenqubekelaphambili yezinqubo zokuvumelana. Ucwaningo lwami lugxile ekuhloleni ukuqeqeshwa, isipiliyoni, ukuzethemba, kanye nekhono elibonwayo lodokotela bezengqondo bezokwelashwa nokweluleka abasebenza nabantu abahlukene ngokocansi. Idatha yaqoqwa njengengxenye yephrojekthi enkulu yamazwe ngamazwe, engiyilungu layo, egxile endimeni yeziqondiso zengqondo mayelana nokufinyelela kwezempilo yengqondo kanye nokwelashwa kwabantu abahlukene ngezocansi kanye nobulili.. Isigaba esisodwa sephrojekthi yamazwe ngamazwe sihlanganisa inhlolovo ye-inthanethi yengqondo. Isampula lami lokugcina labanga-201 lodokotela bezengqondo bezokwelapha nezeluleko abasebenza nabantu abahlukene ngokocansi baphambukele ezindaweni ezinkudlwana zasemadolobheni, abamhlophe, abesifazane, abantu bobulili obuhlukile, kanye nabasabelayo abathandana nabobulili obuhlukile phakathi neminyaka enga-40, besebenza emkhakheni wezempilo ozimele, kuyilapho abangaphezu kwengxenye yesihlanu yabaphendulile behlonzwe njengabantu abazibandakanya kuyizinhlobonhlobo zocansi. Ukuzethemba kwesampula namandla abonwayo athole amaphuzu aphezulu uma kuqhathaniswa namasampuli afanayo e-USA. Ukuzethemba kanye nekhono elibonakalayo kwakuhlotshaniswa nolwazi lomuntu siqu kanye nolwazi lomsebenzi, ukuzibandakanya emisebenzini eqhubekayo yokuthuthukiswa kochwepheshe, kanye nokujwayelana neziqondiso zokuzijwayeza ze-PsySSA. Nakuba ikhula eminyakeni yamuva nje, ingxenye yabaphenduli ibonise ukuthi ayizange ibonakale emisebenzini egxile ku-LGBT+ phakathi nezifundo zabo zeziqu. Njengoba ama-15% wecala labo kungamakhasimende e-LGBT+ noma iziguli, odokotela bazibandakanye emisebenzini emikhulu yokuthuthukiswa kochwepheshe futhi babonise ukuthakazelela okukhulu

ekuqhubekeni nokufunda kulo mkhakha. Abaphendulile abahlukene ngokocansi babike ukuthi bayazethemba futhi banekhono; waba nokuxhumana okwengeziwe, ulwazi lomsebenzi, kanye nokujwayelana nemihlahlandlela ye-PsySSA; futhi babezibandakanye emisebenzini yokuthuthukiswa kochwepheshe kakhulu kunozakwabo abathandana nabobulili obuhlukile. Ngokusekelwe emiphumeleni yocwaningo, izincomo eziyi-16 zenziwa ukwazisa kwezemfundo, ukuqeqeshwa, ucwaningo, ukukhulumela noma ukwazisa kanye nemizamo yokuthuthukisa inqubomgomo ukuze kuqhutshekwe nokuthuthukisa ikhono ekusebenzeni kokuqinisekisa nabantu abahlukene ngokocansi. Lokhu kuhlanganisa ukuqeqeshwa nokugadwa okwandisiwe, okuhlanganisa ukugxila okwengeziwe kumakhono okumela, izingqikithi ezithile ezivela kuyizinkombandlela ze-PsySSA, kanye nokusetshenziswa kolwazi lapho usebenza namakhasimende noma iziguli ezihlukene ngokocansi.

Amagama abalulekile: ukuzethemba, ukuthintana, ukuqhubeka nokuthuthukiswa kochwepheshe, ikhono elibonwayo, ukuqeqeshwa kochwepheshe, isazi sokusebenza kwengqondo, ukuzimela, ukuhlukahluka kwezocansi, ukukhetha ubulili, iNingizimu Afrika

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LIST OF ABBREVIATIONS AND ACRONYMS

Acronym	Meaning
APA	American Psychological Association
ATLG-S	Attitudes toward Lesbians and Gay men scale – short form
CEUs	Continuing Education Units
CHE	Council on Higher Education
CMDs	Common mental disorders
CPAs	Continued Professional Development activities
CPD	Continued Professional Development
GAP	Gay Affirmative Practice Scale
GNC	Gender Non-Conforming
HCW	Healthcare Worker
HEQC	Higher Education Quality Committee
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
IPCP	International Project on Competence in Psychology
IPsyNet	International Psychology Network for Lesbian, Gay, Bisexual, Transgender, and Intersex Issues
IUPsyS	International Union of Psychological Sciences
KMO	Kaiser-Meyer-Olkin measure of sampling adequacy
LGB	Lesbian, Gay, Bisexual
LGB-CSI	Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory
LGB-CSI-SF	The Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory Short Form
LGB-KASH	Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals
LGBPQ+	Lesbian, Gay, Bisexual, Pansexual, Questioning / Queer
LGBQ	Lesbian, Gay, Bisexual, Questioning / Queer
LGBQA	Lesbian, Gay, Bisexual, Questioning / Queer, Asexual
LGBT	Lesbian, Gay, Bisexual and Transgender
LGBT-DOCSS	Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning / Queer, Asexual and other sexually or gender-diverse individuals
LGB-WASES	Lesbian, Gay, Bisexual Working Alliance Self-Efficacy Scales
MCC	Multicultural counselling competencies
MCCS	Multicultural Competence Change Scale
MSJCC	Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession
MHS	Modern Homophobia Scale
MSM	Men-having-sex-with men
PathSA	Professional Association for Trans Healthcare in South Africa
POI	Privilege and Oppression Inventory
PsySSA	Psychological Society of South Africa
PTSD	Post-traumatic Stress Disorder
RCT	Relational-Cultural Theory

Acronym	Meaning
SAJP	South African Journal of Psychology
SAMHSA	Substance Abuse and Mental Health Service Administration
SANAC	South African National AIDS Council
SAQA	South African Qualifications Authority
SASAS	South African Social Attitudes Survey
SASOP	South African Society of Psychiatrists
SGD	Sexuality and Gender Division (A division of PsySSA)
SGM	Sexual and Gender Minorities
SMW	Sexual minority women
SOCCS	Sexual Orientation Counselor Competency Scale
SOCE	Sexual orientation change efforts
SOGIE	Sexual orientation, gender identity and expression
SOGIESC	Sexual orientation, gender identity, gender expression, and sex characteristics
SPSS	Statistical Package for the Social Sciences
UCAP	Unisa Centre for Applied Psychology
Unisa	University of South Africa
UP	University of Pretoria
WPA	World Psychiatric Association
WPATH	World Professional Association for Transgender Health
WSW	Women-that-have-sex-with-women

GLOSSARY

Asexual: "A person who has low or no sexual desire, little or no sexual behaviour, and a concomitant lack of subjective distress. Identifying as asexual does not preclude the ability for the person to have a romantic or love relationship with someone of the same and / or different gender" (PsySSA, 2017, p. 59).

Biological sex: "The biological and physiological characteristics that are socially agreed upon as informing the classification of a person as male or female" (PsySSA, 2017, p. 59).

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 / or with someone of other genders. Such an attraction to different genders is not necessarily simultaneous or equal in intensity" (PsySSA, 2017, p. 59).

Cisgender: "Often abbreviated to simply 'cis', a term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth" (PsySSA, 2017, p. 59).

Coming out: "Coming out refers to the process in which one acknowledges and accepts one's own sexual orientation. It also encompasses the process in which one discloses one's sexual orientation to others. This term can also apply to gender identity" (APA, 2021, p. 56).

Gay: "A man who has sexual, romantic and intimate feelings for or a love relationship with another man (or men). In the South African context, some lesbians also identify as 'gay' which, again, emphasises the importance of enquiring about self-naming and honouring such naming" (PsySSA, 2017, p. 59).

Gender: "The socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for either men or women" (PsySSA, 2017, p. 59).

Gender diversity: "The range of different gender expressions that spans across the historically imposed male–female binary. Referring to 'gender diversity' is generally

preferred to ‘gender variance’ as ‘variance’ implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals” (PsySSA, 2017, p. 60).

Gender expression: “Gender expression refers to the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person’s gender identity” (APA, 2021, p. 56).

Gender identity: “Gender identity is a person’s deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person’s sex assigned at birth or to a person’s primary or secondary sex characteristics. Since gender identity is internal, a person’s gender identity is not necessarily visible to others” (APA, 2021, p. 56).

Heteronormativity: “Related to ‘heterosexism’, it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person’s biological sex as assigned at birth, and that only sexual attraction between these ‘opposite’ genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities also, i.e. it serves to regulate not only sexuality but also gender” (PsySSA, 2017, p. 60).

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” (PsySSA, 2017, pp. 60-61).

Heterosexual: "Having sexual, romantic and intimate feelings for or a love relationship with a person or persons of a gender other than one's own" (PsySSA, 2017, p. 61).

Homophobia: "Also termed 'homoprejudice', it refers to an emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards lesbian women and gay men (or women), or same-sex sexuality more generally. Homophobia is a type of prejudice and discrimination similar to racism and sexism, and lesbian and gay black, coloured or Indian people are often subjected to all three forms of discrimination at once" (PsySSA, 2017, p. 61).

Intersectionality: "The interaction of different axes of identity, such as gender, race, sexual orientation, ability and socio-economic status, in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways" (PsySSA, 2017, p. 61).

Lesbian: "A woman who has sexual, romantic and intimate feelings for or a love relationship with another woman (or women). Note, some lesbians prefer referring to themselves as 'gay'" (PsySSA, 2017, p. 61).

MSM (men having sex with men): "Used in public health contexts to refer to men who engage in sexual activity with other men, including those who do not identify themselves as gay or bisexual, to avoid excluding men who identify as heterosexual. Note, trans men may also be included in such a description" (PsySSA, 2017, p. 61).

Pansexual: "Pansexual refers to those whose sexual or romantic attraction is not defined by gender" (APA, 2021, p. 57).

Queer: "Queer is a formerly pejorative term for LGBT individuals. It has now been reclaimed and operates as an umbrella term for any nonheterosexual identity. It allows for more inclusivity, particularly for those whose sexuality is more fluid or shifts over time" (APA, 2021, p. 57).

Sex assigned at birth: "At birth, a child is usually assigned a sex according to the body parts with which that child is born" (PsySSA, 2017, p. 62).

Sexuality: "Sexuality refers to a broad dimension of human sexual behavior, including sexual values, needs, preferences, and preferred modes of sexual expression, intimacy, and affect" (APA, 2021, p. 57).

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" (PsySSA, 2017, p 62).

Sexual diversity: "The range of different expressions of sexual orientation and sexual behaviour that span across the historically imposed heterosexual–homosexual binary" (PsySSA, 2017, p. 62).

Sexual fluidity: "Sexual fluidity refers to changes in attraction, sexual identity, or orientation over time. It is bi-directional, which means it can mean a change toward or away from same-sex / gender attraction" (APA, 2021, p. 57).

Sexual identity: "Sexual identity refers to the action of claiming through recognition, acceptance, or self-labeling one's sexual orientation as it is relevant to the self" (APA, 2021, p. 57).

Sexual minority: "Sexual minority constitutes a group of individuals whose sexual and affectual orientation, romantic attraction, or sexual characteristics differ from that of heterosexuals. Sexual minority persons are inclusive of lesbian, gay, bi+, and asexual identified individuals" (APA, 2021, p. 57). In South Africa, the term sexual diversity, or sexually diverse people is used in preference to sexual minority.

Sexual orientation: "A component of identity that includes a person's sexual and emotional attraction to another person, along with behavior and social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are

genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others" (APA, 2015, p. 3).

Sexual orientation change efforts (SOCE): "Also known as 'reparative therapy' or 'conversion therapy' is psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client / patient should change her or his sexual orientation" (PsySSA, 2017, p. 62).

Transgender: "Transgender is an adjective that is an umbrella term used to describe the full range of people whose gender identity or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term 'transgender' is commonly accepted, not all transgender and gender nonconforming people self-identify as transgender" (APA, 2021, p. 57).

WSW (women having sex with women): "Used in public health contexts to refer to women who engage in sexual activity with other women, including those who do not identify themselves as lesbian or bisexual, to avoid excluding women who identify as heterosexual. Note, transwomen may also be included in such a description" (PsySSA, 2017, p. 63).

CHAPTER 1: INTRODUCTION

Background to the study

The Psychological Society of South Africa (PsySSA) "Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People" was approved by the PsySSA Council in 2017 (hereafter referred to as PsySSA practice guidelines) (PsySSA, 2017). It was envisioned that the guidelines would be one of several that were to be developed within a broader competency framework that is increasingly being adopted in the South African context. The guidelines are in the process of being revised, with a launch planned for the latter half of 2024. With the guidelines as a foundation for several potential training activities, a need was identified to develop a benchmark against which progress in increasing clinical and counselling psychologists' competence in working with the sexually and gender-diverse people could be measured. One aspect of the benchmark would be to measure clinical and counselling psychologists' competence working with sexually diverse people, including lesbian, gay, and bisexual (LGB) identified people specifically. In addition to a benchmark, this current study could provide valuable information to assist in developing appropriate curriculums and continued professional development (CPD) opportunities, and further research agendas, to support and assist clinical and counselling psychologists in developing competency as well as confidence in providing appropriate psychological care to sexually diverse people. Beyond the anecdotal evidence, there has been no research amongst South African clinical and counselling psychologists to understand to what extent they work with, are trained and educated in, and how competent and confident they feel in working with sexually diverse people.

Objectives of the study

As the title of the study suggests, the primary objectives of the study were to determine the following amongst registered clinical and counselling psychologists in South Africa:

- What graduate and CPD training have they received and want to receive in working with sexually diverse people?
- What professional and personal experience or exposure do they have with sexually diverse people (in their private lives and in practice)?
- What is their perceived competence in practising affirmatively with sexually diverse people?
- How confident are they in affirmative practice with sexually diverse people?

At a secondary level, further research questions were:

- Are there particular segments of clinical and counselling psychologists with potentially different development needs that require different types of intervention to ensure increased affirmative practice?
- Do the measures utilised in this study provide an acceptable level of reliability and validity that can confidently be used in the current research, and future work in this field in South Africa?

Focus on sexually diverse people

The PsySSA practice guidelines provide an affirmative stance on sexual and gender diversity (PsySSA, 2017). The term "sexual and gender diversity" subsumes a variety of diversities, such as sexual diversity, gender diversity (including trans) and biological diversity. The term includes, but is not limited to, people that identify as lesbian, gay,

bisexual, transgender, intersex, queer, and asexual (LGBTIQA+). According to the glossary of the guidelines:

> "LGB" refers to sexual orientations, while "T" indicates a gender identity, "I" a biological variant, "Q" a queer identified person, "'A"' for asexual, and "+" indicating other non-conforming minorities. They are "clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination, and victimisation in a heteronormative and heterosexist society, to ensure equality before the law and equal protection by the law. (PsySSA, 2017, p. 61)

The PsySSA (2017, p. 61) guidelines use this acronym to express solidarity with the activist position:

> However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences and needs of these people may in fact differ significantly and in several respects.

This work in this study focuses on sexual orientations, with reference to gender identity, gender expression, and biological diversity only in relation to sexual orientations. It is noted that a complexity exists in the relationship between the development of sexual orientation and gender identity. Transgender people may identify with different sexual orientations that can be experienced as distinct from their gender identity (Mustanski et al., 2014). In operationalising this benchmark PhD study, the unique differences and distinctions between sexual and gender diversity might be highly relevant in guiding curriculum development, policy input, and setting research agendas. As the area of sexual and gender diversity / LGBTIQA+ psychology develops, it will become increasingly important to develop potentially unique knowledge and skills in the different areas within this field. The current study focusses on clinical and counselling psychologists' practice with sexually diverse

people, in particular people whose sexual orientation does not conform to heteronormative cultural expectations, including lesbian, gay, bisexual, pansexual, questioning, or queer identities (LGBPQ+), as well as other emerging identity markers or self-definitions. The terms sexual diversity, sexually diverse people, diverse sexual orientations, and the acronym LGBPQ+ are used in preference over same-sex sexuality, sexual minorities, and other acronyms of sexual diversity including LGB, LGBQ and LGBQA. Similarly, the terms sexual and gender diversity, sexually and gender-diverse people, and the acronym LGBTIQA+ are used in preference over other terms such as queer, LGBT, LGBT+, LGBTQ. In some cases, terms used by the original authors of references will be retained, if it is deemed relevant to the discussion in some way or are part of a specific title or measurement instrument name.

Sexual diversity, mental health, and service delivery in South Africa

South Africa has a progressive legal and policy framework underpinned by the constitution of the country explicitly mandating non-discrimination based on sexual orientation (Moreno et al., 2020; Nyeck & Shepherd, 2019). This framework does not always translate into the lived experience of people, nor public acceptance. Although significant strides have been made, intolerance, stigma, discrimination, and violence remain problematic (Horne et al., 2019; Judge, 2021). Minority stress due to societal stigma and exposure to violence and hate victimisation[1] have been shown to increase sexually diverse people's mental health issues, including depression, suicidality, substance use, and anxiety; indicating a clear need for health provision services to be more affirmative, and even specialised to sexually diverse clients and patients (Blondeel et al., 2016; Cochran et al. 2017; Evans-Polce et al., 2020; Gonzales & Henning-Smith, 2017; Moagi et al., 2021). Unfortunately, high

[1] Hate victimisation includes hate crime, hate speech, and intentional unfair discrimination

levels of stigma and discrimination continue to be experienced by sexually diverse mental health service users, impacting on their openness to acknowledging health issues and accessing care, as well as ultimate wellness outcomes. This situation continues to pose challenges and opportunities for those tasked with improving the mental health outcomes for sexually diverse people, including supporting structural and organisational changes, as well as training and supervision of mental health providers (Luvuno, et al., 2019; Mitchell & Nel, 2017; Müller & Daskilewicz, 2019; Müller & Hughes, 2016).

The profession of psychology has seen a significant shift from complicit or active discrimination against sexually diverse people, including support for sexual orientation change efforts, to a much more progressive and supportive voice in care for sexually diverse people, as evidenced by the PsySSA practice guidelines, and subsequent training, research, and advocacy efforts by the PsySSA African LGBTI+ Human Rights Project[2] (Pillay et al., 2019; PsySSA, 2017). This study represents the first quantitative effort to measure the success achieved in supporting clinical and counselling psychologists in becoming more competent and confident working with sexually diverse people, following the pivotal development and publication of the PsySSA practice guidelines in 2017.

Competence, confidence, and relevance to South Africa

The Health Professions Council of South Africa (HPCSA) is legally mandated to guide and regulate all health professions in South Africa, and through their Professional Board of Psychology, set standards for education and training of registered psychological professionals in the country, and thus ensuring that practitioners are competent, i.e., able to

[2] The PsySSA African LGBTI Human Rights Project, which was initially funded by the Arcus foundation, is a collaboration between PsySSA and the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) of which PsySSA has been a member since 2007.

practice the profession well enough or adequately (Department of Health, 2006; Department of Health, 2011; Sibaya, 2008). There has been an increased focus on defining and specifying competencies for psychology practice in South Africa, and an important work in these debates have been the International Union of Psychological Science's (IUPsyS) "International Declaration of Core Competences in Professional Psychology" (IPCP[3], 2016). One of the IUPsyS competences encompass working with diversity, including cultural competence. (IPCP, 2016). Academic work in diversity or multicultural competencies provide a strong foundational base for grounding the development of affirmative approaches to working with sexually diverse people. Affirmative practice goes beyond general therapy and counselling skills and constitutes a different construct or competence area in addition to other competencies, and endeavours to illuminate and provide therapeutic services (amongst others) that are inclusive and take the lived experiences of sexually diverse people into account. Some of the more recent themes in thinking about affirmative practice includes a focus on multiple intersecting and fluid identities, interpersonal multicultural and strength-based positive psychology frames more dominant with both intra-psycho and inter-personal issues linked to power, privilege and structural considerations, diversity of subjects and intergroup differences (Grzanka & Miles, 2016). Research has developed to include more evidence-based practice, culminating amongst others in the publication of a handbook on affirmative evidence-based practices (Pachankis & Safren, 2019). A significant body of research has indicated that affirmative practice correlates with a stronger therapeutic relationship, and that the relationship is the underlying mechanism through which affirmative practice is associated with psychological well-being of sexually diverse clients (Alessi et al., 2019).

[3] International Project on Competence in Psychology

Locating myself, the researcher, in relation to this field of study

As the researcher of this study, my background in this field forms a large part of the story being told and researched and necessitates including myself as "I". I have been involved in the field of LGBTIQA+ psychology and mental health since 2011 when I started with my master's degree in clinical psychology at the University of South Africa (Unisa). Prior to this I completed my master's degree in research psychology at the University of Pretoria (UP) in 1996, by which time I was already working in the market research industry. At the beginning of 2010, I was diagnosed with stage 4 cancer. After a period of successful chemotherapy, I made the decision to change my career. Having known about Professor Juan Nel's activism and academic work since the 1990s, I met with him to start discussing master's topics. Meeting with Prof. Nel has led to a productive working relationship in the field since then.

My thesis consisted of a qualitative study entitled "Lesbian, gay, and bisexual clients' experience of psychotherapy: The search for LGBTI-affirmative practice," which was completed in 2013, with an article published in 2016 in the South African Journal of Psychology (SAJP) (Victor & Nel, 2016). Having obtained my MA (Clinical Psychology) with cum laude, I started working on the proposal for my doctoral studies, under the guidance of Prof. Nel. My proposal for this work was accepted in 2017 with the original title being "South African psychology counsellors and psychotherapists' training, experience, competence, and confidence in practicing affirmatively with lesbian, gay, and bisexual (LGB) people", along with ethical clearance certificate PERC-17061 provided on 27 October, 2017 (See Appendix I).

In 2011, I became a member of the PsySSA African LGBTI+ Human Rights Project. This funded project has represented a significant innovation for PsySSA as a professional voluntary association. The goal of the project has been to build PsySSA capacity in South

Africa, and in Sub-Saharan Africa more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC). As a core member of the team, I have had the privilege of being involved in several achievements of the project, including co-leading the team that developed and disseminated the PsySSA Position Statement for Psychological Professionals working with Sexual and Gender-Diverse People (Victor, et al., 2014; Victor & Nel, 2017) and the PsySSA practice guidelines (McLachlan et al., 2019; PsySSA, 2017). As indicated, we are in the process of revising the guidelines, with the launch of the revised guidelines planned for 2024. I have been involved in developing and presenting training workshops to over 500 human rights activists, psychology students and professionals including social workers, nursing, and correctional services staff. We are currently in the process of completing an academic article on the impact of the training on perceived competence of social workers (Victor & Nel, 2021). By the end of 2023, I had presented papers in this area of work at 10 international and eight national congresses and conferences on LGBTIQA+.

With the Human Sciences Research Council (HSRC) and The Other Foundation[4], I was involved in a research project to obtain a nationally representative view of attitudes and behaviour of non-normative sexualities and gender identities in South Africa (Sutherland et al., 2016). In the same year I was a part of the team that assisted the World Psychiatric Association (WPA) in developing global competencies for psychiatrists working with sexual and gender-diverse people. This was launched at the World Psychiatric Association International Congress in Cape Town in November 2016 (World Psychiatric Association, 2016).

[4] The Other Foundation is an African trust that raises awareness and funds to support research, advocacy and activist activities in the areas of gender and sexual diversity in Africa.

I am a member and contributor to the Unisa Community Engagement Project called "Towards LGBTI Health and Well-Being" (Project No. CA1200). I was a founding member of the Sexuality and Gender Division (SGD) of PsySSA, which was officially launched in 2014, and remain a member of both the SGD and PsySSA to date. I am a member of the World Professional Association for Transgender Health (WPATH), the Professional Association for Trans Healthcare in South Africa (PathSA), and part of a queer reading group in Cape Town. As a clinical psychologist in private practice, I have had the pleasure of seeing many sexually diverse clients for over a decade. This has included individual, relationship, and group work, as well as working with non-governmental organisations in the field, including Gender Dynamix, Health4Men, The Pride Shelter Trust, and the WITS RHI[5] Trans Clinics.

Coming back to my doctorate; following the acceptance of my proposal in 2017, I experienced a period of significant personal upheaval, which prevented me from working on my doctorate. An amendment to my ethical clearance certificate was issued on 2 October, 2019 (See Appendix II), allowing for amendment of the project, including being allowed to be part of a collaborative project (transnational project referred to below). By late 2021 I was ready to restart the process again to make this lifelong dream a reality. By this time my supervisor was also involved in a transnational study on affirmative practices and that team was getting ready to develop the quantitative component of their study. There appeared to be significant overlap in my objectives and that of the transnational study, and the work converged to me being part of this team, being able to utilise some of the data that was to be collected as well as include some of the areas of enquiry I wanted to do.

[5] University of Witwatersrand Reproductive Health and HIV institute

Convergence with the transnational study

The transnational study is titled "The Role of Psychology Guidelines on Mental Health Access and Treatment of Sexually and Gender-Diverse Individuals". This multi-national study was being conducted in several countries including South Africa, Colombia, Russia, and the Philippines, using a mixed method approach, and the principal investigator on the project is Prof. Sharon G. Horne, Professor of Counselling Psychology at The University of Massachusetts Boston, Professor Extraordinaire at the Department of Psychology, Unisa, and a Global Fulbright scholar. The study has ethics approval from the Ethics Review Committee of the University of Massachusetts Boston Institutional Review Board (Assurance # FWA00004634; IRB Study Number: 2018231) (See Appendix III). The local leg of the study titled "The Role of Psychology Guidelines in Mental Health Access and Treatment of Sexually and Gender-Diverse Individuals in South Africa" is a collaboration between Prof. Horne, Prof. Juan A. Nel (my supervisor), Dr. Abayomi O. Olaseni, and myself, with ethics approval by the Unisa, College of Human Sciences Research Ethics Review Committee (NHREC Registration#: Rec-240616-062, and CREC Reference #: 1115146_CREC_CHS_2022) (See Appendix IV). The study was focused on understanding the potential impact affirmative practice guidelines such as the PsySSA practice guidelines, and related training activities have had on mental health practitioners. More specifically, the primary aim was to develop a comprehensive study of LGBT+ care practices in South Africa, alongside other countries (including Colombia, Russia, USA, and the Philippines). This includes a transnational analysis of the benefits and challenges of affirmative psychology guidelines in mental health access and treatment among sexually and gender-diverse individuals. As mixed method implies, the transnational study had two components. The first, qualitative component involved in-depth interviews with South African members of the team

(See PsySSA African LGBTI+ Human Rights Project) that developed the PsySSA practice guidelines document, as well as in-depth interviews with LGBT+ clients. The second, quantitative component, was an online internet-based survey conducted amongst mental health practitioners, defined as psychiatrists, psychologists, social workers, occupational therapists, and psychiatric nurses working with mental healthcare users. Given the convergence in area of research, as well as my involvement in the larger study, the questionnaire included questions for the transnational study, questions for my doctorate, as well as some questions for use by both. To further minimise overlap between the two studies, I focused on the results for clinical and counselling psychologists specifically. This denotes a change from the initial interest in counsellors and psychotherapists indicated earlier in the study but remains within the broader focus on mental health practitioners of the transnational study.

Overview of method

The study used a primary source, quantitative online web-based internet survey method to collect data, using Qualtrics[6]. The questionnaire was developed by the team of the transnational study, including myself, and was pre-tested before finalisation. The questions I utilised in my analysis included: personal and professional demographics; graduate and CPD training and activities; contact and work experience with LGBTI+ people; the eight items from the 18-item Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) (Bidell, 2017); the 15-item Lesbian, Gay, and Bisexual Affirmative Counselling Self-Efficacy Inventory – Short Form (LGB-CSI-SF) (Dillon et al., 2015); nine items developed from the PsySSA practice guidelines (PsySSA, 2017); six items relating to

[6] Qualtrics is a cloud-based platform that is used to create and administer web-based surveys.

work context and organisational factors; and one item measuring familiarity with the PsySSA practice guidelines (PsySSA, 2017).

The target population was: (a) South African, (b) registered clinical and counselling psychologists, who (c) work therapeutically with sexually diverse clients. A debate in the field is around the continued distinction between clinical and counselling psychology, with a recent study indicating more similarities than difference in areas such as key activities and theoretical considerations (Young & Young, 2019). Given these findings, it was decided to include both registration categories in the current study. A convenience sample was employed, and potential participants were invited to access the survey through e-mail invites to various databases of professional bodies, including PsySSA, advertisements in newsletters and targeted Facebook groups, as well as invitations by the transnational study team and members of the PsySSA African LGBTI+ Human Rights Project to their professional networks. The initial invitation to participate in the survey was sent out to prospective participants and was followed up by two reminder invitations at successive intervals. As incentive to complete the survey, participants could access three articles after they completed the survey and answer 15 multiple choice questions, to potentially earn two Continuing Education Units (CEUs). Fieldwork was conducted between 26 January, 2023 to 11 April, 2023.

After implementing fraud detection and dealing with incomplete surveys, a final sample of 201 clinical and counselling psychologists were obtained, representing a 3.9% response rate compared to data indicating that there are 3290 clinical psychologists and 1848 counselling psychologists registered with the HPCSA (Padmanabhanunni et al., 2022). Reasons for this potentially low response rate are discussed in Chapter 4. Data was analysed with both Qualtrics and SPSS (Statistical Package for the Social Sciences) using descriptive

statistics, cross-tabulations, and significance testing. Internal reliability of measures was calculated, and construct validity was indicated through factor analysis.

Significance of the study

No research in South Africa has endeavoured to understand the extent to which clinical and counselling psychologists in South Africa feel prepared and able to deliver appropriate services to sexually diverse people. This appears important if the profession is to develop interventions to prepare trainees for practice, as well as provide continued learning opportunities for practitioners to ensure appropriate psychological care is provided to sexually diverse people. This is the first piece of quantitative research highlighting the impact of the PsySSA practice guidelines and subsequent efforts by the team to disseminate and train on the PsySSA practice guidelines. This benchmark study will hopefully be the basis for future tracking of competence and confidence in working with sexually diverse people, inspire further research in this area in South Africa, and support continued efforts in training, advocacy, and policy development efforts to eventually ensure that clinical and counselling psychologists are competent and confident in working affirmatively with sexually diverse people. This doctoral dissertation represents an important point for me in my continued engagement in assisting and supporting the shaping and growth of a vibrant and dynamic field of LGBTIQA+ psychology and mental health in South Africa. The results will help guide the PsySSA Africa LGBTI+ Human Rights Project strategy and serve as input in the revision process of the PsySSA practice guidelines currently in progress. It will also provide support for the development and refinement of targeted graduate and CPD activities going forward.

Outline of the study

Chapter 2 and 3 comprises the literature survey. In Chapter 2 the concept of sexual orientation will be positioned within the area of sexuality and defined. This involves examining the South African context for sexually diverse people, covering legal frameworks, public attitudes, and lived experiences. It includes discussions on mental health, violence and hate victimisation, referencing models such as the minority stress model (Meyer, 2003b) and the psychological mediation framework (Hatzenbuehler, 2009) to explain the heightened risk of mental health issues of sexually diverse people. It emphasises the necessity for services, outlines present healthcare practices (including mental health), and concludes with a discussion on the role of psychology in relation to sexually diverse communities in South Africa. Chapter 3 provides an overview of competencies and diversity with specific reference to South Africa. An outline of diversity competence in a multicultural society leads to a discussion of affirmative approaches in psychological care. This includes an understanding of what affirmative practice encompasses, research on psychotherapy with sexually diverse people leading to specific competencies in working with sexually diverse people and outlining the PsySSA practice guidelines working with sexually diverse people in South Africa. The chapter is concluded with a review of training and assessment of competence and confidence in working with sexually diverse people. Chapter 4 outlines the research design and method for the study. Chapter 5 provides the results of the study, concluding with key learnings. In Chapter 6, the results are discussed, closing with conclusions and recommendations.

CHAPTER 2: SEXUAL DIVERSITY, MENTAL HEALTH, AND SERVICE DELIVERY IN SOUTH AFRICA

Introduction

In this chapter the concept of sexual orientation will be positioned within the area of sexuality and defined. Particular attention is paid to sexual orientation and identity, including development and formation, with specific reference to race, queerness, identity labels and language in South Africa. This is followed by providing context in South Africa including legal frameworks, public attitudes, and lived experiences of sexually diverse people in the country. It includes a discussion of the mental health and well-being of sexually diverse people, including reference to violence and hate victimisation, and an outline of the minority stress model (Meyer, 2003b), and the psychological mediation framework (Hatzenbuehler, 2009) to understand sexually diverse people's increased risk of mental health concerns. Highlighting the need for services is followed by outlying current healthcare practices including mental health practices and wrapping with a discussion of the profession of Psychology and sexually diverse people in South Africa.

Sexual orientation and identities

Sexual orientation and sexuality

Sexual orientation is viewed by the World Health Organization as part of an individual's sexuality, which they define as a:

> Central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs,

> attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. (World Health Organization, 2015, p. 5)

A review of sexuality research and training from 2000-2006 indicated five focus areas, namely:

- research on HIV/AIDS including men having sex with men (MSM),
- gender research,
- sexology with its traditional focus on pathologies and dysfunction,
- sexual and reproductive health, focusing on fertility and population growth, and
- human rights, and sexual rights as human rights.

It was highlighted that the complexities of sexual identities, sexual relations, sexual desires, and sexual cultures were largely absent (Fletcher et al., 2013). Tamale (2015: p. 16) underscores that sex and gender are both "creatures of culture and society" and that gender provides a critical analytical lens through which sexuality can be interpreted. Sexuality has various dimensions, including sexual knowledge, belief, values, attitudes and behaviours, procreation, sexual orientation, and personal and interpersonal sexual relations. Tamale (2015) states that it is important to take contextual factors into account that impact and shape our sexualities, and that thinking in terms of multiple sexualities support a move from the essentialist only frame of much sexuality research. Thus, sexuality touches on a range of issues such as pleasure, the human body, dress, self-esteem, gender identity, power, and violence. They further advocate, on the one hand, the heterogeneity of the experience of

sexualities by people from Africa, whilst also supporting the use of Western concepts and theoretical frameworks as both are relevant to our context, rather than "reinventing the wheel" (Tamale, 2015: p. 24) such as Rubin's model of sexual hierarchy with its "charmed circle" encompassing "heterosexual, married, monogamous, procreative, non-commercial, in pairs, in a relationship, same generation, in private, bodies only and vanilla," which all provide privileges and material benefits from society (Tamale, 2015: p. 40). Similarly, Tamale (2015) states that Western identity politics do not necessarily apply in Africa, and within Africa different identity politics play out, as seen in the use of alternative descriptors for same-sex relationships in various countries, cultures, and communities. The use and meaning of terms such as lesbian and gay in, for instance, the modern urbanised context in South Africa, could differ significantly from other African countries, whilst reflecting less difference to those meanings across the globe (Lynch et al., 2021; Tamale, 2015).

Understanding sexual orientation

The term sexual orientation has been firmly established in global and local human rights discourse, including legal, activist, and academic spaces, to encompass the concerns of sexually diverse people. The South African Constitution's Bill of Rights (Republic of South Africa, 1996), for example, includes non-discrimination based on sexual orientation, which has filtered down into the ethical code for psychologists (Department of Health, 2006; Republic of South Africa, 1996). Thus, how sexual orientation is defined, and what these definitions mean and imply, is highly relevant to psychological professionals. At the same time, given our regional context, we need to again problematise the use of the concept of sexual orientation in this study, and the implications of this work for psychological practice.

In the following paragraphs some definitions of sexual orientation(s) are provided and discussed which are useful when talking about sexual orientation, each reflecting the time and place within which the definition was developed, thus providing a sense of the development of work around sexually diverse people. The initial definition was first articulated in the PsySSA position statement (PsySSA, 2013; Victor et al., 2014) and later utilised in the PsySSA guidelines (McLachlan et al., 2019; PsySSA, 2017). The guidelines have provided the framework used by psychological professionals in South Africa when thinking about their practices and has been globally influential in health sciences more broadly. The PsySSA guidelines define sexual orientation as: "A person's lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual / same-sex sexual orientation, bisexual or asexual" (PsySSA, 2017, p. 62).

Several aspects of this definition can be highlighted. The definition talks to various forms of attraction – emotional, romantic, sexual, and affectional – without commenting on relational status / configuration, gender, or identity labels. This moves to providing a definition that is broad enough to be useful in diverse contexts, such as found in our context. Of course, the PsySSA terms above imply some of the labels that are assigned by others or self. PsySSA practice guidelines reflect though, that people might have regular sex with others and not identify with a same-sex identifier such as gay, lesbian, or bisexual (Brown et al., 2013). Scientists are moving away from using the term "homosexual"[7] as this reflects the heterosexual bias in language, has negative connotations with psychopathology, and a focus on only the sexual (behavioural) aspect of a person's identity (Harper, 2005). This issue of identity and identity formation will be discussed in more detail later.

[7] The term "homosexual(s)" / "homosexuality"" is employed in this study in accordance with its historical usage / reference to research and does not necessarily reflect my personal stance on the matter.

The PsySSA practice guidelines' definition does talk to lasting attraction – implying a state of attraction that is more durable, and long lived. The guidelines elucidate this view further when it is noted that people may have sex with other people for multiple reasons other than as an expression of their sexual orientation (Anova Health Institute, 2010). This opens an area of debate around the interaction or correlation of longer-term attraction and intermittent or situational sexual behaviours (however sexual or sex is defined), and the potential discrimination and prejudice faced by people based on intermittent behaviours.

The second definition is included here given the volume of work emanating from that region (North America), and the influence of the American Psychological Association (APA). In the revision of their "Guidelines for psychotherapy with Lesbian, Gay, and Bisexual Clients", which was first published in 2000 (Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients, 2000), sexual orientation indicates "…the sex of those to whom one is sexually and romantically attracted" (APA, 2012). Although they proceed to identify categories, namely, attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals), mention is made that sexual orientation occurs on a continuum rather than the distinctiveness implied by the categories, and that sexual orientation is fluid for some people.

In contrast to the first definition, this definition does not include a durational aspect to attraction, but also includes fewer dimensions of attraction namely sexual and romantic, which would imply an inclusiveness of any attraction, however short. The operationalisation and categorisation (either by the researcher or the participant) for this definition becomes problematic, as it can be expected that a significant proportion of people would indicate a sexual and romantic attraction maybe once or twice in their lives to all (presumed) sexes, thus

implying at the very least a bisexual label. This is further confirmed by the idea of sexual orientation as fluid, which is not disputed here.

Possibly more open to debate is the specifier of (biological) sex of those whom a person is attracted to. They define sex in this context as a person's biological status (male, female, intersex) with indicators of sex including chromosomes, gonads, internal reproductive organs, and external genitalia (APA, 2012). The interaction of (biological) sex or sex assigned at birth and gender is becoming increasingly important as our work around gender identities, gender expressions and the experiences of incongruence with biological sex and gender identity expands and becomes more complex.

In the continuation of definitions of sexual orientation, the following definition provides a different perspective – with gender as the specifier rather than biological sex. This is the definition contained in the Yogyakarta Principles (International Commission of Jurists, 2007) that has guided much of the global legal and activist work in the past 15 years (Park, 2022), namely that sexual orientation refers "to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender" (International Commission of Jurists, 2007; p. 6).

This definition formed the basis for more recent work that endeavoured to provide a global definition that is specific and measurable for utilisation in global law, policy and human development; namely that an:

> Individual's sexual orientation is indicated by one or more of the following: how a person identifies their own sexual orientation, a person's capacity for experiencing sexual and / or affectional attraction to people of the same and / or different gender, and / or a person's sexual behavior with people of the same and / or different gender. (Park, 2022, p. 55)

Park (2022) critiques the Yogyakarta Principles' definition on several grounds. Their[8] primary concern is providing a definition that can be globally applied in legislation and be inclusive of discrimination experienced by sexual diversity. This includes ensuring that the different accepted dimensions of sexual orientation are clearly outlined thus questioning the "and" in the definition implying one concept of identity and attraction and only within an intimate and sexual relationship. For them, it is important to specify attraction, behaviour, and identity as independent, although potentially overlapping aspects of sexual orientation. Park (2022) further feels that the previous definition excludes the possibility of more transient, rather than close relationships. The Chair of the drafting committee of the Yogyakarta Principles responded, on the other hand, that the definition points to the formation of sexual and intimate relations between people as an aspect of sexual orientation (Park, 2022). Potentially adding "/ or" to the "and" between sexual and intimate might have implied a different interpretation. Nevertheless, Park (2022) makes a good point in exploring what "intimate" might mean – both when talking to the meaning of intimacy as well as what relationships might be considered intimate.

Since publication of their revised guidelines in 2012, the APA has shifted in the definition used, in line with substantially more research and previous silent voices speaking in their context. The APA "Guidelines for psychological practice with transgender and gender nonconforming people" moved closer to the PsySSA position and defined sexual orientation as a "person's sexual and emotional attraction to another person" (APA, 2015, p. 835). More recently this was expanded to define sexual orientation as a:

> Component of identity that includes a person's sexual and emotional attraction to another person, along with behavior and social affiliation that may result from this

[8] Gender-neutral pronouns are used throughout, except where authors have referred to self in their preferred gender or, where relevant to the text.

> attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others. (APA, 2015, p. 3)

This definition appears to be closer to where the current study, and my own journey, has taken them since the title for the study was first agreed on in 2017 (Victor & Nel, 2017). More particularly, by the third iteration after the 2000 and 2012 APA guidelines for psychological practice with lesbian, gay, and bisexual clients, the title changed to "Guidelines for Psychological Practice with Sexual Minority Persons" (APA, 2021), thus becoming more inclusive of all people that do not conform to heteronormative expectations. In the 2021 guideline, sexual minority persons are defined as a "group of individuals whose sexual and affectionate orientation, romantic attraction, or sexual characteristics differ from that of heterosexuals. Sexual minority persons are inclusive of lesbian, gay, bi+ and asexual identified individuals" (APA, 2021, p. 57).

Given huge societal influences, trends and factors, the issue of sexual orientation, behaviour, and identity, will continue presenting ongoing challenges within psychology, and all involved in this work need to be sensitive and informed about these challenges within a continual learning frame. Influences particular to South Africa include the history and legacy of colonisation and apartheid, the largely patriarchal society with heteronormative social norms that the country continues to struggle with, including socio-cultural (and often stereotyped) norms around the performance of masculinity and femininity, and how this relates to same-sexuality and open, healthy identification with same-sex sexual orientations (see for e.g., Seale, 2009). Moreover, the experiences and lived realities of these identities can vary significantly among individuals, groups, and communities. What might be considered a healthy and resilient adaptation to a same-sex identity in one community might

not be viewed similarly in other communities. This extends to how psychology professionals, as a community, perceive the identities of the diverse communities they serve.

In being cognisant and sensitive to the particularly complex and nuanced ways in which sexual diversity is lived and experienced, the current study endeavours to be inclusive of the psychological needs and service requirements of all people that are in the process of identifying or have identified with a non-heteronormative sexual orientation.

Assessment of sexual orientation

Several models have been developed to understand and assess sexual orientation, ranging from the dichotomy of homo- versus heterosexuality, to Kinsey and associates' idea of sexual orientation as a continuous variable (De Cecco, 1990; McWhirter et al., 1990), to sexual orientation as a multidimensional construct, often defined in terms of sexual behaviour and activity, sexual attraction, desire and arousal or sexual identity (Michaels, 1996). These have included Klein's Sexual Orientation Grid (Klein et al., 1985; Klein 1990), measuring sexual orientation as a multivariate and dynamic process of seven aspects of sexual orientation: sexual attraction, sexual behaviour, sexual fantasies, emotional preferences, social preferences, self-identification, and lifestyle; 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 (Berkley et al., 1990); and Weinberg et al.'s work (1994) on bisexuality, which looked at sexual orientation on three dimensions, namely sexual feelings, sexual behaviours and romantic feelings.

In the late 1980s Lauman et al. (1994) developed a standardised set of questions that could be easily answered by participants / respondents, and which captures what they

considered the most important aspects of sexual orientation, based on three dimensions – attraction, behaviour, and identity. Significant scientific support for this model has been seen and has influenced the measurement of sexual orientation in research, including large scale representative surveys (Park, 2016; 2022). Park's (2022) definition of sexual orientation was clearly based on that of Lauman et al. (1994) and subsequent work.

The construct of sexual behaviour can be complex and dependent on the study objectives, and include aspects such as number of partners, occasions engaging in a sexual act, anatomical information of both partners and respondents. Sexual behaviour also includes sexual abstinence, celibacy, or behaviours not expressed (e.g., identify as lesbian with no experience of sexual contact with a female) (National Academies of Sciences, Engineering, and Medicine [NASEM], 2022). Measuring sexual attraction mainly focuses on the sex / gender(s) of the people respondents are sexually or romantically attracted to. These measures are maybe more appropriate, (a) when assessing complex and fluid ways an individual experiences attraction, separate from sexual behaviours and sexual orientation identity, (b) as an indicator of sexual orientation in the face of concerns regarding prejudice and stigma that inhibits self-disclosure of sexual orientation identity, and (c) characterising individuals that are not, or not yet, sexually active, such as adolescents (NASEM, 2022). The third component, sexual orientation identity, includes the cognitive and social expression of one's sexual orientation. It is most frequently tied to experiences with different forms of discrimination and has been used most often in population-based data collection, including tracking (NASEM, 2022).

A limitation of these models, certainly at the very least from a psychological perspective, 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). For LGBTIQA+ people, gender and sexual identities are often multiple and in flux, shifting their understanding of their own sexual and gender identities over time. It becomes more important to ensure inclusive survey questions in the digital age for: (a) when who is or is not counted, (b) has a significant impact on visibility, (c) access, and (d) power (Ruberg & Ruelos, 2020). An evaluation carried out by Korchmaros et al. (2013) of commonly used single-indicator measures of sexual orientation included: self-identified sexual orientation, sexual preference (same / other sex combinations), and type of sex partner (same / other sex combinations). The evaluation indicated that: (a) between 10-22% of people could not be categorised using a single-indicator measure, (b) self-identified sexual orientation was often different from preference and behaviour, (c) this incongruence was different by gender, and (d) differences in outcome measures (number of recent sex partners, unprotected sex, and lifetime harassment) varied depending on the measure used. The outcome of this comparison of measures established the possibility of inconsistent conclusions across studies (Korchmaros et al., 2013). Incorporating a more fluid understanding of sexual orientation and gender identity into research poses significant challenges but needs to be addressed through researchers being sensitive to how people label themselves, 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).

Sexual orientation and identity

Sexual orientation identity is generally viewed as the way an individual constructs or thinks about, and labels their sexual orientation (Park, 2022). Some of the labels that are found globally include:

- **Heterosexual, straight:** Sexually oriented toward people of a different, usually binary, sex / gender.
- **Homosexual, gay:** Sexually oriented toward people of the same, usually binary, sex / gender.
- **Lesbian:** women who are sexually oriented toward other women.
- **Bisexual:** sexually oriented toward both men and women.
- **Queer:** an umbrella term for belonging to the LGBTIQA+ community; also used to refer to a person who is sexually oriented toward people of more than one gender.
- **Pansexual:** sexually oriented toward people of any gender.
- **Questioning:** uncertain about sexual orientation identity (NASEM, 2022).

Racial and cultural differences play an important part in defining one's sexual orientation identity in South Africa. 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 themselves in the receptive role and refer to their sexual partner as "straight" (Nel, 2007; Rabie & Lesch, 2009; Reid, 2013). Relevant to the current study is that different identities and identity labels influence the discrimination experienced and coping strategies used by people in their day-to-day life.

