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Introduction

These guidelines are aimed at applied psychologists working with mental distress, but may also be applied in associated psychological fields. Indeed, the principles they are based upon, derived as they are from both the literature and best practice agreement of experts in the field, may be applied to other disciplines, such as counselling, psychotherapy, psychiatry, medicine, nursing and social work.

For this second edition of the guidelines we have not used the term 'minority'. This is to reflect the fact that, in some instances, GSRD people may not be a numerical minority but may still have issues related to their identity or practice which benefit from assistance by a psychologist. One key area where such assistance may be of benefit is that of marginalisation due to a GSRD identity or practice. This marginalisation can cause distress leading to mental health problems[1]. Social attitudes and therapeutic approaches to GSRD have evolved over time to become mainstream and usual. However, it is important to be aware of how the history of stigmatisation and oppression may affect both clients and psychologists. It is particularly important for psychologists to attend to the specific needs of GSRD people, given evidence that psychological treatment outcomes can be poorer for GSRD people[2].

These guidelines relate to gender, sexuality and relationship diverse (GSRD) people. That is broadly people – including psychologists – who do not identify as heterosexual, monogamous or cisgender (a cisgender person is a person who is content to remain the gender they were assigned at birth). This includes lesbian, gay, bisexual and transgender (LGBT) people. However, it also includes people who: identify as asexual (do not or rarely experience sexual attraction); engage in BDSM (bondage and discipline, dominance and submission, and sadomasochism); are agender (have no gender); have a non-binary gender (have a gender other than male or female); are pansexual (have attraction irrespective of gender); and many other groups. The guidelines do not, however, relate to anything non-consensual. The identities and practices considered here are not in themselves pathological, and are part of human diversity[3].

Many of the principles and guidelines discussed below apply equally well to heterosexual, monogamous and cisgender people, as well as people with forms of diversity other than sexuality, gender or relationships. Consequently, the guidelines can be read with that wider applicability in mind. Similarly, while examples may cite specific instances, or recommendations may be focused towards specific groups within the broader term GSRD, most of the principles and guidelines will apply to all GSRD people. Further, people have multiple intersecting identities, some of which are more common than others. A person may be cisgender and a lesbian, for example, and these guidelines apply in such instances.

While these guidelines naturally focus on therapeutic work, GSRD people often have remarkable resilience and strength, and live fulfilling, happy lives just as heterosexual, cisgender and monogamous people do. There should be a focus on wellbeing, as well as on any pertinent difficulties rather than an assumption of deficit[4].

1. Psychology and gender, sexuality, and relationship diversity (GSRD)

A. PSYCHOLOGISTS MUST RESPECT THAT PEOPLE FROM DIVERSE GROUPS HAVE THE SAME RIGHTS AND RESPONSIBILITIES AS THE REST OF THE POPULATION

A fundamental principle is that people from diverse groups have the same rights and responsibilities as those people who are not in those groups, including the right to have individual needs and capacities respected. This means that, for example, a gay psychologist may choose to be out about their identity, in just the same way a heterosexual psychologist may. Similarly, a trans client can expect to be referred to by the correct gender pronouns irrespective of their gender assigned at birth.

B. PSYCHOLOGISTS ARE ENCOURAGED TO SUPPORT THE SELF-DETERMINATION OF THEIR CLIENTS IN THE DEVELOPMENT OF THEIR IDENTITIES, PRACTICES AND RELATIONSHIPS

Psychologists should be mindful that GSRD identities and practices are fully valid and should support people towards optimum wellbeing. Any exploration of a client's identity or practice should be on the understanding that GSRD identities and practices are absolutely as legitimate an outcome as any other (see section 1d). As a part of this, psychologists should be mindful to use the client's preferred terminology (see section 3c).

C. GENDER, SEXUALITY OR RELATIONSHIP DIVERSITY ARE NOT INDICATIVE OF A MENTAL DISORDER

Same-sex or gender attraction is a normal part of human sexuality[1]. Diverse consensual relationships and diverse gender identities are a normal part of human diversity, and are not included as mental disorders within the latest edition of the World Health Organization's *International Classification of Diseases*. For clarity, diverse sexualities, consensual relationships and gender identities are not psychopathological, and psychologists should challenge those who are unaware of this.

