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Ethical guidelines for psychological practice with diverse sexualities, trans and gender diverse, and/or intersex characteristics

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1. Introduction

1.1. The APS recognises that people with diverse sexualities, trans and gender diverse people, and people with innate variations of sex characteristics (intersex people) exhibit variations of humanity and *these characteristics* are not indicative of psychological disturbance. This recognition is based on the weight of scientific evidence. The most common usage in Australia for people with *these characteristics* is LGBTI (Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex) or LGBTIQ+ (Queer or Questioning, with the + signifying other sexual identities such as Asexual). The phrase SOGIESC (Sexual Orientation, Gender Identity and Expression, and Sex Characteristics) is often used when discussing law and policy. While these multiple populations are often described together, they are distinct with different histories, issues, experiences and challenges that can be marginalized, misattributed and mistreated when only seen as part of the same consolidated group. These *Guidelines* focus on the ethical issues that *psychologists* consider when providing *psychological services* to clients with *these characteristics*, recognising that any client could potentially share any of *these characteristics*. Unless specified, the term *client* throughout this document refers to any potential *client* with *these characteristics*.

1.2. These *Guidelines* recommends that *psychologists* are or become familiar with these following foundational terms (Australian Government, 2020). While

recognising that some terms span the different categories, for some *clients*, they may not identify with any of these terms.

1.2.1. Terms associated with people of diverse sexualities: 'Sexual orientation', 'Sexuality', 'Heterosexual', 'Lesbian', 'Gay', 'Bisexual', 'Asexual', 'Pansexual', 'Polysexual', 'Questioning'.

1.2.2. Terms associated with trans and gender diverse people: 'Gender', 'Gender expression', 'Gender Identity', 'Transgender', 'Transsexual', 'Gender diverse', 'Gender-queer', 'Gender fluid', 'Non-binary', 'Sex presumed at birth', 'Dead name', 'Brotherboy', 'Sistergirl', 'Fa'afafine' and 'Takatāpui'.

1.2.3. Terms associated with intersex people: 'Sex assigned at birth', 'Sex characteristics', 'innate variations of sex characteristics', 'Bodily diversity'. Individuals with innate variations of sex characteristics may use any of a variety of different terms, often reflecting what they are taught by parents or clinicians, or in response to misconceptions. For example, there are more than 40 variations of intersex (Intersex Human Rights Australia, 2013) and intersex variations are often clinically referred to as 'Disorders of sex development' or 'differences of sex development' (DSD).

1.2.4. *Psychologists* should apply a critical lens to any of these diagnostic terms: Disorders of sex development (DSDs), Gender Dysphoria, Hypoactive sexual desire disorder (HSDD) and sexual aversion disorder (SAD).

1.3. To assist *psychologists,* these additional terms are useful:

1.3.1. Heteronormativity: Heteronormativity is the assumption that heterosexuality, based on a gender and body binary and the assumption that sexual attraction, behaviour and identity align is the norm for all persons. For *psychologists* this can impact on practice (e.g. assuming a woman who is married to a man is necessarily heterosexual). Countering heteronormative assumptions are terms like cis (for people whose gender aligns with their sex presumed at birth), endosex or dyadic (for people born with sex characteristics that fit medical norms for female or male bodies), allosexual (for people who experience sexual attraction) and amatosexual (for people who experience romantic attraction). An example of non-heteronormative inclusivity is all Australian government records identify individuals as M (male), F (female) or X (indeterminate/ intersex / unspecified). The X is not a 'third sex', but refers to a person of a non-binary gender (Australian Government, 2015).

1.3.2. Heterosexism: Heterosexism is a system of attitudes, bias, and discrimination in favour of heteronormativity, cisnormativity and endosex people. Internalised heterosexism encompasses internalised homophobia, internalised biphobia, internalised transphobia, internalised intersexphobia and other phenomena like toxic masculinity and toxic femininity (Huynh et al., 2020; Thepsourinthone, 2020).

1.3.3. Intersectionality: Intersectionality describes how different parts of a person's identity or circumstances – such as age, race, culture, disability, sexuality, gender, intersex, SES, citizenship status, location or religion – intersect and combine to shape that person's life experience, and the additional compounding forms of identity, expression, stigma, hostility, isolation, and discrimination challenges

(including medical trauma, medicalisation, pathologisation) that can occur with these combinations. For example, the additional challenges for those of gender diverse identities situated in close conservative Christian communities.