A nationally representative survey in South Africa (n=3500), conducted at the end of 2015 by the HSRC and The Other Foundation, found that 1.4% of respondents identified with non-normative sexual orientations:

- 0.7% as lesbian or gay
- 0.5% as bisexual

- 0.2% as “other”

The initial report from the survey, titled “Progressive Prudes”, highlighted that this translated to 530 000 South Africans, 16+ years old, that were prepared to self-identify themselves in a general survey with a sexually diverse sexual orientation (Sutherland et al., 2016). These figures might be underreported as people who identify with these sexual orientations might be at different levels of “coming out” or comfort in expressing these identities within potentially dangerous environments (Stephens, 2010). The findings of the survey are relatively stable across identified gender, race groups, urban versus rural area, age groups, educational level, and income groups. The question asked in the Other Foundation survey pertained specifically to identity, rather than about sexual diversity (e.g., attraction or behaviour) more broadly (Sutherland et al., 2016). Nyeck and Shepherd (2019), utilising census data, estimated that 1.1% of couples in the 2011 census self-identified as being in a same-sex marriage / partnership to data collectors, which translates to just over 10 000 households.

Significant arguments have been made that the concept of sexually diverse identity, and the inherent binary categorisation between heterosexual and sexually diverse sexual orientations, tend to be products of “Western” or “European” history and identity politics, which is significantly based in disorder or disease models to describe what might not be the statistical average – a legacy that psychology in South Africa is dealing with as part of a larger project to assess and take responsibility, and account, for the role of psychology in oppression and discrimination in South Africa, in an endeavour to become part of the solution in providing social justice for all (Nel, 2009; Sandfort et al., 2015b). Sandfort et al. (2015b), in reporting on the 2nd African Same-Sex Sexuality and Gender Diversity (ASSSGD) Conference, held in Nairobi in March 2014, discusses how the conference set out to identify and celebrate evolving same-sex sexual practices, identities, and communities within sub-

Saharan Africa. Sandfort et al. (2015b) identify the term LGBTIQA+ as acceptable within the context and understanding of the issues around using the term to presume inclusivity or smooth over potential differences which could potentially lead to privileging of one group over the other. Certainly, in the context of sexual versus gender diversities, and within sexual diversities, the issue of how people want to, are prepared to, and can identify in some way (or not!) always remains an important consideration when engaging in this area of work. Individuals might have difficulty in recognising and naming a sexual diversity identity for themselves, particularly a positive identity, rather than simply in opposition to "different than". Even more difficult could be expressing such an identity or fluidity of identity given the fear of lack of acceptance by family, friends communities, and their experience of God and religious communities they belong to (Paul, 2017).

Sexual orientation and the special case of men having sex with men (MSM)

To complexify terminologies used in South Africa a little further, the public health arena, particularly as it pertains to HIV prevention and treatment, has often steered away from issues of identity, and focused on behaviour specifically, predominantly MSM – regardless of identity. Muraguri et al. (2012) provides an excellent summary of research amongst MSM and HIV in sub-Saharan Africa, and Jin et al. (2021) similarly report on an overview of epidemiological conditions of HIV amongst key populations, including MSM. This work mostly excludes women having sex with women (WSW), often because of the perceived low risk of contracting HIV, which indicates the view that WSW do not particularly engage in high HIV risk behaviours. In their review of work in the area, Evans et al. (2016) found limited research on HIV and diverse sexualities, particularly WSW, lesbian, bisexual female-identified populations, and sexually diverse youth. In a study by Dunkle et

al. (2013) in KwaZulu-Natal and the Eastern Cape, 5.4% of the male respondents reported a lifetime history of consensual sexual activity with another man.

More recently though, research has explored the complexity, diversity, and fluidity in the expressions of sexuality (and gender) amongst MSM (e.g., Mantell et al., 2016). Sandfort et al. (2012) illustrate how same-sex expressions amongst a black South African MSM sample in Tshwane, Gauteng, differ in several overlapping areas including self-labelling, gender identification, sexual interest around partner type and sexual role, exclusiveness of same-sex attraction and a sense of control and protection in sexual interaction. The term MSM remains primarily in use in academic circles, particularly in HIV research, although Brouard (2009) comments on the emergence of the MSM identity label as in "I am an MSM'' because of the use of the term in HIV care service provision and points out the complex and fluid interrelationship between identity and practice. In a move to be more sensitive to identity issues, the South African National AIDS Council (SANAC) launched the country's national lesbian, gay, bisexual, trans, and / or intersex (LGBTI+) HIV plan at the 8th South African AIDS conference in Durban in June 2017 (South African National AIDS Council [SANAC], 2017). After the launch, Steve Letsike, chairperson of the SANAC Civil Society Forum, said that:

> It is important to realise we have fought and argued to be called LGBTI instead of MSM (men who have sex with men) or women who have sex with women (WSW) because we didn't want to be looked at only as behaviours. A lot of that speaks to behaviour. When we forget identities, we put ourselves at risk. (Igual, 2017)

Sexual orientation and identity development

In this section, three streams of thinking around sexual orientation are highlighted, namely essentialist, social constructionist, and queer theory. This is followed by discussion of research streams exploring patterns of sexual orientation development and sexual identity and concluding with reference to the challenge of integrating these different streams of thinking into training and therapy. According to essentialist theories, sexual orientation is either biologically determined or acquired early in life and is fixed and unchanged. This area of research has focused on the etiological or biological mechanisms that contribute to the development of sexual orientation, which has included evolution, genetic, epigenetic, neuroanatomic, endocrine / hormonal, and fraternal birth-order effect differences based on sexual orientation. These studies tend to conceptualise sexual orientation as a stable trait rather than a dynamic and socially bound construct (Academy of Science of South Africa [ASSAf], 2015; Mustanski et al, 2014; Rosario & Schrimshaw, 2014). A further area of research highlights developmental precursors of sexual orientation to explore the relative influence of social and biological factors in the development of sexual orientation, including childhood gender nonconformity, pubertal timing, and sexual abuse (Mustanski et al, 2014).

There has been an increase in work around fluidity and variability of sexual orientation, including research on bisexual, pansexual and queer (Bi+[9]) people (Feinstein et al., 2023). Research has indicated that nonexclusive attraction to one sex can manifest as attraction to both sexes at the same time, and different sexes at different times. Longitudinal studies of developmental trajectories have more extensively documented the fluidity or change over time of sexual orientation particularly amongst women and those who identify as

[9] BI+ is an inclusive term used for individuals who identify as bisexual who experience any form of attraction to more than one gender identity.

bisexual (Mustanski et al., 2014). Sexual orientation can exhibit very differently for men and women at population level (Diamond, 2014). It has been postulated that male sexual orientation tends to be more stable over time; directed by sexual arousal to one gender or the other. Sexual behaviour stems from these sexual attractions, leading to self-identification. Women's sexual orientation has been described as fluid across the life course, and the different components of sexual orientation does not function in a similar linear fashion as might be the case for men (Mustanski et al., 2014). Some caution has been raised about highlighting gender differences at the expense of noting similarities in men and women but should be read against the background that women's unique experiences have historically been invisible in research, and that the focus challenges models of sexual orientation to be more nuanced in understanding female and male sexuality, including taking account of differential social, and cultural influences (Diamond, 2014).

In the mid-1980s, social constructionists began challenging essentialist conceptualisations of sexuality, arguing that "lesbian", "gay", "bisexual", and "heterosexual" are products or labels of specific 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 sexually diverse people to a fight against intolerance of differences based on any sexuality (Leatt & Hendricks, 2005).

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, 1976/1978). 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. They 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 hetero-cis-normativity 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 hetero-cis-normativity in society, regardless of their sexual orientation (Steyn & Van Zyl, 2009).

The development of sexual orientation for heterosexuals is supported by social norms, whereas same-gender attraction and same-sex sexuality can trigger a more intense psychological process of identity development. Research in this area has included:

- stage theories and models, with stages including identity confusion, comparison, tolerance, acceptance, pride, and synthesis (e.g., Cass, 1984; Isaacs & McKendrick, 1992),

- developmental goals, including sexual debut, relationship formation, and community affiliation. These include experiences within a social context such as feeling different, experiencing same-gender attraction, questioning assumed heterosexuality, onset of sexual behaviour, disclosure, romantic relationships, self-acceptance, and synthesis (e.g., Savin-Williams & Cohen, 2015),
- social processes over the lifetime including exiting a heterosexual identity, developing a personal, social, and familial sexually diverse identity, developing a sexually diverse intimacy status, and entering a sexually and gender-diverse community (e.g., Bilodeau & Renn, 2005),
- intersectional approaches to describe the experiences of different racial and ethnic sexually diverse people to understand social inequality and how different intersectionalities mutually construct each other, including impact of minority stress (e.g., Cyrus, 2017; McConnell et al., 2018).

The previous focus on either biological or sociocultural influences have developed into calls for more integrative approaches, such as Hammack's (as cited in Mustanski et al., 2014) integrative paradigm of life-course development of human sexual orientation. Mustanski et al. (2014) express that a theory of sexual orientation in cultural context needs to take account of divergent development trajectories, how people's experiences are shaped by the characteristics of temporally dynamic settings e.g., the structure and functions of home and school, within larger sociocultural systems, and how social identities may be understood in relation to institutional practices and policies, unequal control, and access to resources in diverse populations. Tolman and Diamond (2014) on the other hand, following a period of advocating for such integration, developed the stance that integration might not be the way forward and argued for the "value and significance of theoretical diversity, even theoretical

promiscuity, in the service of broadening, challenging, questioning, and ultimately enhancing what is known about sexuality and how it is known" (Tolman & Diamond, 2014, p. 3).

Fassinger (2017) provides an interesting discussion of the challenges faced by a therapist wanting to be affirming in the context of sexually diverse identity, integrating some of the ideas in this section into the therapeutic space. They highlight the challenge posed by not just being affirmative of the ways in which a client defines or considers themselves by being specifically queer or LGBTIQA+ affirmative, i.e., therapy organised around the idea of affirming specific identities as defined by the acronyms or terms preceding the term affirmative. These terms imply a support for and delineation of identities that the therapist and client are trying to be flexible about in honouring the client's unfolding narrative of self. In delineating the specific area of affirmative work this also indicates the importance of sexuality, sexual orientation (and gender identity and expression) in the make-up of an individual, and the expectation that the therapy interaction will include exploration of these elements. The dual inquiries that arise from this are, on the one hand, the development of sexual orientation, specifically sexually diverse people while, on the other hand, the lived experience of sexually diverse people, construction, and definition of same or multiple gender sexuality from own perspective versus other perspective. Ultimately, this prompts reflections on the implications for training and practice of competent practitioners.

Sexual orientation, race, and being queer in South Africa

Epprecht (2005) stated that, "The histories of African LGBTI people reveal different and often humane ways that African societies have understood or even honoured people who did not fit heterosexual ideals". Discourses on sexual diversity issues often reveal more about those enquiring than those experiencing sexuality (Reid & Walker, 2005). Leatt and

Hendricks (2005) identify two competing discourses on sexual orientation in South Africa which could be associated with the competing trends of globalisation versus localisation. In the globalisation paradigm human rights are viewed as inalienable to humanity. LGBTIQA+ issues form part of the broader activism of the anti-discrimination struggle for human rights. The localisation narrative views homosexuality as non-African (i.e., Western or European), and white people continuing to corrupt black people as part of a continued intellectual colonisation of Africa by the West. LGBTIQA+ culture is viewed as a "potent North American cultural export to much of the world" (Leatt & Hendricks, 2005, p. 310). This view is positioned as the drive for virility by post-colonial African states trying to find a place in a global world. The response is often a discourse highlighting pre-colonial evidence of homosexual practices.

Nkunzi Zandile Nkabinde's book "Black Bull, Ancestors and Me: My life as a lesbian sangoma" takes a more positive view (Nkabinde, 2009). Through their story, Nkabinde is contributing to Africans' struggle to assert their unique cosmological framework in opposition to the oppression of both colonialism and conservative traditionalism. Nkabinde (2009) presents a picture of African cosmology as flexible, embracing interconnectedness and having the potential where innovation and creativity can become an expression of liberation, rather than African epistemology as a noble cause that was bound to destruction by a modern Western world.

In trying to provide a more culturally appropriate response to World Professional Association for Transgender Health (WPATH)'s Standards of Care, Gender Dynamix (2011) outlines an indigenous healing perspective on transgender, and more broadly LGBTIQA+ people. An ancestor[10] could call a person to become a voice irrespective of gender. A male

[10] In African tradition, ancestors are spirit beings that lived on earth and in death, are now able to provide spiritual guidance and wisdom to chosen individuals.

ancestor might choose a female person (and vice versa). This person could then express gender non-conforming behaviour. Through appropriate rituals and initiation, the family and society can accept such a person. Rather than being viewed as disordered, the person has an "alternative gender experience". Constructions of the ideas of relationships between gender, sexuality and sex are situated in a particular context with histories. Swarr (2009), for instance, looks at the intersection between gender and sexuality in the isiZulu word "stabane". The idea of "stabane" refers to an intersexual person, someone with both male and female sex organs, but in contemporary urban societies such as Johannesburg / Soweto (in Gauteng, South Africa) it is used for individuals who self-identify as lesbian or gay; indicating the co-created understanding that people engaging in same-sex encounters may be intersexed.

Colonialism and apartheid shaped 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. There is a need, or even requirement, to locate current understandings of sexuality within the context of historical and cultural processes (Reid & Walker, 2005). Poverty, violence, unemployment, and familial reliance are placing many local sexual and gender minorities in difficult positions including significant, potentially dangerous, tensions over sex and sexuality. This becomes more pronounced in situations where masculinity / maleness is in crisis and is visible in the reported increase in homophobic and gender-based hate crimes in South Africa (Swarr, 2009). Complicating this picture in South Africa is the history of racial politics that dealt with black and white homosexuality as different – a practice that is visible (arguably, even today) as there appears to be different LGBTIQA+ communities divided on racial lines (Leatt & Hendricks, 2005). Given the history and socio-economic trends in South Africa, Leatt and Hendricks (2005) postulate an

"increasingly visible gay presence that is politically mobilised since identity politics" (Leatt & Hendricks, 2005, p. 315), and that it is important to work towards a society where individual dignity was respected and a strong equalised society exists where people can experience and express their desires without the threat of violence or exclusion.

More recently, Lynch et al. (2021) analysed existing South African research on local terminologies describing male sexually diverse people. They highlight the lack of research on female sexual diversity in the country, beyond a focus on violence against lesbian and bisexual women, as well as the skew to public health studies with key populations, such as MSM. Their analysis mainly draws from work in urban township settings, and to a lesser extent rural and peri-urban settings. They identify two themes from their analysis namely heterogendered subjectivities and a procreative imperative. Heterogendered subjectivities refers to the term gay being used interchangeably with the term lady (as opposed to gents), denoting the receptive partner in same-sex practicing men, and indicating how this reflects gendered binaries rather than foregrounding sexual non-conformity. Similarly, the term "moffie", an Afrikaans based word, is often used to refer to effeminate and cross-dressing men, and interchangeable with the term gay. The term can be used as both derogatory as well as celebratory. This binaried mapping of sexualities is hypothesised to contribute to a level of acceptance of sexually diverse people in discriminatory spaces. The procreative imperative theme reflects on cultural norms around the importance of bearing children, and how same-sex practices become more tolerable in contexts where individuals have their own children. They conclude that while South African communities might be more accepting of sexual diversity within the context of gendered expression, adhering to more traditional male-female norms, and highlight a need to challenge the heterogendered norms as mutual forces of oppressions for multiple, intersecting identities (Lynch et al., 2021). Having outlined the area

of study, the next section moves to understanding the context for sexually diverse people in South Africa, with reference to mental health and need for mental health services.

Legal framework and public attitudes to sexual diversity

During the apartheid years in South Africa, the system of segregation based on race included regulating sexuality. Sexual puritanism became one of the characteristics of segregation. These control efforts are reflected in The Prohibition of Mixed Marriage Act no.55 of 1949 and The Sexual Offence Act no.23 of 1957 which prohibited both interracial and "homosexual" relationships. The Apartheid regime utilised the military, clergy, and the medical establishment to define, diagnose, quarantine, and treat sexual deviants. This was the case across all population groups, with the eradication of homosexuality seen as necessary to maintain racial superiority, which places the concerns of sexually diverse people within a historical perspective of complex, multi-layered and systemic exclusion (Nyeck & Shepherd, 2019). The 1980s saw the emergence of sexually diverse individuals and groups that capitalised on the increasing criticism of the regime to communicate an inclusive social justice platform both locally and abroad – and thus present the sexually diverse political struggle for recognition and equality as part of the broader struggle against oppression – with activists including Tseko Simon Nkoli and Beverly Palesa Ditsi (Gevisser & Cameron, 1994).

The South African Constitution is the primary foundation that has allowed significant recognition and legal protection of sexually diverse people, primarily Chapter 2, The Bill of Rights. Central to the Bill of Rights is the Equality Clause in Section 9(3), which mandates that nobody may be discriminated against based on, among other grounds, their sex, gender, or sexual orientation. Further rights include guarantees that everyone has inherent dignity and has their dignity respected and protected (Section 10), the right to life (Section 11), freedom

and security of the person including “not to be treated or punished in a cruel, inhuman or degrading way” (Section 12), as well as access to healthcare (Section 27) (Beresford et al., 2007; Müller & Daskilewicz, 2019; Republic of South Africa, 2006). The Constitution marked the beginning of remarkable political, legal, and policy developments (Nel, 2007; Moreno et al., 2020). The legal work has included amongst others, (a) protection from discrimination, (b) right to privacy and decriminalisation of same-sex acts, (c) same sex marriage, (d) adoption, (e) access to employment and, (f) access to healthcare (e.g., Medical Schemes Act 131 of 1998 specifying non-discrimination by medical schemes based on sexual orientation) (Moreno et al., 2020; Nyeck & Shepherd, 2019). Unfortunately, the excellent legal and policy frameworks often do not translate into everyday living. 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 place sexually diverse people in increased difficult and potentially dangerous positions, which can also threaten the very human rights sexually diverse 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 sexually diverse people (Horne et al., 2019; Nel, 2007). In their analysis, Judge (2021) concludes that the past 25 years of constitutional democracy has moved South Africa in the direction of relating to each other as equals, and that the paradoxes in our context, including legal discourse relative to lived experiences, should not stop this continued advancement.

Public attitudes

In addition, these rights do not necessarily directly translate into public acceptance, although we are seeing a positive move in attitudes towards sexually diverse people, identities, and lifestyles. The Williams' Institutes' LGBTI Global Acceptance Index – an aggregate indicator of public opinion towards LGBTIQA+ people - ranked South Africa 33rd out of 141 countries for 2014-2017, an improvement from 45th in 2000-2003 (Flores, 2019). In 2013, a Pew Research Centre study conducted between 2 March and 1 May, 2013 (n=37 653, face-to-face interviews, metropolitan areas) indicated that 61% of South African respondents believed society should not accept homosexuality, and 62% personally believed that homosexuality is morally unacceptable. The Other Foundation report on a nationally representative sample of the South African adult population conducted at the end of 2015, indicated a more complex picture (Sutherland et al., 2016). People reflected conservative moral and religious beliefs about same-sex sexual activity, with 72% agreeing that same-sex sexual activity is morally wrong, and the same percentage that sex between men is "just plain" wrong. These beliefs were in contrast with 55% saying they would accept a gay family member, 52% agreeing gay and lesbian people should be included in their culture, and 51% saying that gay and lesbian people in South Africa should have the same human rights as others. This explains the title of the report – typifying South Africans as progressive prudes.

Living in South Africa

It can, by and large, be expected that most sexually diverse people manage well enough but that for a proportion of the population, the stress of being a sexual minority and having to face stigma and discrimination regularly, would lead to mental health concerns. Some of the negative aspects of identifying with a sexually diverse identity includes:

- discrimination, violence and alienation from family, friends, and communities – lack of support including impact on ability to feed and house self,
- viewed as uncaring of cultural practices and beliefs,
- messages disaffirming of self, impacting on self-worth and esteem.

On the other hand, research has identified significant positive aspects of expressive sexual orientation identity, including:

- greater resilience and agency – required to cope effectively within current heterosexist system,
- acceptance within tribe / community – being part of a community,
- families of choice – constructing strong relational connections with community members that are not related by blood,
- being a positive role model to the greater community,
- being authentic and honest with self and others (personal growth),
- increased participating in projects around social justice and activism,
- exploring multiple expressions of sexuality and relationship,
- development of insight, sense of self, increased empathy, and compassion (Paul, 2017; Rostosky & Riggle, 2017*)*.

Academic research focussing on various groups of sexually (and gender) diverse populations in South Africa and neighbouring countries is on the rise. Research to date has included, amongst others, the following:

- exploring the intersections of race, same-sex sexuality and schooling amongst same-sex attracted school-attending youth (Francis, 2017),
- coming out and parental reactions amongst 19- to 32-year-old LGBTPQ youth (Mayeza, 2021),

- 17–19-year-old LGB youth's experience of relationships, intimacy, and desire (Francis & Reygan, 2016),
- black queer identified students negotiating identity at the University of Cape Town, with queer including bisexual, pansexual, panromantic and queer identified sexual orientations (Boonzaier & Mkhize, 2018),
- black MSM in Tshwane's experience of sexuality disclosure and family responses (Gyamerah et al., 2019),
- narratives of sexual practices in gay adult relationships in the Cape Metropole (Henderson, 2018),
- power relationships in sexual agreements among male couples in South Africa and Namibia (Essack et al., 2020),
- understanding of sexuality / gender and experiences of homophobia amongst 22– to 30-year-old LG people in Durban (Reygan, & Lynette, 2014),
- the meanings of same-sex sexuality and Africanness (study conducted in two urban townships in South Africa) (Sigamoney & Epprecht, 2013),
- same-sex desire, agency and social oppression among black male schoolteachers who engage in same-sex relations (Msibi, 2013),
- the experience of school involvement by parents with same-sex sexuality children (Nichols, 2021),
- peer and family reaction to sexual diversity in a community in Lesotho (Hlalele & Matsumunyane, 2021),
- internalised homophobia among South African MSM, with greater levels of homophobia associated with lower levels of education, higher levels of HIV

misinformation, HIV-related conspiracy beliefs and bisexual (vs. homosexual) identity (Vu et al., 2012).

Mental health and well-being of sexually diverse people

Global (particularly North America)

International research has indicated that sexually diverse people, across the life span, experience higher levels of serious psychosocial and mental health disparities compared to heterosexual people. These include increased risk for suicidality, discrimination, violence and hate crimes, school bullying, mood and anxiety disorders, and substance abuse (e.g., Institute of Medicine [IOM], 2011; Plöderl & Tremblay, 2015). The AIDS epidemic during 1980s and 1990s in the USA brought significantly more empirical work around the health of sexually diverse people, predominantly gay, bisexual, and other sexually diverse men at greater risk for HIV contraction in that country. Research indicated that the stressful effects of discrimination and stigma resulted in higher levels of mental health concerns including depression and anxiety disorders. It was found that this higher incidence occurred not just amongst HIV+ people but also more broadly to sexually diverse people. During this time the USA also saw the first randomised control trials evaluating psychosocial interventions for sexually diverse people, focusing on HIV related risk reduction and stress management amongst gay and bisexual men (Pachankis, 2018). One of the criticisms of these research efforts has been the reliance on non-representative samples, primarily with white, educated respondents. Research from the late 1990s in the USA started overcoming these limitations with population-based sampling. In addition, a significant enough body of research has been conducted to allow for meta-analytic studies. These studies confirmed the higher prevalence of several mental health concerns amongst sexual and gender minority individuals relative to

their heterosexual counterparts, and a higher burden of disease posed by mental health conditions (e.g., Blondeel et al., 2016; Cochran et al., 2017; Gonzales & Henning-Smith, 2017).

In a meta-analysis of research on mental health among sexually diverse people published between 1966 and 2005, King and colleagues (2007) examined the prevalence of several mental health outcomes. They found that sexually diverse individuals had a 1.5 times higher risk for depression and anxiety disorders over a period of 12 months or a lifetime, than heterosexual individuals. Further findings revealed that the risk for suicide attempts over a lifetime among lesbian, gay, and bisexual individuals was more than twice as great as that among heterosexual individuals (King et al., 2007). In an integrated literature review of mental health challenges of LGBT people, Moagi et al. (2021) reviewed 21 articles published between 2010 and 2019. The articles were written by authors from the USA (12), Canada (2), Mexico (2), Ireland (1), Italy (1), Thailand (1) and Indonesia (1). In summary, the review indicated:

- higher levels of adverse childhood experiences and mental distress, including depression, suicidal ideation and attempts, substance abuse, post-traumatic stress disorder (PTSD), and anxiety compared to their heterosexual counterparts – particularly amongst lesbian and bisexual women,
- levels of minority stressors, including structural stigma, predicted mental health outcomes,
- stigmatisation, discrimination, victimisation, and social exclusion / isolation lead to lower help seeking behaviour and poorer health outcomes,
- sexually diverse people had more barriers to healthcare access, and higher levels of untreated mental health issues (Moagi et al., 2021).

International work has indicated high rates of co-morbidities between substance abuse and mental health diagnoses, indicating the need for integration of specific substance use treatment with mental and physical healthcare for sexually diverse people. Continuity of care is further recommended, highlighting the importance of co-ordinated care across different providers (in- and out-patient). Furthermore, victims of societal marginalisation experience disproportionate adversity and stress. According to a University of Michigan study, more than half of gay, lesbian, and bisexual individuals who abuse alcohol or tobacco also have a co-occurring psychiatric disorder, whereas only one-third of heterosexual individuals have the same correlation. Having a history of increased early-life trauma and trauma throughout their lives, sexually diverse people may experience the painful and unwarranted consequences of bias and denigration. These findings underscore the strong negative societal impacts experienced by minority groups and should sensitise providers to the additional needs of these individuals (Evans-Polce et al., 2020).

Mental health concerns of sexually diverse people in South Africa

Exposure to violence and anti-sexually diverse hate crimes in South Africa

Violence directed towards sexually diverse people is best understood within the broader context of gender-based violence. The pervasive nature of violence against women in South Africa has been widely documented (see Statistics South Africa [StatSA], 2000). And there is increasing attention being given to develop a better understanding of the nature and extent of violence against men as well. South Africa's rate of rape, as a particular form of gender-based violence, has been found to be one of the highest in the world. Most compelling explanations of gender-based violence point to gender inequality and the prevalence of strong patriarchal norms and values. Patriarchy can be understood as any social system which has a

gender-based hierarchy, in which most power is assigned to men. It is rooted in a deeply binary notion of gender, in which men are seen as very different from, and more highly valued than women. It is maintained by strongly defined and enforced gender roles.

In their work around levels of violence, Mitchell and Nel (2017) found that over half of respondents expressed fear they might experience discrimination due to sexual orientation. Gender non-confirming respondents were more likely than gender conforming individuals to feel unsafe most days. Victimisation due to sexual orientation appear to be particularly high amongst 16– to 24-year-olds relative to other age groups, but also in comparison to their peer group (Nyeck & Shepherd, 2019). Nyeck and Shepherd (2019) found that the experience of discrimination drove consistently low academic performance, and prevalence of discrimination was more prevalent in poorer school settings. In a study done by The Other Foundation (Sutherland et al., 2016), 38% said that they are members of a group that is discriminated against. This mostly related to race (21%), gender (10%), and sexual orientation (8%) (Sutherland et al., 2016). The Müller & Daskilewicz (2019) study, and a subsequent article discussing the experience of violence specifically (Müller et al., 2021), confirms that LGBTIQA+ people are vulnerable to violence, particularly sexual violence due to their real or perceived sexual orientation or gender identity, with gender minorities and black respondents experiencing higher levels of violence in the past year. Nel and Judge (2008) found that verbal, physical and sexual violence were experienced more by black lesbian and gay people than white lesbian and gay people. Previous work by Cook et al. (2013) indicated that visible gender non-conformity heightened the risk of violence, although not necessarily higher levels of depression (see discussion of impact of violence on mental health in previous section). In the Müller & Daskilewicz (2019) study, 73% of respondents indicated that they had experienced verbal harassment, 55% had experienced physical violence, and 48% had experienced sexual violence in their lifetime.

Müller & Daskilewicz (2019) further identified that lesbians were at higher risk of violence, and that the risk of sexual violence was influenced by race, and gender expression with black butch lesbians being at particular risk (Müller & Daskilewicz, 2019). On the other hand, there is also evidence that sexual minority women (SMW) with more feminine gender expression experienced a higher incidence of forced sex (Sandfort et al., 2013). Survivors of sexual violence have been shown to have a significantly higher risk of health consequences, including mental health concerns such as depression and PTSD, and increased suicidality (Krug et al 2002; Müller & Daskilewicz, 2019). Müller et al. (2021) also highlighted that both the healthcare and the criminal justice systems in South Africa were not equipped to provide competent and affirming care to sexually and gender-diverse survivors of sexual violence, and that there was a significant need for sexually and gender-diverse affirming counselling and psychosocial support, as well as medical legal aid for survivors of sexual violence.

Need for services

As the percentages given earlier reflect, the incidence of people self-identifying with sexually diverse orientations, as well as the apparently higher prevalence of risk of mental health concerns due to minority stress, it can reasonably be expected that many, if not most, psychology professionals will deal with sexually diverse people, whether they realise it or not. Graham et al. (2012; as cited in Paul, 2017) report that most mental health professionals are aware that they have worked with sexually diverse people. In the USA, sexually diverse people utilise mental health services disproportionately higher than other groups (Leitch et al., 2021).

Sexually diverse people can access counselling and psychotherapy services for similar or unique reasons compared to their heterosexual counterparts. In the USA, Hancock (1995) identified six specific areas that sexually diverse people would access services for, including coming out, prejudice and discrimination, relationships, youth concerns, parenting issues, and family of origin dynamics. In the Netherlands, Schippers (1997) identified coming out, intimacy issues, relational issues, sexuality and erotica, HIV/AIDS, victimisation, and violence as key reasons for sexually diverse people accessing services. These aspects can also indicate internalised issues, such as shame, guilt, and lower self-esteem (Brown et al., 2020; Greene & Britton, 2013, as cited in Paul, 2017).

Sexually diverse people could also seek sexual orientation change. This becomes an ethical issue for therapists when clients, with severe conflicts around their sexual orientation, may seek change in those orientations because of their struggles. Sexual orientation change efforts (SOCE) have been scientifically thoroughly discredited and is ethically dubious if not unlawful (Substance Abuse and Mental Health Service Administration [SAMHSA[11]], 2015). Conversion or 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 a reality in our society (ASSAf, 2015; Nel, 2007; PsySSA, 2017; SAMHSA, 2015; South African Society of Psychiatrists [SASOP], 2015). Attempts at sexual orientation change has been shown to likely be unsuccessful and potentially harmful. It can result in further shame and internalised homophobia, and potential self-harm / suicide (APA, 2009; Beckstead & Israel, 2007; Israel et al. 2008; SAMHSA, 2015). This type of therapy is often terminated after a single session (Dobinson et al., 2005, as cited in Leitch et al., 2021).

[11] SAMHSA is an agency within the USA Department of Health and Human Services

The Minority Stress Model

We have discussed that sexually diverse people experience higher levels of stigma, prejudice, discrimination, and violence than their heterosexual counterparts. This impacts on their ability to deal with stress and trauma, as well as potential health and wellness outcomes, such as likelihood to abuse substances or commit suicide. Three concepts are useful in understanding this, namely minority stress, resilience, and intersectionality. In a review by Ng et al. (2019), minority stress describes the chronic stress resulting from experiences or perceptions of unfair treatment or abusive behaviour based on belonging to a stigmatised minority group. There are two conceptual pathways through which discrimination may affect health: through activation of an emotional and physiological stress response, and by impacting health behaviour. Discrimination operates as a stressor in the first route, negatively affecting physiological (such as elevated blood pressure) and emotional (such as rage) responses. When discrimination is activated repeatedly over time, it puts strain on biological systems and raises the risk of negative physical and mental health outcomes. Discrimination affects health behaviour in the second pathway either directly as stress coping, or indirectly, through self-regulation. For instance, discrimination may cause individuals to engage in unhealthy behaviour (such as using drugs or alcohol as coping techniques) or refrain from engaging in beneficial behaviour (such as illness screening or management), all of which have definite effects on health outcomes (Ng et al., 2019).

Meyer's (1995, 2003b) minority stress model assists in understanding the increased risk associated with stigma and discrimination on the mental health outcomes of sexually diverse people. The model proposes that the stress experienced by being marginalised in society (beyond general stress experienced by most people), can reach debilitating levels for some. The discrimination, prejudice, stigma, and other relational and internal difficulties can

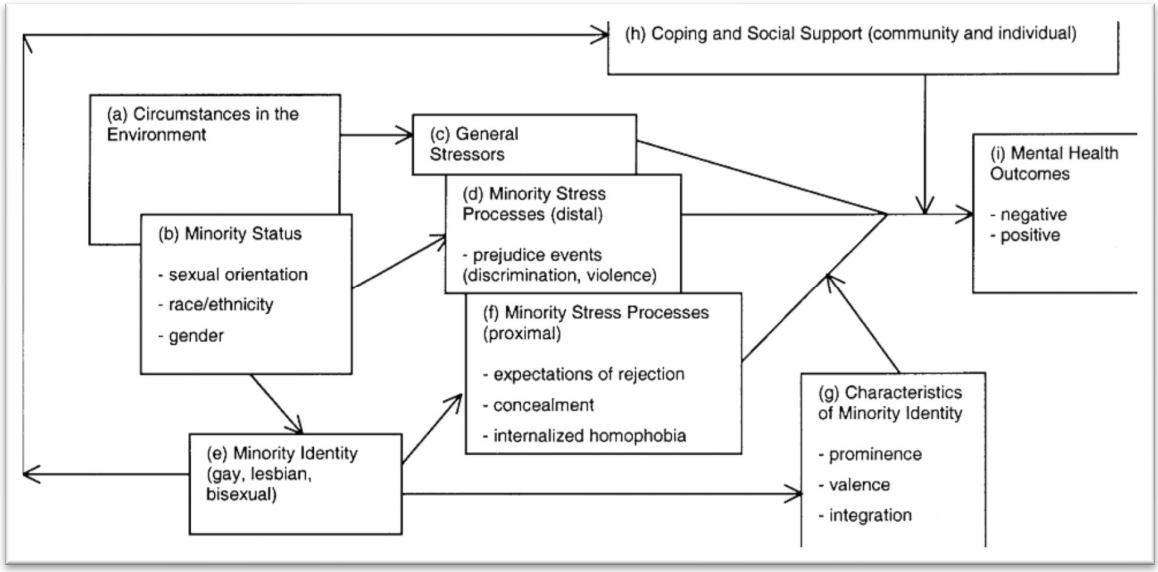
increase the risk for mental health concerns. Minority stress has been correlated with depression, anxiety, and substance use disorders. For Meyer (2003b), minority stress is more than the actual experience of stressful events, it also includes the broader impact of oppression, the meaning we make of our lived situation and the impact this has on relationships with self and others. They explain minority stress processes on a continuum from distal stressors, such as actual prejudicial events, to proximal personal processes based on individual perceptions and appraisals. Minority stress is associated with four contributing processes namely:

- actual prejudice events – whether acute events or chronic, social circumstances such as discrimination at healthcare facilities, or continual familiar disaffirming statements,
- perceived stigma or expectations of rejection and discrimination, and defences against the perception,
- internalised homophobia, and
- concealment of same-sex sexual identity (Meyer, 2003b).

These processes can compound general life stress, emerging during adolescence with potential effects across the life span (Pachankis, 2007, Pachankis & Hatzenbuehler, 2013, Pachankis et al., 2015b).

Figure 2. 1

Minority Stress Model (Meyer, 2003b)



In Figure 2.1, the Minority Stress Model is outlined as follows: minority stress happens within general environmental situations (a), which includes minority status (b). Intersectional factors such as race, socio-economic class, culture, and gender impact on levels of minority stress (Bidell & Whitman, 2013). Due to environmental circumstances a person is exposed to general stressors (c), such as the death of someone close, as well as stressors specific to sexually diverse people, such as being excluded from a funeral due to their sexual orientation (d). Continued exposure to these interdependent stressors is likely to increase in proximal stress processes, such as expectation of rejection. Minority status (b) often leads to identifying with that minority, which can increase stressors, particularly an individual's own perception of feeling "less than". Minority identity can increase or decrease the impact of stressors (g), for instance, depending on how integrated a person's positive sense of self is relative to outside discrimination. In addition, identity can also be a source of strength and

resilience (h) when associated with increased affiliation, social support and activating coping mechanisms (internal and external) (Meyer, 2003b).

Hatzenbuehler (2009) expanded the model by exploring the impact of institutional stigma, finding that sexually diverse youth from areas with high anti-sexually diverse prejudice were more likely to attempt suicide. Further work (Hatzenbuehler, 2014; Hatzenbuehler, 2017) on structural stigma (social prejudice against sexually diverse people at community level – including legal and policy frameworks), found that those who died from suicide in high stigma areas were on average 18 years younger than those who died from suicide in low stigma areas.

According to Ng et al. (2019) and Wilks et al. (2022), resilience is a generic term for effective coping with adversity, including dangers and trauma (such as unfavourable childhood events). A process of adjustment, overcoming adversity, or the absence of, or reduced occurrence of mental health problems because of adversity are examples of common traits. The focus is on how people use resources to bargain, "bounce back," or adjust to difficulty. The association between the "antecedent" event - exposed to adversity, and eventual health - is moderated, and this results in the probable pathway between resilience and health outcomes. Protective factors that promote resilience include family ties, social support, religious commitment, and a variety of friendships. Vulnerability factors include poverty, interpersonal violence, dysfunctional households, increased vigilance to threats, and parental mental illness. Resilience can be facilitated or hampered by one's sexually diverse identity. Sexually diverse people employ a variety of personal coping techniques, resilience, and hardiness to resist stressful situations, much like other people who manage general stress. However, group-level social structural variables can also be beneficial for mental health in addition to such individual coping. Through membership in a minority group, stigmatised individuals can encounter social contexts where they are not stigmatized by others and

receive support for their criticism of the stigmatized minority group, respectively (Ng et al., 2019; Wilks et al., 2022).

In contrast to many previous theoretical frames, the minority stress model has been rigorously tested and adapted, providing an empirically based foundation for more recent evidence-based affirmative practice (Pachankis, 2018). Hatzenbuehler's (2009) psychological mediation framework, and subsequent research has focused on identifying probable mechanisms underlying the association between stigma-related stress exposure and stress-sensitive mental health outcomes (Hatzenbuehler, 2009; Pachankis, 2018). Some of these processes are general or universal risk factors for psychopathology but appear elevated among sexually diverse individuals. These include emotion regulation deficits, rumination, social isolation and depressogenic cognitive biases such as hopelessness and negative self-schemas (Hatzenbuehler, 2009), which represent modifiable targets of existing evidence-based treatments such as emotion-focused and cognitive behavioural therapies. Other processes are more specific risk factors for sexually diverse people (see Pachankis, 2015). These include the psychosocial experience of sexual orientation concealment (Bränström & Pachankis, 2018), anxious expectations of rejection (rejection hypervigilance) and internalised stigma (Pachankis et al., 2015a). These factors would require adaptation of existing or new practice tools to be addressed adequately, such as the ESTEEM[12] protocol (Pachankis et al., 2015b).

Concluding comment

Following the outline around sexual orientation and sexual diversity, this section has discussed the environmental context experienced by sexually diverse people and mental

[12] Effective Skills to Empower Effective Men

health concerns of sexually diverse people, and thus the need for specialised, affirming mental health services. The discussion included reference to the minority stress model, and psychological mediation framework to support understanding of the mental health challenges faced by sexually diverse people. The next section will focus on current healthcare practices in South Africa, with a focus on mental health and psychology specifically, pointing to the particular challenges faced by sexually diverse people when wanting to access services as well as health professionals, including clinical and counselling psychologists wanting to deliver appropriate affirming care to sexually diverse people.

Current healthcare practices in South Africa, with specific reference to psychological services

General healthcare provision for sexually diverse people

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 (referred to as National Health Insurance[13]) which the government plans to develop and implement. In addition, the field of sexology in South Africa is developing, and sex psychotherapy is available to a minority in private healthcare facilities in urban centres (see for instance Southern African Sexual Health Association [SASHA] on https://www.sasha.org.za).

The under-resourced and overburdened public health system is used by most of the population. Access to healthcare is impeded based on race, class, and rural location. In contrast, 17% of the population have access to private healthcare through private medical aid,

[13] National_Health_Insurance_Bill/B11B_2019

with 72% of white South Africans having medical aid compared to 11% of black South Africans (Mayosi & Benatar, 2014; StatsSA, 2017). StatsSA's data for 2017 showed that a quarter (24.7%) of individuals in metros were members of medical aid schemes, exceeding the national average of 16.9%. The data also showed that the highest membership was noted in the City of Cape Town (29.2%) and the City of Tshwane (29.1%), while the lowest membership was measured in Buffalo City (19.4%) and eThekwini (19,6%). The data also shows that public clinics are still the first point of contact for most South Africans, with the bulk of the population (63.7%) making use of them, compared to the 24.6% of the population that head to a private doctor. However, the use of traditional healers (0.7% of the population) has seen a resurgence, having reached the highest point in the past 14 years. Just under 400,000 people are using traditional healers as their primary healthcare provider. The population estimate excluding "Unspecified" and "Don't know" answers were 56,129,000 (StatsSA, 2017). In the absence of other data, we assume a similar pattern amongst sexually and gender-diverse people.

The adoption by the government of the National Health Insurance Policy (Department of Health, 2017) has provided the initial impetus to explore how the private sector can play a larger role in the provision of health services, including mental healthcare services, to a broader population. This opens the possibility for private enterprise to play a role in developing affirmative services for specific minority populations that currently experience significant stigma and discrimination in both the public and private health system, and where healthcare workers are already under significant strain to deliver service to the majority and thus, have limited time and energy to spend on endeavouring to provide affirmative services to often invisible minorities. This not only includes providing care, but also in offering facilities that train and educate affirmative mental health staff, as well as implement data

collection and research programmes that will lead to the development of South-African evidence-based best practice in working with sexually and gender-diverse people.

Nyeck and Shepherd (2019) highlight some of the national health guidelines (and related White Paper on the proposed National Health Insurance) that mention sexually and gender-diverse people including:

- Standard Treatment Guidelines and Essential Medicines List for South Africa: Primary Health Care Level 2018. The guidelines present evidence-based standardised guidance for healthcare workers. In the guidelines, being LGBTIQA+ was identified as a key risk factor for self-harm / suicide, and mental illness being more common amongst people with diverse sexual orientations, and transgender people,
- National Adolescent and Youth Health Policy 2017, that provides guidance to organisations and departments working with the Department of Health around the health needs of young people and highlights that sexual and reproductive health services often do not meet the needs of LGBTIQA+ youth and adolescents,
- Socio-Economic Impact Assessment System (SEIAS) Final Impact Assessment (Phase 2): White Paper on National Health Insurance (NHI) noted that consultations with stakeholders in civil society does not adequately address the LGBTIQA+ community needs and issues.

South Africa has committed to achieving the United Nations Millennium Development Plan and its goals, which include sexual and reproductive health (StatsSA, 2017). 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).

The stated goal of the South African National LGBTI HIV Plan 2017-2022 has been to:

> Provide consolidated guidance to reverse the burden of disease from HIV, STIs and TB and to promote a rights- and evidence-based environment for LGBTI people in South Africa. This will be achieved through the implementation of five interlinked service packages: health, empowerment, psychosocial support, human rights, and evaluation. (SANAC, 2017, p. 3)

The objective of the psychosocial support package has been to "develop and implement effective mechanisms to deal with human rights abuses and violence from the public, police and healthcare providers; sensitisation of police and prosecuting authorities; and legal literacy and paralegal support" (SANAC, 2017, p. 147). The plan was to implement a variety of efforts including workshops, building referral networks, and a variety of online and face-to-face trainings. The plan suggested topics for counselling to include general HIV issues, self-worth and assertiveness, effective intimate relationships, effective coping strategies, substance use, depression as well as other mental health issues, and transitioning (for transgender people) (SANAC, 2017). Most of these areas are fraught with the possibility of simply reproducing heteronormativity in delivery of healthcare. Let the reader ponder for a moment what an "effective" intimate relationship would look like to make this point clear.

Despite the positive developments discussed, people engaging in consensual same-sex behaviour, such as MSM, face significant problems in accessing healthcare services in South Africa, particularly in the mainstream public sector health service (Desmond Tutu HIV Foundation, 2011; Müller & Daskilewicz, 2019). High levels of stigma and discrimination are experienced by mental health service users, both in public and private healthcare, relative to the general population. A qualitative study by Müller (2017), indicated that all the health service users and representatives of LGBT organisations interviewed reported experiencing

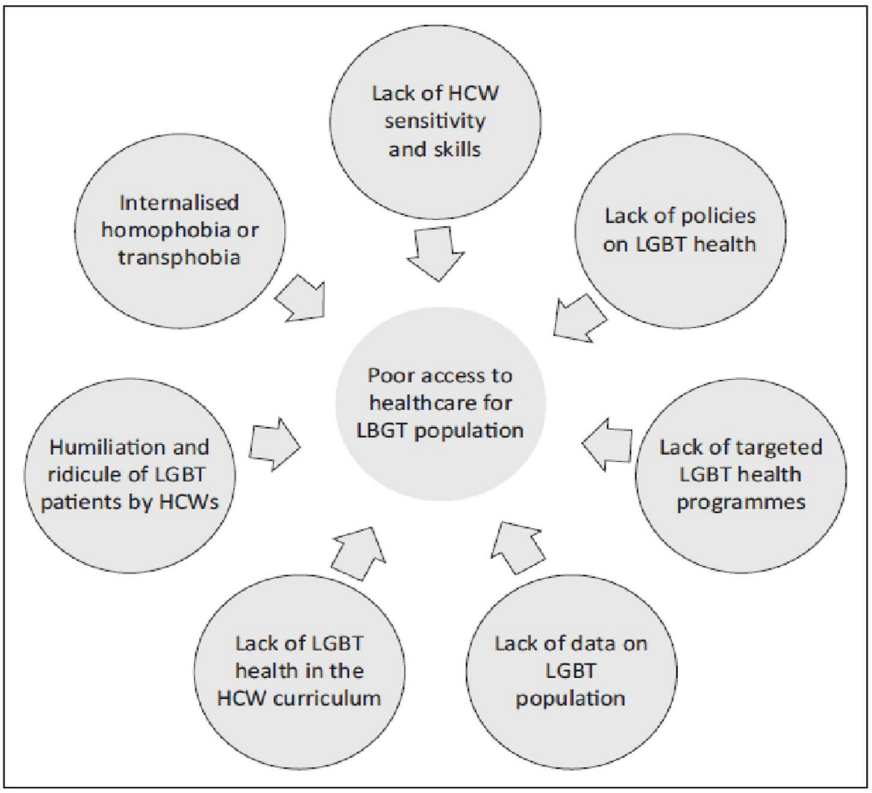
discrimination by healthcare providers based on their sexual orientation and / or gender identity, including: (a) a lack of public healthcare facilities and services, both for general and LGBT specific concerns, (b) refusal by healthcare providers to provide care for LGBT patients, (c) moral disapproval of LGBT identities and subjection to religious practices, (d) lack of knowledge about LGBT identities and health needs (Müller, 2017). These disaffirming encounters impact on the well-being of sexually and gender-diverse people, possibly increasing mental health issues and willingness to access mainstream mental healthcare or hiding health concerns relating to their sexual orientation or gender identity / expression (Brown et al., 2020). In their scoping review Luvuno et al. (2019) identified 17 articles relating to LGBT health in South Africa published between 1996 and 2016, which included three literature reviews (Mprah, 2016; Newman-Valentine & Duma, 2014; Rispel & Metcalf, 2009), three qualitative (Lane et al., 2008; Smith, 2015), four quantitative (Cloete et al., 2011; Müller, 2013, Sandfort et al., 2008; Stevens, 2012; Stoloff et al., 2013); two mixed method (McAdams-Mahmoud et al., 2014; Rispel et al., 2011) and five editorial / commentary articles (Bateman, 2011; Imrie et al., 2013; Müller, 2014; Müller, 2015; Wilson et al., 2014b). They identify three themes from the review:

- South African terminology used: seven articles use MSM, one article uses WSW, four articles use LGBT, four articles use trans and gender non-conforming (GNC), and one article uses the terms lesbian and bisexual women,
- South African healthcare workers (HCW) lack training on LGBT issues, leading to lack of sensitivity, homophobia, stigma / discrimination, and thus either non-disclosure or non-attendance to state facilities,
- lack of LGBT policies, and guidelines for care in South Africa, including lack of measurement, but increased inclusion in policy / strategy documents.

