EXHIBIT 1

Guidelines for Psychological Practice with Sexual Minority Persons

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Guidelines for Psychological Practice with Sexual Minority Persons

Introduction

Sexual minority persons are a diverse population inclusive of lesbian, gay, bi+ (e.g., bisexual, pansexual, queer, fluid), and asexual sexual orientations[1]. The *Guidelines for Psychological Practice with Sexual Minority Persons* provide psychologists with: (1) a frame of reference for affirmative psychological practice (e.g., intervention, testing, assessment, diagnosis, education, research, etc.) with sexual minority clients across the lifespan, and (2) knowledge and referenced scholarship in the areas of affirmative intervention, assessment, identity, relationships, diversity, education, training, advocacy, and research. These guidelines also recognize that some sexual minority persons possess diverse gender identities and expressions (e.g., transgender, gender nonbinary or gender fluid).

These practice guidelines are a third iteration, built upon the *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (American Psychological Association's [APA] Division 44/Committee on Sexual Orientation and Gender Diversity Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients, 2000) and the revised *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (APA's Division 44/Committee on Lesbian, Gay, Bisexual, and Transgender Concerns Guidelines Revision Task Force, 2012). These practice guidelines were created by the process outlined by the *Criteria for Practice Guideline Development and Evaluation* (APA, 2002), and consistent with the APA's (2017) *Ethical Principles of Psychologists and Code of Conduct* (including 2010 and 2016 amendments).

[1] A component of identity that includes a person's sexual and emotional attraction to another person, along with behavior and social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others (APA, 2015a).

Need

The *Guidelines for Psychological Practice with Sexual Minority Persons* assist psychologists in their work with sexual minority persons. A contemporary revision of the guidelines is warranted at this time given the notable advances in psychological science and affirmative psychological practice (see Appendix A) with sexual minority persons. In the years since the revised version of the *Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients (2012)* was released, there has been significant growth in rigorous psychological research published on sexual minority persons, as well as important legal and policy changes in the United States and elsewhere. Longstanding, important topics have evolved, and scholars have expanded into new areas of relevance for psychologists working with sexual minority persons. Previous guidelines on psychological practice with lesbian, gay, and bisexual clients have been used nationally and internationally in practice, training, and to inform public policy. APA's Office on Sexual Orientation and Gender Diversity have translated previous versions of guidelines into Arabic, Chinese, Czech, Hungarian, and Spanish, which reflects the global relevance and importance of these guidelines to international communities.

Task Force Process and Language

The revisions task force was formed in October 2018 and concluded its work on these guidelines on August 31, 2020. The task force met during that period (both in-person and virtually), and task force members met exclusively using virtual conferencing software during the COVID-19 global pandemic of 2020. Task force members agreed that scholarship and scientific research produced over the past ten years were to be prioritized to inform these practice guidelines. Sources included meta-analyses and systematic reviews; quantitative, qualitative, and mixed- methods studies published in peer-refereed journals; and select books and book chapters.

Task force members intentionally highlighted available scholarship from scholars of color, as well as sexual and gender minority scholars. Reviewers with scientific and clinical expertise on sexual minority populations were solicited to provide feedback on these guidelines throughout the writing and revision process.

Task force members had multiple conversations about language. Task force members were cognizant that terminology related to sexual minority populations have changed over time and across ecological contexts, and will continue to evolve beyond the publication of these guidelines. Terminology used in these guidelines is consistent with current trends in science, scholarship, and psychological practice. For instance, task force members decided to use the term *sexual minority* rather than lesbian, gay, and bisexual. We believe the term *sexual minority* is consistent with the sexual minority stress theory (Meyer, 1995, 2003) scaffolding these guidelines (see below for further discussion on these conceptual foundations). The task force recognizes, however, that sexual minority is a term that some find problematic, as it can homogenize a widely diverse group of people and center individual experiences against the dominant hegemony of heterosexuality. Psychologists understand that, although some clients may use this terminology, others may refer to sexual orientations that are not mentioned in these guidelines. In some instances, clients may not wish to use any existing term or label. Psychologists do not force terms or labels on any client, and educate themselves on evolving linguistic trends (APA, 2017b).

Conceptual Foundations

The current practice guidelines are conceptually rooted in the theoretical frameworks of sexual minority stress theory (Meyer, 1995, 2003, 2015), intersectionality (Crenshaw, 1989), and principles of affirmative psychology (see Moradi & Budge, 2018 for review). According to the sexual minority stress model, sexual minority persons experience both general stressors and unique stressors as a result of encountering societal and interpersonal prejudice and stigma (Meyer, 2003); in turn, these stressors can lead to poor health and identity-based disparities (Meyer, 2003, 2015). Sexual minority persons encounter stress along a continuum of *distal* minority stressors and *proximal* minority stressors throughout their lifespan. Distal minority stressors, which are experiential encounters distant of a sexual minority person, include interpersonal discrimination, victimization, hate crimes, microaggressions, and other daily hassles (Meyer, 2003). Proximal minority stressors, stressors that are internalized via cognitive and affectual processes of a sexual minority person, include internalized heterosexism, internalized binegativity, anticipation of stress and stigma (including resulting anxiety and worry), and identity concealment (Meyer, 2015).

Minority stressors occur across the lifespan, and intersect with other forms of internalized and enacted stigma (i.e., racism, sexism, classism, discrimination, objectification, ableism, ageism; English et al., 2018; Hatzenbuehler, 2009; Velez et al., 2017). Minority stressors also are associated with numerous psychological and physical health risks, and occur across a variety of environmental contexts (e.g., school, home, work, and community). Adaptive coping strategies and mechanisms, social supports, and resilience buffer against the effects of sexual minority stress, helping to reduce, or prevent poor health outcomes (Kwon, 2013; Meyer, 2015).

Although sexual minority persons experience oppression from heterosexism, the task force acknowledges the impact of additional systems of oppression that influence the lives of

many sexual minority persons (e.g., institutional racism, systemic sexism, colonialism). Since social identities are not mutually exclusive, people embody multiple positions of oppression and privilege, whereby "stress produces vulnerabilities that are differentially distributed across multiple axes of difference" (Riggs & Treharne, 2017, p. 603). Thus, these practice guidelines utilize the framework of intersectionality, a term originally coined by Kimberle Crenshaw (1989) to describe the discrimination experienced by Black women that is rooted in both racism and sexism. Although Crenshaw did not specifically focus on sexual minority persons in her analyses, sexual minority women of color who preceded her laid important groundwork that has influenced current understandings of intersectionality (Combahee River Collective, 1977; Moraga & Anzaldúa, 1981). For example, the Comabahee River Collective Statement (1977) posited, "The most general statement of our politics at the present time would be that we are actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking" (p. 1). Thus, intersectionality recognizes that individual and collective experiences are shaped by multiple interlocking systems of oppression including, but not limited to, racism, sexism, heterosexism, and classism (Crenshaw, 1989; Moradi & Grzanka, 2017; Nash, 2019; Rosenthal, 2016).

Social categories (e.g., race, gender, sexual identity, age, disability status, religion and spirituality, social class) are multiple, interdependent and mutually constitutive (Bowleg, 2013; Collins 1991). As such, sexual minority persons experience various privileges and oppressions based on how their other social identities are valued or denigrated by society. Much of the psychological research on sexual minority persons reflects the experiences of those with more privilege, whereas those who experience multiple forms of oppression are often overlooked.

These guidelines consider sexual minority status, as well as other social identities that sexual minority persons embody. We further recommend that psychologists utilize other APA guidelines that address working with diverse populations such as the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017b) and *Race and Ethnicity Guidelines in Psychology: Promoting Responsiveness and Equity* (APA, 2019b).

These revised guidelines are further rooted in scholarship encouraging psychologists to affirm sexual minority persons in the practice of psychology. Affirmative principles and practices include, but are not limited to: approaching and including sexual minority identities as a normal component of human sexuality; not pathologizing behavior and affection expressed between sexual minority persons; acquiring and utilizing accurate knowledge of sexual minority persons to effectively practice psychology; addressing and counteracting anti-sexual minority attitudes, stigma, and sexual minority stress; and providing encouragement, support, and promoting resilience and pride (Moradi & Budge, 2018; Pachankis, 2018; Pepping et al., 2018). Consistent with affirmative practices, psychologists also engage in critical self-reflection as a means of increasing their awareness of any implicit and explicit attitudes, beliefs, values, and assumptions they may have when engaged in psychological practice with culturally diverse individuals (APA, 2015a, 2017b, 2019b). Similarly, psychologists are encouraged to engage in critical self-reflective practices when working with sexual minority persons. Psychologists should reflect on their various social positions, examine how their identities are embedded within various systems of privilege and oppression, and critique and modify how these various stances impact their work with sexual minority persons.

Purpose, Scope, and Organization

Sexual minority identities exist and persist throughout the lifespan. In the 2015 U.S. Youth Risk Behavior Surveillance study, authors estimated that there are approximately 1.29 million youth (under the age of 18) who identify as a sexual minority (Zaza et al., 2016). The Williams Institute (2019) estimated that there are approximately 10.34 million adults (18 years of age and older) living in the United States who identify as a sexual minority, with approximately 42% of them also identifying as people of color. Using a representative sample of sexual minority adults living in the United States, Rothblum et al. (2019) estimated that 1.66% of respondents identified as asexual. Asexual persons are underrepresented in the psychological literature and more research is needed to provide them with appropriate psychological services. Further, it has been estimated that there are over 2.4 million sexual minority older adults over age 50 in the United States, with the expectation that this number will double to over 5 million by the year 2030 (Fredriksen-Goldsen et al., 2014).