It has been consistently found that stigmatising, stressful experiences for GSRD individuals can lead to increased risk of emotional problems, suicide attempts and substance abuse[5]. This should not be treated as de facto evidence that GSRD is psychopathological, as it is the marginalisation and repression which causes the difficulties, rather than the identities and practices themselves. Psychologists must therefore encourage wider acceptance of diversity, and challenge any assertions of GSRD being pathological, in order to mitigate this.

D. PSYCHOLOGISTS MUST NOT ENGAGE IN 'REPARATIVE' OR 'CONVERSION' 'THERAPIES'

Attempting to change or suppress a client's gender, sexuality or relationship as the goal of treatment is unethical when that attempt is made on the basis of a negative attribution, by psychologist, client, or others, towards GSRD. The BPS endorses the *Memorandum of Understanding Against Conversion Therapy* (Version 2)[6].

As part of the therapeutic endeavour, a person may wish to explore their gender and/or sexual identity or relationships, express distress at the thought that they may have a GSRD identity or practice, or wish to mitigate distress which has arisen as a result of having previously been subject to conversion or reparative 'therapies'. Psychologists must work ethically and within their competence. This will involve considering how the identities or practices may be integrated into the client's current or desired life, and any gains or losses which may be associated with the various options considered[7], but must always consider GSRD identities and practices to be absolutely as valid and legitimate an outcome as any other identity or practice.

E. PSYCHOLOGISTS REQUIRED TO MAKE FORMAL ASSESSMENTS SHOULD DEFAULT TO RESPECT FOR A GSRD CLIENT'S IDENTITY OR PRACTICE

Some applied psychologists have additional training make formal assessments that impact upon a client's life. This includes but is not limited to:

- mental capacity assessments;
- neuropsychological assessments;
- forensic risk assessments;
- assessments made as part of a role as an approved clinician or responsible clinician;
- assessments for cross-sex hormones and gender-related surgeries;
- expert witness assessments;
- child custody assessments.

Applied psychologists undertaking these assessments will naturally have to take due account of the clinical circumstances involved in their assessment and resulting practice or recommendations. However the basic principle should be one of respect for the GSRD client's identity or practice. Robust clinical reasoning should be presented on those occasions when an identity or practice is not supported. In these instances consideration should be given as to how any GSRD identity or practice could be expeditiously supported in the future.

GSRD identities and practices, just as heterosexuality, cisgender and monogamy, should not be considered to be pathological (although in extremely rare instances, behaviours and feelings may be evidence of a mental health condition or acquired brain injury for example). These identities and practices should therefore usually be accommodated and facilitated. The discomfort of others is insufficient reason not to accommodate or facilitate an identity or practice – just as one would accommodate and facilitate a person from a non-white background irrespective of racist discomfort.

2. The Socio-political context and attitudes towards gender, sexuality, and relationship diversity

A. PSYCHOLOGISTS ARE ENCOURAGED TO RECOGNISE THAT ATTITUDES TOWARDS GENDER, SEXUALITY AND RELATIONSHIP DIVERSITY ARE LOCATED IN A CHANGING SOCIO-POLITICAL CONTEXT, AND TO REFLECT ON THEIR OWN UNDERSTANDING OF THESE CONCEPTS

Social attitudes and therapeutic approaches to GSRD have evolved over time to become mainstream and usual. However, it is important to be aware of how the history of stigmatisation and oppression may affect both clients and psychologists. Indeed, the global political situation includes regions where GSRD identities and practices are not supported or are severely punished, and so may negatively affect both clients and psychologists.

Therefore, some individuals may internalise societal negative attitudes such that they experience loathing and shame of their own gender, sexuality, and/or relationship identities or practices. Psychologists are also encouraged to recognise how their own attitudes, assumptions and knowledge may impact upon assessment and treatment.

B. PSYCHOLOGISTS SHOULD REFLECT ON THE LIMITS TO THEIR PRACTICE WHEN WORKING WITH GENDER, SEXUALITY AND RELATIONSHIP DIVERSITY, AND CONSIDER APPROPRIATE REFERRAL AND TRAINING WHEN APPROPRIATE

People have a wide diversity of genders, sexualities and relationships. This is something that psychologists should acknowledge and support. Sometimes this requires psychologists to work with people who are very different from themselves, and on occasion those differences may be difficult for psychologists to understand. It is the psychologist's responsibility to learn about these forms of diversity, so that they can become more comfortable, familiar and effective in their work. In most cases, the psychologist's usual practice will apply for all forms of diversity.