1.3.4. Queering: Queering refers to the act of seeing particularly historical lives and circumstances through a non-heteronormative, non-cisnormative, intersex and intersectionality lens. It is not intended to imply that people with these characteristics are queer. The critical analysis of past and current psychological research and practice is helpful to understand what has contributed to negative findings and outcomes for diverse sexualities, trans and gender diverse, and/or intersex people.

1.4. *Psychologists* understand that sexual behaviour is, and can be, distinct from *clients* of *these characteristics*, relating to all people. Assumptions should not be made based on behaviours reported or desired.

1.5. The APS recognises that *clients*, both collectively and individually, have historically and often continue to face challenges with regards to autonomy and self-determination, identity, expression, stigma, violence, hostility, isolation, discrimination, trauma, and internalised heterosexism marginalising their experience, identity and their ability to receive equal respect and rights in specific communities and broader Australian society (American Psychological Association [APA], 2012; Ellis, Riggs & Peel, 2020; Halliday & Caltabiano, 2020). Additionally, where a *client's* identity and bodily diversity intersects further with additional minority identifications (e.g. cultural and religious, disability, refugee), there are additional complexities and sensitivities that need to be considered. *Psychologists* recognise that without sensitivity to these challenges, their context and their strengths and resilience, there will be barriers to access, to effective therapeutic processes, and negative impacts on the wellbeing and functioning of *clients* (Bradstreet et al., 2014; Csabs et al., 2020).

1.6. *Psychologists* are aware that there are various legal, social, ideological, medical, and scientific theories and debates regarding sexual behaviour, sexuality, sex characteristics, intersex and gender diversity (APA, 2009; 2012; 2020) and the need for *psychologists* to rely on current scientific evidence. *Psychologists* understand the gendered dimensions of health and wellbeing, whether from biological or sociocultural limitations, and the influences and implications of social determinants of health (Hyde et al, 2019).

1.7. *Psychologists* are aware that currently or historically some forms of psychological theory, research and practice have distorted, marginalised and pathologized diverse sexualities, trans and gender diverse, and/or intersex people (Ellis, Riggs & Peel, 2020) with significant adverse impacts on individuals, communities and societies. *Psychologists* understand that the APS has policies and position statements (APS 2015, 2016; International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues, 2018) that commit to mental health practices and research that affirm the experiences of these *clients*.

1.8. These *Guidelines* are to be read in conjunction with the APS *Code of Ethics* (2007), and particularly the Ethical guidelines for psychological practice with men and boys (2017), the Ethical guidelines for psychological practice with

women and girls (2012), the Ethical guidelines for working with young people (2018), the Ethical guidelines for working with older adults (2014),and the Ethical guidelines for psychological practice with clients with an intellectual disability (2016).

1.9. *Psychologists* are aware of the need to engage in inclusive, affirming, non-discriminatory, culturally safe, trauma-informed, and competent practices when working with these heterogeneous minority *client* groups (Bradstreet et al., 2014). This could include non-judgmental assessments of sexual practices and sexual partner relationships. *Psychologists* should strive to ensure clients experience consistent inclusive, affirming, non-discriminatory, culturally safe and competent *psychological practice* in all aspects of their receipt of service (GLHV@ARCSHS, Latrobe University, 2020). This could include ensuring organisational procedures, protocols, practices, materials, signage, toilets/change rooms, referral pathways and staff training are inclusive and affirming and that there is community engagement in service planning, development and review processes.

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.

1.10. *Psychologists* acknowledge the value of lived experiences of diverse sexualities, trans and gender diverse, and/or intersex individuals (Australian Human Rights Commission, 2015) and thus the therapeutic value of peer support and allyship, and specialist organisations, services, communities and resources that can be consulted or for client referrals to complement the work of the *psychologist* (Hobaica et al., 2018). For example, these Guidelines have been developed with consultation with peak bodies of diverse sexualities, trans and gender diverse, and/or intersex variations in the mental health field.

1.11. Having regard to the context when providing *psychological services*, *psychologists* consider the potential impact of their own sex, sexuality, gender, gender identity or physical characteristics on the *client*. *Psychologists* acknowledge the inherent power differentials between a *client* and a *psychologist*, and the ways in which heteronormativity may amplify such differentials. Where indicated, *psychologists* explore and address *clients'* preference for a practitioner's bodily diversity, sexuality, gender and gender identity.

