AFRICAN LGBTQIA+
HUMAN RIGHTS PROJECT

PsySSA
Psychological Society of South Africa

Practice Guidelines for Psychology Professionals

Working with Sexually and Gender-Diverse People

2nd Edition, 2025

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ABBREVIATIONS AND ACRONYMS

ACHPR	African Commission on Human and Peoples' Rights
APA	American Psychological Association
ASSAf	Academy of Science of South Africa
BACP	British Association for Counselling and Psychotherapy
CPD	Continuing Professional Development
CSO	civil society organisation
CSVR	Centre for the Study of Violence and Reconciliation
DOJ&CD	Department of Justice and Constitutional Development
DSD	differences in sex development
HPCSA	Health Professions Council of South Africa
HR	human resource
HRW	Human Rights Watch
ID	intellectual disabilities
IGM	intersex genital mutilation
IPPF	International Planned Parenthood Federation
IPsyNet	International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues
IPV	intimate partner violence
IUPsyS	International Union of Psychological Science
LBT	lesbian, bisexual and transgender
LGBT-DOCSS	Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual
LRC	Legal Resources Centre
MSM	men who have sex with men
MSMW	men who have sex with men and women
NAP	National Action Plan to Combat Racism, Racial Discrimination, Xenophobia, and Related Intolerance
NGO	non-governmental organisation

OHCHR	United Nations Office of the High Commissioner for Human Rights
PATHSA	Professional Association for Transgender Health South Africa
PEPUDA	Promotion of Equality and Prevention of Unfair Discrimination Act
PrEP	Pre-exposure Prophylaxis
PsySSA	Psychological Society of South Africa
RLP	Reflective local practice
SACSSP	South African Council for Social Service Professions
SAHRC	South African Human Rights Commission
SANAC	South African National AIDS Council
SASOP	South African Society of Psychiatrists
SAWEI	South African Workplace Equality Index
SGBV	sexual and gender-based violence
SGD	Sexuality and Gender Division
SGM	sexual and gender minorities
SOGIE	sexual orientation, gender identity, and gender expression
SOGIESC	sexual orientation, gender identity and/or expression, and sex characteristics
SOGIECE	Sexual orientation and gender identity/expression change efforts
TGDNB	Trans, gender-diverse, and non-binary
WAS	World Association for Sexual Health
WHO	World Health Organisation
WPATH	World Professional Association for Transgender Health
WSW	women who have sex with women

Introduction

This document is the second edition of the Practice guidelines for psychology professionals working with sexually and gender-diverse people (McLachlan et al., 2019; Psychological Society of South Africa [PsySSA], 2017). Since science and practice evolve, these guidelines are an updated consolidation of best practice evidence in South African and international psychology as it pertains to understanding sexual and gender diversity. The umbrella term of 'sexual and gender diversity' includes, but is not limited to, people who identify as lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual (LGBTQIA+).

Towards diversity competence

In recent years, and in line with international trends in the profession, efforts to identify core competencies for psychology professionals have become increasingly important, especially in terms of how we select, teach, train, examine, licence, and monitor psychology professionals. Given the history of South Africa, our diverse society, and the complexities around working with differences across race, gender, culture, sexual orientation, class, and health status, it goes without saying that diversity competence is essential.

The International Declaration on Core Competencies in Professional Psychology of the International Union of Psychological Science (IUPsyS) (2021) clearly outlines work with diversity as key for psychology professionals. This set of competencies includes:

- knowledge and understanding of the historical, political, social and cultural context of clients, colleagues, and relevant others;
- cultural humility;
- respecting diversity in relevant others;
- realising the influence of one's own values, beliefs, and experiences on one's professional behaviour, clients, and relevant others;
- working and communicating effectively with all forms of diversity in clients, colleagues, and relevant others; and
- inclusivity of all forms of diversity in working with clients, colleagues, and relevant others (IUPsyS, 2021).

IUPsyS defines competence as a "combination of practical and theoretical knowledge, cognitive skills, behaviour, and values used to perform a specific behaviour or set of behaviours to a standard, in professional practice settings associated with a professional role" (IUPsyS, 2021, p. 4).

The term 'diversity' includes working with sexual and gender diversity, the specific area of application dealt within the current guidelines. While there is an expanding vocabulary in terms of sexual and gender diversity in academic theorising, empirical research, and from people's lived experiences, these guidelines opt to use the acronym LGBTQIA+ throughout the document, with the plus (+) meant to indicate further complexity, diversity, and possibilities. Quite often, the term 'diversity of sexual orientation, gender identity and/or expression, and sex characteristics' (SOGIESC) is used along with LGBTQIA+ (World Health Organisation [WHO], 2023). Sexual and gender diversity may also include diverse relationship orientations that challenge, resist, or opt out of the traditional hetero-cisnormative expec-

tations of what a relationship or family ought to look like. The tapestry of sexual and gender diversity is therefore wide and varied, and encompasses a diversity of identities related to:

- sexual orientations;
- gender identities, gender expressions, and gender roles;
- sex characteristics;
- sexual behaviours; and
- relationship orientations.

These guidelines, therefore, contribute to an improved understanding of sexual and gender diversity competence for psychology professionals working in a multicultural society.

Background and history

This project is led by the PsySSA African LGBTQIA+ Human Rights Project, a research and training subgroup of the PsySSA Sexuality and Gender Division (SGD), in collaboration with the University of South Africa (UNISA) and the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) (see Appendix I for details about each organisation).

Historically, this works dates back to the publication of the PsySSA sexual and gender diversity position statement (PsySSA, 2013; Victor et al., 2014), which outlined the official stance by PsySSA that psychology professionals ought to work affirmatively with LGBTQIA+ people and issues. The subsequent practice guidelines (McLachlan et al., 2019; PsySSA, 2017) expanded the position statement into twelve comprehensive guidelines. The guidelines were launched at events across the country, in Johannesburg, Durban, and Cape Town, and received substantial media attention. These were, and continue to be, the only such set of guidelines in South Africa, and on the African continent more broadly. Despite their professional and geographic specificity, the guidelines have become a global health resource in varied contexts, including Cameroon and Nigeria (see Pillay et al., 2022) and have been translated and adapted for use.

In South Africa, the guidelines have been generally well received and are used to train and run workshops for a wide range of professionals, including social workers, psychologists, medical doctors, and nurses. In particular, the Department of Social Development in Gauteng has consistently invited the project team to train over 500 social service professionals over the years, firmly positioning the guidelines as an interdisciplinary mental health resource. Additionally, the guidelines have been used as a teaching resource for psychology master's coursework at some universities across the country.

Development process

The process of updating the original guidelines began in 2022, five years after the original publication. The development process can be summarised as follows:

- formation of a core working group of nine psychologists with expertise in LGBTQIA+ issues, viz. the African LGBTQIA+ Human Rights Project (see Appendix XII for full biographies). Four of these nine psychologists were authors of the original guidelines (McLachlan et al., 2019; PsySSA, 2017);

- a scoping review of existing reviews of African LGBTQIA+ research (2011–2022) (Pillay et al., in press);
- a reading and critical appraisal of newly published literature in the (South) African context;
- undertaking three engagements with stakeholders prior to making any changes, namely –
    - a survey of practitioners' knowledge, use, and experience of the original guidelines;
    - a survey of PsySSA members to solicit feedback on their use of the guidelines and suggestions for improvement;
    - interviews with and feedback from the extended working group who reviewed the original guidelines;
- three dedicated writing retreats for the core working group;
- peer-reviewing by 23 national and international experts (see Appendix XIII: Acknowledgements, for full list);
- review and approval by three PsySSA Standing Committees: Science of Psychology; Equity and Transformation; and Ethics;
- review and approval from the PsySSA Executive Committee (10 September 2024);
- review and approval from the PsySSA Council (18 September 2024);
- ratification at the PsySSA Annual General Meeting (2 October 2024);
- official launch at the 30th annual PsySSA Psychology Congress (9 October 2024); and
- publication of full report on the PsySSA website (free to download) with a pending academic publication in the South African Journal of Psychology in 2025.

The above process ensured a comprehensive and transparent scientific method that aspired to balance the internal expertise of the primary authors with the external expertise and feedback of reviewers and relevant organisational structures. Notably, detailed peer review from a wide range of international experts ensured a credible global feedback mechanism with scholars from across the world. This collaborative undertaking spanned two years (2022–2024), and was independently funded with money generated from continuing professional development-accredited training programmes based on the original guidelines.

As far as possible, these guidelines have tried to make recommendations that draw from South African research. Evidence is however not always clearly available for specific subgroups. Research tends to focus on people who identify as lesbian, gay, and transgender, to the exclusion of bisexuality (Choi & Israel, 2019), pansexuality (Hayfield, 2020), or asexuality (Kelleher et al., 2022). There is also limited research on working with intersex individuals, and the psychosocial dimensions of identifying as intersex (Behrens, 2020). Additionally, there is limited literature in the context on diverse relationship practices, such as consensual non-monogamies (Spilka, 2018), mono-normativities, or non-normative and kinkier forms

of sex(ualities) (Martin, 2024). This is not to say that good work is not being done by practitioners throughout the country. Indeed, best practices do emerge both from the ground up and from empirical research studies, and we have tried to incorporate some of the undocumented but valuable advances in knowledge that draw from a range of geographic and intersectional contexts, such as rural areas, private healthcare, public health innovations, and teaching experiences. These practice guidelines have taken various international guidelines into account in the development process.

Overall framework

Guidelines serve a number of goals, and can be utilised in a variety of ways. The primary purpose of the guidelines is to consolidate the latest evidence in the areas of LGBTQIA+ psychology and related fields, and to understand the implications for psychology professionals working with sexually and gender-diverse people. These guidelines, therefore, provide a resource for psychology professionals to deal more sensitively, ethically, and effectively with matters of sexual and gender diversity.

The guidelines are not limited to psychologists, but extend to all legal categories of psychology professionals registered with the Health Professions Council of South Africa (HPCSA), i.e. registered counsellors, psychometrists, and clinical psychologists, educational psychologists, counselling psychologists, neuropsychologists, industrial psychologists, and research psychologists. The guidelines are however not statutory guidelines and cannot be legally enforced; they are aspirational, but can certainly be used by statutory bodies, such as the HPCSA, to create relevant standards of care, ethics codes, and even board examination questions. It is indeed our hope that the HPCSA use these guidelines to guide the profession and protect the public, as is their mandate. This is especially important where professionals continue to stigmatise and discriminate against LGBTQIA+ people.

Relatedly, these guidelines are a resource for government departments where psychology professionals are frequently employed, especially the Department of Health, Department of Education, Department of Correctional Services, and the South African Police Service (SAPS). Related social service professionals in the Department of Social Development will also benefit from using these guidelines due to the relevance for all mental health professionals, including medical doctors, psychiatrists, occupational therapists, social workers, and nurses. We welcome attempts by government departments to use our guidelines as a resource to develop policies, standard operating procedures, or other LGBTQIA+-friendly interventions that improve service delivery for LGBTQIA+ people.

As the above sections imply, these guidelines are not limited to psychotherapy and counselling services, i.e. these are not only treatment guidelines for seeing clients or patients. The guidelines are a general set of principles, values, best practices, and lenses that can be applied to all professional activities and a variety of work contexts, such as counselling or psychotherapy, research, psychometric assessments, policy work, teaching and curriculum design, community interventions, etc.

Finally, guidelines cannot address every unique situation faced by professionals, just as a roadmap does not indicate every pothole, roadblock, or speed bump. Our own reflexivity should therefore hone our wisdom, humility and knowledge, and insight into what we do not know. With these practice guidelines, we hope to spur learning and unlearning:

- to acquire the ability to see new ways;
- to acknowledge our blind spots, our biases, our beliefs and conventions of how the world is;
- to decrease our knowledge gaps;
- to limit our prejudices, which are shaped by how we were taught, socialised and supervised; and
- to question our norms and values that inhibit curiosity, respect and acceptance of diversity.

Theoretical lenses

The guidelines are informed by a diverse but mutually beneficial and coherent range of theoretical and conceptual standpoints. At its core, the guidelines use, endorse, and further develop the concept of affirmative practice (see Guideline 1), which argues that professionals should respect and value people who identify as LGBTQIA+ (Mendoza et al., 2020; PsySSA, 2013). Affirmative practice demands a socio-political and contextual awareness of how homo-, bi-, and transphobia, heterosexism, cisgenderism, prejudice, and stigma affect mental health and wellbeing, resulting in what is termed 'minority stress' (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003). The use of minority stress theory is core to understanding the unique, chronic, and structural marginalisation that affects LGBTQIA+ people (Semlyen & Rohleder, 2021).

Throughout the guidelines, we adopt an ecosystemic lens, keeping in mind the multiple and overlapping contexts and systems that interplay when working with LGBTQIA+ people. Relatedly, we maintain an intersectional lens in all our thinking and writing, to remind ourselves continuously that LGBTQIA+ people face a range of intersecting forms of discrimination in addition to their SOGIESC. Structural positions informed by one's race, culture, geographic location, home language(s), educational qualifications, class, and health status, to name a few identity markers, all form a complex matrix of psychosocial experience that should not – and cannot – be reduced to simplistic formulations of people's lived realities (see Guideline 5).

Given the shortcomings of intersectionality theory, and some criticism in terms of its usage, we further use a critical, decolonial, and feminist lens in our work, to foreground the radical nature of such scholarship and practice. Advancing a progressive and evidence-based LGBTQIA+ psychology is part of the decolonial turn in psychology, given that much of the hetero-cisnormativity we see in South African psychology and in mental health practice more broadly, are continuities of the African history of imperialism, colonialism, and apartheid.

Finally, we situate this work as part of global and public mental health, noting that theory, evidence, and guidelines from the Global South can indeed inform and influence global and transnational agendas (Pillay et al., 2022). Nel's (2014) call for action continues to remain

relevant: South African psychology can and should provide leadership in advancing understanding of sexual and gender diversity on the African continent.

Main changes in the current edition

We have maintained the overall 'look and feel' of the original document so that readers who are familiar with the first edition can still easily navigate this updated version. There are still 12 guidelines, but the notable changes are:

- removal of the previous guideline 3 ("Enhancing professional understanding"), which is now integrated into other sections, notable the terminology section;
- provision of the required emphasis and conceptual clarity, upfront, on the meaning of affirmative practice, which is now Guideline 1;
- addition of a new guideline on resilience and relational wellbeing (Guideline 9);
- addition of a new introductory section on terminology;
- addition of two applied case studies for each guideline;
- use of 'hetero-cisnormativity' as a standard term;
- use of 'homo-, bi-, and transphobia' as a standard phrase;
- stronger emphasis on trans and gender issues;
- more inclusion of bisexual and asexual examples;
- an updated glossary;
- addition of organisational resources to assist LGBTQIA+ people;
- addition of a list of non-predatory journals to publish LGBTQIA+ research;
- updated list of policies, laws, clinical forms, and relevant declarations;
- updated citations and an extensive reference list of new research; and
- greater consistency in terms of writing, length, and formatting across all guidelines.

How to engage with this document

- This is a 'living document' and subject to revisions when indicated.
- The guidelines provide broad principles and entry points into local and international debates, keeping in mind that some areas are evolving and contentious.
- Each guideline and section was written by a different lead author with review and input from the broader team. Writing styles may therefore differ in some sections.
- Importantly, all the guidelines and sections cross-reference each other.
- Skim-read the document, as a whole, before focusing on the specific guideline(s) or section(s) most relevant to your specific case, enquiry or concern.
- Remember to consult the glossary when in doubt about the meaning of a specific term.
- Make use of the extensive reading list provided in the References.

An orientation to terminology

For psychology professionals and the public, the language and concepts of sexuality and gender can be complex and confusing. What does it mean to identify as gay or bisexual, a trans woman or a cisgender man, a polyamorous couple, or an asexual individual? Are these identities social constructs? Can we opt out of labelling ourselves – or are we forced into compulsory social identities? What are the psychosocial consequences of challenging taken-for-granted assumptions about sexuality and gender? This guidelines document invites psychology professionals to think beyond the simplistic binaries associated with sexual and gender identity, and to develop an appreciation of the expansive, fluid, overlapping, and evolving nature of language and its important role in understanding the psychology of sexuality and gender.

This section provides an orientation to some foundational terminology. It differs from the glossary, which provides brief definitions of words (see Glossary p.85). The current section contains longer explanations, citations for further reading, and an overview of contemporary debates, to help contextualise how words and phrases are used in psychological literature and practice, but also in these guidelines.

Umbrella terms: sexual and gender diversity, LGBTQIA+ and SOGIESC

The term 'sexual and gender diversity' serves as a broad, inclusive starting point to remind us that we are first and foremost dealing with human diversity. Such diversity is not unusual, unexpected, or strange; it is a natural part of the human experience. Across cultures, countries, and throughout nature, we find endless examples of the rich tapestry of sexualities, genders, and related identities, reinforcing that diversity is a universal aspect of human life.

'Sexual and gender diversity' is an umbrella term referring to people who identify as lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual (LGBTQIA+). Notably, the A in LGBTQIA+ may also be understood in reference to agender identities. While the academic vocabulary around sexual and gender diversity continues to expand, these guidelines use the abbreviation LGBTQIA+ throughout, with the plus (+) symbol indicating further diversity, complexity, and possibilities. Importantly, when we speak of sexually and gender-diverse people in this document, we affirm their right to define and express their own identities.

There is also ongoing debate about the use of the phrase "identify as" when referring to LGBTQIA+ individuals. On one hand, this language honours self-determination and personal agency, emphasising the act of naming oneself as an assertion of identity. However, critics argue that it can unintentionally suggest that these identities are merely labels or subjective choices rather than inherent and valid aspects of an individual's being. In these guidelines, we aim to strike a balance between respecting the power of self-naming while affirming that LGBTQIA+ identities are intrinsic and deeply rooted in lived experience.

LGBTQIA+ is not a homogenous abbreviation. We must be mindful not to oversimplify the diverse communities and individuals it represents. This abbreviation acts as shorthand

for diversities across at least five domains: sex characteristics, gender, sexual orientation, relationship configurations, and political identities. Each of these categories contains unique experiences and complexities, and the experiences of individuals within them may overlap, intersect, or differ widely. An alternative umbrella term is therefore 'sexual orientation, gender identity and expression, and sex characteristics' (SOGIESC) (WHO, 2023), which does provide specific identity categories, such as gay or bisexual, but is a rather generic abbreviation.

Variations in sex characteristics

Sex characteristics, often used to classify individuals at birth, exist on a spectrum. Typically, a doctor inspects a newborn's external genitalia and announces, "It's a boy!" or "It's a girl!" – a moment that reinforces binary expectations about sex and gender. This process can, however, overlook the natural diversity of sex characteristics, which includes variations in chromosomes, hormones, and genitalia that do not fit neatly into male or female categories (Crocetti et al., 2024; Monro et al., 2021).

While sex is often determined by visible physical traits, this classification does not capture the full complexity of sex characteristics, which may include less visible aspects, such as internal reproductive organs, chromosomes, or hormone levels. Individuals with variations in sex characteristics, sometimes referred to as 'intersex', may discover these traits at different stages of life, such as during puberty or when seeking medical care, while others may not be aware of them at all (Hegarty & Smith, 2023).

'Intersex' is another umbrella term that refers to individuals whose biological traits do not fit typical definitions of male or female bodies (Carpenter, 2024). These traits can present in various ways, such as external genitalia that differ from conventional male or female classifications, variations in internal reproductive organs, chromosomal patterns beyond the usual XX or XY, or differences in how the body responds to sex-related hormones (Wolff et al., 2022).

Historically, the medical field has referred to these variations as 'disorders of sex development' (DSD), a term that is criticised for being pathologising and stigmatising (Lundberg et al., 2018). More inclusive terminology, such as 'differences in sex development', 'diversity of sex development', or 'variations in sex characteristics', is gaining acceptance for its emphasis on diversity without suggesting that these differences are medical conditions that require correction (Carpenter, 2018). This shift acknowledges that the sex assigned at birth does not determine an individual's gender identity or sexual orientation, which may evolve over time, independent of physical characteristics (Carpenter, 2020).

Gender

Although sex is typically linked to physical characteristics, gender is understood as a social construct shaped by societal expectations, norms, and cultural interpretations. Gender encompasses behaviours, roles, and attributes that society assigns to individuals based on their sex assigned at birth (Butler, 1990, 2004; DeLamater & Hyde, 1998; Lorber, 1994). From

practices, such as 'gender reveal' parties to childhood socialisation, societal norms around gender roles and identities are enforced early, normalising binary assumptions of male and female.

Socialisation agents – including family, media, and religious institutions – shape an individual's understanding of gender within their cultural context. Gender, however, is fluid and multifaceted, challenging traditional binary notions. Terms, such as 'gender identity' (an internal sense of self), 'gender expression' (outward presentation), and 'gender roles' (behavioural expectations), provide a more nuanced understanding of diversity in terms of gender.

For many people, their gender identity aligns with their sex assigned at birth, and they are referred to as 'cisgender'. In contrast, individuals whose gender identity does not align with their sex assigned at birth may identify as transgender (McLachlan, 2010; Sanchez et al., 2009). Not all transgender individuals experience gender dysphoria, and their gender identity is valid whether or not they experience discomfort related to their assigned sex. Gender diversity extends far beyond the binary categories of cisgender and transgender, including a broad range of identities, such as non-binary, genderqueer, genderfluid, and agender.

The terms 'trans and gender diverse' (TGD), 'trans and non-binary' (TNB) or a combination of both (TGDNB) are also commonly used to describe individuals whose gender identities fall outside the masculine–feminine binary. These terms serve as umbrella categories for gender. A person assigned male at birth who identifies as genderfluid may express both traditionally masculine and feminine traits, embodying the fluidity of gender. In South Africa, the gender binary is often upheld to sustain patriarchal belief systems that have become culturally normative (Madlala, 2023; Vipond, 2015).

Sexual orientation

'Sexual orientation' refers to an individual's enduring romantic, emotional, and sexual attraction to others. Lesbian women who are primarily attracted to women, and gay men who are primarily attracted to men, are considered *monosexual*. In contrast, *plurisexual* individuals, such as those identifying as bisexual, pansexual, or omnisexual, experience attraction to more than one gender. While bisexuality is sometimes misunderstood as a binary or static identity, it encompasses fluid and diverse experiences across gender boundaries (Hayfield, 2020; Ramirez & Pulice-Farrow, 2016; Rios-Rivera, 2024).

Sexual orientation is not limited to sexual attraction but is also deeply intertwined with romantic attraction. For instance, some individuals may identify as homoromantic but pansexual, meaning their romantic attraction is directed toward one gender while their sexual attraction spans many genders. These experiences reflect the fluid and multifaceted nature of orientation, where sexual behaviour, romantic attraction, and identity intersect in complex ways (Hayfield & Křížová, 2021; Klein, 2024).

In public health discourse, terms such as 'MSM' (men who have sex with men), 'WSW' (women who have sex with women) and 'MSMW' (men who have sex with men and women) refer to sexual behaviour rather than orientation or identity.

These categories acknowledge the complexity and contextual nature of human sexuality, recognising that some individuals engage in sexual relationships with people of different genders without identifying as gay or bisexual (Brown et al., 2013; Fernando, 2017; Ito et al., 2021; Rubini et al., 2023).

As our understanding of sexual orientation continues to expand, so has the terminology surrounding bisexuality. The 'bi+ umbrella' is now used to encompass a range of plurisexual identities, acknowledging that bisexuality may include attractions to more than one gender, and reflecting the fluidity of sexual orientation. Bisexual individuals however continue to face ***bi-erasure***, where their identities are invalidated or dismissed both within LGBTQIA+ communities and in society at large (Nelson, 2024). This erasure often compounds the heightened risks bisexual people face in relation to mental health and wellbeing (Cross et al., 2023).

Asexuality, often considered a sexual orientation, involves experiencing little or no sexual attraction toward others. Asexuality however also lies on a spectrum of diverse experiences. Some asexual individuals, such as ***demisexuals***, may only experience sexual attraction after forming a deep emotional bond, while ***greysexuals*** experience sexual attraction infrequently. Asexual people may still desire emotional or romantic intimacy, and some pursue romantic or platonic relationships without sexual attraction (Brunning & McKeever, 2020; Hayfield & Křížová, 2021).

Aromantic individuals, who may identify as asexual or within the asexual spectrum, experience little or no romantic attraction. While they may not desire romantic relationships, they often engage in meaningful platonic or ***queerplatonic*** connections, where emotional intimacy and commitment exist outside normative romantic frameworks (Urh, 2023). As with other sexual identities, asexuality is valid and diverse, although it remains under-researched, and is often subject to ***ace (asexual) erasure***, where asexual identities are dismissed or misunderstood.

Relationships

While monogamy is often assumed to be the default relationship structure, many people – regardless of their SOGIESC, including cisgender heterosexuals – engage in alternative configurations that challenge traditional norms. Monogamy is typically characterised by exclusivity and commitment to one partner at a time. Other relationship styles, such as polyamory, ethical non-monogamy, and ***queerplatonic*** partnerships, however disrupt the conventional understanding of relationships, and expand the possibilities for intimate connection (Easton & Hardy, 2017).

Polyamory refers to consensual, romantic, and/or sexual relationships with multiple partners, where all parties are aware of and agree to the arrangement. This might include a ***polycule***, a network of interconnected partners, or ***kitchen table polyamory***, where multiple partners and ***metamours*** (partners of one's partner) have friendly or familial relationships. Unlike polygamy, which often operates within a gendered hierarchy, polyamory is based on mutual

consent and the recognition that individuals can form multiple intimate connections without the requirement of exclusivity or marriage (McCoy et al., 2015).

In real-world contexts, this might look like a married couple who are both romantically involved with other people, where each partner has the knowledge and consent of the other. Alternatively, a solo polyamorous person may choose to engage in multiple relationships without seeking to form a primary partnership. Ethical non-monogamy, a broader term that includes open relationships and 'swinging', emphasises honesty, communication, and consent across all partnerships (Balzarini et al., 2019). For some, these relationships foster a great sense of autonomy and emotional fulfilment, providing alternatives to the cultural expectation of lifelong monogamous commitment.

Queerplatonic relationships, or QPRs, further challenge societal norms around intimacy by prioritising deep emotional connections that may not fit within traditional romantic or sexual frameworks. These relationships may involve varying levels of physical or emotional intimacy without necessarily being sexual or romantic, allowing partners to form strong, committed bonds outside of normative relationship structures (Urh, 2023). For example, two people in a queerplatonic relationship might live together, share financial responsibilities, or raise children, even though their relationship is not defined by romantic or sexual attraction. Such relationships are especially relevant for asexual and aromantic individuals, who may seek forms of intimacy that do not revolve around sexual attraction or romantic love.

A note on queer

'Queer' was historically used as an anti-gay slur but has been reclaimed since the late 1980s with multiple, interconnected meanings. Today, it serves as an expansive, inclusive 'umbrella term' covering a spectrum of diversity related to biological sex, sexual orientation, gender identities and expressions, sexual behaviours, and relationship configurations. It is commonly used in both pop culture and academic discourse to describe sexual and gender diversity. The term can also carry socio-political connotations, often used by those who reject traditional gender categories, distinct sexual orientation labels, or hetero-cisnormativity. Some may identify as lesbian or gay and queer simultaneously, while certain spaces – such as Pride festivals or drag venues – are often described as 'queer-friendly' or 'queer spaces'.

In academic contexts, queer theory has become a critical lens through which researchers challenge and 'trouble' normative assumptions about human behaviour, identity, and power structures. This approach, known as 'queering' (Pillay et al., 2019, 2022), is often used by scholar-activists to resist dominant narratives about sexuality and gender, offering a transgressive way of understanding identities outside binary norms (Judge, 2021). For example, queer theory encourages psychology professionals to question binary assumptions when designing research studies or interacting with clients, promoting an expansive understanding of identity. Queer theory aligns with the goal of

this document, to encourage psychology professionals to question power dynamics, normativity, and fixed labels; thus, promoting an inclusive and expansive understanding of sexuality and gender.

'Queer' is deeply personal, and means different things to different people in different contexts. While some embrace it as a central part of their identity, others may prefer different labels. Given its complex history, not all sexually and gender-diverse people feel comfortable with the term, making it essential to respect each individual's preferences.

In summary, the wide-ranging tapestry of sexual and gender diversity includes:

- variations in sex characteristics;
- gender identities, gender expressions, and gender roles;
- sexual orientations;
- sexual behaviours;
- relationship orientations; and
- queer identities.

These guidelines aim to offer overarching principles of practice that psychology professionals can apply in their diverse work contexts, with detailed discussions of these concepts explored throughout the document. It is important for psychology professionals to engage with the complex and evolving terminology in an affirmative manner – and not in a dismissive manner – in order to challenge hetero-cisnormativity, patriarchy, and homo-, bi-, and transphobia.

Practice guidelines for psychology professionals working with sexually and gender-diverse people

2nd Edition, 2025

GUIDELINE 1: Adopt an affirmative stance

Psychology professionals adopt and adhere to an affirmative stance towards sexual and gender diversity in all aspects of professional practice including, but not limited to, psychological assessment and interventions, such as counselling, psychotherapy, or community engagement; policy development and implementation; research, writing, and publication; education, training, and curriculum design; and public or media engagements.

GUIDELINE 2: Ensure non-discrimination

Psychology professionals respect the human rights of sexually and gender-diverse individuals, ensuring non-discrimination based on sexuality and gender, including sexual orientation, gender identity and/or expression, and sex characteristics (SOGIESC).

GUIDELINE 3: Uphold individual self-determination

Psychology professionals prioritise and privilege individual self-determination, support sexually and gender-diverse individuals' decisions around self-disclosure, affirm their diverse identities, and help them navigate socio-cultural and systemic challenges.

GUIDELINE 4: Recognise normative social contexts

Psychology professionals understand the evolving nature of normativity and the unique challenges faced by sexually and gender-diverse individuals within various normative pressures (e.g. heteronormativity, homonormativity, cisnormativity). This understanding must go beyond mere acknowledgement, encompassing how these norms shape societal attitudes, behaviours, and institutional structures.

GUIDELINE 5: Understand 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 based on gender; sexual orientation; biological diversity; relationship or family choices; socio-economic status; race, culture, ethnicity, or language; age or life stage; disabilities or health status; neurodiversity; citizenship status; geographical location; faith, religion and spirituality; and other characteristics, experiences or positionalities.

GUIDELINE 6: Counteract stigma, prejudice, and violence

Psychology professionals understand stigma, prejudice, discrimination, and violence, and the potential detrimental effect of these factors on the mental health and wellbeing of sexually and gender-diverse persons and communities.

GUIDELINE 7: Recognise multiple developmental pathways

Psychology professionals acknowledge the diverse and evolving sexual and gender developmental pathways that all people traverse from infancy through childhood, adolescence, adulthood, and advanced age.

GUIDELINE 8: Support diverse family structures and relationships

Psychology professionals recognise the unique relational experiences and challenges faced by sexually and gender-diverse individuals, including issues within families of origin and choice, relationship dynamics, and challenges related to parenting, fostering, and adoption.

GUIDELINE 9: Increase social support, and foster resilience by prioritising relational wellbeing

Psychology professionals recognise the importance of resilience, and promote relational wellbeing and increased social support within the lives of sexually and gender-diverse persons.

GUIDELINE 10: Affirm diversity and resist normalisation efforts

Psychology professionals recognise the importance of adopting best practices that not only respect and affirm sexual and gender diversity but also move beyond hetero-cisnormativity frameworks and culturally normative standards of being that have historically marginalised sexually and gender-diverse individuals.

GUIDELINE 11: Disclose and rectify personal biases

Psychology professionals address and disclose personal biases regarding sexual and gender diversity through reflection, learning, and development. If competency gaps arise, they seek supervision and/or additional training, and make appropriate referrals to ensure affirming care.

