

# Lesbian, gay, and bisexual clients' experience with counselling and psychotherapy in South Africa: implications for affirmative practice

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## **Abstract**

The Psychological Society of South Africa has embarked on a process of developing affirmative practice guidelines for psychology professionals working with sexually and gender-diverse people, inclusive of, but not limited to, lesbian, gay, bisexual, transgender, and intersex concerns. Towards informing the guidelines, we explored self-identified lesbian, gay, and bisexual people's experiences of psychotherapy and counselling in South Africa. A total of 15 qualitative in-depth interviews were conducted with selected participants. Among others, positive experiences entailed receiving unconditional positive regard, acceptance, and non-judgement from counsellors and/or psychotherapists. This included the counsellors and/or psychotherapists positively affirming participants' sexual orientation by, for instance, viewing same-sex attractions, feelings, and behaviour as normal variants of sexuality and seeing sexual orientation as one aspect of the person, not the only aspect. Negative experiences were almost exclusively ascribed to the counsellors and/or psychotherapists being disaffirming of the client's sexual orientation. Findings provide a potential basis for future affirmative practice guidelines and indicate that taking a stance affirming of sexual orientation was considered to be important.

## **Keywords**

Affirmative practice, bisexual, counselling, gay, lesbian, LGBTI psychology, psychotherapy, sexual minorities, sexual orientation

The advent of democracy in South Africa in 1994 brought with it an era of significant development of the legal rights of lesbian, gay, and bisexual (LGB) people (Nel, 2014). The Bill of Rights in the South African Constitution enshrines the right to non-discrimination on the basis of sexual orientation, making South Africa the first country in the world to do so (Republic of South Africa, 1996).

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This led to significant strides in relevant legislation, which since 1998 includes protection against labour discrimination on the basis of sexual orientation and, more recently, in 2006, allows same-sex marriage (Brouard & Pieterse, 2012). Advancements in the legal protection of LGB people have, however, not necessarily filtered through to the general public. A nationally representative study conducted in 2007 indicated that at that stage, 88% of the South African population believed that it is always or almost always wrong for two adults of the same sex to have sexual relations (Roberts & Reddy, 2008).

Internationally, there is consensus that prejudice and discrimination can threaten LGB people's well-being and liberation in various ways (Nel, 2014). As a result, LGB people may experience a range of mental health issues, including internalised oppression, fragmented identity and living a double life, poor mental health, psychosocial problems, social isolation and rejection, powerlessness and discrimination, harassment, and violence (Harper, 2005). In South Africa and elsewhere, the stress caused by prejudice, stigma, and discrimination has been correlated with depression, anxiety, and substance use disorders. In South Africa, this includes an increased risk of post-traumatic stress disorder (PTSD; Theuninck, 2000), vulnerability to depression (Polders, Nel, Kruger, & Wells, 2008), and the risk of suicidal ideation (Wells, 2006). This vulnerability is aggravated if LGB people face additional discrimination based on other variables, such as gender, race, poverty, unemployment, familial reliance, and poor education (Clarke, Ellis, Peel, & Riggs, 2010).

Current healthcare practices in South Africa often assume heterosexuality in service delivery, which negatively affects the quality of the support rendered to LGB people and serves as a barrier to access healthcare services (Victor, Nel, Lynch, & Mbatha, 2014). A number of local studies have indicated discriminatory or negative experiences with healthcare providers (Graziano, 2005; Meyer, 2003; Rich, 2006; Stephens, 2010; Wells, 2005; Wells & Polders, 2003). The majority of healthcare providers in South Africa appear ignorant of sexual orientation issues or have difficulty in providing adequate services (Nel, 2007). Their limited understanding is partially due to a lack of training on sexual minority issues in health care (Coetzee, 2009; Nel, 2007). The positive value of a psychotherapeutic support group for lesbian and gay people under the auspices of what is now called OUT LGBT Well-being in Pretoria was shown by Nel, Rich, and Joubert (2007).