The present document provides guidelines that enhance psychological practice with sexual minority persons. These guidelines provide general recommendations for psychologists and psychologists-in-training who seek to increase their awareness, knowledge, and skills in psychological practice with sexual minority persons. The beneficiaries of these guidelines are all consumers of psychological practice including clients, students, supervisees, research participants, consultees, and other health and mental health professionals. Although the guidelines and supporting scholarship place substantial emphasis on counseling and psychotherapy practice, they are applicable to psychologists across areas of practice (e.g., individual, couples and family work, group work, psychoeducational programming, consultation, testing and assessment, diagnosis, prevention, clinical supervision, teaching, career counseling, and observational and intervention research), across multiple related helping professions (e.g.,

nursing, social work, counseling, psychiatry), and across settings (e.g., university counseling centers, hospitals, clinics, veterans hospitals, medical centers, rehabilitation facilities, schools, military, community mental health facilities, corrections settings, and private practice). Rather than offering a comprehensive review of content relevant to all areas of practice, this document provides examples of empirical and conceptual literature that support the need for practice guidelines with sexual minority persons. We encourage institutions, agencies, departments, and individuals to discuss ways in which these guidelines may be applied to their own settings and relevant activities.

Professional practice guidelines are statements that suggest specific professional behaviors, endeavors, or conduct for psychologists (APA, 2015b). Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are aspirational in intent, and they are intended to facilitate the continued systematic development of the profession to help assure a high level of professional practice by psychologists (APA, 2015b). Guidelines may be superseded by federal or state laws, and APA (2015b) distinguishes between clinical practice guidelines and professional practice guidelines, noting that the former provides specific recommendations about clinical interventions whereas the latter are "designed to guide psychologists in practice with regards to particular roles, populations, or settings and provide them with the current scholarly literature … representing [and] reflect consensus within the field" (p. 823). Additionally, as noted by APA (2015b), guidelines "may not be applicable to every professional and clinical situation" (p. 824). Thus, these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists. Consistent with the recommendations and procedures outlined by APA (2015b), these guidelines will need to be periodically reviewed and

updated every 10 years, from the year of acceptance by the APA Council of Representatives. Updating these practice guidelines will account for advances in research and changes in practice, as well as changes in contemporary social forces and contexts that influence the professional practice of psychology. Hence, readers are advised to check the status of these guidelines to ensure that they are still in effect and have not been superseded by subsequent revisions.

This document contains 16 guidelines for psychological practice with sexual minority persons and groups, along with appendices defining key terms and providing additional resources to psychologists. Each practice guideline includes a *Rationale* section, which reviews relevant scholarship supporting the need for the guideline, and an *Application* section, which describes how the particular guideline may be applied in psychological practice. These practice guidelines are organized into five topical sections: (a) foundational knowledge and awareness; (b) impact of stigma, discrimination, and sexual minority stress; (c) relationships and family; (d) education and vocational issues; and (e) professional education, training, and research.

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Guidelines for Psychological Practice with Sexual Minority Persons

Foundational Knowledge and Awareness

- **Guideline 1.** Psychologists understand that people have diverse sexual orientations that intersect with other identities and contexts.
- **Guideline 2.** Psychologists distinguish issues of sexual orientation from those of gender identity and expression when working with sexual minority persons.
- **Guideline 3.** Psychologists strive to affirm bi+ identities and examine their monosexist biases.
- **Guideline 4.** Psychologists understand that sexual minority orientations are not mental illnesses, and that efforts to change sexual orientations cause harm.

Impact of Stigma, Discrimination, and Sexual Minority Stress

- **Guideline 5.** Psychologists recognize the influence of institutional discrimination that exists for sexual minority persons, and the need to promote social change.
- **Guideline 6.** Psychologists understand the influence that distal minority stressors have on sexual minority persons, and the need to promote social change.
- **Guideline 7.** Psychologists recognize the influence that proximal minority stressors have on the mental, physical, and psychosocial health of sexual minority persons.
- **Guideline 8.** Psychologists recognize the positive aspects of being a sexual minority person, and the individual and collective ways that sexual minority persons display resilience and resistance to stigma and oppression.

Relationships and Family

- **Guideline 9.** Psychologists strive to be knowledgeable about and respect diverse relationships among sexual minority persons.

- **Guideline 10.** Psychologists recognize the importance and complexity of sexual health in the lives of sexual minority persons.
- **Guideline 11.** Psychologists strive to understand sexual minority persons' relationships with their families of origin, as well as their families of choice.
- **Guideline 12.** Psychologists strive to understand the experiences, challenges, and strengths faced by sexual minority parents and their children.

Education and Vocational Issues

- **Guideline 13.** Psychologists strive to understand the educational and school system experiences that impact sexual minority students in K-12 and college/university settings.
- **Guideline 14.** Psychologists strive to understand career development and workplace issues for sexual minority persons.

Professional Education, Training, and Research

- **Guideline 15.** Psychologists strive to educate themselves and others on psychological issues relevant to sexual minority persons, and to utilize that knowledge to improve training programs and educational systems.
- **Guideline 16.** Psychologists strive to take an affirming stance toward sexual minority persons and communities in all aspects of planning, conduct, dissemination, and application of research to reduce health disparities and promote psychological health and well-being.

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that people have diverse sexual orientations that intersect with other identities and contexts.

Rationale. Sexual minority identity labels are culturally specific, widely varying, and ever evolving. Some commonly used terms are lesbian, gay, bi+ (pronounced "bi plus"), queer and asexual, although this is not an exhaustive list. Additional within-group differences can be found. For example, within the bi+ community some may identify as bisexual, fluid, pansexual, or panromantic. There are also important differences between sexual minority groups. For instance, efforts to achieve marriage equality seem to have improved the standing of lesbians and gay men but have been criticized for underrepresenting the concerns of bi+ individuals (Marcus, 2018). The invisibility experienced by bi+ individuals, including within communities working on behalf of sexual minority persons, is called "bisexual erasure" (Yoshino, 2000).

Important cultural differences exist among sexual minority persons. For example, most research on sexual minority persons is conducted with Western samples, and our understanding of sexual orientation is skewed to a Western perspective (Nakamura & Logie, 2020). There is no universal experience shared by sexual minority persons around the globe (Patil, 2013; Puri, 2016), including when working in Western countries with sexual minority immigrants or binational couples.

Additional cultural differences influence how sexual identity is expressed and enacted (Fassinger & Arseneau, 2007). Important differences exist between racial and ethnic groups of sexual minorities (McConnell et al., 2018) and collective knowledge about the experiences of individuals who identify as sexual minority people of color is valuable. People of color who are members of sexual minority groups may experience racism in sexual minority communities as

well as heterosexism in racial and ethnic communities (Velez et al., 2017); thus, they may feel excluded from or be mistreated by multiple communities. For example, when sexual minority men utilize online dating services, many user profiles specify “No Asians” (Nakamura et al., 2013). Furthermore, sexual minority people of color may experience tension between different aspects of their identities or conflicted allegiances (Sarno et al., 2015). People of color who encounter both racial and sexual minority stressors are at increased risk of developing mental health issues, such as depression or anxiety (Sutter & Perrin, 2016).

Expressions and enactments of sexual identity may depend on other circumstances as well, such as whether sexual minority individuals are refugees or immigrants, are living in poverty or are homeless, are affiliated with a religion or not, are teenagers or older adults, have disabilities of any kind (e.g., physical, developmental, sensory, psychiatric, chronic illness), or live in rural or urban areas. For example, research has documented greater barriers to health care access and more negative interactions with healthcare providers from sexual minority persons who live in rural areas compared to those who live in urban areas (e.g., Barefoot et al., 2015; see review in Rosenkrantz et al., 2017)

Rather than considering identities as separate, it is important to consider multiple identities together (e.g., sexual orientation, gender, race and ethnicity), because all are central to mental health. Intersectionality theory provides a useful framework for this understanding (Bambara, 1970; Beale, 1969; Crenshaw, 1989). Lesbians of color have been described as “triple minorities” for over 20 years (Greene, 1996). Yet, the impact of interlocking systems of oppression may be different for different groups, such as the impact of colonialism on Indigenous, Aboriginal, and Native peoples, for whom the terms “two spirit” and bi+ may or may not overlap (Robinson, 2017). Two or more axes of oppression may combine to create

unique structural barriers (Collins & Bilge, 2016), and these inequities can vary across different contexts or eras (Moradi & Grzanka, 2017).

Gender serves as another example when applying intersectionality with sexual minority persons. Many transgender individuals living in the United States describe themselves as queer, pansexual, bisexual, gay, lesbian, or same-gender-loving (James et al., 2016). Furthermore, bi+ individuals who identify as transgender are at greater risk of poor physical health outcomes than those who identify as cisgender (Katz-Wise et al., 2017). In addition, North American bi+ people of color who identify as either female or gender diverse have reported that they never feel like they belong in any of their communities; experience "passing" as heterosexual or White as a stressor rather than an advantage; and cannot find resources relevant to their concerns (Ghabrial, 2019).

Sexual minority persons often demonstrate resilience when faced with heterosexism, racism, and sexism (Cerezo et al., 2019; Watson et al., 2018), but resilience may look different in various cultures. For instance, young Latinx gay and bisexual men demonstrated resilience in the face of family microaggressions by developing their own self-acceptance and understanding of what it means to be a Latinx gay or bisexual man, when no support for this endeavor was available in either their cultural or LGBTQ+ communities; by adapting to social settings in which they were aware of microaggressions but did not internalize or become consumed by them; and through self-advocacy (Li et al., 2017). Minority statuses can create unique opportunities for community building, consciousness raising, political resistance, and collective action that reduces symptoms of discrimination stress (DeBlaere et al., 2014). For instance, multiracial bi+ people have reported that they can develop strong connections within small

communities of similar others, that their identities make them feel strong and unique, and that they enjoy having multiple perspectives and experiences (Galupo et al., 2019).