Figure 2.2 outlines the seven key factors they highlight that contributes to poor healthcare access by the LGBT community (Luvuno et al., 2019):

Figure 2. 2

Factors contributing to poor healthcare access by sexually and gender-diverse people (Luvuno et al., 2019)



Note: Healthcare Worker (HCW)

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, 2011; Cloete et al., 2008; Lalla-Edward, 2010).

The Müller and Daskilewicz (2019) results of the South African leg of their 9-country research study on violence, mental health, and access to healthcare amongst a convenience sample of 832 self-identified LGBTI people 18 years and older, indicated the following:

- friends were by far the group approached most for support and being "out" (75%),
- around accessing care for mental health issues:
    - counselling or psychosocial support (12% CBO / NGO[14], 7% public health facilities, and 14% private health care),
    - care for mental health conditions (5% CBO / NGO, 4% public, and 8% private),
- around discrimination in healthcare:
    - 64% had disclosed their SOGIE,
    - 54% of the sample reported being treated with less respect because of their SOGIE, with 73% of gender minority participants saying the same,
    - 19% had sometimes or often been called names, or insulted in a health facility because of their SOGIE (36% of gender minority participants),
    - 13% had sometimes or often been denied healthcare because of their SOGIE (28% of gender minority participants),
    - 44% have tried to hide health concerns related to SOGIE.

Nel et al. (2013) analysed data of a sample of people who identified as MSM. 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

[14] Community-based organisation (CBO)
Non-governmental organisation (NGO)

services in the healthcare environment. The study highlighted the need for the health service sector to be more LGBTIQA+ friendly.

This lack of sensitivity and commitment is also visible in the lack of training on concerns experienced by sexually diverse people in healthcare and related service provider training, such as in human rights awareness and diversity sensitisation. Many 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 sexually diverse issues has led to the provision by CBOs and NGOs of health and psychosocial services, such as OUT LGBT Well-being in Pretoria and the Triangle Project[15] in Cape Town, South Africa (Brouard & Pieterse, 2012; Letsike, 2009; Swartz & Erasmus, 2016). Müller (2017) confirms that LGBTIQA+-specific health services are generally not available in public sector facilities. Swartz and Erasmus (2016) did a case study of the organisation OUT LGBT Well-being and concluded that the organisation was dedicated to building healthy and empowered communities in South Africa, had a comprehensive service delivery model which was sustainable, and could be adapted for utilisation by other organisations. Nel (2005) highlighted the importance of LGBTIQA+ 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 LGBTIQA+ community views.

The Unisa Centre for Applied Psychology (UCAP), under the auspices of the Joint Working Group (a national group of LGBTIQA+ organisations in South Africa), conducted

[15] South African LGBT organisations

several 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 provinces, including an understanding of the healthcare interface from the perspective of LGBT people (Rich, 2006; Wells, 2006; Wells & Polders, 2003; Wells & Polders, 2004). The relevant key results from these studies are indicated in the following tables:

Table 2. 1

Health practitioners consulted in past two years

Type	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

Note. Multiple mentions possible

Table 2. 2

Agreement with statements about healthcare professionals

Statement	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

Statement	Gauteng (n=481) %	KwaZulu-Natal (n=410) %	Western Cape (n=955) %
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

Note. Multiple mentions possible

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

Table 2. 3

Treatment interactions

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

Note. Multiple mentions possible

Nyeck and Shepherd (2019) analysed data on the survey conducted by The Other Foundation (Sutherland et al., 2016), based on the 92 health sector professionals and

associate professionals interviewed in the sample. A total of 48% said that they think it is disgusting when men dress like women, and women like men, and 42% agreed that they think gay men / lesbians are disgusting, indicating the substantial work required in supporting the development of affirmative practices in healthcare settings. Recent work has researched the experience of ageing sexually diverse people with care services. Mange et al. (2022), in their study amongst HIV-positive black gay men in a township in South Africa, found that the men were stigmatised and experienced discrimination at healthcare facilities. Furthermore, rejection from family and community, and the death of life partners, led to isolation and depression. A study exploring the experience of LGBT ageing with care services (Reygan et al., 2022) highlighted intersecting experiences of marginalisation based on race, class, disability and LGBT identities across services, families, and communities, including LGBT spaces. Accessing care, including healthcare, appropriate housing, and even sanitation (access to clean toilets) was problematic. Faith-based organisations were a source of care and support in some cases but with the concomitant homophobia experienced. These experiences were balanced with experiences of agency and resilience, including belonging in communities and mutual care for each other. In a qualitative sample of university students similar to general healthcare services, Kleinhans (2018) found that healthcare services at university were heteronormative in nature, excluding of LGBTI students, that heteronormative attitudes held by healthcare professionals created barriers for LGBTI students accessing healthcare services, and that religiously motivated stigma and discrimination prevented healthcare professionals from providing culturally appropriate healthcare services to LGBTI students, and thus resulting in students not accessing those services. Based on this, the recommended action to university management was to support human rights of LGBTI students, sensitisation training as well as inclusion of LGBTI issues in training curriculum for healthcare professionals (Kleinhans, 2018).

Müller (2018) explores the normalised exclusion that queer people experience in public healthcare in South Africa. Using a queer framework, they suggest that the invisibility that these experiences represent has at least two aspects that needs to be foregrounded. The first is symbolic annihilation which refers to the how queer people are represented in the media (e.g., signage and pamphlets at care points), which includes omission, trivialisation or condemnation, and the second queer (un)intelligibility, which refers to how queer experiences of their own health and bodies are interpreted in a heterosexual frame that might not be reflective of them (e.g., you cannot contract HIV if you are a lesbian) and the impact of that frame on healthcare delivery. This research on healthcare practices in South Africa, also links to a study on queer bodies and the social production of healthcare spaces (Meer & Müller, 2017). Meer and Müller highlight how the absence of queer appropriate material in public health is indicative of healthcare spaces that are intended and equipped for heterosexual healthcare users. Further, remedying a specific aspect of healthcare, such as information materials, may not have fully positive results, due to the spaces being heterosexual by default, including staff and protocols. They find that the view of public healthcare facilities being “not for you” plugs into existing ideas of queerness as un-African and unpatriotic, pushing queer healthcare into the realms of private or community-based services. A spatial analysis of queerness in healthcare indicates how individual queer people navigate heteronormative socio-spatial orders through the balance between health seeking behaviours and resistive queer identity practices in the healthcare space. They conclude that more efforts are needed to transform both the material and ideological space of healthcare facilities through law and policy reforms, as well as continued professional training for healthcare providers (Meer & Müller, 2017).

Mental health services specifically

Numerous South African studies have now indicated the lack of mental health services for sexual diversity, the challenges in accessing services, including stigma and discrimination or negative experiences with mental healthcare providers (Graziano, 2005; Matebeni et al., 2013; Meer & Müller, 2017; Meyer, 2003a; Müller, 2017; Rich, 2006; Smith, 2015; Stephens, 2010; Wells, 2006; Wells & Polders, 2003). This can result in poor health outcomes, isolation, and high suicide rates, including amongst adolescents (Meyer et al., 2019). It has been found that lay counsellors at victim support centres are not always affirming in their counselling of sexually diverse 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 sexually diverse people and serve as a barrier to access (Nel & Judge, 2008). 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 LGBTIQA+ 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 CBO's in

providing such services, but also of affirmative therapeutic practice. Finally, Meyer (2003a) conducted seven focus group discussions to explore lesbian and gay experiences of a visit to a psychologist. Based on the results as well as their literature study, they suggested guidelines for educational psychologists working with "homosexual clients". Their study indicated that most 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. Most of the respondents preferred a psychotherapist with the same sexual orientation as themselves (Meyer, 2003a).

Sexual diversity and South African psychology

Historically, sexually diverse 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 Organization's International Classification of Diseases. The application of European research methods to understanding of the so-called primitive in Africa as a tool to understanding European social and sexual problems was driven by prominent theorists such as Marie Bonaparte and Carl Jung. This eventually led to the development of what was called ethno-psychiatry and later known as

cross-cultural or comparative psychology (Epprecht, 2008). In contrast to individual psychotherapy, African cultures in general, tended to view mental illness and sexual difference as signs of a broader social relationship issue. This could be caused by various factors including witchcraft (one person to another), revenging spirits (dealing with injustices to a family) or ancestral ill-will due to broader community failures (e.g., not conducting appropriate rituals). Healing thus also became less an individual matter and rather communal or social in nature; breaching heterosexual norms were a potential threat to the continued existence of the family and community. The cause of the behaviour needed to be determined and could be a manifestation of an honoured spirit, simply curiosity of youth or even the involvement of spirits or witchcraft. Evidence suggests that these issues tended to be dealt with through face-saving ceremonies or compensation to an aggrieved family to restore the public appearance of normalcy (e.g. in the case of their boy being seduced by a man) (Epprecht, 2008).

It has been argued that psychology can make a significant contribution to empowering the sexually diverse community (Nel, 2005; Nel, 2014). Pillay et al. (2019) provide a history of South African psychology. They highlight the work that has been done showing how the apartheid regime regulated the intimate lives of people, and the intersection between race and sexuality calls attention to the racist, hypermasculine and heterosexist discourse within apartheid. 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 sexually diverse individuals (July, 2009; Yen, 2007). Following the Forest Town raid in 1966, dubbed South Africa's own Stonewall moment, a special parliamentary committee was set up in 1968 to provide inputs into the immorality amendment bill. Submissions from psychiatrists' and psychologists' views tended to hold more liberal views about "homosexuality", mostly

supporting decriminalisation if not depathologisation as a mental illness. Many practitioners reflected a support for the heteronormative and patriarchal views of sexuality, but differing views around etiology and treatment of "homosexuality" (Pillay et al., 2019). A particular example of the apartheid state in action within mental health would be the human rights abuses of the South African Defence Force psychiatrists against white gay male conscripts, which included compulsory reparative psychotherapy with electroconvulsive shock treatment (Nel, 2007; Schaap, 2011). Involvement of psychologists in the military in perpetuating human rights violations, despite their own more liberal attitudes, is well documented (Pillay et al., 2019). The 1980s saw the growth of more progressive voices in organised psychology, particularly challenging the apartheid status quo of racial discrimination. This era also saw the first community-based organisations such as the Gay Association of South Africa (GASA) in 1981, which later developed into what is today the Triangle Project, and the involvement of psychologists in these groups and organisations. It was only post 1994, and the adoption of the constitution in 1996, that more significant strides were made in academic research output around sexual and gender studies (Horne et al., 2019).

Several 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 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 sexually diverse 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.

A significant shift was indicated when PsySSA joined the International Psychology Network for Lesbian, Gay, Bisexual, Transgender, and Intersex Issues (now IPsyNet) in 2007. Substantial progress has been made in the field, as evidenced by a strong sexually diverse-affirmative stream of presentations at the recent PsySSA conferences as well as statements condemning the potential introduction of anti-sexually diverse legislation in Uganda, amongst other initiatives (Nel et al., 2010). Telling of this progress is the keynote address delivered by now-retired Constitutional Court Judge, Edwin Cameron, that commended PsySSA for trying to protect minorities through its amicus role in the Qwelane matter (Pillay et al., 2019).

IPsyNet facilitated funding support from the Arcus Foundation for PsySSA's efforts led to the establishment of the PsySSA African LGBTI+ Human Rights Project in 2011. The work of this group has led to the PsySSA position statement for psychology professionals working with sexual and gender diversity (PsySSA, 2013; Victor et al., 2014; Victor & Nel, 2017), and the "PsySSA Practice Guidelines for Psychology Professionals Working with Sexually and Gender-diverse People" (McLachlan et al., 2019; PsySSA, 2017). The PsySSA

African LGBTI+ Human Rights Project team has been active in supporting training for master's degree psychology students at several universities in South Africa, but the lack of inclusion of sexual diversity issues in the curriculum for aspirant psychologists, including the lack of mention in textbooks, remains an issue. Online and in-person training courses that are accredited often talks to sexual and gender diversity as a unitary concept (Coetzee, 2009; Pillay et al., 2019).

Heterosexism, heteronormativity, and micro-aggression in psychotherapy practice

Victor et al. (2014, p. 298) defines heterosexism as:

> A system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. [Heterosexism] 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.

Related to heterosexism, heteronormativity 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, that is, it serves to regulate not only sexuality but also gender. (Victor et al., 2014, p. 298)

Although significant positive social changes have been recorded in more recent times, a heterosexist system of power and privilege remain strong globally and in South Africa (Meyer, 2003b; Paul, 2017). Subtle and overt forms of heterosexism in counselling and psychotherapy can range from support for conversion therapies to micro-aggressions.

Psychology professionals, as members of society, are affected by societal attitudes and norms, including heteronormativity, even where they might cognitively understand that negative attitudes constitute unethical behaviour, whether expressed or subtle (Bowers et al., 2005; Department of Health, 2006; Longo, 2013). This type of bias and ignorance can have a detrimental effect on the counselling or psychotherapeutic process, and can perpetuate trauma and stigma (Matthews, 2007). Bowers et al. (2005) conducted an interpretative and social constructivist study on the experience of minority identity in counselling (which I assume was conducted in Australia) and reported on the intricacies of heterosexism in psychological practice (they used the term homophobia, but their discussion indicates the broader concept of heterosexism). They highlighted the subtle, complex, and varied ways that counsellors' lack of knowledge, assumptions, bias, prejudice in perspective and approach to therapy, and how these interplay with counsellor behaviours and responses, can be read as heterosexist or unhelpful. The study highlighted how counsellors may believe that they are accepting and respectful but communicate something quite different (Bowers, et al., 2005).

A study in South Africa indicated that heterosexist attitudes and practices was a significant reason for negative encounters with psychotherapists and counsellors (Victor, 2013; Victor & Nel, 2016). The study indicated that negative experiences with counsellors and psychotherapists are largely due to how they dealt with the client's sexual orientation, all of which indicates a heterosexist bias. This included viewing the client's sexual orientation as abnormal, sustaining negative myths about sexually diverse lifestyles, viewing sexual orientation as fixed rather than fluid, not dealing with the client's own internal homophobia,

not realising the specific challenges faced by sexually diverse people in our society or focusing counselling on sexual orientation, regardless of whether this is indicated (Victor, 2013; Victor & Nel, 2016). This heterosexist bias also speaks to a lack of appropriate training on same-sex sexual orientation concerns in healthcare (Coetzee, 2009; Müller, 2013; Müller, 2015; Nel, 2007). Finally, a dated study by Tarrant (1992) provides a qualitative snapshot of the attitudes and approaches to psychotherapy with gay clients amongst a group of psychologists working in the Durban / Pietermaritzburg area (KwaZulu-Natal). The results indicated a clear lack of affirmative practice amongst this group.

In summary

This chapter started with a discussion of sexual diversity and sexual orientation. Several definitions of sexual orientation led into an overview of sexual orientation assessment, sexual orientation, and identity in South Africa, including reference to the special case of MSM. A discussion around the development of sexual orientation and identity also highlighted issues of race in South Africa, confirming some of the challenges that researchers in this field need to continuously attend to. Having outlined the area of work, attention was given to the legal framework, public attitudes and challenges faced by sexually diverse people living in South Africa. This led to a discussion highlighting the increased mental health concerns experienced by sexually diverse people, including depression, suicidality, anxiety, substance abuse, and violence, and the need for affirming mental health services, concluding with two models to support understanding of minority stress and mediating factors leading to increased mental health concerns within the sexually diverse population.

The final section in the chapter focused on current healthcare practices in South Africa, with specific reference to mental health services and the role of psychology as a

profession. It was highlighted that although significant strides have been made, sexually diverse people continue to experience significant barriers in accessing care, as well as stigma and discriminatory practices when accessing such. The history of psychology in South Africa gave emphasis to the complicity of the profession in pathologising and discriminatory practices based on sexuality, leading to a significant drive in working towards the establishment of a more affirming psychology, including the PsySSA affirmative practice guidelines launched in 2017. Having built the foundation, the discussion in the next chapter moves to talking to competencies, affirmative practice, guidelines, training and assessment of competencies and confidence of psychological professionals working with sexually diverse people.

CHAPTER 3: COMPETENCIES, AFFIRMATIVE PRACTICE, GUIDELINES, TRAINING, AND ASSESSMENT

Introduction

Having grounded the work, this chapter provides an overview of competencies and diversity with specific reference to South Africa. An outline of diversity competence in a multicultural society leads to a discussion of affirmative approaches in psychological care. This includes an understanding of what affirmative practice encompasses, research on psychotherapy with sexually diverse people, leading to specific competencies in working with sexually diverse people, and outlining the practice guidelines of working with sexually diverse people in South Africa. The chapter is concluded with a review of training and assessment of competence and confidence in working with sexually diverse people.

Competencies, professional development, and diversity

Being competent can be viewed as "doing something successfully and satisfactorily, though not outstandingly well; being 'good enough' or simply adequate" (Naidu & Ramlall, 2016: p. 83). The IUPsyS defines competence as a "combination of practical and theoretical knowledge, cognitive skills, behaviour, and values used to perform a specific behaviour or set of behaviours to a standard, in professional practice settings associated with a professional role" (IPCP, 2016: 4). IUPsyS makes a distinction between competences and competencies, as the term competencies is also used in some countries in a broader sense that includes desirable qualities or personality attributes of the person (IPCP, 2016). My research includes the broader area of competencies, including the IUPsyS competences.

In addition to the IUPsyS definition, Knapp et al. (2017) emphasises the importance of emotional competency as the "ability to withstand the emotional difficulties associated

with professional practice" (p. 52). Emotional competency is important when delivering services to distressed clients, but also applies to the ability to feel and express compassion, empathy, and other aspects of good interpersonal relationships. Knapp et al. (2017) point out three areas within this domain, namely the importance of practicing self-care, confronting professional stressors, and flourishing as a psychologist. Psychological professionals need to be functioning well themselves, and if they are not, risk limiting their ability to be of help to others or becoming impaired. They need to be aware of the possibility of compassion fatigue, burnout, vicarious trauma, and the threat of assault or actual assault. Improving and retaining self-care, own well-being and own functioning are important to ensure continued emotional competence (Knapp et al., 2017).

Endeavours to define and specify competencies for the practice of psychology has a long, somewhat convoluted history. The process in the USA started as early as 1949 but was mainly defined by experience and teaching time. This was until the development of the first major competency model for that country in 1986, with significant work on competency benchmarks and competency assessments (Borden & McIlvried, 2010; DeMers, 2009; Fouad et al., 2009; Johnson et al., 2008; Kenkel, 2009; Rodolfa et al., 2014).

Competencies in South Africa

Locally, the HPCSA is mandated by the Health Professions Act No. 56 of 1974, and amended by Act No. 29 of 2007, to guide and regulate all health professions in South Africa. This includes registration, education and training, professional conduct, and ethical behaviour, including continued professional development. As mentioned in Chapter 1, the Professional Board of Psychology within the HPCSA is constituted to, amongst others, set standards for education and training for registration, including accreditation of learning

institutions and CPD activities, as well as being the Standards Generating Body (SGB) for psychology. The Health Professions Act No. 56 of 1974, contains both the regulations defining the scope of the profession of psychology (Department of Health, 2011) and the ethical rules of conduct for registered practitioners (Department of Health, 2006). Annexure 12 of the Act outlines rules of conduct for the profession of psychology. The HPCSA controls the professional route to registration as a psychologist, including accreditation of the training programmes offered by higher institutions. For this reason, the curricula across institutions are comparable, which also allows for portability across different courses. All qualifications are registered with the Department of Education, the South African Qualifications Authority (SAQA), and the Council on Higher Education (CHE), with the latter operating through its Higher Education Quality Committee (HEQC). These bodies, together with the HPCSA, work co-operatively to ensure quality in professional qualifications (Sibaya, 2008).

In recent years, and in line with international trends in the profession, a move has been made to identify competencies for local psychology professionals. The HPCSA currently defines the five core competencies for psychologists as: (a) psychological assessment, (b) psychological intervention including psychotherapy, counselling and advanced psychoeducation, (c) referral expertise, (d) research, and (e) consultation. Categories of registration currently limit the scope of practice of these competencies, although this is under serious debate (PsySSA, 2016; Sibaya, 2008).

According to IUPsyS, the:

> International Declaration of Core Competences in Professional Psychology seeks to identify a set of internationally recognized and endorsed competences that can serve as the foundation for a coherent global professional identity and possibly an international recognition system for equating professional preparation systems,

> program accreditation, professional credentialing, and regulation of professional competence and conduct. (IPCP, 2016, p. 1)

This set of competences is of particular importance as professional psychology increasingly moves to a competence-based model of training and continued professional development, such as reflected in a recent PsySSA report on the scope of practice in psychology (PsySSA, 2016); underlining the use of these competencies to enhance the standards of training and practice regulations. In South Africa this has led to healthy debates on the applicability of such global competencies as we increasingly engage around decolonisation of psychology in South Africa, and refinement to reflect the unique lived experiences of South Africans and concomitant needs that could be met by psychology professionals (e.g. PsySSA, 2018).

The IUPsys competences include:

- knowledge and skills relate to possessing necessary generalised and specialised knowledge and skills,
- behavioural competences including practicing ethically; acting professionally; establishing, maintaining, and developing appropriate working relationships with clients and colleagues; operating from an evidence-based orientation; self-reflection; and diversity,
- professional activity competences including setting relevant goals; psychological assessments and evaluations; psychological interventions; and communicating effectively and appropriately (IPCP, 2016).

The IUPsyS competences address diversity, which includes cultural competence. This set of competences comprises: (1) knowledge and understanding of the historical, political, social, and cultural context of clients, colleagues, and relevant others, (2) cultural humility, (3) respecting diversity in relevant others, (4) realising the impact of one's own values,

beliefs, and experiences on one's professional behaviour, clients, and relevant others, (5) working and communicating effectively with all forms of diversity in clients, colleagues, and relevant others, and (6) being inclusive of all forms of diversity in working with clients, colleagues, and relevant others (IPCP, 2016). The term “diversity” includes working with sexually diverse people.

With the establishment, and endorsement, of competences that could be applied in South Africa, an important area of significant research and application is enabled in the country. The current study provides an important early piece of research to assist in the process of bringing these and other global competencies to life within a South African context. This study offers ground-breaking work, particularly as it addresses the current landscape in dealing with a group that has seen significant discrimination in the past, and which organised psychology has identified as one group to focus on in addressing past inequalities and providing social justice leadership in South Africa, and possibly the rest of Sub-Saharan Africa.

Diversity competence in a multicultural society

Psychological professionals in South Africa are increasingly focused on the idea of being competent in working with diverse populations. Globally, this work has been primarily based on theoretical models developed to identify the competencies required by counsellors in dealing with multicultural populations. The primary model referenced is the Tripartite Model, developed, and revised, by Sue et al. (1992). The model defines three areas that constitute competence namely: (a) having the necessary cultural knowledge of the population being assisted, (b) being aware of cultural biases, and (c) having the necessary skills to assist clients from a different culture, including knowing when to refer clients (Hall et al., 2014).

In their discussion around the measurement of multicultural counselling competence, Constantine and Ladany (2001) expanded the conceptualisation of competence to include self-awareness, general multicultural knowledge, multicultural psychotherapy self-efficacy, ability to understand unique client variables, effective psychotherapy alliance, and multicultural psychotherapy skills. Of interest here is also contextual aspects that are postulated to affect the development of these competencies. Heppner et al. (2012) identify three contextual aspects impacting on multicultural competency development:

- personality characteristics and attitudes, as well as coping skills, such as the multicultural personality, proposed by Ponterotto (2010) which includes ability to embrace diversity, negotiate multiple roles in different contexts, self-reflection, cognitive flexibility, and security in one's own identity (Ponterotto, 2010; Reynolds & Rivera, 2012),
- experiences in immersion in the host culture, which also include home language speakers, as learning mechanisms,
- processing of encounters, and continual learning through the process of experiencing, reflecting, and dialoguing (Heppner et al., 2012).

Although viewed as an important development, the Tripartite Model (and subsequent improvements), has been open to various criticisms, and has led to new developments that would be relevant to the current study. Sue et al. (1992) Tripartite Model is predominantly a service provider-focused model and neglects the importance of the therapeutic alliance. It leads counsellors to teach clients how to best operate in the dominant culture (such as heteronormativity) rather than addressing significant intersectionalities, including specific areas of importance in individual populations such as sexually diverse people. This has led to calls to expand the focus to include relational and contextual factors, including multicultural

training courses that contain direct experiential aspects beyond didactic requirements, for a more diverse set of clients (Hall et al., 2014).

The move to more systemic conceptualisations has seen a call for inclusion of, for instance, the Relational-Cultural Theory (RCT) (Miller, 1986; Miller & Stiver, 1997). The theory is grounded in feminist theory and highlights the importance of mutuality and authenticity between client and counsellor, both gaining from shared experiences and leaving with a better understanding of self and others' perspectives. The mutual growth experience focusses on the relationship rather than autonomy as the key to growth, thus building relational resilience. This brings a new perspective to the ideas of "multicultural competence" and incorporates knowledge regarding specific diverse populations to enhance skills development, using mutual empathy and enhancement of the therapeutic alliance (West, 2005). The client's worldview, and how we make sense of it together, are more important than presumed objective facts and becomes the basis for connections / disconnections (Jordan, 2001). This also implies an awareness of power-over structures, such as potentially found in the therapeutic relationship and institutional heteronormativity (Jordan, 2008).

Based in part on their own experiences in urban, mostly lower socio-economic communities, La Roche and Christopher (2010) reflect that it was not sufficient to promote change based on individual aspects only. Social and contextualised change was also required, and that psychotherapy should also have the goal to bring about social change through clinical practice. La Roche and Christopher (2010) support the use of a multidimensional approach with three different dimensions of psychotherapy, including the individual client, the therapeutic relationships or alliance, and the context. In their view, therapies focusing on the individual (e.g., maladaptive behaviours and thoughts) should be enhanced by a focus on the therapist-client relationship, with the potential for focus on the interaction, as well as reflection on differences and similarities between the therapist and client, to improve the

psychotherapy alliance, where clients might feel more comfortable exploring issues relevant to them, as well as support the therapist's exploration of their own beliefs and potential biases. These two dimensions operate within a third dimension, namely specific cultural or contextual environment. Following a more constructivist approach, it encourages clinicians and clients to explore how their own feelings, thoughts and interactions may reflect larger socio-political, cultural, and economic issues, including issues of power and privilege, violence, and intergenerational trauma. La Roche and Christopher (2010) feel that psychotherapy should incorporate community-based treatment elements, including advocacy and community-based prevention and change efforts for the client and the practitioner. Finally, they stress the importance of integrating these three dimensions, rather than viewing them as distinct sets of practices, and ensuring that none of these aspects are minimised in favour of the other, for example, a focus on cultural historical elements to the detriment of individual responsibility and resilience (La Roche & Christopher, 2010). To support this integration, they suggest a three-stage therapeutic process as guide rather than manualised intervention. These are: (a) addressing chief complaints and reducing symptoms, (b) exploring and understanding client narratives and stories, and (c) fostering empowerment and awakening of social consciousness (the social justice element).

Work on social justice in counselling has gained importance, including research indicating that the intersection of multiple identities has important influences on mental health outcomes and health disparities. This has culminated in the publication of the Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession (MSJCC) in 2016[16] (Ratts et al., 2016). The MSJCC highlights the following four aspects as important for counsellors and clients:

[16] In 2014, the Association for Multicultural Counseling and Development (AMCD) appointed a committee to revise the Multicultural Counseling Competencies developed by Sue, Arredondo, and McDavis in 1992 and operationalised by Arredondo et al. in 1996. The article by Ratts et al. (2016) presents the revised competencies and is titled the Multicultural and Social Justice Counseling Competencies.

- **The complexities of intersecting identities.** The social construction of identities is viewed as dynamic and complex and differentially contribute to people's experience. Intersectionality helps in thinking about the way that multiple social identities impact on mental health and are affected by systems of power, and proposes ways to identify, challenge, and resist various forms of oppression (APA, 2017; Leitch et al., 2021). The collection of identities, and relative importance of different identities to individuals at a time are influenced by the larger environment.
- **The influence of oppression on well-being.** Oppression, in the forms of sexism, racism, homophobia and heterosexism, among others, manifests at different levels – from individual to societal. The minority stress model (Meyer, 2003b) discussed earlier, provides a strong theoretical foundation for understanding how societal oppression and stigma can lead to negative health outcomes. Individual level oppression can be based on dehumanising interpersonal interactions that occur over time, referred to as micro-aggressions (Nadal et al., 2011; Nadal 2019; Shelton & Delgado-Romero, 2011).
- **A socioecological approach to understanding individuals in the context of their environment.** The MSJCC incorporates Bronfenbrenner's work (1979) and the subsequent development and expansion of frameworks that look at how different systemic levels mutually impact the other. It recommends counsellors analysing and considering the following levels that impact well-being and health: (a) intrapersonal, (b) interpersonal, (c) institutional, (d) community, (e) public policy, and (f) global politics and affairs.
- **Balancing and integrating individual counselling and social justice advocacy.** Utilising a quadrant model to illustrate intersections of identities and the various

> ways that power, privilege, and oppression are enacted in various privileged-marginalised client-counsellor relationships (thus four variations), the MSJCC highlights the importance of attending to counsellor self-awareness, client's worldview, and the counselling relationship (and how privileged and marginalised statuses influence the relationship), to support decisions on which counselling and advocacy interventions are required (Ratts et al., 2016).

Smith and Trimble (2016) explore social justice as an objective for psychological professionals. They ask for a continued engagement and critical thinking about core ideas, assumptions, conceptualisations, and frameworks. They acknowledge the influence of social justice on psychology, and multicultural psychology, with its aims of promoting equity by eradicating discrimination and poverty. They focus on three strengths or assumptions, which they relate to the philosophical concepts of dialectic materialism and critical pedagogy, praxis and political activism and liberation psychology:

- primacy of power and attending to power to promote equality through social change,
- role of advocacy in mental health efforts,
- emphasis on empowerment.

In their research, they find that much of the multicultural psychology literature does not align, measure, or operationalise these issues. They speculate that this might be due in part to:

- the concepts being too abstract or complex for psychological professionals, and not grounded in lived experiences,
- liberation psychology being taught as a theory rather than a worldview with reality-based engagement,

- narrowly interpreting liberation psychology as implying advocacy and political activism only,
- psychological professionals choosing their career as they prefer to work with individuals and small groups rather than working at macro levels,
- lack of paid opportunities to engage in social justice work.

To address this and considering an increasingly internet-based society with its need for unity in diversity, they recommend the discussion and integration of a broader relational paradigm to underpin and operationalise social justice in psychological practice, in addition (or even instead of) current philosophical materialism and its focus on liberation, grassroots political activism and advocacy. This represents a build on the focus on relational factors discussed earlier (Hall et al., 2014; La Roche & Christopher, 2010). Seven general principles are provided to clarify:

- connectedness and innate yearning for attachment with others, interpersonal intimacy gives meaning and purpose in life, and poor social networks are related to poorer mental health outcomes,
- emphasis on contextualisation and holism – considering both specific events and their contexts,
- interactive volition, and how innate agency interacts with the environment to restrict or enhance choices, but also our freedom and choice to change our perspectives, repair relationships, form new relationships, strengthen our ability to respond, and work to modify our environment,
- seeing relational development as ongoing – becoming being,

- seeing the self as a highly complex and fluid pattern, a self-in-relation – understanding ourselves through interaction with others, implying the dynamic shared nature of identity,
- responsibility to others, a moral sensibility that asks for other-engagement and we-consciousness – interacting in mutually beneficial ways and being attentive in our relationships,
- notion of human rights as grounded in relationships, not contexts, human vulnerability, and the right to protection.

As done by La Roche and Christopher (2010), they discuss some implications for psychotherapy including working on issues such as the therapeutic alliance, clients' relationship patterns to gain insight and better coping strategies, strengthening social skills and intimacy with others, involving others in client's improvements, and modelling desired interpersonal interactions in the here and now (Smith & Trimble, 2016).

Reflecting the increased consideration of contextual factors and intersectionality among and between groups identities, the APA published practice guidelines when working with diversity and multiculturalism in 2017 (APA, 2017). It is important to remember that these guidelines are meant to be aspirational and informative rather that constituting standards that mandates that psychological professionals must adhere to. Nor are they intervention specific treatment guidelines and recommendations. These guidelines encourage psychologists to explore identity, incorporating developmental and contextual factors of identity in engaging with individuals and groups. They further highlight the importance of within-group differences and the role of self-definition in identity, and included a broad section of identity groups, including sexual orientation and gender diversity, in these guidelines, in addition to their guidelines focusing specifically on race / ethnicity (APA, 2002; APA, 2003; APA, 2017).

For the APA, cultural competence is based on the idea of cultural humility (APA, 2017). IUPsyS also refers to cultural humility specifically as one of their diversity competences (IPCP, 2016). The term "cultural humility" refers to a constructivist framework where providers engage in ongoing self-development and reflection about their power and the dynamics this creates with their client's *vis a vis* their cultural identities (Leitch et al., 2021). In a ground-breaking article Tervalon and Murray-García (1998) express concern around defining diversity competence as a simple mastery of knowledge that can be shown through comparative quantitative assessments. They rather consider diversity competence as a lifelong commitment and active, ongoing engagement with diverse clients, colleagues, and communities, which they term "cultural humility". For them, cultural humility implies (a) continual self-reflection and self-critique, (b) checking and dealing with the power imbalances inherent in the client-practitioner relationship, and (c) developing and maintaining mutually respectful and dynamic interactions and advocacy with communities on behalf of clients. They caution against a false sense of security derived from our past training, and the potential stereotyping this might result in, underscoring continued discrimination in healthcare as evidence of the need for practitioner self-engagement. As important as they rate the basic knowledge foundation to be, they also rate ongoing and realistic self-evaluation, and a commitment to lifelong learning – a change of attitude, which is renewed continually as equally important. They ask for practitioners to be flexible and humble enough to recognise when they do not know, to learn from clients, and to search for and access resources to support their work with diverse people. Beyond the inter-individual context, they also challenge practitioners to involve themselves in community-based care and advocacy, and broader institutional consistency with the goal of serving local, diverse constituents.

The APA developed an integrated model, the "Layered Ecological Model", as a basis for developing the multicultural and diversity guidelines. The foundation for this model is set

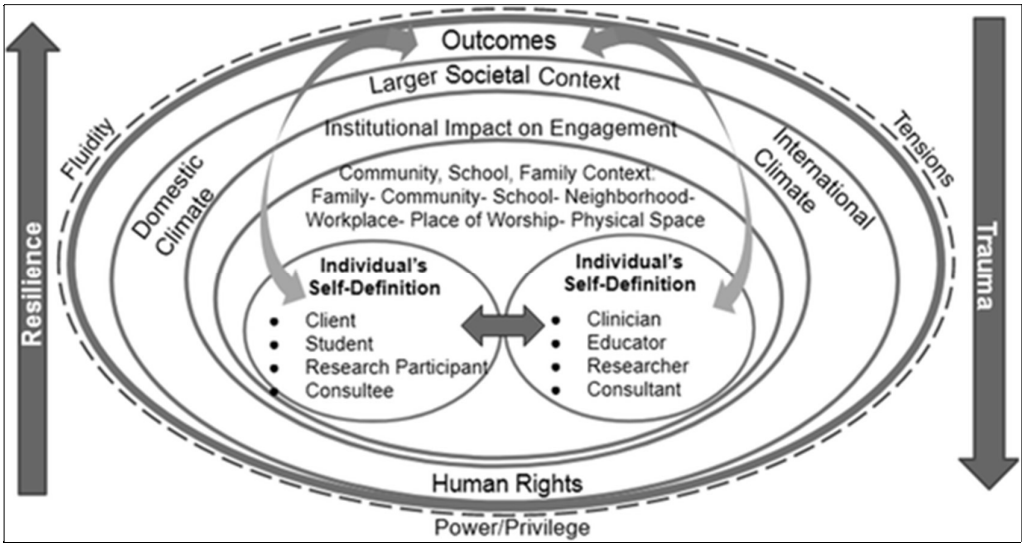
in the ecological metaphor. The ecological metaphor refers to the interaction between individuals and the multiple social systems in which they are situated. Communities are viewed as open systems with many different levels and connections (D'Augelli, 2003). Following the ideas of Bronfenbrenner (1979), smaller systems are nested within the larger systems and the various levels are interdependent – larger systems impact smaller systems and vice versa. Bronfenbrenner (1979) proposes five concentric and dynamic systems (or circles):

- the microsystem of immediate family, friends, teachers, and institutions that have direct influence on the individual,
- the mesosystem of interrelations between the microsystem entities,
- the exosystem referring to societal and cultural forces impinging on the individual without necessarily a direct link to individual,
- the macrosystem relating to the larger systems such as government laws and policies and expressed cultural values and norms,
- the chronosystem incorporating the influence of time on the above, such as historical trends and context, as well as future trajectories.

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. In summary, *The Layered Ecological Model of the Multicultural Guidelines* (APA, 2017), comprises of five levels, three processes, and two goals, as per Figure 3.1.

Figure 3. 1

The Layered Ecological Model of the Multicultural Guidelines (APA, 2017)



The five levels are:

- **Level 1**: the two inner circles represent a bi-directional model of self-definition and relationships. The circle on the left talks to the self-definition of the client, student, research participant, or consultee. The circle on the right talks to the self-definition in the role of clinician, educator, researcher, or consultant. Each of these circles can represent one or more people such as a couple, family, or therapist team. The bi-directional arrow represents the dynamic interaction between the two and the roles they play,
- **Level 2**: the community, school, and family context have a direct impact on the bi-directional relationship, and includes family, community, school, neighbourhood, workplace, place of worship, and physical space,
- **Level 3**: Level 1 and 2 operate within level 3, which talks to the influence of the institutional context on the individual (client and psychologist) experience of the community, school, and family context, and how this experience impacts the

relationship with one another as well as everyone's self-definition. This can include government, legal systems, medical systems, mental and behavioural systems, and educational systems,

- **Level 4**: talks to a larger societal context, including the local and international climate, and human rights, and how this influences levels 1-3,
- **Level 5**: talks to the outcomes of the bi-directional relationship, and how these outcomes are influenced by interactional experiences (Level 1), community, school, and family context (Level 2), institutional context (Level 3), and the larger societal context.

Consideration is given in the model to three dynamic processes that should be considered in the participant-provider relationship. These three processes operate within and across all the levels of the model. These are:

- power and privilege experienced by participants involved in therapy. Therapists keep in mind these dynamics and promote ways for all systems (including themselves) to identify, own and respond to their experiences,
- tensions are dynamic and contextual and develop in interactions between and within each of the levels, and therapists and clients work to identify these as they relate to interactions,
- fluidity further implies that these mentioned interactions are dynamic and shift over time, and therapists consider how these changes impact them and their client over time.

According to the model, the two ultimate goals of these bi-directional relationships would be to increase resilience and decrease trauma. Resilience is defined as "the ability to overcome structural and individual challenges through a combination of character traits, cultural background, cultural values, and environmental supports. As such, resilience is

considered an ability to overcome challenges given both individual and contextual strengths" (APA, 2017, p. 168). Trauma is defined as:

> experiences of extraordinary, terrifying events such as accidents, natural disasters, interpersonal violence, political violence, and war. Recent conceptualizations of traumatic experiences include hate-based victimization (e.g., violence against racial groups and LGBTQ+ communities). Responses to traumatic events involve an array of psychological and physical concerns such as nightmares, flashbacks, hypervigilance, difficulty regulating affect, headaches, difficulty concentrating on tasks, loss of trust in others, and relational challenges. (APA, 2017, p. 168)

Using the model as the basis, the APA (2017, pp. 4-5) guidelines are:

Level 1: Bidirectional Model of Self-Definition and Relationships

Guideline 1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

Guideline 2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

Level 2: Community/School/Family Context

Guideline 3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they

interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

Guideline 4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

Level 3: Institutional Impact on Engagement

Guideline 5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

Guideline 6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

Level 4: Domestic and International Climate

Guideline 7. Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

Guideline 8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

Level 5: Outcomes

> Guideline 9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the Layered Ecological Model of the Multicultural Guidelines.
>
> Guideline 10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context (APA, 2017, pp. 4-5).

In summary

Being competent implies being able to practice your profession well enough. In South Africa the HPCSA is legally mandated to regulate all health professionals, including psychology, with regards to registration, education and training, professional conduct, and ethical behaviour. There has been an increase in discussion around defining clearer competencies for psychological professionals, including incorporating the IUPsyS competences. Being competent to work with diversity, including sexual diversity, becomes important in a multi-cultural country, with significant scholarship in diversity competence outlined, including the APA's Layered Ecological Model of Multicultural Guidelines (APA, 2017). The next section moves to discussing affirmative approached to psychological care for sexually diverse people, within this context of diversity competence.

Affirmative approaches to psychological care

What is affirmative practice?

Building on the discussion of how sexually diverse people were marginalised and persecuted as part of the larger project of apartheid, of racism, hypermasculinity and heterosexism, of regulating the intimate lives of people in South Africa. The history of organised psychology / psychiatry globally has focused on sexual diversity as pathological, a mental illness. Locally, given the strong connection to both continental and Anglo-Saxon psychologies, the trends in these countries also impacted in the development of psychology in South Africa.

The subject of "the homosexual" provides an insight into the marginalisation of other identities and sexually diverse people. In Chapter 2, the discussion around reparative or conversion therapies highlighted some of the more damaging therapies in South Africa, such as those in the military in the 1970s and 1980s. This model of sexual diversity as pathology permeated the discipline through training, academic research and treatments that were developed. Despite this, it can reasonably be expected that numerous practitioners across the world, as well as locally, have provided care to sexually diverse clients that was experienced as caring and affirming. This practice was provided mostly outside the historically pathologising eye of organised and academic psychology, and potentially at significant professional and personal cost (Pillay et al., 2019).

The move away from the medical model of homosexuality started globally in the 1960s and 1970s, leading to the increased development of a sexual and gender diversity specific psychology. This was driven by an increased focus on human rights, the gay liberation movement, increased academic work positing homosexuality as normal and natural whilst also focusing on the psychosocial stressors sexually diverse people must deal with, and

lack of positive results with sexual orientation change efforts (Schippers, 1997). The development of affirmative approaches has been identified as important in providing appropriate and ethical psychological care to sexually diverse people (e.g., Dorland & Fischer, 2001; Fassinger, 1991; Matthews, 2007; Victor, 2013). The focused efforts to greater sensitivity to LGBTIQA+ issues in South African psychology have been emphasised. Reference has been made to the role of organised psychology in the development of affirmative therapies and the unique political, social, and institutional aspects that supported the development of LGBTIQA+ psychology in the country (Pillay et al., 2019). The support and connectivity with global colleagues have been mentioned, with the naming and definition of affirmative practices on the global stage reflecting the significant increase in scholarship in the subjects of sex, sexuality, and gender diversity in psychology.

Terminology in work on affirmative therapy has seen a move from gay-affirmative practice to more inclusive LGBPQ+, LGBT, LGBTI, LGBTIQA+ and more recently "sexual and gender minority therapy" and "queer affirmative therapy" denoting the expansion of thinking and theory, on the one hand, to be more inclusive, but on the other hand, also illuminating the distinct lived experiences of these identities (Grzanka & Miles, 2016; Johnson, 2012; Leitch et al 2021; Pachankis, 2018; Pachankis & Goldfried, 2013; Ramirez, 2020). These practices have endeavoured to be sensitive to the unique and distinct life experiences of sexually diverse people that heterosexual people might not have, and that could have an influence on the mental health of sexually diverse people (Pachankis, 2018).

What constitutes sexual diversity affirmative practice has been debated and will continue to be defined in different ways as work continues to grow in this area. The viewpoint that it is a general, non-discriminatory, and contextually aware attitude when working with sexually diverse people, and advocates incorporation of this attitude into mainstream psychology theories, although possibly, and initially important politically, has

increasingly been shown to fall far short of the needs of sexually diverse people. There is increasing acceptance that affirmative practice goes beyond general therapy and counselling skills and constitutes a different construct or competence area (e.g. Dillon & Worthington, 2003). Davies (1996) and Milton and Coyle (1999), for instance, view it as a distinct way of operating and taking a specific stance, rather than a more general view. Ritter and Terndrup (2002) agree, and state that taking a neutral therapeutic posture as advocated by psychoanalytic theory may be problematic for sexually diverse people. At the very least it is felt that "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). This does not negate general counselling and psychological work but can rather be viewed as an adjunct or addition to practice (Pachankis, 2018).

In the early 2000s, with a significant increase in this area of work, some authors described the different streams of thought of affirmative practice as a conglomeration of ideas or heuristic principles that guide practice (van den Bergh & Crisp, 2004). Schippers (1997) saw a general accepting attitude as a starting point but notes that the psychotherapist also needs to realise that different presenting problems may require different approaches. Schippers' (1997) view contains principles that are important in sexual diversity affirmative practice and include viewing a sexually diverse orientation as one's sexual and emotional preference that is to a greater or lesser extent, present in all individuals and of equal value to heterosexual norms. In line with work around resilience, Schippers (1997) felt that it should be acknowledged that sexually diverse clients, and the subculture, have the same potential creativity and internal resources to deal with their difficulties and problems – thereby taking a strength, rather than deficit viewpoint. Recent work locally has expanded on this by arguing that resilience science should become more central in affirming LGBTIQA+ persons and communities (Wilks et al., 2022). 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 CPD and accessing lesbian and gay resources – in the words of Marmor (1996, p. 543), knowing the "specific subcultural network systems" of sexually diverse groups. This was expanded on by Milton et al. (2002) who endeavoured to provide a summary at the time of an affirmative practitioner as someone that views diverse sexualities and gender identity as normal and natural, rather than the cause of psychological difficulties or pathology; is comfortable with and open about their own sexuality to avoid their own biases impacting on the psychotherapy or counselling; can empathise with the experiences of sexually diverse clients, which includes being knowledgeable about diverse sexualities and lifestyles; and has a contextual awareness of sexual diversity issues, including an understanding of how factors such as homophobia, heterosexism, prejudice and stigma impact on the mental health of sexually diverse people.

Pachankis and Goldfried (2013), in their review of key aspects of LGB affirmative therapy, draws attention to the importance of attending to homophobia or heterosexism (external and internal), addressing LGB identity development models, acknowledging potentially unique considerations in same-sex relationships and family dynamics, as well as the importance of the availability of community support resources. They, and others, have worked to addressing the critique that affirmative practice lacks clear operational definitions and have endeavoured to: (a) more strongly define these practices and (b) have a stronger theoretical grounding for this work (Alessi et al., 2015; Bidell & Whitman, 2013; O'Shaughnessy & Speir, 2018; Pachankis et al., 2015a). In line with this work, Pachankis (2018) summarises the typical characteristics of affirmative practice as assisting individuals

to develop insight into stigma and the impact of stigma, including the experience of hopelessness and low self-worth, sensitising sexually diverse people to feelings such as shame and guilt that might not be constructive, promoting resilience, pride and community building to counter stigma related stress, providing specific resources for sexually diverse people and be informed enough to advocate against social injustices. They base their work on Meyer's (1995, 2003b) minority stress model and Hatzenbuehler's (2009) psychological mediation framework discussed earlier.

As early as the mid-2000s ideas of competence, and specifically cultural or diversity competence was brought into the understanding of sexual diversity affirmative therapy. For Crisp (2006), affirmative practice focuses on the person in their environment; the psychotherapist's cultural competency, including knowledge, attitudes, and skills as well as a strength-perspective focusing on self-determination, health rather than pathology, and raising consciousness of rights and relevant issues. Perez (2007) defines affirmative therapy as:

> The integration of knowledge and awareness by the therapist of the unique developmental cultural aspects of LGB(T) individuals, the therapist's own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process. (p. 408)

Three core conditions for affirmative therapy are defined as therapist's competence, affirmation of LGB(T) culture, and openness to attending to sexual orientation and identity issues (Perez, 2007). Building on this work some authors (e.g., Pope et al., 2010, cited in Paul 2017) have highlighted the importance of attending to multiple cultural and social identities in therapy. In line with this development, O'Shaughnessy and Speir (2018, p. 4) recently defined affirmative practice as:

> therapy that is culturally relevant and responsive to LGBQ clients and their multiple social identities and communities, addresses the influence of social inequities on the

lives of LGBQ clients, fosters autonomy, enhances resilience, coping, and community building, advocates to reduce systemic barriers to mental, physical, and sexual flourishing, and leverages LGBQ client strengths.