1.12. *Psychologists* understand that language (encompassing definitions, terminology, names, pronouns, identity categories, bodily diversity) can play a powerful role in the lives for all people, particularly in how their rights and identities are recognised by institutions and broader society (Australian Government, 2015). *Psychologists* should consult with *clients* regarding their own identity and pronouns, full names and terms to describe their sexuality,

gender and/or being intersex (Ellis et al., 2020; Telfer et al., 2018). *Psychologists* recognise that language and terms in this field can vary across different contexts and continue to evolve. Additionally, it is helpful for *psychologists* to be aware of historical and evolving symbols, flags and other visual imagery positively and negatively associated with *these characteristics* and the potential impact these can have on *clients*.

2. Justice

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.

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 their *clients*.

2.1. *Psychologists* support *clients* to have autonomy and be involved as far as possible in shared decision making in all aspects of their receipt of service, especially if their cognitive state or ability are being questioned by others in their lives (e.g. because of their age or being neurodivergent). Due to the historical and often still current pathologizing of diverse sexualities, trans and gender diverse, and/or intersex variations, clients may have justified concerns of being subjected to coerced or involuntary treatment.

2.2. *Psychologists* are aware that as gender is a determinant of health, *clients,* particularly those of trans and gender diverse and intersex, can have different health requirements, face different challenges in managing their health, and face different barriers in accessing services. This is further amplified for *clients* with additional intersectionalities issues.

2.3. *Psychologists* support *clients* to obtain fair treatment and services in accordance with their rights and entitlements when accessing relevant public and private services (e.g., health and housing services, educational institutions, prisons).

2.4. *Psychologists* are alert to the experiences of stigma, discrimination, harassment, violence, and threats to physical safety and psychological wellbeing that diverse sexualities, trans and gender diverse, and/or intersex individuals and those close to them (e.g. partners, parents) can be subjected to from their families, the broader community, institutions, or when accessing health and social services. This might include *psychologists* supporting the *client* to access a suitable independent advocate, reinforcing their clients' awareness of their legal rights, or referring them to appropriate legal and protective services.

2.5. *Psychologists* are alert to the experiences of diverse sexualities, trans and gender diverse, and/or intersex individuals and those close to them (e.g. partners, parents) regarding formal and informal therapeutic practice attempts to change or suppress a person's sexuality, gender or bodily diversity is counter to current APS policies and position statements (2015; 2016; International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues, 2018), many Australian state and territorial laws and the safety and wellbeing of those individuals and their communities.

2.6. When involved in multidisciplinary teams related to intersex, gender and sexuality issues, *psychologists* advocate for and, where appropriate, exercise leadership to ensure *clients* experience mental health principles, practices and research that respect and affirm these *clients* and advocate for autonomy and self-determination consistent with contemporary scientific knowledge, legal and human rights movements (Liao & Simmonds, 2014; Roen, 2019).

Refer to the APS *Charter for clients of psychologists* (2017).

3. Informed consent

Refer to the *Code,* standard A.3. Informed Consent.

A.3.3. *Psychologists* ensure consent is informed by:
(a) explaining the nature and purpose of the procedures they intend using;
(b) clarifying the reasonably foreseeable risks, adverse effects, and possible disadvantages of the procedures they intend using;
(c) explaining how information will be collected and recorded;
(d) explaining how, where, and for how long, information will be stored, and who will have access to the stored information;
(e) advising *clients* that they may participate, may decline to participate, or may withdraw from methods or procedures proposed to them;
(f) explaining to *clients* what the reasonably foreseeable consequences would be if they decline to participate or withdraw from the proposed procedures;
(g) clarifying the frequency, expected duration, financial and administrative basis of any *psychological services* that will be provided;
(h) explaining confidentiality and limits to confidentiality (see standard A.5.);
(i) making clear, where necessary, the conditions under which the *psychological service* may be terminated; and
(j) providing any other relevant information.