Under the pre-1994 dispensation, psychology in South Africa, either by remaining silent or being actively supportive of the political mainstream of the day, was an oppressive force for many, including sexual minorities (Yen, 2007). In recent years, progress has been made in establishing more sexual orientation-affirming healthcare practices, as evidenced by the position statement on homosexuality by the South African Society of Psychiatrists (SASOP, 2005), the strong LGB affirmative stream of presentations at the more recent congresses hosted by the Psychological Society of South Africa (PsySSA; Nel, Mitchell, & Lubbe-De Beer, 2010) and PsySSA's position statement for psychology professionals working with sexual and gender diversity (Victor et al., 2014).

By the 1980s, new gay and lesbian affirmative models in the mental health field were being developed internationally. For example, *The Journal of Homosexuality* published a special double issue in 1982 titled 'Homosexuality and psychotherapy', bringing together work on gay affirmative practice and therapy as a reference for practitioners (Gonsiorek, 1982). In this publication, Malyon (1982) saw gay affirmative practitioners as challenging a pathological view of homosexuality and developing an appropriate understanding to working with gay clients as an integrated part of their practice. At the beginning of the new millennium, Harrison (2000), in his analysis of gay affirmative therapy, identified 33 articles, internationally, that alluded to gay affirmative therapy.

According to authors such as Davies (1996), Milton, Coyle, and Legg (2002), and Ritter and Terndrup (2002), common elements of approaches in psychology that are affirmative of LGB sexualities include the recognition of LGB sexualities as normal and natural variances in that sexual

diversity per se is not seen as the cause of psychological difficulties or pathology. Contextual awareness is emphasised, including an understanding of how aspects such as homonegativity, heterosexism, prejudice, and stigma affect mental health and well-being. Practitioner ability to empathise with the experience of LGB clients, including being knowledgeable about LGB sexualities, diversity, and lifestyles, is regarded as important. An affirmative approach emphasises that practitioners should be comfortable with and open about their own sexuality to avoid their own biases affecting their practice (Davies, 1996; Milton et al., 2002; Ritter & Terndrup, 2002). An affirmative position assumes that LGB clients have the potential creativity and internal resources to deal with their difficulties and problems and that it is important for the practitioner to acknowledge the influence of society and significant others on the LGB client, actively take a positive view of LGB lives, and be aware of the damaging effect of discriminatory sentiments in practice (Schippers, 1997).

In tandem with the move to articulate an affirmative stance, individual authors and national mental health organisations and associations in several parts of the world initiated the development of position statements, standards of care, and practice guidelines to assist healthcare providers when working with LGB people (American Psychological Association, 2011; Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2003; Australian Psychological Society, 2010; British Psychological Society, 2012; Davies, 1996; Schippers, 1997). These international practice guidelines, however, may not provide for the potentially unique situation in South Africa and also the rest of Africa.

In recent years, there has been increasing calls for the development of affirmative guidelines for psychotherapeutic practice in Africa (Nel, 2007; Nel et al., 2010). Consequently, PsySSA, the only member in Africa of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNET), has embarked on a process to develop affirmative guidelines for psychology professionals working with sexually and gender-diverse people specifically for South Africa, with potential application to the rest of Africa (Victor et al., 2014). Building on the work done in producing the mentioned position statement – a first on the African continent – such guidelines could be a significant step in assisting psychology professionals to provide appropriate care to sexually and gender-diverse people.

## **Aim of the research**

Against the developments discussed above, a need was identified to explore South African lesbian, gay, bisexual, transgender, and intersex (LGBTI) people's experiences of psychotherapy and counselling to inform the structure and content of the guidelines. The acronym LGBTI indicates a symbolic unit of collective identity, given similar issues around stigmatisation, discrimination, and victimisation experienced by people within this grouping (Nel, 2007). Yet, different sectionalities form the basis of such experiences, namely, sexual orientation, gender diversity, and biological variance. Mental healthcare needs might well differ between minority groups within the sectionalities (Nel, 2007). Given these potential differences, the decision was made to focus the study that informed this article on sexual orientation, only and more specifically, on researching LGB people's experiences of psychotherapy and counselling.