However, if psychologists are struggling to act positively or within their skill set, they should refer people to other more appropriate practitioners or services, rather than simply discharging them. Where this occurs, the psychologist should seek further supervision and/or CPD (see 7 below).

Psychological practice should be evidence-based and include established best practice. Where this conflicts with personal opinion this can be acknowledged and explored in supervision, but must not affect practice.

C. PSYCHOLOGISTS SHOULD STRIVE TO UNDERSTAND THE WAYS IN WHICH SOCIAL STIGMATISATION (E.G. PREJUDICE, DISCRIMINATION, AND VIOLENCE) POSE RISKS TO GENDER, SEXUALITY AND RELATIONSHIP DIVERSE CLIENTS

Psychologists should integrate an affirmative stance to their models of practice when working with GSRD clients. Central to this is the recognition that diversity in gender, sexuality and relationships is simply a natural part of human variation[8]. Psychologists should

have an understanding of the adverse effects of social stigmatisation on clients' identities and the distress caused to individuals who are seen as different. Assessments, formulations and interventions should acknowledge this explicitly. Modalities which do not accept GSRD identities and practices as being entirely as valid and legitimate as other identities and practices must not be used.

D. PSYCHOLOGISTS ARE ENCOURAGED TO CONSIDER ENGAGEMENT WITH THE WIDER SOCIAL AND POLITICAL CONTEXT REGARDING GENDER, SEXUALITY, AND RELATIONSHIP DIVERSITY IN ORDER TO REDUCE SOCIAL STIGMA

Psychologists may consider working on an institutional level, such as by informing policy, supporting community groups, and in social action. Psychologists can be proactive in effecting change, which will ultimately lead to improvement of quality of life and wellbeing. Psychologists should be aware of GSRD associations within their workplace, locally, and nationally as they may be a valuable source of information and/or support.

3. Gender, sexuality and relationship diverse identities and practices

A. PSYCHOLOGISTS SHOULD BE KNOWLEDGEABLE OF THE DIVERSITY OF GENDER, SEXUALITY AND RELATIONSHIP IDENTITIES AND PRACTICES

There are many sources of information on GSRD and psychologists should strive to be aware of those beyond academic or medical literature (see recommended reading below). This includes engagements with community literatures and work. Psychologists are advised to provide the space, for clients who wish to, to explore possible identities and practices rather than assuming any particular outcome.

Psychologists should be aware that some sexual identities and practices do not refer to the gender that people are attracted to – for example asexuality, celibacy and BDSM – and that people may adopt more than one identity or practice.

Psychologists should be aware of the diversity of gender identities – including both binary and non-binary genders – and not assume medical interventions will necessarily be involved, or that a person will have any specific sexuality.

B. PSYCHOLOGISTS GENERAL PRACTICE SHOULD USE LANGUAGE WHICH IS INCLUSIVE OF DIVERSITY

Psychologists should ensure that their language and practice does not inadvertently exclude GSRD people as they may not be aware that the people they are engaging with are GSRD. For example, the word *partner* is preferred to *husband* or *wife* if the nature of the relationship to a single person is unknown, or *partner or partners* if it is not known if the person is monogamous. Similarly, care should be taken that forms, signs, questionnaires, waiting room literature, etc., reflect diversity.

C. PSYCHOLOGISTS ARE ENCOURAGED TO USE THE PREFERRED LANGUAGE OF GENDER, SEXUALITY AND RELATIONSHIP DIVERSE PEOPLE

Clients may use many different terms to refer to their identities and practices and psychologists are advised to use those that are used by clients themselves or to ask which terms are preferred.

Some people do not use GSRD or LGBTQ (lesbian, gay, bisexual, transgender and queer) labels, but may be comfortable with, for example, MSM (men who have sex with men), WSW (women who have sex with women), culturally specific terms, or reclaimed terms like dyke or slut. A client's preferred name and pronoun should be used in person and, in almost all cases, in documentation. These may be gendered (*he* or *she*) or if the client prefers, gender-neutral (*they*, or the client's preferred gender neutral term). Similarly, psychologists should use the client's preferred term for their relationship and understand how they define it.

4. Families and friends

A. PSYCHOLOGISTS ARE ENCOURAGED TO UNDERSTAND THE VARIETY OF FORMS OF RELATIONSHIPS AND FAMILIES OF GENDER, SEXUALITY, AND RELATIONSHIP DIVERSE PEOPLE

Psychologists should consider the many viable forms of relationships, including monogamous relationships and non-monogamous relationships, which may both be sexual or non-sexual. Psychologists should be aware that GSRD people may refer to their networks of friends, partners and/or ex-partners as family or kin as well as, or instead of, their family of origin.