Application. When applying intersectionality theory to sexual minority individuals, psychologists consider the influences of multiple, interlocking systems of oppressions related to race, gender, sexual orientation, disability status, socioeconomic status, age, and religion, among others. Although psychologists aspire to be inclusive of all sexual minority persons and knowledgeable about their diverse experiences and perspectives, this is a difficult, ongoing task. Nonetheless, psychologists attempt to refrain from assuming that the experiences of bi+ women are the same as those of lesbian women, for example, or that White, Western models apply to sexual minority persons living in other parts of the world. In some cases, other cultural approaches to healing may offer opportunity for symptom relief, such as Asian American sexual minorities suffering from chronic, cumulative stress who benefit from qi gong, acupuncture, and meditation (Ching et al., 2018). Culturally-specific psychotherapy approaches theorized to reduce racial minority stress (Comas-Diaz et al., 2019), along with therapeutic models that address multiple identities and minority stressors among sexual minority persons are recommended (Balsam et al., 2017; Choi & Israel, 2016; Dominguez, 2017; Ferguson, 2016).

Psychologists strive to concurrently address racism, heterosexism, sexism, ageism, ableism, and other structural oppressions. Recommendations include recognizing economic, environmental, and socio-political forces that impact the mental health of diverse sexual minority individuals who may face additional barriers; developing an interdisciplinary understanding of social determinants of health, health disparities, and epigenetics; formulating structural conceptualizations of how inequities and barriers to inclusion are produced and impact individuals and groups; imagining and implementing structural interventions to address the

impact that current financial, legislative, and cultural decisions have had on health infrastructures; and recognizing with humility the limitations of the structural competencies listed above, as economies and other national or cultural issues shift over time (Metzl & Hansen, 2014). Psychologists may find it beneficial to consult the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017b) and *Race and Ethnicity Guidelines in Psychology: Promoting Responsiveness and Equity* (APA, 2019b) for further guidance.

Psychologists consider interventions that promote resistance, recognize that people can experience both privilege and oppression simultaneously, and foster the exploration of individual experiences with oppression and privilege to inform their interventions (Moradi & Grzanka, 2017; Rosenthal, 2016). Psychologists aspire to integrate social justice into training curricula and to foster deeper understandings of privilege. Finally, identifying the groups of sexual minority people who may have been neglected within the specific settings in which psychologists work can help inform systemic interventions and advocacy efforts: for example, noting settings where lesbian and gay male clients seek services but not bi+ clients, where White sexual minority clients seek services but not sexual minority people of color, or where barriers to persons with disabilities being served are not addressed.

Guideline 2. Psychologists distinguish issues of sexual orientation from those of gender identity and expression when working with sexual minority persons.

Rationale. Sexual orientation, gender identity, and gender expression are distinct, but interrelated characteristics (APA, 2015a). *Gender identity* is defined as a person's felt, inherent sense of one's own gender (APA, 2015a). *Gender expression* refers to the external, physical

appearance of a person's gender identity (e.g., clothing, makeup, hair style), as well as behaviors that express aspects of one's gender (APA, 2015a). Gender expression may or may not be consistent with a person's gender identity; this is referred to as *gender conformity or nonconformity*, respectively. Although sexual orientation may involve attraction to various aspects of gender, an individual's gender identity and expression do not imply any specific sexual orientation. That is, sexual minority persons may be cisgender, transgender, nonbinary, or identify with other diverse genders (Chang et al., 2017). Conflating sexual orientation, gender identity, and gender expression, or to assume a person's sexual orientation based on their gender identity or expression, is a common error that psychologists aspire to refrain from making.

Sexual minority youth and adults may present with diverse styles of gender expression, which may or may not be traditionally gender-conforming. Because it continues to be highly stigmatized, gender nonconformity can result in prejudice and discrimination. Gender nonconformity has been negatively associated with well-being, regardless of one's identified sexual orientation (Gordon et al., 2017; Rieger & Savin-Williams, 2012). Research with youth indicates that gender nonconformity (regardless of sexual orientation) evokes at least as much antipathy among high school students as does a sexual minority orientation alone, and has been associated with increased risk of abuse and posttraumatic stress disorder (e.g., Horn, 2007; Roberts et al., 2012). Among adolescent and young adult men, regardless of sexual orientation, gender nonconformity has also been identified as an important risk indicator for intimate partner violence (Adhia et al., 2018). Psychologists may work with sexual minority persons who voice their concerns about how gender expression (conforming or nonconforming) is related to their sexual orientation and the perceptions of others (e.g., for safety reasons).

Transgender individuals and gender nonbinary persons may identify with any sexual orientation, and psychologists should not assume them to be a sexual minority. Likewise, some individuals, regardless of gender, may find that labels or categories are inadequate to describe their sexuality (APA, 2015a; Chang et al., 2017). Transgender and gender nonbinary sexual minority persons may be more likely to identify as bi+, pansexual, or queer (James et al., 2016; Kuper et al., 2012). In some instances, sexual orientation may become more fluid in the context of gender-affirming medical interventions, such as hormone therapy, for transgender persons (dickey et al., 2012; Galupo et al., 2014; Galupo et al., 2016; Yaish et al., 2019). A causal link has not been established between gender-affirming medical interventions and shifting sexual attractions, however, and it is unclear whether such reported changes in sexuality are related to physiological changes with gender transition, increased self-confidence and wellbeing, decreased dysphoria, or other interrelated factors (Fox Tree-McGrath et al., 2018). Sexual fluidity, of course, has been described in cisgender individuals as well (e.g., Diamond, 2008; Diamond et al., 2017).

Application. Psychologists are in a position to assist individuals of all gender identities and expressions with exploring their sexual orientations. Psychologists are encouraged to validate, normalize, and assist others in understanding the complex interactions between sexual orientation, gender identity, and gender expression keeping cultural differences in mind. Distinction between these concepts is not acknowledged universally, with some ethnocultural and Indigenous communities viewing sex, gender, sexual orientation, and gender expression as much more fluid and intertwined. Indeed, some communities push against such distinctions, viewing this particular understanding of sex/gender to arise from a White, economically-privileged context that erases Indigenous formations of identity and terminology through a long

history of colonization and oppression (Crouch & David, 2017; Rider et al., 2019). As such, this guideline may generalize most to Western conceptualizations of sex/gender.

Providing psychoeducation on the constructs of sexual orientation, gender identity, and gender expression, as well as how they overlap, can be beneficial at individual, family, and community (e.g., schools, medical systems) levels, and may be particularly useful when working with culturally diverse youth and families (APA, 2015a; Eisenberg et al., 2019; Gower et al., 2018; Singh & Burnes, 2010). Psychologists are also encouraged to be aware of the ways in which attitudes toward gender nonconformity may exacerbate stigmatization and discrimination against sexual minority individuals. Because of their roles in assessment, treatment, and prevention, psychologists are in an excellent position to help sexual minority individuals better understand and integrate the various aspects of their identities, including gender identity and expression (APA, 2015a; Chang et al., 2017).

Psychologists strive to recognize, reflect upon, and, where appropriate, challenge their own values and biases regarding sex/gender, gender identity, gender expression, and sexual orientation (APA, 2017a; Boroughs et al., 2015; Hyde et al., 2019; Riggs & Sion, 2017). Additionally, to work effectively with issues related to sexual orientation, gender identity, and gender expression, psychologists can benefit from seeking ongoing education and, as needed, supervision and peer consultation in this rapidly evolving area of the field (Boroughs et al., 2015; dickey, 2017; Pepping et al., 2018; Singh, 2016b). Psychologists who work with sexual minority persons, especially those who also identify as gender diverse, are encouraged to utilize the emerging professional literature as well as online resources (see Appendix B) to keep abreast of the changing context for this population. Because sexual orientation, gender identity, and gender expression are often conflated by professionals and by those they serve, psychologists are urged

to carefully examine resources that claim to provide affirmative services for sexual minority individuals, and to confirm which are inclusive of the needs of gender diverse individuals before providing referrals or recommendations (APA, 2015a; Coleman et al., 2012).

Guideline 3. Psychologists strive to affirm bi+ identities and to examine their monosexist biases.

Rationale. Bi+ (pronounced "bi plus") is an umbrella term used to capture multiple sexual orientations that involve having an attraction to more than one sex/gender, including but not limited to those individuals who identify as bisexual, pansexual, fluid, or queer. There are more bi+ women than lesbians, gay men, and bi+ men combined in the United States, with an increasing trend toward women identifying more often as bi+ than lesbian (Compton & Bridges, 2019), especially young Black women (Bridges & Moore, 2018). Although it has long been known that bi+ individuals are the largest sexual minority group (Copen et al., 2016; Pew Research Center, 2013), the unique needs and interests of individuals with bi+ identities have been severely underrepresented in research and advocacy efforts (Funders for LGBTQ Issues, 2019; Ross et al., 2018).