GUIDELINE 12: Enhance practice through continuing professional development

Psychology professionals enhance their affirming stance by engaging in continuing professional development (CPD) on sexual and gender diversity, including understanding the needs of sexually and gender-diverse individuals and utilising affirmative resources for optimal referrals.

GUIDELINE 1: Adopt an affirmative stance

Psychology professionals adopt and adhere to an affirmative stance towards sexual and gender diversity in all aspects of professional practice including, but not limited to, psychological assessment and interventions, such as counselling, psychotherapy, or community engagement; policy development and implementation; research, writing, and publication; education, training, and curriculum design; and public or media engagements.

Key points

- 'An affirmative stance' is an umbrella term to indicate recognising, respecting, and remaining informed about sexually and gender-diverse identities.
- An affirmative stance helps professionals to redress past injustices perpetrated by the psychology profession, with the aim of optimising mental health systems, research, and psychological practice for LGBTQIA+ people.
- An affirmative stance should also actively challenge hetero-cisnormative stereotypes about gender diversity and sexual minority groups in a manner that facilitates active reflection on root causes of prejudices and biases towards LGBTQIA+ persons.
- An affirmative stance enables empathic, positive, and strengths-based assumptions about sexual and gender diversity, which inform all areas of professional practice – not just counselling and psychotherapy.
- Affirmative practices require a broad socio-political and contextual awareness of how hetero-cisnormativity affects mental health and wellbeing through minority stress.
- Affirmative practitioners aspire to be resolute in creating safe, supportive, caring, and equitable forms of practice.

Rationale

What does it mean to take an affirmative stance? An affirmative stance is an umbrella term, which indicates recognising, respecting, and remaining informed about sexually and gender-diverse identities, and using this knowledge to enact evidence-based research, theory and practice. The premise of an affirmative stance is that individuals who are lesbian, gay, bisexual, transgender, queer, intersex and/or asexual (LGBTQIA+) are entitled to live in the body, gender and/or sexual orientation that is most authentic to them. To affirm is to validate; however, such validation is not uncritical or unthinking, but is rooted in a holistic understanding of the specific psychosocial needs of LGBTQIA+ people (Madlala, 2023; Victor, 2024).

Psychology professionals recognise that psychological approaches have historically pathologised and caused harm to sexually and gender-diverse individuals, both globally and in South Africa (Nakamura & Logie, 2020; Pillay et al., 2019). Past approaches were deeply biased, and psychology – both as a social science and as a field of mental health practice – was often actively engaged as part of the problem. To undo this negative legacy, it is not enough for current practitioners merely to avoid doing harm. An affirmative stance therefore must lead to affirmative practices.

As part of a broader social commitment to embracing diversity and human rights, affirmative practices *actively* use approaches that are ethical, responsible, respectful, empathic, non-judgmental, and comprehensive in their understanding of sexual and gender diversity. This is the essence of an affirmative stance – taking deliberate steps to redress past prejudices and abuses with the aim of optimising mental health systems, research, and psychological practices for LGBTQIA+ people (Chang et al., 2018; McLachlan et al., 2019; Mendoza et al., 2020; PsySSA, 2013).

An affirmative stance respects sexual and gender diversity, which informs not only counselling and psychotherapy but all areas of professional practice. Psychology professionals often find themselves in a wide range of settings where they are expected to provide input and expertise, such as in the role of psychometrist, researcher, policymaker, committee member, organisational leader, manager, supervisor, expert witness, media commentator, interviewer, coach, community interventionist, etc. All of these contexts may involve issues related to sexual and gender diversity, either directly or indirectly, and require adopting an affirmative stance.

A core premise of an affirmative stance is that sexual and gender diversities are recognised as variances of the human experience, and are not the inherent cause of psychological difficulties. This demands a socio-political and contextual awareness of how homo-, bi-, and transphobia, heterosexism, cisgenderism, prejudice, and stigma affect mental health and wellbeing, resulting in what is termed 'minority stress' (see Guideline 6). Minority stress theory argues that LGBTQIA+ people experience disproportionate and qualitatively different forms of stress compared to the general population, because of the stigma, prejudice, and discrimination of belonging to a marginalised minority group. Minority stress often leads to, and is associated with, poor health outcomes (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003). These unique, chronic, and socially rooted stressors call for an affirmative stance in order to understand specific pathways to risk and resilience (see Guideline 9).

Despite a well-documented body of evidence on minority stress and its association with mental health disparities (Lee & Rosenthal, 2023; Semlyen & Rohleder, 2021), there is widespread failure in South Africa to incorporate sexual and gender diversity into undergraduate and postgraduate psychology training, or related health sciences curricula (De Vries et al., 2020). This is perpetuating a limited understanding of LGBTQIA+ issues in professional practice (Kgosamang, 2021). As such, sexual and gender diversity are often downplayed or neglected when psychology professionals design, implement, or evaluate interventions, such as policies, curricula and teaching methods, psychotherapies, research projects and data collection tools, or public health programmes. Without active efforts to sensitise emerging psychology professionals about LGBTQIA+ issues, the profession risks reinforcing hetero-cisnormativity.

Research indicates that LGBTQIA+ people experience substantial negative experiences in the counselling room (Horne et al., in press;

Victor & Nel, 2016; Vybíral et al., 2024). Psychotherapy and counselling, as hallmark activities of the psychology profession, require a radical sensitisation towards sexual and gender diversity in order to enable positive outcomes and personal growth for people who seek such services (Ebersole, 2019). Developing and maintaining a therapeutic alliance is a core aspect of the healing process, and such an alliance cannot be maintained if LGBTQIA+ people experience harm, microaggressions, judgement, or ignorance. Although negative experiences tend to come from therapists who do not identify as LGBTQIA+, some evidence indicates that matching clients to therapists based on sexual or gender identity does not necessarily improve outcomes; rather, empathy, alliance, genuineness, and positive regard play an integral role in fostering a collaborative therapeutic environment (Ellis et al., 2020).

There have been recent mischaracterisations of 'affirmative' as simply an automatic validation or acceptance of a person's identity. In psychotherapy, for example, this mischaracterisation assumes that a therapist prematurely affirms a young person's stated identity without helping them explore and develop a deeper understanding of themselves. While an affirmative stance validates an individual's feelings and experiences, it also acknowledges the validity and value of self-exploration, fluidity, and holding space for uncertainty and ambiguity.

Application

In practice, an affirmative stance calls for psychology professionals to remain aware of both explicit and implicit hetero-cisnormative biases, assumptions, and use of language, that may consciously or unconsciously influence their practice or thinking. Professionals should aim to be inclusive and flexible rather than rigid and exclusionary. Six areas of potential application are discussed, but these are examples, and not an exhaustive list.

In policy development, LGBTQIA+ people should be included as lived experience experts and as active and equal partners in developing policies, plans or legislation that concern LGBTQIA+ people. PsySSA is a member of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), which underscores the importance of inclusion ('nothing about us, without us') (IPsyNet, 2018) (see policy statement attached as Appendix III).

In community intervention settings, such support groups or services rendered by non-profit organisations, when designing, implementing, or evaluating projects, an affirmative lens would require professionals to take a human-centred design approach and imagine the intervention from the point of view of the beneficiaries. Does this intervention include and/or adopt inclusive vocabulary, for example, in its administrative forms, data collection tools, or marketing material? (The APA Inclusive Language Guide is a useful resource for bias-free language [American Psychological Association [APA], 2023].) Affirmative practice encourag-

es professionals to invite LGBTQIA+ individuals to assess potential interventions critically and to provide relevant feedback. LGBTQIA+ people must be included as expert voices and as active, equal partners in the development of interventions that concern them (Burger & Pachankis, 2024; Glyde, 2021).

In educational settings, practitioners involved in training, teaching, examinations, interviews and selections, assessments, curriculum development and appraisal, and other forms of educational agenda setting, must remain aware of the effect of those processes and content on sexually and gender-diverse students, or parents and siblings of such students, and their colleagues. While acknowledging that psychology is taught from a predominantly North American and European vantage point, practitioners who call for the decolonisation of psychology curricula should also evaluate and replace psychological theories steeped in patriarchal and hetero-cisnormative assumptions and values. Decolonising curricula is therefore as much about the changing content and pedagogy, as it is about actively using an intersectional, feminist and/or queer lens in education (Boonzaier et al., 2019).

In academic settings, researchers should strive to be sensitive to the ways in which data is collected and analysed, and consider whether the tools and forms they use are sensitive to and inclusive of sexual and gender diversity (Knutson et al., 2019). Additionally, where data collection is linked to access to services, questions on screening tools or administrative forms should not become a barrier to access if service users perceive the questions as too personal and invasive.

In school settings, psychology professionals must remain aware of how schools become sites that (re)produce hetero-cisnormativity. Teachers' personal viewpoints on sexual and gender diversity often become official school policies on what is appropriate behaviour, leading to stigma, victimisation and marginalisation of students who do not fit into the predetermined, expected norms of behaviour and interaction (Bhana, 2022; Francis, 2021a, 2023; Msibi, 2012) (see Case study 1).

In treatment spaces, professionals should practise affirmative psychotherapy and counselling (Freeman-Coppadge & Langroudi, 2021), noting that affirmative healthcare improves mental health outcomes and can be potentially life-saving (Lee & Rosenthal, 2023). If a client's sexual orientation or gender identity has not been disclosed, the practitioner should not assume that the client is heterosexual or cisgender, or that the client will necessarily disclose their identities, or that disclosed identities are fixed and unchanging. Based on a systematic review of literature assessing the effectiveness of affirmative psychotherapy for sexually and gender-diverse clients, the British Association for Counselling and Psychotherapy (BACP) (2007, p. 33) recommends, "all psychotherapy training institutes regard knowledge of LGBTI development and lifestyles as part of *core training*" (emphasis added). Such calls have been repeated worldwide since then (see Oranzky et al., 2019; Pillay et al., 2022). Using a strengths-based approach, practitioners should draw on pragmatic case studies, supervision groups, and expert practitioners, in order to improve their competencies, and offer affirming services (the case of 'Felix' by

Glassgold [2009] and that of 'Adam' by Mandel [2014] are instructive examples, as is the Gender Affirmative Lifespan Approach by Rider et al. [2019]). The process of 'becoming' an affirmative therapist is ongoing and one never truly 'arrives' (McGeorge et al., 2021) (see Guideline 12).

This introductory guideline has argued that adopting an affirmative stance requires all professionals to unlearn the conceptual binaries and cultural biases that have become normalised through the many hetero-cisnormative socialising agents throughout various systems including, but not limited to, family, religion, education, the media, and larger socio-political climates. Choosing a profession where one works actively to improve the wellbeing of fellow humans, means remaining resolute in one's commitment to co-creating safe, supportive, caring, and equitable forms of practice for all individuals.

Case studies

Case study 1:

The Department of Basic Education (DBE) (2023) is developing guidelines for "the socio educational inclusion of diverse sexual orientation, gender identity, expression and sex characteristics (SOGIESC) in schools". The department also notes:

> Many stereotypes exist about how boys and girls should look, speak and behave. Early learning environments are important places to help children feel safe and accepted … In addition, there is increased inequality in schools perpetuated by racism; xenophobia; gender stereotypes; harmful gender norms; and discrimination and related intolerances, including against vulnerable populations such as LGBTQI+ communities … Diversity, in all its forms, should be embraced and entrenched by all actors of society in the ethos of every school community (DBE, 2023, para. 3).

What role can psychology professionals play to help schools become affirmative and inclusive spaces?

Case study 2:

In April 2023, PsySSA and Outright International hosted a pan-African symposium of mental healthcare professionals to help eradicate conversion practices on the continent. Conversion practices are scientifically discredited, harmful, and unethical practices that forcibly try to change a person's sexual orientation or gender identity or expression, thereby undermining the person's autonomy and self-determination. A key outcome of this gathering was the drafting and adoption of the *Johannesburg Declaration Against SOGIE [sexual orientation, gender identity, and gender expression] Change Efforts and Conversion Practices*, underscoring the need for affirmative practices (see Appendix IV to read the declaration).

What role can psychology professionals play in increasing awareness of – and eradicating – conversion practices?

GUIDELINE 2: Ensure non-discrimination

Psychology professionals respect the human rights of sexually and gender-diverse individuals, ensuring non-discrimination based on sexuality and gender, including sexual orientation, gender identity and expression, and sex characteristics (SOGIESC).

Key points

- The Constitution and its Bill of Rights, as well as the Promotion of Equality and Prevention of Unfair Discrimination Act (No. 4 of 2000), emphasise the protection of human rights for all citizens and residents in South Africa.
- Psychology professionals are legally obligated and ethically bound to respect the human rights of sexually and gender-diverse individuals, including non-discrimination based on SOGIE, and biological diversity.
- Sexual and gender rights, including access to healthcare, gender-affirming care, and services for survivors of sexual and gender-based violence (SGBV), are integral components of human rights for all individuals.
- Despite efforts by organisations, such as the African Commission on Human and Peoples' Rights (ACHPR), discrimination and violence against LGBTQIA+ individuals in many African countries persist and are worsening, necessitating the reinforcement of support structures in South Africa to support LGBTQIA+ migrants and refugees.
- Psychology professionals in South Africa aspire to uphold human rights at personal, institutional, and societal level, and should engage in affirmative practices, ongoing education, and advocacy for sexually and gender-diverse individuals.

Rationale

This guideline is to be read closely with Guideline 6 (Stigma, prejudice, and violence).

The South African Constitution and the Bill of Rights (Republic of South Africa [RSA], 1996), is the highest national law that unambiguously protects the equality, human rights, and dignity of all people in the country, including sexually and gender-diverse people. Appendix X provides a summary of South African legislation, policies, and programmes that are affirmative of sexually and gender-diverse people. In compliance with human rights-related international obligations, such as –

- the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA or the Equality Act) (No. 4 of 2000) (RSA, 2000);
- the National Action Plan to Combat Racism, Racial Discrimination, Xenophobia and Related Intolerance (NAP) (Department of Justice and Correctional Services [DoJ&CS], 2019); and
- the recent Prevention and Combating of Hate Crimes and Hate Speech Act (No. 16 of 2023) (RSA, 2023).

Human rights are not special rights but rather a set of checks and balances to ensure equality and equity for all citizens and residents, including sexually and gender-diverse people (International Commission of Jurists, 2007,

2017; United Nations Office of the High Commissioner for Human Rights [OHCHR], 2012). The need to recognise, respect, and affirm human rights has sparked a range of changes at institutional and disciplinary level, including the ethical rules of conduct for social workers (South African Council for Social Service Professions [SACSSP], 2012), and for healthcare professionals (HPCSA, 2016). The ethical rules of conduct pertaining to psychology as a profession cover the duty to respect human rights, commitments to non-discrimination, avoiding harm, and sensitivity to diversities of, amongst others, sexually and gender-diverse service users (HPCSA, 2016).

Sexual and gender rights are embedded in the human rights framework. Sexual rights are human rights applied to sexuality (including asexuality) and sexual reproductive health. These include the right to –

- enjoy, regardless of sex, sexuality or gender, equality, and freedom from all forms of discrimination;
- free and meaningful participation;
- life, liberty, security, and bodily integrity;
- privacy;
- recognition before the law and autonomy over decisions related to sexuality;
- exercise freedom of thought, opinion, and expression around sexuality;
- health and benefits of scientific progress;
- comprehensive sexuality education;
- choose whether or not to marry and found and plan a family, including decisions over how and when to have children; and
- hold those responsible for protecting these rights accountable (International Planned Parenthood Federation [IPPF], 2008; World Association for Sexual Health [WAS], 2014).

Gender rights ensure that no person faces discrimination based on their gender. This right includes the crucial entitlement to access skilled and sensitive care, particularly in matters pertaining to gender, ensuring that all individuals, regardless of gender identity or gender expression, are accorded equal treatment and opportunities. This includes the right to access gender-affirming care, which is essential for individuals undergoing gender affirmation or seeking to align their physical presentation with their gender identity.

Moreover, the right to access healthcare extends to encompassing services tailored to meet the unique needs of survivors of SGBV. By advocating for these rights and advancing access to justice, initiatives such as the South African National AIDS Council (SANAC, 2023), and the work of Tomson et al. (2021) on gender affirming healthcare contribute to fostering a society where every individual's human rights and dignity are respected and upheld.

The ACHPR 'Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity' expresses concern over ongoing violence, discrimination, and rights violations across Africa based on sexual orientation or gender identity (ACHPR, 2014a). The above commission condemns attacks by both state and non-state actors and urges an end to violence and abuse,

emphasising the need for a safe environment for human rights defenders, including those advocating for sexual minorities (ACHPR, 2014a). Subsequent work has included, amongst numerous others, press statements raising concern around the implication of anti-homosexuality legislation on the work of human rights defenders in Uganda (ACHPR, 2014b), the harm caused by pathologisation of LGBTQIA+ people (ACHPR, 2016), and urging more legislative protection for LGBTQIA+ people in the face of violent attacks in Kenya (ACHPR, 2023a).

Despite efforts by the ACHPR, discrimination, violence, and human rights violations against LGBTQIA+ individuals in Africa have intensified over the past decade. This includes the criminalisation of LGBTQIA+ people, often justified by divergent moral, cultural, or religious views within certain states. In extreme cases, consensual same-sex activities between adults can result in severe penalties, including death or long prison sentences. The African Charter on Human and Peoples' Rights (Organisation of African Unity, 1981) and related protocols lack explicit prohibitions against discrimination based on sexual orientation or gender identity, leaving such issues marginalised within the African human rights framework. The enactment of the Ugandan Anti-Homosexuality Act in 2023 underscores these challenges, presenting a grave threat to the human rights and safety of minority groups (Ssenyonjo, 2023).

Given the negative legislative changes in parts of Africa, the progressive South African Constitution and legal protections for LGBTQIA+ individuals become increasingly significant. The influx of LGBTQIA+ asylum seekers and refugees from countries with anti-gender and homophobic laws underscores the need for South African psychology professionals to prepare and reinforce the support structures for individuals seeking refuge, safety, dignity, and access to healthcare within our borders (Judge, 2018; Marnell et al., 2021). Additionally, PsySSA is a signatory to the IPsyNet Policy Statement and Commitment on LGBTI Matters (IPsyNet, 2018), and the Johannesburg Declaration against SOGIE Change Efforts and Conversion Practices (PsySSA & Outright International, 2023), which provide useful introductions to important considerations when dealing with sexual and gender diversity-related rights (see Appendices III and IV).

In the context of historical neglect, the UN Human Rights Council adopted a groundbreaking resolution in 2024 urging member states to intensify their efforts to combat discrimination, violence, and harmful practices against intersex people. The resolution also calls on member states to tackle underlying causes, such as stereotypes, the spread of misconceptions and inaccurate information, stigma, and taboo, and to strive to ensure the highest attainable standard of physical and mental health for individuals with innate variations in sex characteristics (OHCHR, 2024). Notably, the ACHPR (2023b) recognised that most States Parties to the African Charter do not have appropriate legislative, policy, or other measures to guarantee the protection of the rights of intersex persons, and thus called for such measures on the continent.

Application

Psychology professionals must ensure the application of human, sexual, and gender rights within their area of work. All registered psychology professionals in South Africa are legally and ethically bound to uphold the human rights of the people with whom they work. There are at least three levels where the human, sexual, and gender rights of service users, patients, clients, students, colleagues, and/or research participants need to be upheld and respected by psychology professionals:

- personal level – as an individual working in the profession of psychology;
- institutional environment – the place where such professionals and/or their work are situated; and
- broader contextual system – the community, society, country, global space within which the psychology professionals live and work

When thinking about working with sexually and gender-diverse people, a useful question to consider at each level would be 'How does what I do uphold the human rights of sexually and gender-diverse people? And in what ways do I not uphold these rights?'

In *personal practice*, psychology professionals should proactively take individual steps towards improving their knowledge, attitudes, and behaviour related to LGBTQIA+ people and practice. A starting point is to maintain a steadfast commitment to ethical practice within a human rights framework. This means reading and knowing the contents of the Bill of Rights in the Constitution. Pursuing CPD and knowledge acquisition focusing on diversity appreciation and prejudice reduction is essential (see Guideline 12). Psychology professionals should engage with and become familiar with key declarations concerning sexual and gender rights including, but not limited to, the Yogyakarta Principles (2017) (International Commission of Jurists, 2007, 2017), and those issued by others such as WAS (2014) or SANAC (2023). Psychology professionals should foster a reflexive practice to discern between personal opinions and professional best practices, thereby advancing the human rights of sexually and gender-diverse individuals. Joining professional forums to stay abreast of latest developments is essential, such as being a member of the PsySSA SGD and the Professional Association for Transgender Health South Africa (PATHSA). Ultimately, the hope is that all psychology professionals understand and apply an affirmative practice stance as delineated in these guidelines.

In fostering an affirming *institutional or work environment*, recommended actions could include facilitating sexual and gender diversity sensitisation training within the workplace setting; supporting the initiatives of non-governmental organisations (NGOs) dedicated to this field, through –

- corporate sponsorship or inclusion in workplace resource lists;
- aiding colleagues and service users in accessing resources as needed, including legal support in addressing discriminatory practices, such as the exclusion of same-sex partners from work functions or the refusal to acknowledge a colleague's pronouns or the name a person uses;

- having inclusive bathrooms and related facilities;
- developing protocols for assessing, diagnosing, and treating that are not gender-specific or that do not assume all persons are cisgender;
- ensuring all forms are inclusive;
- visual displays communicating an affirming space; and
- advocating for and promoting access to resources pertaining to sexual and gender diversity, including directory listings within the workplace environment.

In *school environments,* consideration needs to be given to providing safe and inclusive environments for all, including affirming language, contextually responsive curricula, as well as resources and support groups for sexually and gender-diverse learners (see for e.g. Gender Dynamix, 2018).

In *broader society*, professionals play a crucial role in advocating for human rights, both generally and specifically for LGBTQIA+ individuals, including actively supporting trans, gender-diverse, and non-binary (TGDNB) service users, among others, by assisting them in various ways, such as navigating the legal process to amend their gender description on identification documents, and engaging with medical aids and/or health insurers to seek approval or appeal for specific health-related services. Psychologists can play a role in the legal space by acting as experts in court cases, writing expert opinions, doing pro bono work in human rights organisations, working with test cases, etc.

Furthermore, people must be made aware of the avenues to report human rights violations and discriminatory practices, including informing them about Chapter 9 institutions, such as the South African Human Rights Commission (SAHRC) and the Commission for Gender Equality, as well as the Equality Courts established under PEPUDA, taking into account that the lived reality is that there is a low likelihood of justice, and the legal process(es) may result in adverse mental health outcomes.

Case studies

Case study 1:

At Company A, an employee faced significant challenges after socially transitioning her gender identity, including exclusion from meetings and negative reactions from colleagues. She contacted a trusted human resource (HR) manager, who invited her to join the diversity committee of the company. The committee used the South African Workplace Equality Index (SAWEI) as a benchmark to improve inclusivity. Following SAWEI guidelines, the committee implemented gender-neutral bathrooms, external training for staff and management, and discussion groups to address transgender-related issues. These efforts created a supportive workplace, and the employee reported feeling more accepted (see https://lgbtforum.org/index).

What role can psychology professionals play in helping organisations achieve high SAWEI scores and creating affirming workplaces for TGDNB employees?

Case study 2:

The following is based on a case study discussed in Nel et al. (2024).

Bongani, an intersex woman who underwent gender assignment surgery aligning with her female sex characteristics soon after birth, works in a physically demanding factory role. Despite her muscular frame, her gender identity is female, and she is comfortable with her assigned gender. Her employer recently introduced output-based bonuses, causing colleagues to question her perceived advantage in physical tasks. This raises concerns about potential discrimination. Psychology professionals should consider how to support Bongani's right to non-discrimination and bodily autonomy, advocating for objective performance assessments and fostering a workplace culture of equality, beyond just physical output.

GUIDELINE 3: Uphold individual self-determination

Psychology professionals prioritise and privilege individual self-determination, support sexually and gender-diverse individuals' decisions around self-disclosure, affirm their diverse identities, and help them navigate socio-cultural and systemic challenges.

Key points

- Upholding self-determination is a core ethical responsibility, requiring ongoing informed consent, confidentiality, and continuous self-assessment to respect clients' rights and autonomy.
- Using inclusive language and respecting clients' pronouns are essential for affirming identities and building trust. Avoid misgendering and exclusionary practices in all communications.
- Supporting clients in accessing gender-affirming care, including providing informed consent and referrals, is key to enabling educated decisions about their health.
- 'Coming out' is a personal process that may occur multiple times in different contexts. Professionals should assist clients in navigating the exhausting challenge of balancing authenticity with physical and emotional safety, especially for those who do not immediately 'read' as LGBTQIA+.
- The expanding LGBTQIA+ acronym highlights the importance of inclusivity and self-expression, representing a wide range of identities within the community.

Rationale

Self-determination is key to human dignity, enabling individuals to live authentically and to make decisions aligned with their true identities. For LGBTQIA+ individuals, this includes the freedom to express their SOGIESC without fear of marginalisation. Psychology professionals must protect this autonomy and dismantle heterosexist, cisgenderist, and monosexist norms, ensuring safe spaces for LGBTQIA+ people to navigate their lives (Allen et al., 2024; Clements, 2023; Slayton, 2023).

Socio-economic and cultural barriers, including poverty, limited access to affirming healthcare, and cultural or religious opposition to non-normative identities, however often prevent LGBTQIA+ individuals in South Africa from fully realising self-determination. Intersectional discrimination further complicates this, with many facing compounded marginalisation due to race, gender identity, and class (Cruz, 2021). These challenges are particularly severe for black African LGBTQIA+ individuals in rural areas, where economic marginalisation limits access to essential resources, such as education and employment (Luvo & Kang'ethe, 2023; Slayton, 2023). Effective policy development is needed to address these barriers and promote inclusive environments that protect LGBTQIA+ rights (Daly, 2022).

Access to healthcare remains a significant challenge, as LGBTQIA+ individuals often experience discrimination within healthcare settings. Cultural and religious opposition compounds these difficulties, with entrenched norms often resulting in social ostracism and even violence (Ayoub & Stoeckl, 2024). These forces perpetuate harmful stereotypes and make it difficult for individuals to assert their autonomy (Ayhan et al., 2020; Meer et al., 2017).

The decision to disclose one's SOGIESC is deeply personal, and requires repeated navigation across different contexts. 'Coming out' is not a singular milestone but an ongoing process shaped by risks, benefits, and the need for safety (Kekana & Dietrich, 2020; Shabalala et al., 2023). As Harrison (2019) poignantly notes, "to be visibly queer is to choose your happiness over your safety". The expectation to come out can privilege hetero-cisnormative frameworks that do not require such disclosure (Khuzwayo, 2021). In many African cultural contexts, for instance, same-sex relationships and diverse gender identities are discreetly integrated into social structures without explicit declaration, challenging the Western notion that visibility is essential for LGBTQIA+ emancipation (Gyamerah et al., 2019; Morgan & Wieringa, 2005). While research shows that disclosing one's SOGIESC in supportive environments could improve mental health (Lindqvist et al., 2021; Tan et al., 2020), it is important to recognise that not being out in all contexts does not automatically equate to poorer mental health (Pachankis et al., 2015).

Self-determination is vital for LGBTQIA+ asylum seekers in South Africa, who flee violence and persecution in their home countries (Beetar, 2016; Camminga, 2020; Gevisser, 2020; Luvo & Kang'ethe, 2023). Under draconian laws, for example the Ugandan Anti-Homosexuality Act of 2023, many face the dilemma of seeking conversion practices to avoid persecution, highlighting the complex situations they navigate to secure wellbeing and autonomy. While this may initially appear to be an exercise of self-determination, research has consistently shown that so-called 'conversion therapy' and similar practices are harmful and ineffective (Bosire, 2023; Haldeman, 2024; Kinitz & Salway, 2022; Outright International, 2019, 2023, 2024). This presents an ethical dilemma for psychology professionals, who must navigate the tension between respecting a client's autonomy and protecting them from interventions that could cause harm.

For TGDNB individuals, social transitioning (e.g. changing names or pronouns) is an important aspect of self-determination, although not all choose to transition socially or medically. The concept of being "trans enough" marginalises those who defy binary norms or opt out of medical transitions (Sutherland, 2023, p. 1). Psychology professionals must recognise the pressures of transnormativity and support individuals' choices in their gender expression (Bell, 2023; Hendriks, 2023).

Sexually and gender-diverse individuals enhance self-determination through identity terms that serve as broad categories or nuanced descriptors. While these categories can help embrace diverse identities, the categories may also feel limiting to those who prefer not to use labels. The expanded LGBTQIA+ acronym

aims to inclusively represent various sexual orientations, gender identities, and differences in sex development (DSD), balancing individual differences with advocacy needs. Although some critics find the length of the LGBTQIA+ acronym confusing, supporters view the acronym essential for inclusivity and self-determination, breaking down rigid categories, and fostering acceptance (Kinitz & Salway, 2022; Lindqvist et al., 2021). Non-binary identities, such as genderqueer, agender, and genderfluid, move beyond the traditional male–female binary. For example, a 'non-binary-trans-masc' individual may use pronouns, such as he/him/they/them to signify a fluid identity.

Self-determination is not a solitary endeavour, but is nurtured through relationships and community engagement. The concept of 'becoming-with' illustrates that identity formation is a collaborative process, continuously shaped and reshaped through interactions with others (Garner, 2014). Rather than viewing identity as fixed or solely individual, 'becoming-with' highlights how individuals and their communities co-create identities, influencing each other's experiences, values, and sense of self. This perspective disrupts rigid categories of identity, allowing for more fluid, dynamic understandings of selfhood, fostering a sense of belonging and supporting self-determination (Levitt, 2019). Asexual individuals often face epistemic injustice and social exclusion; hence, finding or forming communities where their identities are understood and validated is invaluable (Cuthbert, 2022; Kelleher et al., 2023). Guideline 8 addresses the importance of diverse family structures and broader community ties, complementing the current discussion by acknowledging the role these connections play in fostering identity and belonging.

Engaging in cultural and spiritual practices that affirm identities is another vital aspect of self-determination. This can involve participation in LGBTQIA+ events, forming chosen families, or integrating identities into religious traditions in affirming ways (Meer et al., 2017). By speaking out against discrimination, lobbying for policy change, and participating in grassroots movements, individuals assert their agency and advocate for the rights and dignity of themselves and others (Christensen, 2020; Hendricks & Testa, 2012; Mulaudzi, 2023).

Application

Psychology professionals must recognise and dismantle barriers to self-determination to promote the wellbeing of sexually and gender-diverse individuals. Systemic challenges, such as discrimination, stigma, and legal constraints, require practitioners to advocate for clients' rights and to navigate socio-cultural dynamics to facilitate self-determination. This involves cultural humility, political consciousness, and challenging discriminatory practices within healthcare systems to create more inclusive environments that extend beyond individual interactions (Imazumi-Hegarty, 2021; Shabalala & Campbell, 2023).

Ethical responsibilities, including informed consent, confidentiality, and advocacy for service users, patients, clients, and colleagues, are critical for psychology professionals. By maintaining ethical decision-making and continuous self-assessment, practitioners address complex dilemmas with integrity and compassion.

Using correct pronouns provides gender affirmation, fosters trust, and indicates a safe environment. Misgendering, whether in personal interactions or within institutional settings, can be disrespectful and invalidating, particularly when health systems disregard gender identity. For example, assigning trans women to 'male' wards highlights issues of sexual segregation rooted in gender essentialism. Inclusive language should be used on intake forms, documents, and communications, offering options for self-identification. Avoid using 'preferred pronouns' as this implies that using the correct pronouns is optional. Professionals should also offer their own pronouns to normalise the practice and foster an affirming environment. See Appendix VII: Sample inclusive client Intake Form.