Some forms of family relationship are not currently legally recognised – for example, polyamorous relationships – and so psychologists should strive to facilitate ad hoc arrangements as necessary – for example, by amending family visiting rules – rather than relying on legal recognition of relationships only.

Psychologists should take care not to erroneously assume that the only family unit which may appropriately raise children is a heterosexual, cisgender, monogamous marriage or relationship as there are many ways of successfully having and raising children[9,10]. Psychologists should adopt an approach which is attuned to, and respectful of, GSRD, and should be aware of their own internalised assumptions which may be based on heterosexual, cisgender and monogamous models of parenting[11].

Psychologists should facilitate people's reproductive and family options when it coincides with job roles, and be careful not to use the extra barriers faced by some GSRD people as a reason not to do so. Indeed, psychologists may wish to consider young GSRD people's reproductive options particularly (see 6b below). Psychologists should be aware that children with GSRD parents do as well emotionally, socially and educationally as their peers[12].

B. PSYCHOLOGISTS SHOULD BE AWARE OF THE POTENTIAL ISSUES FACING GENDER, SEXUALITY, AND RELATIONSHIP DIVERSE CLIENTS IN THEIR RELATIONSHIPS AND FAMILIES.

While many relationship issues will naturally be the same for all people, there are some issues which are specific to GSRD people. For example, issues can sometimes be hidden such as for a same-sex couple if there is an assumption that power imbalances and violence only occur in different-sex couples, where a trans client feels unable to complain in any way about a partner who has been accepting of their transition, where one member of a couple has a change in sexual identity or goes through a gender transition, or where there is a disparity – for example, where only one partner is asexual, non-monogamous or practices BDSM. Psychologists should be careful to enquire sensitively and appropriately in order to identify any unique issues[8].

5. Diversity and intersectionality

A. PSYCHOLOGISTS SHOULD BE MINDFUL OF THE INTERSECTIONS BETWEEN GENDER, SEXUALITY AND DIVERSE RELATIONSHIPS WITH OTHER FORMS OF DIVERSITY

GSRD people may be adversely affected by the additive or interactive negative effects of having other marginalised or minority status(es). Some ethnic, cultural and religious communities may not be accepting of an individual's gender, sexual or relationship diversity. Further, some mainstream GSRD spaces may not always be welcoming to people with intersections of marginalisation either, which often leads to alienation. Such marginalising positions have the potential to stigmatise, eroticise or shun GSRD individuals[13]. Similarly, the socio-economic status of individuals may limit access to GSRD spaces and services and psychologists should strive to ensure equal access for GSRD people with intersections of marginalisation.

B. PSYCHOLOGISTS SHOULD RECOGNISE AND ADDRESS THE PARTICULAR ISSUES EXPERIENCED BY GENDER, SEXUALITY AND RELATIONSHIP DIVERSE CLIENTS WITH PHYSICAL AND/OR MENTAL HEALTH CONDITIONS, NEURODIVERSITY, AND (DIS)ABILITIES

GSRD people with mental or physical health conditions, learning disabilities or neurodiversity may experience multiple forms of oppression and may not have their identities or practices recognised by virtue of those conditions. Psychologists should facilitate clients in the expression of their identity or practice.

Psychologists are encouraged to be aware of the sensitivities inherent in discussing mental or physical health conditions with people from GSRD communities. For example, Lesbian, trans and bisexual women's health tend to be marginalised, and conventionally gendered body parts and differing body morphologies of transgender people will need sensitive discussion[14]. These health concerns and associated problems of access to non-prejudicial, affirmative healthcare may prove to be particularly stressful to GSRD individuals.

Due to previous experiences of discrimination, or anticipated discrimination, GSRD people may feel uncomfortable about accessing services. This may be exacerbated if a person experiences marginalisation from intersecting identities. Indeed, access to services may be impeded and psychologists should ensure that their services are open and welcoming to all GSRD people. Psychologists may also need to facilitate, and in some cases advocate for, access to appropriate healthcare services.