## **Method**

### *Participants*

Participants had to self-identify as LGB and, in the previous 5 years, had to have experienced (in one or more sessions) psychotherapy or counselling with a psychologist, psychiatrist, or counsellor

(including lay counsellors) in South Africa. The psychotherapy or counselling could have been individual, family, or group based. Participants, both male and female, were selected according to the following criteria:

- Had to be living in the major metropolitan areas of Gauteng or Cape Town and surrounds, to obtain a regional view;
- Had to be representative of different life stages/age groups (18–35 years; 36–65 years) as the expectations and experiences of these groups may differ significantly (Ritter & Terndrup, 2002);
- Had to be from different race groups to ensure representation across the South African population.

Through convenience sampling methods, the participants were recruited from a variety of accessible sources, including personal and professional networks, LGBTI community groups such as OUT LGBT Well-being, and social media such as Facebook. Interested individuals were provided with an introduction letter explaining the research, a biographical recruitment questionnaire for their completion to ensure representation, and a diverse spread of participants, as well as a consent form they were required to sign. A total of 15 in-depth interviews were conducted between April and June 2012.

### *Instruments*

A qualitative semi-structured interviewing technique was used to collect data. The interview schedule began by requesting the participants to relate or describe a recent experience of psychological counselling.<sup>1</sup> The following was used as potential probes to fully expand on the experience:

- Before the experience:
  - What led to the experience? Who decided and on what basis was decided which counsellor to utilise? What was the process followed? How did you go about selecting the counsellor?
  - How did you feel at different points before the experience? Looking forward to/dreading the experience?
  - How often/frequently have you visited someone for counselling services? How would you rate your general experience with these visit(s) versus the more recent experience? Was it for the same reason or for a different reason? Please describe these?
- During the experience:
  - How long ago was the experience/last session? How many sessions did the experience entail?
  - Describe the counsellor in detail. What appealed to you? What bothered you, if anything?
  - During sessions, a counsellor can do many things, including talking, using activities, giving homework, and so on. What did the counsellor do?
  - Describe the setting in which the session(s) happened.
  - Anyone else involved in the session(s)? If so, who else was involved, for example, family? What made them an important part of the session(s)?
  - Your thoughts, feelings, and impressions during the experience?
  - What influence did the session(s) have on your life outside the session(s)? In what way?
  - Your evaluation of the experience and what about it gave you this evaluation?

- After the experience:
  - What happened?
  
- Sexual orientation (note, probed after the broader experience was discussed):
  - Was sexual orientation discussed? How did this unfold or happen? How did it make you feel?
  - Do you feel sexual orientation was relevant in the session(s)? If so, why?
  - What, if anything, about the experience did you find affirming/disaffirming of your sexual orientation?

Finally, participants were given 30 cards, each with a statement gleaned from the earlier mentioned affirmative practice literature, such as 'Understanding that LGB orientations are not mental illnesses' and 'Assists in developing a positive LGB identity'. To provide a sense of ranking or importance of aspects of affirmative practice, participants were asked to sort these cards into at least three groups – a group with statements that are important/relevant to them in counselling (whether past or future), a group that is not important/relevant, and an unsure group. If a participant placed more than 19 statements in the important/relevant group, he or she was requested to sort this group into a further two groups – more important and less important. Finally, the group of important/relevant statements and those of which the participants were unsure were discussed.

Kerlinger and Lee (2000) consider the ranking of items as a useful form of a scale. Items can be ranked according to some criterion, such as importance. Each of the ranked items, or groups of items, can be assigned a value, providing rank-order or ordinal values of unspecified size. Key benefits of the ranking of items over, for instance, Likert scales are that ranking provides variability to data when all items are considered important or relevant and escapes the tendency for participants to agree with socially desirable items (Kerlinger & Lee, 2000).