The cultural context of invisibility, hostility, and misunderstanding that impacts bi+ communities is best understood as *monosexism*. Monosexism is the institutionalized privileging of attraction to only one sex or gender, and the corresponding idea that being attracted to more than one sex or gender is impossible, problematic, or even dangerous (Craney et al., 2018). Monosexist structures support direct, indirect, and structural violence against bi+ individuals (Messinger, 2012). For example, bi+ individuals are at greater risk of workplace discrimination than lesbians and gay men (Arena & Jones, 2017) and are more often the victims of intimate partner and sexual violence (Flanders et al., 2019; Turell et al., 2018).

The social invisibility, marginalization, stigma, and negative stereotypes that are encountered by bi+ persons together are referred to as *binegativity* (Israel et al., 2019). Binegative attitudes include hostility, disgust, pressure to change, titillation, lack of acceptance, and perceiving bi+ individuals as unattractive or not dateable. In mixed-orientation relationships (i.e., when relationship partners have different sexual orientations; Vencill & Wiljamaa, 2016), binegative reactions from lesbian and gay romantic partners can be especially painful and may even contribute to the internalization of binegativity (Arriaga & Parent, 2019). Binegative stereotypes often attack sexuality, such as by suggesting that promiscuity and hypersexuality are inherently part of bi+ sexuality or that bi+ individuals are responsible for causing the spread of sexually transmitted infections like HIV. Such inaccurate ideas can be refuted (Israel et al., 2019), without stigmatizing the sexual expression or the HIV status of some bi+ individuals (Davids & Lundquist, 2017).

Little is known about how to effectively support bi+ individuals who are distressed by their encounters with binegativity or sexuality-based discrimination, yet there is an urgent need to intervene. The highest rates of suicide-related outcomes by sexual orientation group have been found among bi+ individuals, especially bi+ women (Nystedt et al., 2019; Salway et al., 2019; Taylor et al., 2019). Suicidal ideation has been partially explained by bi+ individuals perceiving themselves to be burdensome to others (Baams et al., 2015). Further, without parental support for their sexual orientations, bi+ youth are at greater risk of experiencing depression (Pollitt et al., 2017). Additional health disparities include a heightened risk of cardiovascular disease, disability, eating disorders, posttraumatic stress symptoms, and mental health concerns (Borgogna et al., 2019; Conron et al., 2011; Dworkin et al., 2018; Fredriksen-Goldsen et al., 2012; Lambe et al., 2017; Ross et al., 2018; Salim et al., 2019; Taylor et al., 2019; Watson et al.,

2016), which have been associated with a lack of bi-affirmative support, bi-invisibility, and discrimination based on sexual orientation (Rimes et al., 2019; Salway et al., 2019).

Application. Psychologists are encouraged to seek out education, training, supervision, and consultation regarding bi+ identities and concerns. Psychologists strive to validate the possibility of attraction to more than one sex or gender and attempt to refute binegative stereotypes. In addition to taking an affirmative stance, psychologists consider asking bi+ persons how they describe their relationships and identities, which aspects of being bi+ they enjoy, and what it is about being bi+ that makes them feel proud. Psychologists strive to affirm the courage it takes to transgress monosexual social norms; affirm successful navigation of other people's expectations and assumptions; affirm the benefits to exposing monosexist assumptions; and affirm self-constructions of sexual and romantic inclinations (Fassinger, 2016).

Lack of access to bi-affirmative healthcare has heightened the vulnerability of this population to health-related risks (Smalley et al., 2015); therefore, psychologists consider utilizing bi-sensitive counseling and psychotherapy approaches (Firestein, 2007), including by appreciating that bisexuality, pansexuality, and fluid sexualities are legitimate and healthy identities. Such affirmative stances can help reduce the symptoms of anxiety and depression that are associated with the internalization of binegativity (Dyar & London, 2018). Further, psychologists aspire to reduce barriers related to social invisibility, marginalization, stigma, and negative stereotypes that are encountered by bi+ youth, adults, and older adults. Psychologists strive to educate communities, families, and trainees about how to reduce bias toward and increase affirmative support for bi+ individuals.

Psychologists recognize that negative attitudes toward bi+ persons are so pervasive that they are found even among supportive family and friends as well as within sexual minority

communities. Psychologists attempt to challenge binegative stereotypes and myths as well as the sexual objectification of bi+ women (Brewster et al., 2014). Psychologists are encouraged to dismantle their own biases and to strive to refrain from further stigmatizing bi+ persons. To challenge their own biases, psychologists are encouraged to improve the accuracy of their information, including by using the data that has been provided in these guidelines and that contradict popular myths (Dyar et al., 2015; Israel & Mohr, 2004).

Effective assessment of bi+ persons should not assume pathology due to their sexual orientations. Rather, psychologists may need to gather information about exposure to bullying in school, workplace discrimination, intimate partner violence, and binegativity, which are risk factors for suicidal ideation, disordered eating, and post-traumatic stress symptoms. Psychologists assist bi+ individuals with building positive and affirming support networks, including by making referrals to bisexuality-centered organizations (Lambe et al., 2017). Psychologists help bi+ persons enhance their ability to bounce back from stressful events (Cooke & Melchert, 2019), including by helping them identify how they have previously rejected binegative messages, so they can generalize that approach to instances they find more difficult to overcome. Increased self-efficacy, hardiness, and adaptive coping methods may be more important than enhanced support networks to certain individuals, such as young Black bi+ men (Wilson et al., 2016).

Psychologists attempt to understand the reasons why bi+ persons come out less frequently than lesbians and gay men to their family, friends, and coworkers (Pew Research Center, 2013). This is especially true of bi+ men, who may strategically limit disclosures of their sexual identities to manage binegative stigma, to prevent rejection and relationship loss (Schrimshaw et al., 2018), and to minimize the potential for painful exclusion from their gay

communities (Welzer-Lang, 2008). Disclosing a bi+ identity to others increases the risk of encountering binegativity and discrimination, also called "disclosure stress," which has been linked to depression and other health concerns (Feinstein et al., 2019; Pollitt et al., 2017). Holding multiple minority identities may exacerbate the situation; for example, bi+ people of color may encounter both binegativity and racism. Therefore, urging bi+ individuals to come out may not always serve to enhance their well-being. Psychologists strive to understand that involvement with sexual minority communities, which reduces stress levels for some lesbians and gay men, may not necessarily offer the same respite to all bi+ persons (Craney et al., 2018; Watson et al., 2018). Bi+ individuals may not feel a sense of belonging in either sexual minority or heterosexual communities, which can exacerbate their psychological distress (Bostwick & Hequembourg, 2014). Psychologists strive to be sensitive to such between-group differences, especially when the needs and concerns of bi+ persons diverge from the needs and concerns of lesbians and gay men.

Psychologists are encouraged to examine their own monosexual privilege, if they are not members of the bi+ community, or to examine their internalized binegativity, if they are. Uncovering biases toward bi+ people helps psychologists avoid reinforcing binegativity (Mohr et al., 2013). Psychologists strive to dismantle their monosexual privilege through increased contact with bi+ communities (Dyar et al., 2015), continuing education specific to bi+ affirmative therapy and other bi+ community concerns, and consultation with bi+ psychologists and specialists. Psychologists aspire to educate clients about binegativity in its cultural and internalized forms; validate the stressful impact of binegative experiences; acknowledge the unique sexual minority stress and adversity faced by bi+ persons; contextualize client symptoms as related to the chronic discrimination and microaggressions inherent in a monosexist society;

offer strategies for managing contextual stigma, such as exploring the pros and cons of coming out in specific situations before deciding whether or with whom to share; and foster resistance to monosexism and self-affirmation of bi+ identities.

Psychologists seek to critique social structures that erase bi+ persons. For example, psychologists who work in school settings address the additional risks that bi+ youth face from being stigmatized by both heterosexual and other sexual minority youth (Rimes et al., 2019). Rather than overemphasizing individual solutions to systemic problems, psychologists promote reduced exposure to hostile environments, intervene to prevent anti-bisexual aggression from traumatizing bi+ persons, advocate for bi-affirming policies, and create or support public awareness campaigns. Lastly, psychologists consider bi+ populations as separate groups when conducting research, further consider the impact of multiple minority statuses (NIH, 2019), and utilize bi-sensitive research measures (Brewster & Moradi, 2010).

Guideline 4. Psychologists understand that sexual minority orientations are not mental illnesses, and that efforts to change sexual orientations cause harm.

Rationale. Sexual minority orientations are normal variations of human sexuality (APA, 2009a, APA 2009b). No scientific basis exists to support that sexual minority orientations are caused by psychopathology (Blanchard, 2018; Breedlove, 2017; LeVay, 2016; Swift-Gallant et al., 2019; Xu et al., 2020), or that a predisposition to psychopathology is intrinsic to those with diverse sexual orientations (Gonsiorek & Weinrich, 1991). Rather, any noted differences in health outcomes between sexual minority persons and their heterosexual counterparts are attributed to the effects of sexual minority stress (Feinstein, 2019; Hsieh & Ruther, 2016; Katz-

Wise et al., 2017; Mereish & Poteat, 2015; Meyer, 2003; Michaels et al., 2019; Moscardini et al., 2018; Pachankis & Branstrom, 2018; Roi et al., 2019).

Early literature classifying sexual minority orientations as mental illnesses that could be "cured" is now regarded as methodologically unsound, containing serious methodological flaws, unclear definitions of terms, inaccurate classification of participants, inappropriate comparisons of groups, discrepant and biased sampling procedures, ignorance of confounding social factors, use of questionable outcome measures, idiosyncratic definitions of sexuality, and statistical errors (APA, 2009a). For example, the author of a widely cited and now repudiated study that suggested that sexual orientation could be changed (Spitzer, 2003), later issued an apology, acknowledging that major critiques of the study were largely correct and substantiated (Becker, 2012; Drescher, 2016; Spitzer, 2012).