3.1 *Psychologists* clarify the parameters of the psychological services being requested by *clients*. Recognise that any *client* may seek assistance from *psychologists* for a range of diverse sexualities, trans and gender diverse, and/or intersex issues that can include:

- understanding sexuality, gender and/or intersex variations, identity, expression, behaviours, attractions, intersectionality issues, internalised heterosexism and sexism, fluidity, lifespan changes, and 'coming out'/disclosure processes;
- assisting trans and gender diverse young people face unique stressors at the onset of puberty, and navigate the disruption to other interacting developmental processes if access to transitioning pathways is limited

(Spivey & Edwards-Leeper, 2019), while recognising that some identify with the label trans or gender diverse most just want to be seen as their authentic sex;

- assisting intersex individuals to understand, affirm and adapt to their body and identity (e.g. many only discover they are intersex from their parents, doctors/clinicians or during puberty, pregnancy or when trying to conceive), grief related to infertility, navigate trauma and adjustment associated with medical interventions related to intersex status (e.g., long term impact of forced and coerced medical interventions, repeated surgery experiences, parents withholding information), while recognising that some will be heteronormative others may have intersecting issues of sexuality and/or gender identity (Roen, 2019);
- assisting family members, friends and partners adapt to discovering and continued relating to diverse sexualities, trans and gender diverse, and/or intersex individuals (Westwater et al., 2019);
- affirming asexual and aromantic identities and assisting asexual and aromantic individuals in exploring forms of relationships beyond amatonormative restrictions (Chasin, 2015);
- understanding the complex relational and community issues relevant to identity and self-expression, including non-normative relationships and sexual practices, family and parenting, legal standing, health status, allyship, systemic discrimination, social transitioning, social action, and when legal guardianship arrangements may make choices counter to *client choices*;
- addressing mental health problems and conditions resulting from or compounded by past and ongoing stigma, discrimination, violence, trauma, coerced or involuntary psychological or medical interventions, and internalised heterosexism;
- addressing general mental health or other issues that may not be central to their sexuality, gender and/or intersex in a way that is non-discriminatory and respectful of diverse sexualities, trans and gender diverse, and/or intersex issues and experiences. Making an issue of sexuality, gender and/or intersex when it is irrelevant can be as problematic as ignoring sexuality, gender and/or intersex issues when it is relevant to a person's experience (Urry, 2020).

3.2 *Psychologists* inform clients that any psychological practice or research that regards diverse sexualities, trans and gender diverse, and/or intersex variations as disordered and attempts to change or suppress these aspects is counter to current APS policies and position statements (2015; 2016), many Australian state and territorial laws and detrimental to the safety and wellbeing of individuals and their communities.

3.3 To assist *psychologists,* it is useful to note that for clients of trans and gender diverse the term 'informed consent' has a specific meaning in reference to the 'Informed Consent Model', a framework and protocol to enable GP-facilitated access to gender affirming hormonal treatment without the required involvement of a mental health professional in a gatekeeper role (Lipshie-Williams, 2020). This model is reflected in the current Australian guidelines for treatment of trans and gender diverse adults (Cheung et al., 2019) but not with children and adolescents that still use the 'Australian Standards' model (Telfer et al., 2018), however note 6.2.

3.4 When clients are seeking assessment and treatment services related to *these characteristics*, where relevant, *psychologists* disclose to the *client* the limits of their knowledge, practice or competence and are mindful of the responsibility to communicate alternative or complementary appropriate options and pathways (Halliday & Caltabiano, 2020) and play a role in ensuring appropriate continuity of care. This may involve contacting the APS National Office for suitable colleague referrals or referring to an appropriate specialist or peer-led service.

3.5 When clients whose capacity to give consent is, or may be, impaired or limited, attempts as far as practically possible to obtain the *client's* consent and continually involve them in decision making throughout the whole duration of service should be undertaken.

> A.3.6. *Psychologists* who work with *clients* whose capacity to give consent is, or may be, impaired or limited, obtain the consent of people with legal authority to act on behalf of the *client*, and attempt to obtain the *client's* consent as far as practically possible.

Refer to *Ethical guidelines for working with young people* (2018), or any other guidelines of relevance to the specific client group.

4. Competence

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*.
>
> B.1.3. To maintain appropriate levels of professional competence, *psychologists* seek professional supervision or consultation as required.

4.1. *Psychologists* recognise that relevant legal issues and rights of people with *these characteristics* continue to evolve and *psychologists* are expected to have a reasonable currency of knowledge related to their client work.

4.2. *Psychologists* who provide *psychological services* to *clients* develop and maintain their competence with these *client* groups as well as the competence of any of their staff that have contact with their *clients*. Competence can include awareness and sensitivity to the cultural and contextual challenges faced by

these heterogeneous minority *client* groups, knowledge of common psychological and mental health issues affecting these groups, their prevalence and etiology, relevant life span development issues, risk assessment concerns, issues in providing culturally sensitive assessments and interventions, and awareness of higher rates of suicidal behaviour (APA, 2009; APA, 2012; Ellis et al., 2020). Competence should also include knowledge about historical and evolving approaches to diverse sexualities, trans and gender diverse, and/or intersex individual and specific communities' resilience and empowerment, as well as relevant research findings.