In this regard, the concept of attending to intersectionality in psychological work has been rising in importance.

Grzanka and Miles (2016) developed a three-tier model to represent the shift in LGBT psychology, research, and practice from the period up to the early 1970s of pathologising sex, sexual and gender diversities, to the era of "incorporation" starting with the declassification of homosexuality from the DSM in 1974. Moving then into the area of "affirmation", reflecting the discourse of LGBT affirmative therapy since the mid-1990s, up to their analysis ending on available material till August 2015. They follow the narrative of Hammack et al. (2013) in providing a synthesis of research and practice in the area, and comments that these tiers do not represent homogenous or uniform efforts in the area but are reflective of other critical histories of psychology in this area of work.

The tier of "affirmation" includes the move away from rigid taxonomies of sexual orientation to a greater attention of the heterogenous lived experiences of sexually diverse people, influenced by queer theoretical approaches. This shift also reflects the larger multicultural turn in psychology, which has included the concept of multicultural competency / competence for example, the chapter on multicultural competency with LGBT communities (Wilton et al., 2009) in the "Handbook of Multicultural Counseling" by Ponterotto et al. (2010). The themes from the "affirmation" tier include:

- focus on identity, rather than typology or taxonomy,
- more inclusive of different identities,
- science embraces liberal politics, LGBT psychology as inherently political, if not explicitly activist,

- moving beyond clinical and social psychology paradigms to include counselling and multicultural feminist paradigms influenced by queer theory and intersectionality,
- strengths-based, positive psychology, and interpersonal, multicultural frames become dominant theoretical orientations to treatment,
- desexualised and depoliticised subjects[17], with sexually diverse individuals wanting normalcy,
- sexual orientation and gender intersect with other elements of identity, and sexual orientation not being the only definitive element of the sexually diverse subject,
- psychological issues, both intra-psychic and inter-personal, linked to relations of power and privilege, and structural considerations key to understanding presenting issues, with privilege as central to subject's experience,
- start to move to diversity of subjects and not just white, male experiences,
- intergroup differences between identities are also considered,
- multiple social identities as the dominant paradigm of identity construction, identity enactment and rhetoric of identity complexity (Grzanka & Miles, 2016, pp. 375-376).

Ruth and Santacruz (2017) proudly highlights how increasingly LGBT psychological research and clinical practice has been moving away from trying to prove to heterosexual, mainstream audiences that being LGBT is not a pathology, and showing how heteronormative methods extend to LGBT client. They state that increasingly the field is "defining its agenda as working within, by, and for LGBT communities" (Ruth & Santacruz, 2017, p. 3) and "becoming less interested in explaining LGBT psychological realities to non-

[17] Where the term subject refers to sexually diverse individual

LGBT audiences and more interested in providing servant leadership to our own LGBT communities" (Ruth & Santacruz, 2017, p. 3).

Global research on psychotherapy with sexually diverse people

Internationally, this area of work has seen a significant increase in research and academic output (in English) over the past few years. The systematic review by King et al. (2007) mentions 24 studies of which – 14 were from the USA, three from the USA / Canada and seven from the United Kingdom (UK). Based on their analysis, they conclude that affirmative therapies appear to assist LGBT people to normalise their everyday experiences, face and counteract the homophobic nature of their early development and receive therapy that is appropriately focused on issues brought to therapy, rather than on their sexual identity. King (2015) re-iterates the importance of education and training to develop therapists' affirming attitudes and practice, including dealing with both own and institutional homophobia.

Bieschke et al. (2007) reviews the empirical literature on client experiences of counselling and psychotherapy, therapists' attitudes to LGB clients, and conversion therapy. In line with the previous study, they refer to the increased trend of therapists affirming LGB clients, the increase in more complex understanding of working with sexually diverse people (bias, context, therapeutic alliance), and the potential harm caused by conversion therapies. Johnson (2012), in talking to the lack of a theoretical framework, operational definitions, and outcome research in the area, suggests that affirmative therapy can be viewed as a culturally competent approach in working with LGB clients. They subsequently completed their dissertation on the impact of different training methods on perceived and demonstrated cultural competence with LGB clients amongst social work students (Johnson, 2013). Budge

et al. (2017) highlight the lack of evidence-based practice research amongst sexual and gender minorities (SGM), except for work on behavioural couple therapy for gay and lesbian couples with alcohol use disorders (Fals-Stewart et al., 2009) and Cognitive-Behavioural Therapy with young adult gay and bisexual men utilising the ESTEEM transdiagnostic intervention (Pachankis et al., 2015b). They provide several ideas and suggestions for psychotherapy research that study the efficacy and effectiveness of interventions through randomised controlled trials, and process-orientated research that focus on the mechanisms underlying treatment and change process to contribute to the development of theory, improve the quality of therapy and support training efforts, including:

- in the randomised controlled trials considering how minority stress and client's multiple identities interact with the process and outcome of psychotherapy and focus on sexual and gender minority specific health disparities,
- process research to explore how micro-aggressions occur in psychotherapy, processes of how minority stress is dealt with and using current technology to look at micro-components of therapy, such as utterances or body movements when discussing distal stressors (such as rejection and discrimination) and proximal stressors (such as internalised stigma and concealment),
- when conceptualising and measuring psychotherapy outcomes, to consider commonly used measures of symptomology incorporating criticisms around use for SGMs, proximal and distal stressors unique to SGMs, more focus on strength-based and resilience in the community and working alliance measures that are relevant to SGM clients (Budge et al., 2017).

In their mixed-methods systematic synthesis of LGBQ affirmative therapy clinical research between 2000 and 2015, O'Shaughnessy and Speir (2018) identified 49 articles examining the experiences with, or perception of, therapeutic intervention by LGBQ adults

and youth - thus excluding therapist or researcher-only work, such as case studies and therapist perceptions of their own sexual diversity affirmative therapy competency. They grouped the studies into three tiers:

- the 17 first-tier studies included randomised controlled trials and nonrandomised efficacy trials (open trials, and therapy process and outcome studies),
- the second-tier studies included 10 articles on programme evaluation of mental-health related programmes or non-therapy intervention studies,
- tier 3 studies included 14 qualitative and 7 quantitative studies looking at LGTQ clients' prior experience with therapy or their preferences for future work with mental health providers (O'Shaughnessy & Speir, 2018).

They acknowledge the significant contributions supporting a deepened understanding of effective strategies for LGBQ affirmative therapies. They concur with Budge et al. (2017) that future work needs to include more diversity (not just gay, white men) and move to more intersectional frameworks, to also support a continued move to clarify operational definitions for LGBQ affirmative therapy. In addition, they recommend more work that supports in dealing with or preventing minority stressors, developing measures that integrate the themes identified as important qualities in therapy, and more research on client experiences of therapists' competencies.

In their review of evidence-based affirmative practice Pachankis (2018) tracks the progress made in 4 areas namely: (a) identifying clear, measurable treatment targets, (b) conducting treatment studies of efficacy of affirmative practice, (c) assess SGM status in randomised controlled trials conducted with the general population, and (d) reduce stigma itself – which impacts on the potential to create treatment related evidence. Like O'Shaughnessy and Speir (2018), Pachankis (2018) identifies future directions of evidence-

based practice for SGMs that include: (a) if and how existing evidence-based treatments can address SGM-specific concerns, and (b) reasons why, under what conditions, and for whom SGM-affirmative treatments work (Pachankis, 2018). Significantly, Pachankis and Safren edited a handbook on evidence-based mental health practice with sexual and gender minority clients (Pachankis & Safren, 2019). More recently, we see reviews of empirically based psychological interventions with sexual minority youth (Hobaica et al., 2018) and broadened to include interventions with LGBTIQA+ youth (Bochicchio et al., 2022). Many of the studies are reflected in O'Shaughnessy and Speir (2018) and Pachankis (2018), but they also include more practice-based evidence such as case studies. The latter is also recommended as a complementary alternative to randomised controlled trials by Moradi and Budge (2018). Finally, Broadway-Horner and Kar (2022) reviewed 15 studies. What is striking though, is that most of the research is from studies conducted in the USA. Even the last review by a UK / India team is heavily skewed to studies from the USA, with some inclusion from the UK, Netherlands, and South Africa – the latter by Nel (2007). This is important to mention as the reviews might not necessarily reflect the unique dynamics in South Africa – whether the lived experience of sexually diverse people, the dynamics of psychotherapy in the country today, or the research goals and demands in the country, although certainly being salient to thinking about sexual diversity affirmative therapy in a global context.

Competencies in working with sexually diverse people

Perez (2007) defines one of the core conditions for affirmative counselling and therapy as a therapist's competence. Counselling psychology in the USA has been particularly active in theory and assessment development in sexual diversity affirmative therapy (O'Shaughnessy & Spokane, 2013). Guidelines are more generalised in nature

whereas competencies (e.g., Harper et al. 2013) are more specific regarding what is expected of counsellors. Based on Sue et al. (1992) Tripartite Model for multicultural competence, Israel et al. (2003) developed 33 knowledge, 23 attitudinal and 32 skills components of counsellor competence with sexually diverse clients. A similar study was conducted in Thailand, but with the inclusion of an action component in line with the MSJCC (see footnote 16) (Ratts et al., 2016). The results from feedback of both practitioners and clients included 41 knowledge, 35 awareness / attitude / belief competencies, 14 skills competencies, and 35 action competencies, rated from those with consensus and majority agreement to those contested or even highly controversial (Ojanen et al., 2021).

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) published competencies for counselling lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals in 2013 (Harper et al., 2013). The authors also used Sue et al. (1992) Tripartite Model but expanded the scope to include not just working with individuals, but also groups and communities, and concomitantly, the importance of continued self-reflection and personal growth in developing knowledge, awareness, and skills. This provided a broader perspective that included strength-based, feminist, and social justice perspectives, as well as stressing the importance in addressing systemic issues beyond the confines of individual practices through advocacy (Harper et al., 2013). The section covering working with lesbian, gay, bisexual, queer, and questioning individuals contains a substantial 120 competencies that are grouped as follows:

- Human Growth and Development (19 competencies)
- Social and Cultural Diversity (12 competencies)
- Helping Relationships (18 competencies)
- Group Work (21 competencies)

- Professional Orientation and Ethical Practice (13 competencies)
- Career and Lifestyle Development (12 competencies)
- Assessment (16 competencies)
- Research and Program Evaluation (9 competencies)

Boroughs et al. (2015) outlined their recommendations for minimum standards for psychology training programmes and CPDs to support practitioners in sexual and gender diversity-specific cultural competence. They based their work on research from both practitioner and client perspectives. Martell (2015) supports these recommendations and is of the opinion it will enhance training in cultural competence for graduate, intern, post-doctoral and CPD training for clinical, counselling and school psychologists. They observe that some of these recommendations are more properly guidelines that are aspirational rather than standards that are enforceable by accreditation bodies. Some recommendations are geared toward training institutions, whereas others relate to individual competencies, with the latter including development of cultural competence, awareness and use of LGBT-specific language, sensitivity around confidentiality and documentation for LGBT clients, familiarity and exploration of social context, and distinguishing LGBT-specific presenting problems from general mental health concerns (Boroughs et al., 2015). Beyond numerous suggestions for training standards (Boroughs, et al., 2015 [in USA]; Cree & O'Corra, 2006 [in UK], there has also been a flurry of guidelines for organisations and institutions (including private practices) on providing more affirmative care to sexually diverse people. These have included guidelines from:

- **Gay and Lesbian Medical Association. (2006):** Guidelines for care of lesbian, gay, bisexual, and transgender patients. GLMA: San Francisco, USA.

- **The Joint Commission. (2011):** Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide. The Joint Commission: Oak Brook, IL.
- **Müller, A. (2012):** Sexual and reproductive health for transgender and gender non-conforming people: Guidelines for healthcare workers in primary care. Cape Town: Gender DynamiX.
- **Substance Abuse and Mental Health Services Administration (SAMHSA). (2012):** A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals.
- **Walker & Mars. (2013):** LGBTI Cultural Competency Framework: Including LGBT people in mental health and suicide prevention organisations. Newtown NSW, Australia: National LGBTI Health Alliance.

Developing an affirmative stance

In developing and affirmative stance Paul (2017) suggests ongoing dialogue about potential tensions or conflicts for therapists – more specifically they advocate for ongoing conversations around how heterosexism has shaped our biases, belief systems and ways of conducting therapy. Attention is given to the oppressive nature of heteronormative systems, and limits of technical skills alone with these powerful systems. They highlight the dilemma of respecting the belief systems of all practitioners in a way that still support the well-being and right to freedom from oppression experience by sexual minorities. On one hand is the growing social support for sexually diverse people, but on the other hand, this occurs alongside continued oppressive heteronormative systems (a reflection of the idea of

Progressive Prudes in South Africa in a real way) (see Sutherland et al., 2016). Clinicians may feel enough to care and be generally competent, but growing up and living in a heteronormative society means the struggle to be affirmative can be real, regardless of sexual orientation – for both sexually diverse therapists as well as allies (Paul, 2017).

Bieschke et al. (2007) see the road to practising affirmatively as complex, even with the best of intentions. As members of a heterosexist society, practitioners bring these biases to their work, regardless of their own sexual orientation. Heteronormativity might be evident in more subtle practices for example, responses to ways that sexually diverse individuals have sex (e.g. anal sex) or the issue of stereotyping certain areas (e.g. top / bottom[18] discussion). Bieschke et al., (2005, as cited in Paul, 2017) express that it is important to allow ourselves to cognitively, affectively, and experientially be affected by the stories and experienced of sexually diverse clients and friends. Bieschke and Dendy (2010), propose a process of becoming affirmative using Berry's (1980) model of acculturation to ethics as framework. They suggest that a basic level of affirmation is required, otherwise heteronormative attitudes might colour judgement. Personal experiences influence perceptions, views, and conceptualisations of therapeutic encounters, with Paul (2017) agreeing with the use of affirmation as a lifelong process. They warn against the dangers of practising only by following the letter of the law or a "checklist" approach to guidelines and competencies and suggest care in making guidelines mandatory as this might not serve the larger project of countering systemic heterosexism (Bieschke & Dendy, 2010; Paul, 2017). Clinicians with conflicting beliefs and religious concerns might not share or process an openly given affirmative stance in the field. It has been shown that religious conservatism can significantly impact therapy outcomes. Bieschke and Dendy (2010) feel that the activist stance might have

[18] Queer lexicon: refers to sexual preferences around dominant (top) versus submissive (bottom) sexual roles

stymied engagement in how cultural and religious values may compete with an affirmation of sexually diverse people – thus marginalising individuals that will have to support such persons without opportunity to develop competence in the area (Bieschke & Dendy, 2010). The ethical choice would be to engage in the lifetime process of being affirming or to refer to others considered specialists in the area. Even this issue is not as simple as ethical guidelines state, as a referring clinician is possibly participating in the continued oppression of heterosexism. Referring out might also not be a possibility, such as in public health services or smaller towns and rural areas. Yet, even in referral situations it remains important for therapists to engage in self-reflection in dealing with client processes, and here supervision is important. If personal tension around working with sexually diverse people feels too great then the therapist can find ways not to include it in practice, but only after substantial processing of these issues. Demographic competence and dynamic inclusivity are viewed as necessary to ensure referrals of sexually diverse people, as with other practice decisions, are not discriminatory (Bieschke & Mintz, 2012; Hancock, 2014).

A significant body of research has indicated that affirmative practice correlates with a stronger therapeutic relationship, and that the relationship is the underlying mechanism through which affirmative practice correlates with psychological well-being of sexually diverse clients (Alessi et al., 2019). No research in South Africa has endeavoured to understand the extent to which clinical and counselling psychologists in South Africa feel prepared and able to deliver appropriate services to sexually diverse people. This appears important if the profession is to develop interventions to prepare trainees for practice, as well as provide continued learning opportunities for practitioners to ensure appropriate psychological care is provided to sexually diverse people.

Affirmative practice guidelines for working with sexually diverse people in South Africa

The past two decades have seen several affirming statements, position papers, general psychological practice and psychotherapy practice guidelines working with sexually diverse people across the globe. These either speak more broadly to SOGIE, gender, sexuality and relationship diversity, sexual and gender minority or specifically to sexually diverse people, including the APA (2000, 2012, 2021), Australian Psychological Society (2010), British Psychological Association (2012, 2019), Hong Kong Psychological Society (2012), IPsyNet (2018), National Council of the Italian Association of Psychologists (Lingiardi et al., 2015), New Zealand Psychologists Board (2019), Philippines Psychological Association (2011) and the Psychological Society of Ireland (2015). Locally, a particularly important and influential moment in time was the development and publication of the PsySSA Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People in 2017 (Greenbaum, 2019; McLachlan et al., 2019; PsySSA, 2017). The guidelines are forming the basis for similar guidelines to be developed across the African continent and potentially be a significant step in the drive to normalise sexually and gender-diverse people and their lives on the continent. The guidelines are in the process of being updated, with an envisioned launch date of 2024 for the updated guidelines.

The guidelines were developed within the context of a set of guidelines for psychology professionals to enhance diversity competence in South Africa (PsySSA, 2017), and the summary states:

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

Guideline 1: Non-discrimination. Psychology professionals respect the human rights of sexually and gender-diverse people and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity and biological variance.

Guideline 2: Individual self-determination. Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as 'coming out') of sexual orientation, or of gender diversity, or of biological variance.

Guideline 3: Enhancing professional understanding. Psychology professionals acknowledge and endeavour to understand sexual and gender diversity and fluidity, including biological variance.

Guideline 4: Awareness of normative social contexts. Psychology professionals are aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative and cisgender contexts.

Guideline 5: Intersecting discriminations. Psychology professionals are sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive-emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality.

Guideline 6: Counteracting stigma and violence. Psychology professionals have an understanding of stigma, prejudice, discrimination and violence, and the potential

detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals.

Guideline 7: Recognising multiple developmental pathways. Psychology professionals recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age.

Guideline 8: Non-conforming family structures and relationships. Psychology professionals understand the diversity and complexities of relationships that sexually and gender-diverse people have, which include the potential challenges:

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

Guideline 9: The necessity of an affirmative stance. Psychology professionals adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training, and education (including curriculum development, assessment and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions).

Guideline 10: Foregrounding global best practice care. Psychology professionals support best practice care in relation to sexually and gender-diverse service users/clients/participants by:

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

Guideline 11: Disclosing and rectifying of personal biases. Psychology professionals are, if it be the case, aware of their own cultural, moral or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist her or him in finding an alternative psychology professional should the client so wish.

Guideline 12: Continued professional development. Psychology professionals seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals. (PsySSA, 2017, pp. 12-13)

The guidelines represent an important move in assisting in the development of early career psychological professionals and CPD for practising psychological professionals to working affirmatively with sexually and gender-diverse clients, including sexually diverse people. One of the challenges going forward lies not just in ensuring that the guidelines

document is accessible by aspirant and current psychological professionals, but also in developing ways to underpin the development and application of affirmative counselling and therapy in practice when working with sexually (and gender) diverse people. More specifically, each of the guidelines contain an application section. The recommendations in this application section can be utilised to define the perceived competence of therapists and counsellors from basic competence required to practice to specialised competence in working with sexually diverse people. Developing a list of competencies based on the guidelines would support the work that has been done, as well as more accurately measure local practitioners' exposure and use of the guidelines. Given that the guidelines are part of diversity competence, as defined by IUPsyS, this framework is utilised to identify the specific competencies required when working with sexually diverse people (IPCP, 2016). This study, focussed specifically on clinical and counselling psychologists working with sexually diverse people and formed one basis for this development and application, and are also framed within the guidelines.

In summary

In this section we have explored the elements or aspects of affirmative practice when working therapeutically with sexually diverse people. Affirmative practice goes beyond a general accepting attitude and therapy to specific ways of thinking about and continually engaging with sexual diversity concerns. Scholarship and practice in this area has developed significantly with an increased focus on intersectional identities and the heterogeneous lived experiences of sexually diverse people, increased framing of affirmative practice in multicultural diversity competencies, and more contextual approaches in addition to an intra-psychic view, with an understanding of the system and interpersonal interplay, and linked to

ideas of power and privilege. The discussion moved to a focus on global research on psychotherapy with sexually diverse people, leading to a specific discussion of competencies in working with sexually diverse people, the challenges faced when developing and maintaining an affirmative approach, leading into an outline of localised work in the form of the PsySSA affirmative practice guidelines. The discussion now moves to training and education of psychological professionals, and the evaluation of such training, with reference to the important developments in South Africa over the past few years.

Training in working with sexually diverse people

Current graduate and CPD training

Training, both graduate and CPD training, have been identified as important when a practitioner will work with sexually diverse people, including human rights and social justice as core aspects (Bieschke & Mintz, 2012; Ellis et al., 2002; Green et al., 2009). In the USA, providers report that they have received little to no formal training in working with sexually diverse people (Lyons et al., 2010). Health professionals report a lack of access to training, or it is not mandatory when available. A survey amongst clinical psychologists (APA members), indicated that they had an interest in additional training, but did not think their work would improve substantially due to the training (Murphy et al., 2002). It has been postulated that practitioners may find it difficult to access such training due to personal bias (Lyons et al., 2010). Some trainees have argued that due to their religious beliefs they should not be required to provide services to sexually diverse people, or services that are affirming of sexually diverse identities or same sex sexuality (Bieschke & Mintz 2012).

Hunt (2020) conducted a synthesis of research pertaining to the experiences of therapists and counsellors working with sexually and gender-diverse clients. 14 studies were

identified for the period 1991-2019. 10 were USA based (Asta & Vacha-Haase, 2013; Dillon et al., 2004; Eliason, 2000; Garnets et al., 1991; Hancock et al., 2014; Harris et al., 2017; O'Hara et al., 2013; Rivers & Swank, 2017; Salpietro et al., 2019; Whitehead et al., 2012), two UK based (Grove, 2009; Owen-Pugh & Baines, 2014), one from Canada (Ristock, 2001) and one from Brazil (Gaspodini, & Falcke, 2018). They distilled the overarching theme of "the silencing and erasure of gender and sexual diversity" in therapy and counselling, with six core concepts emerging:

- Silencing and erasure perpetuated by:
    - heterosexism and transphobia, including beliefs that demean or trivialise gender and sexual diversity, and oppressive interactions,
    - fear and apprehension in "getting it wrong" or integrating new identities,
    - lack of knowledge, skills, and resources, that covered inadequate training, barriers to learning and the weight of responsibility in therapy and counselling.
- Silencing and erasure prevented by:
    - gender and sexual diversity affirmative practice, such as knowledge and application, and respecting differences,
    - continuous growth and development including learning from oneself and from interpersonal relationships,
    - social advocacy, including recognising marginalisation and giving voice to gender and sexually diverse people and groups (Hunt, 2020).

Most novice psychologists possibly find themselves working with sexually diverse clients early in their careers. Even when their expressed attitudes are highly affirming, their skills and knowledge can remain relatively undeveloped, and they might feel unprepared by

their training (Mohr, 2002; Owen-Pugh & Baines, 2014). In counsellors' reflection of their journeys working with LGBT clients in the UK, Owen-Pugh and Baines (2014) show thematic categories of engaging with learning, finding strategies that work, and entering the client's world. They concluded that providing trainees with opportunities for facilitated exploration of sexuality issues, that goes beyond simple didactic knowledge provision, could significantly improve counsellor (and thus therapists') competence and confidence in working with sexually diverse people (Owen-Pugh & Baines, 2014). A more recent study explored queer affirmative approaches with eight queer-identified clinicians in the USA from a range of ethnicities, gender identities and sexual orientations (Ramirez, 2020). Areas explored during counselling included intake, diagnostics, systemic privilege and oppression, self-disclosure, and the use of self in therapy. Lack of formal training, reliance on own experiences as queer, finding affirming supervisors, seeking, and sharing resources, and the need for advanced or specialised training (beyond basic introductory causes to sexual and gender diversity were highlighted) (Ramirez, 2020).

Similarly, the lack of training in South Africa for healthcare providers working with sexually- and gender-diverse people have been revealed (Coetzee, 2009; Müller, 2013; Müller, 2015; Nel, 2007). Müller (2013) conducted a study at the Faculty of Health Sciences at the University of Cape Town and found that LGBT health related content in the MBChB[19] curriculum was largely discretionary, unsystematic, and not incorporated into the overarching structure. More recently we have seen changes such as the development of more LGBTIQA+ content in graduate courses in the health sciences at the University of Stellenbosch. Since the launch of the PsySSA practice guidelines (PsySSA, 2017), more training courses aimed at mental health students and professionals have seen the light of day. This has included

[19] Bachelor of Medicine and Surgery (MBChB)

workshops by the PsySSA African LGBTI+ Human Rights Project aimed at Masters-level psychology students at the Unisa, University of KwaZulu-Natal, University of North-West, Rhodes University and the University of the Free State. The team has also developed an experiential, sensitisation introductory training course for providers (healthcare and social work professionals in particular) working with sexually and gender-diverse people. A research study on the effectiveness of this training makes a significant contribution to the field in South Africa (Victor & Nel, 2021). Although interrupted by the COVID pandemic, the PsySSA annual congress has in recent years hosted an active stand-alone stream of presentations and symposia around issues of sexual and gender diversity, under the auspices of their Sexuality and Gender Division (SGD). Other organisations such as the Professional Association of Transgender Health South Africa (PATHSA – www.pathsa.org.za) and Southern African Sexual Health Association (SASHA – www.sasha.org.za) have also provided more content to support health professionals, including psychologists, working with sexually and gender-diverse people. Finally, some basic introductory courses in working with sexually and gender-diverse people, ranging from face-to-face courses to online courses have been presented for psychologists and counsellors.

Recommendations for training development and content

In the USA, recommendations have been made for training health and social service practitioners in becoming more culturally competent in working with sexually and gender-diverse people. Hope and Chappell (2015) identified some specific aspects when considering the inclusion of sexual diversity content in clinical psychology graduate training programmes:

- identifying core competencies, including attitudes and beliefs, knowledge, skills, and advocacy / action,
- choosing integration into excluding curricula or separate courses,
- recruiting and retaining sexually diverse faculty and students,
- selecting or creating sites for practical experience,
- including sexually diverse people in research competency,
- choosing strategies to evaluate multicultural counselling competencies (MCC), including competency with sexually diverse individuals (Hope & Chappell, 2015).

In their discussion on the inclusion of human rights of sexually and gender-diverse people and communities in training psychologists, Koch et al. (2020), discuss relevance of language and terminology, the importance of including issues of human rights through exposure to the Yogyakarta principles amongst others, and human rights training objectives covering (a) values / attitudes / self-awareness, (b) knowledge, and (c) skills. Koch et al. (2020) further provide recommendations around the structure of courses and learning activities such as role plays, group research projects, and field placement training. Training not only relates to graduate course work but also to training for psychological practitioners as part of ongoing professional development, and training for people wanting to become paraprofessionals to assist sexually and gender-diverse people with mental health needs. Phillips and Fitts (2017) indicate the importance of including opportunities for self-reflectiveness and engaging in the systemic influences on people's lives, including gender binary oppressions, societal heterosexism, and the minority stress model. They highlight the relevance of including journals as important material, and the importance of affirmative supervision (Phillips & Fitts, 2017). O'Shaughnessy and Ladany (2017) also point out the importance of affirmative clinical supervision, and adaptation of existing supervision models to facilitate LGBTQ therapy competence. Some tools have been developed specifically for

supervisors, including the Sexual Orientation Matrix for Supervision (Long & Lindsey, 2004).

More recently, recommendations have been made to guide training for healthcare and social service practitioners in working with LGBTIQA+ patients (Pratt-Chapman et al., 2022):

- Prepare for a training:
    - Focus on who you are training when conducting a needs assessment to determine goals of training as well as the politics of the request for training.
- Aspects to consider in a training curriculum:
    - Foundational information on sexual and gender diversity concepts, terminology, culture, discrimination, and health disparities; health promotion strategies, and intersectionality; facilitating learner self-awareness of assumptions and biases; communication skills to optimise respectful shared decision-making; address stereotypes and generalisations, encourage resiliency; laws and other social determinants of health and health care for sexually and gender-diverse patients; organisational environment, policies, and processes that are welcoming and unwelcoming to sexually and gender-diverse patients.
- Methods of delivery focused on adult learning and transformational learning including:
    - Learners identifying their needs and sharing expertise; supporting learners to disrupt old patterns of meaning and create new understandings; multiple modes of interactive learning (multimedia, case studies, narrative, and self-reflection); and follow-up sessions if possible.

- Choose the right trainers and use them effectively.
- Evaluate the training (Pratt-Chapman et al., 2022).

Matza et al. (2015) conducted a systematic review of current LGBT key health reports and webinars with a USA focus. They identified 26 LGBT health key reports, which they rated on terminology, differences within LGBT populations, health and health disparities, transgender specific content, and diversity. A total of 27 LGBT focused webinars were identified, and the content graded on the same five criteria as mentioned above, as well as clinical practice, to provide a total grade. They concluded that although little attention is paid to LGBT health in professional psychology programmes, there are high-quality educational resources available, including up-to-date, easily accessible webinars freely available online (Matza et al., 2015). In commenting on the article Pantalone (2015) congratulates the authors but raises concern whether self-study alone is sufficient to increase one's cultural competency skills. They highlight that cultural competency requires a high degree of self-reflection, inherently an interactive skill, and cultural competency practice is about a clinician's actions and the consequences of those actions, rather than intent or training alone (Pantalone, 2015).

Evaluation of training programmes

According to Israel and Bettergarcia (2017) much of the research on teaching and training mental health providers on LGBTQ issues have focused on what is lacking, what is required, and what learners are or are not getting from their training programmes. Fewer studies have examined multimodal approaches to teaching, and even less on specific activities or teaching methods. They note the emphasis of current available research on lesbian and gay populations, with less attention paid to other sexual orientations, identities, and gender diversity issues. Overall, they conclude that these studies provide a basis for more

evidence-based research to support teaching and training methods when training providers working with sexually and gender-diverse people (Israel & Bettergarcia, 2017).

In a systematic review of studies published between 2000-2020, Bettergarcia et al. (2021) analysed 13 studies that reported on the effectiveness of training mental health students and providers in queer-affirming practice. Training ranged from one-hour sessions to annual graduate courses, and all used a combination of didactic and experiential or interactive elements. A range of evaluation methods were used including qualitative and ethnographic (Frick et al., 2017; Goodrich & Luke, 2010); post-test only (Craig et al., 2015; Finkel et al., 2003; Kauth et al., 2016), and pretest / posttest with comparison / control group designs (Bidell, 2013; Byrd & Hays, 2013) and without (Doherty et al., 2016; Israel & Hackett, 2004; Leyva et al., 2014; Pearson, 2003; Pepping et al., 2018). Almost all the studies indicated increases in knowledge, positive attitudes, and behaviour related measures such as clinical skills, self-efficacy, behavioural intentions, or change. It was noted that none of the articles mentioned cultural humility as a framework, only a few explicitly mentioned intersectionality, and less than half referred to teaching about social justice advocacy or advocacy opportunities (Bettergarcia et al., 2021). Pantalone and Abreu (2021) concur that cultural humility is an essential aspect of diversity competence, with a renewed call for continued and updated engagement, and research about training providers to work with sexually and gender-diverse people, including community-based participatory research (Pantalone & Abreu, 2021).

A recent randomised controlled trial in Romania of online delivery relative to in-person delivery of a two-day training course to mental health providers indicated similar improvements in LGBTQ-affirmative practice, and reduced bias over multiple follow-up measurements. After the first follow-up after five months, participants were invited to receive two-hour monthly online supervision for eight months. Those that attended at least one

supervision session also measured markedly higher on the measures of affirmative practice and decreased bias (Lelutiu-Weinberger et al., 2023). With the advent of COVID, we have seen significantly more online training opportunities, and we can expect to see more work on the evaluation of the success of online training on practice, given some of the issues raised by Pantalone (2015) around self-study, cultural humility, and clinician's practice.

Turning to training evaluation done in South Africa, we know of two studies. The first is a study on a six-session training programme amongst intern clinical psychologists (six from the University of Cape Town and two from the University of the Western Cape) aimed at increasing knowledge, raising awareness, changing specific attitudes, and imparting specific skills required for treating lesbian and gay patients (Coetzee, 2009). The author provides in-depth detail of course content and materials, with the course covering understanding of sexuality, homophobia and heterosexism, identity development and "coming out", intimate and social relationship issues, lesbian / gay families and parenting, and HIV / Aids and sexuality. The programme evaluation includes consideration of the course duration and timing, climate / group process, format – including didactic presentation, prescribed reading, experiential activities, speakers' panel, therapy role-plays, and audio-visual material, group composition, homework assignments, and impact on trainees' sense of competence (using the Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory [LGB-CSI]) and indicates that the programme succeeded in increasing competency and a greater sense of self-efficacy amongst participants (Coetzee, 2009).

Recently Victor and Nel (2021) determined the efficacy of PsySSA's LGBTIQA+ sensitisation training programme among a cohort of social workers. The training consisted of three rounds of 3-day workshops, and one round of 4-day workshops at five different locations in Gauteng, South Africa, between February 2019 – November 2020 and employed a multi-method approach of both didactic and experiential elements (Victor & Nel, 2021).

The training programme was developed based on the PsySSA practice guidelines and is contained in a detailed training manual (Van Dyk et al., 2022). This pre-post design used a locally adapted version of Bidell's (2017) LGBT-DOCSS as well as a post workshop evaluation, and found a significant increase in clinical preparedness (from 3.0 to 6.1 average on a 7-point scale), and basic knowledge (from 3.5 to 5.4 average). Attitudinal awareness increased from 5.1 to 6.1, and items measuring experience increased from 2.6 to 4.1 (Victor & Nel, 2021).

In summary

Current graduate and professional development training globally was discussed, with the core theme of increased training available but trainees continuing to express their need for further training. Some recommendations for training development and content were outlined, followed by a summary of the evaluation of training, including important work more recently conducted in South Africa. The evaluation of the PsySSA LGBTIQA+ sensitisation training programme among a cohort of social workers (Victor & Nel, 2021) represents a significant milestone in this country. This then brings the work to a discussion of the assessment and measurement of diversity competence, affirmative practice and self-efficacy or confidence when working with sexually and gender-diverse people.

Assessment of competencies and confidence / self-efficacy working with sexually diverse people

The development of multicultural, including social justice, competencies in counselling and psychotherapy over the past (almost) three decades has made a significant impact in practice, institutional and organisational change (Arredondo & Tovar-Blank, 2014).

Assessment of competencies have needed to take into consideration the multidimensional, sometimes liminal nature of the counselling or psychotherapeutic context and relationship. Different methods have been used to assess competence, including self-reporting measures, closed-ended tests, open-ended written feedback such as case formulation based on clinical vignettes, individual and group discussions, client surveys, observations of actual or simulated client interactions, and portfolios (Naidu & Ramlall, 2016).

Issues in operationalising and measuring competencies

One of the major issues faced by regulators and educators in developing competencies for psychology professionals more broadly, and counsellors and psychotherapists more specifically, is the difficulties in operationalising competencies, including measuring and evaluating whether someone can be considered good enough in the particular competency. Important aspects of psychological practice do not lend themselves easily to operationalisation. Competence in cultural humility for instance is possibly quite resistant to concretely defined standards, and measurement against such standards (IPCP, 2016; Naidu & Ramlall, 2016). In addition to cultural humility, other concepts important in the work of psychologists that might be difficult to operationally define and measure include ongoing critical self-reflection, development and trust in one's intuition, personal well-being, mutual dialoguing and sharing, and supervision (Naidu & Ramlall, 2016).

Worthington et al. (2007) conducted a content analysis of 75 articles reporting on multicultural counselling competencies (MCC) in the USA over the previous 20 years (focusing on race / ethnic diversity). The bulk of the articles (51) reported on professional and / or trainee self-report measures, and a further 17 articles on client ratings of counsellor MCCs. Nine articles contained observer ratings of counsellor / trainee MCCs. They noted

that an increasing number of studies, especially the client and observer rating studies, indicated consistency with the underlying assumptions of the MCC model. These process / outcome studies consistently show that counsellors who possess MCCs tend to have improved counselling processes and outcomes with clients across racial and ethnic differences. They conclude with the call to continue the development of efforts, including application of MCCs into empirically supported treatments (Worthington et al., 2007). In furthering the discussion, Arredondo and Tovar-Blank (2014) recommend more focus on exploring cognitive and emotional aspects of multicultural counselling and change over time, such as proposed by Caban's (2010) Multicultural Competence Change Scale (MCCS) for use by trainees and supervisors in MCC development. In a similar vein, Owen et al. (2011) recommend consideration of cultural processes in psychotherapy, including therapists' openness and ability to explore client's beliefs, their willingness and ability to learn new techniques, client perceptions of therapists as credible cultural healers, and therapists' reactions to clients' cultural values and beliefs (Owen et al., 2011).

Perceived competence and confidence in working with sexually diverse people

The assessment of competencies in working with sexually and gender-diverse clients has generated substantial research, particularly in the USA. The rest of this section will focus on a brief review of the main methods and instruments used to date. A comprehensive review of the Sexual Orientation Counselor Competency Scale (SOCCS) and the two self-efficacy scales namely the LGB-CSI and the Lesbian, Gay, Bisexual Working Alliance Self-Efficacy Scales (LGB-WASES) can be found in Bidell and Whitman (2013), including development, psychometric properties, limitations, and use in research. Bidell and Whitman (2013)

conclude that the three scales are psychometrically valid and reliable assessments, advancing understanding of sexual diversity affirmative counselling, training, and supervision.

A more recent review of scales used to measure LGBTIQA+ affirmation and discrimination constructs in adults included 36 assessment instruments divided into counsellor competency (4 instruments), attitudes to LGBTIQA+ population (15), experiences of discrimination for LGBTIQA+ individuals (8), and internalised attitudes (9) that either had a minimum mean citation per year or measured unique constructs (Peterson et al., 2017). The four counsellor competency instruments included in the review are the SOCCS, the Lesbian, LGB-WASES, the Gay Affirmative Practice Scale (GAP) and the Privilege and Oppression Inventory (POI) (Hays et al., 2007). The POI inventory contains items related to white privilege, Christian privilege, sexism, and heterosexism awareness, but was not developed with mental health practitioners in mind. The SOCCS, developed for use in work with counsellors, also measures awareness of bias and oppression. The POI had a mean citation on Google Scholar of 3.30 per year (Hays et al., 2007; Peterson et al., 2017).

The Sexual Orientation Counselor Competency Scale (SOCCS) (Bidell, 2005) and Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) (Bidell, 2017)

The **SOCCS** has been the most cited instrument of counsellor competency in working with sexually diverse people with a mean citation on Google Scholar of 9.12 per year according to a review by Peterson et al. (2017). The 29-item SOCCS is based on multicultural counselling theory extended to LGB groups, and theoretically measures attitude, knowledge, and skills dimensions. Participants rate each statement on a 7-point Likert-type scale (1=not at all true, 7=totally true). Evidence for validity and reliability are provided, including content validity, validity relative to other variables, and an Exploratory Factor

Analysis (Bidell, 2005). Higher sexual diversity counsellor competency, as measured by SOCCS, has been associated with:

- lower self-reported sexual diversity bias and prejudice levels (Henke et al., 2009),
- sexually diverse sexual orientation of practitioners (Shi & Doud, 2017),
- training working with sexually diverse people, including graduate courses and stand-alone training and workshops (Carlson et al., 2013; Graham et al., 2012; Lewis, 2008; Rivers & Swank, 2017; Rock et al., 2010; Rutter et al., 2008; Shi & Doud, 2017),
- organisational sexual and gender diversity competence (McCarty-Caplan, 2018), inclusion of sexually diverse affirmative course content (McGeorge et al., 2018), and perceived level of open and affirming services for sexually and gender-diverse youth (Moe et al., 2015),
- lower political and religious conservatism (Bidell, 2013; Bidell, 2014),
- geographic region in the USA (higher perceived competence in West vs. South of the country) (Shi & Doud, 2017).

The **LGBT-DOCSS** was based on the SOCCS (Bidell, 2005), revised versions of the SOCCS (Bidell, 2015), and the Attitudes Towards LGBT Patients Scale (ATLPS) (Wilson et al., 2014a). The LGBT-DOCSS is an interdisciplinary self-assessment for health and mental health providers and graduate students, to measure perceived competency in working with sexually and gender-diverse people. The final 18-item scale consists of three sub-scales – Clinical Preparedness (items 4, 10, 11, 13, 14, 15, and 16), Attitudinal Awareness (items 3, 5, 7, 9, 12, 17, and 18), and Basic Knowledge (items 1, 2, 6, and 8), with participants indicating agreement with statements on a 7-point Likert scale (1=Strongly disagree to 7=Strongly agree). The seven items of the Attitudinal Awareness sub-scale, and one item on the Clinical Preparedness sub-scale, are negative statements that need to be reverse scored in the final

analysis. Scoring includes a total LGBT-DOCSS score, and scores for each of the three sub-scales.

A total of 37 items were initially selected and adapted by the author, and subsequently 20 items were selected based on USA, UK, and European Union expert ranking of importance for each of the competency domains of knowledge, prejudicial attitudes, and clinical skills. Research participants for three subsequent studies were voluntary recruited from the USA and UK, and included trainees, clinicians, and educators from applied psychology, counselling, psychotherapy, and primary care medicine. A first study (n=602) utilising exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) techniques identified the 18-item three-factor structure. The final confirmatory factor analysis (CFA) solution explained 58.54% of the cumulative variance, with the sub-scale Clinical Preparedness accounting for 29.16% of the variance, the Attitudinal Awareness sub-scale 18.55% of the variance, and the Basic Knowledge sub-scale 10.84% of the variance (Bidell, 2017). A second study with the same respondent data (n=602) explored reliability estimates, and results indicated good internal consistency for the overall LGBT-DOCSS composite score, as well as the scores for each of the three sub-scales. In addition, a smaller sample (n=27) of undergraduate students in the UK, provided strong test-retest correlations for the overall and sub-scale scores indicating temporal stability (Bidell, 2017). The third study (n=564) provided support for content and construct validity by utilising hypothesis around certain participant criteria (sexual orientation and education level), as well as convergent and discriminant validity utilising four established scales that measured LGBT prejudice: (a) Right-Wing Authoritarianism-Short Scale [RWA-S], (b) Genderism and Transphobia Scale-Revised-Short Form [GTS-R-SF], (c) the Assessment Skills sub-scale from the LGB-CSI, and social desirability, and (d) Marlowe-Crowe Social Desirability-Short Form-A (MCSD-SF-A) (Bidell, 2017).

Bidell (2017) noted that the psychometric properties of the LGBT-DOCSS, and its sub-scales, made this instrument well suited, amongst others, as an outcome variable for research purposes for guiding further research and training development. Bidell (2017) commented that the naming of the scale as clinical skills rather than competencies reflected their advancing understanding of the complexity in defining and operationalising competencies working with sexually and gender-diverse people. Research using the LGBT-DOCSS amongst primary health care providers in the USA, have shown that perceived competence is related to whether providers worked with sexually and gender-diverse patients, which can in turn also be due to increased provision of training in settings that work with sexually and gender-diverse patients. The researchers highlighted the importance of recognising that separate skills and competencies are required to work with sexually diverse and gender-diverse patients (Boskey et al., 2019).

The Gay Affirmative Practice Scale (GAP) (Crisp, 2002, 2006)

In comparison to psychology, multicultural competence models have more easily been viewed through the lenses of the person-in-context or person-in-environment in social work. This provided impetus for the adoption of affirmative practice, considering not just a practitioner's individual development but also both the importance of context and a strength-based or resilience approach, which in turn led to the development of the Gay Affirmative Practice Scale (GAP) for measuring beliefs about and engagement in affirmative practice (Crisp, 2005, 2006). The Belief scale consists of 15 items answered on a verbal scale ranging from strongly agree to strongly disagree. The Behaviour scale includes 15 items with answers ranging from Always to Never. Measures for reliability and validity were provided, including content validity, confirmatory factor analysis (CFA) for internal structure, and validity relative to other measures and constructs.

The Gay Affirmative Practice Scale (GAP) has subsequently been utilised amongst psychological counsellors and psychotherapists as well (Alessi et al., 2015), and has a mean citation on Google Scholar of 8.82 (Peterson et al., 2017). The terminology of the scale appears to be somewhat dated by now, reflecting terms such as lesbian and gay, to the exclusion of other sexual orientations, and homosexuality and homophobia. Although important, research in this area of work has increasingly moved away from the concept of homophobia towards concepts of stigma and heteronormativity. The scale remains useful when planning development of new scales, as many of the aspects covered remain relevant as part of affirmative practice.

Crisp (2005) found that increased affirmative attitudes and behaviour amongst social workers and psychologists in the USA was mediated by the number of LGB friends they had and whether respondents' primary interest was mental health or another area of work. They found no difference in the average levels of affirmation between psychologists and social workers (Crisp, 2005). A study amongst Iberian mental health professionals indicated that affirmative practices (using the GAP) and competence (using the SOCCS) were predicted by religious and political beliefs, and training / education (Pereira et al., 2019).

The Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) (Dillon & Worthington, 2003), and the short form of the scale – the LGB-CSI-SF (Dillon et al., 2015)

Early research around therapists' self-reported feelings of adequacy in working with sexually diverse clients (e.g., Allison et al., 1994) was further developed to incorporate the idea of self-efficacy, developed by Bandura. Self-efficacy has been hypothesised to influence initiation and performance of therapeutic behaviours and the level of interest and persistence in performing specific psychotherapy-related tasks. Based on Bandura's ideas around self-

efficacy (e.g., Bandura, 1986, 1997), the Tripartite Model (Sue et al., 1992) model, and the ideas around affirmative practice, the Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) was developed (Dillon & Worthington, 2003). This scale, utilising a solid theoretical perspective, assesses counsellor and therapist confidence to perform LGB affirmative practice across five dimensions, namely: (a) applying knowledge of LGB issues, (b) performing advocacy skills, (c) maintaining awareness of attitudes to own and others' sexual identity development (or awareness), (d) developing a working relationship with LGB clients, and (e) assessing relevant underlying issues and problems of LGB clients (Dillon & Worthington, 2003). Reliability and validity were explored over five studies providing evidence for reliability, including test-retest reliability, and validity, including confirmatory factor analysis (CFA) of scale structure, convergent (relative to other variables) and discriminant validity (relative to desirable responding). In the final scale participants are asked how confident they feel in their ability to perform 38 different activities spanning the five dimensions, on a 6-point Likert-type scale ranging from 1=Not at all confident to 6=Extremely confident (Dillon & Worthington, 2003).

Higher self-efficacy as measured by LGB-CSI have been associated with higher levels of professional experience (Dillon et al., 2008) including number of years of practice, and LGB clients seen (O'Heron, 2011; O'Shaughnessy & Spokane, 2013), self-identity as LGB (Dillon et al., 2008; Haag, 2008; O'Heron, 2011), and multicultural training working with sexually diverse people received (Bidell, 2012; Coetzee, 2009; O'Shaugnessy & Spokane, 2013). Some studies have indicated that therapists' express higher self-efficacy if they are committed to exploration of their own sexual and gender identity (Dillon et al., 2008) whereas others did not have this finding (O'Heron, 2011). There is also evidence that gender and gender role adherence, religious affiliation, and prejudice are less predictive of self-efficacy (Haag, 2008).