Table 1. Examples of English pronouns commonly used in South Africa

Pronouns	Subject	Object	Possessive adjective	Possessive pronoun	Reflexive
She/Her	She	Her	Her	Hers	Herself
He/Him	He	Him	His	His	Himself
They/ Them	They	Them	Their	Theirs	Themselves

Providing access to gender-affirming care, such as hormone therapy or surgeries, and making appropriate referrals are essential aspects of supporting self-determination. An informed consent model allows individuals to make educated decisions about their care (Coleman et al., 2012; Tomson et al., 2021). Psychologists now act as allies rather than gatekeepers, focusing on evaluation and support rather than mandatory therapy before treatment. This approach is endorsed by the WPATH and the APA, enabling shared decision-making on treatment options (APA, 2015; Coleman et al., 2012).

In South Africa, the Alteration of Sex Description and Sex Status Act (No. 49 of 2003) (RSA, 2003) still mandates gender-affirming interventions for legal gender recognition, reflecting gender essentialism within state structures (Shabalala et al., 2023). Affirmative practitioners advocate for dismantling legal requirements that reinforce binary assumptions. The Legal Resources Centre's Legal Gender Recognition Guide offers practical support for navigating bureaucratic processes, enabling individuals to affirm their gender identity legally (Legal Resources Centre [LRC], 2020).

Affirming psychological practice requires understanding that 'coming out' is not a one-size-fits-all experience, but a complex process that requires navigating various contexts, and may not always be safe or desirable (Freese et al., 2017; Wilks et al., 2022). Different identity management strategies include navigating visibility through varying degrees of disclosure, such as choosing to be 'implicitly out,' 'explicitly out,' or managing how individuals present their identity in different contexts. These strategies are influenced by personal beliefs and the external environment, recognising that different situations may require adaptive approaches to ensure safety and wellbeing (Holman et al., 2021; Kennedy, 2022; Lopes & Jaspal, 2024; Pham, 2024; Taube & Mussap, 2024). In many societies, notions of individual agency are intertwined with family and community, requiring careful navigation of potential tensions (Matsúmunyane & Hlalele, 2022; Seely, 2020).

Professionals can help by connecting individuals to communities and organisations that meet their needs, or which support local initiatives that promote inclusivity. Schools, for instance, can implement anti-bullying programmes addressing homo-, bi-, trans-, and xenophobia, to challenge hetero-cisnormative norms and provide support for immigrant sexually and gender-diverse learners who experience multiple layers of discrimination.

Professionals can support sexually and gender-diverse individuals in forming and maintaining relationships that honour their authentic selves by validating non-traditional relationship structures. For example, a therapist might work with a client in a polyamorous relationship to develop communication strategies that ensure all partners feel heard and respected.

Psychology professionals should seek to counter internalised shame and stigma, and promote resilience. For example, a therapist working with a bisexual client who feels invalidated by both heterosexual and queer communities could help them recognise the legitimacy of their identity (Freese et al., 2017; Jen, 2019; Wilks et al., 2022).

Transitions in gender identity may occur more than once as individuals' understanding of their gender evolves, reflecting the natural variability and personal growth in their gender journeys. It is important to acknowledge and support the diversity and fluidity of gender identities, recognising that changes in gender expression or identity are legitimate aspects of self-discovery.

Psychology professionals may encounter challenges in balancing respect for client values and self-determination with the need to act affirmatively and ethically, particularly when a client expresses a desire to conform to normative ideals by changing or denying their SOGIE. Declining conversion practices does not mean disregarding the client's right to self-determination. Guideline 10 discusses this in more detail.

Sexually and gender-diverse asylum seekers face unique challenges, compounded by xenophobia, upon arriving in South Africa. Psychology professionals must advocate for inclusive policies and support systems that respect the self-determination of these individuals. This includes supporting asylum seekers in navigating the legal and social services systems, promoting culturally sensitive and trauma-informed care, and fostering environments where they can safely express their identities while mitigating the effects of xenophobia. Organisations such as People against Suffering, Oppression and Poverty (PASSOP), the Triangle Project, the Centre for the Study of Violence and Reconciliation (CSVR), the LRC, and Gender Dynamix offer valuable resources.

Case studies

Case study 1:

Zintle, a non-binary trans-femme individual in a polycule relationship with shared custody of an adopted child, encounters a research questionnaire with limited options for sex, gender, orientation, relationship status, and family configuration. These options fail to represent Zintle's identity and family structure, leading to feelings of exclusion. Due to the lack of representative options, Zintle decides to withdraw from the study. Their withdrawal underscores a significant gap in the study design, leading to findings that inadvertently exclude sexually and gender-diverse people. This highlights the critical importance of designing research with inclusivity in mind to avoid skewing results and perpetuating erasure and invisibility of marginalised groups.

Case study 2:

John and Mark, a young gay couple with intellectual disabilities (ID) in a supportive community, aspire to marry, facing scepticism from carers and refusal from John's father, who holds legal guardianship. This case emphasises the conflict between safeguarding individuals with ID and championing their self-determination. It calls for enhanced advocacy and a supportive legal framework to navigate legal and financial obstacles, advocating for accessible legal information on marital rights and regimes, such as civil unions, customary marriages and antenuptial agreements, which govern the rights and responsibilities between spouses. Providing inclusive decision-making support empowers people to assert their rights and dignity.

GUIDELINE 4: Recognise normative social contexts

Psychology professionals understand the evolving nature of normativity and the unique challenges faced by sexually and gender-diverse individuals within various normative pressures (e.g. heteronormativity, homonormativity, cisnormativity). This understanding must go beyond mere acknowledgement, encompassing how these norms shape societal attitudes, behaviours, and institutional structures.

Key points

- Psychology professionals need to grasp the challenges faced by sexually and gender-diverse individuals due to societal norms, particularly hetero-cisnormativity.
- Hetero-cisnormativity privileges heterosexual and cisgender identities while marginalising sexually and gender-diverse individuals. It also restricts cisgender heterosexual people by limiting emotional expression and reinforcing restrictive social norms.
- Despite progressive laws, South Africa grapples with conservative beliefs affecting marginalised groups across various domains.
- Homonormativity normalises a limited range of sexual and gender diversity even within gay or lesbian communities, potentially excluding and marginalising queer individuals who deviate from dominant socio-homo norms.
- Psychology professionals are pivotal in creating inclusive environments through therapy, research, advocacy, and all other domains of professional practice.
- Advocating for policy reforms and challenging hetero-cisnormative standards is crucial for promoting inclusivity and equality.

Rationale

'Normativity' refers to the process by which social institutions and practices establish and reinforce certain standards within society, dictating how individuals should behave, think, and identify. These norms shape our understanding of what is considered 'normal' or acceptable, often manifesting in discursive forms, such as social norms, cultural practices, institutional policies, and legal regulations (Francis, 2023; Vilakazi & Mkhize, 2020).

In the context of sex and gender, for instance, normativity often privileges heterosexuality and cisgender identities, a phenomenon known as hetero-cisnormativity. Rather than viewing normativity solely as a regulatory force, it can also be the default or preferred human condition, operating in tandem. Most people uphold conventional heterosexual gender norms and values, while simultaneously disregarding non-heterosexual and non-cisgender identities and practices (Madlala, 2023). This ideology is rooted in several assumptions, such as the binary perspective of gender, which asserts that only two distinct genders exist and that they invariably correspond with an individual's sex assigned at birth. We need to examine and challenge these prevailing standards critically. By doing so, we can foster an inclusive understanding and acceptance of diverse identities

and life experiences, moving towards a world where deviations from the prevailing norms are not judged, but rather embraced and valued.

Hetero- and cisnormativity reflects the societal assumption that heterosexuality and cisgender identities are superior. Moreover, it upholds the notion that only heterosexual attraction is deemed normal or natural. Hetero-cisnormativity moulds societies to endorse behaviours that adhere to these norms while penalising those that diverge. Although this primarily affects sexually and gender-diverse individuals by invalidating their identities, it also restricts the freedom of cisgender and heterosexual individuals. For instance, hetero-cisnormativity imposes rigid expectations about gender expression and relationship norms, such as monogamy and the desire for procreation, which may not align with everyone's personal experiences or desires. By being aware of and deconstructing these rigid norms, society can create a more inclusive environment that benefits everyone, fostering greater freedom for individuals to express their identities and relationships without the constraints of prescriptive norms. Additionally, hetero-cisnormativity extends beyond matters of sexuality to prescribe socially accepted masculine and feminine identities, thereby regulating both sexuality and gender (Francis, 2021; Mkhize & Mthembu, 2023; Vilakazi & Mkhize, 2020). Hetero-cisnormativity assumes that everyone is naturally attracted to the 'opposite' sex, identifies with the sex assigned at birth, and expresses their gender accordingly, often leading to a narrow and restrictive view of human diversity.

Cisgenderism, conversely, represents the cultural and systemic ideology that rejects, belittles, or pathologies self-identified gender identities that deviate from the sex assigned at birth, along with the ensuing behaviours, expressions, and communities. This ideology perpetuates the notion that cisgender identities and expressions hold greater value than TGDNB identities and expressions, establishing an inherent hierarchy of power and privilege. Cisgenderism is pervasive across various cultural institutions, including language and the legal system, thereby facilitating prejudice and discrimination against TGDNB communities (De Vries et al., 2020; Francis, 2023; Shabalala & Campbell, 2023).

In the South African context, despite progressive laws, there is a persistent disconnect between policy formulation and its practical implementation. Sexually and gender-diverse individuals are often viewed as inferior in contexts where hetero-cisnormative beliefs prevail, receiving limited social recognition and affirmation (Maake et al., 2023; Madlala, 2023; Pillay, 2023). This marginalisation from mainstream society can negatively affect mental health, and is frequently internalised by individuals who may not realise that these are normative assumptions, and neither universal nor eternal 'truths'.

While heteronormativity and cisnormativity are pivotal in shaping sexual and gender identities and expressions, homonormativity has emerged as another significant ideological framework affecting behaviours related to sexuality and gender (Duggan, 2020; Madlala, 2023). 'Homonormativity' refers to how some

LGBTQIA+ communities create and establish their own norms and practices. While these practices may not always be based on hetero-cisnormative assumptions, they frequently end up resembling them (Mowlabocus, 2021). Fundamentally, homonormativity operates to legitimise or normalise queer, LGBTQIA+ identities within a predominantly hetero-cisnormative society by aligning same-sex relationships and practices with the values of hetero-cisnormativity (Madlala, 2023). This may include monogamy (thus prioritising long-term exclusive romantic relationships) pursuing legally recognised unions that often come with the social and economic benefits of heterosexual marriages, and reproduction. These behaviours reflect mainstream societal values and can help boost social acceptance within a hetero-cisnormative society. This alignment may however also reinforce existing power dynamics and relegate LGBTQIA+ individuals who do not conform to these norms (Nel et al., 2025).

Homonormativity often mirrors hetero-cisnormative characteristics, favouring individuals whose identities closely align with dominant socio-homo norms. This phenomenon is a product of the hetero-cisnormative system into which we are socialised, reflecting the degree to which internalised shame, along with homo-, bi-, and transphobia, can shape interactions within diverse communities. Mainstream hetero-cisnormative cultures typically value ideals of hegemonic masculinity, which include youth, muscularity, athleticism, wealth, and whiteness (Nguyen, 2023; Rothman, 2022). Consequently, a spectrum of individuals – including those who are of advanced age, economically disadvantaged, black African, disabled, or overweight, as well as those embodying diverse queer cultural identities – often encounter exclusion within homonormative environments. These environments, which prioritise conventional socio-homo norms, typically obscure the rich heterogeneity of the LGBTQIA+ community, thereby reinforcing a monolithic view of LGBTQIA+ experiences (Nguyen, 2023; Ubisi, 2021a). Additionally, religion and traditional cultural beliefs can further exacerbate this exclusion, often fuelling contention and stigma.

As societal norms evolve, new normativities, such as trans-normativity, mono-normativity, and able-normativity, will continue to emerge. While these norms may reflect changing values, they can also create new forms of exclusion or privilege. For example, trans-normativity might prioritise certain transgender experiences, while mono-normativity may overlook non-monogamous relationships. Practitioners must remain critically aware of how these evolving constructs shape lived experiences, recognising both the potential of the constructs to promote inclusivity and their capacity to reinforce exclusion. By staying informed, practitioners can better support the diverse identities and experiences within an ever-changing social landscape.

Lastly, in many societies, cis-heterosexual individuals are inherently granted certain rights and privileges simply by virtue of living in a hetero-cisnormative environment. Unlike their sexually and gender-diverse counterparts, cis-heterosexual individuals rarely face interrogation about their sexual and gender identity. Those who identify as same-sex attracted, transgender, bisexual, or intersex often experi-

ence shame and misunderstanding due to external stigma in a hetero-cisnormative society (Brown, 2018; Mkhize & Mthembu, 2023; Ngidi et al., 2020). This external stigma could lead to the development of negative self-beliefs, particularly during the early stages of coming out (Victor & Nel, 2016). These negative self-perceptions often manifest as internalised stigma or oppression, commonly referred to as 'internalised homo-, bi-, or transphobia'. Moreover, this internalised shame is frequently compounded by ongoing non-acceptance from significant individuals in the lives of sexually and gender-diverse individuals (Peltzer & Pengpid, 2019).

Application

Psychology professionals have to recognise and understand the privilege inherently associated with being heterosexual, cisgender, and conforming to societal norms regarding sex and gender. This privilege includes automatic validation of one's identity, easier access to legal and social recognition, and greater protection from discrimination or violence. Additionally, it is crucial to acknowledge the power dynamics and hierarchies that reinforce these privileges, often at the expense of sexually and gender-diverse individuals. This awareness is essential in therapeutic settings, research, and all other areas of professional practice, enabling the creation of inclusive environments where all service users, patients, clients, students, colleagues, and research participants feel validated and respected. By embracing this understanding, professionals can actively work to dismantle systemic barriers that perpetuate hetero-cisnormativity and foster inclusivity in their practice and research endeavours.

In healthcare settings, evaluations often prioritise heterosexual and cisgender individuals while overlooking the needs of sexually and gender-diverse people. This issue extends to service users, patients, clients, students, colleagues, research participants, and user-survivors of mental health systems. Despite increased awareness of LGBTQIA+ issues, forms and mental health interviews frequently overlook these needs, assuming heterosexuality and cisgenderism and reinforcing hetero-cisnormative assumptions (De Vries et al., 2020; Pillay et al., 2022; Shabalala & Campbell, 2023).

Similarly, hetero-cisnormativity is deeply embedded in educational curricula across schools and tertiary institutions, where traditional gender roles and opposite-sex relationships are often promoted as the norm (Bhana, 2022; Francis, 2023). From a young age, children are exposed to cultural biases that favour men over women, and opposite-sex relationships over same-gender ones, while reinforcing harmful stereotypes about TGDNB individuals. This perpetuates a heteronormative model that excludes diverse gender identities, and promotes the traditional family unit of a mother and father with biological offspring as the only valid model. Terms, such as 'family' and 'marriage', typically imply heterosexual unions, excluding same-sex and non-binary families. Additionally, societal expectations around masculinity, such as the pressure for men to be strong and to suppress emotions, further harm mental and psychological wellbeing, particularly for sexually and gender-diverse individuals, who may face increased stress and reluctance to seek support.

In therapeutic settings, employing affirmative practice techniques is critical for establishing rapport and building trust, particularly with clients who identify as sexually and gender-diverse. Sensitivity to the struggles faced by these individuals due to societal hetero-cisnormativity and the effect of homonormativity is crucial, as it enables professionals to provide effective support tailored to their unique experiences. Additionally, psychology professionals must be attuned to the dynamics present in trans–cis couples during counselling sessions, allowing individuals and couples to define their identities and relationship dynamics autonomously (see Guideline 3).

Beyond therapy, psychology professionals play a key role in advocating for policies that support sexual and gender diversity across healthcare, education, and workplaces. This includes conducting research to raise awareness of LGBTQIA+ challenges and inform policies that enhance care and support. By challenging hetero-cisnormative standards and promoting inclusivity, psychology professionals could contribute to creating more inclusive environments and advancing social justice and equality for all, regardless of SOGIESC.

Case studies

Case study 1:

Anna, a 35-year-old woman, attends regular get-togethers organised by a local lesbian social group. Despite her involvement, Anna feels excluded within the group, where most members conform to traditional gender roles and expression. As a butch lesbian, Anna stands out with her rather masculine appearance. She finds herself overlooked or dismissed, feeling her identity is not fully embraced. Anna feels pressure to conform to narrow femininity standards for acceptance, leading to anxiety, alienation, and self-doubt. This diminishes her sense of belonging and wellbeing in a space she hoped would be affirming. Her experience highlights the harmful effects of homonormativity within LGBTQIA+ communities.

Case study 2:

Jamal, a queer inmate, faces psychological conflict as he navigates the coercive dynamics of same-sex relationships in correctional facilities. Already grappling with his changing identity within the confines of prison, Jamal is further burdened by the expectation to conform to heteronormative roles imposed by 'carceral marriages'. Forced into a position of submission, Jamal experiences a sense of betrayal to his authentic self. The pressure to perform traditional gender roles exacerbates his feelings of alienation and disconnection from both the prison community and his own identity. The psychologist at the facility helps Jamal navigate these dynamics, while affirming his authentic identity. Additionally, during management meetings, the psychologist advocates for systemic changes in the prison environment to promote the wellbeing and sense of belonging for all queer individuals.

GUIDELINE 5: Understand 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 diversity; relationship or family choices; socio-economic status; race, culture, ethnicity, or language; age or life stage; disabilities or health status; neurodiversity; citizenship status; geographical location; faith, religion and spirituality; and other characteristics, experiences or positionalities.

Key points

- An affirmative stance includes an intersectional lens, because people embody a diverse matrix of identities, lived experiences, and structural positions.
- Not all LGBTQIA+ people will necessarily foreground their sexual or gender diversity, as other identities or axes of discrimination may be more important at a given time.
- Socially constructed identities are rooted in histories of colonialism, apartheid, and neoliberal capitalism, which continue to shape people's material and emotional worlds.
- The minority stress model provides a useful way of understanding how cumulative and intersecting risk factors lead to poorer health outcomes for LGBTQIA+ people.
- Practitioners use cultural humility to maintain an ongoing attitude of openness, curiosity, and active commitment to ongoing learning.

Rationale

All people embody diverse aspects of their identity, and it is useful to think about everyone as having a shifting matrix of identities that constitute a whole person. This 'matrix of identities' are about structural positions in society, based on people's lived experiences of discrimination, oppression, privilege, and socially constructed power dynamics. These structural positions include, but are not limited to:

- sexual orientation;
- gender identity, expression, and roles;
- biological diversity and sexual characteristics;
- relationship and family arrangements;
- socio-economic or employment status;
- race, culture, ethnicity, or language;
- age or life stage;
- physical, sensory, intellectual, cognitive, or psychosocial disabilities;
- health status, including mental illness;
- neurodiversity;
- citizenship status or homelessness;
- geographical location;
- faith, religion or spirituality; and
- personal life history.

Each person's identity positions vary, operate, and intersect distinctly; 'life stage' and 'race' are different life experiences, and will intersect in different ways. Rather than an additive model (the more minority statuses one has the more marginalised one is), intersectionality-informed formulations remind professionals that LGBTQIA+ people experience forms

of oppression qualitatively differently. For example, homophobia will be experienced differently by a black Muslim lesbian woman, a white atheist lesbian woman, and a gay intersex asylum-seeker. All have marginalised identities, but their experiences of the world differ based on access to social capital, power, privilege, and the histories associated with their identities. Psychology professionals therefore need to move beyond single-axis formulations of people towards a nuanced understanding of "interlocking structural oppression" (Bowleg et al., 2023, p. 4).

In psychology, the concept 'intersectionality', acknowledges that people's mental health is affected by intersecting axes of oppression, such as racism, ableism, heterosexism, cisgenderism, classism, and xenophobia, and these overlap and reinforce an unequal status quo. Intersectionality has been extensively theorised, and has six core themes: social inequality, social power, relationality, social context, complexity, and/or social justice (Crenshaw, 1989; Hill Collins, 2020). The concept is also foregrounded in other international guidelines (e.g. APA, 2021), and theoretically complements the minority stress model (Meyer, 2003; Mongelli et al., 2019) (see Guideline 1).

In some contexts, certain identities are advantageous and normative, and are therefore foregrounded. In other contexts, those identities might be distressing or dangerous and therefore downplayed. People are diverse, and an intersectional lens helps psychology professionals appreciate these complexities better. Consider the negotiation of identities for an openly bisexual black African woman who lives and works in a cosmopolitan urban area and speaks openly about her dating life to her multi-racial circle of middle-class friends – but who has to conceal numerous aspects of identity and experiences when visiting her biphobic parents and siblings in a rural village. In addition, despite hard work, she may also experience obstacles to her career progression. Evidence indicates that, even though women, in general, experience barriers in the workplace, white lesbian, bisexual and transgender (LBT) women in South Africa tend to experience more privilege than black[1] LBT women who "find themselves at the intersection of racist, classist, and heterosexist discrimination" (Isaacs et al., 2020, p. 77).

Consider also the Pride marches, which are global events to celebrate sexual and gender diversity. In South Africa, Pride events are sometimes marred by the way different LGBTQIA+ groups stigmatise and exclude others: such events are often more lesbian/gay(LG)-focused, excluding the 'BTQIA+'. Black activists have contended that Pride is racially exclusionary, has lost its political agenda, and is unable to represent their needs (Soldati-Kahimbaara & Sibeko, 2012). Sometimes these exclusions are articulated as being classed, not only raced. Responses from black queer communities to the white dominance (materially and symbolically) in gay venues and during Pride events have brought about the rise of township and inner-city spaces that are affirming of black queerness (Matebeni, 2017), such as Soweto

1 In the South African context, 'black' could refer to people who are of black African descent, or of Indian descent, or 'Coloured', i.e. historically of mixed race. 'Black' is a term with racial, ethnic, cultural, and political identity connotations, and is used differently in different contexts.

Pride. Practitioners must therefore be aware of the nuanced ways in which sources of support could also become sources of oppression.

What are the consequences of these negotiations on the wellbeing of the person concerned? How are globalised and localised aspects of oneself – specifically with regard to gender and sexuality – internally and externally negotiated in different contexts?

When using or producing research, psychology professionals should remain aware of how intersectionality is reflected in the research, because even South African LGBTQIA+ research tended to reflect the experiences of white, middle-class, urban men and, sometimes, white women (Gevisser & Cameron, 1995; Potgieter, 1997). Fortunately, more recent research is increasingly diverse and foregrounding intersectionality (Daniels et al., 2023; Luiz & Terziev, 2024; Ntombana et al., 2020; Pillay, 2022).

Application

Firstly, practitioners are urged to remain aware of the multiple intersecting identities of sexually and gender-diverse individuals. Practitioners should not assume that sexual and gender diversity is necessarily the most prominent aspect of identity for LGBTQIA+ people. During an initial interview for psychotherapy, for instance, a psychotherapist should not assume that sexuality or gender is going to be the focus of discussion, point of departure, or therapeutic concern for an LGBTQIA+ client.

Secondly, practitioners are urged to remain aware of the diversity of experiences amongst sexually and gender-diverse individuals. Practitioners should therefore remain informed of the diversities within LGBTQIA+ communities, and not assume that all LGBTQIA+ people have similar psychosocial experiences. A study on black African, Christian, lesbian women in Bloemfontein, demonstrated the complexity of how race, place, space, gender, sexuality, and heteropatriarchal religious institutions all intersect in the formation of "queer spiritualities" (Ntombana et al., 2020, p. 1). A study on LGB South Africans of Indian descent found that, despite experiences of discrimination by some participants, other participants felt optimistic that social attitudes are improving (Pillay, 2022). Bonthuys and Erlank's (2012, p. 269) study of attitudes of Muslim people in Johannesburg revealed that community attitudes to homosexuality "usually involve denial and secrecy in order to maintain the social fabric of daily life and relationships between community members". These studies reveal a range of experiences that differ based on contextual and cultural complexities.

Thirdly, professionals involved in research should disaggregate the data to reflect the experiences of specific communities more accurately. For example, a study may use the umbrella acronym 'LGBTI' but in reality, might have no substantial data on intersex people or bisexual people – or, in most instances, researchers ignore the fact that participants can be LGBTI and allosexual, or LGBTI and asexual. A trans man who is asexual will have different psychosocial experiences compared to a trans man who is sexually active and enjoys regular sex.

Fourthly, practitioners should remain cognisant of the enduring effects of apartheid and coloniality on the lives of sexually and gender-diverse individuals, due to which the lives of black Africans have been destabilised and dehumanised consistently. For centuries, racial discrimination has been manifesting itself in the enduring effects of colonialism, slavery, apartheid, and neo-liberal capitalism. Despite three decades of democracy since 1994, the social engineering of apartheid has left centuries of inequality intact. As a result, hetero-cisnormativity operates within a matrix of coloniality, normalising and reinforcing Euro-American values, attitudes, beliefs, behaviours, and cultural activities in society. Notwithstanding the historical documentation of fluid sexual practices in pre-colonial Africa and a greater acceptance for gender diversity in traditional African tribes (Bhugra et al., 2022; Epprecht, 2004; Murray & Roscoe, 1998), negative beliefs about LGBTQIA+ people continue to exist (Sutherland et al., 2016).

Colonial value systems can filter into 'queer-friendly' spaces to mirror the racial dynamics of the broader society. For example, Tucker (2009) demonstrates how Cape Town's queer-tourism district had nightclubs that historically admitted to having informal policies to exclude patrons of colour (Matebeni, 2017). This places black queer people in a precarious and isolated place. While black individuals might hope to find solidarity in a social community of fellow sexually and gender-diverse people, this might not occur if the space is predominantly white or skewed toward whiteness in its value systems, practices, and expectations. Moreover, should black individuals find solidarity amongst their black peers and community in the fight against racism, they might experience alienation and discrimination in the fight against homo-, bi-, or transphobia. Caught between two communities where a sense of belonging is conditional and premised on impossible demands, black LGBTQIA+ individuals may experience significant minority stress.

Lastly, practitioners should use cultural humility as a tool when working with cultures and lived experiences different from their own. Cultural humility is a lifelong commitment to self-evaluation and self-criticism in order to address the potential power imbalances between practitioners and the culturally diverse people with whom they work (Tervalon & Murray-Garcia, 1998). The process of working with culturally diverse individuals or groups requires a multicultural orientation that includes cultural competency training (Yu et al., 2023). Further, it requires an ongoing, active, aspirational process of assessing one's attitudes, knowledge, and skills to improve one's ability to work with diversity (Koch et al., 2020; Sue & Sue, 2013; Tervalon & Murray-Garcia, 1998). Cultural safety may also be a relevant concept in this regard (Reynolds, 2020).

Unlike cultural competency, a commitment to cultural humility ensures that expertise is never finite or complete, and that ongoing reflective practice is expected (see guidelines 11 and 12). Similarly, this is what DasGupta (2008, p. 980) calls "narrative humility". For example, reflecting on his experiences of being an insider-researcher during a study on queer South African men of Indian descent, Pillay (2023,

p. 13) avoided making too many assumptions about his participants, despite him sharing overlapping identities with them, because his own identity was mediated by a range of intersectional factors. These include "middle-classness, suburban geospatial location, supportive family, stable relationship status, professional identity, and access to social capital". He concludes, "being an insider is therefore not apolitical, and formulations of queer subgroups, however familiar, must avoid homogenization" (Pillay, 2023, p. 405 - 406).

As Rothblum (2012, p. 268) urges, "we must view our users/clients/participants, friends, neighbours, co-workers – as well as ourselves – as forming multiple, interlocking dimensions, each one adding colours, shades and hues to a rainbow tapestry".

Case studies

Case study 1:

Gender empowerment interventions in organisations can sometimes fail to affirm gender diversity in an intersectional manner. Ndzwayiba and Steyn (2018) researched gender transformation initiatives across the healthcare, retail, and financial sectors in South Africa. They found that gender continues to be insularly defined as a male–female binary. Gender empowerment strategies ignores complex intersections of power and privilege by ironically erasing gender complexity, even amongst black African women who are viewed as a homogeneous social group. The focus on cisgender and heterosexual women, to the exclusion of gender-diverse people, entrenches heteropatriarchy and hetero-cisnormativity under the guise of 'gender empowerment'. Which strategies would you recommend to an organisation wanting to do better in future?

Case study 2:

In a study exploring the experiences of ageing and care among elderly LGBT individuals, one participant, Diane, from Gauteng, articulated her refusal to become invisible:

Well, for me of course it's intersectional. I'm black, I'm a woman, I'm disabled, I'm a lesbian, shit I'm vegetarian! … So, I don't feel invisible. I insist on ageing not being invisible because if I'm invisible, I am causing a great disservice to everyone else who comes after me with the same set of intersections (Reygan et al., 2022, p. 71).

How do psychosocial services ensure that older people remain 'seen' in their full complexity?

Case study 3:

Lethabo, a black African lesbian woman living with bipolar disorder, has recently been released from prison after serving a sentence for the murder of her uncle, who had sexually abused her since childhood. Without employment to support herself, she was released to the care of her distant family. Unfortunately, Lethabo experienced discrimination from her family, further exacerbating her mental condition. Eventually, she decided to seek mental health services from her local clinic. Guideline 5 emphasises the importance for psychologists working with Lethabo to recognise the intersecting discriminations she faced, which compounded to worsen her mental health.

GUIDELINE 6: Counteract stigma, prejudice, and violence

Psychology professionals understand stigma, prejudice, discrimination, and violence, and the potential detrimental effect of these factors on the mental health and wellbeing of sexually and gender-diverse persons and communities.

Key points

- Psychology professionals should recognise the importance of choice and a menu of adaptable strategies and interventions to offer in addressing stigma, prejudice, and violence experienced by LGBTQIA+ individuals, including resilience-building techniques, strengthening coping mechanisms, and advocacy approaches.
- Psychology professionals should foster collaboration with LGBTQIA+ community organisations, advocacy groups, and support networks to understand the needs and priorities of these communities better; hence, enhancing intersectional and inclusive mental health services.
- Psychology professionals should integrate trauma-informed care principles into interventions for those experiencing stigma, prejudice, and violence, prioritising safety, trust, and empowerment.
- Psychology professionals should encourage research and programme evaluations to assess intervention effectiveness and acceptability for users to increase uptake, collecting data on outcomes, client satisfaction, and long-term effect in collaboration with the target user; participatory or human centred approaches are recommended to inform evidence-based practice and service improvement.
- Psychology professionals should address internalised oppression, pivotal to psychological issues in adolescence and adulthood, boosting self-esteem by supporting resistance to stereotypes, buffering against internalising stigma, and promoting positive role models by connecting clients with community organisations.
- Psychology professionals should create open and welcoming spaces that are not exclusionary in any way to assist LGBTQIA+ people to navigate and embrace their sexual desires, orientation, and/or gender identity and expression, even in oppressive socio-political environments.

Rationale

This Guideline is to be read closely with Guideline 2 (Non-discrimination), and Guideline 9 (Resilience).

Stigma, anticipated stigma, marginalisation, exclusion, discrimination, violence, and (hate) victimisation, also known as 'prejudice events' based on sexual and gender diversity (Alessi et al., 2013; Nel et al., 2025), persist in Africa with many countries imposing legal restrictions on certain sexual desires and behaviours (ILGA World, 2020).

In several countries, including Russia, the United States, Hungary, Kyrgyzstan, Indonesia, and Brazil, it has become politically expedient to scapegoat LGBTQIA+ persons and their relationships (Horne, 2020). Similarly, negative attitudes are increasingly expressed in some

African countries, such as Uganda, Cameroon, and Kenya, where same-sex sexuality is considered 'foreign' or 'unAfrican', and where cultural and religious condemnation abound (see, for instance, Cullinan, 2023). Arguably, tied in with the enduring effects of colonialism, and fuelled by right-wing religious organisations exporting Western 'culture wars', such as the use of moral panic (see, for instance, Titeca, 2024), Nigeria and Uganda passed stringent anti-homosexuality laws in recent years, with Ghana following suit in 2024. State-sanctioned and extrajudicial victimisation exacerbate social discrimination, leading some health providers to neglect the needs of sexually and gender-diverse individuals (Dramé et al., 2013), thereby hampering public health interventions, such as HIV prevention for men who have sex with men (MSM) or women who have sex with women (WSW). Notably, the effects extend to those whose gender identity and expression do not match their assigned gender, i.e. trans women who have sex with men.

