Ethical guidelines for psychological practice with lesbian, gay, and bisexual clients

1. Other definitions used in these Guidelines

1.1. ***Bisexual*** refers to a man or woman whose emotional, romantic, sexual or affectionate attraction is to both men and women.

1.2. ***Gay*** refers to a man whose primary emotional, romantic, sexual or affectionate attraction is towards other men.

1.3. ***Lesbian*** refers to a woman whose primary emotional, romantic, sexual or affectionate attraction is towards other women.

1.4. ***Sexual orientation*** is one of the four components of sexuality and is distinguished by an emotional, romantic, sexual or affectionate attraction to individuals of a particular sex. The three other components of sexuality are **biological sex** (whether born as male or female), **gender identity** (the psychological sense of being male or female) and **social gender role** (the extent to which people conform to what is regarded in our society as feminine and masculine behaviour).

2. Introduction

Refer to the APS *Code of Ethics* (2007), standard A.1. Justice.

A.1.1. *Psychologists* avoid discriminating unfairly against people on the basis of age, religion, sexuality, ethnicity, gender, disability, or any other basis proscribed by law.

A.1.2. *Psychologists* demonstrate an understanding of the consequences for people of unfair discrimination and stereotyping related to their age, religion, sexuality, ethnicity, gender, or disability.

A.1.3. *Psychologists* assist their *clients* to address unfair discrimination or prejudice that is directed against the *clients*.

Refer to the *Code*, standard A.2. Respect.

A.2.1. In the course of their *conduct*, *psychologists*:
(a) communicate respect for other people through their actions and language;
(b) do not behave in a manner that, having regard to the context, may reasonably be perceived as coercive or demeaning;
(c) respect the *legal rights* and *moral rights* of others; and
(d) do not denigrate the character of people by engaging in *conduct* that demeans them as persons, or defames, or harasses them.

Refer to the *Code*, standard B.1. Competence.

B.1.2. *Psychologists* only provide *psychological services* within the boundaries of their professional competence. This includes, but is not restricted to:
(a) working within the limits of their education, training, supervised experience and appropriate professional experience;
(b) basing their service on the established knowledge of the discipline and profession of psychology;
(c) adhering to the *Code* and the *Guidelines*;
(d) complying with the law of the *jurisdiction* in which they provide *psychological services*; and
(e) ensuring that their emotional, mental and physical state does not impair their ability to provide a competent *psychological service*.

2.1. Sexual orientation is different from sexual behaviour because it refers to feelings and an individual's views about what they consider themselves to be. Sexual behaviour is how people behave in a sexual situation. Individuals may or may not express their sexual orientation in their behaviours. (Refer to the APS Tip Sheet *Sexual orientation and homosexuality*, 2008). Three sexual orientations are commonly recognised: **heterosexual**, attraction to individuals of the other sex; **gay or lesbian**, attraction to individuals of one's own sex (same–sex attracted); or **bisexual**, attraction to members of both sexes.

2.2 Same-sex attraction or a non-heterosexual sexual orientation were once assumed to be evidence of a mental disorder. The inclusion of lesbians, gays, and bisexuals in the classification system of mental disorders was often based on research into the high prevalence of lesbians, gays and bisexuals with a mental health issue. There is, however, no evidence of disproportionate psychopathology in non-clinical studies of gay and bisexual men and women. Further, an extensive body of literature has failed to identify significant differences between heterosexual, lesbian, gay, and bisexual people on a wide range of variables associated with overall psychological functioning (Gonsiorek, 1991). When studies have noted differences between heterosexual, lesbian, gay, and bisexual participants with regard to psychological functioning and higher prevalence rates for non-heterosexuals, these differences have been attributed to the effects of stress related to stigmatisation based on sexual orientation (Meyer, 2003). This stress may lead to increased risk of suicide attempts, substance abuse, and emotional distress.

2.3. The research that classified same-sex attraction or non-heterosexual sexual orientation as a mental illness has been found to be methodologically unsound (Gonsiorek, 1991). The flaws include unclear definition of terms, inaccurate classification of participants, inappropriate comparison of groups, discrepant sampling procedures, an ignorance of confounding social factors, and questionable outcome measures. The results from these flawed studies have been used to support theories of same-sex attraction or a non-heterosexual sexual orientation as mental illness and/or arrested psychosexual development. These studies have no valid empirical support and yet serve as the basis for inaccurate representations of lesbian, gay, and bisexual people.