Despite the established notion that sexual minority orientations are normal variations of human sexuality, attempts to modify sexual minority orientations persist, and are referred to as *sexual orientation change efforts* (SOCE). Such efforts were often referred to as "reparative therapy" or "conversion therapy" (APA, 2009a; Drescher et al., 2016). However, SOCE is a more accurately descriptive term.

Research examining sexual minority persons' experiences with SOCE indicates that such practices are ineffective and cause substantial harm, in part due to reinforcing sexual minority stress and creating false hopes and treatment failures that become internalized by the consumer (APA, 2009a). Documented negative outcomes from SOCE include increased identity confusion, anxiety, anger, emotional numbness, dissociation, depression, suicidality (i.e., thoughts and attempts), intimacy avoidance, isolation, gender role conflicts, sexual dysfunction, high risk behaviors (e.g., substance use, unprotected sex), worsened family relationships, decreased sense

of self-worth, lower levels of life satisfaction, loss of faith, financial costs, and delayed resolution of identity conflicts and developmental tasks (APA, 2009a; Bradshaw et al., 2015; Dehlin et al., 2015; Fjelstrom, 2013; Haldeman, 2002; Ryan et al., 2018; Shidlo & Schroeder, 2002; Weiss et al., 2010). Sexual minority persons who have been subjected to SOCE are twice as likely to think about suicide and attempt suicide compared to sexual minority peers who did not experience SOCE (Blosnich et al., 2020). Even the existence of SOCE causes harm because it reinforces prejudice (Begelman, 1975) and prohibits the public from receiving safer and more effective methods for resolving possible distress associated with their sexual minority orientation (Beckstead & Morrow, 2004). Any reported benefits noted in the literature (e.g., finding community; Flentje et al., 2014) are not universal, and are also achieved with other safe and scientifically-based approaches that do not attempt sexual orientation change (APA, 2009a; 2009b).

It is important to distinguish that those who report success from SOCE tend to describe changes to how or whether they act on their sexual attractions, instead of changes to their sexual minority orientation (Beckstead, 2003; Beckstead & Morrow, 2004). Sexual minority clients receiving SOCE are often misled about the nature of sexual orientation, as well as the normative life experiences of sexual minority persons (Schroeder & Shidlo, 2002; Shidlo & Gonsiorek, 2017). Of additional concern, many SOCE clients, especially sexual minority youth, report not receiving adequate informed consent regarding SOCE procedures as delineated in APA's policy on *Appropriate Therapeutic Responses to Sexual Orientation* (APA, 2009a).

Given these significant ethical concerns, many major professional health associations have deemed SOCE harmful and subsequently released statements condemning the practice of SOCE including the American Psychological Association (2009a), the American Psychiatric

Association, the American Academy of Child and Adolescent Psychiatry, the American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the World Health Organization, the American School Counselor Association, the Association for Marriage and Family Therapy, the American College of Physicians, the American Counseling Association, the American Psychoanalytic Association, and the National Association of Social Workers, among others. In addition, 20 states and the District of Columbia (as of August 31, 2020) have passed legislation prohibiting the use of SOCE with minors by licensed mental health professionals (Movement Advancement Project, 2020). However, these laws do not cover religious providers. The basis is clear for concluding that SOCE constitute a mental health hazard in which psychologists should not participate.

The international context of SOCE remains particularly concerning. British colonization in the nineteenth and twentieth centuries resulted in the spread and embedment of fundamentalist Christian attitudes about sexuality. Religious institutions, often introduced through colonial rule, continue to shape the present-day social and cultural narrative about sexual minority persons in many post-colonial countries (Barrows & Chia, 2016). As such, the importation of heteronormativity and homonegativity is reclassified as Indigenous in nature (Danil, 2020). Now as a result of such colonization, in many parts of the world – including regions of Africa, the Middle East, Eastern Europe, the Caribbean, Oceania, and Asia – nonheterosexual sexual behaviors remain illegal and are punishable by death in certain places, with SOCE falsely promoted as cures (Bailey et al., 2016). British colonial legacy continues to be salient today as remaining colonial-era penal codes still criminalize sexual minority sexuality and affect attitudes toward sexuality and sexual orientation change practices across the world (Danil, 2020).

Application. Psychologists avoid attributing sexual minority orientations to arrested psychosocial development or psychopathology. Practice that is informed by inaccurate, outdated, and negating views of diverse sexual orientations and behaviors can subtly manifest as the inappropriate attribution of a client's problems to their sexual minority orientation and to themselves (Pachankis & Goldfried, 2013). Psychologists are encouraged to correct colleagues' incorrect and outdated views and provide accurate and affirming information on the normative variations of human sexuality, particularly in any teaching and supervision endeavors.

Psychologists avoid using SOCE, given the lack of scientific basis and substantial harm to many clients (APA, 2009a, 2009b). Psychologists consult with state laws given that some states have banned licensed mental health professionals from using SOCE for minors. Rather, given that psychologists are ethically bound to "strive to benefit those with whom they work and take care to do no harm" (APA, 2017a, p. 3), psychologists should become familiar with affirmative psychological practices (refer to conceptual foundations found in the beginning of this document), which is accumulating a growing evidence base (Pachankis, 2018; Pachankis & Safran, 2019). Affirmative psychological practices uphold that sexual minority and heterosexual orientations are equally valid (Morrow & Beckstead, 2004), and functions to increase resilience and coping by fostering client strengths, exploring positive options for sexual orientation diversity, and facilitating community building. Relatedly, affirmative approaches are designed to reduce the effects of sexual minority stress on sexual minority persons by being responsive to culturally relevant factors; incorporating an understanding of multiple and intersecting identities and communities; and countering subsequent social inequities.

Practicing from an affirmative stance also encourages involvement in advocacy efforts to reduce systematic and institutionalized barriers (e.g., discriminatory laws) to improve overall

physical and mental wellbeing (dickey & Singh, 2016; O'Shaughnessy & Speir, 2018). Given that SOCE are harmful for sexual minority persons across the lifespan, the following alternative, affirmative practices are recommended by the APA task force report on *Appropriate Affirmative Responses to Sexual Orientation Distress and Changes Efforts* (APA, 2009a): providing acceptance and support; conducting a comprehensive assessment of sexual minority stress and other psychosocial stressors impacting the client; building active coping skills; promoting increased social connection and support; and facilitating identity exploration and development without imposing a specific identity outcome. Additionally, the literature also supports fostering reduction of internalized stigma (O'Shaughnessy & Speir, 2018; Pachankis et al., 2015).

Psychologists are ethically obligated to avoid the misrepresentation of scientific or clinical data (e.g., the unsubstantiated claims that sexual orientation can be changed or is caused by psychosocial factors), and instead to provide accurate and affirming information about sexual orientation and SOCE to clients who are misinformed (APA, 2009a). Psychologists are encouraged to identify and address bias and internalized prejudice about sexual orientation that may have a negative influence on the client's self-perception and coping. In providing the client with accurate information about the social stressors (i.e., sexual minority stress) that lead to distress with same-sex attraction, psychologists may help neutralize the effects of stigma and inoculate the client against further harm (Pachankis et al., 2015). Some clients may present as a result of efforts to reconcile their sexual orientation with their religious beliefs. Therefore, psychologists consider familiarizing themselves with affirmative treatment plans to resolve such conflicts (e.g., APA, 2009a; Bayne, 2016; Beckstead & Israel, 2007; Bozard & Sanders, 2011; Haldeman, 2004; Kashubeck-West et al., 2017), and research that highlights reducing the effects of minority stress on sexual orientation and religious identity development (e.g., Beagan &

Hattie, 2015; Bourn et al., 2018; Brewster et al., 2016; Lassiter, 2014; Rosenkrantz et al., 2016; Walker & Longmire-Avital, 2013).

The APA Ethics Code (APA, 2017a) and APA's policy on *Appropriate Therapeutic Responses to Sexual Orientation* delineate a clear mandate for informed consent and assent for minors (APA, 2009a, 2017). Informed consent should include a discussion of the lack of empirical evidence that SOCE are effective and their potential risks to the client (APA, 2009a), and the provision of accurate and affirming information about sexual orientation. Psychologists attempt to inquire carefully about the basis for a client's distress over their sexual minority orientation. Further, psychologists consider discussing their treatment approach, theoretical basis, reasonable outcomes, and alternative treatment options with their sexual minority clients.

Impact of Stigma, Discrimination, and Sexual Minority Stress

Guideline 5. Psychologists recognize the influence of institutional discrimination that exists for sexual minority persons, and the need to promote social change.

Rationale. Institutional discrimination refers to "societal-level conditions that constrain the opportunities, resources, and well-being of socially disadvantaged groups" (Hatzenbuehler et al., 2011; p. 452). Other words used to describe this construct include structural stigma (Hatzenbuehler, 2016) and environmental microaggressions (Nadal et al., 2011; Vaccaro & Koob, 2019). Research indicates that exclusionary policies (e.g., same-sex marriage bans) have resulted in increased rates of mood disorders, alcohol use disorders and generalized anxiety disorder among sexual minority persons (Hatzenbuehler et al., 2010). Sexual minority persons who were in same-sex binational relationships in the weeks before the U.S. Supreme Court overturned the Defense of Marriage Act (DOMA), had higher levels of perceived stress

compared to normative data found in previous studies of the general population, as well as severe levels of anxiety and depressive symptoms (Nakamura & Tsong, 2019). When legal recognition was available to same-sex couples, sexual minority persons had less psychological distress and greater well-being (Riggle et al., 2010). In addition, legalization of same-sex marriage at the state level was associated with reduction in reported adolescent suicide attempts (Raifman et al., 2017).