Despite post-1994 legal remedies, such as the South African Constitution and PEPUDA (discussed in Guideline 2), LGBTQIA+ people in South Africa face ongoing adversity. Numerous South African studies have documented prejudicial events and their harmful effects (Arndt & Hewat, 2009; Academy of Science of South Africa [ASSAf], 2015; Breen et al., 2016; Judge, 2018; Judge & Nel, 2018; Marais et al., 2022; Müller & Daskilewicz, 2019; Nel & Judge, 2008; Nel & Mitchell, 2019; Padmanabhanunni & Edwards, 2013; Polders et al., 2008; Tshisa & Van der Walt, 2021).

Oppressive social environments and structural stigma (Hatzenbuehler, 2016) increase minority stress (Meyer, 2003), negatively affecting health and wellbeing, manifesting in increased vulnerability to depression, anxiety, and substance use (Koch et al., 2019; Marais et al., 2022; Müller & Daskilewicz, 2019; Polders et al., 2008). Minority stress, exacerbated by intersectional social discrimination, compounds when clients encounter prejudiced service providers in healthcare, criminal justice, home affairs, or other social service settings. Stigma or anticipated stigma in these service contexts not only diminishes support quality (Victor & Nel, 2016; Victor et al., 2014) but also deter individuals from seeking the necessary assistance (Arndt & Hewat 2009; Müller & Daskilewicz, 2019). For example, LGBTQIA+ survivors of violence encounter institutional discrimination and face obstacles in reporting hate crimes to law enforcement officials, potentially exacerbating prejudice and trauma (Human Rights Watch [HRW], 2011; Nel & Judge, 2008; Nel & Mitchell, 2019). Trans persons, for instance, face challenges altering their gender on legal documents due to discrimination by Home Affairs officials, resulting in legal and social complications (Gender Dynamix & LRC, 2014; Triangle Project, 2023). Impeded health-seeking behaviours contribute to poor health outcomes and a high burden of untreated conditions (Müller & Daskilewicz, 2019).

Recognising the harm caused by prejudice events, including hate speech, is crucial. Many jurisdictions, such as Canada, Germany, and the European Court of Human Rights, have enacted hate-crime laws and/or provisions to limit the dissemination of hate speech, emphasising diversity and human worth (Breen et al., 2016; Nel & Breen, 2013). These restrictions

aim to safeguard individuals' psychological integrity and prevent societal harm by countering messages of inferiority and hatred towards targeted groups. The recent passing of the South African Prevention and Combating of Hate Crimes and Hate Speech Act (No. 16 of 2023) promises additional measures of legal protection, relief, support, and respite for victims (Nel & Venter, 2024; RSA, 2023; Van Wyk & Nel, 2023).

An affirmative stance encourages practitioners to recognise and address homo-, bi-, and transphobia, heterosexism, heteropatriarchy, cis-normativity, and the effects of prejudice events on mental health. To promote wellbeing and social justice, practitioners should engage in stigma-reducing research and ensure access to healthcare and educational resources for sexually and gender-diverse communities historically labelled as 'criminal', 'sick', and 'sinners'. In doing so, cognisance is required of right-wing organising in various realms, such as schools and universities, that perpetuates and continues to normalise stigma, prejudice and intolerance (e.g. fear mongering about bathroom usage to override concerns for human rights, in general, and the vulnerabilities of many queer people) (Francis & McEwen, 2023). Notably, at times, science is co-opted in these contexts, and studies are misused to perpetuate political agendas.

Application

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

Research findings by Nel and Judge (2008) and by Nel and Mitchell (2019) indicate that openly expressing sexual and gender diversity often results in hate victimisation, escalating with LGBTQIA+ visibility. In South Africa, verbal and physical assaults against sexually and gender-diverse individuals are prevalent, often accompanied by hate speech (Judge & Nel, 2018). Discrimination extends to those challenging normative gender and sexual orders, regardless of sexual orientation or gender identity (Nel & Judge, 2008; Nel & Mitchell, 2019). The South African history of institutionalised discrimination during apartheid and colonialism (discussed in Guideline 5) contributes to ongoing prejudice and hate-based victimisation (Pieterse et al., 2018). In recognition of this, attention has focused on the targeting of TGDNB persons and black African lesbians, since the mid-2000s, especially in disadvantaged communities (Judge, 2018; Müller & Daskilewicz, 2019; Padmanabhanunni & Edwards, 2013). Targeting of particular LGBTQIA+ communities highlights the need for an intersectional understanding that recognises the simultaneous effect of race, socio-economic status, sexual orientation, and gender identity (Judge, 2018; Nel & Judge, 2008) (see Guideline 5).

Practitioners are encouraged to recognise the nature and extent of microaggressions, bullying, hate speech, and hate crimes experienced by sexually and gender-diverse people

Microaggressions take various forms, including nuanced ways in which full citizenship as a lived reality is hindered in public, institutional and private spaces in everyday life. For example, a lesbian woman going to the GP with her wife, and having the GP refer to her as "your friend", constitutes erasure as a microaggression. Microaggressions, including daily provocations, persistent bullying, deadnaming, and misgendering (Dayal, 2022; Nel & Mitchell, 2019), along with negative gossip (Carrim et al., 2024), are normalised in communities, targeting sexually and gender-diverse individuals for behaviours deemed socially unacceptable. South African schools exhibit high levels of homo-, bi-, and transphobia, resulting in frequent verbal and physical harassment, leaving many learners feeling unsafe (Bhana, 2012; Francis, 2021b; Msibi, 2012). In South Africa, 62% of sexually and gender-diverse respondents encountered negative jokes about their sexual orientation in school, with 37,1% experiencing verbal abuse, 15,6% reporting physical abuse, and nearly 8% suffering sexual abuse, particularly among black African persons (Nel & Judge, 2008). There have also been media reports on learners who died by suicide, purportedly due to being bullied because of their sexual orientation or gender identity (Mbatha, 2024; SASOP, 2024; Ubisi, 2021b). Family alienation exacerbates the harmful effects of discrimination, potentially obstructing cognitive and non-cognitive skill development and long-term educational achievement (Lee, 2014).

Research highlights widespread verbal abuse, harassment, and ridicule faced by sexually and gender-diverse persons in South Africa, contributing to a culture of hate speech and hate crimes (Breen et al., 2016; HRW, 2011; Nel & Breen, 2013). Verbal abuse and harassment increase vulnerability to depression, instil fear and shame, and inhibit access to public spaces and justice (Polders et al., 2008). Practitioners have to address experiences of anti-LGBTQIA+ violence and explore the influence of these on presenting issues.

Practitioners recognise and counteract the psychological effects of stigma, prejudice, discrimination, and violence on individuals and targeted groups or communities

The Academy of Science of South Africa [ASSAf] report (2015) underscores health challenges among sexually and gender-diverse individuals globally, including elevated sexually transmitted infection rates, mental illness, and suicide, largely stemming from societal discrimination. In Africa, socio-economic discrimination compounds these challenges, particularly among adolescents and young adults pressured to conform to gender norms.

Victims of hate experience anger, hopelessness, distrust, internalised oppression, shame, and loss of dignity and worth, leading to secrecy due to fear of further discrimination and violence and limiting their participation in society (Judge, 2018; Marais et al., 2022; Nel & Judge, 2008; Nel & Mitchell, 2019). Homophobic hate speech inflicts significant psychological harm (Judge & Nel, 2018), increasing vulnerability to depression (Polders et al., 2008). Minority

stress is associated with depressive symptoms (Metheny et al., 2022), underscoring the need for increased support. Notably, TGDNB people in South Africa disproportionately face daily barriers, discrimination, and hate victimisation and, in response, many resort to risky substance use and abuse (Müller & Daskilewicz, 2019; Tomson et al., 2021). Intersex persons, too, have a heightened vulnerability to social stigma, rejection, and victimisation. In some places, including rural South Africa, intersex neonates are considered a sign of witchcraft and a curse on families and communities (Behrens, 2020; Collison, 2018). Those who display DSD are thus at risk of significant harm at birth, but also over their life course, through neglect, abandonment, mutilation or even murder. For this reason, Behrens (2020) proposes ethical guidelines for intersex surgeries that consider these risks of harm.

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

Hate victimisation perpetuates societal divisions and exclusions by stigmatising identities and practices, fostering intolerance towards non-conforming behaviours (Nel & Breen, 2013). Homo-, bi-, and transphobic hate speech undermines human dignity and equality, central to the South African constitutional democracy, hindering participation in public life (Judge & Nel, 2018). Psychology professionals are instrumental in promoting wellbeing and social justice. Recognising the interconnectedness of human rights, health, and wellbeing, these professionals ought to advocate for policies safeguarding the rights of sexually and gender-diverse persons, and which protect them against discrimination and violence, while enhancing their health, economic contribution, and intergroup harmony in society (Nel, 2014). It is similarly crucial to recognise and address stigma within healthcare facilities and to conduct more research that challenges oppressive norms in such settings and which supports inclusive policy reform that benefits sexually and gender-diverse persons. Notably, stigma finds its way into all documents and even in 'well-meaning' approaches, e.g. MSM are at an increased risk of HIV infection. Pre-exposure prophylaxis (PrEP) therefore needs to be prioritised for this group, but to do so, they need to disclose this practice. Inadvertently, such an approach may traumatise people who seek healthcare.

Case studies follow on the next page.

Case studies

Case study 1:

In 2008, journalist Jon Qwelane published a homophobic article supporting Robert Mugabe's views on same-sex relationships, comparing them to bestiality, and advocating for a ban on same-sex marriages. This sparked legal action with the SAHRC, involving PsySSA as amicus as an expert witness on related psychological hurt and harm. In 2021, after a decade-long battle, the Constitutional Court ruled Qwelane's article as homophobic hate speech, clarifying freedom of expression boundaries. This landmark case, *Qwelane* v. *SAHRC*, marked a significant step in defining hate speech and protecting LGBTQIA+ rights (Judge & Nel, 2018; Van Wyk & Nel, 2023).

Case study 2:

In 2023, the retail store Woolworths ran a campaign in celebration of Pride Month, 'Be an Ally'. The campaign was met with bigotry and backlash from some customers, with calls to boycott Woolworths flooding social media platforms. What role could an in-house industrial or organisational psychologist play in making sense of this occurrence, and towards informing future related preventative strategies?

Case study 3:

Diana, a white, homeless woman, is brought to a Thuthuzela Care Centre suspected of sexual assault. Refusing medical examination, she recounts being assaulted by a police officer. Terrified, Diana shares her struggles, including unemployment and familial disapproval and rejection and pressure to accept her assigned gender. She reveals use of feminising hormones obtained on the illegal market and that her assault followed on discovery of her transgender identity. Facing threats of rape and death from her assailant, Diana seeks support but lacks resources for gender-affirming care. Diana's narrative underscores the urgent need for psychosocial support and resources for transgender persons in crisis in public health facilities.

GUIDELINE 7: Recognise multiple developmental pathways

Psychology professionals acknowledge the diverse and evolving sexual and gender developmental pathways that all people traverse from infancy through childhood, adolescence, adulthood, and into advanced age.

Key points

- Psychology professionals should recognise the diverse and evolving developmental pathways around sexual orientation and gender identity that individuals traverse throughout their lives, from infancy to advanced age.
- The development of sexuality and gender identity is influenced by a complex interplay of genetic, hormonal, environmental, social, and cultural factors. There is no single determinant of sexual orientation or gender identity.
- Providing supportive environments in person or online, including affirmative healthcare and educational settings, is crucial to improve mental health outcomes and help individuals explore and express their gender identity and sexual orientation safely.
- Sexually and gender-diverse individuals often face significant social stigma, discrimination, and psychological challenges. Professionals should be aware of these issues and work to create inclusive and non-pathologising language and practices. This includes understanding the unique challenges faced by older TGDNB individuals, who often experience higher rates of isolation and mental health issues than young individuals.
- Sexual orientation and gender identity are lifelong processes that may change and evolve over time. It is important to recognise the fluidity of these identities and the ongoing journey of self-discovery and identity formation that individuals may experience at different stages of their lives.
- Engage with LGBTQIA+ individuals in research and community efforts to co-design strategies that support de-stigmatisation and develop culturally appropriate practices and language for South Africans.

Rationale

Psychology professionals acknowledge that individuals experience successive developmental stages from birth until the end of life. This knowledge is a fundamental part of psychology education, originating from diverse and sometimes conflicting psychological schools of thought, such as Piaget's Cognitive Developmental Theory, Erikson's Psychosocial Developmental Theory, Vygotsky's Sociocultural Theory, Freud's Psychosexual Developmental Theory, and Bandura's Social Learning Theory, to name but a few. These theories commonly depict human development as a sequential series of stages. Literature on the development of sexuality and gender explores how SOGIESC and behaviour evolve from infancy through adulthood, integrating perspectives from biological, psychological, social, and cultural dimensions to understand the complex nature of human sexuality (see Kar et al., 2015).

Gender identity development

Gender development in a child begins at infancy, and advances progressively through childhood. Some perspectives suggest the process of gendering takes root before birth. Advances in medical technology allow the determination of a baby's gender before birth, leading expectant parents to prepare based on this knowledge. Practices such as gender reveal parties and naming and clothing the child according to societal norms could impose stress on families of children born with ambiguous genitalia or those who are intersex, pressuring them to conform to traditional gender binaries. This remains a stressor for all parents to monitor their children's gender, particularly those with TGDNB children.

Gender identity development is influenced by biological, cognitive and social factors as well as social scripts (Alanko et al., 2008). In early childhood, individuals are often socialised into cis-het values and norms, which are societal expectations based on the assumption that people are cisgender and heterosexual. This socialisation shapes people's understanding of binary gender identities, seeing gender strictly as male or female with distinct roles and behaviours. Certain individuals might become aware during childhood, adolescence, or adulthood that their gender identity does not fully align with their gender assigned at birth. Some experience their gender identity as fluid over time (Lev, 2004; McLachlan, 2010). The experience of questioning one's gender could create confusion, especially for those unfamiliar with the range of possible gender identities (Tomson et al., 2021). A lack of nuanced terminology could contribute to this confusion, leading some gender-diverse people to assume they must be cis-gender gay, lesbian, bisexual (Bockting et al., 2009).

Gender dysphoria, that is the distress caused by a discrepancy between a person's gender identity and their gender assigned at birth, could persist and worsen with physical changes during adolescence. The WPATH, however, argues that, for many, gender dysphoria does not persist, and they develop a cisgender identity (WPATH, 2011). Health professionals vary in their language, with some using terms such as 'gender incongruence of childhood' or 'gender dysphoria'. The priority should be to avoid language that pathologises nonconforming gender identities. Non-pathologising language, such as 'gender fluidity' or 'gender questioning', recognises gender diversity as a natural occurrence. Supportive environments significantly improve mental health outcomes. Social transitioning to explore and express one's gender and the use of puberty blockers may in some cases alleviate gender dysphoria.

Factors, such as socio-economic status, access to affirmative healthcare, societal attitudes, and safety, influence the experiences and expression of gender diversity (Tomson et al., 2021). The effect of gender dysphoria that persists into adulthood could lead to adverse effects on both the physical and mental health of individuals. Older TGDNB individuals face stigma, discrimination, and health disparities due to a lack of knowledgeable and affirming healthcare services (Holt et al., 2020). Social connectedness (also see Guideline 9) plays a crucial role in the mental health of adult and

older TGDNB people, while isolation and internalised transphobia decrease self-esteem and wellbeing (Fabbre et al., 2023). Healthcare providers are encouraged to understand the unique challenges faced by this group, including end-of-life care and the complexities introduced by intersecting identities, such as race and socio-economic status (Catlett et al., 2023).

Sexual orientation development

Research suggests that genetics, prenatal hormone levels, and brain structure influence sexual orientation and behaviour, but there is no single 'gay gene' (Bogaert & Skorska, 2020). Instead, sexual orientation results from a complex interplay of genetic, hormonal, and environmental factors. Social and cultural influences – societal norms, cultural beliefs, family dynamics, peer interactions, homo-, bi-, and transphobia, politics, and media exposure – also shape sexual attitudes, behaviours, and gender identity formation (Li & Leander, 2022; Parmenter et al., 2022). Cognitive theories emphasise the importance of individual thought processes, learning, and emotional maturity in developing sexual and gender identity. Understanding of sexual orientation (attraction to the same sex, opposite sex, both, or neither) and sexual identity (how individuals perceive and label their sexuality) has evolved significantly, recognising the fluidity of sexual orientation beyond traditional categories (Katz-Wise & Todd, 2022). Development of sexuality is a lifelong process that may change and evolve over time, with adolescence being critical for sexual identity formation but continuing into adulthood and beyond due to its fluidity (Katz-Wise & Todd, 2022).

Sexual orientation is not a choice but an inherent part of an individual's makeup (ASSAf, 2015; Zhang et al., 2023). Despite societal beliefs, there is no empirical evidence suggesting that sexual orientation can be acquired through interaction with sexually and gender-diverse individuals (ASSAf, 2015). Research indicates a significant potential biological basis for the development of sexual orientation, although the extent to which any individual can become self-aware about and express their sexual orientation may be constrained in particular social and cultural contexts (Hall et al., 2021). Dominant social norms regulate expressions of sexual orientation, and people often face social exclusion and discrimination for diverging from these norms, which could lead to significant harm, such as anti-lesbian or anti-gay rape (sometimes referred to as so-called 'corrective rape') (Gaitho, 2021). The expression of sexual orientation is influenced by social and cultural systems as well as personal agency (Msweli, 2020). Sexually diverse youth navigate adolescent challenges alongside a marginalised sexual identity, often lacking support from their family, the community, and society (Richter et al., 2017). They struggle with self-acceptance, bullying – including cyber or online bullying – and social stigma, contributing to high rates of mental health issues (Gold et al., 2007; Newcomb & Mustanski, 2010; Richter et al., 2017). Conversely, as also discussed in Guideline 9, supportive and/or affirming environments may enhance psychosocial wellbeing (Hall et al., 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

The process of developing a sexual identity related to same-sex attraction is iterative and dynamic, encompassing self-identification and assimilation into a collective identity. These processes interact but not always at the same pace (Coetzee, 2009). Frameworks have to adopt a respectful and flexible approach toward individual identity narratives, avoiding oversimplified categorisations (Page, 2007). Identities such as 'gay' may resonate differently across socio-economic contexts, suggesting the importance of understanding cultural landscapes (Leatt & Hendricks, 2005). It is also worth noting that identities may be expressed differently, and might mean different things – even in similar socio-economic contexts.

Without essentialising race and culture, research indicates that racial and cultural intersectionalities play a crucial role in defining sexual orientation (Leatt & Hendricks, 2005; Msweli, 2020). For example, in some communities, same-sex sexual practices might not influence identity formation, as seen in men who have sex with men and women (MSMW) (Msweli, 2020). Sexually and gender-diverse individuals may face issues such as a lack of supportive healthcare, potential isolation, and a lack of caregiving concerns, especially if estranged from biological family members (Fredriksen-Goldsen et al., 2011).

Application

Psychology professionals should assist clients in differentiating between sex, gender identity, and sexual orientation, highlighting the harm of strict gender norms, and providing information about SOGIESC. Normalising each individual's unique pathway in the development of their sex, gender identity, and sexual orientation is crucial, recognising that these identities might change over time (Katz-Wise & Todd, 2022).

Educational institutions can be both obstacles and opportunities for young sexually and gender-diverse people during their development. Addressing hetero-cisnormativity and queerphobia in the school system is essential, and educational institutions have a responsibility to manage discrimination and improve safety for all learners (Francis & Msibi, 2011; Msibi, 2012). Comprehensive sexual education promotes healthy sexual development and informed decision-making.

Psychology professionals should consider the historical and current social, political, and cultural contexts of the life stage of the service user, patient, client, student, colleague, and/or research participant, as well as parental, partner, and other social support. They should discuss different developmental models of gender identity and sexual orientation development, making it clear that these are not fixed but useful for understanding of these key concepts. Various models exist, each with criticism that need to be taken into account (Robertson & Louw, 2013). Professionals should recognise that individuals in relationships might identify their orientations differently, and be sensitive to the effect of stigma, prejudice, discrimination, and violence on the developmental health of sexually and gender-diverse people. Professionals should seek up-to-date information and resources to support service users, patients, clients, students, colleagues, and/or research participants effectively.

Case studies:

Case study 1:

Imagine you are a researcher in a longitudinal study investigating the development of sexual orientation, and your team faces challenges in capturing the complexity of multiple developmental pathways. Traditional measures typically focus on a narrow understanding of sexual orientation, limited to a binary framework of heterosexual or homosexual identities, failing to account for the diverse experiences of individuals whose sexual orientation might evolve over time, change, or manifest differently across contexts. You suggest using a mixed-methods approach, combining quantitative surveys with qualitative interviews. This would allow participants to articulate their unique developmental trajectories, encompassing factors such as fluidity, exploration, and identity shifts. This nuanced and inclusive approach will provide a rich understanding of the diverse pathways shaping the development of sexual orientation.

Case study 2:

If you were designing a study to investigate the mental health outcomes of transgender individuals, how would you collect data on gender identity? Traditional survey measures rely on binary categorisations of gender (male–female), failing to capture the diverse spectrum of gender identities, thereby leaving some participants feeling excluded or misrepresented by these options. This will lead to inaccurate data, non-participation, drop-out, or even psychological harm. To address this, survey instruments should incorporate open-ended questions allowing participants to describe their gender identity in their own words. Additionally, researchers should provide a range of options beyond the binary, such as non-binary, genderqueer, and genderfluid. This approach enables more accurate, nuanced, and inclusive data collection, affirming the importance of sensitivity and flexibility in measuring gender identity in psychological research.

GUIDELINE 8: Support diverse family structures and relationships

Psychology professionals recognise the unique relational experiences and challenges faced by sexually and gender-diverse individuals, including issues within families of origin and choice, relationship dynamics, and challenges related to parenting, fostering, and adoption.

Key points

- Sexually and gender-diverse individuals often face significant challenges within their families of origin, including lack of acceptance, potential psychological and physical harm, abuse, and violence. Families of choice, consisting of friends and supportive networks, often play a crucial role in providing the acceptance and support that families of origin may not.
- Romantic and intimate relationships can play an essential role for personal and emotional wellbeing, including monogamous and non-monogamous arrangements. Psychology professionals must provide non-judgmental support and facilitate provision of relevant individual and family psychotherapy based on challenges faced as a result of complexities associated with sexual orientation and gender diversity.
- Sexually and gender-diverse individuals face unique challenges in parenting, including discriminatory practices in adoption and eligibility assessments, difficulties in accessing reproductive treatments, and navigating societal and legal barriers. Psychology professionals should advocate for fair treatment, and should support these individuals in their parenting journeys.
- Psychology professionals should adopt a systems approach, provide individual and family therapy, assist in navigating family dynamics, and support disclosure processes. They should also seek to enhance safe disclosure and expression spaces within family circles where every family member feels accepted and free to thrive beyond the family structure.

Rationale

Potential challenges within families of origin and families of choice could affect sexually and gender-diverse individuals significantly. A non-accepting environment raises minority stress, potentially harming both physical and mental health (Crandall et al., 2022; Ogunbajo et al., 2021). Conversely, affirmation from the family of origin reduces negative outcomes, including symptoms of depression and attempted suicide (Miller et al., 2020). Disclosing sexual or gender diversity to family may however sometimes cause psychological and physical harm due to societal attitudes. Sexually and gender-diverse individuals often face abuse and violence within their families (Nuttbrock et al., 2014; Ogunbajo et al., 2021), leading to stigma and rejection (Benestad, 2002; Meier et al., 2013). Families of these individuals often need support to navigate changes, such as using different names and pronouns. Psychology professionals are encouraged to work within a systems approach.

When family ties, such as emotional support, weaken, sexually and gender-diverse people

ideally form extended networks of friends, known as 'families of choice', especially if their family of origin is exclusively cisgender and heterosexual. These networks may include both current and previous romantic and sexual partners. Both families of origin and families of choice can provide strong support systems, helping individuals navigate societal rejection and discrimination, deal with shame and loss, and develop a strong, connected identity (Pachankis & Goldfried, 2013).

Potential challenges of different relationship configurations

Relationships play a central role in shaping interpersonal skills and self-identity (Msweli, 2020). Romantic relationships provide social, psychological, and emotional benefits, such as a sense of closeness and belonging (Greene et al., 2015; Miller at al., 2022). Sexually and gender-diverse people may still form and maintain hetero-cisnormative relationships for an array of personal and contextual reasons. For MSMW, relationships with women may align with expected gender roles, insulating them from homophobic backlash, while relationships with men satisfy suppressed desires (Dangerfield et al., 2017; Fields et al., 2015; MacKenzie, 2018; Ravenhill & De Visser, 2017; Rhodes et al., 2011; Silva, 2017). Some sexually diverse individuals may desire relationships excluding sex or in which sex occurs only under specific conditions, such as those on the asexual spectrum.

Various relationship types exist for all people, within the sexually and gender-diverse community. These may include monogamous and non-monogamous arrangements (British Psychological Society, 2012; Msweli, 2020). The fluidity of monogamy–non-monogamy becomes apparent as individuals progress through life stages. Regardless of SOGIESC, partners might negotiate different forms of monogamy or non-monogamy. The assumption that bisexual and other sexually and gender-diverse people are often non-monogamous is fallacious (Lynch, 2013). Non-monogamous people may face discrimination due to monosexist attitudes favouring monogamy. Notably, romantic relationships can include two or more individuals, such as polyamorous and polygamous relationships (Mogilski et al., 2023). Some individuals – regardless of SOGIESC – may enter into a throuple, also known as a triad or three-person relationship, which is a romantic or sexual relationship involving three people (Page, 2022). Some people are in consensual polyamorous relationship, where individuals have multiple consensual romantic or sexual partners. Partners may navigate their relationship dynamics, boundaries, and agreements in various ways to suit the needs and preferences of all involved.

In South Africa, despite the legality of same-sex marriages and acceptance of diverse family structures (e.g. polygamous relationship formations) (Breshears & Le Roux, 2013), heterosexual, monogamous marriage is privileged (Lynch & Maree, 2013). Many in non-heteronormative relationship configurations face hostility, violent opposition, or stigma (Erasmus & Martin, 2024; Marnell, 2013).

Gender-diverse people negotiating their relationships may experience stressors. Early disclosure of a gender-diverse identity correlates with better relationship outcomes, while later

disclosure may be perceived as betrayal (APA, 2015). Couples often have to renegotiate roles, share news with support structures, and grieve relationship changes. TGDNB individuals in relationships may face questioning their sexuality, and partners of TGDNB persons may experience transphobia and violence (Gallardo-Nieto et al., 2021; Theron, 2009). Some couples may separate or divorce due to stressors, while others renegotiate roles, sometimes introducing open relationships or polyamory.

Potential challenges of sexually and gender-diverse parents and their children, including fostering, adopting, and eligibility assessments

Many sexually and gender-diverse people are parents or wish to become parents. Some have biological children, while others choose fostering, adoption, or surrogacy. Sexual and gender diversity could affect custody proceedings. Although more countries, including South Africa, allow sexually and gender-diverse individuals to raise children, adoption and fostering remain fraught with difficulties, such as finding non-discriminatory agencies (APA, 2015). Practitioners should be aware of the stress of the adoption process and additional stressors due to homo-, bi-, and transphobia.

Some sexually and gender-diverse individuals require reproductive treatment to conceive. Finding willing and competent medical professionals can be challenging (Swain & Frizelle, 2013). Hormonal treatments may limit reproductive choices, and socio-economic status could affect available reproductive options (APA, 2015; Tomson et al., 2021). TGDNB people changing their gender markers face marriage status complications. South African laws may require couples to divorce and remarry under the Civil Union Act (No. 17 of 2006) (RSA, 2006).

While a common misperception, studies show children of sexually and gender-diverse parents do not experience more psychopathology than those from other families (Breshears & Le Roux, 2013; Breshears & Lubbe-De Beer, 2016). While societal acceptance of diverse families is increasing in South Africa, many still face discriminatory environments. Research indicates no long-term negative effects on children due to a parent's gender transition. Family quality of relationships is more important than structure or form (Lubbe-De Beer, 2013; Zhang et al., 2023).

Application

Psychology professionals work with sexually and gender-diverse individuals across their lifespan to address relationship issues related to the family of origin, romantic relationships, and parenting issues

- Families of origin and of choice

Practitioners help negotiate family dynamics, possibly through individual or family therapy, to explore and establish sexual and gender identity. This may involve dealing with relationship changes and the loss of previous identities. Professionals support disclosure processes and foster resilience in relationships, providing support to intimate partners and exploring fluidity in sexual orientation during transitions (Meier et al., 2013). Within the South African context,

practitioners need to be sensitive to the intersectional realities of individual families.

- Relationship configurations

Practitioners assist clients in exploring various relationship types, establishing ethical boundaries, and ensuring consent in non-monogamous relationships. High levels of trust and the absence of coercion between partners are essential. Professionals work with clients to embrace relationship diversities and to understand roles within their configurations.

- Sexually and gender-diverse parents and their children

Practitioners are advised to support and guide individuals or couples navigating parenting options, providing a safe space to explore choices. Affirmative practice helps negotiate status as an 'alternative family' within the community (Zhang et al., 2023). Psychological screening and assessment during adoption processes involve evaluating wellbeing and relationship dynamics. Eligibility assessments during divorce and separation require sensitivity to internalised biases and focus on the child's best interests.

Professionals assist in differentiating between sexual orientation and gender identity, highlighting the harm of policing gender norms. Practitioners are advised to provide information about sexual orientation and gender identity, normalise unique developmental pathways, and consider historical and current social, political, and cultural contexts. Facilitating strong social support networks through evidenced-based practices, such as psycho-education, is crucial.

Professionals discuss potential phases of sexual orientation and gender identity development, clarifying that these are not fixed. Various models, with their criticisms, aid in understanding. Professionals should be open to differing orientations within relationships and sensitive to stigma, prejudice, discrimination, and violence, seeking up-to-date resources for self-education and client support.

Case studies

Case study 1:

David, a 23-year-old bisexual man, and his partner Alex, a transgender woman, seek counselling to navigate challenges as LGBTQIA+ parents raising their adopted child. They face pressure from their extended families and society, questioning their ability to parent due to their identities. David worries about the effect of discrimination on their child, while Alex is determined to foster resilience. In counselling, you offer support, helping them affirm their strengths as parents and explore strategies to manage societal pressures, and building confidence, focusing on creating a loving, open family environment that embraces their unique identity and fosters pride.

Case study 2:

At 17, Maya, a bisexual and transgender girl, flees her home to escape the looming pressure of a traditional initiation ceremony imposed by her family. Struggling with her identity in a religiously conservative household, she fears rejection and misunderstanding. She seeks refuge in a non-profit shelter for queer youth. Due to funding constraints, the shelter is however closing down in a few weeks. Despite the uncertainty of her future, Maya finds solace in the supportive community of the other residents and seeks psychological services from a registered counsellor at a primary health clinic, where she is put on a waiting list. Maya remains determined to embrace her true self and to embark on a journey of self-discovery and empowerment, to leave behind the constraints of societal expectations to forge her own path toward acceptance and liberation.

Case study 3:

In an affluent school, Alex, a non-binary student, faces resistance when seeking to transition socially. School administrators, fearing potential repercussions on other students' gender identities and sexualities, deny Alex's request. Despite facing discrimination, Alex remains resolute in their identity. With support from allies within the school community, including teachers, an educational psychologist and fellow students, Alex advocates for their rights. Their courage sparks conversations about inclusivity and acceptance, challenging the rigid policies of the school.