Refer to *Ethical guidelines relating to clients at risk of suicide* (2014); and *Ethical guidelines for psychological assessment and the use of psychological tests* (2018).

4.3 *Psychologists* acknowledge the therapeutic value of diverse sexualities, trans and gender diverse, and/or intersex peer support and specialist organisations, services, communities and resources that can be consulted or for client referrals to complement the work of the *psychologist*.

4.4. When appropriate, *psychologists* should seek secondary consultation, further guidance, supervision or aid in assisting clients to suitable referrals through consulting professional colleagues or individuals, organisations or peak bodies that represent these heterogeneous minority groups and obtaining relevant professional development. The APS National Office can provide a starting point for consulting with professional colleagues.

4.5. *Psychologists* understand that the APS (2016) has a policy which recommends mental health practices that affirm the experiences of *clients* with trans and gender diverse. This approach affirms the person's gender as they express it, challenges negative social attitudes towards gender diversity, and advocates for the support needs of gender diverse people.

4.6. *Psychologists* assist *clients* with trans and gender diverse who are seeking to undertake surgical, hormonal, psychological and other allied health interventions by respectfully exploring all relevant information and options. *Psychologists* are aware that they may be placed in an 'assessor' role with the power to approve, deny or delay clients receiving necessary and timely interventions. *Psychologists* avoid making assumptions regarding their *clients'* decisions about possible medical interventions, for example, not all trans and gender diverse clients seek medical gender affirmation. *Psychologists* understand that gender diverse *clients* may adapt gender affirming treatments to their individual needs or may refuse such treatments all together. When appropriate, *psychologists* should seek further guidance for their work or assist *clients* with more appropriate referrals (see 4.3 & 4.4).

Refer to *Ethical guidelines for working with young people* (2018).

4.7. The APS opposes medical interventions for intersex infants and young people to fit heteronormative ideas of male and female, unless these are medically necessary (Refer to APS Information sheet: Children born with intersex variations*,* 2016). *Psychologists* involved in decision-making within multidisciplinary teams should critically question concepts of medical necessity when urgency is not required. *Psychologists* recognise that while intersex variations have historically and continue to be pathologised (e.g. described as

Disorders of Sex Development) by traditional biomedical approaches, contemporary medical and psychological research continues to highlight these conceptions as problematic (Roen, 2019; Vora & Srinivasan, 2020). Instead, the direction of research continues to support approaches and processes that uphold a *client's* right to bodily and mental integrity, autonomy and self-determination (Carpenter, 2020).

4.8. The APS opposes any approach to psychological practice or research that regards lesbians, gay men, and bisexual people as disordered, and any approach that attempts to change or suppress an individual's sexual orientation (Refer to APS *Position Statement on the Use of Therapies that Attempt to Change Sexual Orientation,* 2015). This approach affirms the person's sexuality as they express it, challenges negative social attitudes towards diverse sexuality, and advocates for the support needs of diverse sexuality people. This opposition to viewing a person's sexuality as disordered extends also to asexual individuals, who are clinically distinct from distressed individuals with disorders such as hypoactive sexual desire disordered (Brotto & Yule, 2017).

5. Professional responsibility

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*:
(a) act with the care and skill expected of a competent *psychologist*;
(b) take responsibility for the reasonably foreseeable consequences of their *conduct*;
(c) take reasonable steps to prevent harm occurring as a result of their *conduct*;
(d) provide a *psychological service* only for the period when those services are necessary to the *client*;
(e) are personally responsible for the professional decisions they make;
(f) take reasonable steps to ensure that their services and products are used appropriately and responsibly;
(g) are aware of, and take steps to establish and maintain proper professional boundaries with *clients* and colleagues; and
(h) regularly review the contractual arrangements with *clients* and, where circumstances change, make relevant modifications as necessary with the informed consent of the *client*.

5.1. *Psychologists* understand that overall, individuals with *these characteristics* access psychological services at a lower rate and with higher reported dissatisfaction of the service (Morris, 2020). This is often amplified for *clients* with intersectionality issues. Where possible, *psychologists* should work with these *clients* to identify appropriate referral pathways and support options, and address identified risk factors.