6. Lifespan development

A. PSYCHOLOGISTS SHOULD RECOGNISE THE DIVERSITY OF DEVELOPMENTAL PATHWAYS FOR GENDER, SEXUALITY AND RELATIONSHIP DIVERSE PEOPLE ACROSS THE LIFESPAN

Psychologists should be mindful that there are many different developmental pathways for GSRD people. Some young people feel 'different' from an early age; however, others may have been brought up in situations which are accepting of diversity, and so not feel 'different'. It is important neither to assume difficulties, nor a lack of them.

Young people may not be able or wish to label their sexuality, gender or relationship form, and some people may not explore the possibility of same-sex attraction, non-monogamous relationships or a change of gender until later in life. While labels are useful, psychologists should not assume they are the same as identity or practice. Indeed, some people live with two identities, one of which is public and the other private.

For some, identity formation may create a phase of consideration with possible isolation and distress followed by exploration to the point of integration and acceptance with healthy functioning and life satisfaction. Psychologists should bear in mind that it can sometimes be useful for those without healthy functioning to explore previous experiences of isolation and distress which may have had lasting effects on how a person is able to express themselves[15].

B. PSYCHOLOGISTS SHOULD RECOGNISE THE NEEDS AND ISSUES OF GSRD YOUNG PEOPLE, AND THEIR PARTICULAR VULNERABILITIES AND RISKS

Psychologists should be careful not to assume that bisexuality, non-binary genders or other forms of sexuality, gender or relationships are 'just a phase' as, for many, they are a stable and lasting identity. The unconsidered position of seeing heterosexuality, cisgender and monogamy as being innate and GSRD as being a *possible* deviation should be avoided, as it is incorrect. All sexualities, genders and relationship forms, including heterosexuality, cisgender and monogamy are possibilities. Psychologists should be aware that some people may prefer to avoid identity labels entirely and/or see their sexuality or gender as fluid, or on a continuum.

Many people need to come out about their GSRD identity or practice; however, for others it is simply a part of life with no special discussions needed. Psychologists may need to assist any coming out process with others in the person's life who are not accepting, or who do not understand.

Despite positive trends, some GSRD youth continue to fear and experience rejection, intolerance and even abuse when coming out. This can have a lasting impact on their mental health and wellbeing, leaving GSRD youth vulnerable to depression, deliberate self-harm, suicide, substance misuse, homelessness, dropping out of school, and failing to reach their potential. Psychologists should therefore consider whether to initiate cross-disciplinary work to support the GSRD young person.

Psychologists who use diagnoses, especially those which suggest a lifelong pattern of behaviour, should be aware of these potential vulnerabilities as the issues which 'fit' the diagnosis may disappear when the underlying issues associated with being in a group which is subject to prejudice and stigmatisation have been addressed.

Psychologists working with GSRD youth should be aware that reproductive options and considerations may be more complex

than with their heterosexual or cisgender peers. Assistive reproductive options may be needed and should be discussed openly and frankly, perhaps especially in the case of trans youth who are seeking treatments which will remove reproductive options at an age below that which people commonly consider becoming a parent[17].

C. PSYCHOLOGISTS SHOULD RECOGNISE AND ADDRESS THE NEEDS AND ISSUES OF GSRD PEOPLE OF WORKING AGE

Psychologists should be aware that for many GSRD people, coming out is a process that will be repeated many times throughout their adult life, and some people may never feel able to be open about their identity or practice. For some people this can be a source of additional stress at times of transition (e.g. starting a new job) which can have an impact on their mental health. Despite positive advancements for many GSRD individuals living in the Britain, GSRD adults experience disproportionate levels of discrimination in the workplace. This may be in the form of direct abuse or indirect discrimination; for example, barriers to recruitment or promotion[18]. Additionally, a proportion of GSRD individuals do not feel able to be open about their GSRD identities at work. Psychologists should be aware of the potential opportunities and challenges associated with being open about one's GSRD identities at work and should support clients in navigating this in the workplace.

D. PSYCHOLOGISTS ARE ENCOURAGED TO RECOGNISE THE DIFFERENT LIFE EXPERIENCES OF OLDER PEOPLE IN RELATION TO THEIR GSRD IDENTITY OR PRACTICE

Psychologists should consider the impact of ageing and being an older adult on individuals' experiences. As with all clients, psychologists should take into account the societal contexts which the older adult client has experienced – particularly at the time of key identity formation in childhood, adolescence and early adulthood[19]. For example, many current older adults were young people at a time when sexual acts between men were illegal and attractions to the people of the same sex were considered an illness. Some may have sought 'aversion' or 'conversion' 'therapy', or had it imposed upon them against their will. As a result of such experiences, older adults are more likely to have experienced internalised stigma or to have concealed their diverse gender, sexuality, or relationship experiences, in some cases for their whole life. Psychologists should endeavour to sensitively rebuild trust being very mindful of this context, and perhaps especially the role mental health professionals such as psychologists have played in the previous stigmatisation of the person.