Alessi et al. (2015) conducted research among heterosexual therapists that tested a model based on Bandura's social-cognitive theory, including the influence of attitudes toward sexually diverse individuals, training hours, affirmative counselling self-efficacy, and beliefs about affirmative practice on therapist engagement with sexual diversity affirmative practice (Alessi et al., 2015). Apart from demographic information and questions around training hours, the researchers included four subscales from the Lesbian, Gay, and Bisexual Knowledge and Attitudes Scales for Heterosexuals (LGB-KASH) (Worthington et al., 2005), the LGB-CSI, and the Gay Affirmative Practice Scale (GAP) in their study. They concluded that a focus on improving knowledge, skills and attitudes form only a part of the required training, with interventions to improve self-efficacy and influencing beliefs potentially further increasing engagement in affirmative practice.

Based on the success of this scale, a short form of the LGB-CSI was developed to facilitate research with time constraints from both client and clinician (Dillon et al., 2015). The Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory Short Form (LGB-CSI-SF) was developed from the original 32-item LGB-CSI (Dillon & Worthington, 2003), to facilitate sexual diversity affirmative counselling training, as well as process and outcome research (Dillon et al., 2015). The short form scale was developed amongst a sample of mental health professionals (n=435) and graduate students / trainees (n=140). Items were selected by using the items with the highest loadings on each of the five factors and that demonstrated good fit and structural integrity with the original five-factor model, ensuring significant internal correlations between items and sub-scales, as well as good internal consistency. Convergent validity was demonstrated by correlation with participant criteria (training in LGB issues, number of LGB clients, number of LGB family / friends) and attitudes toward LGB people, as measured by the LGB-KASH (Worthington et al., 2005). Divergent validity was indicated by correlation on the Balanced Inventory of Desirable

Responding [BIDR] (Paulhus, 1991). It was indicated that the short form took only 5-10 minutes' administration times, assessed the same 5-dimensions of the original and has more stable test-retest reliability. The final LGB-CSI-SF is a 15 items scale (1=not confident to 5 = extremely confident), with three items each measuring application of knowledge, advocacy skills, self-awareness, assessment, and relationship.

The Lesbian, Gay, Bisexual Working Alliance Self-Efficacy Scales (LGB-WASES) (Burkard et al., 2009)

A refinement of this research, using Bordin's work around the tripartite model of alliance (Bordin, 1994), led to the development of the LGB Working Alliance Self-Efficacy Scale (LGB-WASES). The scale consists of 32 items with responses on an 11-point scale ranging from 0-10 with 0 = cannot do at all, to 5 = moderately certain can do, to 10 = certain can do, and includes three sub-scales namely: (a) Emotional Bond (13 items), (b) Establishing Tasks (13 items), and (c) Setting Goals (6 items) (Burkard et al., 2009). This expansion further adds to our understanding of the client-practitioner relationship. It is not meant to represent the entire counselling relationship, but rather to support the work by exploring factors that provide the basis for clients engaging and following treatment (Burkard, et al., 2009). Measures of reliability and internal consistency (including test-retest reliability), exploratory factor analysis, divergent and convergent validity were reported. The LGB-WASES had a mean citation of 1.88 on Google Scholar (Peterson et al., 2017).

Other measurements of perceived competency and self-efficacy / confidence

Several studies have developed instruments that measure specific aspects or populations within the area of affirmative practice. Two doctorate examples from the USA are the Lesbian and Gay Affirming Social Justice Competency Scale (Kizer, 2011), and the

Counseling Bisexual Clients Competency Scale (Klinger, 2012). Kizer's final scale included 28 items measuring self-efficacy, attitudes, actions (such as volunteering) and awareness of social justice issues when working with LG people, as well as a further 5-item scale measuring general attitudes to social justice (Kizer, 2011). The Kizer (2011) study showed the importance of engaging in social justice issues, whereas the Klinger (2012) study focused attention on breaking the silence around working with bisexual clients in the field. A USA study by Brooks and Inman (2013) used the SOCCS and the Attitudes Regarding Bisexuality Scale (Mohr & Rochlen, 1999) showed that attitudes towards bisexuality were significant predictors of perceived and actual bisexual counselling competency (Brooks & Inman, 2013).

Some studies developed their own scales to address their specific purpose, whether geographic or target populations. A study amongst USA Veterans Health Administration psychologists contained 52 quantitative questions including demographic (5), training (21), experience (7), current practice (6), attitudes and knowledge (6), self-reported competence (2) and need / interest for training (2). They found that the group of psychologists had minimal training and experience in working with LGBT people, and that younger psychologists, more progressive regions, and psychologists with more training had more LGBT-affirming attitudes (Johnson & Federman, 2014). A study amongst primary health care providers in Indiana, USA, developed a 27-items questionnaire covering attitudes (5), what providers do in their practice (10), and 12 items evaluating knowledge (Nowaskie & Sowinski, 2018). The results indicated a lack of cultural competency and substantial endorsement of negative biases, attitudes, inconsistencies in practice and deficiencies in knowledge, and recommendations for increased sexual and gender diversity specific education were made. A subsequent comment further recommended that practitioners be supported in finding their own training and experience solutions, given the complexities of shifting curricula (Nathan, 2019). A recent study conducted amongst healthcare providers in Lebanon developed 14

questions to specifically reflect attitudes and behaviours in the country (Naal et al., 2019). The latter study indicated the importance of ensuring that instruments stay both relevant to time and place, thus ensuring measurement reflects the unique circumstances of the country, whilst also creating an implicit challenge to create measurements that are globally relevant.

In some case, attitudes of mental health providers towards sexually diverse clients are measured utilising more generalised measures such as the Modern Homophobia Scale (MHS) (Raja & Stokes, 1998), Attitudes Regarding Bisexuality Scale (ARBS) (Mohr & Rochlen, 1999), Attitudes toward Lesbians and Gay men scale – short form (ATLG-S) (Herek, 1988), the Riddle Homophobia Scale (Coetzee, 2009; Finkel et al., 2003), the Lesbian, Gay, and Bisexual Knowledge and Attitudes Scales for Heterosexuals (LGB-KASH) (Worthington et al., 2005), and the Modern Homonegativity Scale (MHS) (Morrison et al., 2009). Peterson et al. (2017) highlights 15 scales, of which the ATLG-S and the MHS has the highest mean citations per year on Google Scholar – 42.00 and 24.00 respectively. These might be considered explicit attitudes, given the self-report nature of the instruments.

An interesting developing area is the idea of measuring implicit attitudes that are outside a person's conscious awareness or control. Work has indicated that implicit attitudes measures can predict a variety of behaviours, including discrimination (Greenwald et al., 2009). The Sexual Orientation Implicit Association Test is a computer-based task utilising visuals associated with good / bad as two attributes, and has been utilised in measuring the implicit and explicit attitudes towards lesbian women and gay men amongst healthcare workers (including mental health workers) (Sabin et al., 2015), genetic counselling students (Nathan et al., 2019), substance abuse treatment providers (Cochran et al., 2017), early-career physicians (Wittlin et al., 2019) and the impact of an affirmative-training course on mental health professionals in Romania (Lelutiu-Weinberger et al., 2023).

Limitations of self-report instruments

Limitations of self-report competency instruments have been explored in length, with issues including:

- definition of user population / client type either being too narrowly defined "gay" (to the exclusion of for e.g. transgender clients), or heterosexual providers; or too broadly defined "LGBTIQA+", neglecting inter-group differences and making comparisons between instruments difficult,
- reliance on quantitative item-based self-report measures only,
- measurement of explicit attitudes without exploring implicit bias, such as heterosexist bias,
- lack of attention to treatment outcomes, case conceptualisations and client perspective or satisfaction (e.g., Bidell, 2012; Boysen, 2010; Dunn et al., 2010).

In self-report measures providers tend to overestimate their level of skill as well as perceived improvements in clients due to therapy (Johnson & Federman, 2014). Furthermore, in quantitative research, operational definitions are predetermined by researchers, and control the range and type of responses obtained through the type of scales used (Ponterotto et al., 2002). In general, it can be expected that participants tend to be more positive than negative in Likert-style ratings, which would then imply that the average or norm for ratings would be higher than the mid-point. A part of this would be related to expressing socially desirable responses and ceiling effects (see e.g., Leitch, 2021).

Mixed method and qualitative research

Bidell (2005) acknowledges the complexity of quantitatively measuring sexual diversity affirmative and multicultural counsellor competency, recommending that qualitative methodologies also be considered. In many qualitative methods, participants are keenly involved in the process of defining and evaluating the variables of interest in the study. Being more collaborative in nature, the outputs are potentially more relevant to consumers of the research, including the participants themselves, and others tasked with developing and evaluating competence (Ponterotto et al., 2002).

The methodology of using qualitative case conceptualisation data to assess competency has been used successfully in the multicultural competency literature (e.g., Constantine & Ladany, 2001; Inman, 2006; Ladany et al., 1997). The area of counsellor competence in working with sexually diverse clients has also seen the increased use of alternative methods to assess competence including a quantitative evaluation of responses to a case history (Harris et al., 1995), case conceptualisation based on four clinical vignettes randomly assigned to different groups with two trained coders' rating responses on 5-point scales (O'Shaughnessy & Spokane, 2013), and a doctoral study by Longo (2013) that looked at how mental health clinicians assess the level of mental health of gay male clients utilising two case vignettes. The latter compared a small sample of Colorado (USA) based students and clinicians' assessment of psychological functioning of two vignettes that were the same, except for implied straight versus gay sexual orientation of the client. Psychological functioning was measured using the Mental Health Inventory (MHI-18), the Brief Psychiatric Rating Scale (BPRS), and Global Assessment of Functioning (GAF) (Longo, 2013). The O'Shaugnessy and Spokane (2013) study asked USA based psychology trainees five open-ended questions following exposure to one of four clinical vignettes including: (a) presenting

problem, (b) key issues to address in therapy, (c) goals for working with client, (d) issues they might have working with the client, and (e) how prepared they felt working with this client. The average scores on the case conceptualisation task were low, which might have been due to low actual competencies or the internet research environment relative to assessing competency in situ. Additional measurement issues around how participants interpreted the questions and interrater reliability were also highlighted, with a recommendation of further methodological research utilising this method.

A recent instrument, the Competency Assessment Tool for Lesbian, Gay, Bisexual, and Transgender Clients (LGBT-CAT) consisted of 12 open-ended questions about providers' direct practice (8), organisational practice (2), and community / policy practice with LGBT clients (2). The answers were scored from 0 (no competency) to 3 (strong competency). Inter-rater reliability, and completion length for both participants and researcher, remain issues with this type of instrument, and it was concluded that this tool is potentially useful for pre-post-test training evaluation, including as a tool for supervision and participant self-reflection (Leitch et al.,2021).

In summary

This section has reviewed measurements of competency, with a focus on perceived competence and self-efficacy or confidence working with sexually diverse people. Several instruments were discussed with two, namely the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Scales (LGBT-DOCSS) and the short form of Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI-SF) being more recent, and with proven psychometric properties. The limitations of self-reporting quantitative measures and the potential of including more qualitative assessments were discussed, but it

was noted that further development work is required in this area. In developing this local benchmark study, ensuring comparability across countries with known instruments, appears important and will therefore be used in this study, while understanding the limitations, and hopefully ensuring a base for expanded academic interest in the area in South Africa. The discussion in this chapter now leads to the next chapter discussing the research method of the study.

CHAPTER 4: RESEARCH DESIGN

Introduction

In Chapter 2, sexual diversity and sexual orientation was delineated and defined. The current South African landscape for sexually diverse individuals was discussed with a focus on mental health needs, service delivery and the role of psychology. Chapter 3 described diversity competencies in a multicultural society, with a focus on psychological professionals working with sexually diverse people. This was followed by exploring affirmative practice in working with sexual diversity, culminating in outlining the PsySSA practice guidelines (PsySSA, 2017). Issues around training when working with sexually diverse people were followed by a review of measurements of self-efficacy / confidence and perceived competence, and concluded by highlighting the two most recent and relevant instruments for use in my research, namely the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) and the short form of Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI-SF).

In this chapter the research design for the study is discussed, starting by revisiting the research objectives; the link with a transnational study, including discussing the differences in focus between the two studies; target population; questionnaire design; data collection; data processing and diagnostics; and the data analysis strategy.

Research objectives revisited

As discussed in Chapter 1, the primary research objectives of the study were to determine the following amongst registered clinical and counselling psychologists in South Africa:

- What graduate and CPD training have they received and want to receive in working with sexually diverse people?
- What professional and personal experience or exposure do they have with sexually diverse people (in their private lives and in practice)?
- What is their perceived competence in practising affirmatively with sexually diverse people?
- How confident are they in affirmative practice with sexually diverse people?

At a secondary level, further research questions were:

- Are there particular segments of clinical and counselling psychologists with potentially different development needs that require different types of intervention to ensure increased affirmative practice?
- Do the measures utilised in this study provide an acceptable level of reliability and validity that can confidently be used in the current research, and future work in this field in South Africa?
- provide confidence in this and future work in this area in South Africa?

The transnational study

As indicated, my research proposal was accepted in 2017, but I was only able to spend more active time in implementation since 2021. By this time a larger multinational, or transnational study team that I am part of, was also in the process of developing the quantitative leg of research. Given the clear convergence, and to avoid duplication of effort, it was agreed that my data would be collected utilising the same questionnaire and data collection opportunity. The distinguishing features between my doctorate and the transnational study are:

Table 4. 1

Comparison between my doctorate and the transnational study

	My doctorate	Transnational study
Geographic area	South Africa	Multinational, including South Africa
Topic	Training, experience, perceived competence, and confidence	Role of psychology guidelines on mental health access and treatment
Working with	Sexually diverse people	LGBT+ people
Method	Quantitative	Qualitative and quantitative
Target population	Clinical and counselling psychologists	Mental health practitioners, including social workers, registered counsellors and psychologists, psychiatrists, nurses, and occupational therapists

The benefits of the convergence of the research included shared effort and expertise, and data collected amongst the target group in one instrument at one time, ensuring data equivalency and comparability, as well as maximising our opportunity to have more participants respond on both studies rather than one or the other. Some overlap in the work was inevitable and will be outlined in the questionnaire section specifically. Given the transnational study focus on LGBT+ clients / patients, some of the work I am reporting on refer to LGBT+ clients / patients rather than to LGB or sexually diverse clients / patients specifically, particularly in the data collected around training and experience. This will be referred to when discussing the results when relevant. In the following section, the target population for my study will be more fully discussed.

Target population

The target population for my study was: (a) South African, (b) clinical and counselling psychologists who (c) work with sexually diverse clients. More specifically the target was:

- HPCSA registered clinical and counselling psychologists that,
- do full- or part-time counselling or psychotherapy work,
- with sexually diverse clients, including lesbian, gay, and bisexual sexual orientations.

Louw and Machemedze (2015) utilised the 2011 South African census results to understand psychology education in South Africa. Their results show 45 335 people that indicated "psychology" as their main field of education. Comparing this number to the number of HPCSA registered practitioners, we see how the subject of psychology provides a base for many different careers, keeping in mind that many other allied professions such as social work and medicine would not indicate psychology as their main field of education. According to the most recently available information from the HPCSA, there are a total of 9474 registered psychologists across seven registration categories in South Africa, of which 76% are female and 66% are white, with a significant majority found in the metropolitan areas in the provinces of Gauteng, Western Cape, and KwaZulu-Natal (Padmanabhanunni et al., 2022). More specifically, the HPCSA data indicates a total of 3290 registered clinical psychologists, and 1848 registered counselling psychologists. In the face of significant mental health disorders in South Africa, South Africa has a significantly below average rate of psychologists per 100 000 of the population relative to the global average and continues to struggle with racial and gender skews in the profession (HPCSA, 2017; Lappeman et al., 2021; Padmanabhanunni et al., 2022; Williams, 2014). There has been a significant

commitment to change, and student demographics in psychology has seen a more equitable race profile, yet a lot of work remains (Padmanabhanunni et al., 2022). The number of registrations does not include the number of registered counsellors, nor does it consider multiple registrations that is possible for the same person (such as is the case for both my supervisor, Prof. Nel, and me). Unfortunately, the registered counsellor registration category, although initially well supported in training institutions, mostly did not realise into appropriate employment opportunities, particularly with the Department of Health, as initially envisioned (Pillay, 2016). Another registration category debate in the field is around the continued distinction between clinical and counselling psychology, with a recent study indicating more similarities than difference in areas such as key activities and theoretical considerations (Young & Young, 2019). Given these findings, it was decided to include both registration categories (clinical and counselling psychologists) in the current study. Although we do not know what proportion of registered clinical and counselling psychologists work with LGBT+ clients, it is likely a large proportion, even if the practitioners are not aware of it. Having discussed the target population, the next section will discuss the ethical consideration for the study, followed by detail of the data collection phase.

Ethical Considerations

The ethical considerations for my project were based on the HPCSA's code of conduct for psychologists (Department of Health, 2006) and the Unisa policy on research ethics, which includes the four established pillars of ethics being autonomy, beneficence, non-maleficence, and justice (Unisa, 2016). The code of conduct specifies the requirement for institutional approval prior to conducting research (Department of Health, 2006) and the following ethical clearances were obtained:

- my doctorate received ethical clearance certificate PERC-17061 on 27 October, 2017 (Appendix I), and amended on 2 October, 2019 (Appendix II). The latter states that the Ethics Committee have no objection to the project or the dissertation research forming part of a collaborative project,
- transnational study ethical clearance by Ethics Review Committee of the University of Massachusetts Boston Institutional Review Board (Assurance # FWA00004634; IRB Study Number: 2018231) (Appendix III),
- South African part of the transnational study received ethical clearance from the Unisa Ethics Review Committee (CREC Reference #1115146_CREC_CHS_2022) (Appendix IV).

One element of ethical research would be to ensure that participation in research is freely given based on full disclosure from the researcher and for the purpose of the research specifically called "informed and non-coerced consent" (Unisa, 2016). Participants received a detailed information sheet prior to starting the survey that detailed the nature of the research and how the information will be utilised, freedom of participation and withdrawal at any time, confidentiality of information and security of data, incentive, and nature of this inducement for participation, potential length of survey, and options for contacting the researcher for further information if so required. Consent to this was provided by clicking on a relevant link (see Appendix V). Furthermore, research needs to be carried out to maximise public interest and social justice (Unisa, 2016). My research, and indeed the broader field of LGBTIQA+ psychology, has at its core the belief and drive for social justice and health for people that have had to deal with a long history of stigma, discrimination, and violence. This larger societal project is ongoing, and my research will form one small part through informing education, training, and professional development activities for both aspirant and registered clinical and counselling psychologists, and potentially, mental health professionals more broadly.

Data collection

Online / internet-based survey

The studies (both my doctorate and the transnational study) used as primary source, a quantitative online web-based internet survey method to collect data. This choice was based on key considerations including the work already conducted in this area as discussed in the previous chapter: (a) utilising the same method across countries as part of the transnational study ensuring comparability across countries, (b) to allow for the application of standardised measures with known reliability and validity, (c) to allow for comparative measurement over time, and importantly (c) as the objectives would best be answered by numerical data gained from the largest possible sample of the target population. Questions including "how many", "to what extent", and "to determine" are best answered by quantitative, numerical data, whereas qualitative data is better suited to exploratory work asking the "why" question - see for instance Taherdoost (2021) and Taherdoost (2022) for a concise up to date discussions of the choice of data-collection method.

Survey data collection methods have long been an important data collection tool across many research fields, with online surveys, particularly web surveys, dominating today as preferred method in areas such as market research (Vehovar & Manfreda, 2017). The dramatic advance in technology has meant more people being able, willing, and preferring to access the internet, through numerous devices such as laptops and mobile phones, with increasingly sophisticated and user-friendly interfaces. Concurrently there has been a dramatic proliferation of easy-to-use tools to support the development and implementation of surveys with increased levels of quality and ethics. By 2015 there were already around 300 online survey design and recruitment software products and packages in English (Vehovar & Manfreda, 2017), and which have since then seen significant development and refinement, to

the point that software names have in some cases become common use nouns in language such as “Please send a Doodle Poll” or “Let’s do a Survey Monkey to see how clients feel about X”.

It can be safely assumed that all mental health professionals have access to the internet on some device and have an e-mail address, with most having completed some form of web-based internet surveys, and mostly on their own devices. An internet survey provides the most cost effective, and arguably the most international common and comparative, method of accessing the responses of larger numbers of mental health practitioners.

Instrument design process

My involvement in the larger transnational project has been discussed. Suffice to repeat here is that there were clear synergies between my doctorate and the quantitative part of the transnational project, which the transnational team started exploring in June 2021. The Columbian and Russian survey questionnaires from the project, and my doctoral proposal draft questionnaire, formed the basis for an intensive, interactive design process from the beginning of 2022 through to the final pre-testing and subsequent final questionnaire by beginning of 2023. The questionnaire was loaded onto the Qualtrics[20] system hosted by the University of Massachusetts Boston.

Pre-testing

The online questionnaire was pre-tested amongst, at the time, the five permanent members of the PsySSA African LGBTI+ Human Rights Project. They provided detailed

[20] https://www.qualtrics.com

content and process feedback. Based on their feedback the revised online survey was completed by six practitioners working with sexually and gender-diverse people – four clinical psychologists and two psychiatrists – that I personally knew. This final pre-test was done between 20-27 October, 2022, followed by discussion and finalisation of the online survey for launch early the following year. Based on the pre-testing feedback, the questionnaire would take an estimated 25-35 minutes to complete.

Sampling

The South African leg of the transnational study utilised a convenience sample to endeavour to reach as many mental health professionals working with LGBT+ people as possible through the following channels:

- E-mail invites to:
    - PsySSA's general database, which included psychologists registered with the HPCSA,
    - Professional Association for Transgender Health South Africa (PATHSA) membership base,
    - the databases of both the South African Society of Psychiatrists (SASOP) and the South African Clinical Psychology Society, through Healthman[21]: the organisation administering both,
    - the Occupational Therapy Association of South Africa database.
- Invitation advertisement was placed:

[21] https://www.healthman.co.za/

    - in the newsletter sent to members of the South African Council for Social Service Professions (SACSSP), which include clinical social workers, social workers, and auxiliary social workers,
    - on the following South African mental health practitioners Facebook groups:
        - "South African Psychologists in Private Practice",
        - "SA CPD Events, Talks & Training – Mental Health",
        - "SA Psychologists Resources and Discussion Group",
        - "Cape Town Mental Health Professionals".
- Invitations sent by the transnational research team as well as the members of the PsySSA African LGBTI+ Human Rights Project to their professional and personal networks, including colleagues, private health facilities and organisations (with request for further distribution by them).
- Invites to the participants of the PsySSA African LGBTI+ Human Rights Project guidelines training conducted for the Department of Social Development Gauteng.

Through the above distribution of the invite, most registered clinical and counselling psychologists would have received the invite (at the very least via the PsySSA / HPCSA database). Many would have received multiple invitations from different sources, particularly those working with LGBT+ people. Two reminders were sent out to boost participation rates. The e-mail invitations were customised by the organisations with content provided by us, and we designed the invite advertisement used. The invitations contained both a URL link and a QR (Quick Response) code to facilitate access (Appendix VI).

Participant information sheet and informed consent

On accessing the link from the invitation, participants were provided with an information sheet outlining the title of the research study, team, ethical clearance, purpose of the study, reason for being invited, nature of participation, right to withdraw, confidentiality of information, data security, potential benefits of taking part in the study, and contact information. Participants had to click on a "proceed" button to acknowledge that they had read and understood the information, had sufficient opportunity to seek clarity and prepare for participation, understood that they would voluntarily participate and were aware of how the results would be processed, thus informed consent (Appendix V).

Final instrument utilised

Following the participant information sheet, leading to informed consent acceptance, the final online questionnaire (Appendix VII) consisted of the following sections and instruments:

Screener questions and demographics. Screening questions included that the respondent is 18 years and above, a registered mental health professional, who has worked with LGBT+ clients / patients in South Africa currently, or in the past. Personal demographics included area residing in, age, race, sex assigned at birth, gender identity, and sexual identity / orientation. Organisational and practice demographics include occupation / registration category, highest level of education, place of work, type of work, and years of practice.

Training. Questions around training including year graduate training was completed, LGBT+ content during graduate studies, CPD activities previously engaged in ever and in the past year, and want to receive training or be involved in training into the future.

Contact and work experience with LGBT+ people. This section included number of LGBT+ acquaintances, close friends and family, categories of LGBT+ clients / patients ever seen, and percentage of workload per week consisting of LGBT+ clients / patients.

LGBT-DOCSS. The 18 item Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) (Bidell, 2017), discussed in the previous chapter, was included to measure healthcare provider competencies in working with LGBT+ people. The inclusion of this scale was primarily aimed to address some of the objectives of the larger multinational study.

For my analysis, ten of the items from the LGBT-DOCSS were utilised, with eight mentioning LGB clients / patients, and two LGBT clients / patients. The items used for my analysis are:

- Clinical Preparedness
    - I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity (item 4),
    - I have received adequate clinical training and supervision to work with LGB clients / patients (item 11),
    - I have experience working with LGB clients / patients (item 13),
    - I feel competent to assess a person who is LGB in a therapeutic setting (item 14).
- Attitudes
    - A same-sex relationship between two men or two women is not as strong and committed as one between a man and a woman (item 5),
    - LGB individuals must be discreet about their sexual orientation around children (item 7),
    - The lifestyle of a LGB individual is unnatural or immoral (item 12),

    - I would be morally uncomfortable working with a LGBT client/patient (item 18).

- Knowledge
    - I am aware of institutional barriers that may inhibit LGB people from using health services (item 2),
    - I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals (item 6).

Items related to sexual orientation and gender identity change efforts and working with sexually and gender-diverse children and adolescents. Fourteen items were developed for this section for use in the larger multinational study.

Items from T-KAB. Eight items from the Transgender Knowledge, Attitudes, and Beliefs (T-KAB) Scale (Clark & Hughto, 2019) were included for use in the transnational study. The full scale consists of 22 items loading on 3 factors: Acceptance of the gender spectrum (8 items), Social tolerance (7 items), and Acceptance and Comfort (7 items). The seven items on the Social Tolerance sub-scale, and one item from the Acceptance and Comfort sub-scale were included in the questionnaire. This section was not utilised in my own analysis, given my focus on working with sexually diverse people.

LGB-CSI-SF. The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory – Short Form (LGB-CSI-SF) (Dillon et al., 2015), discussed in the previous chapter, was included. This is a 15-item scale measuring practitioner confidence in the Application of knowledge (3 items), Self-awareness (3 items), Assessment skills (3 items), Advocacy skills (3 items), and Relationship skills (3 items). This scale expands on the Bidell (2017) statements to include deeper richness in self-assessment of competencies that can significantly support targeted curriculum and training development.

Eight further items were identified and added to the scale, derived from the Application Section of each of the 12 guidelines in the PsySSA practice guidelines (PsySSA, 2017). The items, and which guidelines they relate to are:

- support clients' / patients' decisions on whether they come out or not, regardless of research indicating positive mental health outcomes with coming out – relating to guideline 2,
- talk to clients / patients about the prejudicial impact of multiple intersectionalities, such as race and sexual orientation, on their lives – relating to guideline 5,
- discuss the effects of colonialism, apartheid and postcolonialism on clients' / patients' experiences – relating to guidelines 5,
- assist clients / patients in distinguishing sexual orientation and gender identity – relating to guideline 3,
- apply affirmative practice principles in working with LGB clients / patients – relating to the whole guidelines document, and specifically to guideline 9,
- normalise a client's / patient's different identity labels and expressions of sexuality – relating to guideline 3,
- normalise different relationship configurations including polyamory and consensual non-monogamy – relating to guideline 8, and
- identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress – relating to guideline 6.

Contextual / organisational factors. The importance and relevance of contextual factors in supporting the delivery of affirmative practice to LGBT+ people were discussed in the previous section. It was pointed out that numerous guidelines have been published globally to support healthcare organisations to be more affirmative, including the standards of service provision outlined by the National LGBTI Health Alliance's (Australia) in their

LGBTI Cultural Competency Framework (Walker & Mars, 2013). The standards cover seven areas including access to services, reliable data, values of LGBTI communities, demonstrating knowledge, staff training, addressing discrimination, and needs of staff. Items based on these standards of service delivery were included to gain a measure of the organisational or practice context within which the therapist / psychotherapist works. This can include larger organisations they work with, down to how they manage and set up their own private practice. The six items included provide an assessment of some key aspects that could differentiate between more and less affirmative workspaces and settings, and use a 5-point Likert Scale (1=Never to 5=Always) to assess the extent to which participants feel their work setting does the following:

- uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms,
- regularly reviews the needs of LGBT+ people and communicates this information to staff (including administrative staff),
- ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in services delivery,
- engages with other service providers or organisations with LGBT+ expertise,
- provides access to information and resources for sexually and gender-diverse clients / patients, and
- ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff.

Awareness and engagement with relevant guidelines. The final section of the questionnaire contained eight items to assess the awareness and engagement of respondents with the "PsySSA Practice Guidelines for Psychology Professionals Working with Sexually and Gender-diverse People" (PsySSA, 2017), the "South African Clinicians Society Gender-

Affirming Healthcare Guideline for South Africa" (Tomson et al., 2021), and the "Commitment Statement on LGBT Concerns of the International Psychological Network for LGBTI Concerns" (IPsyNet, 2018), as well as training received by the PsySSA African LGBTI+ Human Rights Project training team. In my analysis, I only looked at familiarity with the PsySSA practice guidelines, whereas all these items form part of the local leg of the transnational study.

Qualtrics

The questionnaire was loaded onto the Qualtrics software platform by the research team at the University of Massachusetts, Boston. The software is one of the leading online survey software tools in the world and is GDPR-compliant, referring to General Data Protection Regulation, or data privacy laws enacted by the European Union (EU) in 2018 (https://www.qualtrics.com).

Incentive

As an incentive for respondents to participate, we provided a button at the end of the survey that sent the respondent an e-mail with a unique link to access three articles to read (IPsyNet, 2018; McLachlan, et al., 2019; Pillay, et al., 2019), and complete 15 multiple choice questions (5 questions per article) and earn 2 CEUs if they scored above 70% overall. This data has been kept separate from the survey data to ensure confidentiality of the survey data. Accreditation for this CPD activity was obtained through the Medical Association of South Africa (SAMA), which is accredited as a CPD service provider by the HPCSA. The individual data from the CEU activity was sent to the HPCSA via SAMA to have the CEU points recognised on their system. See Appendix VIII for the 15 multiple choice questions,

approvals, and templates. A total of 86 respondents completed the CPD activity successfully and received the CEU units.

Field work period

The final survey was activated on 26 January, 2023, and closed on 11 April, 2023.

Data processing and diagnostics

Qualtrics and IBM SPSS Statistics

In addition to Qualtrics, IBM's SPSS Statistics was used for data processing and analysis. SPSS is a statistical software suite developed by IBM for data management, advanced analytics, multivariate analysis, business intelligence, and criminal investigation. The software name stands for Statistical Product and Service Solutions[22] and is one of the most widely used analysis software in the world. Data was exported from Qualtrics and imported into SPSS (version 28) for data processing and analysis. The final processed dataset was exported to Qualtrics for additional further analysis.

Fraud Detection and Incomplete Surveys

Several measures were utilised to ensure that bots, spam data, duplicates and other fraudulent data were eliminated from the dataset for the transnational study. In addition, data where respondents completed less than half of the survey, and not completed at least the first scale, were eliminated.

[22] https://www.ibm.com/products/spss-statistics

A field name Status indicated response type, which identified whether the survey was conducted through an IP address, survey preview, or spam. Of the 702 responses, 28 were eliminated.

Bot detection in Qualtrics allows tracking of responses that are likely bots by adding a field to each response called Q_RecaptchaScore. Every response is rated on the probability that the respondent was a bot, which can then be used to filter out data. This field uses Google's invisible reCaptcha technology. The responses range from 0 to 1. A score of greater than, or equal to 0.5 means the respondent is likely a human. A score of less than 0.5 means the respondent is likely a bot[23]. This procedure resulted in two responses being eliminated.

RelevantID improves fraud detection by assessing respondent metadata to determine the likelihood that the same respondent is answering over and over. RelevantID does not necessarily check the content of the responses for duplicates as the respondent can answer multiple times while giving different answers. This feature in Qualtrics has four fields associated with it: Q_RelevantIDDuplicate, Q_RelevantIDDuplicateScore, Q_RelevantIDFraudScore, and Q_RelevantIDLastStartDate. These fields are calculated using RelevantID technology. This technology checks if the respondent is cheating by taking the survey multiple times or whether a survey taker is fraudulent by analysing a user's browser, operating system, and location to provide a fraud score. See RelevantID's site for more details. The first two measures, Q_RelevantIDDuplicate and Q_RelevantIDDuplicateScore were utilised. In Q_RelevantIDDuplicate "if true", indicated by 1, it means the response is likely a duplicate. In Q_RelevantIDDuplicateScore a score of greater than or equal to 75 means the response is likely a duplicate. In a recent blog, feedback was given that Q_RelevantIDFraudScore "…is a legacy Imperium solution and is not accurate. I had a call

[23] https://www.qualtrics.com/support/survey-platform/getting-started/qualtrics-topics-a-z/ (accessed 2023/06/28)

with them to try to make sense of the scores, they are working on a better technology not supported in Qualtrics"[24]. Given this feedback the measure was not used as part of the fraud detection. The last measure is simply the last date the survey was started if Q_RelevantIDDuplicate is true (1).

Increasingly reviewers are asking assurance due to bots, etc. so a Credibility Question was added more than halfway through the survey, since the first half of the survey is technically more time consuming due to filling in blanks. The question was "You are making good progress and are more than halfway! Please enter the number 7: _ (open ended)". Not only does this support identifying a human entering the number, but also highlights whether a participant has completed the questionnaire up to this point. If not, this means that the participant has completed less than about half of the survey, thus not even completed the first scale, and the responses are eliminated. This resulted in 233 eliminations. A further two respondents were eliminated as they indicated that they are students busy with graduate studies, bringing the total sample for the transnational study to n=417. At this point the data for other variables were also sense checked:

- Screener questions: All respondents had affirmed that they are 18 years and above, and that they were registered mental health professionals who had worked with LGBT+ clients / patients in South Africa, currently or in the past.
- The lowest duration a survey took to complete was 563 seconds (9,4 minutes), which was the data for one of the researchers. In more detail, 62,6% of respondents completed the survey in under 30 minutes, 24,3% between 30-60 minutes, 3,9% between 61-90 minutes, 1,6% between 91-120 minutes, and 7,9% more than 120 minutes. The maximum length to complete the survey was

[24] https://community.qualtrics.com/survey-platform-54/how-to-make-sense-of-relevantid-fraud-score-16292 (accessed 2023/06/30)

1023235 seconds or 284,2 hours (or nearly 12 days). This probably indicates that some participants kept the survey open and completed parts of it as they got a chance. This takes the mean score for completion of survey to just over 2 hours (7291.22 seconds). Given this skew, a more useful descriptive would be the median, which in this case is 1533 seconds, or 25.55 minutes. Based on our own testing, as well as the pre-testing, the team estimated the questionnaire length to be around 25-35 minutes, thus the actual length fell within our estimates.

- A total of 93,6% of respondents had completed the survey, with the rest (6,4%) completing more than 50% of the survey.

Sample achieved

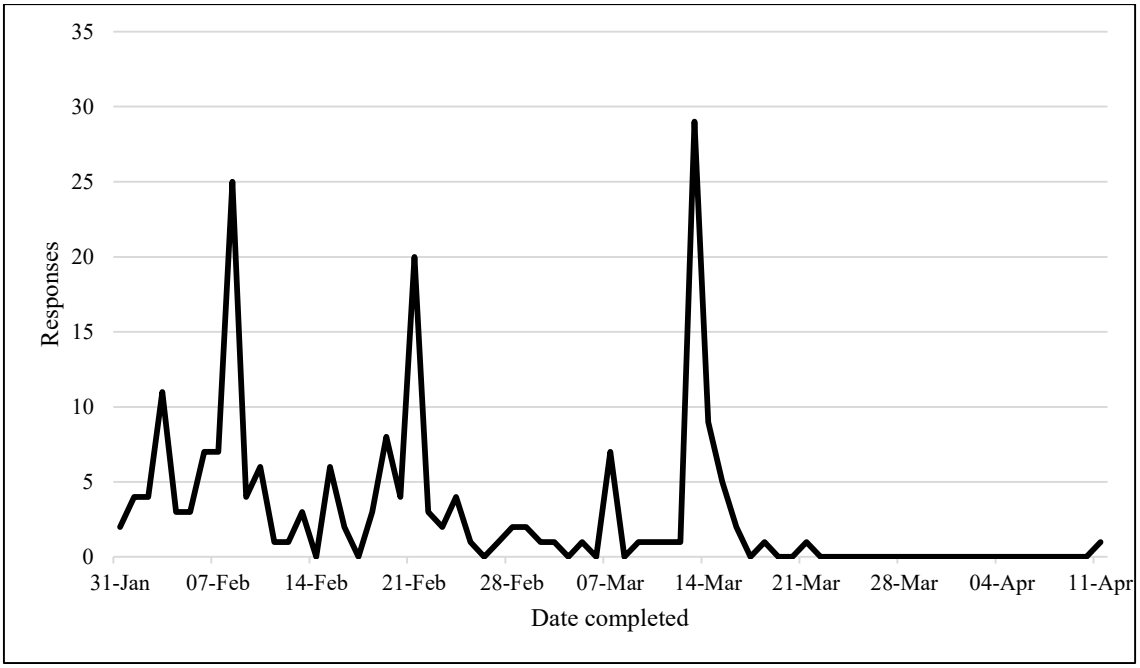
After the data cleaning, data for respondents registered as clinical psychologists or counselling psychologists were filtered and retained for my analysis. The sample achieved for my study was n=201, which was 48,2% of the transnational survey data. The questionnaires were completed between 31 January and 11 April, 2023 (71 days), and half the respondents had completed the questionnaire by 20 February, 2023. Of the 201 respondents, 194 completed the questionnaire (96.5%), and the other 7 (3.5%) completed at least half the questionnaire. In more detail, 201 completed the LGBT-DOCSS, 198 completed the LGB-CSI-SF, and 196 completed the statements relating to work setting.

Data from the HPCSA indicated that there were 3290 registered clinical psychologists and 1848 registered counselling psychologists in 2021, totalling 5138 (Padmanabhanunni et al., 2022). The sample of n=201 then represents a 3.9% response rate. Although a minimum sample of 200 was required, as per proposal, this response rate appears low. A 2017 study conducted on behalf of the HPCSA amongst registered psychologists in South Africa

obtained an 18.9% response rate (HPCSA, 2017) – which likely represents the best rate possible, given that this was work from the registration body themselves. If we take a step back, we find that 245 participants, who said they were clinical and counselling psychologists, accessed the survey in the first place, which means that 44 participants were excluded following fraud and completion checks. The 245 still represent a low response rate of 4.8%. Several reasons can be postulated to account for this response rate. Firstly, the HPCSA database might not be fully up-to-date and may overstate actual number of practising professionals - thus include records of people that stopped practising in South Africa for various reason (retirement, move to another country, death, etc.). Secondly, not all clinical and counselling psychologists would be doing psychotherapy or counselling e.g., they might be involved in organisational development activities. Thirdly, lack of participation could be due to survey fatigue (receiving too many requests for research), time constraints, lack of adequate incentive or, because the topic is of less interest, with little interest in the results. A recent global survey indicated that 7% of South African respondents self-identified as a sexual minority (Ipsos, 2023). which implies that this specific sub-population of clients or patients might be of less interest to the majority of practitioners, even if they see at least some sexually diverse people in a therapeutic context.

Figure 4. 1

Recorded date surveys completed



The line chart in Figure 4.1 indicated when surveys were completed over the time of fieldwork. The three highest bars indicate the periods directly after the first invitation and the two subsequent reminders were sent to potential participants. In the first period, initial invitations were not necessarily sent at the same time due to logistics in managing the e-mailer with our partner organisations. More than half the respondents had completed the survey by 20 February, 2023.

Data analysis / analytic strategy

Calculation of composite scores

The following composite scores were calculated before data was analysed:

- LGBT+ specific training:

  - Continued Professional Development activities – called CPA score,
  - total training score: Sum of CPA score and any graduate training received.
- Contact and professional experience with LGBT+ people:
  - a score combining number of LGB clients / patients ever seen.
- LGBT-DOCSS:
  - total Perceived LGB competency: sum of 10 items from LGBT-DOCSS, with negatively worded statements recoded,
  - LGB Clinical Preparedness: sum of 4 items, with one negatively worded item recoded,
  - LGB Attitudes: sum of 4 items, all negatively worded and recoded,
  - LGB Basic Knowledge: sum of 2 items.
- LGB-CSI-SF:
  - total LGB Self-Efficacy: total of 15 items,
  - three items of each sub-scale of LGB-CSI-SF summed to provide scores for Self-efficacy – Application of Knowledge, Self-efficacy – Advocacy Skills, Self-efficacy – Self-Awareness, Self-efficacy – Assessment, and Self-efficacy – Relationship,
  - PsySSA practice guidelines statements, which is the sum of 8 statements specific to the guidelines,
  - total of 23 statements reflecting confidence / self-efficacy.
- Organisational Factors:
  - sum of 6 items to create Affirming Work Setting variable,
  - sum of a reduced set of 4 items with lower ‘Not Applicable’ mentions.

Dealing with missing data

Following the initial data cleaning process to eliminate fraud, data with respondents completing less than 50% of the survey, and not completing the LGBT-DOCSS scale were eliminated. In the final sample, 194 participants completed the full survey, with seven completing more than 50%. More specifically:

- all completed the LGBT-DOCSS scale,
- three respondents did not complete the LGB-CSI-SF scale,
- seven respondents that did not complete the survey were coded to "Not applicable" on the statements relating to work setting.

Reliability and validity measures

Aspects of the reliability and validity of the 10-items utilised from the LGBT-DOCSS, the LGB-CSI-SF, as well as the additional items based on the guidelines were evaluated. This included:

- content validity was assessed during the pre-testing and development phase,
- construct validity was assessed by means of a principal-axis factor extraction analysis, with rotation as relevant on the LGB-CSI-SF, the PsySSA practice guidelines statements, the LGB-CSI-SF and PsySSA practice guidelines statements combined, the 10-items used from the LGBT-DOCSS, the 4 items retained for affirmative work setting statements, and finally the combined items (37 items),
- internal consistency measured using Cronbach's Alpha for the composite scores that were created.

Descriptive and inferential statistics

Frequency tables with means, standard deviations, and standard errors, were generated for all variables, with cross tabulations done looking at subsets of at least 30 participants based on demographics, professional practice aspects, training, contact with LGB people, and experience working with LGBT+ people. Test of significant differences included:

- between two proportions or two means using a pairwise Z-test (indicated by capital letter after significantly higher column percentage),
- $\chi 2$ between two categorical variables,
- Analysis of Variance (ANOVA) between a categorical and a numerical variable.

Finally, Pearson correlation coefficient between variables / composite scores were used to assess the relationship between variables.

Research outputs and actions

In chapter 1, the significance of the study as a first benchmark of perceived competence and confidence was outlined. It was mentioned that the study will hopefully be the basis for future tracking of competence and confidence in working with sexually diverse people, inspire further research in this area in South Africa, and support continued efforts in training, advocacy, and policy development efforts to eventually ensure that all clinical and counselling psychologists feel competent and confident in working affirmatively with sexually diverse people. The results of this study will help guide the PsySSA Africa LGBTI+ Human Rights Project strategy, be used as input into the guidelines revision process currently in progress and support the development and refinement of targeted graduate and continued professional development activities going forward. This doctoral dissertation represents an important point for me in my continued engagement in assisting and supporting the shaping

and growth of a vibrant and dynamic field of LGBTIQA+ psychology and mental health in South Africa. This will include the publication of a peer reviewed article, and presentations at local and international level in this area of work. Having outlined the research design for the study, the next chapter will focus on analysis of the research data, including the sample achieved.

In summary

The chapter outlines the research design of my study, including a discussion of the transnational study, the target population, and ethical considerations. An outline of data collection including reference to sampling, the instrument used, and fieldwork, followed by data processing and diagnostics, and closing with the data analysis strategy, and research outputs and actions. The next chapter will detail the results of my study.

CHAPTER 5: RESULTS

Introduction

In the previous chapter, it was noted that most of the variables (relating to graduate training, CPAs, contact and professional experience, as well as how affirming work settings are), focus on LGBT+ clients / patients more broadly rather than on sexually diverse or LGB clients / patients specifically, except for the variable "Number of LGB clients ever seen". In addition, the LGB-CSI-SF scale items (Dillon et al., 2015), with themes from the PsySSA practice guidelines, as well as 8 of the 10 items for the analysis selected from the LGBT-DOCSS scale (Bidell, 2017), all refer to LGB clients / patients. Holding this in mind, this chapter starts with an overview of the sample achieved amongst registered clinical and counselling psychologists that have ever worked with LGBT+ clients / patients in South Africa and how this compares to other known population parameters. This is followed by the results for the demographics and professional practice / work life, graduate training, CPAs, contact and professional experience with LGBT+ clients / patients. The reliability and construct validity of the scales and items used are then provided. The discussion of the level of affirmation of respondents' work settings is followed by the confidence respondents have in working with LGB clients / patients, as measured by the 15-item, LGB-CSI-SF scale (Dillon et al., 2015) and 8 items added to this scale specifically covering further themes from the PsySSA practice guidelines (PsySSA, 2017). This is followed by the results of the 10 items selected from the 18-item LGBT-DOCSS scale (Bidell, 2017). The chapter concludes with key findings from the results in preparation for the discussion, conclusions, and recommendations in the next chapter.

Demographics and professional practice / work life

In the previous chapter it was reported that the total sample achieved amongst clinical and counselling psychologists that have ever worked with LGBT+ clients or patients in South Africa was *N*=201. The fieldwork dates, and flow of questionnaire completions were outlined, with a discussion of the potential reasons for a relatively low response rate. The demographic and professional practice / work life characteristics of the sample will now be discussed and compared to known parameters for this population.

Table 5. 1

Demographic characteristics of sample

	n	*%*
Province		
Gauteng	73	36.3
Western Cape (WC)	70	34.8
KwaZulu-Natal (KZN)	26	12.9
Eastern Cape (EC)	16	8.0
Free State (FS)	5	2.5
Limpopo	5	2.5
Mpumalanga	4	2.0
North West	2	1.0
Northern Cape	0	0
Age (*M*=46.6; *SD*=11.90)		
39 or less	67	33.3
40-49	60	29.9
50+	73	36.3
Not answered	1	0.5
Race identified with		
White	137	68.2
Black African	36	17.9
Indian / Asian	14	7.0
Coloured	11	5.5
Another	3	1.5
Sex assigned at birth		
Female	150	74.6
Male	50	24.9
Not answered	1	0.5
Gender identity		

	n	%
Cisgender woman	134	66.7
Cisgender man	46	22.9
Gender non-confirming	7	3.5
Male / Female	6	3.0
Another gender diverse identity	4	2.0
None / Not Applicable	4	2.0
Sexual identity / orientation		
Heterosexual / Straight	157	78.1
Gay	18	9.0
Bisexual	13	6.5
Lesbian	7	3.5
Pansexual	3	1.5
Queer	2	1.0
Asexual	1	0.5

Note. *N* =201

Medpages[25], possibly the largest actively managed healthcare provider contact database, gives details of the provincial spread of clinical and counselling psychologists in South Africa. Compared to this database, our sample had a higher proportion of respondents from the Western Cape (34.8% vs. 26.4% in Medpages) and KwaZulu-Natal (12.9% vs. 11.8%). Conversely, lower proportions were found in our sample for Gauteng (36.3% vs. 42.0%) and other provinces combined (15.9% vs. 19.9%). This could indicate that the research team and the larger connectivity of the team had more weight in getting people to respond (even though all psychologists in South Africa received several invitations), or that people in the Western Cape were somehow more open and willing to complete questionnaires on the topic. Finally, it might be that the Western Cape has a higher proportion of therapists doing therapy with LGBT+ clients relative to other provinces or that LGBT+ people feel more comfortable accessing psychological services in this area relative to other parts of the country, being that Cape Town is known as the “gay capital” of South Africa.