5.2. *Psychologists* are aware of and sensitive to how their knowledge, values, attitudes, practice and community affiliations and engagements related to sex, sexuality, gender and/or intersex variations (e.g. political parties that oppose trans and gender diverse rights) may influence the *psychological services*

provided and client outcomes. *Psychologists* need to seek supervision if their effectiveness may be compromised towards the *client* and/or the *client's* presenting issues. In such situations, *psychologists* consider assisting *clients* with more appropriate referrals (see 4.3 & 4.4).

5.3. *Psychologists* are aware of the theoretical, empirical support and possible gender and heterosexist bias for assessment practices they use when working with these *clients*, including the degree to which these assessment practices have been found to apply to these *clients*.

5.4. *Psychologists* are sensitive to the ethical issues and challenges inherent in providing assessment or evaluation reports in general, and particularly as required to support hormonal and/or surgical interventions (Mizick & Lundquist, 2016). Using affirmative inclusive practice, knowledge of alternative pathways (Informed Consent Model compared with the Australian Standards model) and up to date knowledge of relevant legislation is vital for the wellbeing of *clients*. Where a *psychologist* is unsure of their competence regarding these matters, they should assist *clients* with more appropriate referrals (see 4.3 & 4.4).

5.5. *Psychologists* are sensitive to the ethical issues and challenges inherent in providing multiple *psychological services* such as psychotherapy (i.e., treatment and care) and assessment or evaluation reports that are required to support hormonal and/or surgical interventions (Mizick & Lundquist, 2016). If *psychologists* are providing both formal assessment and treatment services to *clients*, *psychologists* anticipate the likely consequences and as far as possible act to mitigate any potential negative effects or assist *clients* with more appropriate referrals (see 4.3 & 4.4).

5.6. *Psychologists* with *these characteristics* are aware of the potential risks inherent in providing *psychological services* to clients who may be a part of their own community, which includes managing any *multiple relationships* that might develop as a result of working and socialising within these relatively small communities.

Refer to *Ethical guidelines for managing professional boundaries and multiple relationships* (2016).

6. Young people (Those under the legal age of adulthood)

Refer to the *Code,* standard A.3. Informed Consent.

> A.3.6. *Psychologists* who work with *clients* whose capacity to give consent is, or may be, impaired or limited, obtain the consent of people with legal authority to act on behalf of the *client*, and attempt to obtain the *client's* consent as far as practically possible.

6.1. *Psychologists* are aware that sexual identity, interests and behaviours of infants, children and adolescents are often viewed by adults through a problematic lens rather than a diverse sex positive multifaceted lens (Harden, 2014) which can impact research and legal guardianship decisions. This is further amplified for infants, children and adolescents of diverse sexualities, trans and gender diverse, and/or intersex variations.

6.2. *Psychologists* who provide *psychological services* to clients who are young people, respectfully balance considerations of autonomy, privacy, confidentiality and informed consent, and any relevant legal requirements. This can be further compounded for young people with intersectionality issues (e.g. disability, cultural/ethnic, neurodivergence). *Psychologists* acknowledge that legal issues and rights of young people with *these characteristics* continue to evolve and *psychologists* are expected to have a reasonable currency of knowledge related to their client work. The current evolving trend is towards greater autonomy and self-determination for young people, with the Australian Family Court potentially playing a mediator role.

6.3. Psychologists recognise that while *clients* who are young people can be recommended for training to behave and express themselves more aligned to a particular gender, these recommendations need to be considered with a critical lens.

6.3. *Psychologists* who provide *psychological services* to young people prioritise the wellbeing of the young person and carefully consider when and how the family and the young person's school or community (e.g. ethnic/religious) are involved if relevant. *Psychologists* work in ways that respect and uphold the autonomy of the young person, taking into account their vulnerabilities, needs, preferences, capacity, and competence to make informed consent, and specific circumstances encouraging and supporting clients to participate in decisions about the type of psychological services provided to them (Telfer, Tollit, Pace, & Pang, 2018).

6.4. *Psychologists* are aware of and sensitive to the individual challenges that young people may face due to familial, social and cultural contexts including such issues as racism, prejudice, discrimination, bullying, violence, distress, trauma and intergenerational shame and secrecy. *Psychologists* aim to support young people to minimise the impact of these issues and provide appropriate psychological assistance as they navigate through these difficulties (APA, 2020; Hillier et al., 2010).