GUIDELINE 9: Increase social supports and foster resilience by prioritising relational wellbeing

Psychology professionals recognise the importance of resilience and promote relational wellbeing and increased social supports within the lives of sexually and gender-diverse persons.

Key points

Psychology professionals enhance the effect of service by:

- Exploring the dynamics of social support networks: assessing the quality and nature of support from various sources to mitigate mental health issues among sexually and gender-diverse individuals.
- Investigating links between social safety and health disparities: longitudinal studies to capture changes over time and to understand the effect of intersecting identities on support availability.
- Addressing intersecting discrimination: applying resilience-building strategies to overcome barriers and optimise support access.
- Understanding resilience-building preventions and interventions: adapting strategies to navigate limited support access and stigma-related challenges.
- Researching family structures and dyadic coping: informing policies and interventions for healthcare providers to promote wellbeing in romantic relationships.

Rationale

This Guideline proposes a shift from 'coping' to 'thriving', and is to be read closely with Guideline 2 (Non-discrimination), Guideline 6 (Stigma and violence), and Guideline 8 (Relationships).

Psychology faces criticism for historically prioritising individual and intrapsychic pathologisation, including for sexually and gender-diverse individuals. While recent shifts are towards systemic, interpersonal, contextual, and affirmative approaches, South African LGBTQIA+ scholarly works still focus heavily on the individual experience, adversity, and from a deficit perspective. Such focus has fostered adaptive problem-solving and solution-focused behaviours among certain LGBTQIA+ populations, leading to creative resilience responses rooted in intersectional perspectives that include, but are not limited to, race, ethnicity, culture, religion, socio-economic status, history, and political oppression (Wilks et al., 2022).

Resilience science, evolving from individual trait conceptualisation (Ungar & Theron, 2020), and research that is conducted from a strength-based perspective complement affirmative practices and understanding of LGBTQIA+ resilience (Fernandes et al., 2023). Such practices address diverse vulnerabilities and sustainable adaptive solutions, recognising the positionalities, marginalities, and inequalities faced by

LGBTQIA+ communities. Theories that focus on aspects of resilience help to inform our understanding of the role of intersectionality in resilience disparities to avoid oversimplifying the complex systems and strategies needed by differently situated queer individuals (Daniels et al., 2021). Establishing a foundation for application, particularly for those marginalised by factors, such as race, class, nationality, and geography, is paramount (Wilks et al., 2022).

Resilience is seen as an enduring constructive adaptation to one's circumstances and environment during adversity. Higher trait resilience (a greater capacity to adapt constructively to challenging circumstances) corresponds with positive mental health outcomes. Conversely, lower trait resilience (a reduced ability to cope effectively with adversity) often results in poorer mental health outcomes (Watson & Tatnell, 2022). Watson and Tatnell assert that resilience could empower LGBTQIA+ individuals to cope with experiences of minority stress and fostering social support that could improve mental health. There is however a need for heightened emphasis on external community-level resources for resilience, including the cultivation of social networks among and beyond LGBTQIA+ communities. "Although individual and community resilience should be seen as part of a continuum of resilience, it is important to recognize the significance of community resilience in the context of minority stress" (Meyer, 2015, p. 209). Recognising the pivotal role of support from friends, family, significant others, and the community in resilience is imperative, alongside acknowledging individuals' relational skills in overcoming adversity.

Building on the insights of Wilks et al. (2022) and others, this Guideline proposes a shift towards a multisystemic resilience perspective in South African LGBTQIA+ scholarly work. By comparing the 2017 PsySSA practice guidelines with international resilience science, Wilks et al. highlight the need to move beyond individual-focused approaches, and to address multisystemic factors in resilience, thereby broadening the scope of existing resilience frameworks. In this manner, the guidelines may serve to intervene in the prevailing approaches to psychological practice, offering a valuable counterbalance to the predominant focus on adversity by psychology professionals.

Application

Psychology professionals recognise and champion the resilience of sexually and gender-diverse individuals and communities in facing substantial adversity

Although sparse, some South African scholarly works focus on resilience behaviours and abilities, including those of LGBTQIA+ persons and communities (Alessi et al., 2021; Haffejee & Wiebesiek, 2021; Rothmann, 2018; Theron et al., 2022; Van Breda & Theron, 2018). Matebeni (2011) depicts the lives of innovation, creativity, and pleasure of black African lesbian people in Johannesburg, despite enduring fear and threats of violence. Stephens and Boonzaier (2020) similarly highlight ways in which black African lesbian people disrupt and challenge oppressive contexts through their resilience. Reid (2013) emphasises how economically vulnerable black African gay men organise and create networks and access resources in rural

South Africa, displaying a remarkable capacity to imagine and create life worlds in a harsh environment. Livermon (2021) reports on how informal networks of support amongst LGBTQ youth in Cape Town enable resilience in the context of housing insecurity and homelessness.

Psychology professionals are encouraged to work with LGBTQIA+ communities for solutions rather than just acknowledging the adversity that sexually and gender-diverse individuals experience. A shift towards strength-based approaches in scholarly work exploring LGBTQIA+ lived experiences within their unique contexts and relationships is warranted (Nel et al., 2025; Randall & Lannutti, 2025). Unfortunately, knowledge regarding beneficial psychological and social resilience factors remains scant, despite the well-documented associations between our social relationships and health outcomes. Notably, resilience depends not only on individual but also on systemic resources, especially during times of distress (Ungar & Theron, 2020).

Multifaceted interactions across systems predict resilience, empowering individuals to navigate adversity effectively (Ungar & Theron, 2020; Wilks et al., 2022). Systems intertwined with LGBTQIA+ persons and communities are encouraged to acknowledge and operationalise shared responsibility for fostering resilience, avoiding overly individual-centric views of resilience (Wilks et al., 2022). Championing resilience is crucial, as LGBTQIA+ persons have the potential creativity and internal resources to deal with their difficulties and problems (Victor et al., 2014).

Resilience skills and trauma-informed psychotherapy could facilitate recovery from trauma, and restore psychological stability, reshaping mental health trajectories towards authenticity (Wilks et al., 2022). Resilience can be advanced through training. One such intervention that shows promise is group mindful self-compassion training (an eight-week group programme that focuses on cultivating self-compassion and mindfulness) to improve mental health outcomes for LGBTQIA+ young adults (Finlay-Jones et al. 2021). Resilience-building interventions may require alterations to accommodate stigma-related challenges (Nel et al., 2025). Stressors, particularly in the absence of protective legislation, create competing desires for authenticity and self-determination among LGBTQIA+ individuals, and could lead to various strategies, which include, but are not limited to, concealing one's identity, finding community support, and developing political consciousness (Levitt et al., 2016; Nel et al., 2025).

Psychology professionals acknowledge the significance of interventions and policies aimed at bolstering social safety and fostering connections, recognition, and inclusion within romantic relationships

In the LGBTQIA+ context, resilience denotes positive adjustment to adversity, shaped by negotiations between individuals and the reciprocal social processes within affirming networks (Shilo et al., 2015). In this regard, Cooper et al. (2020) examined the link between stress experienced outside the relationship (external) and within the relationship (internal) for individuals (stress spillover) and their partners (stress

crossover). Enduring emotional connections and social support play key roles in resilience and wellbeing within LGBTQIA+ communities. Access to such support may however vary, especially when facing rejection or discrimination from health and support organisations. Sensitivity to intersectional differences is essential for social justice, diversity, and inclusion (see Guideline 5). Marginalised communities should lead discussions on these concepts to ensure their voices are heard (Brown, 2021). Social justice, diversity, and inclusion intersect, forming the basis of solidarity, which entails unity, support, mutual obligation, and the pursuit of equality (Brown, 2021).

A large South African study that explored LGBTQ+, targeted violence, mental health concerns and discrimination in healthcare settings ascertained that the respondents received social support from friends (75%), followed by family members (45%), and current romantic partners (44%) (Müller & Daskilewicz, 2019). In the study, TGDNB people were more likely to report being out to LGBTQIA+ civil society organisations (CSOs) (57% versus 39% of cisgender participants) and using such organisations for social support (24% versus 11% of cisgender participants), suggesting LGBTQIA+ organisations are a particularly important resource for TGDNB people in South Africa. Further, TGDNB participants reported more support from healthcare providers (20% versus 13% of cisgender participants), reflecting the use of gender-affirming treatment facilities and open communication about gender identity with healthcare providers (Müller & Daskilewicz, 2019).

Wilks et al. (2022) underline the importance of social safety, including reliable connections, recognition, inclusion, and protection, across all life stages. Interventions and policies promoting social safety and fostering connections, recognition, and inclusion, including within romantic relationships, are crucial for improving the psychological wellbeing of sexually and gender-diverse individuals in South Africa.

Psychology professionals aim to extend the concept of 'wellbeing' beyond the individual to include one's interpersonal relationships

Minority stress affects relational wellbeing for LGBTQIA+ individuals (see Randall & Lannutti, 2025); however, research that documents these associations in a South African context is scarce. Understanding the associations between minority stress and relational wellbeing could inform interventions to enhance overall wellbeing. Nel et al. (2025) offer an overview of initial South African scholarship focusing on the association between minority stress and LGBTQIA+ relational wellbeing. One area of focus is that of sexually diverse individuals in romantic relationships and families altering their behaviour in public to avoid negative experiences due to societal prejudice. In this regard, Breshears and Lubbe-De Beer (2016) found that participating same-sex-parented families in their study demonstrated resilience by merely ignoring negative social attitudes directed at their sexual diversity towards increasing their safety. The sexually diverse student couples in a study by Lesch et al. (2017) chose to conceal their identities by limiting expressions of intimacy in public spaces.

Another focus in South African LGBTQIA+ relational wellbeing scholarship is on intimate partner violence (IPV), a serious public health problem affecting sexually and gender-diverse individuals and communities. Research highlights themes such as relationship dissatisfaction, with partners exhibiting anger issues and jealousy or intimidation, as well as a correlation between experiences of minority stress and IPV. Comprehensive interventions are needed to address the physical and psychological consequences of IPV (Nel et al., in press).

The legal recognition of sexually and gender-diverse individuals and their relationships in post-apartheid South Africa has influenced individuals' sense of belonging and their ability to form enduring romantic relationships. While this legal acknowledgement is a step toward inclusivity, further research is required to understand its long-term consequences on the wellbeing of sexually and gender-diverse individuals in South Africa (Nel et al., 2025). Such efforts include the need to understand how partners can help one another cope with stress in the context of their relationship (e.g. dyadic coping) (Bodenmann et al., 2016; Randall & Lannutti, 2025; Randall et al., 2016; Totenhagen et al., 2023). Such strategies hold particular significance for sexually and gender-diverse people in South Africa considering the unique challenges and minority stressors they face. Investigating how partners may engage in dyadic coping could shed light on shared experiences, resilience, and support mechanisms within these relationships (Nel et al., 2025).

Case studies

Case study 1:

Zanele Muholi, a South African photographer and visual activist, internationally acclaimed for their work focusing on black African lesbian and transgender bodies subjected to violence, showcases resilience, empowerment, and identity reclamation. Psychology professionals could present Muholi as a role model to clients, illustrating how Muholi's work embodies resilience and empowerment. See https://www.artshelp.com/zanele-muholi-pioneers-change-through-the-lens-of-identity/

Case study 2:

Caster Semenya, a South African 800-metre athlete and two-time Olympic and triple world champion, is arguably the nation's most prominent intersex individual. Despite public scrutiny and the International Association of Athletics Federation (IAAF) controversial testosterone ruling, Semenya has displayed remarkable resilience. Review the PsySSA (2019) statement, condemning the violation of Semenya's human rights.

GUIDELINE 10: Affirm diversity and resist normalisation efforts

Psychology professionals recognise the importance of adopting best practices that not only respect and affirm sexual and gender diversity but also move beyond hetero-cisnormative frameworks and culturally normative standards of being that have historically marginalised sexually and gender-diverse individuals.

Key points

- Actively oppose and work to eliminate normalisation efforts, including conversion practices, non-consensual medical interventions, and restrictions on gender-affirming care.
- Apply an intersectional framework to understand and address the compounded marginalisation experienced by sexually and gender-diverse individuals, considering the influence of race, socio-economic status, disability, and other intersecting factors.
- Implement trauma-informed and affirmative care practices that validate and support sexually and gender-diverse individuals, with a focus on healing from the harms of normalisation efforts.
- Champion the rights of intersex individuals by advocating against non-consensual and medically unnecessary interventions, and promoting policies that ensure bodily autonomy and informed consent.
- Facilitate access to gender-affirming care for TGDNB individuals of all ages by advocating for supportive environments, removing barriers to care, and promoting inclusive policies.

Rationale

Normalisation efforts refer to practices, policies, and social pressures aimed at forcing individuals to conform to dominant societal norms and standards. These efforts often involve attempts to suppress, change, or eliminate behaviours, identities, or characteristics that deviate from what is considered 'normal' by mainstream society (Davids & Matebeni, 2017; Ewing et al., 2020). Examples include conversion therapy aimed at changing sexual orientation or gender identity, non-consensual surgeries on intersex infants to conform their bodies to binary sex norms, and withholding gender-affirming care for transgender individuals. These are prominent forms of anti-SOGIESC normalisation efforts.

In South Africa, these efforts are deeply intertwined with the legacy of apartheid, which enforced rigid social hierarchies and norms that continue to affect contemporary societal attitudes towards sexually and gender-diverse individuals (Judge & Nel, 2018; McLachlan, 2019). Despite constitutional protections for equality and dignity, these harmful practices persist, undermining individuals' psychological and bodily autonomy (RSA, 1996). Promoting normalisation efforts under the guise of wellbeing or moral conformity results in significant harm, particularly for SOGIESC minorities, by reinforcing stigma and marginalisation (Behrens, 2020; Vilakazi & Mkhize, 2020).

Efforts to change SOGIESC identities are widely discredited by major medical bodies, including the WHO and the American Psychological Association (APA, 2023; Davids & Matebeni, 2017; Jowett et al., 2021; Keogh et al., 2023; Outright International, 2019, 2022, 2023, 2024; Turban, King et al., 2020; WHO, 2019). The removal of trans-related diagnoses from the ICD-11 aims to destigmatise gender diversity, recognising a spectrum of identities and shifting away from pathologising frameworks. Notably, the Diagnostic and Statistical Manual-5 (DSM-V) also recognises asexuality, ensuring that asexual individuals are not misdiagnosed with sexual disorders. Despite this progress, some professionals continue to endorse harmful practices, perpetuating ethical violations, and disregarding evidence showing the ineffectiveness and harm of normalising interventions (Ashley, 2022; Blosnich et al., 2020; Green et al., 2022; Haldeman, 2024; Ryan et al., 2020).

Addressing normalisation efforts requires an intersectional and trauma-informed approach that considers the compounded marginalisation experienced by sexually and gender-diverse individuals, particularly those with intersecting identities, such as race, class, and disability (Crenshaw, 2013; Davids & Matebeni, 2017; Green et al., 2022; McGuire et al., 2021; PsySSA, 2023). For example, microaggressions in bathroom spaces at a South African university revealed that sexually and gender-diverse students of colour endure both racial and gendered microaggressions, compounding their experiences of exclusion and discomfort (Brown et al., 2020). This compounded marginalisation underscores the necessity of an intersectional approach to address and dismantle normalisation efforts effectively, as such approach acknowledges the unique challenges faced by individuals at the intersection of multiple marginalised identities (Francis, 2021b).

'Conversion therapy', a prominent form of normalisation practices, is often endorsed by religious and societal pressures. The concept of 'curative violence', as discussed by Kim (2017), highlights how these so-called 'cures' inflict both symbolic and physical harm under the guise of universal good. In South Africa, the damaging effect of conversion practices is evident in the distress, trauma, and long-term psychological damage reported by survivors (Ngidi et al., 2020; Vilakazi & Mkhize, 2020). These practices lead to severe mental health issues, including depression, anxiety, and suicidal ideation (Ashley, 2022; Haldeman, 2024; Jowett et al., 2021; Turban, Beckwith et al., 2020). They undermine the individual's self-worth and identity, perpetuating stigma and discrimination against sexually and gender-diverse individuals (Brown & Njoko, 2019; Davids & Matebeni, 2017; McGuire et al., 2021).

The Johannesburg Declaration Against SOGIE Change Efforts and Conversion Practices (see PsySSA & Outright International, 2023) underscores the importance of protecting sexually and gender-diverse individuals from these harmful practices.

The focus on TGDNB youth in discussions of gender-affirming care is particularly important because youth are often at the centre of societal debates and misunderstandings about gender diversity. As Ashley (2020) points out,

opponents of gender-affirmative approaches have mistakenly likened these approaches to so-called 'conversion therapy', arguing that they are driven by homophobia. There is, however, no evidence to support this claim, and gender-affirmative care is, in fact, fundamentally dissimilar to conversion therapy. Youth are especially vulnerable to these debates and the associated stigma. This makes access to gender-affirming care critical. Restrictions on this care reflect normalisation efforts that seek to prevent TGDNB youth from living authentically (Ashley, 2020). Denying gender-affirming care exacerbates gender dysphoria and leads to poor mental health outcomes (Durwood et al., 2022; PATHSA, 2020b; South African Society of Psychiatrists [SASOP], 2024).

This necessity is underscored by the *Embracing diversity, upholding rights: A South African position statement on evidence-based care for transgender and gender-diverse young people*, which advocates for evidence-based care tailored to the needs of transgender and gender-diverse youth in South Africa (PATHSA, 2024). Gender-affirming care includes developmentally appropriate and culturally sensitive psychological and social support services, along with medical care when needed, to help individuals live authentically according to their gender identity (Coleman et al., 2012; Munoz-Laboy et al., 2021; Redfield et al., 2023; Tomson et al., 2021).

Intersex individuals often face non-consensual and medically unnecessary interventions aimed at aligning their bodies with binary sex norms. At the root of intersex genital mutilation (IGM) are gender norms, societal pressures, and dynamics of control and power (Barigye, 2024). Historically, these interventions were justified under the concealment model, which sought to 'normalise' intersex bodies by making them conform to male or female norms, often through surgery during infancy or childhood. This approach has been widely criticised for disregarding the bodily autonomy and psychological wellbeing of intersex individuals (Carpenter, 2024; Jones, 2022). In response, there has been a significant shift towards an agency-based and person-centred model, which prioritises the individual's right to make informed decisions about their own bodies, emphasising bodily autonomy and the cessation of normalising medical interventions until the person can exercise fully informed choice regarding treatment (Crocetti et al., 2021). Policies, such as those aligned with the Yogyakarta Principles (see Yogyakarta Principles, 2017), call for the protection of intersex individuals from harmful normalising practices (Carpenter, 2020a).

Application

Psychology professionals should validate and support the identities of sexually and gender-diverse individuals, creating a safe and supportive environment where clients can explore their identities without fear of judgement (Ashley et al., 2023; Olson et al., 2022). Affirmative practices are crucial for mitigating the psychological harm caused by normalisation efforts and conversion practices, helping individuals build resilience and self-acceptance. For example, when working with TGDNB youth, incorporating family into the therapy process, providing education on gender diversity, and

facilitating open communication could promote acceptance and support (Green et al., 2022; Olson-Kennedy et al., 2016; Ryan et al., 2023).

Implementing trauma-informed care is essential for supporting survivors of conversion practices. Trauma-informed care ensures that the survivors' experiences of trauma are acknowledged and addressed in a safe and validating environment (Levenson et al., 2023). In the context of conversion practices, it is important to recognise specific manifestations of trauma, such as deep-seated shame; internalised homo-, bi-, or transphobia; identity conflict; and challenges with intimacy and sexual expression that align with their authentic selves (Meanley et al., 2020; Tillewein & Kruse-Diehr, 2023). By integrating trauma-informed care with affirmative practices, professionals would support survivors in rebuilding their self-worth and navigating the complex after-effects of trauma on their mental health and identity (Dromer et al., 2022; Ellis, et al., 2020).

Providing culturally responsive care involves understanding and respecting the diverse cultural contexts of sexually and gender-diverse individuals (Olson et al., 2016; Tomson et al., 2021). Engaging with communities and understanding their unique challenges and strengths is essential (Davids & Matebeni, 2017; Ewing et al., 2020). Psychology professionals should work with families and communities to promote acceptance and support for sexually and gender-diverse individuals, providing education and resources that build supportive environments (Olson-Kennedy et al., 2016; Ryan et al., 2020).

Psychology professionals are ethically obligated to condemn and refuse participation in any form of conversion practices or SOGIE change efforts (SOGIECE). Instead, they should advocate for affirmative practices that support the inherent worth and dignity of all individuals (McGuire et al., 2021; Redfield et al., 2023). This includes educating other professionals but also the public about the harms of conversion practices, and promoting safe, evidence-based practices within professional organisations through regular training and oversight (Ashley et al., 2023; Green et al., 2022; Haldeman, 2024).

All psychological and medical interventions should be grounded in the principles of informed consent, self-determination, and respect for diversity, rather than in efforts to enforce conformity (Carpenter, 2024; Drescher, 2016). Psychology professionals should advocate against non-consensual, medically unnecessary interventions on intersex individuals, and actively promote policies that protect bodily autonomy and uphold informed consent (Redfield et al., 2023; Vilakazi & Mkhize, 2020). Additionally, professionals should educate medical professionals and the public about the harms associated with these interventions, and support intersex individuals in making informed decisions about their own bodies (McLachlan, 2019). Extending support to parents and caregivers of intersex children is also crucial, helping them navigate the complexities of informed decision-making and fostering environments where the child's bodily autonomy and identity are respected.

Psychology professionals should further encourage healthcare providers to adopt a multidisciplinary approach that includes endocrinologists, psychologists, ethicists, and intersex advocates to ensure comprehensive and ethical care for intersex individuals (National LGBTQIA+ Health Education Center, 2020).

Finally, psychology professionals should advocate for and facilitate access to gender-affirming care for TGDNB youth, recognising the significant benefits of such care on their wellbeing (Green et al., 2022; Olson-Kennedy et al., 2016). This involves working with families, schools, and healthcare providers to ensure that TGDNB youth receive the support they need; providing education and training on gender diversity; and advocating for policies that protect the rights of transgender youth (Ashley et al., 2023; McGuire et al., 2021). Listening to their experiences and validating their feelings is essential, using developmentally appropriate language to ensure they feel heard and understood.

Case studies

Case study 1

Dr Patel, a clinical psychologist, encountered a client, Sarah, who was described pejoratively as "uncooperative", "resistant" and "defensive" in the referral letter. Sarah was struggling with deep-seated shame and self-hatred after enduring years of so-called conversion 'therapy' by another psychologist, in order to change and 'treat' her asexual identity, leaving Sarah with PTSD and a mistrust of mental healthcare professionals. Dr Patel navigated the delicate process of alliance building and helping Sarah heal from the trauma, rebuilding her self-esteem, and affirming her asexual identity. Together, they explored the harmful messages that Sarah internalised during previous conversion attempts, working towards self-acceptance and authenticity. Sarah gradually reclaimed her sense of agency, and found solace in embracing her identity.

Case study 2

Mpho and Thandi were initially surprised to learn their newborn baby, Nandi, was intersex. Doctors recommended immediate surgery to 'normalise' Nandi's genitals, aligning them with binary sex norms, justifying the decision by claiming it would prevent future psychological distress and ensure easier social integration. The couple hesitated, questioning the necessity of non-consensual medical interventions that could affect Nandi's bodily autonomy. They were also afraid their child might face stigma or risk within their community.

This case highlights the importance of informed decision-making, advocating for delaying medically unnecessary surgeries until Nandi herself could consent, and ensuring that psychology professionals champion the rights and wellbeing of intersex individuals.

GUIDELINE 11: Disclose and rectify personal biases

Psychology professionals address and disclose personal biases regarding sexual and gender diversity through reflection, learning, and development. If competency gaps arise, they seek supervision and additional training, and make appropriate referrals to ensure affirming care.

Key points

- Actively identify and confront explicit and implicit biases regarding sexual and gender diversity, ensuring the biases do not compromise the quality of care.
- Maintain transparency about limitations in competence related to sexual and gender diversity, and take responsibility for addressing gaps through self-reflection and professional development.
- Ensure that personal biases do not lead to discriminatory practices or substandard care, and take proactive steps to prevent such outcomes, including facilitating referrals.
- Actively recognise and address how colonial systems and structures may shape personal biases, ensuring these do not contribute to the marginalisation of sexually and gender-diverse clients.
- Engage in regular reflective practices to assess and mitigate the effect of biases continuously, ensuring that the approach remains ethical and client-centred.

Rationale

Psychology professionals' explicit or implicit hetero-cisnormative biases, attitudes, and assumptions could significantly affect the quality of service they provide across various roles (Hahn & Gawronski, 2019; Khalaf et al., 2023; Zestcott et al., 2016). Biases, often formed through socialisation and influenced by personal experiences, may perpetuate harmful stereotypes and norms, such as compulsory sexuality, which assumes that all people are inherently sexual and should engage in sexual activity (Gupta, 2015). Despite intentions to be progressive, professionals may inadvertently uphold norms that marginalise those who do not conform to these expectations (FitzGerald & Hurst, 2017; Gleicher et al., 2022; McDowell et al., 2020). Addressing biases requires ongoing education, professional development, and self-reflection, which are essential for providing ethical, unbiased, and informed care, especially to sexually and gender-diverse clients (Pachankis & Safren, 2019; Powell & Cochran, 2021; Wittlin et al., 2019).

The counselling environment often reveals power dynamics where LGBTQIA+ clients may find themselves educating their psychologists, highlighting gaps in professional knowledge, and raising ethical concerns about the fairness of such expectations (De Beer-Procter, 2022). While collaborative learning from clients is valuable, it should not replace the responsibility of professionals to enhance their competencies proactively. This commitment to professional development ensures care that is sensitive, respectful, and supportive of the mental health and resilience of sexually and gender-diverse individuals (Ben Hagai & Zurbriggen, 2022; British Psychological Society, 2024; Canvin et al., 2022).

Psychology professionals who themselves identify as sexually and gender-diverse are not immune to bias, and may also hold negative or incorrect attitudes and assumptions that affect the quality of service they provide. These biases could manifest through their use of language, adherence to outdated models, or overreliance on personal experiences, potentially leading to negative outcomes for clients (Grant et al., 2018; Lelutiu-Weinberger et al., 2023; Matsick & Rubin, 2018).

The use of sexual and gender-neutral models in psychology could inadvertently perpetuate a hetero-cisnormative framework, failing to recognise the unique experiences of sexually and gender-diverse individuals. This oversight could contribute to the erasure of LGBTQIA+ identities, reinforce binary views, and lead to internalised prejudice and discrimination (Dixon et al., 2022; Morgenroth & Ryan, 2018; Pachankis & Safren, 2019). Resistance to changes in the gender–sex binary often stems from deep-seated identification with gender norms and a preference for rigid categories, which can further entrench opposition to gender diversity (Ben Hagai & Zurbriggen 2022; Butler, 1990; Lindley et al., 2024; Martin & Slepian, 2021; Morgenroth et al., 2020; Van der Toorn et al., 2020).

Various frameworks and models have been developed to guide the process of identifying and rectifying biases, including RESHAPE – Reducing stigma among healthcare providers to improve mental health services (Kohrt et al., 2018), as well the iterative model (Kolb, 1984), vertical model (Rogoff, 1990), and the ADDRESSING model (Hays, 2001). Gleicher et al. (2022) discuss four educational models, namely the competence, skills-based, social contact, and critical models. Reflective practice, including reflective writing and journaling, is useful for identifying and rectifying personal biases. Reflective local practice (RLP), which involves identifying hot spots (areas of frequent issues), blind spots (areas overlooked or unknown biases), and soft spots (areas needing more attention and sensitivity), could further facilitate self-reflection (Habib et al., 2023; Lingras, 2022). Self-assessment tools, such as the Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) (Bidell, 2015. 2017); Project Implicit and other implicit bias tests (Dixon et al., 2022; FitzGerald & Hurst, 2017; Greenwald et al., 2003; Hahn & Gawronski, 2019; Ratliff & Smith, 2024) are valuable for this process.

Affirming care must be a standard practice, independent of the practitioner's personal comfort level or attitudes toward the queer community (Patel & Nowaskie, 2024). Recognising and addressing professional limitations through supervision, additional training, or consultation is essential in avoiding the perpetuation of discrimination (Müller et al., 2020; Ojeda, 2021; Rees et al., 2021). When a referral is necessary due to genuine limitations in competence, professionals are ethically obliged to facilitate this process responsibly, ensuring that clients receive care from a competent colleague while simultaneously working to improve their own skills (Bishop et al., 2023; Grant et al., 2018).

In this context, adherence to the South African ethical rules for psychology professionals is particularly relevant, as these rules provide

the necessary framework for maintaining competency and appropriately handling referrals. These rules emphasise the importance of:

- Competency limits: Limiting practice to areas within the boundaries of one's competence based on formal education and training, supervised experience, and appropriate professional experience, while ensuring that work is grounded in established scientific and professional knowledge (Health Professions Act, 1974; HPCSA, 2016).
- Interruption of psychological services: Preventing the premature termination of a professional relationship by ensuring appropriate arrangements are made for the continuity of care, especially during periods of foreseeable absence, and making reasonable efforts to plan for service continuity in the event of disruptions, such as illness, unavailability, or relocation (PsySSA, 2007).

Colonial systems and structures have deeply influenced the field of psychology, embedding biases that frequently marginalise sexually and gender-diverse clients. Western-centric psychological models often fail to account for the cultural nuances required in diverse contexts, reinforcing exclusionary practices (Horne, 2020). There is a pressing need to integrate indigenous and sociocultural perspectives into mental healthcare, challenging the dominance of Western biomedical approaches (Asongu & Moola, 2024). In South Africa, colonialism and apartheid continue to shape societal attitudes, and are contributing to the ongoing marginalisation of queer individuals, even where formal equality exists (Judge, 2021). Decolonial praxis, as explored by Meer and Müller (2023), involves continuously reflecting on and dismantling the colonial power dynamics embedded in healthcare systems, ensuring that professionals actively work to challenge the biases these structures produce and sustain (Overstreet et al., 2020).

Application

In practice, psychology professionals must translate these principles into specific actions that ensure competent and affirming care for all clients. This includes actively engaging in ongoing self-reflection and recognising their limitations from the outset of the professional relationship, such as during intake or contracting, and taking proactive steps to address these limitations through supervision, training, or consultation (Boekeloo et al., 2024).

Failing to address these limitations could lead to the misuse of a lack of competence, where a professional might use it as an excuse to avoid growth and evade their responsibility to work with sexually and gender-diverse clients, especially when these issues make them feel uncomfortable. Professionals should therefore not only acknowledge their limitations but also seek out opportunities to identify and address their biases as a necessary step in their professional development. When a professional's personal values or worldviews hinder – or have the potential to hinder – the therapeutic process or service delivery, such profession is ethically obligated to recognise and remedy such limitations.

For example, if a couple in an open relationship seeks marriage counselling, and the practitioner lacks knowledge about ethical non-monogamy, the practitioner should seek supervision, consult with experts, pursue additional training, and review relevant literature. If they are unable to address the topic adequately, their ethical duty mandates them to refer the clients to a competent professional with the necessary expertise and experience.

Psychology professionals may work with LGBTQIA+ people or issues in various ways, with the required knowledge and competency varying depending on the service offered. Regardless, they have to demonstrate insight and understanding of how stigma, power dynamics, and implicit bias affect their decisions. Adopting cultural humility, as highlighted by the IUPsyS (2021), involves recognising that the professional is not the sole expert, and requires ongoing self-reflection, self-criticism, and the inclusion of diverse cultural worldviews to foster respectful relationships. See Appendix VIII: Self-interview guide for psychology professionals: Addressing personal biases on sexual and gender diversity.