[25] https://www.medpages.info

A study amongst clinical and counselling psychologists reported the average age for clinical psychologists at 44.0 years and for counselling psychologists at 43.3 years (Young & Young, 2019), compared to the age of 46.6 years in this study, indicating a slightly older group of respondents in comparison. The race split found in this study is very similar to that from the HPCSA database (as reported in Padmanabhanunni et al., 2022), namely 68.2% versus 66.7% (HPCSA) white, and 17.9% versus 20.9% black respectively. Furthermore, the proportions found for sex assigned at birth in this study is like those reflected by the HPCSA, namely 74.6% female (vs. 75.1% HPCSA) and 22.9% male (vs. 24.9%) (Padmanabhanunni et al., 2022). A significantly higher proportion of respondents in the current study indicated they were sexually diverse (21.5%) compared to comparative South African adult population findings such as an Ipsos global survey indicating that 7% of South African respondents self-identified as a sexual minority (Ipsos, 2023). This is the first quantitative result indicating the proportion of clinical and counselling psychologists self-identifying as sexually diverse.

Table 5. 2

Professional / work life characteristics of sample

	n	*%*	*M*	*SD*
Registration category				
Clinical Psychologist	138	68.7		
Counselling Psychologist	63	31.3		
Highest level of education				
Masters' degree	169	84.1		
Doctorate degree	32	15.9		
Psychotherapy / Counselling workload			60.4	25.6
50% or less	81	40.3		
More than 50%	119	59.2		
Not answered	1	0.5		
Years in professional practice			15.6	10.4

	n	*%*	*M*	*SD*
10 or less	74	36.8		
11-19	61	30.3		
20 or more	66	32.8		
Sector working in*				
Total private health / companies	164	81.6		
Total public health / government, higher education	61	30.3		
Total NGO / CBO / NPO[26]	15	7.5		
Number of sectors working in				
1	163	81.1		
2	35	17.4		
3	3	1.5		

Note. *N*=201; *multiple options possible

Results indicated a similar proportion of clinical psychologists (68.7%) and counselling psychologists (31.3%) respectively relative to HPCSA data (64.0% and 36.0% respectively) (as reported in Padmanabhanunni et al., 2022). Comparably, the data in this study reflects similar proportions: 15.9% with doctorate degrees (counselling and clinical psychologists combined) relative to 18% for clinical psychologists with doctorate degrees and 22% for counselling psychologists with doctorate degrees in the Young and Young study (2019). Furthermore, the average years in professional practice in the sample is 15.6 years, compared to 14.3 years for clinical psychologists and 14.1 years for counselling psychologists in the study by Young and Young (2019).

The sample appears to have a significantly higher percentage of respondents involved in private health / companies (81.6%) relative to the 56.3% found across registration categories in a HPCSA study on professional identity (HPCSA, 2017). The latter indicated that clinical psychologists spend 48.9% of their time in private / limited private practice.

[26] Non-governmental Organisation (NPO), Community-based Organisation (CBO), Non-profit Organisation (NPO)

Whereas counselling psychologists spend 53.6% of their time in private / limited private practice, 5.7% in private organisations and 5.1% in employee assistance programmes. A significant proportion of respondents are involved in more than one work setting (18.9%).

Following the commentary that was made in comparing the sample characteristics with known population parameters, consideration can be given to specific differences within subgroups. Tables 5.3 and 5.4 provide results where there were statistically significant differences between demographic and professional practice / work life variables.

Table 5. 3

Provincial differences

Column %	Total *N*=201	Gauteng A *n*=73	WC B *n*=70	KZN C *n*=26	Other D *n*=32
Registration category					
Clinical Psychologist	68.7	67.1	80.0D	65.4	50.0
Counselling Psychologist	31.3	32.9	20.0	34.6	50.0B
Sectors working in*					
Total private health / companies					
Total public health /	81.6	84.6D	88.6D	80.8	59.4
government, higher education					
Total NGO / CBO / NPO	30.3	24.7	25.7	26.9	56.3ABC
	7.5	5.5	8.6	7.7	9.4

Note. Registration category (p=0.02), Working in private health/companies (d=0.267, p=0.03), * multiple options possible

Table 5.3 indicates that a higher proportion of respondents from the smaller provinces work in the public sector, relative to the Western Cape and Gauteng respondents. In addition, the profile of Western Cape respondents is significantly skewed towards clinical

psychologists relative to the other provinces. Beyond the significant differences in province, there are no other significant demographic or professional practice skews for people working in the private sector. Most of the respondents that indicated that they were male assigned at birth identified as cisgender men (92%) and most of the respondents indicating they were female assigned at birth identified as cisgender females (89.3%). A significantly higher proportion of female assigned at birth respondents identified as heterosexual / straight (87.3%) relative to male assigned at birth respondents (52.0%) (p=0.00). A similar result was found with gender identity, with 88.1% of cisgender women identifying as heterosexual relative to 45.7% of cisgender men identifying as sexually diverse. In furthering the discussion around the higher levels of sexually diverse respondents in our sample, this result indicated a particular skew in the sample towards cisgender identified sexually diverse males.

Table 5. 4

Registration category / highest level of education differences

	Total	Registration Category		Level of Education	
		Clinical A	Counselling B	Masters C	Doctorate D
	N=201	*n*=138	*n*=63	*n*=169	*n*=32
Age					
M	46.6	48.0B	43.5	45.7	51.5C
(SD)	(11.9)	(11.8)	(11.6)	(11.7)	(12.1)
Years in professional practice					
M	15.6	16.9B	12.7	14.8	19.9C
(SD)	(10.4)	(11.0)	(8.5)	(10.3)	(10.0)

Note. Age: p=0.01 and p=0.01 respectively, Years in professional practice: p=0.03 and p=0.00 respectively

Table 5.4 indicates that clinical psychologists are older and have more years in practice than counselling psychologists in our sample. Similarly, people with doctorate degrees are older and have more years in practice. Further to this, a significantly higher

proportion of males are registered as clinical psychologists (82.0%) relative to females (64.7%) (p=0.02). A significantly higher proportion of respondents with a doctorate degree work in higher education institutions (21.9%) relative to respondents with masters' degrees (8.3%). In summary, the sample of 201 respondents were skewed towards the three major provinces of Gauteng (36.3%), Western Cape (34.8%), and KwaZulu-Natal (12.9%). The majority were white (68.2%), female assigned at birth (74.6%), cisgender identified (89.6%), heterosexual or straight (78.1%), with an average age of 46.6 years. The sample has a higher proportion of sexually diverse respondents than for the general population, with a skew towards sexually diverse males identifying as cisgender. Furthermore, the sample was predominantly clinical psychologists (68.7%), with a masters-level degree (84.1%), working in the private sector (81.6%), with an average of 60.4% of their workload consisting of psychotherapy or counselling, and an average of 15.6 years in professional practice.

Graduate training

A total of 199 respondents reported the year that they graduated from their mental health professional training programme / graduate studies. As indicated in Table 5.5, the year respondents graduated in ranged from 1972-2022 with a mean of 2006 (SD 10.86), median of 2009, 25th percentile of 2000, and 75th percentile of 2014. As expected, there is a significant correlation between age, years in professional practice and year of graduation, as seen in Table 5.6.

Table 5. 5

Graduation year distribution

	n	*%*
Up to 2000	51	25,6
2001-2009	52	26,1
2010-2014	50	25,1
2015 onwards	46	23,1

Table 5. 6

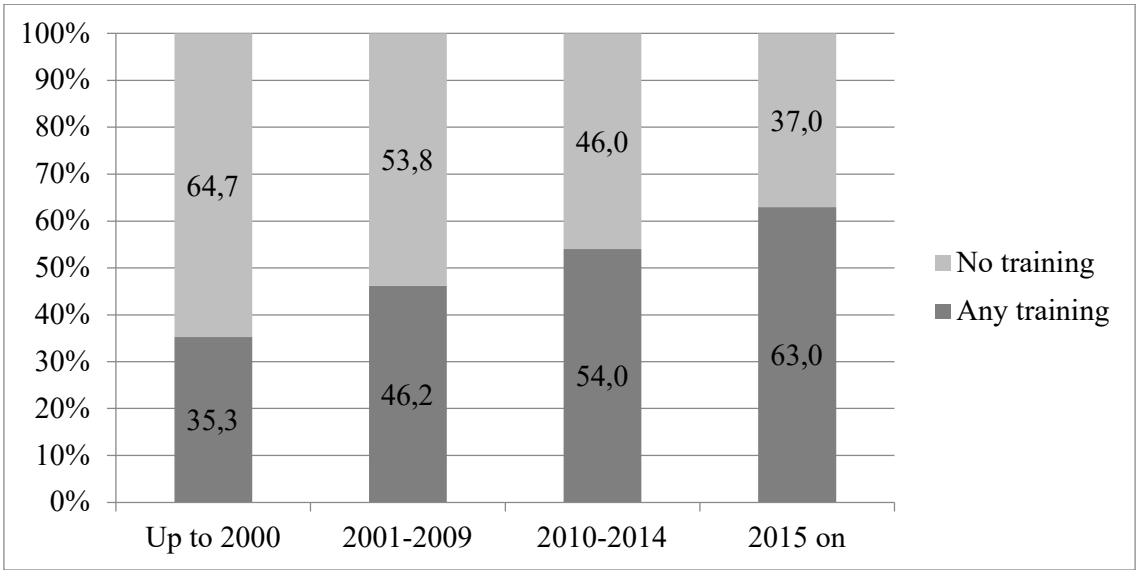
Correlation matrix of age, years in professional practice, and year of graduation

	1	2	3
1.Age			
2.Years in professional practice	0.85**		
3.Year graduated	-0.85**	-0.97**	

Note. *p<0.05 significant at 95% confidence, ** p<0.01 significant at 99% confidence

Figure 5. 1

LGBT+ activities and training received over different graduation years



Note. *N*=201

Respondents that graduated later are statistically significantly more likely to have been exposed to any LGBT+ focused activities during their graduate studies ($\chi 2 = 8.13$, $p=0.04$). Figure 5.1 indicates that around a third of respondents graduating before 2000 received any LGBT+ focused training, with that figure increasing to 63.0% of respondents who graduated 2015 or later. As seen from the Table 5.7, just over half of the respondents report not having been exposed to any LGBT+ focused activities during graduate studies (50.2%). When counting the number of activities reported during graduate training, 38.8% of the sample reported one activity, 8.0% - two activities, 2.5% - three activities, and 0.5% - four activities.

Table 5. 7

LGBT+ focused activities during graduate studies

	n	*%*
No training	101	50,2
Course in sexuality and/ or gender that covered working with LGBT+ clients / patients including sex therapy	47	23,4
Workshop specifically in LGBT+ health and well-being	43	21,4
Research on LGBT+ concerns	27	13,4
Clinical / practical training experience working with LGBT+ people	12	6,0
Discussion / Supervision / Interest group on LGBT+ topics	7	3,5

Note. *N*=201. Multiple options possible.

It is interesting to note that respondents under 40 years old were also more likely to have attended a workshop specifically on LGBT+ health and well-being at university (29.9%) compared to the 40–49-year-old group (20.0%) and the 50+ group (15.1%). This is also reflected in respondents with ≤10 years in practice, with 33.8% of them having attended a workshop at university, compared to 16.4% (being in practice for 11-19 years) and 12.1% (with 20+ years in practice) respectively – more than double the percentages for either of

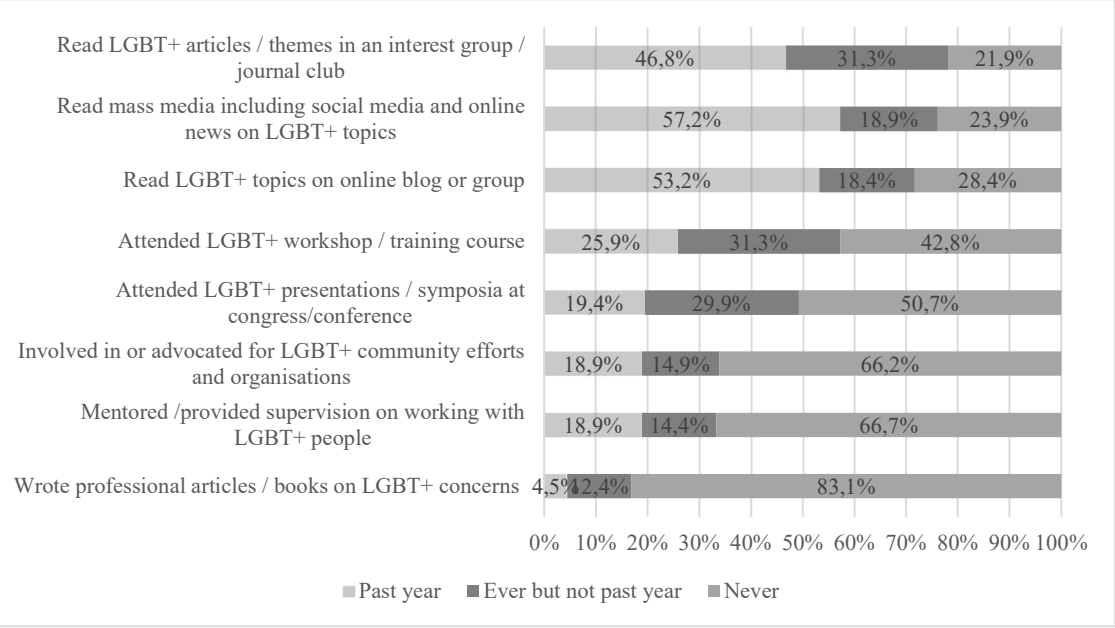
these groups. Furthermore, a comparison of training received with years in practice shows that 59.5% of the respondents with ≤10 years in practice have received training, compared to respondents with a 11-19-year practice (47.5%), and respondents with a 20+ practice (40.9%) respectively. In addition, a higher proportion of respondents from KwaZulu-Natal attended a workshop specifically on LGBT+ health and well-being (38.5%) compared to Gauteng (19.2%) and Western Cape (17.1%), although it must be noted that the base of respondents in KwaZulu-Natal are less than half either those in Gauteng or Western Cape.

Continued professional development activities (CPAs)

Having discussed information on respondent's graduate studies and exposure to LGBT+ focused activities during their studies, this section will report on respondents' engagement and interest in CPAs, as well as familiarity with the PsySSA practice guidelines.

Figure 5. 2

CPAs engaged in



Note. *N*=201

Figure 5.2 indicates the CPAs that respondents have engaged in, ranked from attended most in past year to attended least in the past year. Sexually diverse respondents were more likely than their heterosexual counterparts to have engaged in:

- mass media including social media and online news on LGBT+ topics (p=0.00),
- LGBT+ topics on online blog or group (p=0.00),
- articles / themes in an interest group / journal club (p=0.00),
- LGBT+ presentations / symposia at congress / conference (p=0.01),
- mentoring / supervision on LGBT+ people (p=0.01),
- involvement / advocacy in LGBT+ community efforts and organisations (p=0.00).

The exceptions would be attending LGBT+ workshops / training courses, which is similar across sexual orientation, and writing of professional articles / books on LGBT+ concerns which has a too small respondent base for those that "have ever engaged in" or in "past year engaged in" to do meaningful analysis.

Table 5. 8

Descriptive statistics: CPA score

Min	0
Max	16
Percentile	
25th	4
50th / Median	6
75th	9
Mean	6.6
Standard Deviation	4.0

Note. N=201

A composite score was created for the eight LGBT+ focused CPAs, with a score of 2 allocated to each activity engaged in the past year, and a score of 1 allocated to each activity

ever engaged in. Descriptive statistics for the new total, called CPA score, are outlined in Table 5.8. The median of 6 indicates that half of the respondents had participated in the equivalent of three LGBT+ focused CPAs in the past year. A total training score was created by combining the number of graduate activities respondents had received with the CPA score. This provides a single measure of training received by respondents, with descriptive characteristics highlighted in Table 5.9.

Table 5. 9

Descriptive statistics: Total training score

Min	0
Max	18
Percentile	
25th	4
50th / Median	7
75th	10
Mean	7.3
Standard Deviation	4.2

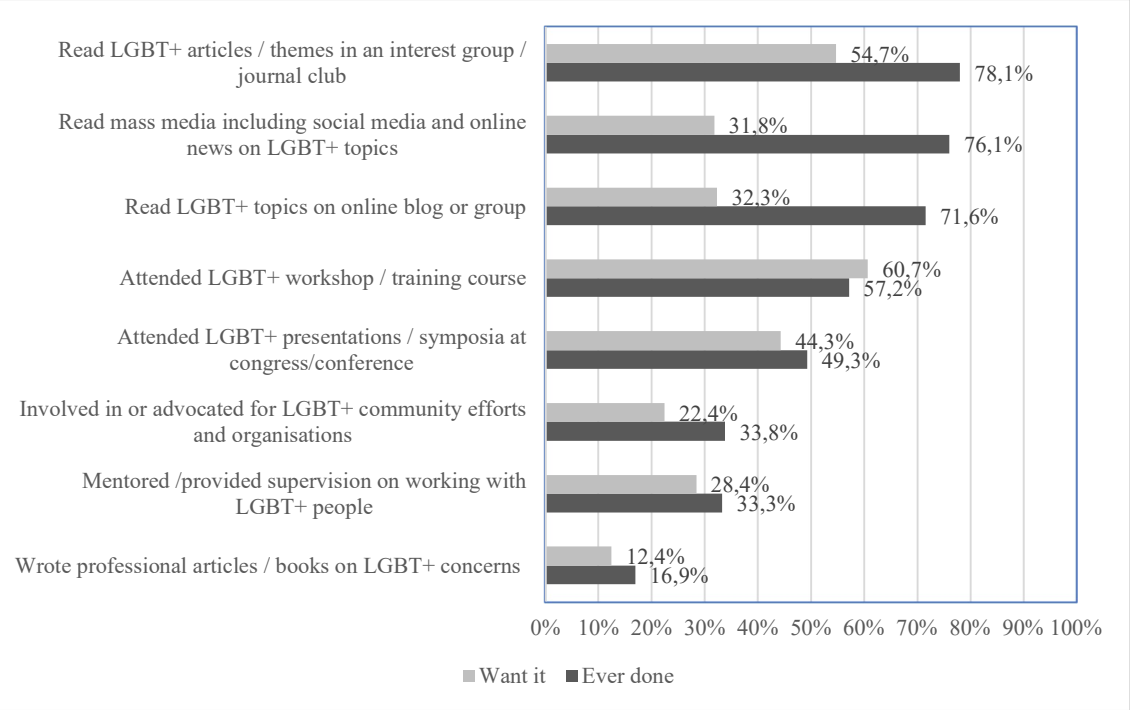
Note. *N*=201

The total training score was also bucketed into three categories, with 38.8% of respondents obtaining a score of 5 or less (low), 27.9% with a score of between 6 and 8 (medium), and 33.3% with a score of 9 or higher (high). A question was asked on how true respondents considered the statement "I am familiar with the Psychological Society of South Africa (PsySSA) Guidelines for Psychology Professionals working with sexually and gender-diverse people" on a 7-point semantic scale ranging from "Very untrue for me" to "Very true for me" with the mid-point being "Neutral". A total of 55.7% of respondents felt the statement to be true (three top boxes), 10.4% neutral, and 30.3% untrue (three bottom boxes).

A higher proportion of sexually diverse respondents felt the statement to be true (70.5%) relative to heterosexual respondents (51.6%). Respondents who said they are familiar with the PsySSA practice guidelines have a significant higher total training score (M=8.6, SD=4.4) relative to those that felt neutral (M=5.9, SD=4.1) or felt that the statement was untrue for them (M=5.6, SD=3.1) (p=0.0). A breakdown of the individual elements of the training score is as follows: (a) those who felt the statement to be true were more likely to have attended workshops / training courses (p=0.01), (b) presentations and symposia at congresses / conferences (p=0.00), (c) read articles as part of an interest or journal club (p=0.01), (d) mentored or provided supervision to others (p=0.00), (e) wrote professional articles / books (p=0.00), and (f) be involved in or advocated for LGBT+ community efforts and organisations (p=0.00).

Figure 5. 3

CPAs ever done and want to be involved in



Note. N=201

Figure 5.3 outlines the CPAs respondents indicated that they have ever been involved in and would want to receive or be involved in the future. The activities are ordered by "those ever been involved in". Firstly, the top three activities respondents want to be involved in are: attending a LGBT+ workshop / training course (60.7%), reading articles / themes in an interest group / journal club (54.7%), and LGBT+ presentations at a symposia / congress / conference (44.3%). If these findings are compared with those that have ever been involved in attending a LGBT+ workshop / training course or presentation / symposia at a symposia / congress / conference, these garnered similar mentions, whereas the interest group / journal club reflects many more being involved in the past in this activity compared to those wanting it. Secondly, there are notably high levels of respondents who had read LGBT+ topics in mass media, online blogs, and groups, but significantly fewer respondents want to be involved in this in the future. Finally, involvement or advocacy in community efforts and organisations, supervision and writing professional material remain relevant to a smaller proportion of respondents. Future interest ("wants to be involved in") falls significantly compared to "ever involved in" when it comes to involvement or advocacy in community efforts and organisations.

Furthermore, sexually diverse respondents were significantly more likely than heterosexual respondents to want to receive or be involved in articles / themes in an interest group / journal club (68.2% vs. 51.0%), LGBT+ presentations / symposia at congress / conference (68.2% vs. 37.6%), LGBT+ topics on an online blog or group (45.5% vs. 28.7%), mentoring / supervision on LGBT+ people (40.9% vs. 24.8%), involvement / advocacy in LGBT+ community efforts and organisations (43.2% vs. 16.6%), and writing professional articles / books on LGBT+ concerns (29.5% vs. 7.6%). Receiving or being involved in LGBT+ workshop / training courses (54.5% vs. 62.4%), and mass media including social

media and online news on LGBT+ topics (40.9% vs. 29.3%) were not significantly different between sexually diverse and heterosexual respondents.

Personal and professional experience with LGBT+ people

The results of exposure to LGBT+ activities during graduate training and CPAs were discussed in the previous sections. In this section, respondents' personal experience and professional contact with LGBT+ people, clients, and patients are discussed, with Table 5.10 outlining the descriptive statistics for the variables in this section.

Table 5. 10

Descriptive statistics: Personal and professional experience with LGBT+ people

	Number of LGBT+ acquaintances *N*=201	Number of LGBT+ friends / close family *N*=201	Number of LGB clients ever seen *N*=199	% of LGBT+ caseload per week *N*=201
Min	0	0	0	0%
Max	500	65	36	100%
Percentile				
25th	5	2	9	5%
50th / Median	10	4	18	10%
75th	20	7	29	20%
Mean	18.3	6.3	19.0	14.7%
Standard Deviation	40.2	8.7	11.5	16.6

With "number of LGBT+ acquaintances", there are a few outliers, with one respondent saying they have 500 acquaintances, one respondent saying 150 acquaintances, and 6 respondents saying 100 acquaintances (n=8 or 4.0% of sample). This explains why the mean is so much higher than the median. More specifically, 24.9% of respondents said they have no LGBT+ acquaintances, 16.9% said 5 LGBT+ acquaintances, 22.9% said 10 LGBT+

acquaintances, 20.4% said 15-20 LGBT+ acquaintances, and 16.4% said more than 20 acquaintances.

Similarly, with the variable "Number of LGBT+ close friends / family", one respondent said they have 65 LGBT+ close friends / family, two respondents said 50, four respondents said they have 30, and four respondents said they have 25 LGBT+ close friends / family (n=11, 5.5% of sample). Interestingly fewer respondents said they have no LGBT+ close friends / family (10.4%) relative to those that said they have no LGBT+ acquaintances (24.9%). A further 27.9% said they have 1-2 close friends / family, 17.9% with 3-4 close friends / family, 20.4% with 5-7 close friends / family, and 23.4% with 8 or more LGBT+ close friends / family.

Respondents were asked to indicate how many clients / patients they have had by indicating in a grid the separate number of gay, lesbian, bisexual, transgender, and queer / other LGBT identifying clients with options 0, 1-3, 4-6, 7-9 and 10+. To obtain averages, each of these options were assigned a number (mostly the midpoint) to each response, i.e., the number 2 was assigned for option 1-3, number 5 for option 4-6, number 8 for option 7-9, and number 12 for option 10+. The "number of LGB clients ever seen" variable was composed by summing the gay, lesbian, and bisexual categories. Given that the maximum indicated for each of the three categories was 12, the maximum number for this combined variable would be 36. A total of 17.1% of respondents indicated that they had seen 10+ LGB clients (or 36 in the combined variable), with 2.0% indicating they had not seen any LGB clients.

In respect of the percentage of the weekly workload consisting of LGBT+ clients / patients, 15.9% reported having no LGBT+ clients / patients, 23.9% reported up to a 5% weekly workload of LGBT+ clients, 28.4% reported between 6-15%, and 31.8% reported having a weekly workload of 16% or more LGBT+ clients. Respondents in the private sector reported a statistically significant higher LGBT+ case load than those in the public sector

(d=0.16, p=0.04). The four personal and professional experience variables are all highly correlated, as indicated in Table 5.11 below.

Table 5. 11

Correlation between personal and professional experience variables

	1	2	3	4
	N=201	*N*=201	*N*=199	*N*=201
1. Number of LGBT+ acquaintances				
2. Number of LGBT+ friends / close family	0.459**			
3. Number of LGB clients ever seen	0.299**	0.330**		
4. % of LGBT+ caseload per week	0.224**	0.339**	0.417**	

Note. *p<0.05 significant at 95% confidence, ** p<0.01 significant at 99% confidence

Table 5. 12

Personal and professional experience: Sexual orientation

	Heterosexual	Sexually Diverse	
M (SD)	*n*=157	*n*=44	*p*
Number of LGBT+ acquaintances	13.6 (17.9)	35.0 (77.4)	<0.01**
Number of LGBT+ friends / close family	5.1 (6.8)	10.7 (12.6)	<0.01**
Number of LGB clients ever seen	18.1 (11.4)	21.9 (11.6)	<0.07
% of LGBT+ caseload per week	12.2% (14.1)	23.4% (21.3)	<0.01**

Note. *p<0.05 significant at 95% confidence, ** p<0.01 significant at 99% confidence

Table 5. 13

Correlation between work, personal and professional experience variables

	Age	Years in practice	CPA score	Total training score
	N=200	*N*=201	*N*=201	*N*=201
Number of LGBT+ acquaintances	0.056	0.038	0.304**	0.304**
Number of LGBT+ friends / close family	0.095	0.145*	0.304**	0.290**
Number of LGB clients ever seen	.325**	0.355**	0.263**	0.232**
% of LGBT+ caseload per week	-0.08	0.058	0.438**	0.442**

Note. *$p<0.05$ significant at 95% confidence, ** $p<0.01$ significant at 99% confidence

As seen in Table 5.12, sexually diverse respondents tended to have more personal and professional experience with LGBT+ people than heterosexual respondents. Table 5.13 shows that the number of LGB clients ever seen correlates very highly with age and years in practice, which indicates that the longer a respondent does therapy and the older they are, the more likely they are to have seen LGB clients. There is a high correlation between the training measures (CPA score and Total training score) and the experience measures (Number of LGBT+ acquaintances, Number of LGBT+ friends / close family, Number of LGB clients ever seen, and % LGBT+ case load). Respondents with a higher LGBT+ case load (16% or higher) tended to also be significantly more interested in receiving or getting involved in more CPAs, that those with a medium LGBT+ case load (6-15%) or lower LGBT+ case load (5% or less), as outlined in Table 5.14.

Table 5. 14

Interest in future activities based on LGBT+ case load

Column %	Total	5% or less A	6-15% B	16% or more C
Training	60,7	56,3	66,7	60,9
Interest group	54,7	50,0	54,4	60,9
Presentations	44,3	40,0	45,6	48,4
Blog	32,3	22,5	35,1	42,2A
Mass media	31,8	22,5	35,1	40,6A
Supervision	28,4	16,3	31,6A	40,6A
Involvement	22,4	11,3	24,6A	34,4A
Writing	12,4	5,0	12,3	21,9A

Note. *N*=201

Having discussed the demographics, work life, training, and experience with LGBT+ people, the following two sections will discuss the reliability and validity measures for the scales used including the LGB-CSI-SF, LGBT-DOCSS, and statements relating to the PsySSA practice guidelines and respondents' work settings.

Reliability estimates

Internal consistency estimates, based on the total sample of 201, were calculated for the whole questionnaire, the LGB-CSI-SF and statements relating to the PsySSA practice guidelines, the work setting items, the LGBT-DOCSS statements used, as well as the sub-scales within these scales. Internal consistency refers to whether the results of different parts of the questionnaire or tool are in line with the general results or not (Bahariniya et al., 2021). In the following table the Cronbach Alpha coefficients obtained are almost all above the 0.700 mark, indicating good reliability. The exception is the LGBT-DOCSS: Basic

knowledge sub-scale, but this coefficient can be due to there being only 2 items in the sub-scale.

Table 5. 15

Cronbach Alpha coefficients

	Cronbach Alpha
LGB-CSI-SF (15 items)	0.929
LGB-CSI-SF: Application of knowledge (3 items)	0.877
LGB-CSI-SF: Advocacy skills (3 items)	0.909
LGB-CSI-SF: Self-awareness (3 items)	0.817
LGB-CSI-SF: Assessment (3 items)	0.851
LGB-CSI-SF: Relationship (3 items)	0.790
PsySSA practice guidelines statements (8 items)	0.924
All self-efficacy / confidence (23 items)	0.955
Work setting (6 items)	0.792
Work setting (reduced 4 items) *	0.775
LGBT-DOCSS (10 items)	0.723
LGBT-DOCSS: Clinical preparedness (4 items)	0.788
LGBT-DOCSS: Attitudes (4 items)	0.725
LGBT-DOCSS: Basic knowledge (2 items)	0.526
Total for all items	0.938

Note: *the reduction from 6 to 4 statements will be discussed in a later section

Construct validity

Construct validity looks at the degree of efficiency of a scale and endeavours to answer whether results presented by the questionnaire are consistent with theoretical evidence. Factor analysis is considered a good way to explore construct validity (Bahariniya, et al., 2021). A Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) and Bartlett's test of sphericity were used to test the factorability of different data sets. Principal axis factoring explicitly assumes the existence of latent factors underlying the observed data, and oblique

rotation is used when factors are assumed to be correlated (Bidell, 2017; Dillon & Worthington, 2003). Following Bidell (2017), and Dillon and Worthington (2003), principal axis factoring with oblique rotation (promax rotation with Kaiser normalisation), were conducted. When interpreting factors from an oblique factoring method, the pattern, structure, and factor correlation matrices are used. The pattern matrix contains the loadings of each question to the factor, whereas the structure matrix are the correlations between the variables and the factors[27].

LGB-CSI-SF

The KMO score for the LGB-CSI-SF was 0.907, with Bartlett's test significant (p=0.00), thus supporting the suitability of the study data for factor analysis. Given that the scale measures five areas of self-efficacy, a 5-factor solution was endeavoured but could not be extracted as the communality of a variable exceeded 1.0. Instead, a 4-factor solution was obtained, explaining 68.8% of the cumulative variance. The factors were extracted in 12 iterations and 6 iterations were required for the rotation to converge. Factor 1, named *Therapy Practice Skills,* accounted for 50.2% of the cumulative variance and contained items from the original *Assessment* and *Relationship* sub-scales. Factor 2, relating to *Advocacy Skills* accounted for 9.4%, factor 3, covering areas of *Self-Awareness*, accounted for 5.2%, and factor 4, *Application of Knowledge*, accounted for 4.1% of the cumulative variance. Table 5.16 outlines the factor correlation matrix, indicating relatively high inter-factor correlations.

[27] https://www.ibm.com/support/pages/pattern-matrix-and-structure-matrix-definition-spss-factor-output accessed 2023/10/01

Table 5. 16

Factor correlation matrix for LGB-CSI-SF factors

	1	2	3	4
1	1.000			
2	0.540	1.000		
3	0.711	0.570	1.00	
4	0.638	0.331	0.674	1.00

Note. *N*=198

PsySSA practice guidelines statements

The KMO score for the eight PsySSA practice guidelines statements was 0.925, with Bartlett's test significant ($p<0.001$), thus supporting the suitability of the study data for factor analysis. Only one factor with an initial Eigen value of higher than 1 was identified. The factor contributed to explaining 61.7% of the variance, with variables showing high correlations with each other ranging between 0.374 and 0.727.

Combining the LGB-CSI-SF and PsySSA practice guidelines statements

A next step in the analysis was to include the 15 items from the LGB-CSI-SF scale and the eight PsySSA practice guidelines statements into factor analysis, as they were in the same section, worded in similar cadence and utilised the same 6-point semantic scale. The KMO score for the 23 statements was 0.938, with Bartlett's test significant ($p=0.00$), thus supporting the suitability of the study data for factor analysis. Factor analysis with different factor solutions were calculated, with a 5-factor solution appearing conceptually as the clearest and explaining 67.7% of the total variance. Table 5.17 outlines the pattern matrix with items loadings higher than 0.250 on each of the five factors.

Table 5. 17

Pattern matrix for LGB-CSI-SF and PsySSA practice guidelines statements

		Factor				
		1	2	3	4	5
	% Variance explained	51.2	6.6	3.8	3.4	2.7
1	Identify specific mental health issues associated with the coming out process		0.266			0.543
2	Assist LGB clients / patients to develop effective strategies to deal with heterosexism & homophobia					0.896
3	Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes					0.763
4	Refer LGB clients / patients to affirmative legal and social supports			0.744		
5	Refer an LGB client / patient to affirmative social services in cases of estrangement from their families of origin			0.786		
6	Help a same-sex couple access local LGB-affirmative resources and support			0.904		
7	Identify my own feelings about my own sexual orientation and how it may influence a client / patient				0.799	
8	Examine my own sexual orientation / identity development process				0.977	
9	Recognise my real feelings versus idealised feelings to be more genuine and empathic with LGB clients / patients				0.574	
10	Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations / identities		0.459			0.426
11	Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of an LGB client / patient		0.923			
12	Assess the role of alcohol and drugs on LGB clients' / patients' social, interpersonal, and intrapersonal functioning		0.877			
13	Establish a safe space for LGB couples to explore parenting	0.294	0.299			
14	Establish an atmosphere of mutual trust and affirmation when working with LGB clients / patients	0.335	0.565			
15	Normalise a LGB client's / patient's feelings during different points of the coming out process	0.398	0.353			
G1	Support clients' / patients' decisions on whether they come out or not, regardless of research indicating positive mental health outcomes with coming out	0.271	0.411			
G2	Talk to clients / patients about the prejudicial impact of multiple intersectionalities, such as race and sexual orientation, on their lives	0.627				0.367
G3	Discuss the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences	0.539				0.282
G4	Assist clients / patients in distinguishing sexual orientation and gender identity	0.770				
G5	Apply affirmative practice principles in working with LGB clients / patients	0.706				

		Factor				
		1	2	3	4	5
	% Variance explained	51.2	6.6	3.8	3.4	2.7
G6	Normalise a client's / patient's different identity labels and expressions of sexuality	0.829				
G7	Normalise different relationship configurations including polyamory and consensual non-monogamy	0.805				
G8	Identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress	0.866				

Note. *N*=198

Table 5.17 indicates that Factor 1 consists of most of the application of the PsySSA practice guidelines statements, but also indicates the overlap with Factor 2 that can be called *Therapy Practice Skills*. Factor 3 – *Advocacy Skills*, and Factor 4 – *Self-Awareness,* are distinct. Whereas Factor 5 – *Application of Knowledge* shows some overlap with both Factor 1 - *PsySSA practice guidelines application* and Factor 2 - *Therapy Practice Skills*. When examining the structure matrix, the correlations between items and the factors range from:

- Factor 1 - *PsySSA Practice Guidelines Application* between 0.439 and 0.853
- Factor 2 - *Therapy Practice Skills* between 0.434 and 0.833
- Factor 5 - *Application of Knowledge* between 0.440 and 0.922

The factor correlation matrix further supports this observation with the correlation between Factor 1 - *PsySSA Practice Guidelines Application* and Factor 2 - *Therapy Practice Skills* (0.715), as well as Factor 1 - *PsySSA Practice Guidelines Application* and Factor 5 - *Application of Knowledge* (0.721) being particularly high. The exception to this pattern of high correlation between items and factors is the lower correlations between items loading on Factor 3 - *Advocacy Skills* and Factor 4 - *Self-Awareness.* The three items loading on Factor 4 - *Self-Awareness* correlate lower with Factor 3 - *Advocacy Skills* (ranging between 0.169 and 0.306), and the three items loading on Factor 3 - *Advocacy Skills* correlate lower with Factor 4 - *Self-Awareness* (0.296 to 0.370). The rest of the items correlate between 0.304 to 0.921

with Factor 3 - *Advocacy Skills,* and between 0.421 and 0.832 with Factor 4 - *Self-Awareness.* This finding indicates that Factor 3 - *Advocacy Skills* and Factor 4 - *Self-Awareness* are distinct from each other, although respectively still showing high correlations with the other three factors.

LGBT-DOCSS

The KMO score for the ten LGBT-DOCSS items used was 0.775, with Bartlett's test significant ($p<0.001$), thus supporting the suitability of the study data for factor analysis. A 3-factor solution explained 48.0% of the variance. The pattern matrix with loadings above 0.30 is outlined in Table 5.18. The factors follow closely on those from Bidell (2017), with Factor 1 – *Clinical Preparedness* explaining 27.6% of variance, Factor 2 – *Attitudes* explaining 14.3% of the variance, and Factor 3 – *Basic knowledge* explaining a further 6.1% of the variance.

Table 5. 18

Pattern matrix for LGBT-DOCSS items used by factor

		Factor		
		1	2	3
	% Variance explained	27.6%	14.3%	6.1%
2	I am aware of institutional barriers that may inhibit LGB people from using health care services			0.602
4	I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity (reverse scored)	0.569		
5	A same-sex relationship between two men or two women is not as strong and committed as one between a man and a woman (reverse scored)		0.706	
6	I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals			0.629
7	LGB individuals must be discreet about their sexual orientation around children (reverse scored)		0.764	

		Factor		
		1	2	3
	% Variance explained	27.6%	14.3%	6.1%
11	I have received adequate clinical training and supervision to work with LGB clients / patients	0.608		
12	The lifestyle of a LGB individual is unnatural or immoral (reverse scored)		0.682	
13	I have experience working with LGB clients / patients	0.798		
14	I feel competent to assess a person who is LGB in a therapeutic / counselling setting	0.920		
18	I would be morally uncomfortable working with a LGBT client / patient (reverse scored)	0.322	0.381	

Note. *N*=201

Items relating to work / organisation setting

Due to the high "Not Applicable" response on two statements (both relating to staff), they are excluded from this analysis. A more detailed discussion of the exclusion of these two items and their potential meaning will be found under the work setting analysis heading where a related table also features. The KMO score for the four work setting statements, that had lower "Not Applicable" mentions, was 0.809, with Bartlett's test significant (p<0.001), thus supporting the suitability of the study data for factor analysis. One factor with an initial Eigen value of higher than 1 was identified (2.50), which explained 62.6% of the variance. The factor matrix showed the highest loading was with the factor for the statements "Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery" (0.871), "Engages with other service providers or organisations with LGBT+ expertise" (0.832), followed by "Provides access to information and resources for sexually and gender-diverse clients/patients" (0.740), and then followed by "Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms" (0.708).

Factor structure for combined items

A final factor analysis was done with all the items outlined above, including the 15 items from the LGB-CSI-SF, the eight PsySSA practice guidelines statements, the 10 items used from the LGBT-DOCSS, and the four retained work setting items. The KMO score for the 37 items was 0.913, with Bartlett's test significant (p=0.00), thus supporting the suitability of the study data for factor analysis. Different factor solutions were calculated and examined, with an 8-factor solution retained, as it provided better conceptual or construct distinction following the original item scales. The 8-factor solution explained 63,9% of the variance. Table 5.19 contains the loadings of items to each of the factors, with loadings of 0.250 or higher retained to assist in interpretation. The eight factors can be named as follows:

- Factor 1 - Therapy practice skills
- Factor 2 – Work setting
- Factor 3 – Advocacy skills
- Factor 4 – Clinical preparedness
- Factor 5 – Self-awareness
- Factor 6 – Knowledge
- Factor 7 – Attitudes
- Factor 8 – Application of knowledge

These factors have a high similarity to the constructs measured by:

- Bidell (2017) – Clinical preparedness, Knowledge, Attitudes,
- Dillon and Worthington (2003) / Dillon et al. (2015) – Therapy practice skills (the two constructs Assessment and Relationship), Advocacy skills, Self-awareness, and Application of knowledge,
- the work setting attributes factor on their own.

Table 5. 19

Pattern matrix for 37 items 8-factor analysis

		Factor							
		1	2	3	4	5	6	7	8
	Variance explained (%)	39.1	6.0	4.9	4.1	3.1	2.6	2.5	1.6
LGB-CSI-SF									
Application of Knowledge									
1	Identify specific mental health issues associated with the coming out process	0,293			0,315				0,372
2	Assist LGB clients / patients to develop effective strategies to deal with heterosexism and homophobia								0,938
3	Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes								0,837
Advocacy Skills									
4	Refer LGB clients / patients to affirmative legal and social supports			0,718					
5	Refer a LGB client/patient to affirmative social services in cases of estrangement from their families of origin			0,747					
6	Help a same-sex couple access local LGB-affirmative resources and support			0,822					
Self-Awareness									
7	Identify my own feelings about my own sexual orientation and how it may influence a client / patient					0,847			
8	Examine my own sexual orientation / identity development process					0,934			
9	Recognise my real feelings versus idealised feelings to be more genuine and empathic with LGB clients/patients					0,671			
Assessment									
10	Assess for post-traumatic stress felt by LGB victims of hate victimisation based on their sexual orientations / identities	0,558							0,342
11	Integrate clinical data (e.g., mental status exam, intake assessments,	0,949							

		Factor							
		1	2	3	4	5	6	7	8
	Variance explained (%)	39.1	6.0	4.9	4.1	3.1	2.6	2.5	1.6
	presenting concern) of a LGB client / patient								
12	Assess the role of alcohol and drugs on LGB clients' / patients' social, interpersonal, and intrapersonal functioning	0,929							
Relationship									
13	Establish a safe space for LGB couples to explore parenting	0,444							0,428
14	Establish an atmosphere of mutual trust and affirmation when working with LGB clients / patients	0,808							
15	Normalise a LGB client's / patient's feelings during different points of the coming out process	0,679							
PsySSA practice guidelines									
1	Support clients' / patients' decisions on whether they come out or not, regardless of research indicating positive mental health outcomes with coming out	0,685							
2	Talk to clients / patients about the prejudicial impact of multiple intersectionalities, such as race and sexual orientation, on their lives								0,546
3	Discuss the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences						0,360		0,329
4	Assist clients / patients in distinguishing sexual orientation and gender identity					0,290	0,524		
5	Apply affirmative practice principles in working with LGB clients / patients	0,302					0,285		0,376
6	Normalise a client's / patient's different identity labels and expressions of sexuality	0,303					0,313		
7	Normalise different relationship configurations including polyamory and consensual non-monogamy						0,359		
8	Identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress						0,501		
LGBT-DOCSS									
Basic Knowledge									
2	I am aware of institutional barriers that may inhibit LGB people from using health care services						0,770		

		Factor							
		1	2	3	4	5	6	7	8
	Variance explained (%)	39.1	6.0	4.9	4.1	3.1	2.6	2.5	1.6
6	I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals						0,583		
Clinical Preparedness									
4	I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity (reverse scored)				0,304				0,296
11	I have received adequate clinical training and supervision to work with LGB clients / patients				0,535				
13	I have experience working with LGB clients / patients				0,674				
14	I feel competent to assess a person who is LGB in a therapeutic / counselling setting				0,764				
Attitudes									
5	A same-sex relationship between two men or two women is not as strong and committed as one between a man and a woman (reverse scored)							0,771	
7	LGB individuals must be discreet about their sexual orientation around children (reverse scored)							0,730	
12	The lifestyle of a LGB individual is unnatural or immoral (reverse scored)							0,806	
18	I would be morally uncomfortable working with a LGBT client/patient (reverse scored)				0,485			0,301	
Work setting									
1	Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms		0,722						
3	Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery		0,888						
4	Engages with other service providers or organisations with LGBT+ expertise		0,893						
5	Provides access to information and resources for sexually and gender-diverse clients / patients		0,645						

In summary, the measurement utilised showed high internal reliability and good construct validity, with the final eight factors identified showing high similarity to those proposed in the original scales. Having discussed reliability and validity, the following section will discuss the results obtained from the scales and items, starting with the results from the attributes on work or organisational setting.

Affirming work / organisational setting

Table 5. 20

Analysis of "Not Applicable" responses for work setting statements

Number of respondents	Total *N*=196	Private sector *n*=164
Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms	21	21
Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)	40	40
Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery	15	15
Engages with other service providers or organisations with LGBT+ expertise	8	7
Provides access to information and resources for sexually and gender-diverse clients / patients	5	4
Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff	42	41

Note. *N*=196 (missing = 5)

In analysing the six work setting statements, the first finding is that some of the items had relatively high "Not Applicable" mentions. Table 5.20 provides an analysis of these

statements. As the statements are in the order they were given to respondents, the first observation is the different number of respondents that selected the statements as "Not Applicable". Secondly, almost all the respondents that selected "Not Applicable" work in the private sector. The two statements with the highest number of "Not Applicable" responses both relate to staff. "Not Applicable" selected for these statements constitute 19.9% for "Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)" and 20.9% for "Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff". For the remainder of the analysis for the six work setting variables, the "Not Applicable" was added to the missing values, and new descriptive statistics calculated (Table 5.21). A composite variable, "Total work setting" was created by adding the ratings on these new variables divided by six, to ensure comparability across items.

Table 5. 21

Descriptive statistics for work setting statements

	n	*M*	*SD*
Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff	154	4.0	1.3
Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery	181	3.7	1.3
Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms	175	3.3	1.4
Provides access to information and resources for sexually and gender-diverse clients/patients	191	3.3	1.2
TOTAL WORK SETTING	131	3.3	1.1
Engages with other service providers or organisations with LGBT+ expertise	188	3.1	1.2
Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)	156	2.9	1.3

One statement scored below the mid-point of the 5-point scale, namely "Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)". Another statement, "Engages with other service providers or organisations with LGBT+ expertise" scored marginally below the total work setting score. Table 5.22 reflects the correlation between work setting statements. The work setting variables are all significantly correlated with each other.

Table 5. 22

Correlation between work setting statements

	1	2	3	4	5
Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms					
Regularly reviews the needs of LGBT+ people and communicate this information to staff (including admin)	0.735** (150)				
Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery	0.642** (165)	0.688** (155)			
Engages with other service providers or organisations with LGBT+ expertise	0.572** (171)	0.619** (153)	0.677** (178)		
Provides access to information and resources for sexually and gender-diverse clients / patients	0.487** (173)	0.591** (154)	0.641** (180)	0.647** (188)	
Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff	0.526** (141)	0.551** (140)	0.719** (152)	0.520** (149)	0.617** (151)

Note. ** $p<0.01$ significant at 99% confidence, sample size in brackets

Table 5. 23

Correlation between training / experience and work setting variables

	No. of LGB clients ever seen	% of LGBT+ caseload per week	CPA score	Familiar with PsySSA practice guidelines
Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms	.204** (174)	.224** (175)	.171* (175)	.171* (173)
Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)	.291** (155)	.236** (156)	.201* (156)	
Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in service delivery	.338** (180)	.174* (181)		
Engages with other service providers or organisations with LGBT+ expertise	.315** (187)	.246** (188)	.259** (188)	
Provides access to information and resources for sexually and gender-diverse clients / patients	.288** (190)	.265** (191)	.271** (191)	.245** (191)
Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff	.217** (153)			
WORK SETTING TOTAL score	0.321** (131)	0.247** (131)	0.214* (131)	0.182* (131)

Note. ** p<0.01 significant at 99% confidence, * P<0.05 significant at 95% confidence, sample size in brackets

Table 5.23 reflects the correlation between the work setting items and training, experience, and familiarity with the PsySSA practice guidelines variables. There are significant correlations between overall affirming work setting and number of LGB clients ever seen, LGBT+ case load, involvement in CPAs, and familiarity with the PsySSA practice guidelines. More particularly, respondent familiarity with the PsySSA practice guidelines is highly correlated with work setting using inclusive language and providing access to information, and resources for sexually and gender-diverse clients. The only significant demographic difference is that sexually diverse respondents' work settings are more likely to use LGBT+ inclusive language on forms such as intake forms, incident reports, complaints,

and feedback forms (M=4.4, SD=1.0) compared to their heterosexual colleagues' work settings (M=4.0, SD=1.2) (p=0.05).