2.4. The decision of the American Psychiatric Association in 1973 to remove homosexuality from its list of mental disorders, together with a widening community acceptance, have brought a more enlightened attitude toward issues of sexuality and sexual orientation (Minton, 2001). A wide range of alternative lifestyles and sexual expression is considered acceptable in current Australian society. Within the various cultural groups and communities of Australian society, there is a considerable range of attitudes towards issues of sexuality and sexual orientation (Riggs & Walker, 2004).

2.5. *Psychologists* recognise that same-sex attraction is one variant of human sexuality. *Psychologists* acknowledge however, that lesbian, gay, and bisexual *clients* often experience discrimination in Australian society. This discrimination has frequently been based on an attitude that any deviation from heterosexual orientation, the most common form of sexual orientation, is indicative of psychological disturbance, and there have been attempts to change a person's sexual orientation through various forms of psychological treatment (See APS *Position Statement on the Use of Therapies that Attempt to Change Sexual Orientation*, 2000).

2.6. The marginalisation of lesbian, gay, and bisexual people can lead to many social problems that might best be tackled by social change rather than by psychological treatment of the individual. Some lesbian, gay, and bisexual people may experience unique mental health challenges as a result of living in a society that perpetuates varying forms of discrimination and thus marginalises their experiences. *Psychologists* respect the sexual orientation of their *clients* and treat them with dignity (See APS *Charter for Clients of Psychologists*, 2005).

3. Attitudes and knowledge

Refer to the *Code*, standard B.3. Professional responsibility.

> *Psychologists* provide *psychological services* in a responsible manner. Having regard to the nature of the *psychological service* they are providing, *psychologists*:
> ...
> (c) take reasonable steps to prevent harm occurring as a result of their *conduct*;
> ...
> (g) are aware of, and take steps to establish and maintain proper professional boundaries with *clients* and colleagues;
> ...

Refer to the *Code*, standard C.1. Reputable behaviour.

> C.1.2. *Psychologists* avoid engaging in disreputable *conduct* that reflects negatively on the profession or discipline of psychology.

3.1. *Psychologists* avoid the use of stereotypes or other forms of bias, including the use of sexist or homophobic language, sexist or homophobic jokes, and derogatory or demeaning labels. It is advisable for *psychologists* to negotiate with their *clients* appropriate and comfortable language for both parties. It is important that *psychologists* demonstrate respect for their *clients*, in face-to-face contact, in written reports, and in discussion with colleagues.

3.2. *Psychologists* recognise how their attitudes (explicit or implicit) about lesbian, gay, and bisexual issues may be relevant to the provision of *psychological services*, and seek consultation or make appropriate referrals when indicated. For example, when same-sex attraction is incorrectly regarded as evidence of mental illness, a *client's* sexual orientation is likely to be viewed as a major source of the *client's* psychological difficulties even when sexual orientation has not been presented as a problem.

3.3. Key issues for *psychologists* who provide *psychological services* to lesbian, gay, and bisexual people include:
- an understanding of human sexuality;
- the 'coming out' process and how variables such as age, gender, cultural and linguistic diversity, disability, and religion may influence this process;
- same-sex relationship and family dynamics;
- family of origin relationships;
- struggles with spirituality and religious affiliations;
- career issues and workplace discrimination; and
- coping strategies for successful functioning.

3.4. The psychological consequences of lesbian, gay, or bisexual people themselves possessing negative attitudes toward same-sex attraction are not always obvious or conscious. Therefore, in planning and providing *psychological services*, *psychologists* consider more subtle manifestations of these consequences, such as shame, anxiety and/or low self-esteem.

3.5. When a *client* presents with discomfort about their own sexual orientation, *psychologists* assess the psychological and social context in which this discomfort occurs. For example, such an assessment might include consideration of pressures on *clients* to change their sexual orientation, the presence or absence of social support and models of positive lesbian, gay, or bisexual life, and the extent to which *clients* associate same-sex attraction with negative stereotypes and experiences (Hillier, Turner, & Mitchell, 2005).