6.5. *Psychologists* ensure that any of their opinions, attitudes, values, or biases do not negatively impact upon their capacity to provide professional, non-discriminatory, respectful and competent *psychological services* consistent with contemporary scientific knowledge for the parents/legal guardians of young people (Riley, Sitharthan, Clemson, & Diamond, 2011). *Psychologists* are aware that parental distress and desires can drive poor decision-making related to the rights and desires of young people, including intersex infants (Roen, 2019).

7. Older adults

7.1. *Psychologists* who work in older adult health, mental health or aged care services strive to ensure *clients* experience inclusive, affirming, non-discriminatory, culturally safe, trauma-informed, and competent *psychological services* that recognise each individual *client's* life history, autonomy, needs, preferences, capacity and competence.

7.2. *Psychologists* understand that 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* diverse sexualities, trans and gender diverse, and/or intersex variations.

7.3. *Psychologists* are aware of the ways in which discrimination by health care providers in community or residential services and facilities can lead to negative mental health outcomes for older *clients* that can perpetuate social isolation.

7.4. *Psychologists* are aware of the ways in which the impact of early childhood trauma in medical settings and the loss of autonomy in aged care can lead to negative mental health outcomes for older *clients*.

7.5. *Psychologists* ensure that any of their opinions, attitudes, values, or biases do not negatively impact upon their capacity to provide professional, non-discriminatory, respectful and competent *psychological services* consistent with contemporary scientific knowledge to the carers and legal guardianship of older adult *clients*.

Refer to *Ethical guidelines for working with older adults* (2014); and *Ethical guidelines for reporting abuse and neglect, and criminal activity* (2019).

8. Intellectual disability or communication impairment

8.1. *Psychologists* who provide psychological services to *clients* with intellectual disability or *clients* with a communication impairment, respectfully balance considerations of autonomy, privacy, confidentiality and informed consent, and any relevant legal requirements. *Psychologists* acknowledge that relevant legal issues and rights related to *these characteristics* continue to evolve and *psychologists* are expected to have a reasonable currency of knowledge related to their client work.

8.2 *Psychologists* who provide *psychological services* to *clients* with intellectual disability or *clients* with a communication impairment prioritise the wellbeing of the *client* and carefully consider when and how the family is involved, if relevant. *Psychologists* work in ways that respect and uphold the autonomy of the client, taking into account their psychosocial development, vulnerabilities, needs, preferences and competence to provide informed consent, and specific circumstances allowing *clients* the opportunity to participate in decisions about the type of psychological services provided to them, and which might include supporting the *client* to access supported decision making (Office of the Public Advocate, 2017) and/or a suitable independent advocate (Marks et al.,2020).

8.3. *Psychologists* are aware of and sensitive to the individual challenges that *clients* with intellectual disability or *clients* with a communication impairment may face due to familial, social and cultural contexts including such issues as racism, prejudice, discrimination, bullying, violence, distress and trauma. *Psychologists* aim to support clients to minimise the impact of these issues and provide appropriate psychological assistance to *clients* with intellectual disability or *clients* with communication impairment as they navigate through these difficulties (APA, 2020; Hillier et al., 2010).

Refer to *Ethical guidelines for psychological practice with clients with an intellectual disability* (2016); and
Ethical guidelines for reporting abuse and neglect, and criminal activity (2019).

9. Research

9.1. *Psychologists* are aware that contemporary research in psychology and other disciplines largely sees diverse sexualities, trans and gender diverse, and/or intersex variations as human variation, and is conscious of the context in which the participants and the research is situated in. When conducting any research, *psychologists* should assume the presence of diverse sexualities, trans and gender diverse, and/or intersex participants and use inclusive affirming practices, including appropriate terms, pronouns and other language, and appropriately sensitive measures, as well as striving for their visibility in their findings where relevant.

9.2. *Psychologists* are aware that past and some contemporary research findings in psychology and other disciplines are based on a historical heterosexist, sexist and pathologising paradigm of sexual orientation, sex, gender diversity, intersex or clinical populations unrepresentative of broader populations. All research findings benefit from queering, and there is a continued need to perform research critiquing and challenging past research findings, particularly, but not just limited to those related to sex, gender, sexualities or intersex variations (American Psychological Association, 2009). Any research without a critical lens from all possible minority perspectives can have negative implications for any person of minority.

9.3. Research involving or related to the sexual identity, interests and behaviours of children and adolescents, particularly of diverse sexualities, trans and gender diverse, and/or intersex variations, should have a diverse sex positive multifaceted lens (Harden, 2014) rather than a problematic paradigm.