Self-Efficacy and confidence in working with LGB clients / patients

Table 5. 24

Confidence / self-efficacy sub-scales and total scale averages (ranked from highest to lowest)

	M	*SD*
Self-Efficacy Inventory: Self-awareness sub-scale	5,21	0,61
Self-Efficacy Inventory: Relationship sub-scale	5,03	0,84
Self-Efficacy Inventory: Assessment sub-scale	4.95	0,81
Total Self-Efficacy Inventory (LGB-CSI-SF)	4,75	0,72
Total Confidence (Self-Efficacy Inventory and PsySSA practice guidelines)	**4,70**	**0,74**
Total PsySSA practice guidelines	4,60	0,88
Self-Efficacy Inventory: Application of Knowledge sub-scale	4,49	0.97
Self-Efficacy Inventory: Advocacy Skills sub-scale	4,09	1,19

Note. N=198

In this section, results from the LGB-CSI-SF and additional statements relating to the PsySSA practice guidelines are discussed. Table 5.24 shows the mean scores for all the items related to self-efficacy, the LGB-CSI-SF scale and sub-scales, as well as the PsySSA practice guidelines items. Respondents indicated lower confidence in their Advocacy and Application of Knowledge skills relative to Total Confidence. In addition, respondents indicated a lower confidence in applying the PsySSA practice guidelines statements relative to their overall confidence. The composite scores obtained for the Self-Efficacy Inventory can be compared

to the scores obtained from the original Dillon et al. (2015) study. Their study had a sample of 543 participants (435 mental health professionals and 108 graduate students):

- Application of knowledge – 3.47, 1.05 (t=11.95, p<0.00)
- Advocacy – 3.39, 1.16 (t=7.22, p<0.00)
- Self-awareness – 4.34, 0.67 (t=15.99, p<0.00)
- Assessment – 4.07. 0.96 (t=11.50, p<0.00)
- Relationship – 4.11, 0.91 (t=12.41, p<0.00)
- Total – 3.90, 0.74 (t=13.93, p<0.00)

On all the comparable measures, the South African respondents scored themselves significantly higher on confidence / self-efficacy and the different aspects measured by the LGB-CSI-SF. Table 5.25 outlines correlations between the sub-scales and total confidence scores and training, experience, and familiarity with guidelines attributes of significance. Confidence is significantly correlated with contact (Number of LGBT+ acquaintances and number of LGBT+ friends / close family), professional experience (Number of LGB clients ever seen, LGBT+ case load), involvement in CPAs (CPA score), and familiarity with the PsySSA practice guidelines. The total LGB-CSI-SF score is correlated with years in practice but not number of acquaintances, whereas confidence in applying statements relating to the PsySSA practice guidelines is correlated with number of acquaintances but not to years in practice. Furthermore, the correlation with confidence applying the PsySSA practice guidelines statements is highest for those involved in CPAs, familiarity with the guidelines, and LGBT+ case load. Increasing these aspects could see a particular increase in confidence in applying the PsySSA practice guidelines statements used in this study. As indicated in Table 5.26, sexually diverse respondents are significantly more confident in all aspects of self-efficacy and confidence measured compared to their heterosexual counterparts.

Table 5. 25

Correlation of training and practice variables with self-efficacy / confidence measures

	Years in practice	No. of LGBT+ acquaint	No. of LGBT+ friends / close family	No. of LGB clients ever seen	% of LGBT+ case load per week	CPA score	Familiar with PsySSA guide-lines
Application of Knowledge							
Pearson	.267**	.158*	.226**	.388**	.319**	.354**	.151*
N	198	198	198	197	198	198	194
Advocacy Skills							
Pearson			.201**	.264**	.300**	.322**	.303**
N			198	197	198	198	194
Self-Awareness							
Pearson	.172*			.194**	.149*	.244**	
N	198			197	198	198	
Assessment							
Pearson			.149*	.259**	.155*	.267**	.168*
N			198	197	198	198	194
Relationship							
Pearson			.198**	.332**	.282**	.333**	.155*
N			198	197	198	198	194
PsySSA practice guidelines							
Pearson		.164*	.237**	.292**	.337**	.447**	.346**
N		195	195	194	195	195	191
LGB-CSI-SF Total							
Pearson	.193**		.220**	.359**	.310**	.380**	.234**
N	198		198	197	198	198	194
Total Confidence							
Pearson		.153*	.228**	.346**	.342**	.432**	.307**
N		195	195	194	195	195	191

Note. ** $p<0.01$ significant at 99% confidence, * P<0.05 significant at 95% confidence, non-significant correlations deleted

Table 5. 26

LGB-CSI-SF, sub-scales, and PsySSA practice guidelines statements by sexual orientation

	Total	Heterosexual	Sexually Diverse
	N=201	*n*=157	*n*=44
Application of Knowledge (*p*=0.00)			
Mean	4.5	4.3	5.0
(SD)	(1.0)	(1.0)	(0.7)
Advocacy Skills (*p*=0.05)			
Mean	4.1	4.0	4.4
(SD)	(1.2)	(1.2)	(1.0)
Self-Awareness (*p*=0.00)			
Mean	5.2	5.1	5.5
(SD)	(0.6)	(0.6)	(0.5)
Assessment (*p*=0.00)			
Mean	5.0	4.9	5.3
(SD)	(0.8)	(0.9)	(0.5)
Relationship (*p*=0.00)			
Mean	5.0	4.9	5.4
(SD)	(0.8)	(0.9)	(0.6)
PsySSA practice guidelines (*p*<0.00)			
Mean	4.6	4.5	5.2
(SD)	(0.9)	(0.9)	(0.6)
LGB-CSI-SF Total (*p*=0.00)			
Mean	4.8	4.7	5.1
(SD)	(0.7)	(0.8)	(0.4)
Total Confidence (*p*<0.00)			
Mean	4.7	4.6	5.1
(SD)	(0.7)	(0.8)	(0.4)

Table 5. 27

Confidence / self-efficacy item averages (ranked from highest to lowest)

Item		*M*	*SD*
8	Examine my own sexual orientation / identity development process	5,4	0,6
14	Establish an atmosphere of mutual trust and affirmation when working with LGB clients / patients	5,3	0,8
7	Identify my own feelings about my own sexual orientation and how it may influence a client / patient	5,2	0,7
15	Normalise a LGB client's / patient's feelings during different points of the coming out process	5,1	0,9
G1	Support clients' / patients' decisions on whether they come out or not, regardless of research indicating positive mental health outcomes with coming out	5,0	0,8
9	Recognise my real feelings versus idealised feelings to be more genuine and empathic with LGB clients / patients	5,0	0,9
12	Assess the role of alcohol and drugs on LGB clients' / patients' social, interpersonal, & intrapersonal functioning	5,0	0,9
10	Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations / identities	5,0	1,0
11	Integrate clinical data (e.g., mental status exam, intake assessments, presenting concerns) of a LGB client / patient	4,9	0,9
G6	Normalise a client's / patient's different identity labels and expressions of sexuality	4,8	1,1
	TOTAL CONFIDENCE SCORE	4.7	0.7
13	Establish a safe space for LGB couples to explore parenting	4,7	1,3
G2	Talk to clients / patients about the prejudicial impact of multiple intersectionalities, such as race and sexual orientation, on their lives	4,7	1,0
G4	Assist clients / patients in distinguishing sexual orientation and gender identity	4,7	1,1
G5	Apply affirmative practice principles in working with LGB clients / patients	4,7	1,1
1	Identify specific mental health issues associated with the coming out process	4,7	1,0
G3	Discuss the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences	4,5	1,2
2	Assist LGB clients / patients to develop effective strategies to deal with heterosexism & homophobia	4,4	1,1
3	Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes	4,4	1,1
G8	Identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress	4,4	1,1
G7	Normalise different relationship configurations including polyamory and consensual non-monogamy	4,3	1,2
4	Refer LGB clients / patients to affirmative legal and social supports	4,3	1,3

Item		*M*	*SD*
6	Help a same-sex couple access local LGB-affirmative resources and support	4,1	1,3
5	Refer a LGB client / patient to affirmative social services in cases of estrangement from their families of origin	3,9	1,3

Note. *N*=198, items numbered as per LGB-CSI-SF order in questionnaire, G refers to the PsySSA practice guidelines statements

Table 5.27 outlines the specific individual items and statements used in the self-efficacy / confidence part of the survey. The ranking assists in identifying more focused content areas for professional development for respondents. This includes a focus on improved or increased:

- Advocacy skills:
    - refer LGB clients / patients to affirmative legal and social supports,
    - refer a LGB client / patient to affirmative social services in cases of estrangement from their families of origin,
    - help a same-sex couple access local LGB-affirmative resources and support.
- Knowledge and skills covering certain PsySSA practice guidelines' themes:
    - discuss the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences,
    - normalise different relationship configurations including polyamory and consensual non-monogamy,
    - identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress.
- Application of Knowledge:
    - assist LGB clients / patients to develop effective strategies to deal with heterosexism and homophobia,

- assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.

In summary, the results from the statements exploring practitioners' confidence working therapeutically with LGB people, including the LGB-CSI-SF and the statements relating to the PsySSA practice guidelines, indicated a higher level of confidence relative to comparative results from the USA. Confidence was significantly correlated with contact, professional experience, involvement in CPAs and familiarity with PsySSA practice guidelines. Results indicated that specific areas could benefit from increased focus in the areas of advocacy skills; specific themes touched on in the PsySSA practice guidelines such as the effect of colonialism, apartheid and postcolonialism, different relationship configurations, and the experience of gender diversity; and coping strategies for LGB individuals and couples.

Perceived competence in working with sexually diverse clients / patients

Table 5. 28

Perceived competence sub-scales and total scale averages (ranked from highest to lowest)

	M	SD
Total Attitudes Sub-Scale	6,53	0,81
Total Scale	5,78	0,76
Total Clinical Preparedness Sub-Scale	5,34	1,19
Total Basic Knowledge Sub-Scale	5,09	1,42

Note. *N*=201

In this section, the results of the 10 items used from the LGBT-DOCSS scale are discussed. Table 5.28 highlights the averages for the total scale and the three sub-scales. Respondents scored notably high on the Attitudes sub-scale compared to the other two sub-

scales. The lowest sub-scale score is for Basic Knowledge, which talks to knowledge of institutional barriers to health for LGB people, as well as knowledge of research indicating disproportionate levels of health and mental health problems amongst LGB individuals relative to their heterosexual counterparts. As previously discussed, eight out of the 18 items in the LGBT-DOCSS were excluded for the analysis as they only referred to transgender patients / clients. Comparing results obtained from the 10 items utilised to those reported by Bidell (2017) should thus be interpreted with caution, as practitioners might feel less competent about caring for transgender and gender diverse clients / patients than for sexually diverse (LGB) clients / patients. Nevertheless, it remains useful to compare as the Bidell (2017) work does represent a benchmark against which to evaluate results obtained:

- Total score – study 1 (5.02, 0.87) – t=11.00, p>0.00, study 2 (4.85, 0.93) – t=12.67, $p<0.00$
- Attitudes – study 1 (6.52, 0.72) – t=0.16, $p=0.87$, study 2 (6.41, 0.86) – t=1.71, $p=0.09$
- Clinical preparedness – study 1 (3.51, 1.45) – t=16.00, $p<0.00$. study 2 (3.21, 1.53) – t=17.78, $p<0.00$
- Knowledge – study 1 (4.95, 1.51) – t=1.15, $p=0.25$, study 2 (4.54, 1.75) – t=3.98, $p<0.00$

In total, the South African respondents scored significantly higher overall, including Clinical Preparedness, compared to the two Bidell (2017) samples. South African respondents also scored significantly higher relative to one of the two Bidell (2017) samples on Knowledge and scored similarly relative to the two Bidell (2017) samples on Attitudes. It should be noted that the ratings on Attitude are high, reaching towards the top of the 7-point agreement scale.

Table 5. 29

Correlation between training and experience variables, and LGBT-DOCSS and sub-scales

	Years in practice	No. of LGBT+ acquain-tances	No. of LGBT+ friends / close family	No. of LGB clients ever seen	% of LGBT+ case load per week	CPA score	Total training score	Familiar. with PsySSA practice guide-lines
Clinical Preparedness								
Pearson	.154*	.219**	.222**	.462**	.359**	.303**	.319**	
N	201	201	201	199	201	201	201	
Attitudes								
Pearson			.154*			.140*		
N			201			201		
Knowledge								
Pearson	-.198**	.151*	.195**		.176*	.304**	.304**	.273**
N	201	201	201		201	201	201	194
LGBT-DOCSS Total								
Pearson		.239**	.279**	.317**	.350**	.365**	.374**	.221**
N		201	201	199	201	201	201	194

Note. ** $p<0.01$ significant at 99% confidence, * $p<0.05$ significant at 95% confidence, non-significant correlations deleted

Table 5.29 highlights the correlations between training, experience, and familiarity with the PsySSA practice guidelines variables and the scale and sub-scale scores. Perceived competence, as measured by the 10 selected items from the LGBT-DOCSS, is significantly correlated with contact (Number of LGBT+ acquaintances and number of LGBT+ friends / close family), professional experience (Number of LGB clients ever seen, LGBT+ case load), involvement in CPAs (CPA score), and familiarity with the PsySSA practice guidelines. The Clinical Preparedness sub-scale is positively correlated with years of practice whereas the Knowledge sub-scale is negatively correlated with years of practice. As outlined in Table 5.30, sexually diverse respondents report higher levels of perceived competence as measured by the selected items from the LGBT-DOCSS than heterosexual respondents. Having analysed the total scale and sub-scale, results for individual items are discussed next.

Table 5. 30

LGBT-DOCSS and sub-scales by sexual orientation

	Total	Heterosexual	Sexually Diverse
	N=201	*n*=157	*n*=44
Clinical Preparedness (*p*<0.00)			
M	5.3	5.1	6.1
(SD)	(1.2)	(1.2)	(0.8)
Attitudes (*p*=0.01)			
M	6.6	6.5	6.8
(SD)	(0.8)	(0.9)	(0.4)
Knowledge (*p*=0.00)			
M	5.1	4.9	5.8
(SD)	(1.4)	(1.4)	(1.3)
LGBT-DOCSS Total (*p*<0.00)			
M	5.8	5.6	6.3
(SD)	(0.8)	(0.8)	(0.4)

Table 5. 31

Knowledge and Clinical Preparedness sub-scale items by years in professional practice

	Total	10 or less years A	11-19 years B	20 or more years C
	N=201	*n*=74	*n*=61	*n*=66
KNOWLEDGE ITEMS				
I am aware of institutional barriers that may inhibit LGB people from using health care services (*p*=0.02)				
M	5.0	5.5BC	4.7	4.9
(SD)	(1.7)	(1.5)	(2.0)	(1.6)
I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals (*p*=0.06)				
M	5.1	5.4C	5.2	4.8
(SD)	(1.7)	(1.6)	(1.9)	(1.6)
CLINICAL PREPAREDNESS ITEMS				
I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity (reverse coded) (*p*=0.04)				
M	5.9	5.7	5.7	6.3AB
(SD)	(1.5)	(1.5)	(1.8)	(1.2)

	Total	10 or less years A	11-19 years B	20 or more years C
	N=201	*n*=74	*n*=61	*n*=66
I have experience working with LGB clients / patients (*p*=0.01)				
M	5.7	5.4	5.7	6.2AB
(SD)	(1.4)	(1.5)	(1.5)	(1.0)
I feel competent to assess a person who is LGB in a therapeutic / counselling setting (*p*=0.02)				
M	5.8	5.5	5.8	6.1A
(SD)	(1.3)	(1.3)	(1.5)	(1.1)
Familiarity with PsySSA practice guidelines				
%	55.7	62.2C	60.7	43.9

Note. Only items with significant differences listed

Table 5.31 outlines the results of the means for the individual items included within each sub-scale and comparing these across categories of years of practice. The following are noted:

- Respondents in practice for fewer years (≤10 years) are significantly more likely to be aware of institutional barriers to accessing care or that LGB people than respondents that have been in practice for longer (over 10 years). In addition, respondents that have been in practice for ≤10 years are significantly more likely to be aware of research indicating the higher burden of health and mental health problems for LGB people compared to heterosexual people, than respondents that have been in practice for 20+ years. Respondents in practice for ≤10 years are also significantly more familiar with the PsySSA practice guidelines than respondents in 20+ years in practice.
- Conversely respondents in practice for 20+ years are significantly more likely than those with fewer years in practice to feel prepared to talk to LGBT clients about sexual orientation or gender diversity, as well as have experience working with LGB clients. Furthermore, respondents in practice for 20+ years also feel

significantly more competent to assess a person who is LGB in a therapeutic setting than those in practice for ≤10 years.

Table 5. 32

Perceived competence average scores for items, sub-scales and total scale (ranked from highest to lowest)

Item		M	SD
18	I would be morally uncomfortable working with a LGBT client / patient (reverse scored)	6,8	0,8
12	The lifestyle of a LGB individual is unnatural or immoral (reverse scored)	6,7	0,9
5	A same-sex relationship between two men or two women is not as strong and committed as one between a man and a woman (reverse scored)	6,6	1,2
7	LGB individuals must be discreet about their sexual orientation around children (reverse scored)	6,2	1,3
4	I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity (reverse scored)	5,9	1,5
14	I feel competent to assess a person who is LGB in a therapeutic / counselling setting	5,8	1,3
	TOTAL SCALE	5,8	0,7
13	I have experience working with LGB clients / patients	5,7	1,4
6	I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals	5,1	1,7
2	I am aware of institutional barriers that may inhibit LGB people from using health care services	5,0	1,7
11	I have received adequate clinical training and supervision to work with LGB clients/patients	3,9	1,8

Note. *N*=201

Finally, the average scores on each item can be compared relative to the average for the total scale, as outlined in Table 5.32. The lowest average was for having received adequate training and supervision to work with LGB client / patients. Respondents who received LGBT+ focused graduate training, and respondents with a higher CPA score rate this statement significantly higher. The average for those that have received LGBT+ focused training is 4.3 (*SD*=1.8) relative to 3.6 (*SD*=1.8) for those that did not (p=0.05). Respondents

with a CPA score of 5-8 (M=4.3, SD=1.8) or ≥9 (M=4.2, SD=1.9) score this item significantly higher than those with a CPA score of ≤4 (M=3.4, SD=1.7) with p=0.01. The ranking of items remains stable across different provinces, age and years of practice, clinical and counselling psychology registrations and respondents with master's or doctorate degrees. Two further items, rated below average, covered being aware of institutional barriers and research on burden of disease for LGB people relative to heterosexual people. It was found that people with fewer years in practice scored higher on these items as well as familiarity with the guidelines, potentially indicating that the early career clinical and counselling psychologists have a better basic knowledge base from which to build their confidence and competence.

In summary, although the findings should be read with care, as only selected items from the LGBT-DOCSS were analysed, it does appear that South African respondents rated their perceived competence significantly higher on the overall scale as well as on the Clinical Preparedness sub-scale compared to the two Bidell (2017) samples. Similar to the findings on practitioner confidence, perceived competence was significantly correlated with contact, professional experience, involvement in CPAs, and familiarity with the PsySSA practice guidelines. The low average rating on the item "I have received adequate clinical training and supervision to work with LGB clients / patients" indicates significant potential for improvement into the future. Having discussed the results from the LGBT-DOCSS, the discussion now moves to summarising key findings.

Key findings

Before moving to the next chapter and a more detailed discussion of the results, key findings from the data can be summarised.

Sample characteristics

The following was observed from the sample of 201 respondents:

- skewed towards the three major provinces of Gauteng (36.3%), Western Cape (34.8%), and KwaZulu-Natal (12.9%),
- majority white (68.2%), female assigned at birth (74.6%), cisgender identified (89.6%), heterosexual or straight (78.1%), with an average age of 46.6 years,
- a higher proportion of sexually diverse respondents than for the general population, with a skew towards sexually diverse males identifying as cisgender,
- predominantly clinical psychologists (68.7%), with a masters-level degree (84.1%), working in the private sector (81.6%), with an average of 60.4% of their workload consisting of psychotherapy or counselling, and an average of 15.6 years in professional practice.

Graduate training

In summary, the following results were found around graduate training of respondents:

- graduation happened between 1972 and 2022 with a median of 2009,
- as expected, the year graduated, age, and years in professional practice were highly correlated,
- exposure to LGBT+ focused activities during graduate studies show a significant increase over time, from a low of 35.3% for those graduating in 2000 or before, up to a high of 63.0% amongst those having graduated from 2015 onwards,

- activities included doing a course on sexuality and / or gender that covered working with LGBT+ clients / patients including sex therapy (23.4%), attending a workshop on LGBT+ health and well-being (21.4%), conducting research on LGBT+ concerns (13.4%), and clinical / practical training experience working with LGBT+ people (6.0%).

Professional development activities

Respondents indicated that they had been involved in the following CPAs in the past year, ordered from highest to lowest:

- Read mass media including social media and online news on LGBT+ topics (57.2%)
- Read LGBT+ topics on online blog or group (53.2%)
- Read articles / themes in an interest group / journal club (46.8%)
- Attended LGBT+ workshop / training course (25.9%)
- Attended LGBT+ presentations / symposia at congress / conference (19.4%)
- Involved / advocated for LGBT+ community efforts and organisations (18.9%)
- Mentored / supervised on working with LGBT+ people (18.9%)
- Wrote professional articles / books on LGBT+ concerns (4.5%)

Composite scores were calculated for:

- CPA score, giving one point for each activity ever done but not in last year, and two points for each activity done in past year, with an average score for the sample of 6.6.
- Total training score, combining the CPA score with number of activities during graduate studies, with an average score for the sample of 7.3.

A total of 55.7% of respondents indicated that they are familiar with the PsySSA practice guidelines, and those that are familiar with the guidelines also had a higher total training score.

Finally, respondents indicated which CPAs they want to receive in future:

- Attend LGBT+ workshop / training course (60.7%)
- Read articles / themes in an interest group / journal club (54.7%)
- Attend LGBT+ presentations / symposia at congress / conference (44.3%)
- Read LGBT+ topics on online blog or group (32.3%)
- Read mass media including social media and online news on LGBT+ topics (31.8%)
- Mentor / supervise on working with LGBT+ people (28.4%)
- Be involved in / advocate for LGBT+ community efforts and organisations (22.4%)
- Write professional articles / books on LGBT+ concerns (12.4%)
- None (8.0%)

Personal and professional experience with LGBT+ people

Key findings around personal and professional experience with LGBT+ people, clients, and patients included:

- The sample reported having an average of 18.3 LGBT+ acquaintances and 6.3 LGBT+ friends or close family.
- An average of at least 19 LGB clients or patients ever with an average case load of 14.7% LGBT+ clients / patients. Respondents in the private sector reported a significantly higher case load of LGBT+ client / patients.

- Professional experience variables are significantly correlated with each other, with the CPA score and the total training score. In addition, LGB client or patients ever seen correlated highly with years in practice and age.
- Respondents with a higher case load tend to be interested in more of the CPAs in the future, particularly the more niched opportunities of supervision / mentoring, community involvement and advocacy, and professional writing.

Sexual diversity

Sexually diverse respondents:

- had more personal and professional experience with LGBT+ people,
- were more likely to report that LGBT+ inclusive language was used in their work setting documentation,
- had higher levels of confidence and perceived competence relative to the heterosexual respondents,
- had been involved in more CPAs – apart from attending workshops and writing.
- had higher levels of familiarity with the PsySSA practice guidelines,
- a higher proportion of sexually diverse respondents wanted a wider range of CPAs except for attending workshops and mass media consumption.

Reliability

Good levels of internal consistency were obtained for:

- all items analysed combined,

- the individual scales including the LGB-CSI-SF, the PsySSA practice guidelines statements (and these two scales combined), work setting statements, and the LGBT-DOCSS items,
- all the sub-scales within the LGB-CSI-SF and LGBT-DOCSS items analysed, except for the Basic Knowledge sub-scale, which might be due to there being only 2 items in this sub-scale.

Construct validity

Good construct validity was obtained for:

- The LGB-CSI-SF, the additional PsySSA practice guidelines items, and the combined LGB-CSI-SF and additional PsySSA practice guidelines items:
    - four factors calculated for the LGB-CSI-SF scale. Two sub-scales, namely Assessment and Relationship converged into one factor,
    - combined items for the LGB-CSI-SF and the additional PsySSA practice guidelines items converged into five factors,
    - high correlation between three factors, namely “PsySSA Practice Guidelines Application”, “Therapy Practice Skills”, and “Application of Knowledge”. The other two factors, namely “Advocacy Skills” and “Self-Awareness”, had a low inter-correlation with each other.
- the LGBT-DOCSS items analysed – three factors,
- the four affirmative work setting items retained for the factor analysis – one factor,
- Total of all items:

- solution converged on eight factors, which indicated high similarity with the domains or constructs posited by authors,
- Self-efficacy / confidence, as per Dillon et al. (2015): Therapy Practice Skills (combining Assessment and Relationship domains) (Factor 1), Advocacy Skills (Factor 3), Self-awareness (Factor 5), and Application of Knowledge (Factor 8),
- Perceived Competence, as per Bidell (2017): Clinical Preparedness (Factor 4), Basic Knowledge (Factor 6), and Attitudes (Factor 7),
- Affirming work setting (developed for the study) (Factor 2).

Work context

Key findings from the items on how affirmative respondents perceived their work environment included:

- two statements with highest "Not Applicable" mentions both related to staff, with the mentions almost all from respondents working in the private sector,
- a high correlation between the six work setting variables,
- an overall affirming work setting significantly correlated with number of LGB clients ever seen, LGBT+ case load, involvement in CPAs, and familiarity with the PsySSA practice guidelines,
- below midpoint rating on working setting ''Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)".

Confidence / self-efficacy in working with sexually diverse people

Key findings on confidence included:

- respondents were significantly more confident in working with sexually diverse people, in comparison to USA findings from Dillon et al. (2015),
- overall confidence is significantly correlated with contact with LGBT+ people, professional experience with LGBT+ clients / patients, involvement in CPAs (CPA score), and familiarity with the PsySSA practice guidelines,
- respondents had lower confidence in sub-scales Advocacy Skills, Application of Knowledge and the additional PsySSA statements compared to the average confidence score for the sample,
- confidence applying the PsySSA practice guidelines statements is highest for those involved in CPAs, familiarity with the guidelines, and LGBT+ case load,
- respondents were less confident than average in the following specific statements:
    - Advocacy skills (refer LGB clients / patients to affirmative legal and social supports, refer an LGB client / patient to affirmative social services in cases of estrangement from their families of origin, and help a same-sex couple access local LGB-affirmative resources and support),
    - Knowledge and skills covering certain PsySSA practice guidelines' themes (discussing the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences; normalising different relationship configurations including polyamory and consensual non-monogamy; and identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress),
    - Application of knowledge (specifically assisting LGB clients / patients to develop effective strategies to deal with heterosexism and homophobia, and helping same-sex couples who experience different stages in their individual coming out processes develop coping strategies).

Perceived competence in working with sexually diverse people

In summary, key findings from the selected LGBT-DOCSS items measuring perceived competence indicated:

- South African respondents rated their perceived competence significantly higher overall, including the Clinical Preparedness sub-scale, compared to the two Bidell (2017) samples. Respondents scored significantly higher relative to one of the two Bidell (2017) samples on the Knowledge sub-scale and scored similarly relative to the two Bidell (2017) samples on the Attitudes sub-scale,
- the ratings on the individual items from the Attitude sub-scale is high, reaching towards the top of the 7-point agreement scale,
- as with confidence, perceived competence was significantly correlated with contact, professional experience, involvement in CPAs, and familiarity with the PsySSA practice guidelines,
- the lowest average for an item was for "I have received adequate clinical training and supervision to work with LGB clients / patients",
- two further items that rated below average were respondents being aware of institutional barriers and research on burden of disease for LGB people relative to heterosexual people. Respondents that have been in practice for fewer years tend to be more aware of both institutional barriers and research on burden of disease, as well as higher familiarity with the PsySSA practice guidelines.

In the following chapter, these findings will be discussed in more detail, integrating previous work, leading to conclusions and recommendations for future research and training.

CHAPTER 6: OVERVIEW, DISCUSSION, AND RECOMMENDATIONS

Introduction

Chapter 6 provides a review of the objectives, design, and sample characteristics of my study. This is followed by a discussion of the research findings collected on the training, experience, perceived competence, and confidence of clinical and counselling psychologists working with sexually diverse people, followed by recommendations and limitations of the study, and suggestions for future research. In my study the term sexual diversity has been used to refer to individuals whose sexual orientations do not conform to heteronormative expectations, including lesbian, gay, bisexual, pansexual, questioning, or queer identities (LGBPQ+) as well as other emerging sexual orientation identity markers or self-definitions.

Background and objectives

Following the publication of the "PsySSA Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People" (referred to as PsySSA practice guidelines) in 2017, a need was identified to develop a benchmark against which progress in the use of affirmative practices with sexually diverse people would be measured (PsySSA, 2017). The primary objectives of my study were to determine the following amongst registered clinical and counselling psychologists in South Africa:

- What graduate and CPD training have they received and want to receive in working with sexually diverse people?
- What professional and personal experience or exposure do they have with sexually diverse people (in their private lives and in practice)?

- What is their perceived competence in practising affirmatively with sexually diverse people?
- How confident are they in affirmative practice with sexually diverse people?

Research Design

My research proposal was accepted in 2017 but I was only able to spend more active time in implementation since 2021. By this time a larger multinational, or transnational study team, that I am a member of, was also in the process of developing the quantitative leg of research focusing on the role of psychology guidelines on mental health access and treatment of sexually and gender-diverse individuals. Given the clear convergence, and to avoid duplication of effort, it was agreed that my data would be collected utilising the same questionnaire and data collection opportunity. As a result of using the same questionnaire, some of the results reported on refer to LGBT[28] people generally, rather than to LGB or sexually diverse people, particularly in the data collected in the sections on training and experience. My doctorate received ethical clearance certificate PERC-17061 (see Appendix I) on 27 October, 2017, which was amended (see Appendix II) on 2 October, 2019 to include the possibility of collecting data in conjunction with the larger study.

The target population for my study was South African clinical and counselling psychologists that work with sexually diverse people, whereas the transnational study focused on mental health professionals more broadly. Mental health professionals were invited to participate through various e-mail invites to professional associations' databases, advertisements in relevant newsletters and Facebook groups, and invitations to the

[28] For clarification, note that the terms LGBT, LGBT+ and LGB are applied intermittently to reflect the same terms used in the research articles, scales and / or questionnaires. See also, Limitations of Study.

professional and personal networks of the transnational study team and the PsySSA African LGBTI+ Human Rights Project team. Most, if not all, registered clinical and counselling psychologists would have received the invite, with many potentially receiving multiple invitations from different sources, particularly those working with LGBT+ people.

Participants accessed the online survey on Qualtrics through a link or QR code. On accessing the link from the invitation, participants were provided with an information sheet outlining the title of the research study, team information, ethical clearance, purpose of the study, reason for being invited, nature of participation, right to withdraw, confidentiality of information, data security, potential benefits of taking part in the study, and contact information. Participants had to click on a "proceed" button to acknowledge that they had read and understood the information, had sufficient opportunity to seek clarity and prepare for participation, understood that they would voluntarily participate and were aware of how the results would be processed (see Appendix V).

The online questionnaire was initially pre-tested amongst all five permanent members of the PsySSA African LGBTI+ Human Rights Project. The revised online survey was further pre-tested between 20-27 October, 2022 by six practitioners working with sexually and gender-diverse people – four clinical psychologists and two psychiatrists, followed by discussion and finalisation of the online survey for launch early the next year. Items from the final questionnaire that were utilised for my analyses included:

- screener questions, personal and work demographics,
- training, contact, and work experience with LGBT people,
- ten items from the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) (Bidell, 2017), with eight mentioning LGB clients / patients, and two LGBT clients / patients. The LGBT-DOCSS is a

multidisciplinary health provider tool to measure perceived competence in working with sexually and gender-diverse people,

- the 15-item Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory – Short Form (LGB-CSI-SF) (Dillon et al., 2015) measuring counsellor and psychotherapist confidence / self-efficacy,
- eight further items added to the LGB-CSI-SF derived from the PsySSA practice guidelines (PsySSA, 2017),
- six work setting items derived from the standards of service provision outlined by the Australian National LGBTI Health Alliance in their LGBTI Cultural Competency Framework (Walker & Mars, 2013),
- one item on respondent familiarity with the PsySSA practice guidelines (PsySSA, 2017).

As an incentive for participation respondents could earn 2 CEUs through completion of 15 multiple choice questions based on three articles – IPsyNet (2018); McLachlan et al. (2019); and Pillay et al. (2019). Data was analysed using Qualtrics and SPSS v28. Data cleaning included fraud detection as per Qualtrics standards, as well as a credibility question during completion of the LGBT-DOCSS to eliminate incomplete surveys with little value in retention. After the data cleaning, data for respondents registered as clinical psychologists or counselling psychologists were filtered and retained for my analysis from the larger dataset. The sample achieved for my study is n=201, which is 48,2% of the transnational survey data. The questionnaires were completed between 31 January and 11 April, 2023 (71 days), and half the respondents had completed the questionnaire by 20 February, 2023. Of the 201 respondents, 194 completed the questionnaire in full (96.5%) and the other 7 (3.5%) completed at least half the questionnaire. In more detail, 201 completed the LGBT-DOCSS, 198 completed the LGB-CSI-SF, and 196 completed the statements relating to work setting.

The response rate was estimated at 3.9%, which is relatively low. Some reasons postulated include databases are not up to date; not all clinical and counselling psychologists are involved in counselling or psychotherapy, nor in working with LGBT+ people; research fatigue; participant time constraints; lack of adequate incentive; or lower levels of interest in the research topic. Reliability and validity of the instrument and scales within the instrument indicated good internal consistency and construct validity.

Sample characteristics

The sample of 201 respondents were skewed towards the three major provinces of Gauteng (36.3%), Western Cape (34.8%), and KZN (12.9%). The majority were white (68.2%), female assigned at birth (74.6%), cisgender identified (89.6%), heterosexual or straight (78.1%), with an average age of 46.6 years. The sample had a higher proportion of sexually diverse respondents (21.9%) than for the population, with a skew towards sexually diverse males identifying as cisgender. In a recent online global survey, 7% of South African respondents self-identified as a sexual minority (Ipsos, 2023). This is the first study in South Africa to give some indication of the proportion of clinical and counselling psychologists identifying as sexually diverse and working with LGBT+ people. Intuitively it makes sense that sexually diverse professionals would be more inclined to work with LGBT+ people, given their own experience and journey. More broadly though, this might also indicate that clinical and counselling psychology would be more appealing as a profession for sexually diverse people, thus accounting for a higher proportion of sexually diverse professionals relative to population.

Furthermore, the sample was predominantly clinical psychologists (68.7%), with a masters-level degree (84.1%), with an average of 60.4% of their workload consisting of

psychotherapy or counselling, and an average of 15.6 years in professional practice. A significantly higher proportion of respondents work in private health / companies, such as private practice (81.6%) compared to a larger sample study amongst clinical and counselling psychologists, namely 56.3% (HPCSA, 2017). It can be hypothesised that this significant difference might indicate that clinical and counselling psychologists in private settings are more likely to be doing therapy (rather than for example assessment or research) with LGBT+ clients / patients in these contexts than in other public contexts such as higher learning institutions. Another hypothesis is that clinical and counselling psychologists in public entities might be less aware of working with LGBT+ clients either due to lack of self-identification by clients / patients, or the perceived lack of importance of sexual orientation in the work. A final hypothesis is that private contexts are more accessible to resourced clients / patients (e.g., on medical aid), and that a higher proportion of resourced clients are comfortable with being LGBT+ identified.

Key findings and recommendations

Graduate training

Only half of the respondents had been exposed to any LGBT+ focused activities during graduate studies. Those that did receive any training, on average were only exposed to one activity, mainly a course in sexuality and / or gender that covered working with LGBT+ clients / patients including sex therapy (47%) or a workshop on LGBT+ health and well-being (43%). There has been an increase over time of respondents being exposed to LGBT+ content during graduation studies, but it is concerning that even for people graduating after 2015, over a third had not had any exposure. This indicates that graduate training is still not ensuring that their graduates are competent in working with LGBT+ people, even though all

the respondents in the sample are working with LGBT+ people. This essentially also places the onus on practitioners to ensure competence and confidence through professional development activities.

The higher level of workshops attended by younger respondents with fewer years in private practice might be indicative of the impact of the workshops conducted by the PsySSA African LGBTI+ Human Rights Project to clinical and counselling psychology master's level students since 2017. Rolling out these workshops to more of the universities, enabling more universities to offer a workshop, or providing students with opportunities for a combined online workshop across the country, would further improve graduate training experience.

> *Recommendation 1:* Continue offering introductory courses or workshops on working with sexually diverse people based on the PsySSA practice guidelines, during graduate studies, with increased focus on facilitated exploration of sexuality issues (see e.g., Owen-Pugh & Baines, 2014).
>
> *Recommendation 2:* Explore and implement strategies to support university faculties, including integration into existing curricula, educational and training resources such as a localised handbook on sexual and gender diversity, and advocating for the recruitment and retention of sexually diverse faculties and students (e.g., Hope & Chapell, 2015).

Professional development activities

Given the gap identified in graduate studies, it is then maybe not surprising that respondents had, on average, engaged in three CPAs in the past year. It was driven though by reading mass media, online blogs or groups, and interest or journal groups, which would have increased practitioners' knowledge, and possibly their attitudes, but potentially with less

impact on skills development. In addition, only slightly more than half of the respondents indicated that they are familiar with the PsySSA practice guidelines launched in 2017 already, which leaves a significant gap for improvement in providing services based on the guidelines.

Further analysis indicated that workshops / training courses had the strongest long-term interest of all activities, followed by articles in an interest group / journal club, and presentations / symposia at congresses / conferences. Secondly mentoring / supervision, community involvement / advocacy, and professional writing had more niche appeal. The drop in stated future appeal for community and advocacy efforts, relative to previous involvement, seems to indicate that these opportunities would be better suited to early career practitioners wanting or needing the experience. Although of interest, reading mass media, online blogs and groups appeared to have least appeal, potentially due to credibility issues with such media or that these provide less CPD points.

Recommendation 3: Continue developing and offering training opportunities on working with sexually diverse people, within a CPD frame (i.e., CPD accredited with HPCSA), including more basic introductory courses in the form of webinars, as well as more intensive and advanced experiential and self-reflective in-person workshops (see Matza et al., 2015; Pantalone, 2015; Phillips & Fitts, 2017; Pratt-Chapman et al., 2022).

Recommendation 4: Develop a journal club (e.g., through the Sexuality and Gender Division of PsySSA), or integrate with existing journal clubs, to expose more practitioners to content on working with sexually diverse people that is CPD-accredited.

Recommendation 5: Continue the successful stream of sexuality and gender content at the PsySSA Annual Congress, including a specific focus on new research and work from graduate students.

Professional experience with LGBT+ people

LGBT+ clients / patients made up almost 15% of the sample's case load. This is very significant and could be read that up to 15% of graduate course work should be LGBT+ focused, supporting Recommendation 2 to increase support for faculty. Respondents in the private sector reported a significantly higher case load of LGBT+ clients / patients, which potentially indicates higher level of choice of clientele or higher levels of access by LGBT+ clientele in private practice. Respondents with a higher case load tend to be interested in more of the CPAs in the future, particularly the more niched opportunities of supervision / mentoring, community involvement and advocacy, and professional writing.
Recommendation 6: Provide practitioners in private healthcare with easier access to CPD accredited supervision / mentoring (such as part of a more intensive master class), community involvement and advocacy, as well as professional writing opportunities.

Sexual diversity

Sexually diverse respondents had more personal and professional experience with LGBT+ people; were more likely to report that LGBT+ inclusive language was used in their work setting documentation; had higher levels of confidence, and perceived competence relative to the heterosexual respondents; and had been involved in more CPAs – apart from attending workshops and writing; and had higher levels of familiarity with the PsySSA practice guidelines. A higher proportion of sexually diverse respondents wanted the wider

range of CPAs with the exception of attending workshops and mass media consumption. These results are in line with research indicating that sexually diverse practitioners are more confident in working with sexually diverse people (Dillon et al., 2008; Haag, 2008; O'Heron, 2011), and have higher levels of perceived competence (Shi & Doud, 2017).

Recommendation 7: Niche or targeted offerings for practitioners with higher caseloads and sexually diverse practitioners, such as advanced and case-based supervision / mentoring groups.

Recommendation 8: Include sexually diverse practitioners in delivering activities to both students and practitioners as sources of lived and professional experience and expertise.

Work setting

The high correlation between the six work setting variables might indicate that a commitment and action to being more affirmative from work settings could have a positive impact on all aspects of being more affirming in institutions, organisations, clinics, and private practices. Several statements in this section garnered relatively high levels of "Not Applicable" mentions. The two items that received the highest "Not Applicable" mentions were both related to staff, and the "Not Applicable" mentions were almost exclusively from respondents working in the private sector, potentially reflecting practitioners in solo private practice without staff. The below midpoint rating on the work setting "Regularly reviews the needs of LGBT+ people and communicates this information to staff (including admin)" might indicate a need for more regular or continuously updated information on LGBT+ people's needs as society develops, as well as developing more effective ways of communicating this information to both decision makers and staff (including administration

staff). Overall affirming work settings are significantly correlated with the number of LGB clients ever seen, LGBT+ case load, involvement in CPAs, and familiarity with the PsySSA practice guidelines. The results indicate a significant area of research to understand how different work contexts, ways of working, and therapeutic frames impact on therapists' perceived competence and confidence, and how CPAs can be structured, marketed, and delivered based on these different contextual factors.

Recommendation 9: Develop consultancy and training services to support both public and private organisations in becoming more affirmative.

Recommendation 10: Incorporate affirmative work setting discussions and recommendations in training opportunities and communication efforts, providing support for delegates to implement actions to support their organisations, including those aimed specifically at private practitioners that do not employ any full-time staff members.

Recommendation 11: Encourage research to understand how different work contexts, ways of working, and therapeutic frames impact on therapists' perceived competence and confidence, and how CPAs can be structured, marketed, and delivered based on these different contextual factors.

Confidence / self-efficacy in working with sexually diverse people

Respondents were significantly more confident in working with sexually diverse people, in comparison to USA findings from Dillon et al. (2015). Respondents had lower confidence in their Advocacy Skills, Application of Knowledge, and the additional PsySSA practice guidelines statements, than the average confidence score for the sample. The lower confidence in Advocacy Skills is also reflected in the work setting / context statement

"Engages with other service providers or organisations with LGBT+ expertise" that respondents scored marginally below the Total work setting score. More specifically, respondents were less confident in certain advocacy skills, knowledge and skills covering certain PsySSA practice guidelines themes, and application of knowledge.

Recommendation 12: Improve practitioners' access to resources, including referral possibilities through the development of a resource centre or hub that can easily be accessed, including marketing such a centre or hub to ensure widespread awareness.

Recommendation 13: Incorporate specific themes highlighted in both graduate and CPAs to improve overall confidence in working with sexually diverse people including:

- discussing the effects of colonialism, apartheid and postcolonialism on clients' / patients' experiences; normalising different relationship configurations including polyamory and consensual non-monogamy; and identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress, and
- how to assist LGB clients / patients to develop effective strategies to deal with heterosexism and homophobia, and in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.

Perceived competence in working with sexually diverse people

South African respondents rated their perceived competence significantly higher overall, as well as on the Clinical Preparedness sub-scale, compared to the two Bidell (2017) samples. The sample further scored significantly higher relative to one of the two Bidell

(2017) samples on the Knowledge sub-scale and scored similarly relative to the two Bidell (2017) samples on the Attitudes sub-scale. It should be noted that the ratings on the individual items from the Attitude sub-scale is high, reaching towards the top of the 7-point agreement scale. The items that respondents felt they had the lowest perceived competence on was "I have received adequate clinical training and supervision to work with LGB clients / patients", thus providing a strong indication for a need for increased training and supervision to work with LGB clients / patients, as already recommended. Two further items that rated below average were respondents being aware of institutional barriers and research on burden of disease for LGB people relative to heterosexual people, indicating the opportunity to enhance basic knowledge amongst professionals. Respondents that have been in practice for fewer years tend to be more aware of both institutional barriers and research on burden of disease, and have higher levels of familiarity with the PsySSA practice guidelines, which might be further evidence for the success of training given by the PsySSA African LGBTI+ Human Rights Project at universities, as well as more general training and personal development based on the PsySSA practice guidelines.

> *Recommendation 14:* Include discussions of institutional barriers and research on burden of disease as part of graduate and professional development activities.

Confidence, perceived competence and affirming work settings across training, private and professional experience

Confidence is significantly correlated with contact (number of LGBT+ acquaintances and number of LGBT+ friends / close family), professional experience with LGBT+ people (number of LGB clients ever seen and LGBT+ case load), involvement in CPAs (CPA score), and familiarity with the PsySSA practice guidelines. Similarly, international studies have indicated that higher confidence is linked to higher levels of professional experience (Dillon

et al., 2008), number of years of practice, and LGB clients seen (O'Heron, 2011; O'Shaughnessy & Spokane, 2013). Confidence in applying statements relating to the PsySSA practice guidelines is correlated with number of acquaintances, but not to years in practice. Furthermore, the correlation with confidence in applying the PsySSA practice guidelines statements is highest for those involved in CPA activities, familiarity with the guidelines, and LGBT+ case load.

Perceived competence is significantly correlated with contact (number of LGBT+ acquaintances and number of LGBT+ friends / close family), professional experience (number of LGB clients ever seen and LGBT+ case load), involvement in CPAs (CPA score), and familiarity with the PsySSA practice guidelines. The results are congruent with international work indicating increased perceived competence with increased graduate training and experience (Boskey et al., 2019; Carlson et al., 2013; Graham et al., 2012; Lewis, 2008; Rivers & Swank, 2017; Rock et al., 2010; Rutter et al., 2008; Shi & Doud, 2017). The Clinical Preparedness sub-scale is positively correlated with years of practice. More specifically, respondents that have been in practice longer feel more prepared to talk to LGBT clients about sexual or gender diversity and report more experience working with LGB clients. Conversely the Knowledge sub-scale is negatively correlated with years of practice, with respondents that have been in practice for fewer years being more likely to be aware of institutional barriers that may inhibit LGB people from using healthcare services, as well as research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals. The latter finding is in line with younger respondents having been more likely to have experienced a workshop relating to LGB issues during their graduate studies and being more familiar with the guidelines, indicating the success of the PsySSA African LGBTI+ Human Rights Project's efforts to train master-level students in providing a strong basic knowledge foundation.

There are significant correlations between responses on the total of the affirming work setting items and number of LGB clients ever seen, LGBT+ case load, involvement in CPAs, and familiarity with the PsySSA practice guidelines. More particularly, respondent familiarity with the PsySSA practice guidelines is highly correlated with work settings using inclusive language and providing access to information and resources for sexually and gender-diverse clients. This could either mean that respondents' familiarity with the guidelines are due to their affirming work setting, or that their more affirming work settings ensure a higher familiarity with the guidelines.

Recommendation 15: Incorporate the scales used in the study in future graduate and CPAs, including training, supervision, and research.

Recommendation 16: Develop a single measure from the research that can be included in more general larger scale research or survey efforts with clinical and counselling psychologists.

Summary of recommendations

The following recommendations have been made in the discussion of the research results:

Recommendation 1: Continue offering introductory courses or workshops on working with sexually diverse people based on the PsySSA practice guidelines, during graduate studies, with increased focus on facilitated exploration of sexuality issues (see e.g., Owen-Pugh & Baines, 2014).