Institutional discrimination varies across environmental contexts, varies in the same context across time, and is associated with negative mental and behavioral health outcomes for sexual minority persons. Institutional discrimination can impact the health of sexual minority persons in their respective communities, especially given the evidence that social policies are related to both mental and behavioral health outcomes for sexual minority populations (Hatzenbuehler, 2010; Hatzenbuehler & McLaughlin, 2014). For example, the prevalence of psychiatric disorders was significantly lower for sexual minority persons in states that had hate crime statutes and employment nondiscrimination policies inclusive of sexual minority persons compared to those living in states without such policies (Hatzenbuehler et al., 2009). Relatedly, implementation of hate crime and employment non-discrimination laws that include sexual orientation negatively correlated with reported hate crime incidence (Levy & Levy, 2017). Living in a state with fewer heterosexist laws is associated with greater self-esteem for sexual minority youth (Woodford et al., 2015), whereas negative characteristics of the social environment are associated with elevated suicide attempts (Hatzenbuehler, 2011). Institutional discrimination contributes to greater tobacco and illicit drug use among sexual minority youth (Hatzenbuehler et al., 2015; Pachankis et al., 2014). Lack of legal protections for sexual minority older adults contribute to increased rates of poverty (SAGE, 2017). Bi+ older adults experience

even higher rates of poverty than their lesbian and gay male counterparts and sexual minority older adults of color are more likely to live in poverty compared to White sexual minority older adults (SAGE, 2017). Sexual minority older adults also face challenges related to a lack of affirmative and inclusive senior housing options and concerns for safety in nursing homes (Gardner et al., 2014; Putney et al., 2018).

Religious institutions have been a source of institutional discrimination for many sexual minority persons, both historically and in current times. For example, some religious institutions have negative beliefs about sexual minorities and some refuse membership to or excommunicate sexual minority members (Grigoriou, 2014; Quinn et al., 2016). Greater frequency of church attendance was associated with more symptoms of anxiety for sexual minority persons who perceived their church as rejecting of their sexual orientation (Hamblin & Gross, 2013). In a study of Black, mostly Christian, sexual minority older adults, all reported having experienced church-based discrimination based on their sexual minority identity, with the majority reporting that these experiences occurred when they were youth. Some participants also reported these experiences as young adults or as having occurred in their current churches (Woody, 2014). In a study of Black sexual minority men in the Southeast United States, participants reported feeling rejected by the Church, but also noted that the Church provided education on Black history and the Civil Rights movement and also offered a sense of community and extended kinship (Quinn et al., 2016). This example highlights additional reasons beyond having a strong religious identity that may keep sexual minority persons engaged with rejecting religious institutions. Sexual minority youth residing in counties with higher concentrations of non-affirming faith communities had increased rates of alcohol abuse compared to their sexual minority youth counterparts residing in counties with more affirming faith communities (Hatzenbuehler et al.,

2012). Some religiously affiliated colleges and universities have policies against same-sex romantic expression and bar admission to sexual minority students (Wolff et al., 2016; Wolff et al., 2020). Religiously affiliated colleges and universities vary in their policies and research indicates that sexual minority students attending those with the most restrictive policies report the most incongruence between their sexual minority orientation and religious beliefs (Wolff et al., 2016).

Another example of institutional discrimination is evident in the criminal justice system. When a heterosexual person commits an act of violence against a sexual minority person, many employ a "gay panic" defense which relies heavily on and perpetuates stereotypes against sexual minority persons (Tomei & Cramer, 2016). Only ten states outlaw the use of "gay panic" defenses (Movement Advancement Project, 2020). Sexual minority stress and discrimination contribute to behavioral problems among sexual minority youth, which offers some explanation for their overrepresentation in the criminal justice system (Conover-Williams, 2014). Sexual minority youth are vulnerable to the "school-to-prison pipeline" as they are at increased risk of being punished in school for public displays of affection and self-expression and, when they experience bullying, sexual minority youth often do not receive support from the school or are punished when they attempt to protect themselves (Snapp et al., 2015). If they quit or are removed from school, they are at an increased risk of becoming involved in the juvenile justice system (Snapp et al., 2015). Sexual minority youth and adults, especially girls and women, also are disproportionately represented in the criminal justice system (Meyer et al., 2017; Wilson et al., 2017), and sexual minority youth are two to three times more likely to be held in custody for more than a year compared to heterosexual youth (Wilson et al., 2017). Compared with heterosexual inmates, sexual minority inmates were more likely to have been sexually victimized

as children, to be sexually victimized while incarcerated, and to experience solitary confinement and other sanctions; they also reported current psychological distress (Meyer et al., 2017). There is ample evidence that Black and Latinx youth and adults are overrepresented in the criminal justice system, but the literature on criminal justice involvement tends to focus on one dimension of identity at a time. Results from a meta-analysis on sexual and gender minority youth in the justice system revealed that the intersections of race and ethnicity are inconsistent (Jonnson et al., 2019). Thus, there is need for more research that specifically examines the experiences of Black and Latinx sexual minority youth and adults, accounting for sexual minority stress and racism, as well as other structural factors that likely makes them more vulnerable to incarceration (Wilson et al., 2017). Although there is less published research focused on incarcerated sexual minority older adults, evidence suggests that those populations also experience significant discrimination and victimization during incarceration (Maschi et al., 2016).

Application. Psychologists strive to understand the deleterious impact that institutional discrimination has on sexual minority youth, adults, and older adults. Psychologists should be prepared to address these topics proactively in counseling or therapy with sexual minority clients, and not to minimize the harm to sexual minority clients who endorse institutional discrimination experiences. Psychologists are encouraged to identify the role of institutional barriers in the lives of sexual minority persons. In addition, psychologists work to address institutional barriers at all levels recognizing the mental health consequences that these may have on sexual minority persons. Sexual minority clients may not make the connection between their distress and institutional barriers, or believe that it is appropriate to raise such issues in psychotherapy. In such cases, psychologists may need to raise the potential connection to these

barriers with their clients (Russell, 2012). Where appropriate, psychologists may use their expertise to inform laws and policies that will protect sexual minority persons.

Psychologists strive to recognize how institutional barriers that exist in their workplaces may negatively affect clients, trainees, and students, and are encouraged to advocate for more inclusive environments. For psychologists in practice, this can include intake forms and print material in their offices that reflect heterosexist bias with words like mother and father referring to caregivers, which could be replaced with the terms parent or guardian to be more inclusive of sexual minority parent families. For psychologists in teaching and training settings, this can include reading assignments and case examples for students and trainees that are inclusive of diverse sexual orientations and relationship structures.

Psychologists are encouraged to advocate for inclusive policies in their various work settings. Psychologists can use their expertise to improve the environments where sexual minority persons exist, which can have positive health and mental health implications. Psychologists are encouraged to be cognizant of the intersectional nature of institutional discrimination whereby heterosexism, monosexism, transnegativity, racism, xenophobia, ableism, classism, and religious discrimination work in concert to create greater structural barriers for those who occupy multiple marginalized identities.

Guideline 6. Psychologists understand the influence that distal minority stressors have on sexual minority persons, and the need to promote social change.

Rationale. Sexual minority persons experience interpersonal discrimination, victimization, and microaggressions, which all constitute distal minority stressors. Distal minority stressors based on sexual minority orientation are associated with poor mental health

(Bandermann & Szymanski, 2014; Choi et al., 2013; Mays & Cochran, 2001; McLaughlin et al., 2010). Sexual minority persons further encounter higher rates of employment and housing-related discrimination compared to heterosexual persons (Meyer, 2019). Bi+ persons experience discrimination from heterosexuals, as well as from gay men and lesbians including interpersonal hostility, stereotypes about sexual orientation instability and sexual irresponsibility, invisibility and erasure (Brewster & Moradi, 2010; Roberts et al., 2019). Asexual persons also face discrimination and marginalization from peers, family members, and medical and mental health providers who may dismiss or pathologize their identities (Carroll, 2020; Chasin, 2015; Rothblum et al., 2020).

Across the lifespan, sexual minority individuals report high rates of victimization (Balsam et al., 2005; Fredriksen-Goldsen et al., 2013; Meyer, 2019; Roberts et al., 2010). A meta-analysis by Friedman and colleagues (2011) found that sexual minority youth were more likely to report experiencing sexual abuse, parental physical abuse, and assault at school compared to their heterosexual peers. National longitudinal data indicates that sexual minority youth experienced more childhood sexual and physical abuse than did their heterosexual counterparts, which predicted higher levels of suicidality, depression, and substance use (McLaughlin et al., 2012). Childhood sexual abuse is associated with elevated rates of sexual assault in adulthood and this revictimization is associated with increased psychological distress, suicidality, and alcohol use (Balsam et al., 2011). Although sexual minority persons, overall, report more victimization than heterosexuals, bi+ persons reported more threats, physical assault, and assaults with weapons than did gay and lesbian persons (Katz-Wise & Hyde, 2012). In school settings, sexual minority youth experience elevated levels of victimization during middle and high school compared to their heterosexual counterparts; this is especially true for sexual

minority boys (Toomey & Russell, 2016). Longitudinal findings suggest that harassment and victimization are associated with depressive symptoms and suicidality in sexual minority youth (Barnett et al., 2018; Burton et al., 2013).