Psychology professionals should actively connect with LGBTQIA+ organisations and participate in community activities to deepen their empathy and understanding of the diverse experiences within these communities. To challenge and reduce biases effectively, it is essential to maintain frequent and ongoing contact with diverse groups, as short-term interventions are often insufficient (Cramwinckel et al., 2021). Competence in working with sexually and gender-diverse clients should be developed through a combination of experiential learning, continuous education, reflective practice, and direct engagement with the lived experiences of these communities (Bishop et al., 2023; Blockett, 2017; Gleicher et al., 2022). Additionally, professionals should examine their own sexuality, gender identification, and expression critically, addressing any personal discomfort or conservative values that could affect their work (Powell & Cochran, 2021; Shumilina, 2022).

Professionals should be transparent about their limitations and areas of expertise. For instance, when commenting in the media on sexuality or gender issues, they should refrain from making public statements unless they are well versed in best practice guidelines and appropriate language use (Bradshaw, 2020).

In leadership settings, professionals should challenge stigma, factors influencing minority stress, and implicit biases, aiming for systemic improvements that mitigate adverse effects on sexually and gender-diverse populations, such as educational, workplace or other institutional settings.

Professionals should avoid gatekeeping, such as imposing unnecessary barriers that force TGDNB clients to 'jump through hoops' to access gender-affirming care (Tomson et al., 2021). Psychology professionals need to recognise and address their own unintentional gatekeeping, which may occur when they are complicit in hierarchical procedures set by health institutions. Collaborating with clients and their representative groups ensures their active involvement in decision-making processes, helping to counter hetero-cisnormative biases and promote equitable care.

Psychology professionals who are approached for consultation, supervision, training, and policy development need to create safe, non-judgmental, and supportive learning environments and relationships. Reflective supervision and collaborative reflection foster growth and understanding, while adopting a perspective affirming LGBTQIA+ enhances sensitivity and empathy by helping professionals understand the unique challenges faced by LGBTQIA+ individuals, reducing bias, improving communication, building trust, and promoting inclusivity (Bishop et al., 2022; Carrington & Sims, 2024; Lingras, 2022; Tudino & Jellison, 2022).

In applying decolonial thinking, psychology professionals should actively examine how colonial legacies shape their biases and influence their professional practices. This includes critically questioning psychological theories and methods developed in colonial contexts, identifying where Eurocentric norms and assumptions may perpetuate bias in care. Addressing these biases requires incorporating the knowledge and perspectives of Indigenous and marginalised communities into practice.

This work is complex and requires continuous reflection and commitment to transforming these systems (Meer & Müller, 2023). Ultimately, decolonial thinking enables professionals to uncover hidden biases and reshape their practice, ensuring that their care actively works against marginalisation rather than reinforcing it.

Lastly, even psychology professionals who identify as sexually and gender-diverse have to be vigilant against harbouring hetero-cis-normative biases, their own internalised shame or prejudices, and other unexamined opinions about LGBTQIA+ issues and identities. A commitment to cultural humility and bias exploration is needed for each client, regardless of which aspects of identity may or may not be shared with the client or participant (Grant et al., 2018; Lingras, 2022; Matsuno, 2019; Riggs et al., 2019).

The pursuit of additional training and supervision should form the basis for maintaining competence, and this could be enriched by first-hand narratives from sexually and gender-diverse individuals (Frederick, 2019; Lingras, 2022). Professionals need to commit to behavioural competence that puts aside personal worldviews and works within the frameworks of best practice and the latest scientific evidence (Pachankis & Safren, 2019).

Case studies

Case study 1:

Jerome sought psychotherapy for depression, anxiety, and relationship issues. In the fourth session, he revealed that he is bisexual and in a polyamorous relationship. Although the therapist listened, his own biases about polyamory emerged, leading to discomfort and a referral to a colleague. Jerome however valued the honesty of the therapist, and wished to continue. Acknowledging his limitations, the therapist sought supervision from a colleague specialising in non-monogamous relationships to improve his knowledge, skills, and attitudes, aiming to provide a more ethical, effective, and empathic service in the future.

Case study 2:

A Psychology honours student is taking a course in psychopathology. The student is shocked when their lecturer makes a number of comments about how "this new fad of people wanting unique pronouns and gender identities should probably go into the DSM". Later on, the lecturer confuses correlation with causality, and argues that, since LGBTQIA+ people have higher rates of suicide, substance abuse, and depression than the general population, "these so-called identities must be forms of mental illnesses". The student reports the lecturer to the head of the department, the faculty dean, and to the HPCSA Professional Board for Psychology.

GUIDELINE 12: Enhance practice through continuing professional development

Psychology professionals enhance their affirming stance by engaging in continuing professional development (CPD) on sexual and gender diversity, including understanding the needs of sexually and gender-diverse individuals and utilising affirmative resources for optimal referrals.

Key points

- The continuously evolving landscape of psychology requires psychology professionals to stay abreast of advancements in the field, ensuring their interventions are effective, evidence-based, and informed by the latest research.
- CPD training helps psychology professionals gain a deep understanding of the unique experiences and challenges faced by sexually and gender-diverse individuals.
- Working with sexually and gender-diverse clients requires sensitivity to ethical issues and ethics guidelines.
- CPD training can equip psychology professionals with the skills to offer appropriate and tailored interventions.
- CPD training helps psychology professionals develop cultural competence and cultural humility, including understanding and challenging their own biases.

Rationale

As in the case of other healthcare providers in South Africa, psychology professionals are not only required to engage in CPD, but also to uphold high standards of professional competence (HPCSA, 2017; Pillay & Zank, 2018). The ever-changing field of psychology demands that professionals keep up with advancements, ensuring their interventions remain effective, evidence-based, and guided by the latest research. CPD plays an important part in this regard. The HPCSA (2017) notes that CPD is essential for health professionals to maintain ethical practices and protect the public interest in the South African society. This involves lifelong learning to update and develop knowledge, skills, and ethical attitudes necessary for competent practice. The CPD system relies on trust, and the HPCSA expects health practitioners to fulfil CPD requirements in the belief that practitioners, service users, patients, clients, students, colleagues, research participants, and the broader public will benefit from the lifelong learning of healthcare professionals. This mutual commitment to ongoing education also aims to enhance the quality of care provided by practitioners and to promote better health outcomes for clients and communities (HPCSA, 2017).

LGBTQIA+ content is still substantially underrepresented in undergraduate and postgraduate psychology curricula (Victor, 2024) as well as in medical curricula (De Vries et al., 2020; Muller et al., 2023; Müller, 2013). Proactive post-qualification training, via CPD workshops, webinars, and symposia is therefore essential for psychology professionals engaged in affirmative practice to ensure that they are equipped with the knowledge, skills, and attitudes necessary for providing affirming, competent, and ethically responsible care to all

clients and communities from diverse backgrounds with multiple intersecting discriminations. Continuing professional growth is integral to promoting diversity, equity, inclusion, belonging, and social justice. Given the current socio-political climate in South Africa, which is marked by violence and homo-, bi-, queer- and transphobia against sexually and gender-diverse individuals, psychology professionals should address and challenge these issues critically. To be effective in countering these injustices in both therapeutic and institutional contexts, psychology professionals should first be well informed about the systemic challenges faced by sexually and gender-diverse communities.

CPD is particularly important for health professionals and other stakeholders engaged in affirmative practice and advocacy, as it helps them develop a deep understanding of the evolving cultural, social, and historical contexts that shape the identities and experiences of service users, patients, clients, students, colleagues, and/or research participants (Stephens & Boonzaier, 2020). It is expected of practitioners to challenge systemic inequalities and to promote social justice within the field of psychology and in broad society (Harvey & Kotze, 2022). CPD equips professionals with the tools, strategies, and resources to address issues of power, privilege, discrimination, and oppression in their practice. Affirmative practice requires psychology professionals to engage in ongoing self-reflection, examination of biases, and awareness of their own identities and privileges. Lastly, continuing learning through CPD offers opportunities for professionals to deepen their self-awareness and develop critical reflexivity skills, which are essential for providing affirming and culturally competent care.

Research suggests that CPD can be highly effective in enhancing mental health practitioners' knowledge, skills, and overall effectiveness in their practice (Yu et al., 2023). Antwi (2023) found a positive correlation between the frequency of CPD programme attendance among high school counsellors and their job performance in delivering counselling services to students. The findings led to the conclusion that CPD initiatives are successful in enhancing counsellors' knowledge, competencies, and professional attitudes. A study by Mlambo et al. (2021) found that participating nurses felt that engagement in CPD elevates professional standards by enhancing competencies, consequently improving professional performance, attitudes, and job motivation. This improvement was perceived to be associated with positive outcomes for patients, healthcare organisations, and individual nurses.

While 'CPD points' are important, and the HPCSA regulations provide good incentives and obligations, it is however important for practitioners – as scholar-practitioners – to actively develop a scientifically grounded resource base on which they can draw, and to keep updating their personal knowledge. To better advocate for and meet the mental health needs of sexually and gender-diverse people, an affirmative stance requires keeping up to date with evolving academic research into evidence-based interventions, as well as tracking wider cultural trends to understand the environments that inform the lived experiences of clients and patients.

South Africa has seen a significant body of academic work around sexually and gender-diverse people over the last few years, and South African psychologists have been a leaders in this regard (Lancet Psychiatry, 2022; Nel, 2014; Pillay et al., 2019). Nevertheless, practitioners should acknowledge what remains unknown, and they have to consider how they can contribute to shaping research agendas both locally and internationally. A fundamental aspect of adopting an affirmative stance involves actively sharing up-to-date knowledge as well as advocating for addressing ongoing gaps in knowledge that hinder the effective delivery of affirming practice and care for sexually and gender-diverse clients.

Application

Psychology professionals are urged to engage in regular CPD activities to build and maintain competence in working with sexually and gender-diverse people. Psychology professionals have a legal and ethical obligation to ensure they are competent in working with the populations they serve, especially when those population groups have specific histories, complexities, and needs, such as sexually and gender-diverse people.

Research confirms that attending conferences has the potential of minimising attitudinal bias (Yu et al., 2023). CPD activities could include:

- attending specialised workshops and training courses;
- presentations and symposia at congresses or conferences;
- attending journal clubs or reading LGBTQIA+ journals (see Appendix XI);
- participating in mentoring and supervision sessions with experienced psychology professionals;
- community involvement and advocacy efforts, volunteering at LGBTQIA+ organisations to understand their specific needs and dynamics;
- conducting research and professional writing, such as writing affirmative policies, reference documents, or standard operating procedures.

These are just some examples of how we can improve our knowledge and attitudes.

Furthermore, professionals should compile and update a resource and referral database specific to the geographic areas within which they work, as sexually and gender-diverse people might not be familiar with the sources available to support them (Victor, 2024). This will help professionals familiarise themselves with the network of support and social capital available to improve their own competencies and to assist potential clients (see Appendix IX – LGBTQIA+ resource list). Community engagement is essential in developing community-based resources, as engagement ensures the resources are relevant and culturally appropriate, and they address users' needs effectively. This fosters collaboration, builds trust, and enhances the practicality and acceptance of the resources by incorporating diverse perspectives and first-hand experiences. This aligns with the principle of 'nothing for us without us'. Psychology professionals should collaborate with sexual and gender-diverse individuals and community-based organisations who are at ground level to create effective resources and referral pathways.

By engaging in regular CPD activities, psychology professionals can stay abreast of the latest research, therapeutic techniques, and best practices in their field, ultimately improving their ability to provide effective and affirming care to service users, patients, clients, students, colleagues, and/or research participants across the spectrum of sexual and gender diversity.

Online resources, such as social media, blogs, YouTube, and discussion groups can be useful, but should be interpreted with caution, as these may not be supported by peer-reviewed science, and generally do not have expert editors or moderators. In an era of misinformation, disinformation, and fake news, professionals must be discerning about the information they consume, use, and distribute, and they should also ensure that the veracity, authenticity, and evidence base of the information is of high quality. Predatory journals should be avoided as should organisational resources with a specific anti-gender or anti-LGBTQIA+ agenda (see Appendix XI for recommended LGBTQIA+ journals).

Psychology professionals are encouraged to join and engage with CPD-accredited activities offered by organisations with demonstrated expertise in working with SOGIESC minorities, including professional associations, such as:

- Psychological Society of South Africa (PsySSA);
- Professional Association for Transgender Health South Africa (PATHSA);
- Southern African HIV Clinicians Society;
- OUT LGBT Well-being;
- Gender Dynamix; and
- Intersex South Africa.

In addition to engaging with these guidelines, psychology professionals are also encouraged to engage with other international guidelines and verified articles and reports to stay informed about global developments in the area of sexual and gender diversity. A few recommended documents are:

- Guidelines for psychological practice with sexual minority persons (American Psychological Association) (https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf)
- Guidelines for psychological practice with transgender and gender nonconforming people (American Psychological Association) (http://www.apa.org/practice/guidelines/transgender.pdf)
- Guidelines for psychologists working with gender, sexuality and relationship diversity (British Psychological Society) (https://www.bps.org.uk/guideline/guidelines-psychologists-working-gender-sexuality-and-relationship-diversity)
- Standards of care for the health of transgender and gender diverse people, Version 8 (World Professional Association for Transgender Health) (https://www.wpath.org/soc8/chapters)
- Gender-affirming healthcare guidelines for South Africa (Southern African HIV Clinicians Society) (https://sahivsoc.org/Files/SAHCS%20GAHC%20guidelines-expanded%20version_Oct%202021(3).pdf)

- Clinical guidelines for working with clients involved in kink (Kink Clinical Practice Guidelines Project, 2019) (https://doi.org/10.1080/0092623X.2023.2232801)

Psychology professionals are urged to familiarise themselves with conversion practices, also known as 'change efforts' or 'conversion therapy', and to understand the negative physical health and mental health outcomes experienced by survivors. Professionals are also encouraged to take an active role in combating these practices within their occupational, social, professional, and religious spaces. The following reports provide insights into the consequences of conversion practices for survivors in South Africa, Nigeria, and Kenya.

- Inxebalam: 'Conversion practices' and implications in the South African context (Access Chapter 2) (https://outrightinternational.org/sites/default/files/2022-09/AC2-conversion-report.pdf)
- Shame is not a cure: So-called conversion 'therapy' practices in Kenya (Gay and Lesbian Coalition of Kenya [GALCK+]) (https://outrightinternational.org/sites/default/files/2022-08/galck%2BConversion_Practices_in_Kenya.pdf)
- The nature, extent and impacts of conversion practices in Nigeria (the Initiative for Equal Rights) (https://outrightinternational.org/sites/default/files/2022-09/The_Nature_Extent_and_Impacts_of_Conversion_Practices_in_Nigeria_Web.pdf)
- Outright International health ethics and the eradication of conversion practices in Africa (http://outrightinternational.org/health-ethics-and-eradication-conversion-practices-africa)

For professionals working with sexually and gender-diverse clients, CPD training plays a crucial role in several key areas.

CPD training helps psychology professionals gain a deep understanding of the unique experiences and challenges faced by sexually and gender-diverse individuals. This includes knowledge about diverse sexual orientations, gender identities, and the intersectional factors that could influence these experiences. By staying updated with the latest research, practices, and therapeutic techniques, psychology professionals can provide more informed and effective care.

Working with sexually and gender-diverse clients requires sensitivity to ethical issues. CPD training ensures that psychology professionals are aware of and adhere to ethical guidelines and standards that may be relevant to this population. This includes respecting client confidentiality, understanding informed consent in the context of diverse identities, and addressing biases that may affect treatment.

Psychology professionals who engage in CPD can create a therapeutic environment that is genuinely supportive and affirming. This involves validating clients' experiences, addressing internal and external sources of stigma, and helping clients build resilience. CPD training can equip psychology professionals with the skills to offer appropriate interventions and support tailored to the needs of sexually and gender-diverse individuals.

Furthermore, CPD may empower psychology professionals to be better advocates for their sexual and gender-diverse service users, pa-

tients, clients, students, colleagues, and/or research participants, both within the therapeutic setting and in broader society.

Creating a respectful and inclusive environment is crucial for all forms of psychological practice. CPD training helps psychology professionals develop cultural competence and cultural humility, including understanding and challenging their own biases, fostering an atmosphere of respect, and using inclusive language. This helps build trust with service users, patients, clients, students, colleagues, and/or research participants, making them feel safe and valued.

In summary, CPD training empowers psychology professionals to provide competent, ethical, and supportive care for sexually and gender-diverse clients, and to meet the specific needs of this population while fostering a respectful and inclusive therapeutic environment.

Case study

Case study 1:

PsySSA, contracted by the Department of Social Development, conducted training to enhance the skills of social work staff in serving sexually and gender-diverse clients. Attendees completed pre- and post-training feedback questionnaires along with an evaluation survey. Utilising the LGBT-DOCSS, a clinical self-assessment tool (Bidell, 2017), the training significantly bolstered overall competence, particularly in attitudes and knowledge. Participants lauded the clarity on policies accommodating the LGBTQIA+ community, precise explanations of terminology, and empowerment gained. Qualitative feedback reflected gratitude for the insightful educational experience, emphasising the importance of such information for societal change and personal empowerment in working with diverse populations.

In closing

The development of this second edition of the Practice guidelines for psychology professionals working with sexually and gender-diverse people reaffirms our commitment to creating a locally relevant and contextually informed resource. The evolving landscape of science and practice has brought both challenges and opportunities, allowing us to produce a document which, we believe, reflects a nuanced and comprehensive understanding of sexual and gender diversity in the South African context.

As with the original guidelines, this updated version strives to offer a robust foundation for psychology professionals across diverse work environments, including clinical practice, research, teaching, policy, and advocacy. We hope that the additions and revisions provide further clarity, applicability, and support for professionals at various stages of their careers. From newly qualified practitioners to seasoned experts, these guidelines aim to promote ethical, affirming, and competent practice.

We believe these guidelines not only benefit professionals in South Africa but, as evidenced by the reception of the first edition, also hold potential value for international audiences. As an evolving document, it serves as a catalyst for further research, curriculum development, and policy reform. In particular, we hope that these guidelines contribute to setting higher standards for the treatment and care of LGBTQIA+ individuals, as well as fostering a more inclusive profession.

It is our sincere hope that you find the revised guidelines both useful and thought-provoking. We encourage feedback from all users to refine and improve this resource further in future versions, and we invite continued dialogue on the critical issues addressed here. These guidelines remain a living document, designed to evolve alongside the people and practices it supports.

GLOSSARY

This section outlines and explains a number of key terms, which psychology professionals might find useful in practice. Care should be taken when using language in this area of work. Words may mean different things in different cultural, political, and social contexts. People might attribute different meanings to the terms when they define their own identities and life journeys. Within academic and activist circles, terminology evolves quickly in order to improve our understanding of issues in this area of work, within an affirmative practice framework.

Affirmative practice or **affirmative stance:** affirmative practices *actively* use approaches that are ethical, responsible, respectful, empathic, non-judgmental, and comprehensive in their understanding of sexual and gender diversity as part of a broader social commitment to embracing diversity and human rights.

Agender: a gender identity where a person does not identify with any gender. Agender individuals might feel an absence of gender, view themselves as gender-neutral, or might have the idea that they exist outside the gender binary. Their gender expression can vary, and they might not engage in traditional gender roles.

Aromantic: individuals who experience little or no romantic attraction, similar to how 'asexual' refers to individuals with little or no sexual attraction. Some may identify as both asexual and aromantic, or as just one.

Asexual: often referred to as 'ace', is a sexual orientation where a person experiences little to no sexual attraction. Asexual individuals may still engage in romantic relationships but often without the desire for sexual activity. Asexuality may, among others, present as greysexual (occasional attraction) and demisexual (attraction after emotional connection).

Biological sex: is critiqued as a term that reduces the complexity of the human body to a rigid, binary, biological classification that excludes intersex individuals, and promotes the idea that sex is fixed or more 'real' than gender. Often oversimplified to reference chromosomes, hormones, and genitalia, biological sex often overlooks biological diversity and marginalises transgender, nonbinary, and intersex people.

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

Biphobia: prejudice, discrimination, or negative attitudes directed at bisexual individuals, or those attracted to more than one gender. Biphobia could manifest as denial or erasure of bisexuality, stereotyping bisexuals as confused or promiscuous, or invalidating their identity. This phobia is found in both heterosexual and LGBTQIA+ communities.

Bisexual: a person who is attracted to more than one gender, typically both men and women, though it could include various gen-

der identities. With increasing recognition of gender diversity, some individuals may use terms such as 'pansexual' or 'plurisexuality' to describe their attraction to people across the gender spectrum. Bisexuality contrasts with 'monosexuality', where attraction is limited to one gender. This attraction could take various forms, including romantic, sexual, intimate, or affectionate feelings, and may differ in intensity or expression.

Chemsex: the use of drugs during sexual activity, particularly by gay men, men who have sex with men (MSM), trans women, and sex workers. It commonly involves substances, such as crystal meth, mephedrone, and GHB (gamma-hydroxybutyrate, an illegal drug that acts as a nervous system depressant). Chemsex often spans days, disrupting medication routines and contributing to mental health challenges linked to trauma, loneliness, and self-esteem issues.

Chosen family: the support networks that LGBTQIA+ individuals often create outside of their families of origin. Chosen families provide emotional support, particularly for individuals who may face rejection from their families of origin due to their sexual orientation or gender identity.

Cisgender: individuals whose gender identity matches the sex they were assigned at birth. For example, a person who is assigned female at birth and who identifies as a woman is cisgender. The term is often used in contrast to **transgender**, where a person's gender identity differs from their assigned sex. Cisgender people experience societal privileges and acceptance in line with traditional gender norms, often without having to consider or confront their gender identity in daily life.

Cisprivilege: the unearned advantages that cisgender individuals experience, such as being addressed with correct pronouns, having their gender identity automatically respected, and accessing gender-specific spaces without fear. This privilege often goes unnoticed by those who benefit from it, but it contributes to the marginalisation of transgender, nonbinary, and gender-diverse individuals, who may face discrimination, misgendering, and other forms of bias.

Cisnormativity: the assumption that being cisgender is the default or 'normal' state, leading to the recognition and validation of only cisgender identities. This framework marginalises transgender, nonbinary, and gender-diverse identities, rendering them invisible or 'abnormal'. Cisnormativity permeates institutions and social interactions, contributing to discrimination, exclusion, and the erasure of gender-diverse experiences.

Cisgenderism: the systemic privileging of cisgender identities while marginalising, invalidating, or denying transgender, nonbinary, and gender-diverse identities. It assumes cisgender perspectives on gender are superi-

or, leading to the erasure and devaluation of gender-diverse experiences. Cisgenderism manifests through societal norms, institutional practices, and policies that reinforce the idea that being cisgender is the only valid gender experience, treating transgender identities as inferior or inauthentic. This results in discrimination, misgendering, and barriers to accessing gender-affirming care.

Compulsory heterosexuality ('comphet'): popularised by Adrienne Rich in her 1980 essay "Compulsory heterosexuality and lesbian existence", 'comphet' describes a system of oppression that enforces heterosexuality as the only acceptable form of sexual and romantic relationships. This systemic issue is upheld by various institutions – including political, religious, economic, legal, medical, familial, and educational establishments – that work together to maintain the dominance of heterosexual couples.

Compulsory monogamy: similar to 'compulsory heterosexuality', this concept refers to societal norms that privilege and enforce monogamy as the default or 'natural' relationship structure, marginalising non-monogamous practices, such as polyamory.

Compulsory sexuality: the societal expectation that all individuals should be sexually active or desire sexual relationships. This enforces the idea that sexual attraction and activity are the norm, marginalising non-sexual identities, such as asexuality.

Conversion practices: harmful and discredited interventions aimed at changing or suppressing an individual's sexual orientation, gender identity, or gender expression. Based on the false belief that being LGBTQIA+ is abnormal, pathological, or sinful, these practices seek to 'convert' individuals to heterosexual or cisgender identities, and may include psychological, religious, or physical methods.

Deadnaming: calling a transgender or gender-diverse person by their birth name or original assigned name instead of their chosen name. This practice is harmful and disrespectful, invalidating their gender identity and may cause distress or dysphoria. Deadnaming undermines a person's identity and disregards their need to be acknowledged by their chosen name.

Depathologisation: the process of removing the classification of certain behaviours or identities as medical or psychological disorders. In LGBTQIA+ contexts, it challenges the historical medicalisation of sexual and gender diversity, affirming that identities, such as transgender, nonbinary, gay, and bisexual, are not mental illnesses. Depathologisation reduces stigma, supports self-determination, and promotes dignity for diverse identities. An example is the removal of 'homosexuality' from the DSM in 1973.

Detransitioning: the process of discontinuing or reversing a gender transition, often due to a change in how an individual identifies or conceptualises their gender. This may involve reverting to the name, pronouns, appearance, or legal status associated with their assigned

gender at birth, stopping hormone therapy, or undergoing surgeries to alter physical changes. Detransitioning can occur for personal, social, or medical reasons, and is a highly individual experience that does not invalidate a person's earlier gender journey.

Differences in sex development (DSD): also referred to as 'intersex', describes a group of congenital variations where an individual's chromosomal, gonadal, or anatomical sex traits do not fit typical male or female definitions. These differences may include variations in chromosomes (e.g. XXY or XO), hormone levels, or reproductive anatomy. Intersex or DSD traits may be apparent at birth, puberty, or later in life. The use of 'intersex' is often used in community contexts, while the term 'DSD' is commonly used in medical settings, reflecting natural human diversity

Ethical non-monogamy: relationship structures in which individuals engage in multiple consensual, romantic, or sexual relationships with the knowledge and consent of all parties involved. Ethical non-monogamy can take many forms, including polyamory, open relationships, and swinging. The key distinction is that relationships are built on mutual trust and honesty, avoiding secrecy or deception, which would typically occur in infidelity.

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

Gender: a social construct that refers to the roles, behaviours, and expectations associated with masculinity, femininity, and other expressions. Shaped by societal norms and institutions, gender influences how individuals are expected to behave based on perceptions of their sex assigned at birth. While traditionally viewed as binary (masculine and feminine), gender is now understood as a spectrum of diverse identities and expressions.

Gender identity: an individual's deeply personal experience and understanding of their gender, which may or may not align with their sex assigned at birth or gender expression. Gender identity includes identities such as man, woman, cisgender, transgender, nonbinary, genderqueer, and agender. Gender identity is self-determined, and relates to how individuals understand and express themselves in relation to societal roles, behaviours, and norms of masculinity, femininity, or other gender expressions.

Gender expression: the external display of one's gender identity through behaviour, clothing, hairstyle, voice, and other forms of presentation. It is how individuals communicate their gender to the world, which may or may not align with societal expectations or their sex assigned at birth. Gender expression can range from masculine to feminine, or non-conforming, and is independent of gender identity or sexual orientation. It is a personal choice, and should not be used to assume someone's gender identity.

Gender-affirming care: a range of psycho-social support and medical interventions aimed at helping individuals align their wellbeing with their gender identity. This includes social support (e.g. name changes, pronouns), mental health services, hormone therapy, and surgeries. Gender-affirming care operates on informed consent, and focuses on improving quality of life and mental health, not imposing interventions.

Gender diversity: the wide range of gender identities, expressions, and experiences beyond the traditional binary of male and female. It includes various ways people express their gender through appearance, behaviour, and roles, which may not align with societal expectations of masculinity and femininity.

Gender dysphoria: the distress or discomfort that arises when a person's gender identity does not align with the sex they were assigned at birth or the way their body is perceived. Gender dysphoria could affect emotional and mental wellbeing, leading some to seek gender-affirming care. Not all transgender or gender-diverse people experience dysphoria.

Gender essentialism: the belief that gender is biologically determined and inherently tied to one's sex assigned at birth. This perspective assumes that there are only two fixed genders – male and female. It disregards the complexity and diversity of gender identities and marginalises transgender, nonbinary, and gender-diverse individuals, limiting personal freedom and self-expression.

Gender euphoria: the sense of joy, comfort, and affirmation that arises when an individual's gender identity is recognised and aligns with how they truly see themselves. The may occur through being referred to by the correct pronouns, wearing clothing that reflects one's gender identity, or undergoing physical changes that affirm their sense of self. Gender euphoria encompasses the feeling of being fully seen, valued, and accepted by society, fostering belonging and self-worth. It contrasts with gender dysphoria, by focusing on validation and happiness.

Gender fluidity: a gender identity that is not fixed, but which can change over time or depending on the context. A gender-fluid person may experience shifts in their gender identity, moving between male, female, both, neither, or other identities on the gender spectrum. These changes may occur over varying periods, and challenge the notion of gender as rigid or binary, instead embracing gender as flexible, dynamic, and self-determined.

Gender non-conforming: behaviours, appearances, or identities that do not align with societal expectations of masculinity or femininity typically associated with the sex assigned at birth. Gender non-conforming individuals challenge traditional gender norms through their expression. While still used, the term 'gender non-conforming' is increasingly seen as outdated, as it implies deviation from a 'norm'. Many prefer more inclusive terms, such as 'gender diverse' or 'gender expansive', which recognise a wide range of valid gender expressions without framing them as 'non-conforming'.

Gender policing: a term referring to the enforcement of normative gender roles or expectations by others. It often manifests as comments, judgements, or actions that force individuals to conform to traditional gender roles or expectations.

Genderqueer: a gender identity that challenges or rejects traditional notions of the gender binary (male and female). Individuals who identify as genderqueer may experience their gender as a mix of both male and female, neither, or something entirely different. Genderqueer people often view gender as fluid, non-fixed, or beyond conventional categories. This identity celebrates the diversity of gender experiences and exists outside of rigid norms.

Greyromantic and greysexual: identities that describe people who experience romantic and/or sexual attraction infrequently or under specific circumstances, but still do not fit neatly into 'asexual' or 'aromantic' categories.

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

Heteropatriarchy (cisheteropatriarchy): a socio-political system where cisgender, heterosexual men hold dominance, leading to the marginalisation of women, LGBTQIA+ individuals, and non-binary people. Heteropatriarchy normalises heterosexuality and patriarchy while deeming other identities as abnormal, perpetuating systemic inequality through legal, social, and cultural structures.

Heterosexism: 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 (see Heteronormativity).

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

Homonationalism: first described by Puar (2007), 'homonationalism' refers to the way some countries use LGBTQIA+ rights to promote themselves as progressive, while simultaneously engaging in xenophobic, racist, or anti-immigrant policies. This term is a critique of how LGBTQIA+ rights can sometimes be co-opted to uphold nationalist or imperialist agendas, particularly against marginalised groups (see also Tucker, 2021).

Homonormativity: the system of expected norms and practices that emerges within gay and lesbian communities that serve a normative and regulatory function, in order to create a hegemonic culture wherein gay and lesbian people are expected to behave in certain ways even within LGBTQIA+ spaces (differs from 'Heteronormativity').

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

Internalised stigma or oppression: also referred to as **internalised homo-/bi-/queer-/transphobia** or **internalised negativity**, occurs when individuals from marginalised groups absorb and start to believe negative stereotypes and biases society has about their sexual orientation or gender identity. This could lead to shame, self-hatred, and mental health struggles, affecting the ability of such marginalised groups to accept and express their true identity. Internalised stigma reflects how societal prejudices are internalised, causing emotional distress.

Intersexuality: natural variations in human biology where an individual is born with physical sex characteristics – such as chromosomes, hormones, or genitalia – that do not fit typical male or female definitions. Intersex traits can be present at birth, during puberty, or later in life. Historically, intersex individuals have faced non-consensual medical interventions to 'normalisetheir bodies, causing harm. Intersexuality challenges binary sex norms, and advocates a call for bodily autonomy, informed consent, and recognition of intersex rights. Intersex individuals, like anyone else, may identify with any gender and sexual orientation.