9.4. When conducting research on *clients*, *psychologists* consider how the possible heterosexist biases in the psychological assessment instruments used and the researchers own perspectives and experience may shape the research questions and interpretation of their findings. When reporting the findings, *psychologists* are sensitive to the ways in which their findings may be understood by the broader (usually heteronormative) community (Ellis et al., 2020).

9.5. When conducting and reviewing research on intersex *clients*, *psychologists* recognise the contemporary move towards a patient-centred intersex health care model away from traditional biomedical interventionalist pathologizing views and approach, include standardizing indicator questions for people with congenital intersex variations, including and reporting on intersex bodied norms as opposed to endosex norms, ensuring research that claims to relate to intersex actually include intersex participants, acknowledging the long term impact of decisions made regarding medical interventions or terminations on all stakeholders, involving intersex people in the creation of success measures for treatment evaluations and using more holistic measurements (e.g. Quality of Life indicators) in examining the impact of intersex variations on individual, their parents and other stakeholders (Jones, 2018).

9.6. *Psychologists* ensure that the collection, classification and analysis of research data are disaggregated where appropriate by sexual and gender identity, intersex, intersectional identities, socio-economic status, and other social stratifiers, and ensure the data generated from research are analysed using non-heteronormative-sensitive tools and methods that also account for intersectionality issues.

9.7. *Psychologists* are aware that there may be some limits to the generalisability of research findings to diverse sexualities, trans and gender diverse, and/or intersex individuals and communities in situations where participants of research studies were predominantly heteronormative.

9.8. When trans and gender diverse and intersex *clients* are included in clinical trials, researchers consider the impact on those from vulnerable populations. However, these clients should not be automatically excluded, because many pressing health concerns involve vulnerable populations of trans and gender diverse and/or intersex clients. Rather, researchers consider how to minimise the intrusiveness of the research.

9.9. *Psychologists* understand the risk of misusing scientific or clinical 'expertise' to further disempower a vulnerable party, particularly in forensic contexts. Where some diagnostic, legal and other descriptive terms (e.g., acts of gross indecency, unnatural acts) might carry pejorative connotations in relation to *clients*, *psychologists* take care to prevent such inferences.

9.10. Prior to conducting research and disseminating information related to these *client* groups, *psychologists* engage with and actively include people with lived experiences, relevant psychologists, communities and peak bodies in the design and conduct of such research to improve the quality of their research (APA, 2009).

9.11. When publishing material about diverse sexualities, trans and gender diverse, and/or intersex variations, psychologists state the extent to which they consulted, collaborated or co-authored the publication with diverse sexualities, trans and gender diverse, and/or intersex people.

10. Summary

The *APS* recognises that people with diverse sexualities, trans and gender diverse people, and people with innate variations of sex characteristics (intersex people) exhibit variations of humanity and *these characteristics* are not indicative of psychological disturbance. *Psychologists* understand that sexual behaviour is, and can be, distinct from *clients* of *these characteristics*, relating to all people. *Psychologists* strive to provide inclusive, affirming, non-discriminatory, culturally safe, trauma-informed and competent experiences in all aspects of their *psychological services* to all *clients,* recognising that any client could potentially share any of *these characteristics*. *Competence* should include knowledge of the issues of identity, expression, stigma, discrimination, harassment, heterosexism, historical developments, relevant legal awareness, context and intersectionality at an individual and more societal and systemic level, as well as the resilience of these heterogenous client groups and the role of peers and other specialist bodies, services and communities. *Psychologists* are aware of the ethical implications of their own personal and public identity and community involvements, client issues of autonomy, conducting assessment and research, and treating *client* needs beyond their competence or practice.

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Consultations

ACON, Brave Network, Equality Australia, Intersex Human Rights Australia, Intersex Peer Support Australia, National LGBTI HealthAlliance, Queerspace, Rainbow Health Victoria, Sexual Orientation & Gender Identity Change Efforts (SOGICE) Survivors, Trans Health Australia, and the Victorian Commissioner for LGBTIQ+ Communities.

Approved by the APS Board of Directors, xxxxxx 202Y.

This Ethical guideline supersedes and combines the two previous Ethical Guidelines:

Ethical guidelines for psychological practice with lesbian, gay and bisexual clients (2010); and
Ethical guidelines on working with sex and/or gender diverse clients (2013).