### *Procedure*

The interviews were conducted in English by the first listed author (C.J.V.). All the interviews were conducted in venues where the participants felt comfortable, mainly their homes. The interviews were audio recorded, with the exception of one, during which only notes were taken due to the participant's concerns about confidentiality. On average, interviews lasted about 60 min each. The participants were not incentivised.

### *Ethical considerations*

The ethical principles summarised in the Belmont Report provided the basis for considering ethics in this research study and include respect for persons, beneficence and non-maleficence (i.e., by minimising risk and maximising potential benefit to participants), and justice, which refers to the reasonable and non-discriminatory treatment of participants (Maritz & Visagie, 2011). Ethical approval was obtained from the University of South Africa. On completion, a copy of the full study (Victor, 2013) was provided to each of the participants.

### *Data analysis*

The recorded audio tapes were transcribed, and the transcriptions formed the core of the data that were analysed by C.J.V. A general thematic analysis method, as described in, among others, Terre Blanche, Kelly, and Durrheim (2006) and Smith (1995), was used by C.J.V. to identify patterns and

themes within the subsections of the interviews, with the aid of ATLAS.ti software (ATLAS.ti Scientific Software Development GmbH, 2012). Verbatim comments as appropriate were included to elucidate and ground these themes and elements (Elliott, Fischer, & Rennie, 1999). Following Lincoln and Guba's idea of confirmability (1985 cited in Babbie & Mouton, 2001), the raw data, data reduction, and data reconstruction products are available for audit. Data analysis was completed by April 2013.

## Results

For the purpose of this article, the authors have only included the findings of the full study relating to positive and negative experiences with the counsellor, as well as the findings of the card sort exercise. This information is most critical for readers interested in affirmative practice with LGB people. For further information around participants' reasons for going to counselling; the decision process when choosing a counsellor; prior expectations; duration, frequency, setting, therapeutic techniques, and termination; sexual orientation of the counsellor; and the outcome of counselling, please refer to Victor (2013).

### *Positive experiences with the counsellor*

Participants' positive experiences almost always included mention of receiving unconditional regard, total acceptance, and the counsellor being non-judgemental – '. . . unconditional love and acceptance, whilst still caring enough to be honest with me' (Bisexual female, 18–35 years). This went hand in hand with the counsellor being compassionate, warm, and caring – 'She was warm, yet remained professional' (Lesbian, 36–65 years); honest – 'She will never let me get away with any form of denial if she thinks I'm strong enough to handle it' (Bisexual female, 18–35 years); congruent – '. . . honest about the way that she sees the world' (Bisexual female, 18–35 years); and calm and gentle – 'She had a very gentle way about her' (Bisexual female, 18–35 years).

For some, this was underpinned by the level of life experience or similar experiences the counsellor had gone through – 'It feels like he's been through it all' (Gay, 18–35 years). For others, it was apparent that the counsellor had their best interests at heart. This was enhanced by the level of joining or rapport established by the counsellor and a sense of sharing similar values – 'I felt a very strong connection with her' (Bisexual female, 18–35 years).

The counsellor was often experienced as being a good listener – 'I talk most of the time and he doesn't say much, but it's good to talk. I think he helps me more by just listening' (Bisexual male, 36–65 years); sensitive, emotionally in touch, containing, and empathetic – '. . . he was a very deeply emotional person, so I realised that everything in his office had a deep meaning' (Gay, 18–35 years); and present and observant – '. . . how perceptive she was and that's kind of what made me going [sic] back' (Bisexual male, 36–65 years).

A number of participants felt it was important that the counsellor dealt with them as people and not as 'patients' – 'She never made me feel that she's the therapist and I'm the patient' (Lesbian, 36–65 years). This was enhanced by the counsellor sharing their own experiences when appropriate – 'Another thing I absolutely love and it didn't often happen . . . she would say that she'd also had that feeling in her relationships' (Lesbian, 36–65 years).