Kink: unconventional sexual practices, fantasies, or interests that differ from mainstream sexual norms. These may include consensual activities such as BDSM (bondage, discipline, dominance, submission, sadism, and masochism), role playing, fetishes, and other forms of sexual expression. Kink centres on consent, communication, and the setting of boundaries, ensuring that all participants agree to and feel comfortable with the activities involved. It represents a diverse range of sexual exploration, challenging traditional views on sexuality by embracing consensual pleasure and desire in non-normative ways.

Kitchen table polyamory: a style of polyamorous relationships where all members of the polycule (a network of interconnected relationships) are comfortable socialising together, often in a friendly, respectful, consensual, family-like environment, or 'sitting around the kitchen table'. While some polycules may live together, others maintain strong bonds without cohabiting.

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

LGBTQIA+: an abbreviation representing lesbian, gay, bisexual, transgender, queer (or questioning), intersex, and asexual (or aromantic), with the **+** symbol acknowledging other sexual orientations and gender identities beyond those listed. While united by shared experiences of marginalisation in heteronormative societies, individuals under this umbrella have distinct needs and identities. Despite these differences, the term is used here in solidarity with efforts for equality and to ensure equal protection under the law for all gender and sexual minorities.

Metamours: the partners of one's romantic or sexual partner in a polyamorous relationship, with whom one does not have a direct romantic or sexual relationship. For example, if two people are in a relationship with the same person, they are each other's metamours. The relationship between metamours can vary widely, from close friendships to minimal interaction, depending on the dynamics of the polycule and the preferences of those involved. Metamour relationships are often defined by mutual respect and open communication.

Minority stress: the chronic psychological stress experienced by individuals from marginalised groups, such as LGBTQIA+ populations, due to their social identity. The stress arises from microaggressions, macroaggressions, prejudice, discrimination, and violence, along with fear of rejection or the need to conceal one's identity. This stress affects wellbeing and overall quality of life.

Misgendering: occurs when someone is referred to using incorrect pronouns, names, or gendered language that does not align with their gender identity.

Mono-normativity: the societal assumption that monogamy is the default, ideal, or superior form of romantic and sexual relationships, marginalising the legitimacy of non-monogamous relationships, such as polyamory, open relationships, or ethical non-monogamy.

Monosexism: the societal belief or assumption that being attracted to only one gender (i.e. heterosexual or homosexual) is the norm, while other forms of attraction, such as bisexuality, pansexuality, or other non-monosexual orientations, are invalid or less legitimate. Monosexism often leads to the erasure, discrimination, or misunderstanding of bisexual and pansexual individuals.

MSM (men who have sex with men)**:** used in public health contexts to refer to men who engage in sexual activity with other men, but may not necessarily identify as gay or bisexual, to avoid excluding men who identify as heterosexual. Note: trans men may also be included in such a description (also see WSW and Sexual behaviour).

MSMW (men who have sex with men and women)**:** used in public health contexts to refer to men who engage in sexual activity with both men and women, regardless of how they identify their sexual orientation.

Neo-pronouns: pronouns, such as xe/xem, ze/zir, or fairy/fair, used by some individuals to reflect their gender identity. They challenge traditional language norms, promoting self-determination and inclusivity while serving as a form of activism against binary gender constructs in society.

Non-binary: a gender identity that does not fit within the traditional categories of 'male' or 'female'. Nonbinary individuals may experience a gender that is both, neither, or something entirely different. Terms such as 'genderqueer', 'genderfluid' or 'agender' may describe their gender, and their expression may or may not align with societal expectations of masculinity or femininity. Nonbinary identities challenge the binary view of gender, recognising it as a spectrum with diverse, individual experiences.

Outing: the act of revealing someone's sexual orientation or gender identity without their consent, often causing harm or distress by violating their privacy.

Pansexual: a sexual orientation characterised by the attraction to individuals regardless of their gender or sex. Pansexual individuals may feel romantically or sexually attracted to people of any gender identity, including men, women, nonbinary, genderqueer, or transgender individuals. The term emphasises that gender is not a determining factor in whom they are attracted to, and it highlights a fluid, inclusive approach to attraction that transcends the traditional gender binary.

Passing: this term refers to the ability of a person, often a transgender or nonbinary individual, to be perceived by others as the gender with which they identify, rather than the one assigned at birth. This may involve aspects of physical appearance, behaviour, and social interactions. While passing can be affirming for some, it may also imply societal pressure to conform to gender norms.

Pinkwashing: the practice of using LGBTQIA+ rights to promote a positive image or agenda, often to distract from other forms of injustice or unethical behaviour by corporations, governments, or organisations.

Pink capitalism: the commercialisation of LGBTQIA+ identities and culture, where businesses market products and services to LGBTQIA+ consumers, sometimes without real commitment to LGBTQIA+ rights or inclusion. It is linked to the commodification of queer identities for profit, especially during events, such as Pride (also see Queer baiting).

Plurisexuality: the attraction to multiple genders, encompassing identities, such as pansexuality, bisexuality, omnisexuality, and polysexuality. The term 'plurisexuality' describes individuals who are attracted to more than one gender, such as men, women, non-binary, and genderqueer identities. The experience of plurisexuality is fluid, and may vary from person to person. While bisexuality and pansexuality are more commonly recognised, plurisexual individuals may face challenges related to societal norms, such as monosexism.

Polyamory: a non-monogamous relationship configuration where a person has more than one intimate or sexual partner with the knowledge and consent of all partners, and with an emphasis on honesty and transparency. Polyamory is considered a minority relationship orientation, where monogamy is the dominant orientation. Polyamory includes openness and honesty of being involved with multiple concurrent relationships, as opposed to cheating (hidden concurrent relationships).

Polycule: a network or group of people who are connected through romantic or intimate relationships, typically in ethical non-monogamous or polyamorous arrangements. It illustrates the interconnected nature of multiple relationships, which may include partners, their partners (metamours), and so on. The structure of a polycule may vary widely, with individuals having varying degrees of involvement or commitment, and it recognises the complexity and diversity of non-traditional relationship dynamics.

Pride: the positive stance and celebration of identity within the LGBTQIA+ community, promoting self-affirmation, dignity, and equal rights. Pride represents a rejection of shame and social stigma that historically marginalised sexually and gender-diverse individuals. Pride events, such as parades and celebrations, are public affirmations of this visibility, advocacy for equal rights, and solidarity, while also recognising the ongoing struggles for acceptance and equality.

Pronouns: are used to refer to people in place of their names and often reflect their gender identity. Asking for and using correct pronouns is a basic sign of respect, avoiding terms such as 'preferred pronouns', which imply the pronouns are optional. Common pronouns include he/him, she/her, they/them, and less common ones such as ze/zir or xe/xem. Sometimes people use a combination, such as she/they. Pronouns can also be context-specific, with people using different pronouns in various social settings depending on how safe they feel.

Queer: an umbrella term for sexual and gender identities that fall outside heteronormative and hetero-cisnormative frameworks. It includes identities such as lesbian, gay, bisexual, transgender, nonbinary, and genderqueer. Once used as a slur, 'queer' has been reclaimed by many in the LGBTQIA+ community as an inclusive term celebrating diversity and fluidity in gender and sexuality. It also serves as a political stance, challenging rigid societal norms and embracing individuality in how people experience their identities and relationships.

Queerbaiting: a tactic used in media, politics, or marketing, where LGBTQIA+ representation is hinted at but never fully materialised in order to attract queer audiences without fully committing to queer inclusion.

Queerplatonic relationships: non-romantic relationships that go beyond typical friendships, often deeply intimate, but not based on romantic or sexual attraction.

Queer migration: this term relates to the experiences of LGBTQIA+ individuals who seek refuge in countries that welcome LGBTQIA+ individuals due to persecution in their home countries. 'Queer migration' emphasises the intersection of gender, sexuality, and immigration policies.

Reparative therapy: also known as 'conversion therapy' or 'sexual orientation change efforts' (SOCE), the term 'reparative therapy' refers to psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client or patient should change his or her sexual orientation (see Sexual orientation change efforts). It is not a legitimate 'therapy' and must be avoided.

Retransitioning: the process of modifying or resuming a gender transition as an individual's understanding of their gender evolves. This could involve re-engaging with medical interventions, such as hormone therapy, or transitioning to a different gender identity. The term recognises the fluid nature of gender identity and that a person's gender journey may involve multiple developmental stages or changes over time without implying a return to their gender assigned at birth.

Sex assigned at birth (or **sex assumed at birth**)**:** the classification of an individual as male, female, or intersex, typically made by medical professionals at the time of birth based on physical characteristics, such as external genitalia. This assignment is usually recorded on official documents, such as birth certificates. Sex assigned at birth may not necessarily align with an individual's gender identity, which is their personal experience of gender that could evolve independently of their assigned sex.

Secondary sex characteristics: the physical attributes associated with sex, including primary sex characteristics (such as reproductive organs and external genitalia) and secondary sex characteristics (such as facial hair, breast development, and voice pitch) that emerge during puberty. These characteristics are typically used to classify individuals as male or female, but variations in sex characteristics may occur naturally, such as in intersex individuals or those with **differences in sex development** (DSD). These characteristics do not necessarily determine gender identity.

Sexual behaviour: 'sexual behaviour' is distinguished from 'sexual orientation' because the former refers to behavioural acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour. Individuals – regardless of their SOGIESC, including cisgender heterosexuals – may engage in a wide range of behaviours and practices often associated with sexuality. These may include bondage and discipline and sadomasochism (BDSM), which has nothing to do with sexual orientation and/or gender identity.

Sexual diversity: the range of different expressions of sexual orientation and sexual behaviour that spans across the historically imposed heterosexual–homosexual binary (also see Gender diversity).

Sexually and gender-diverse identities: the range and spectrum of individual identities, related to a person's sexual orientation, sexual behaviour, gender identity/expression, sex characteristics, and relationship configurations, that encompass being LGBTQIA+ (see **SOGIESC**).

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

Sexual orientation change efforts (SOCE): also known as 'reparative therapy' or 'conversion therapy' are a set of scientifically discredited practices that aim to deny, suppress, or forcibly change the diverse sexual orientations, gender identities, and/or gender expressions of sexual and gender minorities (SGM). SOGIECE are associated with significant adverse health and social outcomes. SOGIESC are discredited and lack evidence (see **Conversion Practices**, **Reparative therapy** and **SOGIECE**).

SOGIESC (sexual orientation, gender identity and/or expression, and sex characteristics): an umbrella term used to describe the generic identity categories for LGBTQIA+ people.

SOGIECE (sexual orientation and gender identity and expression change efforts): a set of scientifically discredited practices that aim to deny, suppress, or forcibly change the diverse sexual orientations, gender identities, and/or gender expressions of sexual and gender minorities (SGM). SOGIECE are associated with significant adverse health and social outcomes. SOGIESC are discredited and lack evidence (see **Conversion Practices**, **Reparative therapy** and **SOCE**).

Social transition: the non-medical steps a person takes to live in alignment with their gender identity in everyday life. This may include changing their name, adopting new pronouns, altering clothing and appearance, and using gendered spaces that match their identity. It may also involve communicating their gender to social networks. Social transitioning is highly individual and gradual, with each person making changes based on their comfort level and circumstances (see Transitioning).

TERFs (trans-exclusionary radical feminists): individuals who align with feminist ideologies but reject the inclusion of transgender women in their advocacy, arguing that gender is biologically determined. The term has also been used as an insult, which could hinder constructive dialogue. TERFs advocate for excluding trans women from women-only spaces and promote views that invalidate transgender identities.

Transnormativity: societal expectations that transgender individuals conform to traditional, binary gender norms, often through medical or social transitions. Transnormativity reinforces the idea that only certain trans experiences are valid, marginalising nonbinary and gender-diverse identities or non-medical transitions.

Trans feminine (or **trans femme):** an identity or attribute referring to individuals who were assigned male at birth but identify with or express themselves in ways traditionally aligned with femininity. Trans feminine encompasses a spectrum of identities, and may include people who identify as women, as well as nonbinary or genderqueer individuals with a connection to femininity. Trans feminine people may or

may not undergo medical transitions, and their gender expression may vary, but it is primarily linked to a feminine identity or presentation.

Trans masculine (or **trans masc):** denotes both a person and an attribute, referring to individuals who were assigned female at birth but identify with or express themselves in ways aligned traditionally with masculinity. This term encompasses a spectrum of identities, including men, nonbinary, and genderqueer individuals who feel a connection to masculinity. Trans masc people may or may not undergo medical transitions, and their gender expression may vary, but it is primarily linked to a masculine identity or presentation.

Transgender (or **trans):** individuals whose gender identity differs from the sex assigned at birth. Their internal experience of gender may not align with societal expectations, challenging gender essentialism, which links gender strictly to physical characteristics. 'Transgender' is used as an umbrella term for gender diversity, including trans men, trans women, and genderqueer individuals. While some pursue medical or social transitions, others may not. Being transgender is about living authentically in one's gender identity.

Trans(gender) woman: someone assigned male at birth who identifies and lives as a woman. Trans women may undergo social, legal, or medical transitions, such as hormone therapy, surgery, or changing pronouns and names.

Trans giftedness: as described by Benestad (2002), refers to the unique talents, experiences, and perspectives that trans individuals bring to the world. Rather than viewing trans identities through a pathological lens, trans giftedness celebrates the strengths, resilience, and insights gained from trans people's lived experiences.

Trans(gender) man: someone who was assigned female at birth but identifies and lives as a man. Trans men may undergo social, legal, or medical transitions, such as hormone therapy, surgery, changing pronouns, or names, though each individual's experience is unique.

Transphobia: negative attitudes, beliefs, and actions directed at transgender, nonbinary, and gender-diverse individuals. It includes verbal abuse, harassment, misgendering, microaggressions, and macroaggressions. On an institutional level, transphobia appears in discriminatory healthcare, education, and legal policies. Socially and culturally, it privileges cisgender identities and perpetuates harmful stereotypes and erasure of identities.

Transitioning: the process by which an individual aligns their gender identity with their lived experience, moving away from the sex assigned at birth. This may include social changes (e.g. new name, pronouns, or appearance), legal updates (e.g. gender marker changes), and/or medical interventions, such as hormone therapy or surgeries. Each transition is unique, shaped by personal preferences and available resources, and supports living authentically in one's gender identity.

Transsexual: a term historically used to describe individuals who transition from their sex assigned at birth to align their physical body with their gender identity. Although some countries and people still use this term, it is seen as problematic due to its focus on medical transition. Many prefer 'transgender', which emphasises the internal experience of gender without implying medical intervention is necessary. It is important to respect individual self-determination while recognising the outdated connotations of transsexual.

WSW (women who have sex with women)**:** Used in public health contexts to refer to women who engage in sexual activity with other women, but do not necessarily identify as lesbian or bisexual. Note: transwomen may also be included in such a description (also see MSM and Sexual behaviour).

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APPENDIX I: Collaborating organisations

The project that informs these guidelines comprises collaboration between the PsySSA Sexuality and Gender Division, the University of South Africa (UNISA), the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), and the PsySSA African LGBTQIA+ Human Rights Project.

Psychological Society of South Africa (PsySSA)

PsySSA is a NPO of psychology practitioners (registered counsellors, psychometrists, and psychologists), involved in both academic research and psychological services. Established in 1994, it is the nationally representative professional body for psychology in South Africa. PsySSA is committed to the transformation and development of South African psychology to serve the needs and interests of all South Africa people. PsySSA advances psychology as a science, a profession, and a means of promoting human wellbeing (see www.psyssa.com).

The PsySSA Sexuality and Gender Division (SGD)

As a division of PsySSA, the mission of the Sexuality and Gender Division (SGD) is to promote a psychological understanding of the fields of sexuality and gender. The goal is to support PsySSA in its endeavour to ensure human wellbeing and social justice for all people. This is realised through SGD member participation in research, clinical practice, education and training, networking, and advocacy, order to promote an inclusive understanding of diverse sexual orientations, gender identities/expressions, and sex characteristics (see http://www.psyssa.com/divisions/sexuality-and-gender-division-sgd/).

PsySSA African LGBTQIA+ Human Rights Project

A significant innovation for PsySSA as a voluntary professional association has been the international and local donor-funded PsySSA African LGBTQIA+ Human Rights Project within the SGD. The overall goal of this project is to build PsySSA capacity in South Africa, and more broadly in sub-Saharan Africa, to engage with issues related to SOGIESC (see https://queeringpsychology.co.za/).

University of South Africa (UNISA)

UNISA is the largest open distance learning institution in Africa, and the longest standing dedicated distance education university in the world. It enrols nearly one third of South African students. The Department of Psychology is recognised nationally and internationally for excellence in education, research, and community-engaged scholarship. One of these community engagement projects is named 'Towards LGBT Health and Wellbeing' (see https://www.unisa.ac.za/sites/corporate/default).

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

PsySSA is a member of IPsyNet, and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world, working together to increase understanding of sexual orientation and gender-diverse people, and to promote their human rights and wellbeing (see www.ipsynet.org).

OUR MISSION

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

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

WHAT NEXT?

Has the information in this brochure piqued your interest? Blown your hair back? Excited your mind? If so, consider joining by reaching out to an SGD executive member, or sending your details to sgd@psyssa.co.za to be added to the SGD emailing list.

If you're still just curious, find out more at:

- **www.psyssa.com**/divisions/sexuality-and-gender-division-sgd/
- www.facebook.com/**sgdpsyssa**
- **@SGDPsySSA**
- **info@psyssa.com**

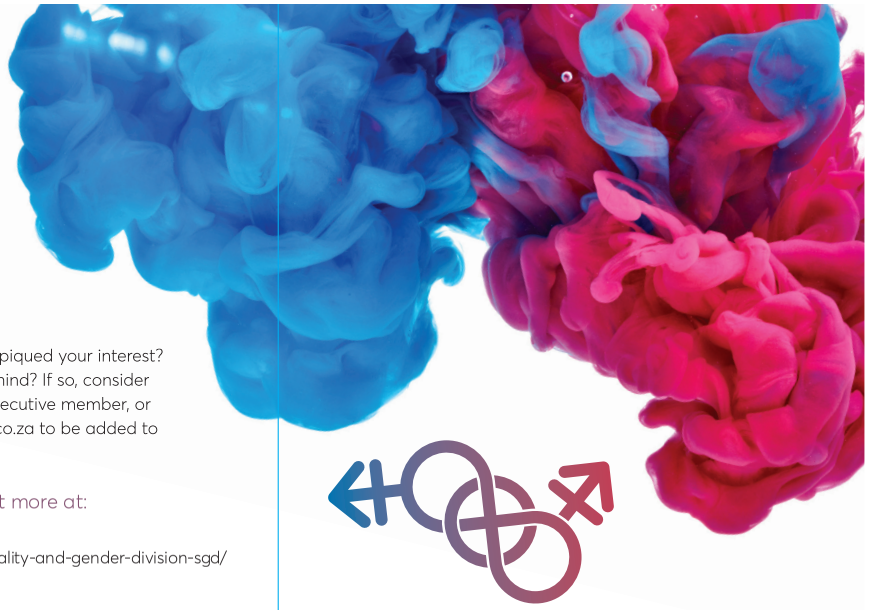
Check out the cutting-edge Practice Guidelines for Psychology Professionals working with Sexually and Gender-Diverse People

Based on the latest local, continental and global research, the practice guidelines are the first of their kind on the African continent. They aim to increase psychological knowledge of human diversity in sexual orientations, gender identities, gender expressions and sex characteristics.

The guidelines are available at http://www.psyssa.com/practice-guidelines-for-psychology-professionals-working-with-sexually-and-gender-diverse-people/

PsySSA Psychological Society of South Africa

SGD SEXUALITY & GENDER DIVISION



SEXUALITY AND GENDER DIVISION

OF THE PSYCHOLOGICAL SOCIETY OF SOUTH AFRICA

- Do you want to know about cutting-edge research on sexuality and gender?
- Are you committed to making psychology diversity-affirming?
- Do you have an interest in collaborations to advance theory and praxis on LGBTIQ+ issues?
- Are you concerned about sexual and gender rights?
- Or, are you just curious?

Why not consider joining the Sexuality and Gender Division of the Psychological Society of South Africa?

OUR WORK

Research

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

Education and training

We provide training for students, clinicians, health workers and academics, informed by the PsySSA Sexual and Gender Diversity Practice Guidelines (2017), to advance the provision of sexuality and gender-affirming and inclusive practices. This includes general training and customised programmes based on specific needs and requests.

Advocacy and expert opinion

We engage in advocacy efforts and policy development on issues concerning sexual and gender rights in South Africa, in the region, and internationally. Through our networks, we are also able to provide expert opinion and advice related to this field of interest.

Practice

We are committed to the development and dissemination of sexual and gender-affirmative practice across the spectrum of mental health providers in South Africa. This includes PsySSA's first position statement and practice guidelines, namely on sexual and gender diversity, that were approved in 2013 and 2017, respectively.

KEY SUCCESSES

2007	PsySSA joins IPsyNET (International Psychology Network for LGBTIQ+ Issues
2009	First focused LGBTI programming at a PsySSA Congress, which has grown to be a premier annual event bringing together the best scholarly and applied work around sexuality and gender in Psychology in South Africa
2010	Statement to the Ugandan government offering a science-based assessment of the proposed "Anti-Homosexuality Bill of 2009" and calling upon them to abandon or defeat it
2010	Open statement to the United Nations (UN) following and condemning the South African vote to remove a reference to sexual orientation from the UN resolution condemning extrajudicial, summary and arbitrary executions and other killings
2011	Recipient of substantial international funding to support the activities of the Division – the first PsySSA Division/ Interest Group to do so. We continue to receive international and local funding support for our work
2013	Development and adoption of the PsySSA Sexual and Gender Diversity Position Statement– a first for the Society, which promotes an affirmative stance in working with sexually and gender diverse South Africans in the mental health context
2014	Official launch of the Division at the 20th PsySSA Congress
2015	SGD Executive Member Prof Juan Nel contributes to the publication of Diversity in Human Sexuality: Implications for Policy in Africa, by the Academy of Science of South Africa
2017	Received an award at the PsySSA AGM for Most Improved Division. Provided expert testimony, as amicus curiae, in the Jon Qwelane hate speech hearing in the Equality Court
2018	Endorsement by PsySSA Presidency of IPsyNet Statement and Commitment to LGBTIQ+ Affirmative Psychological & Psychotherapeutic Practice and Research

OUR LINKAGES

IPsyNet

PsySSA is a member of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world working to increase understanding of sexual orientation and gender-diverse people and to promote their human rights and well-being. A significant innovation for PsySSA, as a professional voluntary association, has been the support of local and international donors for the 'PsySSA African LGBTI Human Rights Project', located within the SGD. The goal of the project is 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.

OUR MEMBERS & BENEFITS

Our membership consists of diverse psychology professionals, including clinicians, researchers, teachers, community practitioners, health workers, community activists, and students from a variety of disciplines across South Africa and the African continent.

Members share training opportunities, articles and other resources related to sexuality and gender.

APPENDIX III: IPsyNet policy statement and commitment on LGBTI issues

PsySSA is a signatory to the IPsyNet policy statement and commitment on LGBTI issues (IPsyNet, 2016, p. 5), which reads as follows:

"1. We acknowledge, as subscribers to the principle that human rights are universal, and that all human beings are worthy of dignity and respect, including respect for diversity on the basis of sexual orientation, gender identity, or differences in sex development. We believe that discrimination and psychological maltreatment are not consistent with international human rights aspirations (Universal Declaration of Ethical Principles for Psychologists, 2008). We actively support the development of and support for LGBTIQ+ affirmative and inclusive treatment as well as service provision.

2. We concur that psychology as a science and a profession has expertise based upon decades of research demonstrating that LGBTIQ+ identities and expressions are normal and healthy variations of human functioning and relationships. For example, as set out in the World Health Organization's ICD-10 (1990, p. 11), homosexuality is not a diagnosable mental disorder. We actively challenge claims made by political, scientific, religious or other groups that claim or profess that LGBTIQ+ identities, expressions, and sex characteristics are abnormal or unhealthy.

3. As LGBTIQ+ identities and orientations are normative variations of human experience and are not diagnosable mental disorders per se, they do not require therapeutic interventions to change them. Given that conversion therapies actively stigmatise same-sex orientations and transgender identities, as well as have the potential for harm, we support affirmative approaches to therapy for LGBTIQ+ people and reject therapies that aim to change sexual orientation or gender identity.

4. Transgender and gender nonconforming individuals have the right to live according to their gender identity and to access medical, psychotherapeutic, and social support as needed. This support should be offered irrespective of whether the person has a binary or nonbinary gender identity and whether they seek access to social or medical transition or one, several, or all treatments available. We furthermore support the full autonomy of transgender and gender nonconforming individuals in affirming their gender identities. We also believe that affirmative psychological support may be beneficial in their identity development and decision-making regarding social and medical transition (Coleman et al., 2012). We strongly oppose regulations forcing transgender and gender nonconforming individuals to undergo sterilization, divorce, or other procedures that might have stigmatizing or mentally, physically, or socially harmful effects in order to access desired transition supports. Therefore, we actively support the right of transgender and gender nonconforming individuals to define their identities as well as to decide on and access affirmative and transition-related health care as desired.

5. Some LGBTIQ+ people may experience psychological distress because of the impact of social stigma and prejudice against LGBTIQ+ people in general or their individual identity within the LGBTIQ+ spectrum. LGBTIQ+ individuals with non-monosexual (e.g., bisexual, pansexual) and non-cis identities (e.g., trans, nonbinary, agender), as well as LGBTIQ+ individuals with intersectional minority identities (e.g., based on race, ethnicity, disability, religion, gender, social class) may be especially at risk for minority stress, discrimination both inside and outside the LGBTIQ+ population, and resultant psychological difficulties. We condemn discrimination on the basis of intersecting minority identities within and beyond the LGBTIQ+ population. We furthermore actively support psychological research and practice that fully considers the intersectionality of LGBTIQ+ identities with others' identities such as ethnicity, social class, and religion."

APPENDIX IV: The Johannesburg Declaration Against SOGIE Change Efforts and Conversion Practices

PsySSA developed and is a signatory to the Johannesburg Declaration Against Sexual Orientation, Gender Identity and/or Expression (SOGIE) Change Efforts and Conversion Practices,[1] which reads as follows:

> "We, the undersigned mental health professionals from across Africa who attended the convening 'Meeting of minds: The role of mental health practitioners and associations in eradicating conversion practices in Africa', recognizing the historic and ongoing harm that some mental health professionals have committed, continue to commit, and/or are coerced into committing, regarding the use and endorsement of efforts to change people's sexual orientation, gender identity and/or expression (SOGIE), through so-called reparative therapies and conversion practices more broadly, declare that any attempt to change a person's SOGIE should have no place in professional mental health practices.
>
> **We declare that all efforts to change people's SOGIE:**
>
> – Are unnecessary, harmful and traumatic;
>
> – Are human rights abuses, forms of gender-based violence and, in some instances, torture;
>
> – Are unscientific, not rooted in authoritative scholarly theories of sexuality and/or gender, and not proven to be efficacious;
>
> – Are unethical and in breach of internationally accepted professional codes of ethics;
>
> – Go against all contemporary and accepted best practices in mental healthcare; and
>
> Must be unequivocally rejected in the interests of human rights, health and well-being.
>
> Developed at a convening of mental health professionals and allies hosted by the Psychological Society of South Africa (PsySSA) in Johannesburg, South Africa, 20–21 April 2023".

1 The Declaration remains open for signatories: https://www.change.org/p/support-the-johannesburg-declaration-against-sogie-change-efforts-and-conversion-practices

APPENDIX V: South African position statement on evidence-based care for transgender and gender-diverse young people

Embracing diversity, upholding rights: A South African position statement on evidence-based care for transgender and gender-diverse young people

18 August 2024 | Cape Town, South Africa

Background

Gender diversity is a fundamental aspect of the human experience, and the right to explore and affirm one's gender identity is integral to the individual, relational, and social wellbeing of our youth. To honour and affirm the existence and dignity of transgender and gender-diverse young people is to challenge the societal norms that seek to diminish their identities, allowing them not just to survive but also to flourish in a world that too often denies their very humanity.

South Africa is a country built on healing from a past that harmed and divided us. We are all called to commit to a future that is rooted in compassion and acts of care and belonging that bring forth the tangible recognition and affirmation of our shared humanity. In this pursuit, transgender and gender-diverse young people are not only fully recognised for their inherent worth but are also honoured as indispensable and cherished members of our society, deserving of the opportunity to reach their fullest potential and contribute to our shared future.

As a nation founded on *ubuntu* and the principles of equality, dignity, and unity, it is our collective responsibility to ensure that every young person in South Africa is afforded the opportunity to live authentically and without fear.

Framing

In keeping with the SA Constitution, child-focused legislation, the Patient Rights Charter as well as international conventions, treaties and charters –

- which create a frame for rights, dignity and care

Mindful of global and local anti-gender movements –

- which create a hostile climate for gender work

And recognising the legacies of colonialism and apartheid

- which erased pre-colonial identities and practices around gender diversity and created profound health inequalities

Resolutions

We call on everyone to stand in solidarity with transgender and gender-diverse young people to:

Recognise the right of all people to self-determine their gender, gender identity and gender expression:

We affirm the inherent right of every individual to determine and express their gender identity freely, without external imposition. This recognition is central to fostering a society where the autonomy and unique identities of transgender and gender-diverse young people are upheld as intrinsic to their personhood.

Protect safe and affirming spaces for young people and their families to explore and realise this self-determination:

It is vital to ensure inclusive environments where young people and their families can confidently consider their options to make informed decisions. These spaces must provide the acceptance and support necessary for healthy development and the full actualisation of their authentic selves, free from the barriers of prejudice or exclusion.

Support, improve and expand access to evidence-based care for transgender and gender-diverse young people and their families across South Africa:

Equitable access to comprehensive, evidence-based care is essential for the wellbeing of transgender and gender-diverse young people. This encompasses psychological and social support services, as well as medical care when needed, all of which must be developmentally appropriate, culturally sensitive, and accessible to everyone. We must expand these services to reach every young person, irrespective of geographic or socio-economic barriers, by advocating for increased resources and mobilising social and political will.

Prioritise the voices of transgender and gender-diverse young people in all decisions that impact their lives:

We underscore the imperative of centring transgender and gender-diverse young people in decision-making processes. Collaboration, support and guidance from families and healthcare professionals are essential in helping young people navigate their gender identity in a way that is safe, informed, and developmentally appropriate. Their insights and lived experiences must be the guiding force in developing policies, practices, and care frameworks that resonate with their needs and aspirations.

This position statement cements our commitment to ensuring that all young people are afforded the rights, respect, and healthcare necessary to live authentically. Grounded in our constitutional values of justice, freedom, and human dignity, we advocate for an inclusive and compassionate approach to evidence-based care for transgender and gender-diverse young people.

We call on all stakeholders, including government bodies, healthcare institutions, and educational systems, to not only stand in solidarity but also to be held accountable for upholding these principles. Concrete actions must be taken to ensure that the societal, legal, and healthcare rights of transgender and gender-diverse young people are fully recognised and realised.

We, the undersigned, thus resolutely support evidence-based care as a vital and ethical imperative.

APPENDIX VI: Sample letter to Home Affairs

This is a suggested letter that clinical, counselling, and educational psychologists could use in support of a client's application to the Department of Home Affairs for change in their gender marker. Note that the language used is in keeping with the requirements of the stated legislation, and is not necessarily in keeping with current best practices in terms of language use.

Organisational/Practice letterhead

Date_____

Attention: Department of Home Affairs

Subject: Letter of Support for Application for Change in Gender Marker in terms of the Births and Deaths Registration Act, 1992 (No. 51 of 1992) read with section 27(A) of the Description and Sex Status Act (No. 49 of 2003)

Identifying details

Surname :

Legal name :

Identity number :

Date of birth :

I have been consulting with _____ regarding gender reassignment. Her/his gender identity is that of female/male and she/he identifies herself/himself as female/male.

This is to verify that she/he is receiving gender reassignment treatment from _____.