Recommendation 2: Explore and implement strategies to support faculty, including integration into existing curricula, educational and training resources such as a

localised handbook on sexual and gender diversity, and advocating for the recruitment and retention of sexually diverse faculty and students (e.g., Hope & Chapell, 2015).

Recommendation 3: Continue developing and offering training opportunities on working with sexually diverse people, within a continued professional development frame (i.e., CPD accredited with HPCSA), including more basic introductory courses in the form of webinars, as well as more intensive and advanced experiential and self-reflective in-person workshops (see Matza et al., 2015; Pantalone, 2015; Phillips & Fitts, 2017; Pratt-Chapman et al., 2022).

Recommendation 4: Develop a journal club (e.g., through the Sexuality and Gender Division of PsySSA), or integrate with existing journal clubs, to expose more practitioners to content on working with sexually diverse people that is CPD-accredited.

Recommendation 5: Continue the successful stream of sexuality and gender content at the PsySSA Annual Congress, including a specific focus on new research and work from graduate students.

Recommendation 6: Provide practitioners in private healthcare with easier access to CPD accredited supervision / mentoring (such as part of a more intensive master class), community involvement and advocacy, as well as professional writing opportunities.

Recommendation 7: Niche or targeted offerings for practitioners with higher caseloads and sexually diverse practitioners, such as advanced and case-based supervision / mentoring groups.

Recommendation 8: Include sexually diverse practitioners in delivering activities to both students and practitioners as sources of lived and professional experience and expertise.

Recommendation 9: Develop consultancy and training services to support both public and private organisations in becoming more affirmative.

Recommendation 10: Incorporate affirmative work setting discussions and recommendations in training opportunities and communication efforts, providing support for delegates to implement actions to support their organisations, including those aimed specifically at private practitioners that do not employ any full-time staff members.

Recommendation 11: Encourage research to understand how different work contexts, ways of working, and therapeutic frames impact on therapists' perceived competence and confidence, and how CPA's can be structured, marketed, and delivered based on these different contextual factors.

Recommendation 12: Improve practitioners access to resources, including referral possibilities through the development of a resource centre or hub that can easily be accessed, including marketing such a centre or hub to ensure widespread awareness.

Recommendation 13: Incorporate specific themes highlighted in both graduate and CPAs to improve overall confidence in working with sexually diverse people including:

- discussing the effects of colonialism, apartheid and postcolonialism on client/patient's experiences; normalising different relationship configurations including polyamory and consensual non-monogamy; and identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress, and
- how to assist LGB clients/patients to develop effective strategies to deal with heterosexism and homophobia, and in the development of coping

strategies to help same-sex couples who experience different stages in their individual coming out processes.

Recommendation 14: Include discussions of institutional barriers and research on burden of disease as part of graduate and professional development activities.

Recommendation 15: Incorporate the scales used in the study in future graduate and professional development activities, including training, supervision, and research.

Recommendation 16: Develop a single measure from the research that can be included in more general larger scale research or survey efforts with clinical and counselling psychologists.

Suggestions for future research

In this section, some of the areas for future research efforts will be outlined. The overview of literature as discussed in Chapter 2 and 3, highlighted the need for significantly more research in sexual diversity, as well as competence and confidence in clinical and counselling psychologists working with sexually diverse people, in South Africa, including research on:

- The lived experience of sexually diverse people including language, identity development and intersections with race, age, gender etc., in different contexts such as school versus work settings.
- The inclusion of sexual orientation measures in population and epidemiology studies, particularly relating to mental health concerns, as well as practitioner-focused research.

- The experience of sexually diverse clients / patients in accessing and utilising mental health services, including psychotherapy and counselling services. This could also include mapping of existing resources and evaluating adequacy, strength, and weaknesses if these resources overall and particular to each resource.
- Treatment-specific research, which could include evidence-based research on how existing treatments (local and international) can be adapted to working with sexually diverse people, and collecting and synthesising case-based material of therapies with sexually diverse clients / patients as part of practice-based evidence.
- Programme and training evaluation, including more detailed evaluation of the PsySSA practice guidelines, including awareness, usability, and engagement. Recent literature overviews and synthesis would be useful both as input into future revisions of the practice guidelines document as well as guiding programme development.

Based on the research survey and results as outlined in Chapters 4 and 5, the following future research efforts can be considered, in addition to those planned by the team analysing the full transnational study results as discussed in Chapter 1:

- Utilising the scales and items from the survey in other work to provide comparison and tracking of results on training, experience, confidence, and perceived competence, over time, and in different contexts.
- Including, and exploring the addition of more qualitative and implicit methods of measuring overall competence of clinical and counselling psychologists in working with sexually diverse people.

- Determining whether there are indeed a higher proportion of clinical and counselling psychologists that identify as sexually diverse, compared to population findings, as well as exploring reasons behind this.
- Exploring how affirming different work settings and contexts are, such as public health relative to private practice, and some of the reasons behind the findings, and how sexually diverse clients / patients experience these contexts differently. This could include assessing how working in multiple work setting contexts impact on competence and confidence, and how this can be leveraged in developing increased competence and confidence for clinical and counselling psychologists in working with sexually diverse people.
- Understanding how different work contexts, ways of working, and therapeutic frames impact on therapists' perceived competence and confidence, and how CPA's can be structured, marketed, and delivered based on these different contextual factors.

Limitations of study

Several limitations can be summarised and highlighted in the study:

- Although the significant convergence between the transnational study and my study led to a shared questionnaire and fieldwork, this also brought certain limitations to my study. Most significantly the training and experience sections of the questionnaire utilised the broader LGBT term, which meant that these sections by and large did not focus on the LGB part specifically, potentially impacting on specificity of the results, and comparability across different scales used. In addition, in talking about "LGB clients / patients", sexually diverse people that do

not identify as such could be excluded. The research assumed that practitioners completing the survey interpreted the "LGB" term to mean "sexually diverse" more broadly. This assumption was not tested.

- The limitations of utilising self-report measures, and the specific scales, were discussed in some detail in Chapter 3, and these are applicable to this study as well. On the other hand, the benefit of utilising these measures will be the possibility of comparability across studies, population, and different countries.
- The sample achieved represented an estimated 3.9% of the total potential responses. This impacts on the generalisability of the results to all clinical and counselling psychologists working with sexually diverse people in South Africa. Nevertheless, the results indicated some important and clear directions for development of confidence and perceived competence in working with sexually diverse people.

Final thoughts

This first benchmark of the training, experience, confidence, and perceived competence of clinical and counselling psychologists working with sexually diverse people, and recommendations flowing from it, will support the continued efforts in training, advocacy, and policy development, in particular the PsySSA Africa LGBTI+ Human Rights Project and our allies. I further mentioned the importance of this doctoral dissertation as a point in time for my own work and efforts of over more than a decade.

In this regard, this work will also partly guide the development of an in-patient psychiatric clinic for sexually and gender-diverse people in South Africa and associated programmes that I co-lead. This clinic, a first in South Africa, will hopefully also become a

hub of excellence in training and research on evidence and practice-based mental health care for sexually and gender-diverse people, both for the specialised programme planned by the clinic, as well as supporting the provision of affirmative care practices in all mental health service contexts. The substantial planning that the business team, including myself have placed behind this is significant, and it is a dream of mine that my work will culminate in the success of this project.

It is my hope that this work is easily available and the language sufficiently accessible to be of benefit and use to all practitioners, advocates and allies that are committed to ensuring that clinical and counselling psychologists are competent and confident in working with sexually diverse people. In addition, my hope is that my work provides the impetus for ensuring training and professional development and continues to retain relevance by being sensitive to the changing lived experiences of all sexually diverse South Africans.

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APPENDICES

Appendix I: Ethical clearance certificate – Unisa

PERC-17061

UNISA university of south africa
Department of Psychology

Ethical Clearance for M/D students: Research on human participants

The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.

Student Name: Cornelius Johannes Victor **Student no.:** 3339 3702

Supervisor: Prof Juan A Nel **Affiliation:** Department of Psychology, Unisa

Title of project:

South African psychology counsellors and psychotherapists' training, experience, competence, and confidence in practising affirmatively with Lesbian, Gay, and Bisexual (LGB) people

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department and the College of Human Sciences of Unisa.

The application was approved by the Ethics Review Committee of the Department of Psychology on the understanding that –

- Any formal conditions set by mediating organizations relating to the use of the contact details of potential participants are to be met;
- Information provided will be treated as confidential and not be used or made available for any other purpose than the goals as stipulated in the research proposal.

Signed: *Date:* 23 October 2017

Prof P Kruger
[For the Ethics Committee
Department of Psychology, Unisa]

Appendix II: Ethical clearance certificate – Amendment

PERC-17061 - amendment

UNISA
university of south africa
Department of Psychology

Ethical Clearance for M/D students: Research on human participants

Re: amendment to an approved research proposal

Dear Mr Victor

There is no objection from the Ethics Committee regarding your amendment to the project or to your thesis research forming part of a collaborative project. The clearance granted on the Ethics Certificate PERC-17061 remains valid.

Signed: *Date:* 2 October 2019

Prof P Kruger
[For the Ethics Committee
Department of Psychology, Unisa]

Appendix III: Ethical clearance certificate – International study

UMASS BOSTON
UNIVERSITY OF MASSACHUSETTS BOSTON
INSTITUTIONAL REVIEW BOARD

100 Morrissey Boulevard
Boston, MA 02125-3393
P: 617.287.5374
F: 617.287.5396
www.umb.edu/orsp

April 5, 2021

Sharon Horne, PhD
Counseling and School Psychology

IRB Study Number:	2018231
Title of Protocol:	The Role of Psychology Guidelines on Mental Health Access and Treatment of Sexually and Gender Diverse Individuals (U.S State Department Fulbright Scholarship)
Type of Review:	Expedited
IRB Approval Date:	4/5/2021
IRB Expiration Date:	4/4/2022

The **continuing review** dated 4/2/2021 of this project has been reviewed and approved by the University of Massachusetts Boston IRB, Assurance # FWA00004634.

Please review the current UMass Boston COVID-19 Research web section. Please also see the COVID-19 Supplement: IRB Guidance.

As Principal Investigator you are responsible for the following:

1. Following the requirements listed in the INVESTIGATOR MANUAL (HRP-103).
2. Submission in writing of any and all changes to this project (e.g., protocol, recruitment materials, consent form, staff changes, etc.) to the IRB for review and approval prior to initiation of the change(s).
3. Reporting any of the information items listed on the last page of the Reportable New Information form (including unanticipated problems involving risks to subjects or others or non-compliance with the regulations or the requirements or determinations of the IRB) within five business days.
4. Use of only IRB approved copies of the consent form(s), questionnaire(s), letter(s), advertisement(s), etc. in your research. It is no longer necessary to have recruitment materials or consent forms stamped by the IRB.
5. Ensuring that all study staff who are engaged in research involving human subjects have a current completed human research (CITI) training prior to conducting and for the duration of their engagement in this project.
6. Submission of a continuation prior to the IRB expiration date.
7. Submission of a final report upon completion of this project.

The IRB can terminate projects that are not in compliance with these requirements. **The study is subject to continuing review on or before 4/4/2022, unless closed before that date. You are to submit a completed continuing review form or final report to request continuing approval or closure at least 30 days before the expiration date.**

Contact (617-287-5374) or email (irb@umb.edu) if you have any questions or require further information.

Sincerely,

Sharon Wang, CIP, CIM
IRB Manager, University of Massachusetts Boston

Appendix IV: Ethical clearance certificate – Local study

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

17 March 2022

Dear S G Horne

Decision:
Ethics Approval from 17 March 2022 2022 to 17 March 2027

NHREC Registration # :
Rec-240816-052
CREC Reference # :
1115146_CREC_CHS_2022

Researcher(s): Name: Prof S G Horne
Contact details: Sharon.Horne@umb.edu /+617-287-7495
Name: Prof JA Nel
Contact details: Nelia@unisa.ac.za / +27(0)83 282 0791
Name: Mr CJ Victor
Contact details: niel.victor@outlook.com /+27(0)83 268 3686
Name: Dr AO Olaseni
Contact details: olaseao@unisa.ac.za / +27(0)71 917 6172

Title: Exploratory, mixed methods, study on the role of LGBTIQA+ affirmative practice guidelines in access and competent mental health treatment.

Purpose: Non-degree

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The ***low risk application was reviewed by*** College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392, UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Appendix V: Participant information sheet and informed consent

Participant Information Sheet

Title of research study: The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa

Researchers:

1. Professor Sharon G. Horne (Professor of Counselling Psychology at the University of Massachusetts [UMass] Boston, United States; Global Fulbright Scholar; University of South Africa [Unisa] Professor Extraordinaire, Department of Psychology)
2. Professor Juan A. Nel (Unisa Research Professor of Psychology)
3. Cornelius J. Victor (Unisa PhD candidate in Psychology)
4. Dr. Abayomi O. Olaseni (Unisa Postdoctoral Fellow, Department of Psychology)
5. Eunhu Chang (UMass Boston doctoral student)

Ethics clearance reference numbers: Unisa CREC Reference # : 1115146_CREC_CHS_2022; University of Massachusetts Boston Assurance # FWA00004634; IRB Study Number: 2018231.

15 January 2023

Dear Prospective Participant

My name is Prof Juan A. Nel, country-specific principal investigator of a transnational study being conducted in collaboration with Prof Sharon G. Horne, who is leading the study, internationally. Other research collaborators are Cornelius J. Victor, Abayomi O. Olaseni, and Eunhu Chang, in the capacities indicated above. We are inviting you, ideally before 15 March 2023, to participate in this study, titled *The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa*.

WHAT IS THE PURPOSE OF THE STUDY?

We are conducting this research to explore a comprehensive study of LGBT+ care practices in South Africa, alongside other countries (such as Colombia, Russia, and the Philippines), to allow transnational analyses of the benefits and challenges of Psychology affirmative practice guidelines in mental health access and treatment among sexually and gender-diverse (LGBT+) individuals. In other words, the purpose of the study is to explore mental health professionals' current care practices, understandings, and needs (i.e., for training, guidelines, etc.) when working with sexually and gender-diverse clients or patients in South Africa.

WHY AM I BEING INVITED TO PARTICIPATE?

You are invited to participate in this quantitative study because you are a registered mental health professional (psychiatrist, psychologist, registered counsellor, social worker, or psychiatric nurse) who works or has worked with sexually and / or gender-diverse clients / patients.

Other criteria for your participation are:

- Resident in South Africa
- 18 years old and above
- Registered member of concerned professional body in South Africa.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

As a mental health professional, you will be asked to respond to a set of survey questions assessing your awareness and knowledge of LGBT+ affirmative practice and their application in practice or consultations to your clients / patients in South Africa. You will be directed to a Qualtrics survey link, following screening questions to determine eligibility, and by clicking on the proceed button confirms your informed consent. To safeguard confidentiality, participants shall not be asked to reveal their real identity or traceable information that could be associated with them.

Your participation in this study, in completing the questionnaire, will take about 30 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and there is no penalty or loss of benefit for non-participation. You are under no obligation to consent to participate in the study. If, on having read this participant information sheet, you do decide to take part, there is a online link at the end hereof that allows you to click on proceed as a sign of giving consent to voluntarily do so. You are free to withdraw at any time and without giving a reason at the point of responding to the survey questions. However, it may not be possible to withdraw once you have submitted the questionnaire and / or data analyses have commenced.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHERS AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your identity shall be strictly confidential. Your name(s) shall not be asked, recorded, or processed with the given data. Your responses may be reviewed by people responsible for quality assurance, including the external coder, and members of the Research Ethics Review Committee. Participants' anonymous data may be used for other purposes, such as a research report, to inform the associated PhD of Mr Cornelius J. Victor, journal articles, and / or conference proceedings. In none of these publications will individual participants be identifiable.

HOW WILL THE RESEARCHERS PROTECT THE SECURITY OF DATA?

Electronic copies of retrieved data will be stored by the researchers for a minimum period of six years in a password-protected hard drive / flash drive. Should any part of the retrieved data be printed for unavoidable reasons, it will be saved in a locked cupboard. Data transfer to the United States for purposes of data analyses will be done in accordance with the South African Protection of Personal Information (POPI) Act. Data shall be saved for future research or academic purposes; electronic information will be password protected. Future use of the stored data will be subject to further Research Ethics Review and approval, if applicable. Should information be destroyed, the printed copy of any part of the data (if any) will be shredded, and / or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

On completing the survey, you will have an additional voluntary opportunity to access three related recent publications and answer 15 MCQs that can earn you 2 CEU (Clinical) points (SAMA accreditation # MDB015/1310/09/2022). The articles are hosted on a separate website and not linked to the questionnaire, again to ensure confidentiality. In addition, although there are no direct benefits to, nor payment of, the participants in this study, the results thereof may inform future policies and interventions to benefit your practice and the lives of sexually and gender-diverse people. The benefits of this research endeavour, indeed, outweigh potential risks that are deemed minimal.

HAS THE STUDY RECEIVED ETHICS APPROVAL

Importantly, this international study of Horne et al. was reviewed and cleared by the Ethics Review Committee of the University of Massachusetts Boston Institutional Review Board (Assurance # FWA00004634; IRB Study Number: 2018231). In addition, this South African study received same from the Unisa Ethics Review Committee (CREC Reference # : 1115146_CREC_CHS_2022).

HOW CAN I SEEK CLARITY AND / OR BE INFORMED OF THE RESULTS OF THE RESEARCH?

You have the right to ask questions about this research before you sign the consent form and at any time during the study. You can reach Prof Sharon G. Horne by email (sharon.horne@umb.edu) or Prof Juan A. Nel (nelja@unisa.ac.za). If you have any questions or concerns about your rights as a research participant, please contact a representative of the Institutional Review Board (IRB), at the University of Massachusetts, Boston, which oversees research involving human participants. The Institutional Review Board may be reached by email (human.subjects@umb.edu), or telephone at +(617) 287-5374. Alternatively, you may contact the Unisa research ethics chairperson, Prof K.B. Khan (khankb@unisa.ac.za) or (012) 429 8210.

Should you like to be informed of the final research results, contact Prof Juan A. Nel (nelja@unisa.ac.za). Thanks for your time to read this information sheet and participating in this study, ideally by 15 March 2023. *Feel free to forward this invitation to relevant others in your networks*.

Prof Juan A. Nel (on behalf of the research team)

Please print or save a copy of this consent page for your records.

By clicking on the proceed button, it confirms that you:

- Have read and understood the study as explained in the Participant Information Sheet.
- Have had sufficient opportunity to seek clarity and are prepared to participate in the study.
- Understand that your participation is voluntary, that you are free to withdraw at any time without penalty in the process of participating, but cannot withdraw at the point after completion.
- Are aware that the results of this study may be processed into a research report, and / or inform an associated PhD, journal publications and conference proceedings, but that your participation will be kept confidential.
  [insert proceed button]

Appendix VI: Examples of invitations to participate

E-mailer

Invitation to participate in a study and earn 2 (Clinical) SAMA-accredited CEUs: The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa.

Dear Prospective Participant

Please feel free to forward this email to relevant others in your networks.

As part of a transnational research collaboration, we are inviting registered mental health professionals (psychiatrists, psychologists, registered counsellors, social workers, and / or psychiatric nurses) who reside in South Africa, and work or have worked with sexually and gender-diverse (LGBT+) clients / patients to participate in a study.

Titled: **The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa**, the purpose of this study is to explore mental health professionals' current care practices, understandings, and needs when working with LGBT+ clients / patients in South Africa. Similar research is being done in other countries, including Colombia, Russia and the Philippines, to also allow transnational analyses.

The study has been approved by the relevant ethics bodies of the University of South Africa (#1115146_CREC_CHS_2022.04.18), as well as the University of Massachusetts Boston (Assurance # FWA00004634; IRB Study Number: 2018231).

Click on the link at the bottom of this email to find a Participant Information Sheet. Should you agree to participate on having perused this Information

Sheet, the link provided at the end thereof will allow you to indicate informed consent, as well as direct you to screening questions. If eligible, participants automatically will be directed to the online survey questionnaire. To ensure confidentiality, completion of the latter will not contain any information traceable back to you.

Completion of the questionnaire will take you approximately 30-40 minutes.

To thank you for completing the questionnaire, you will have the voluntary opportunity to access three related publications and answer 15 MCQs that can earn you 2 CEU (Clinical) points (SAMA accreditation # MDB015/1310/09/2022). The publications are hosted on a separate website, not linked to the completed questionnaire, again to ensure confidentiality.

We are very grateful for your time and effort and, again, feel free to forward this email to relevant others in your networks. When you are ready, and ideally by 15th March 2022, click on the following link: https://umassboston.co1.qualtrics.com/jfe/form/SV_dg6hVsNdvOycmFw to begin (you can also copy and paste the link into your internet browser or scan the QR Code):

CLICK HERE TO TAKE PART IN THE SURVEY

Prof Juan A. Nel
(on behalf of the research team)

E-mail sent

[E-mail header]

Invitation to participate in a study and earn 2 (Clinical) SAMA-accredited CEUs: The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa

[E-mail body]

Dear Prospective Participant

Please feel free to forward this email to relevant others in your networks.

APOLOGIES FOR CROSS-POSTING

As part of a transnational research collaboration, we are inviting registered mental health professionals (psychiatrists, psychologists, registered counsellors, social workers, and/ or psychiatric nurses) who reside in South Africa, and work or have worked with sexually and gender-diverse (LGBT+) clients/ patients to participate in a study.

Titled: ***The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa***, the purpose of this study is to explore mental health professionals' current care practices, understandings, and needs when working with LGBT+ clients/ patients in South Africa. Similar research is being done in other countries, including Colombia, Russia and the Philippines, to also allow transnational analyses.

The study has been approved by the relevant ethics bodies of the University of South Africa *(#1115146_CREC_CHS_2022.04.18),* as well as the University of Massachusetts Boston *(Assurance # FWA00004634; IRB Study Number: 2018231).*

Attached, find a Participant Information Sheet that can also be accessed by clicking the link at the bottom of this email. Should you agree to participate on having perused this Information Sheet, the link provided at the end thereof will allow you to indicate informed consent, as well as direct you to screening questions. If eligible, participants automatically will be directed to the online survey questionnaire. To ensure confidentiality, completion of the latter will not contain any information traceable back to you.

Completion of the questionnaire will take you approximately 30 minutes.

To thank you for completing the questionnaire, you will have the voluntary opportunity to access three related publications and answer 15 MCQs that can earn you 2 CEU (Clinical) points (SAMA accreditation # MDB015/1310/09/2022). The publications are hosted on a separate website, not linked to the completed questionnaire, again to ensure confidentiality.

We are very grateful for your time and effort and, again, feel free to forward this email to relevant others in your networks. When you are ready, and ideally by the 15th of March, click on the following link to begin (you can also copy and paste the link into your internet browser): *https://tinyurl.com/surveyforsa*

Or scan the QR code

Reminder e-mail sent

[E-mail header]

Reminder: Opportunity to participate in an online survey and earn 2 (Clinical) SAMA-accredited CEUs: The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa

[E-mail body]

Dear Prospective Participant

Please feel free to forward this email to relevant others in your networks.

APOLOGIES FOR CROSS-POSTING

For ease of access here with the invitation again as previously disseminated. We urged those who have not yet completed the online survey to do so as soon as possible.

As part of a transnational research collaboration, we are reminding all registered mental health professionals (psychiatrists, psychologists, registered counsellors, social workers, and / or psychiatric nurses) who reside in South Africa, and work or have worked with sexually and gender-diverse (LGBT+) clients / patients to participate in a study.

Titled: ***The role of Psychology guidelines in mental health access and treatment of sexually and gender-diverse individuals in South Africa.*** Completion of the questionnaire will take you approximately 30 minutes.

To thank you for completing the questionnaire, you will have the voluntary opportunity to access three related publications and answer 15 MCQs that can earn you 2 CEU (Clinical) points (SAMA accreditation # MDB015/1310/09/2022). The publications are hosted on a separate website, not linked to the completed questionnaire, again to ensure confidentiality.

We are very grateful for your time and effort and, again, feel free to forward this email to relevant others in your networks. When you are ready, and ideally by the 15th of March, click on the following link to begin (you can also copy and paste the link into your internet browser): *https://tinyurl.com/surveyforsa*

Or scan the QR code

Feel free to forward this invitation to relevant others in your networks.

Prof Juan A. Nel (on behalf of the research team)

First advertisement

OPPORTUNITY TO PARTICIPATE IN A RESEARCH STUDY

UNISA | university of south africa

WHO

Registered mental health professionals (psychiatrists, psychologists, registered counsellors, social workers, and/or psychiatric nurses) in South Africa working with LGBT+ clients

AIM

To explore current care practices, understandings, and needs when working with LGBT+ clients

BENEFIT

Earn 2 CEU (Clinical) points

SCAN QR CODE OR CLICK ON LINK

https://tinyurl.com/surveyforsa

DEADLINE: 15 MARCH 2023

Please share

Any questions, contact Prof JA Nel nelja@unisa.ac.za

Reminder advertisement

REMINDER: OPPORTUNITY TO PARTICIPATE IN AN ONLINE SURVEY

UNISA | university of south africa

WHO

Registered mental health professionals (psychiatrists, psychologists, registered counsellors, social workers, and/or psychiatric nurses) in South Africa working with LGBT+ clients

AIM

To explore current care practices, understandings, and needs when working with LGBT+ clients

BENEFIT

Earn 2 CEU (Clinical) points

SCAN QR CODE OR CLICK ON LINK

https://tinyurl.com/surveyforsa

DEADLINE: 15 MARCH 2023

Feel free to forward to others in your networks

Any questions, contact Prof JA Nel nelja@unisa.ac.za

Appendix VII: Final online questionnaire

Screen Tools

Q1. Are you 18 years and above? (skip to end of survey if no)

- ❑ Yes
- ❑ No

Q2. Are you a registered mental health professional who has worked with LGBT clients / patients in South Africa, currently or in the past? (skip and thank you for accessing our survey if no)

- ❑ Yes
- ❑ No

Background & Demographics

About you:

Q3. City / town you live in_____

Q4. What is your age in years? _____

Q5. The race you most identify with:

- ❑ Black-African;
- ❑ Coloured;
- ❑ Indian / Asian;
- ❑ White;
- ❑ Other (specify)_____

Q6. Please select your sex assigned at birth:

- ❑ Female
- ❑ Male
- ❑ Intersex
- ❑ Not mentioned in list, please specify: _____

Q7. Please select your gender identity:

- ❑ Cisgender woman
- ❑ Cisgender man
- ❑ Transgender woman;
- ❑ Transgender man;
- ❑ Gender non-conforming person;
- ❑ Non-binary person;
- ❑ If not mentioned in list, please specify: _____

Q8. Please select your sexual identity / orientation:

- ❑ Heterosexual / Straight;
- ❑ Gay
- ❑ Lesbian;
- ❑ Bisexual;
- ❑ Pansexual;
- ❑ Asexual;
- ❑ Queer;
- ❑ Category not mentioned in list, please specify: _____

About your professional / work life

Q9. Occupation (select all that apply)

- ❑ Social Worker;
- ❑ Clinical Social Worker;
- ❑ Registered Counsellor;
- ❑ Clinical Psychologist;
- ❑ Counselling Psychologist;
- ❑ Educational Psychologist;
- ❑ Research Psychologists;
- ❑ Organisational / Industrial Psychologist;
- ❑ Psychiatrist;
- ❑ Psychiatric nurse;
- ❑ Other (specify) _____

Q10. What is the highest level of education you have completed?

- ❑ Diploma
- ❑ University degree
- ❑ Honours degree
- ❑ Master's degree
- ❑ Doctoral degree
- ❑ Other (specify) _____

Q11. Estimate percentage of time doing counselling or psychotherapy with clients / patients in an average week? (drop down menu in 10% through 100)

Q12. I work in (please select all that apply):

- ❑ Private Health / Companies
- ❑ Public Health / Government
- ❑ NGO / CBO / NPO
- ❑ Other places that are not in the list, please specify: _____

Q13. I have been in professional practice (only count years after completing mental health professional training) for _____years (round up your response—e.g., 0.5 year to 1).

Training Programme for Mental Health Professionals

Q14. In which year did you graduate from your mental health professional training programme / graduate studies? (Write in)

Q15. Which, if any, of the following LGBT+ (Lesbian, Gay, Bisexual, Transgender) focused activities were you involved in during your mental health profession training programme / graduate studies? (Select all that apply)

- ❑ No training
- ❑ Course in sexuality and / or gender that covered working with LGBT+ clients / patients
- ❑ Workshop specifically in LGBT+ health and well-being
- ❑ Research on LGBT+ concerns
- ❑ Clinical training experience at a clinic specialising in LGBT+ services
- ❑ If other, please describe: _____

Q16. Which, if any, of the following continued professional development activities focused specifically on LGBT+ concerns have EVER participated in since starting to practice? And which have you participated in in the past year?

	Ever	Past year
Attended LGBT+ workshop / training course	❑	❑
Attended LGBT+ presentations / symposia at congress /conference	❑	❑
Read LGBT+ articles / themes in an interest group / journal club	❑	❑
Mentored / provided supervision on working with LGBT+ people	❑	❑
Wrote professional articles / books on LGBT+ concerns	❑	❑
Read LGBT+ topics on online blog or group	❑	❑
Read mass media including social media and online news on LGBT+ topics	❑	❑
Involved in or advocated for LGBT+ community efforts and organisations	❑	❑

Q17. Which, if any, of the following continued professional development activities focused specifically on LGBT+ concerns would you want to receive / be involved in?:

- ❑ None
- ❑ LGBT+ workshop / training course
- ❑ LGBT+ presentations / symposia at congress / conference
- ❑ Articles / themes in an interest group / journal club

- ❑ Mentoring / supervision on LGBT+ people
- ❑ Writing professional articles / books on LGBT+ concerns
- ❑ LGBT+ topics on online blog or group
- ❑ Mass media including social media and online news on LGBT+ topics
- ❑ Involvement / advocacy in LGBT+ community efforts and organisations

Q18. I have approximately ____acquaintances who are LGBT+.

Q19. I have approximately ____close friends and family who are LGBT+.

Q20. As a mental health professional, I have had the following number of clients / patients:

	0	1-3	4-6	7-9	10+	N/A
Gay	❑	❑	❑	❑	❑	❑
Lesbian	❑	❑	❑	❑	❑	❑
Bisexual	❑	❑	❑	❑	❑	❑
Transgender	❑	❑	❑	❑	❑	❑
Queer/ other LGBT identity	❑	❑	❑	❑	❑	❑

Q21. Estimate the percentage of LGBT+ clients / patients in your caseload on average per week_____ (e.g., 10%, 50%).

Clinical Experience Working with LGBT people in your profession (Bidell, 2017)

Instruction: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients / patients. Please use the provided scale to rate your level of agreement or disagreement for each item. Please note, items on this scale primarily inquire about either sexual orientation (LGB = lesbian, gay, and bisexual) or gender identity (transgender). Two questions are inclusive and refer collectively to LGBT clients / patients.

Strongly Disagree		Somewhat Agree / Disagree			Strongly Agree	
1	2	3	4	5	6	7

Q22. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Q23. I am aware of institutional barriers that may inhibit LGB people from using health care services.

Q24. I think being transgender is a mental disorder.

Q25. I would feel unprepared talking with a LGBT client / patient about issues related to their sexual orientation or gender identity.

Q26. A same-sex relationship between two men or two women is not as strong and committed as one between a man and a woman.

Q27. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Q28. LGB individuals must be discreet about their sexual orientation around children.

Q29. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to other individuals.

Q30. When it comes to transgender individuals, I believe they are morally deviant.

Q31. I have received adequate clinical training and supervision to work with transgender clients / patients.

Q32. I have received adequate clinical training and supervision to work with LGB clients / patients

Q33. The lifestyle of a LGB individual is unnatural or immoral.

Q34. I have experience working with LGB clients / patients.

Q35. I feel competent to assess a person who is LGB in a therapeutic / counselling setting.

(Credibility Question): You are making good progress and are more than halfway! Please enter the number 7: _____ (open ended)

Q36. I feel competent to assess a person who is transgender in a therapeutic / counselling setting.

Q37. I have experience working with transgender clients / patients.

Q38. People who dress opposite to their biological sex have a perversion.

Q39. I would be morally uncomfortable working with a LGBT client / patient.

Below are items from main scale kept for this data collection:

Q40. Homosexuality is a mental disorder than can be treated through mental health / psychiatric care.

Q41. LGB people could be heterosexual if they received quality treatment.

Q42. A transgender person is not as psychologically stable as a non-transgender person.

Q43. If a patient / client reports distress as an LGB person, there are times when it is appropriate to work with them to change their sexual orientation to be heterosexual.

Q44. If a patient / client reports distress with their gender identity, there are times when it is appropriate to work with them to accept their gender assigned at birth.

Q45. When warranted, I have practiced therapy / counselling to change sexual orientation from homosexual to heterosexual.

Q46. When warranted, I have practiced therapy / counselling to help patients / clients identify with their gender assigned at birth.

Q47. Child patients / clients experience true same-sex attractions only when they reach adulthood.

Q48. Adolescent patients / clients experience true same-sex attractions only when they reach adulthood.

Q49. Child patients / clients are too young to know if they are transgender.

Q50. Adolescent patients / clients are too young to know if they are transgender.

Q51. I have practiced therapy / counselling to help a patient / client's gender identity be congruent with the patient / client's sex assigned at birth.

Q52. Before adopting a transgender identity, people should explore their gender thoroughly with a medical or mental health care professional to safeguard clients / patients from rushing the process.

Q53. Before receiving gender affirming medical transition care, patients should explore their gender identity under the guidance of a mental health care professional and receive their approval.

T-KAB Scale (Clark & Hughto, 2019) Social Tolerance Scale Only (1-7)

1- Strongly disagree	2- Disagree	3- Agree	4- Strongly agree

Q54. Transgender people should have the opportunity to undergo operations to change their anatomy.

Q55. Transgender people should be accepted completely into our society.

Q56. Transgender people should have the opportunity to change their name.

Q57. Organisations that promote transgender rights are necessary.

Q58. It should be illegal for people to have their genitalia surgically removed.

Q59. Being transgender is a sin.

Q60. Transgender people are a worthwhile part of our society.

Q61. I avoid interacting with people whose gender is unclear to me.

LGB-CSI-SF (Dillon et al., 2015)

Indicate your confidence in your ability to perform each activity by marking the appropriate answer below each question ranging from NOT CONFIDENT TO EXTREMELY CONFIDENT. Please answer each item based on how you feel now, not on your anticipated (or previous) ability. We are interested in your actual judgments, so please be HONEST in your responses.

How confident am I in my ability to …….?

1	2	3	4	5	6
Not at All Confident	Not Confident	Somewhat Not Confident	Somewhat Confident	Confident	Extremely Confident

Q62. Identify specific mental health issues associated with the coming out process.

Q63. Assist LGB clients / patients to develop effective strategies to deal with heterosexism & homophobia.

Q64. Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.

Q65. Refer LGB clients / patients to affirmative legal & social supports.

Q66. Refer a LGB client / patient to affirmative social services in cases of estrangement from their families of origin.

Q67. Help a same-sex couple access local LGB-affirmative resources & support.

Q68. Identify my own feelings about my own sexual orientation & how it may influence a client / patient.

Q69. Examine my own sexual orientation / identity development process.

Q70. Recognise my real feelings vs. idealised feelings to be more genuine & empathic with LGB clients / patients.

Q71. Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations / identities.

Q72. Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of a LGB client / patient.

Q73. Assess the role of alcohol & drugs on LGB clients' /patients' social, interpersonal, & intrapersonal functioning.

Q74. Establish a safe space for LGB couples to explore parenting.

Q75. Establish an atmosphere of mutual trust & affirmation when working with LGB clients / patients.

Q76. Normalise a LGB client's / patient's feelings during different points of the coming out process.

Q77. Support clients' / patients' decisions on whether they come out or not, regardless of research indicating positive mental health outcomes with coming out.

Q78. Talk to clients / patients about the prejudicial impact of multiple intersectionalities, such as race and sexual orientation, on their lives.

Q79. Discuss the effects of colonialism, apartheid and postcolonialism on client's / patient's experiences.

Q80. Assist clients / patients in distinguishing sexual orientation and gender identity.

Q81. Apply affirmative practice principles in working with LGB clients / patients.

Q82. Normalise a client's / patient's different identity labels and expressions of sexuality.

Q83. Normalise different relationship configurations including polyamory and consensual non-monogamy.

Q84. Identifying the impact of being cis-gender, transgender or gender non-conforming on the experience of minority stress.

Statements relating to work setting

Statements related to work setting: 5-point scale (1-Never to 5-Always; 0-Not applicable)

Now some questions around your work setting, which can include your institution, organisation, clinic, or private practice. To what extent does your main work setting do the following:

Q85. Uses LGBT+ inclusive language on forms such as intake forms, incident reports, complaints, and feedback forms.

Q86. Regularly reviews the needs of LGBT+ people and communicate this information to staff (including admin).

Q87. Ensures differences and values of the LGBT+ community are recognised and incorporated as relevant in services delivery.

Q88. Engages with other service providers or organisations with LGBT+ expertise.

Q89. Provides access to information and resources for sexually and gender-diverse clients / patients.

Q90. Ensures non-discriminatory practices and equitable services for sexually and gender-diverse staff.

Awareness of PsySSA Guidelines

Q91. I am familiar with the Commitment Statement on LGBT Concerns of the International Psychological Network for LGBTI Concerns (IPsyNet).

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

Q92. I am familiar with the Southern African HIV Clinicians Society Gender-Affirming Healthcare Guidelines for South Africa.

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

Q93. I have applied (or drawn from to make clinical decisions) the Southern African HIV Clinicians Society Gender-Affirming Healthcare Guideline for South Africa.

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

Q94. I am familiar with the Psychological Society of South Africa (PsySSA) Guidelines for Psychology Professionals working with sexually and gender-diverse people.

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

Q95. I have applied (drawn from to make clinical decisions) the Psychological Society of South Africa (PsySSA) Guidelines for Psychology Professionals working with sexually and gender-diverse people.

1	2	3	4	5	6	7
Very untrue of me	Untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	True of me	Very true of me

Q96. Have you received training focused on using the Psychological Society of South Africa (PsySSA) Practice Guidelines for Psychology Professionals working with Sexually and Gender-Diverse people?

- ❑ Yes
- ❑ No

Q97. If yes to above question, which training was it?

- ❑ During post-graduate studies
- ❑ CPD approved training course
- ❑ Presentation / workshop (e.g., at a congress)

Q98. If yes, who presented the training?

- ❑ PsySSA / Sexuality and Gender Division (SGD) / African LGBTI+ Human Rights project team (Chris McLachlan, Juan Nel, Suntosh Pillay, Delene van Dyk, Niel Victor
- ❑ Other (Please, specify below)

Thank you for finishing the survey. You have reached the end!

If you are accessing the articles to earn 2 CPD point, the link will be provided after submitting the survey by clicking the proceed button.

End of the survey message:

Thank you very much for completing the survey. We really appreciate it

If you want to access the articles and complete the questionnaire to earn 2 CPD points, please click on the following button. You will be directed to a separate system and page. Note that you will have to provide your personal details on the latter system to earn your points. This system is separate from the survey and your data kept entirely separately.

If you do not wish CPD points, please close your browser.

***Important Note: Open the **Complete Questionnaire** link and save this link to your browser while you review the articles and then return to your saved link. If you review one article and complete the questions and then return to download or read the next one, your data will not be saved and you will need to open the link again and re-enter your responses.

Button: Click to proceed to CPD articles

[url = victorpsychology.co.za/qualtrics]

Again, thank you for your time spent taking the survey.

Appendix VIII: Incentive: Multiple choice questionnaire for CPD points

THE SOUTH AFRICAN MEDICAL ASSOCIATION
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Reg No 1927/000136/08 | NPC

14 September 2022

Dear CJ Victor

CPD (Continuing Professional Development) Certificate of Accreditation

On behalf of the SAMA CPD Unit I am pleased to inform you that your application for accreditation of HPCSA registered medical professionals Doctors and Specialists, within their scope of practice has been successful. Please issue all delegates who are not registered with the HPCSA, with an attendance certificate only (E.g., Nurses). This can be converted at their Councils if necessary. Accreditation of the MCQ is awarded subject to the conditions below. Should your application waiver from HPCSA or SAMA guidelines after approval of application, the onus is on the applicant to inform SAMA. Please note that SAMA CPD Committee Members may attend conferences to monitor and audit events. Please apply for annual renewal.

The CPD activity listed below is duly accredited according to the HPCSA and SAMA MCQ Guidelines 2022. Please use the reference numbers below for all communications. Please note that the HPCSA has the right to revoke accreditation if needed.

ACCREDITATION NUMBER: Please use this number on all correspondence relating to this CPD activity	**MDB015/1310/09/2022**
SERVICE PROVIDER:	CJ Victor
CPD DESCRIPTION:	Affirmative practice working with sexually and gender diverse people
THIS ACCREDITATION IS VALID FOR:	2022
CPD POINT ALLOCATION FOR PARTICIPANT: **LEVEL 1**	2 Clinical on 70% pass rate per MCQ
AUTHOR POINT ALLOCATION: **LEVEL 1**	Please see latest CPD guidelines for health practitioners, July 2017, Section 2.1.2, Page 15 of 22. Service Provider to allocate accordingly.
SAMA ACCOUNTS REFERENCE NUMBER:	BOO1136/15

CONDITIONS:
Any additional information or changes to the questionnaires and accompanying reading material to be sent through to SAMA. No product promotion in room or on enduring materials (e.g. course documents, invitations, programmes, certificates). No combining of level 1 and 2 activities at a single activity. (Questionnaires and Lectures). You may not issue points for attending an event and a questionnaire within 24 hours. Maximum of 3 questionnaires to be completed at any activity or linked to any activity/event. Ensure all HPCSA CPD and SAMA MCQ Guidelines are adhered to.

RECORDS:

- Adequate records of attendance for administrative and auditing purposes must be kept. Attendance registers to be sent through electronically to the HPCSA via the template provided. Please ensure you submit the HPCSA spreadsheet through to helenad@hpcsa.co.za for point upload.

You will have access to the list of articles which you can view and read through before proceeding to the questions.

Click on the view link to access the three articles. Then click on download document

Once you are ready to answer the questions, click on the proceed to questionnaire button.

There will be 15 multiple-choice questions, 5 for each article, for you to complete. Once complete, click the submit answers button.

Your answers will be scored, and if you have 11 or more correct as per minimum requirement, your information will be provided to SAMA to load onto the HPCSA system to recognise your CPD points.

Article 1: McLachlan, C., Nel, J.A., Pillay, S.R., & Victor, C.J. (2019). The Psychological Society of South Africa's guidelines for psychology professionals working with sexually- and gender-diverse people: Towards inclusive and affirmative practice. South African Journal of Psychology, 49, 314-324

1. Which one of the following statements about the development of the guidelines is FALSE?:
    a. Based on similar developments internationally
    b. Following IPsyNet guidelines
    c. The guidelines document was developed for healthcare professional in Africa working with sexually and gender-diverse people
    d. Redresses historical injustices and biases
    e. Based on PsySSA's position statement

Correct answer = b

2. In what specific one way does the guidelines conform to the South African human rights legal framework?:
    a. The South African human rights legal framework only applies to the way the State operates
    b. The guidelines are based on the African ethical codes for mental health professionals
    c. These guidelines help professionals focus on human rights, non-discrimination, benevolence, non-malevolence and do no harm principles
    d. The guideline document, instead, follows a mental wellbeing model

Correct answer = c

3. Which one of the following statements dealt with in the article is considered a heteronormative assumption?:
    a. Some people that have same-sex attractions experience shame due to these attractions
    b. There are many ways of experiencing your gender identity
    c. Non monogamous couples can have the same fulfilling relationships as monogamous couples may have
    d. Only sexual attraction between opposite genders is normal

e. Practitioners should consider their own normative assumptions about sexuality and gender when working with clients

Correct answer = d

4. Which one of the following factors are posited by the authors of this article to counteract stigma and violence, in general, experienced by sexually and gender-diverse people?:
    a. Continuously update oneself about trends on hate speech and hate crimes in South Africa
    b. Taking a general person-centred stance
    c. Telling clients not to worry about prejudice in the legal system, as many changes have already been implemented
    d. Highlighting that all people, indeed, may experience stigma and violence, and sexually and gender-diverse people are no different
    e. Telling clients that all people are welcome in public facilities

Correct answer = a

5. What reasons (note, more than one option, may apply) are given in the article for the need to develop awareness of personal biases of professionals working with sexually and gender-diverse people?:
    a. Your own cultural and religious biases can negatively impact the mental health of LGBTIQ+ people
    b. To continue to improve your ability to retain clients in therapy
    c. Research carried out shows lack of knowledge around diversity can cause harm
    d. General self-reflective practise suffices in providing adequate care to everyone
    e. Keeping current with a variety of academic and popular culture trends helps support sexually and gender-diverse people

Correct answers = a, c, and e

Article 2: International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet). (2018). IPsyNet Statement on LGBTIQ+. Washington, DC: Author

1. The mission of the IPsyNet is to facilitate and support psychological contributions, globally, in sexual and gender diversity:
    a. True
    b. False

Correct answer = a

2. Which one of the following statements is a correct reflection of IPsyNet's aims?:
    a. Increase knowledge of sexual orientation and gender identity
    b. Applying psychological knowledge so that gender diverse people can better themselves
    c. Develop practice guidelines for use by psychologists globally

d. Support the capacity of psychological organisations, internationally, to engage with sexual health issues

Correct answer = a

3. Which one of the following terms is reflected in the acronym LGBTIQ+?:
    a. Inquisitive
    b. Binary
    c. Transient
    d. Hermaphrodite
    e. Queer

Correct answer = e

4. Which one statement is true: Pathologising LGBTIQ+ individuals and groups by service providers result in?:
    a. Increased access to mental health services
    b. Increased support from families
    c. Increased employment opportunities
    d. Increased psychological distress
    e. Potentially increased sense of self

Correct answer = d

5. Which is FALSE: The IPsyNet Statement and Commitment?:
    a. Support universal human rights
    b. Support access to sterilisation and divorce services for transgender people
    c. Support affirmative psychological support
    d. Support the inclusion of LGBTIQ+ as experts in research
    e. Support the right of people to live according to their identity

Correct answer = b

Article 3: Pillay, S.R., Nel, J.A., McLachlan, C., & Victor, C.J. (2019). Queering the History of South African Psychology: From Apartheid to LGBTI+ Affirmative Practices. American Psychologist, 74(8), 954-966.

1. According to the article, the following event can be regarded as pivotal in the law reform movement around same-sex sexuality in South Africa:
    a. Forest Town raid
    b. Stonewall uprising
    c. Rivonia Trial
    d. Apartheid
    e. Pride Parade in 1994

Correct answer = a

2. Most mental health professionals' submissions to the Select Committee in 1968 indicated that:
    a. Homosexuality should be considered a mental illness
    b. Sex between people of the same sex should be criminalised
    c. There was general agreement on the causes of homosexuality

d. Lesbian relationships, too, were considered deviant
e. They had less liberal views on homosexuality than the general public

Correct answer = b

3. The Triangle Project evolved from:
    a. The Gay Association of South Africa
    b. The Gay and Lesbian Archives
    c. The AIDS Support and Advocacy Trust
    d. The Aversion Project
    e. OUT LGBT Well-Being

Correct answer = c

4. In the article, research by the Other Foundation (2016) indicated that:
    a. 42% of South Africans support a gay member of their family
    b. 72% felt that gender non-conformity is “morally wrong”
    c. 47% felt that they would not approve of men wearing women’s clothing
    d. 47% felt that women should be submissive to their husbands
    e. 51% believe that gay people should have the same rights as all other citizens

Correct answer = e

5. The PsySSA practice guidelines for psychological professional working with sexually and gender-diverse people are aimed at all people that might use psychological knowledge in their professional practice:
    a. True
    b. False

Correct answer: a

Appendix IX: Turnitin receipt and summary

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Page count:	363
Word count:	84,873
Character count:	501,357
Submission date:	26-Feb-2024 09:51AM (UTC+0200)
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