It was also relevant at times, or for some of the participants, that the therapeutic boundaries were kept strong – 'I actually know very little about him, because of what I'm going through' (Gay, 18–35 years). Sometimes the boundaries became blurred as part of the therapeutic process – '. . . she was starting to feel like my mother . . . I was duplicating a dependency syndrome with [the counsellor]' (Bisexual male, 36–65 years). This also speaks to the ethical issue of dealing with

multiple roles – ‘He removed me from Facebook as soon as he became my therapist’ (Gay, 18–35 years).

### *Positive affirmation of sexual orientation by the counsellor*

Positive affirmation of one’s sexual orientation by a counsellor is at least part of having unconditional regard and being totally accepting and non-judgemental, and this was specifically probed in the interviews. Themes that the participants highlighted as evidence of their experience being affirming were as follows:

- Viewing same-sex attractions, feelings, and behaviour as normal variants of human sexuality – ‘She never said to me that being gay is wrong. It was always about how can we take this and how it could work for me best’ (Gay, 36–65 years);
- Accepting of sexual fluidity – ‘Yes, initially I was completely gay and over the years I became completely bi. No, he [the counsellor] had no issues about it and didn’t force me into anything’ (Bisexual male, 36–65 years);
- Acceptance of sexual orientation as potentially only one aspect of the therapeutic experience – ‘. . . we did discuss my sexual orientation, because that was one of the biggest reasons I was there. It played a big part at the start, but then we moved on to other issues’ (Gay, 18–35 years);
- Dealing with internalised homonegativity – ‘I worked through that whole thing of wishing I wasn’t gay. You want everything to be normal’ (Gay, 18–35 years);
- Sensitivity to and respect for same-sex relationships – ‘Yes, what I fear most about it is having my relationships trivialised and that doesn’t happen’ (Gay, 18–35 years);
- Using context-appropriate language – ‘He reflects my words. If I say gay, he doesn’t say homosexual’ (Gay, 18–35 years);
- The counsellor adopting a curious stance – ‘. . . she was interested anyway, even though she was heterosexual and happily married and [sic] children and all of that’ (Lesbian, 36–65 years).

### *Negative experiences with the counsellor*

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

- Viewing a client’s sexual orientation as abnormal – ‘. . . she then referred me to a horrible woman . . . who told me that I was absolutely sick’ (Bisexual male, 36–65 years);
- Heterosexism and negative myths – ‘. . . he suggested that I should go to the first adult site and get laid as quickly as possible by a guy’ (Lesbian, 36–65 years);
- Viewing sexual orientation as an either/or dichotomy rather than affirming the fluidity of a client’s sexual feelings – ‘One of the reasons why I wanted to leave is because I felt that she was pushing me in a particular direction that I didn’t want to go . . . there’s gay and there’s straight and you’re either in the one or in the other’ (Bisexual male, 36–65 years);
- Not dealing with a client’s internalised homonegativity – ‘. . . it brought up all those fears again of my own fears and judgement of myself, saying yes, gay is wrong’ (Bisexual male, 36–65 years);
- Not realising that LGB youth face different challenges than heterosexual youth – ‘She was comparing me to others my age and said that this was just part of growing up. I hated that

and now that I can compare it, I'd safely say that I'll never go back to a straight counsellor' (Lesbian, 18–35 years);

- Meeting in a different context, for example, a nightclub, and the consequent concern about confidentiality;
- Viewing a client only through their sexual orientation – 'I felt as if she was sexualising or interpreting it through a prism that said it's just about the sex' (Bisexual male, 36–65 years).

### *Affirmative practice statements*

As the card sorting exercise provided a ranking of importance and relevance, weights could be applied in calculating a final importance/relevance score (Kerlinger & Lee, 2000):

- Important/relevant – 2;
- Less important/relevant – 1;
- Not important/relevant – 0;
- Unsure – omitted.

Table 1 contains the scores calculated across the sample of 15 participants. If every participant gave a statement a score of 2 (important/relevant), the total would be 30 and the percentage 100. The percentages, therefore, provide an indicator of importance or relevance of aspects of affirmative practice.