3.6. *Psychologists* are aware of the possibility that lesbian, gay, and bisexual *clients* can experience negative attitudes, stereotyping and experiences from other lesbian, gay, and bisexual people, which can include both obvious and subtle forms of racism, sexism, ageism and other forms of prejudicial attitudes and behaviours.

4. Work settings

Refer to the *Code*, standard B.12. Conflicting demands.

> B.12.1. Where the demands of an organisation require *psychologists* to violate the general principles, values or standards set out in this *Code*, *psychologists*:
> (a) clarify the nature of the conflict between the demands and these principles and standards;
> (b) inform all parties of their ethical responsibilities as *psychologists*;
> (c) seek a constructive resolution of the conflict that upholds the principles of the *Code*; and
> (d) consult a senior psychologist.

Refer to the *Code*, standard A.1. Justice.

> A.1.1. *Psychologists* avoid discriminating unfairly against people on the basis of age, religion, sexuality, ethnicity, gender, disability, or any other basis proscribed by law.

4.1. *Psychologists* ensure that their services are not used to discriminate unfairly based on sexual orientation. This includes, but is not limited to, vocational and selection assessments.

4.2. When *psychologists* identify work policies or practices that may be discriminatory to lesbian, gay, or bisexual employees, they clarify and inform relevant parties, and seek a constructive resolution of the conflict that upholds the principles of the *Code*.

5. Professional development

Refer to the *Code*, standard B.1. Competence.

> B.1.1. *Psychologists* bring and maintain appropriate skills and learning to their areas of professional practice.
> ...
> B.1.3. To maintain appropriate levels of professional competence, *psychologists* seek professional supervision or consultation as required.

5.1. *Psychologists* increase their knowledge and understanding of sexual orientation through professional development, training, supervision, and consultation. Preparation for the provision of *psychological services* to lesbian, gay, and bisexual *clients* may include additional education, training, consultation, or supervision in such areas as:

- human sexuality;
- lesbian, gay, and bisexual identity development;
- the effects of stigmatisation upon lesbian, gay, and bisexual individuals, couples, and families;
- linguistic, spiritual/religious, and cultural factors affecting identity; and
- unique career development and workplace issues experienced by lesbian, gay, and bisexual individuals.

5.2. *Psychologists* are aware of the range and availability of lesbian, gay, and bisexual community resources for *clients* and their families. *Psychologists* unfamiliar with local lesbian, gay, or bisexual resources may obtain consultations or referrals from local agencies, and information from the APS Gay and Lesbian Issues and Psychology Interest Group website.

6. Relationships

Psychologists consider the negative effects of societal prejudice and discrimination on lesbian, gay, and bisexual relationships. *Psychologists* understand that, in the absence of socially sanctioned forms and supports for their relationships, lesbian, gay, and bisexual people may create their own relationship models and support systems (Short et al., 2007). Therefore, *psychologists* are knowledgeable about the diverse nature of lesbian, gay, and bisexual relationships, and value and respect the meaning of these relationships.

7. Bisexual clients

Negative individual and societal attitudes toward bisexuality in heterosexual and gay and lesbian communities adversely affect bisexual individuals. Bisexual adults and youths may experience a variety of stressors in addition to the societal prejudice due to being same-sex attracted, and may feel excluded from the gay/lesbian and heterosexual worlds. Research has shown that this exclusion and the associated stress of stigma can result in multiple mental health burdens, including earlier onset and greater persistence of some psychological disorders (Hatzenbuehler, 2009). *Psychologists* adopt a comprehensive understanding of sexual orientation in their provision of *psychological services* to bisexual *clients* and show respect for the diversity of their *clients'* experiences and relationships.

8. Young people

It is important that *psychologists* understand the unique difficulties and risks faced by lesbian, gay, and bisexual young people. Lesbian, gay, and bisexual young people may experience estrangement from their parents when revealing their sexual orientation, and may be at increased risk of suicide, alcohol and other drug use, becoming homeless, and at increased risk of sexually transmitted infections (Hillier, Turner, & Mitchell, 2005). *Psychologists* create a trusting environment for lesbian, gay, and bisexual young people to explore sexual orientation issues.

Refer to *Ethical guidelines for working with young people* (2009).