Sexual minority youth and adults also are at risk for intimate partner abuse or violence (Brown & Herman, 2015; Luo et al., 2014; Martin-Storey, 2015; Whitton et al., 2019). Native American and Alaska Native sexual minority women experience sexual and physical abuse at rates that exceed those of White sexual minority women and Native American and Alaska Native heterosexual women. Native American and Alaska Native sexual minority women who were older, had lower education levels, and had lower socioeconomic status (SES) were more likely to experience intimate partner violence (Lehavot et al., 2010). Sexual minority persons face additional barriers to help-seeking when experiencing intimate partner abuse or sexual assault, including concerns about law enforcement not being helpful (Brown & Herman, 2015), and friends and family not providing adequate support (Jackson et al., 2017).

In a national community-based sample study, sexual minority older adults reported on average experiencing victimization and discriminatory events six times in their lifetime (Fredriksen-Goldsen et al., 2013). Sexual minority older adults are at risk for victimization related to their age and sexual minority status and live with the cumulative effects of a lifetime of discrimination (Fredriksen-Goldsen et al., 2013; SAGE, 2017). Lifetime victimization is associated with poor health, disability, and depression among sexual minority older adults (Fredriksen-Goldsen et al., 2013). Sexual minority older adults who experience discrimination related to their sexual orientation, and those who expect discrimination, have the highest levels of loneliness, whereas having a social network of other sexual minority persons buffered against the impact of sexual minority stress (Kuyper & Fokkema, 2010). There is emerging evidence

suggesting that older sexual minority persons may be at increased risk of premature cognitive decline, which may be a function of chronic sexual minority stress (Correro & Nielson, 2019; Flatt et al., 2018).

Sexual minority people of color report more experiences of discrimination of any type in the past year compared to their White counterparts (Bostwick et al., 2015). Those who experienced discrimination based on sexual minority orientation or race/ethnicity alone were not at increased risk for mental health disorders but those who experienced a combination of discrimination based on sexual minority orientation, race/ethnicity, or gender were at increased risk (Bostwick et al., 2015). In a community-based sample of bi+ and lesbian women, Black and Latina women were more likely to have experienced any childhood victimization, childhood physical abuse, and intimate partner violence compared to White women (Bostwick et al., 2019). Despite higher rates of both childhood and adult victimization, Black bi+ and lesbian women were significantly less likely than White lesbian women to report lifetime depression (Bostwick et al., 2019). More intersectional research that attends to diversity within sexual minority groups is needed to better understand these relations.

A sexual orientation-related hate crime is a criminal offense toward a person or property motivated by bias toward sexual minority persons (Bell & Perry, 2015). Prevalence estimates from a national probability sample found that about 20% of sexual minority-identified individuals in the United States experienced a hate crime in adulthood based on their sexual minority orientation (Herek, 2009). Sexual minority persons who are not out to their families, employers, or neighbors—or who are fearful about how they will be treated by the police—may be especially reluctant to report hate crimes (Gerstenfeld, 2017). Sexual minority identity-based hate crime victimization has been associated with symptoms of posttraumatic stress disorder

(PTSD; Bandermann & Szymanski, 2014). Individuals who have been exposed to hate crimes based on their sexual minority sexual orientation report greater emotional and psychological distress than victims of other crimes, and this distress seem to be longer lasting (Herek, 2009; McDevitt et al., 2001). Psychologists understand that hate crimes against sexual minority persons have negative impacts beyond those for the direct victim. Research indicates that other sexual minority persons also experience negative mental health effects after hearing about hate crimes (Bell & Perry, 2015; Stults et al., 2017). For example, evidence indicates that marijuana use is higher among sexual minority youth who live in neighborhoods with more sexual- and gender identity-based hate crimes, potentially reflective of coping-motivated substance abuse (Duncan et al., 2014).

Another common form of distal stress experienced by sexual minority persons is sexual orientation-related microaggressions, defined as "brief and commonplace slights and insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative heterosexist and homonegative slights and insults towards gay, lesbian, bisexual and queer people" (Nadal et al., 2016, p. 492). Examples of sexual orientation-related microaggressions include use of heterosexist language, endorsement of heteronormativity, assumptions of a universal experience by sexual minority persons, denial of the existence of heterosexism, and the pathologizing of sexual minority persons (Nadal et al., 2010). Sexual minority persons also experience microaggressions in religious and spiritual communities where they may receive the message that their sexual minority and religious/spiritual identity are not compatible, that their sexual minority identity is not real, and that they are sinful (Lomash et al., 2018).

Research on sexual orientation-related microaggressions suggests that there are within-group differences among racial and ethnic groups, genders and sexual orientations, as well as

among sexual minority persons with physical disabilities (Balsam et al., 2011; Conover & Israel, 2018). Sexual minority people of color experience unique microaggressions related to their intersecting racial/ethnic and sexual identities, including disapproval of their sexual orientation or sexual minority identity from within their racial/ethnic or religious communities, gender role stereotypes, the assumption of a universal sexual minority experience, exoticization, ascription of intelligence to women of color, the assumption of criminality; denial of personal privacy; and pressure to conform to gender and sexual norms (Nadal et al., 2015; Weber et al., 2017). However, there has been little published research that has taken an intersectional approach to understanding how microaggressions are experienced by sexual minority people of color (Nadal et al., 2016). More research is needed to understand how microaggressions are experienced by various sexual minority groups, with particular attention to bi+ identities, as well as microaggressions experienced by those who occupy multiple marginalized identities (Nadal et al., 2016). For example, sexual minority persons living with physical disabilities experience microaggressions within sexual minority communities and sexual orientation related microaggressions within disability communities, which is related to greater depressive symptoms (Conover & Israel, 2018). Quantitative research is just beginning to take an intersectional approach to examining the impact of microaggressions on sexual minority people of color (Fattoracci et al., 2020).

Application. Psychologists consider how distal minority stressors increase the cumulative burden of stress, and create legitimate concerns about personal safety for sexual minority persons. Psychologists working with sexual minority clients should be prepared to assess lifetime discrimination experiences, and to address an individual's reactions to these experiences in a therapeutic manner. Psychologists strive to validate the psychological pain

caused by distal minority stressors, and not to minimize this impact of experiences of interpersonal discrimination. Because stigma is so culturally pervasive, its effects may not be evident to all sexual minority persons. Therefore, it may be helpful for psychologists to consider the ways in which stigma may manifest in the lives of their clients, even if the clients do not raise it as a presenting complaint or describe their experiences specifically in those terms, and create awareness of systemic oppression when working with sexual minority clients. Encouraging clients to discuss their experiences of discrimination may decrease psychological distress (Hinrichs & Donaldson, 2017).

The associations between trauma and discrimination based on sexual orientation can manifest in different ways. Sexual orientation discrimination experiences can exacerbate pre-existing PTSD symptoms (Keating & Muller, 2020). Cumulative, harm-related experiences stemming from sexual orientation discrimination alone (that do not necessarily meet *Diagnostic and Statistical Manual Version 5* [DSM-5; American Psychiatric Association, 2013] Criterion A for PTSD; Livingston et al., 2019) can result in PTSD symptoms (Dworkin et al., 2018). Therefore, integrating trauma-informed care treatment goals that incorporate discrimination-related themes, such as ensuring safety, social connection, increased trust, among others, may benefit sexual minority persons (see Substance Abuse and Mental Health Administration, 2014).

Psychologists strive to create welcoming and affirming therapeutic environments for diverse sexual minority clients from a variety of cultural backgrounds. In addition, psychologists monitor against engaging in microaggressions toward their clients. Activities in support of these goals can include ensuring the use of inclusive language and avoiding language that belies heteronormative or monosexist assumptions. Psychologists are encouraged to adopt the therapeutic framework of cultural humility, which urges therapists to engage in critical self-

examination and self-awareness, build the therapeutic alliance, repair cultural ruptures, and navigate values differences (Davis et al., 2016).

Psychologists strive to consider the relative levels of safety and social support that clients experience in their social environment, and plan interventions accordingly, with particular consideration of the social environment of youth and older adults. For clients who are more comfortable with their sexual minority orientation, it may be helpful for the psychologist to consider referrals to local support groups or other community organizations to increase social support. However, many such groups implicitly cater to those with lesbian or gay identities and may not be as experienced with, sensitive toward, or welcoming for bi+ persons. Similarly, sexual minority people of color may not experience the same support in such spaces as do White sexual minority persons. Some sexual minority older adults are less likely to disclose their sexual minority orientation, which may result at least in part from historical oppression (Morales et al., 2014). For example, many sexual minority older adults came of age during an era of repression and silence when sexual minority persons were pathologized and legal protections were nonexistent (D'Augelli & Grossman, 2001; Shankle et al., 2003). Thus, they may be less likely to seek supportive services, which can lead to isolation and lack of social support (Morales et al., 2014). Psychologists are encouraged to find ways to support sexual minority persons who may experience marginalization within the broader sexual minority community. More mainstream sexual minority-focused environments may yet expose sexual minority persons to microaggressions, including binegativity, racism, ableism, and religious discrimination, among others.

Guideline 7. Psychologists recognize the influence that proximal minority stressors have on the mental, physical, and psychosocial health of sexual minority persons.

Rationale. Proximal minority stressors are internalized psychological conflicts that can be triggered by, or be the result of, distal-related stressors, societal sexual stigma, and prejudicial stereotypes (Brewster et al., 2013; Dyar et al., 2018; Hatzenbuehler, 2009; Mereish et al., 2017; Meyer, 2003, 2015; Velez et al., 2017). Proximal minority stressors include internalized heterosexism, internalized binegativity, expectations of stigma (including resulting anxiety and worry), and in certain contexts, identity concealment. Transgender, gender nonbinary, and gender diverse individuals who hold sexual minority identities have additional proximal minority stressors that include internalized transnegativity, including gender-related identity concealment and expectations of stigma (Hendricks & Testa, 2012).