## **Discussion**

Israel, Gorcheva, Burnes, and Walther (2008) found that the most commonly described helpful situation in respect of the counselling experience occurred where counsellors were warm, trustworthy, and caring, followed by counsellors being affirming in dealing with their clients' sexual orientation or gender identity. Similarly, the study that informed this article first highlighted that positive experiences in counselling situations almost always included mention of receiving unconditional positive regard, total acceptance, and the counsellor being non-judgemental. This went hand in hand with the counsellor being compassionate, warm and caring, honest, congruent, and calm and gentle. In addition, good experiences were related to the counsellor appearing to have the participant's best interests at heart, being a good listener, empathetic, present, observant, and prepared for the sessions, as well as dealing with the participant as a person and not as a 'patient'. For some, it was important that the counsellor reflected having dealt with something similar to themselves or had the life experience to understand what the participant was going through. Sharing their own stories provided evidence of this, but it was still important for the counsellors to maintain the therapeutic boundaries.

Being affirming of participants' sexual orientation included viewing same-sex attractions, feelings, and behaviour as normal variants of sexuality, being accepting of sexual fluidity, seeing sexual orientation as one aspect of the person and not the only aspect, helping the participant deal with internalised homonegativity, having sensitivity and respect for same-sex relationships, using context-appropriate language, and the counsellor adopting a curious stance.

With very little exception, the participants' negative experiences with a counsellor related to how the counsellor dealt with sexual orientation. Themes that emerged included the following:

- The counsellor viewing the participant's sexual orientation as abnormal;
- Evidence of heterosexism and negative myths and stereotypes;

**Table 1.** Findings of the affirmative practice statements sorting.

Statements	Total	Percentage
Understanding that lesbian, gay, and bisexual orientations are not mental illnesses	28	93
Understanding that same-sex attractions, feelings, and behaviour are normal variants of human sexuality	28	93
Knowledgeable about and respects importance of LGB relationships	28	93
Provides a safe, trusting environment or setting	27	90
Comes across as being accepting of an LGB lifestyle	27	90
Assists in developing a positive LGB identity	25	83
Does not use sexist, homophobic, or stereotypical language	25	83
Does not try to change sexual orientation	25	83
Understands that not all needs are based on your sexual orientation – some needs are the same as any other person's, regardless of sexual orientation	25	83
The psychotherapist or counsellor is aware of his or her own attitudes and knowledge about LGB issues	22	73
The psychotherapist or counsellor is comfortable with his or her own sexual orientation	22	73
Understanding of the effects of prejudice, discrimination, and hate crimes on your life	18	60
Respects my confidentiality around my sexual orientation	18	60
Explores the area of sexuality sufficiently – not too much and not too little	17	57
Continually increases his or her knowledge and understanding of LGB lives and issues	15	50
Counters biased views held by others, including other professionals	15	50
Has the same sexual orientation as I do	15	50
Understands the unique developmental or life issues that LGB people face, such as the 'coming out' process	15	50
Understands the unique problems and risks faced by LGB youth	15	50
Considers the influences of religion and spirituality in the lives of LGB people	15	50
Strives to understand the ways in which sexual orientation impacts on the family of origin and relationships within the family of origin	14	47
Provides relationship information that you can relate to, for example, positive LGB role models	12	40
Recognises age group and life stage differences among LGB people	12	40
Strives to understand the impact of HIV/AIDS on the lives of LGB people	11	37
Distinguishes between sexual orientation issues and issues of gender identity	10	33
Shares information on an LGB lifestyle	10	33
Recognises the challenges faced by LGB people with physical, sensory, or cognitive-emotional disabilities	8	27
Recognises that the families of LGB people may include people who are not legally or biologically related	7	23
Strives to understand the experiences and challenges faced by LGB parents	6	20
Recognises the challenges faced by LGB people of different population, language, and cultural groups	5	17

LGB: lesbian, gay, and bisexual.