9. Older clients

Psychologists consider generational differences within lesbian, gay, and bisexual populations, and the particular challenges that may be experienced by lesbian, gay, and bisexual older adults. Older adults are a diverse group, and normative changes in ageing, may be positive as well as negative, and are not necessarily related to pathology or a *client's* sexual orientation. *Psychologists* are aware that Commonwealth and State laws and regulations may affect the rights of their *clients*. *Psychologists* also support *clients* in considering the need for legal advice related to medical crises, financial crises, and death. *Psychologists* are aware of the ways in which discrimination by health care providers and in aged care facilities can lead to negative mental health outcomes for older lesbian, gay, and bisexual *clients*, and can perpetuate social isolation.

10. Cultural, linguistic and religious/spiritual diversity of clients

Refer to the *Code*, General Principle A: Respect for the rights and dignity of people and peoples.

> They [*Psychologists*] have a high regard for the diversity and uniqueness of people and their right to linguistically and culturally appropriate services. *Psychologists* acknowledge people's right to be treated fairly without discrimination or favouritism, and they endeavour to ensure that all people have reasonable and fair access to *psychological services* and share in the benefits that the practice of psychology can offer.

In offering *psychological services* to culturally and linguistically diverse lesbian, gay, and bisexual *clients*, it is not sufficient that *psychologists* simply recognise the cultural, linguistic and religious/spiritual diversity of their *clients*. *Clients* may be affected by the ways in which their culture views same-sex attraction. The effects of racism within lesbian, gay, and bisexual communities are also critical factors to consider for *psychologists*. *Psychologists* are sensitive to the complex dynamics associated with cultural values about gender roles, religious and procreative beliefs, and degree of individual and family acculturation within Australia. They are also sensitive to the *client's* personal and cultural history of discrimination or oppression (Greene, 1994). All of these factors may have a significant impact on identity integration and psychological and social functioning.

11. Clients with a disability

11.1. Lesbian, gay, and bisexual *clients* with a disability may experience a wide range of challenges related to the social stigmas associated with both these needs and sexual orientation. Lesbian, gay, and bisexual *clients* with physical and/or sensory needs may not have access to information, support, and services available to other lesbian, gay, and bisexual people.

11.2. People with a disability are often inaccurately assumed to be asexual. It is recommended that *psychologists* enquire about the *client's* sexual history and current sexual functioning where appropriate, and provide information and facilitate problem-solving in this area. Many lesbians and gay men with physical and/or sensory needs have experienced coercive sexual encounters, and it may be important for *psychologists* to assess the extent to which the person may have experienced sexual or physical victimisation.

12. Research

12.1. *Psychologists* do not use psychological assessment tools and measures that have a biased view of homosexuality as indicative of pathology. Such bias is more common with older psychological tests, or tests that have been developed on the basis of psychological theories which have been superseded. Furthermore, *psychologists* do not use the results of psychological assessment tests and measures to discriminate against lesbian, gay, and bisexual people on the basis of their sexual orientation.

12.2. *Psychologists* who use surveys and questionnaires in research conducted with lesbian, gay, and bisexual individuals ensure that they use the specific terms most appropriate for these communities. Early research measures often deployed language that constructed same-sex attractions in negative ways, or presumed heterosexuality as the norm from which other sexualities deviate. Some measures of sexual identity may also be considered problematic from the perspective of some lesbian, gay, and bisexual individuals. As noted in section 2, *psychologists* consider a broad range of sexual identities in their research practice, and do not collapse all non-heterosexual identities into simplistic categories determined solely on the basis of behavioural measures of sexual practices.

12.3. Research on lesbian, gay, and bisexual people covers a broad spectrum of issues including those that are lesbian, gay and/or bisexual-specific, and those that cover the general experiences of lifespan development, relationships, and health and well-being. Researchers thus include lesbian, gay, and bisexual participants, not simply when examining issues relating to lesbian, gay and/or bisexual-specific concerns, but also as members of a truly diverse research sample on general topics.

12.4. *Psychologists* are cognisant of the ways in which their research may be understood by the broader community, and are mindful of undertaking adequate consultation with the minority group community to ensure the appropriateness of the research topic. Similarly, all researchers, regardless of sexual orientation, recognise how their own perspectives and experiences can frame their research questions and affect the interpretation of their findings.

12.5. Researchers who identify as lesbian, gay or bisexual consider the competing demands made on their position as a researcher by the research participants, the minority community, the funding body and the researcher's institution. Such considerations include the benefits and limitations their 'insider' status can pose, the risk of assuming greater authority to conduct research, whilst still maintaining ethical practice.