Kind regards

_____

Name

Professional registration category

Professional registration number

Appendix VII: Sample inclusive client Intake Form

(Demonstrative purposes only)

***Note/Disclaimer**: This form is designed to ensure inclusivity, respect for self-identified names and pronouns, and sensitivity to diverse relationship structures. It should be customised to meet South African legal standards, including the Protection of Personal Information Act (POPIA) (or the POPI Act) (No. 4 of* 2013).

Personal details

Name you go by : _____

Use "Name you go by" instead of "Preferred name" to affirm the client's identity. This language signals that their chosen name will be respected in all interactions.

Pronouns : _____

(e.g. they/them, she/her, he/him, etc.)

Avoid "Preferred pronouns" to affirm that these pronouns must be used in reference to the individual, reinforcing respect for their identity.

Honorific : _____

(e.g. Mx, Mr, Ms, Dr, etc.)

Including a range of honorifics, such as Mx, ensures nonbinary and gender-diverse clients feel respected.

Legal name (if different) : _____

This allows for legal documentation without undermining the client's chosen name.

Date of birth : _____

Gender identity : _____

(e.g. man, woman, nonbinary, etc.)

An open field encourages clients to self-identify without being limited to binary options.

Sex assigned at birth : _____
(if necessary for medical purposes)

Only include this if it is medically relevant, to avoid unnecessary discomfort or dysphoria.

Contact information

Phone number : _____

Email : _____

Physical address : _____

Emergency contact information

Name : _____

Pronouns : _____

Phone number : _____

Relationship : _____

Preferred method of communication:

- Use the name and pronouns provided above
- Use alternate name and pronouns:

Name : _____

Pronouns : _____

It is important to give clients the option to specify how to be referred to when communicating with emergency contacts. This respects their identity in all contexts.

General communication preferences

How would you like to be addressed in communications (voicemails, emails, texts, etc.)?

- Use the name and pronouns provided above
- Use alternate information:

Name : _____

Pronouns : _____

Offering flexibility in communication preferences ensures that the client's identity is respected across all interactions.

Relationship status

- Not in a romantic/sexual relationship
- Not seeking romantic/sexual relationships
- Married
- In a relationship(s) but not married
- In relationship(s) with multiple partners
- In a platonic/companionship relationship
- Separated/divorced/widowed
- Other : _____

This inclusive list respects the diversity of relationships, including asexual and queer platonic partnerships.

Relationship structure

- Monogamous
- Polyamorous
- Non-monogamous/open
- Other : _____

Recognising diverse relationship dynamics, such as polyamory or open relationships, ensures all clients feel validated in how they define their partnerships.

Medical aid & billing information

Medical aid provider : _____

Member number : _____

- Are you the main member? ☐ Yes ☐ No

Specify name, pronouns, and honorific for use with medical aid records:

Name : _____

Pronouns: : _____

Honorific : _____

Allow clients to specify the information they wish to use for medical aid communications while complying with necessary legal requirements.

Appendix VIII: Self-interview guide for psychologists: Addressing personal biases on sexual and gender diversity

Exploring implicit biases

1. **First impressions:** reflect on your initial reactions when learning about a client's sexual orientation or gender identity. Which assumptions or feelings emerged, and how do they reveal implicit biases?
2. **Language use:** consider the language you use when discussing sexual orientation and gender identity. Have you ever used terms that may reflect bias? How can you improve to be more inclusive?
3. **Learning from mistakes:** think of a time you were corrected on language or approach. What did it teach you about your biases or knowledge gaps?

Addressing systemic and explicit biases

1. **Challenging comfort zones:** how does your professional environment address sexual and gender diversity? Which steps can you take to challenge both personal and systemic biases?
2. **Power dynamics:** reflect on the power dynamics in your work with sexually and gender-diverse clients. How might these hinder recognising biases, and how can you address this?
3. **Bias in decisions:** reflect on a decision affecting a sexually or gender-diverse individual. Were biases involved? How can you ensure future decisions are equitable?

Enhancing sensitivity and awareness

1. **Exploring discomfort:** identify an area of sexual or gender diversity that challenges you. How can addressing this discomfort foster professional growth?
2. **Seeking growth opportunities:** how can you engage with education or experiences that challenge your biases and promote growth?
3. **Personal narratives:** reflect on a story from someone with a different sexual or gender identity. How has it influenced your understanding or practice?
4. **Feedback mechanisms:** which feedback systems are in place to help you identify biases? How will you act on this feedback?
5. **Ongoing reflection:** which steps will you take to reflect continuously on and address biases in sexual and gender diversity?

APPENDIX IX: LGBTQIA+ resource list

Organisation	Telephone number	Email address	Website / Location
Access Chapter 2	+27 (0)10 100 3177	info@ac2.org.za	http://www.ac2.org.za/ Gauteng
BeTrue2me	+27 (0)81 455 1183	contactus@betrue2me.org group@betrue2me.org	https://www.betrue2me.org/ Johannesburg and Pretoria
Christ for All Ministries (Universal Fellowship of Metropolitan Community Churches [UFMCC])			https://visitmccchurch.com/our-churches/mcc-churches-in-south-africa/christ-for-all-ministries/ Johannesburg
Coalition of African Lesbians (CAL)	+27 (0)11 403 0007	info@cal.org.za	https://www.instagram.com/cal-coalition/?hl=en International
Contemporary Catholic Community	+27(0)11 680 0197 +27 (0)76 604 5582	fr.og.felix@mweb.co.za	http://www.whiterobedmonks.org/sa/ Johannesburg
Department of Health	+27 (0)800 012 322	info@health.gov.za	https://www.health.gov.za/ National
Diamond Gay and Lesbian Organisation (D'GAYLE)	+27 (0)828168438	dgaylenc@gmail.com t.emakwati@gmail.com	https://dgayleorg.wordpress.com/about-us-2/ Northern Cape
Durban Lesbian & Gay Community & Health Centre	+27 (0)31 312 7402	info@gaycentre.org.za joymclyte@gmail.com	https://www.facebook.com/p/Lesbian-Gay-Community-and-Health-Centre-100084962704021/ Durban
Engage men's health	+27 (0)82 607 1686 +27 (0)10 500 0934	info@engagemenshealth.org.za	https://engagemenshealth.org.za/ Johannesburg, Nelson Mandela Bay, Buffalo City
Free State Rainbow Seeds	+27 (0)514301023	admin@fs-rainbowseeds.org.za	https://fs-rainbowseeds.org.za/ Bloemfontein and Welkom
Gender DynamiX (GDX)	+27 (0) 21 447 4797	info@genderdynamix.org.za	www.genderdynamix.org.za Cape Town
Gender and Sexuality Alliance			https://web.facebook.com/GSAbuffalocity/ Buffalo City
Global Interfaith Network	+27 (0)115687172	info@gin-ssogie.org	https://gin-ssogie.org/ Johannesburg

Organisation	Telephone number	Email address	Website / Location
Good Hope Metropolitan Community Church			http://www.goodhopemcc.org/ Cape Town
Health4Men	+27 (0)60 633 2512	info@health4men.co.za	https://www.health4men.co.za/ Johannesburg and Cape Town
Intersex Society of South Africa		intersexsa@gmail.com	https://www.instagram.com/intersex_south_africa/ Johannesburg
Iranti-Org	+27 (0)11 339 1468	getinfo@iranti.org.za	http://www.iranti.org.za Johannesburg
LifeLine	+27 (0)800 150 150 +27 (0)861 322 322	info@lifeline.org.za safetalking@lifeline.org.za	http://lifelinesa.co.za/ National
Matimba	+27 (0)66 242 2888	info@matimba.org.za	www.matimba.org.za Gauteng
OUT LGBT Well-being	+27 (0)12 430 3272	hello@out.org.za	www.out.org.za Pretoria
Pride Shelter Trust	+27 (0)21 423 2871	info@prideshelertrust.org.za	https://www.prideshelertrust.org.za/ Cape Town
Professional Association of Transgender Health South Africa (PATHSA)		secretary@pathsa.org.za	www.pathsa.org.za National
Psychological Society South Africa Sexuality and Gender Division (PsySSA SGD)	+27 (0)11 486 3322	info@psyssa.com	https://www.psyssa.com/ National
Reforming Church	+27 (0)82 326 9385	amuller@tiscali.co.za	www.reformingchurch.co.za Pretoria
Same Love Toti	+27 (0)82 654 8635	samelovetoti@gmail.com	https://web.facebook.com/SameLoveToti Amanzimtoti and Durban
Social, Health and Empowerment (SHE) Feminist Collective of Transgender Women of Africa	+27 (0)43 722 0750	She.transmedia@gmail.com	https://transfeminists.wordpress.com/ https://www.facebook.com/transfeminists1/?_rdr East London

Organisation	Telephone number	Email address	Website / Location
Sonke Gender Justice	+27 (0) 21 423 7088	info@genderjustice.org.za	https://genderjustice.org.za/help-line-numbers/ Cape Town and Johannesburg
South African Depression and Anxiety Group (SADAG)	+27 (0)11 2344837 0800 567 567	supportgroups@anxiety.org.za	www.sadag.org National
South African National AIDS Council	+27 (0)12 748 1000	info@sanac.org.za	https://sanac.org.za/ Pretoria
The Aurum Institute Transgender Clinics	+27 (0)10 590 1300 +27 (0)78 703 6941	info@auruminstitute.org popinn@auruminstitute.org	https://www.auruminstitute.org/ eThekwini, Tshwane, Ekurhuleni, Mbombela, uMgungundlovu
The Fruit Basket	+27 (0)64 215 7577	info@thefruitbasket.co.za	https://thefruitbasket.org.za/contact/ Johannesburg
The Inner Circle	+27 (0)21761 0037	admin@theinnercircle.org.za	https://theinnercircle.org.za/ Cape Town
The Living Sober Group	+27 (0)861435722		Johannesburg
The Q Network		tribe@theqnetworq.org	https://theqnetworq.org/ National
TransHope	065 826 0386	info@transhope.co.za	https://www.transhope.co.za/ Durban
Triangle Project	+27 (0)21 422 0255	info@triangle.org.za	https://triangle.org.za/ Cape Town
Uthingo (formerly the Pietermaritzburg Gay and Lesbian Network)	+27 (0)33 342 6165	info@uthingonetwork.org.za	https://www.uthingonetwork.org.za/ Pietermaritzburg
We Belong Centre (Specialist Primary Healthcare Clinic)	+27 (0)76 413 7041	info@ac2.org.za	https://ac2.org.za/we-belong-center/ Pretoria
Wits Research Institute (RHI) Transgender Clinic	+27 (0)11 358 5300 / 0658014495	rhicomms@wrhi.ac.za	http://www.wrhi.ac.za/ Johannesburg, East London, Gqeberha, Cape Town
Yellow Dot Doctors	+27 (0)79 116 1034	info@anovahealth.co.za	https://www.yellowdotdoctor.co.za/ Johannesburg

APPENDIX X: LGBTQIA+ legislation and policies

Rights of LGBTQIA+ people

1995: Labour Relations Act (No. 66 of 1995) specifically prohibits discrimination on grounds of sexual orientation and marital status, in line with the Constitution

1996: Constitutional protection for gender (inclusive of gender identity) and sexual orientation, including Human Rights Commission (SAHRC) and Commission for Gender Equality (CGE)

1998: Basic Conditions of Employment Act (No. 75 of 1997) and Employment Equity Act (No. 55 of 1998) outlaws workplace discrimination, also on grounds of gender and sexual orientation, allowing serving openly in the military

1998: Limited recognition of unregistered partnerships through the Medical Schemes Act (No. 131 of 1998) that specifically allows same-sex partners to be registered as dependants

1998: Domestic Violence Act (No. 116 of 1998) expands the definition of domestic relationships to include same-sex couples

1998: Refugees Act (No. 130 of 1998) recognises gender and sexual orientation as grounds for vulnerability and persecution, and thus, for seeking asylum in South Africa

2000: Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) (No. 55 of 2003) outlaws unfair discrimination on the basis of, among others, gender, sex, sexual orientation, but also contains catch-all definitions dealing with any discrimination that causes systemic disadvantage – including establishment of Equality Courts

2002: While LGBTQIA+ people had already been able to adopt children individually, same-sex couples granted the ability to jointly adopt children

2003: Alteration of Sex Description and Sex Status Act (No. 49 of 2003) allows for gender marker and name change, but only after surgical or medical gender affirming treatment

2006: Civil Union Act (No. 17 of 2006) legalises both same-sex marriage and civil partnerships affording the same benefits of heterosexual marriage

2020: Civil Union Amendment Act (No. 8 of 2020) removing section 6 of the Civil Union Act, which allows Home Affairs officials to refuse to marry same-sex couples on the grounds of their "conscience, religion [or] belief"

2023: The Prevention and Combating of Hate Crimes and Hate Speech Act (No. 16 of 2023) includes sexual orientation, gender identity and expression (SOGIE)

2023: SANACs National Strategic Plan for HIV, AIDS and STIs (2023–2028). An updated version is available at https://sanac.org.za/wp-content/uploads/2023/05/SANAC-NSP-2023-2028-Web-Version.pdf

2024: Western Cape Department of Health: Circular evidence-based care for transgender and gender-diverse people (ETGDP), Position Statement 26 August 2024

Government programmes

2009: Victims of (SOGIE-based) hate victimisation included as priority target group in policy guidelines for the Victim Empowerment Programme (VEP) led by the National Department of Social Development (DSD)

2011: The National Task Team (NTT) led by the Department of Justice initiated a National Intervention Strategy aimed at addressing violence targeted at LGBTQIA+ persons

2011: the South African National AIDS Council (SANAC) initiates a LGBTI sector recognising men who have sex with men (MSM) as a key population in the National Strategic Plan

2016: The Department of Basic Education issues Safer schools for all: Challenging homophobic bullying (guideline)

2016: The Department of Justice and Constitutional Development (DoJ&CD) releases their National action plan against racism, racial discrimination, xenophobia and related intolerances, inclusive of SOGIE

2017: The SANAC National LGBTI HIV Plan (2017–2022) is launched with an expanded focus, and is considered a milestone in the South African response to HIV, AIDS, sexually transmitted infections (STIs), and tuberculosis (TB), making it a world first

2018: The National Department of Home Affairs announces that officials will undergo sensitisation training to end xenophobia and homophobia targeted at queer asylum seekers

2018: The South African Police Service (SAPS) finalises a draft of their standard operating procedures to respect, protect, and promote the rights of LGBTQIA+ persons

2020: Western Cape Education Department draft guidelines on gender identity and sexual orientation in public schools aimed at sensitising all public schools and school communities to assist in creating an educational environment that does not discriminate directly or indirectly against anyone on one or more grounds, gender, sex, sexual orientation, conscience, belief, culture and birth, among others

Appendix XI: Recommended journals for LGBTQIA+ research

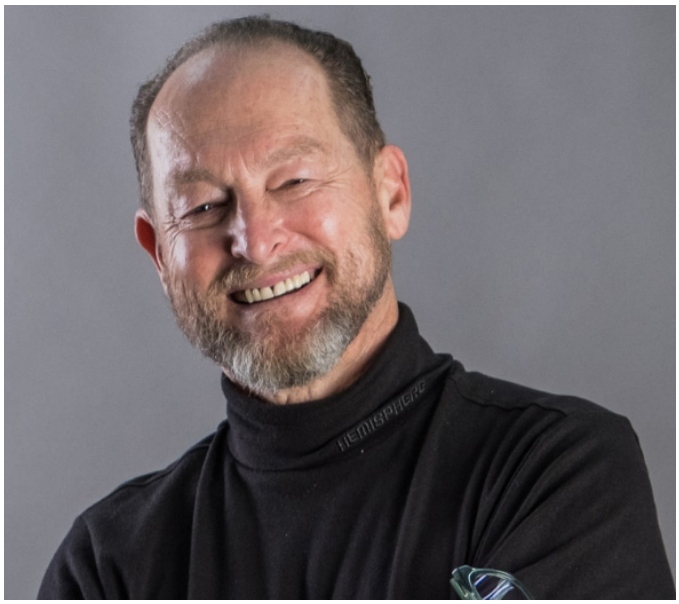
The following is a list of non-predatory journals that are on the approved list of journals by the Department of Higher Education and Training (DHET) and are accredited by the South African Post-Secondary Education (SAPSE) list for South African universities. These are journals that have a specific focus on sexuality and gender; however, LGBTQIA+ research can (and is) published in a wide range of other specialist and general journals (e.g. the South African Journal of Psychology).

- Agenda
- Culture, Health and Sexuality
- Feminism and Psychology
- Gender Questions
- GLQ: Journal of Gay and Lesbian Studies
- Journal of Bisexuality
- Journal of Gay & Lesbian Mental Health
- Journal of Gay and Lesbian Social Services
- Journal of Gender and Religion in Africa
- Journal of Gender Studies
- Journal of Homosexuality
- LGBT Health
- Psychology and Sexuality
- Psychology of Men and Masculinity
- Psychology of Sexual Orientation and Gender Diversity
- Sexuality and Culture
- Studies in Gender and Sexuality

APPENDIX XII: Author biographies

These are brief biographies of the PsySSA African LGBTQIA+ Human Rights Project team.

Juan A Nel



Juan A Nel (he/him) holds a doctorate, is a registered clinical and research psychologist, and full professor of Psychology at the University of South Africa. As a National Research Foundation (NRF) B-rated researcher, and an elected member of the Academy of Science of South Africa (ASSAf), he is internationally recognised in LGBTQIA+ mental health and wellbeing, hate victimisation, and victim empowerment and support, more generally. A former president of the Psychological Society of South Africa (PsySSA) (2014–2015), Juan is a member of its Council, founder member of the executive committee of the PsySSA Sexuality and Gender Division (SGD), and representative of PsySSA on (inter)national structures towards furthering its profile as a learned society. In this regard, most noteworthy are his roles as leader of the research sub-committee of the South African Hate Crimes Working Group; co-representative on the International Psychology Network for LGBTI Issues (IPsyNet); and leader of the PsySSA SGD African LGBTQIA+ Human Rights Project towards promoting wellbeing and human rights for LGBTQIA+ persons in Africa.

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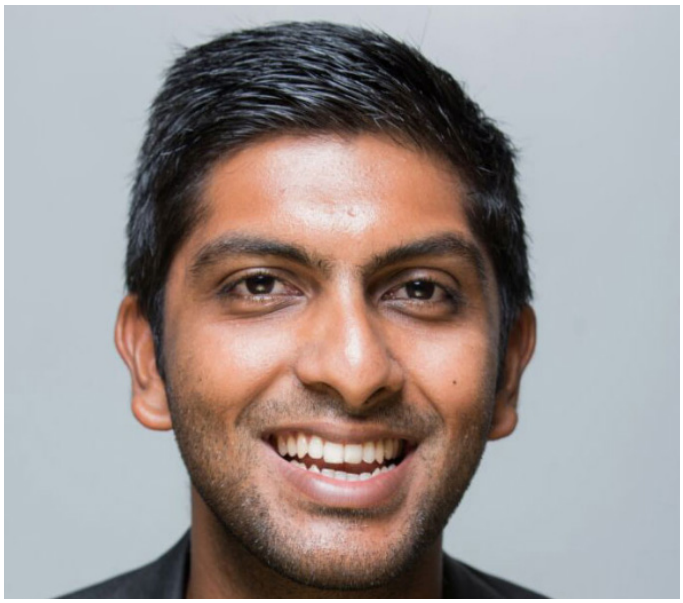
Suntosh R Pillay



Suntosh R Pillay (he/him) is the chief clinical psychologist for the eThekwini and iLembe districts in the KwaZulu-Natal Department of Health. He has over 15 years of experience working in public healthcare, mostly at King Dinuzulu Hospital Complex in Durban, as a psychotherapist, supervisor and researcher. He has a research affiliation to both the Nelson R Mandela School of Medicine at the University of KwaZulu-Natal, and the Department of Psychology at the University of South Africa. He is an associate editor for Psychology in Society (PINS) and the South African Journal of Psychology (SAJP), and has been widely pub-

lished in local and international journals. He has been featured in two local documentaries on LGBTQ+ issues: When the Rainbow is bittersweet (2022) and the Reimagine Freedom series (2025).

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Nkanyiso Madlala

Nkanyiso Madlala (he/him) is a clinical psychologist working for the Department of Correctional Services (DCS). He holds a bachelor's degree in psychology (summa cum laude); an honours degree (cum laude); a master's in Social Sciences (Clinical Psychology) from the University of KwaZulu-Natal; and a doctorate from UNISA. He is a member of PsySSA SGD, PATHSA, and the African LGBTQIA+ Human Rights Project. Nkanyiso was involved in the development of the gender affirming healthcare guidelines by the Southern African HIV Clinicians Society. He has been extensively involved in the training of correctional services personnel on affirmative practices in the management of LGBTQI+ offenders. He has also provided training for psychologists and social workers (Gauteng region, DCS), psychologists (Gauteng region, social development), psychologists (Southern East Rand district, Department of Heath) on affirmative practices and ethical considerations when working with LGBTQIA+ clients and/or patients.

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Thembisile Dlamini

Thembisile Dlamini (she/her) is an intern clinical psychologist at Weskoppies Psychiatric Hospital and is pursuing her Master of Arts in Clinical Psychology at the UNISA. After a 14-year career in finance, she transitioned to psychology, driven by her passion for mental health and the desire to have a meaningful influence. Thembisile holds a Bachelor of Arts in Social Science and a Bachelor of Arts Honours in Psychology, both from UNISA. A proud

alumnus of the Young African Leadership Initiative (YALI), she earned a Certificate in Public Management in 2017, honing her leadership skills. She now blends these skills with a culturally sensitive, affirmative approach to therapy, committed to promoting mental wellbeing and addressing systemic barriers to care. Thembisile is passionate about advocating for LGBTQIA+ individuals, women, and children, particularly from disadvantaged backgrounds who face barriers to mental health care. She is committed to providing affirmative support to empower these vulnerable populations. Driven by a strong sense of social justice, Thembisile creates safe, equitable spaces for healing and resilience, helping clients overcome systemic challenges.

Zindi Venter

Zindi Venter (she/her) is a postgraduate assistant (PGA) in the Department of Psychology at the UNISA. She actively supports the 'Towards LGBT Health and Wellbeing' project, led by Prof. JA Nel, and is a key member of the organising committee for the International Network of Hate Studies conference which took place in November 2024. As a PGA, she manages administrative tasks, including planning, coordination, and budgeting, while contributing to research, teaching, and learning efforts. Zindi earned her Master of Arts in Psychology with distinction (cum laude), and is currently pursuing her PhD, focusing on SA citizens' experiences with plant-based foods. Her research interests include health psychology, social norms, and attitudes, with an aim to raise awareness of how these factors influence behavioural intentions, especially in relation to food choices.

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Sakhile Msweli

Sakhile Msweli (he/him) holds a doctoral degree in Psychology from the University of KwaZulu-Natal (UKZN). He is a registered clinical psychologist. He was trained for his clinical

master's at The Nelson Mandela University. He also holds a master's in research psychology (UKZN). He started working in the area of gender, sexuality and sexual health as a Research Psychologist at the Human Sciences Research Council (HSRC). He is a founding and board member of the PATHSA and a member of the PsySSA SGD African LGBTQIA+ Human Rights Project. His research interests involve navigations of sexual identities within the presence of homophobia in rural SA contexts; how men who have sex with men and women (MSMW) maintain long-term relationships, paying special attention to issues involving trust and sexual safety within these relationships. As a clinician, Sakhile has also done some work in gender-affirming healthcare for trans persons, with Wits Research Institute, and the East London trans clinic. He has also provided mental healthcare services to persons in the LGBTQIA+ community. Sakhile is currently working for the KwaZulu-Natal Department of Health at Ngwelezana Hospital, where he continues to provide a range of psychological services within this clinical setting. He continually provides gender and sexuality sensitisations and has remained vocal about tailored healthcare services for queer persons within his rural context.

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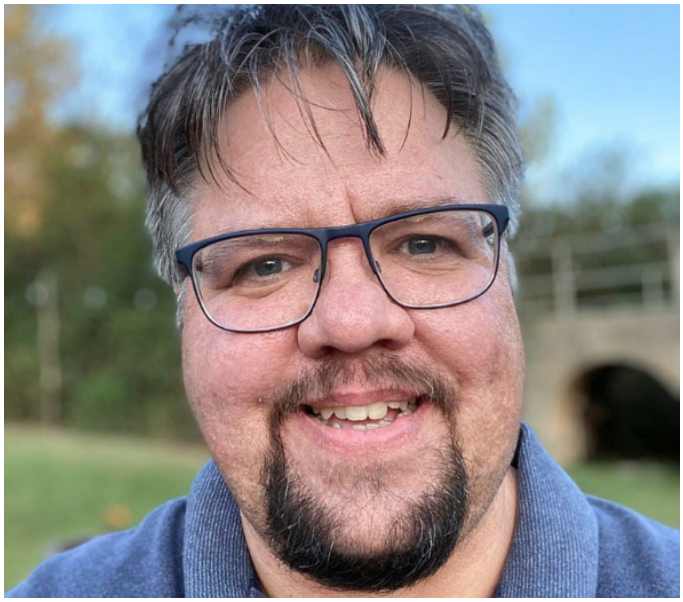
Chris McLachlan



Chris McLachlan (he/him/they/them) holds three master's degrees and is completing his PhD at the UNISA. Chris is a clinical psychologist and expert in gender-affirming healthcare. With a focus on supporting survivors of sexual offences and gender-based violence, Chris works at the Thuthuzela Care Centre in KwaZulu-Natal while also managing a private practice dedicated to the LGBTQIA+ community. Chris holds various leadership roles, including being the first African board member and incoming secretary of the World Professional Association for Transgender Health (WPATH); co-chair of the WHO's Guideline Development Group on transgender and gender-diverse health; and co-representative on the IPsyNET. Within South Africa, Chris chairs the PATHSA and the PsySSA SGD. Chris was the co-chair of the team that developed the first gender-affirming healthcare guideline for South Africa, and has contributed to the Standards of Care 8 of WPATH. Chris is an ordained minister in the Reforming Church, and the parent of two wonderful tweens.

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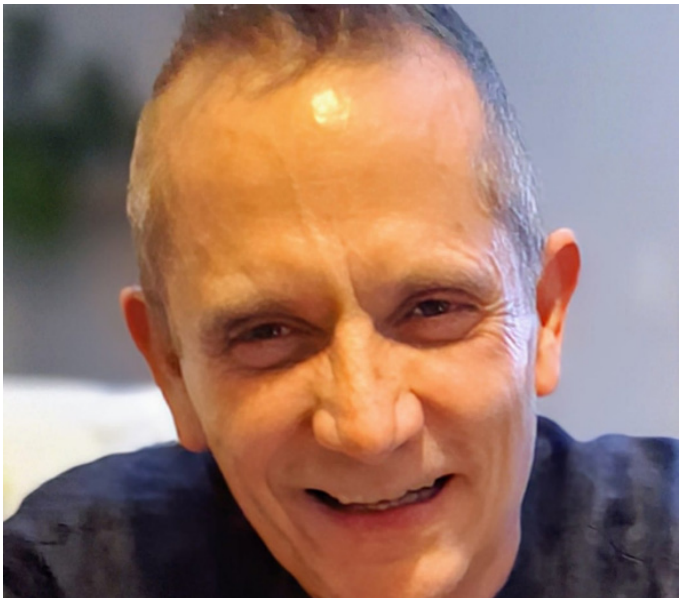
Cornelius (Niel) Victor



Cornelius (Niel) Victor (he/him) is a clinical and research psychologist in Cape Town, with a PhD in Psychology from the UNISA and master's degrees in Clinical and Research Psychology. After a 20-year career in market research and recovering from cancer in 2010, Niel moved to Clinical Psychology. He provides psychotherapy in his private practice and is part of a multi-disciplinary team at several clinics. His work in LGBTQIA+ psychology includes academic publications, guest lectures, and facilitating training courses. Niel has been a member of the PsySSA SGD and African LGBTQIA+ Human Rights Project since its inception in 2012, and co-led the development of the original PsySSA practice guidelines for working with sexually and gender-diverse persons. His PhD was on South African psychologists' competence in practising affirmatively with sexually diverse people. He is a member of PATHSA.

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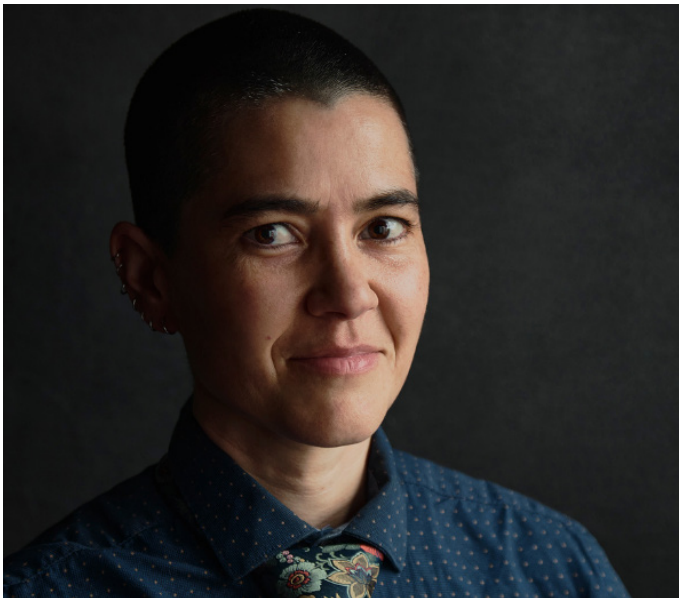
Jenna-Lee de Beer-Procter



Jenna-Lee de Beer-Procter (they/them) is a clinical psychologist and researcher based in Cape Town. They run a LGBTQIA-exclusive psychotherapy practice, and work for Wits Research Institute at their Key Populations, transgender health centre in Belleville, Cape Town. They have worked in the public sector for the Department of Health in the field of intellectual and developmental disabilities as well as in the NGO sector in gender-based violence. Jenna-Lee is the vice-chair of the PATHSA, a member the PsySSA SGD, and a member of the World Professional Association for Transgender Health (WPATH). They contributed to the Southern African HIV Clinicians' Society gender-affirming healthcare guideline for South Africa on informed consent and intellectual and developmental disabilities. They are currently doing their PhD on the inter-subjectivity of transitioning genders at Stellenbosch University.

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APPENDIX XIII: Acknowledgements

The members of the PsySSA African LGBTQIA+ Human Rights Project who gave their time, commitment and enthusiasm to compile these guidelines are:

Core team members (left to right):

- Jenna-Lee de Beer-Procter
- Chris McLachlan
- Nkanyiso Madlala
- Sakhile Msweli
- Cornelius (Niel) Victor
- Thembisile Dlamini
- Juan A Nel
- Suntosh R Pillay
- Zindi Venter

The extended team of national and international critical readers and subject specialists:

Prof. Adam Jowett, Dr Alexander Moreno, Dr Angelique Stephens, Dr Asa Radix, Celenkosini Thembinkosi, Dr Kristin L Dunkle, Dr Susan Gitau, Prof. Elma de Vries, Dr Elizabeth du Preez, Dr Ernst Strydom, Dr Jarred Martin, Jonathan Bosworth, Letitia Rambally-Greener, Dr Michal Pitonak, Prof. Nadine Nakamura, Pierre Brouard, Prof. Ashley K Randall, Prof. Mershen Pillay, Prof. Sharon G Horne, Ron Addinall, Sasha Watling, Siyanda Shabalala, Dr Sudarshan R Kottai, and Dr Themba Nxumalo.

Our gratitude also goes to the PsySSA structures who commented on draft versions of the guidelines: The Ethics Standing Committee, Equity and Transformation Standing Committee, and Science of Psychology Standing Committee. In addition, we thank the executive committee and council for their feedback and endorsement, and Dr Fatima Seedat (executive director) for her guidance and support throughout the process.

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Finally, we thank each and every individual and organisation who provided their voice and input in the creation of these revised guidelines.