- Viewing sexual orientation as an either/or dichotomy within which the participant had to 'choose' or 'decide' where he or she belonged;
- Not dealing with the participant's internal homonegativity;
- Not realising that LGB youth may face different challenges than heterosexual youth;
- A lack of comfort in meeting the counsellor in social contexts;
- The counsellor viewing the participant only through his or her sexual orientation.

A key finding of the card sorting exercise was that most of the participants placed nearly half of the statements in the most important and relevant group. This indicates that taking an LGB affirmative stance in general was perceived to be important to the participants, regardless of whether the presenting problem was specifically related to sexual orientation.

Based on the research findings, incorporating the qualitative feedback as well as the card sort exercise, the following are important considerations in affirmative practice with LGB people. The counsellor

- Understands that LGB orientations are not mental illnesses;
- Understands that same-sex attractions, feelings, and behaviour are normal variants of human sexuality;
- Provides a safe environment or setting that the person can trust. This aspect includes having unconditional positive regard for the client; being accepting and non-judgemental; being compassionate, caring, congruent, and empathetic; as well as retaining a curious stance and being open to the unique experience of the client;
- Comes across as being accepting of an LGB lifestyle;
- Assists in developing a positive LGB identity, including dealing with internalised homonegativity;
- Uses context-appropriate language, for example, does not use sexist, homophobic, or stereotypical language;
- Does not try to change sexual orientation and is accepting of sexual fluidity;
- Views sexual orientation as one aspect of the person, not the only aspect;
- Is aware of his or her own attitudes and knowledge about LGB issues, including awareness of heterosexist views as well as myths and stereotypes about LGB people;
- Is comfortable with his or her own sexual orientation;
- Understands the effects of prejudice, discrimination, and hate crimes on LGB people;
- Addresses and respects the confidentiality of information shared;
- Understands the developmental and life stage issues that LGB people face, such as the 'coming out' process;
- Has sensitivity about and respect for the importance of LGB relationships;
- Strives to understand the ways in which sexual orientation affects families and significant others;
- Strives to understand the role of aspects such as religion and spirituality; HIV/AIDS; physical, sensory, or cognitive-emotional disabilities; parenthood; and different population, language, and cultural groupings as additional sources of stress, prejudice, and discrimination for LGB people.

## Conclusion

The dramatic advancements in legal protection in South Africa have not necessarily meant changes in either public attitudes or attitudes experienced by LGB people accessing healthcare services.

Prejudice, discrimination, and victimisation are still a reality for many LGB people in the country. However, progress is being made within South African psychology. PsySSA has embarked on a process to develop relevant affirmative practice guidelines for psychology professionals. A first step in the process was the PsySSA position statement that provides psychology professionals with an affirmative view of sexual and gender diversity. Against this background, a need was identified to explore sexually and gender-diverse people's experiences of psychological practice as possible inputs for the guidelines. This article outlined the key findings of a qualitative study into the experience of a particular group, namely, LGB clients, with psychotherapy and counselling in respect of their sexual orientation, aimed at providing a localised basis from a client perspective as input for the development of practice guidelines.

The study that informed this article provided the opportunity for LGB clients of psychotherapists and counsellors to voice their experiences. Yet, it should be kept in mind that the use of a convenience sampling method and the size of the sample mean that the findings of this study may not be transferable to contexts outside the study population or even within the diverse population of LGB people in South Africa.

The findings, in addition to those obtained from other stakeholders, could hopefully become the basis for the development of more suitable interventions, such as guidelines, programmes, and training courses, aimed at the LGB client group. In this way, clients (and other LGB-focused stakeholders) become co-creators of the interventions aimed at them. It is finally the hope of the authors that the study will inspire readers to become more aware of their own attitudes and biases in relation to sexual orientation, in order to work proactively to become more affirmative in their practices.

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### Note

1. Unless otherwise indicated, the term 'counsellor' refers to either a psychotherapist or counsellor. Similarly, 'counselling' refers to either psychotherapy or counselling. Where participants or other authors used the term 'therapy' to refer to psychotherapy and/or counselling, it was retained.

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