13. Lesbian, gay, and bisexual psychologists

Refer to the *Code*, standard B.3. Professional responsibility.

> B.3. *Psychologists* provide *psychological services* in a responsible manner. Having regard to the nature of the *psychological services* they are providing, *psychologists*:
> ...
> (g) are aware of, and take steps to establish and maintain proper professional boundaries with *clients* and colleagues.
> ...

Refer to the *Code*, standard C.4. Non-exploitation.

> C.4.1. *Psychologists* do not exploit people with whom they have or had a *professional relationship*.
>
> C.4.2. *Psychologists* do not exploit their relationships with their assistants, employees, colleagues or supervisees.
>
> C.4.3. *Psychologists*:
> (a) do not engage in sexual activity with a *client* or anybody who is closely related to one of their *clients*;
> (b) do not engage in sexual activity with a former *client*, or anybody who is closely related to one of their former *clients*, within two years after terminating the *professional relationship* with the former *client*;
> (c) who wish to engage in sexual activity with former *clients* after a period of two years from the termination of the service, first explore with a senior psychologist the possibility that the former *client* may be vulnerable and at risk of exploitation, and encourage the former *client* to seek independent counselling on the matter; and
> (d) do not accept as a *client* a person with whom they have engaged in sexual activity.

Refer to *Ethical guidelines on the prohibition of sexual relationships with clients* (2007).

Refer to *Ethical guidelines for managing professional boundaries and multiple relationships* (2008).

13.1. Lesbian, gay or bisexual *psychologists* who work with lesbian, gay or bisexual *clients* are often working and living within a small sub-group of the wider community. This has many of the features and difficulties of working in a small community (Graham & Liddle, 2009). In a small community it is likely that most people will know someone who knows the *psychologist* or the *client*, knows about the *psychologist* or the *client*, or knows of the *psychologist* or the *client*. This can result in difficulties regarding privacy and confidentiality for both the *psychologist* and the *client* (Brown, 1989; Dworkin, 1992; Morrow, 2000).

Refer to *Ethical guidelines for psychological practice in rural and remote settings* (2004).

13.2. Referral to lesbian, gay and bisexual psychologists is often by word-of-mouth from current or *ex-clients*, gay or lesbian doctors or other professionals, or through advertisements in gay or lesbian media, which means that *psychologists* are sometimes known figures in the community. It is important that *psychologists* are vigilant with respect to their own privacy and maintain an awareness of the nature of communication networks in small communities. There is a need therefore for special vigilance around *client* records, appointment books, scheduling of appointments and waiting room privacy.

13.3. Lesbian, gay, and bisexual *psychologists* working with lesbian, gay, and bisexual *clients* may experience challenges to maintaining their professional boundaries, and the potential to engage in nonsexual *multiple relationships* (Graham & Liddle, 2009; Kessler & Waehler, 2005). The most common categories of nonsexual *multiple relationships* identified as challenging and requiring thoughtful negotiating and appropriate responding were: incidental and recurring social interactions; personal connections (pre-existing or discovered between friends and/or partners); and overlapping business or professional services. The context will play a significant role in the decision of whether to engage in such *multiple relationships* which in most instances is to be avoided.

13.4. *Clients* who are in the process of 'coming out' progress at different rates and may have different levels of comfort with the process as a whole and with the various stages of the process. *Psychologists* are alert to the level of comfort for the *client* with his/her sexual orientation, and respect the pace and progress for the *client* while coming out. In particular gay, lesbian and bisexual *psychologists* are aware of the attachment that some *clients* may develop towards the *psychologist* as part of the process of being understood and supported.

13.5. Lesbian, gay, and bisexual *psychologists* who use physical contact in their procedures or assessments, fulfil their duty to protect *clients* by:
i) obtaining full and informed written consent from *clients*; and
ii) ensuring appropriate consultation with the *client* about the proximity of a third party.

Refer to *Ethical guidelines relating to procedures/assessments that involve psychologist-client physical contact* (2006).

14. Summary

Psychologists, regardless of their own sexual orientation, increase their knowledge and understanding of human sexuality and diversity of sexual expression through ongoing professional development, and provide competent *psychological services* in a just and respectful manner to lesbian, gay, and bisexual *clients*.

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