Some older adults may not agree with some younger people's reclaiming of certain words such as *queer*; indeed, they can find such terms distressing if these words were associated with experienced or observed stigma or victimisation. As stated elsewhere, psychologists should use the client's preferred term wherever possible.

E. PSYCHOLOGISTS SHOULD SUPPORT OLDER GSRD PEOPLE IN THEIR IDENTITY OR PRACTICE, TAKING DUE NOTICE OF THE SAFETY OF THE CLIENT AND THE CONTEXT OF THE CLIENTS' EXPERIENCE

GSRD older adults are more likely to be single and living alone, less likely to be parents, and have less contact with biological family members. This is associated with greater anticipated need to rely on formal support services and associated anxiety about issues such as independence, mobility, finances and future care requirements. Older GSRD

adults often express profound concerns about how care home staff and other care providers will respond to their relationships or identity, and may conceal past identities or practices, including those they have been open about[20].

Psychologists should be respectful of decisions regarding disclosure, while making it clear that they have a positive attitude towards GSRD. If information regarding GSRD identities or practices is disclosed, as with all clients, psychologists should always check with the older client about sharing of such information with others – being mindful that this can have profound consequences for those relying on care staff. Psychologists should be aware that fears may be realistic – prejudice and discrimination still occur and clients may need support in coping with or addressing these situations. Psychologists should consider whether there are gaps in understanding by staff that need to be addressed and should initiate remedial measures as appropriate. They should be alert for signs of elder abuse, which is highly under-reported and should act quickly should safeguarding concerns be found.

F. PSYCHOLOGISTS SHOULD AFFIRMATIVELY SUPPORT THE PARTNERS OF OLDER GSRD PEOPLE

The needs of partners should be considered. If a partner dies or is taken into a care home where their relationship was not known or understood by others, the remaining partner is less likely to receive adequate support and may experience more complex adjustment or grieving processes[21]. After the death of a partner, there may also be additional stressors that can impact on mental health; for example, in relation to lack of partner pension support or legal challenges over wills by other family members. Psychologists should therefore use their professional status as necessary to mitigate unreasonable attitudes and practice.

7. Education, training and personal development

A. PSYCHOLOGISTS SHOULD HAVE SUFFICIENT TRAINING IN GENDER, SEXUALITY AND RELATIONSHIP DIVERSITY THAT THEY CAN WORK IN A RESPECTFUL AND INCLUSIVE MANNER

Psychologists should have sufficient training to work affirmatively and self-reflectively with GSRD clients irrespective of their main therapeutic approaches. Therapeutic approaches which do not consider GSRD practices and identities to be absolutely as valid and legitimate as any other practice or identity, or which seek to change a GSRD identity or practice, must not be used. Training courses are advised to include issues of diverse gender, sexuality and relationships throughout their regular teaching in order to avoid mere tokenistic inclusion of these issues.

Psychologists can use CPD and supervision to develop self-reflection, skills and knowledge about issues of gender, sexuality and relationships, especially if this was omitted by their pre-qualification training course. All psychologists must use CPD in this way because there are no areas of psychology where GSRD clients will not be accessing services.

It is not acceptable to expect clients to provide knowledge of GSRD through clinical contact. While clients will elaborate individual meanings for them personally, general understanding must be obtained outside of the clinical encounter.

B. PSYCHOLOGISTS SHOULD REFLECT ON THEIR OWN GENDER, SEXUALITY AND RELATIONSHIPS

The *BPS Practice Guidelines* expect psychologists to engage in reflective practice and make sure that reflection is part of their clinical practice as well as their planning for continuing professional development[22]. This may be especially useful for those psychologists whose identities and practices are not commonly questioned, such as those who are cisgender, heterosexual and/or monogamous.

Psychologists will inevitably not be completely bias-free, nor should they be expected to be aware of every issue relating to sexuality, gender and relationships. However, with self-reflection on their own sexuality, gender and relationships, as well as the limits of their knowledge, psychologists should be able to identify their limits of competence and how to respond accordingly.

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