Proximal minority stressors can occur across the lifespan, and can intersect with other forms of internalized and enacted stigma (e.g., racism, sexism, genderism, cissexism, objectification, ableism, ageism; Dispenza et al., 2019; English et al., 2018; Velez et al., 2017). These intersections may lead to negative outcomes for sexual minority youth and adults, alike. For example, Velez et al. (2015) reported that both internalized heterosexism and internalized racism were associated negatively with self-esteem and life satisfaction for Latinx sexual minority individuals. Proximal minority stressors also can take place across a variety of environmental, cultural, and relational contexts that are not always safe or secure (e.g., school, home, work, healthcare settings, assisted living facilities, community, interpersonal relationships). For instance, Noyola et al. (2020) found ambivalence from family members, traditional Latinx gender roles expectations (e.g., *marianismo* and *machismo*), sexual objectification, marginalization from other sexual minority persons, intersectional invisibility,

and lack of representation in media nuanced the experience of minority stress for sexual minority Latinx individuals.

Proximal minority stressors function as the mediational mechanisms through which daily hassles, stigma, and distal stressors influence the health of sexual minority persons (Brewster et al., 2013; Dyar et al., 2020; Sarno et al., 2020; Velez et al., 2017). Further, proximal minority stressors are associated with cognitive, social, interpersonal, coping, and emotional regulation processes (Hatzenbuehler, 2009; Puckett et al., 2018). Examples of psychological processes include rumination, suppression (Hatzenbuehler et al., 2009), self-criticism, decreased social connections (Puckett et al., 2015), and poor coping self-efficacy (Denton et al., 2014). Although direct causal links between proximal minority stressors and psychological processes are under continued investigation, psychologists understand that proximal minority stress and psychological processes play a joint role in the mental health, physical health, and psychosocial well-being of sexual minority persons.

To varying degrees, proximal minority stressors are associated with mental health outcomes, such as stress-sensitive or internalizing mental health symptomology (e.g., depression, anxiety; Dyar et al., 2020; Pachankis et al., 2015a; Sarno et al., 2020), psychological distress, suicidality, trauma symptoms, PTSD, and disordered eating (Berg et al., 2016; Chen & Tyron, 2012; Dyar & London, 2018; Hoy-Ellis & Fredriksen-Goldsen, 2016; Mason et al., 2018; Newcomb & Mustanski, 2010). Further, proximal minority stressors are understood to influence behavioral and psychosocial health (Goldbach et al., 2014; Hoy-Ellis & Fredriksen-Goldsen, 2016; Pachankis et al., 2018), including sexual compulsivity, sexual risk-taking behaviors (Newcomb & Mustanski, 2010, 2011; Pachankis et al., 2015), and substance use and abuse among sexual minority youth and adults (Goldbach et al., 2014; Kuerbis et al., 2017). Proximal

minority stressors are associated with increased perceptions of body image dissatisfaction and compulsive exercise for sexual minority men (Brewster et al., 2017) and are connected to higher rates of disordered eating and body image concerns for sexual minority women (Mason et al., 2018). Across the lifespan, proximal minority stressors are negatively correlated with life satisfaction (Michaels et al., 2018), psychological well-being (Brewster et al., 2013), self-acceptance (Camp et al., 2020), and self-esteem (Lambe et al., 2017; Mason et al., 2015). Proximal minority stressors also are associated with both victimization and perpetration of physical, sexual, and psychological intimate partner violence (Longobardi & Badenes-Ribera, 2017).

Emerging evidence also indicates that proximal minority stressors are associated with physical health outcomes for sexual minority persons (Flenar et al., 2017; Frost et al., 2015; Katz-Wise et al., 2017). For instance, Hoy-Ellis and Fredriksen-Goldsen (2016) reported that internalized heterosexism was associated with chronic health conditions among a sample of older sexual minority persons. Flenar et al. (2017) found that proximal minority stressors correlated with physical health problems, as well as decreased engagement in health promoting behaviors (e.g., exercise, healthy eating, seeking healthcare when ill) among sexual minority adults and older adults. In some instances, proximal minority stressors are indirectly associated with physical health symptoms (e.g., sleep problems, aches, pain), whether the indirect link is through emotion focused coping self-efficacy (Denton et al., 2014), shame (Mereish & Poteat, 2015), or mental health concerns (Walch et al., 2016).

Application. Proximal minority stressors have the capacity to exacerbate mental, behavioral, and physical health symptoms (Mereish & Poteat, 2015; Pachankis et al., 2015a; Pachankis et al., 2018). Psychologists attempt to assess for proximal minority stressors when

working with sexual minority persons, validate that proximal minority stressors are real experiences, and educate their sexual minority clients on the impact that proximal minority stressors have on overall health and well-being. Psychologists are encouraged not only to assess mental health symptomology and psychological distress, but also to inquire about physical health and physical distress. Psychologists are encouraged to make necessary referrals to affirmative health care providers when a sexual minority client's physical health is a concern.

When addressing internalized heterosexism, internalized binegativity, and expectations of stigma, psychologists strive to enhance adaptive coping strategies, coping self-efficacy, assertive communication skills, and to help sexual minority persons engage in health-promoting lifestyles in order to decrease distressing symptoms associated with proximal minority stressors (Denton et al.,2014; English et al., 2018; Flenar et al., 2017; Pachankis et al., 2015). Psychologists also may find that decreasing self-criticism, rumination, and suppression tendencies could help ameliorate mental/behavioral health symptoms, psychological distress, and proximal minority stressors (Hatzenbuehler et al., 2009; Pachankis et al., 2015b; Puckett et al., 2018). Although data are currently limited, mindfulness and cognitive-behavioral interventions are minimally to moderately effective at reducing proximal minority stress among sexual minority persons (Israel et al., 2019; Pachankis et al., 2015b; Smith et al., 2017; Yadavaia & Hayes, 2012), and thus, show some clinical efficacy. Decentering, the psychological observation of one's thoughts or feelings without judgment, has also been found to buffer the relations between internalized heterosexism and psychological distress among sexual minority persons (Puckett et al., 2018), which has implications for clinical intervention. In addition to traditional in-person interventions, online and Internet-related modalities may be effective modes of

delivery when addressing internalized heterosexism and internalized binegativity (Israel et al., 2019).

Psychologists are encouraged to consider interventions that facilitate authentic decision making around concealment and disclosure of sexual minority identity, without forcing anyone to disclose their sexual orientation (Rostosky et al., 2017). In some instances, identity concealment can be adaptive and keep sexual minority persons safe from harm, threat, violence, or death. This may be particularly true for sexual minority youth who may reside in unsupportive environments, as well as sexual minority persons living in or originating from countries where persecution based on sexual orientation is commonplace. Psychologists may find it helpful to have clients explore the risks and benefits of disclosing sexual orientation, to whom, at which times, and in which settings (Jackson & Mohr, 2016). Also, psychologists consider encouraging their sexual minority clients to engage with affirming sexual minority communities in order to enhance their identities, resilience, and collective action. This is especially important when working with bi+ persons. Psychologists consider ways to assist bi+ persons becoming involved with bi+ communities to ward off internalized binegativity and other forms of proximal minority stress (Lamb et al., 2017).

Psychologists consider how proximal minority stressors and other forms of stigma (e.g., racism, sexism) co-occur, interact, and influence mental/behavioral, physical, and psychosocial health among sexual minority persons who possess multiple marginalized identities (Mason et al., 2018; Velez et al., 2015; Velez et al., 2017). Effective and affirming clinical practice with diverse sexual minority persons considers interventions that empower individuals to develop resilience against proximal minority stressors (Pachankis et al., 2018), helps eliminate structural inequities that reinforce stigma and proximal minority stressors (English et al., 2018), and

reduces heterosexism, binegativity, and transnegativity in health care systems (Katz-Wise et al., 2017).

Guideline 8. Psychologists recognize the positive aspects of being a sexual minority person, and the individual and collective ways that sexual minority persons display resilience and resistance to stigma and oppression.

Rationale. Sexual minority persons are not only coping, but many are thriving within their diverse communities despite experiences of minority stress, stigma, and systemic oppression (de Lira & de Morais, 2018; Meyer, 2015; Riggle & Rostosky, 2014; Rostosky et al., 2018). Resilience is the ability to experience increased wellness, successfully adapt, thrive, and survive when confronted with risks and adversity (e.g., Masten, 2007). Key concepts of resilience have been integrated into major models of sexual minority stress and coping, most notably by Meyer (2010; 2015). Sexual minority persons engage in psychologically healthy behaviors, self-efficacy, positive views of one's sexual identity, connections with family and social supports, and religion and spirituality as ways to resist stigma and other negative impacts of oppression (de Lira & de Morais, 2018; Lehavot, 2012).

Sexual minority youth and adults report enhanced well-being by coming out when safe to do so, belonging to a community, creating families of choice, serving as positive role models, enhancing authenticity and empathy for self and others, engaging in social justice and activism, challenging gender-specific roles, and exploring sexuality and relationships (Poteat et al., 2016; Riggle & Rostosky, 2014; Riggle et al., 2008; Szymanski et al., 2017; Vaughan et al., 2014). Psychological strengths centered on valuing relationships, advocacy, social justice work, living with integrity, experiencing positive emotions, being creative, adaptive coping, self-regulation, treating others equitably, and positive spirituality also are associated with increased resilience

(Vaughn et al., 2014). Scholarship on the positive aspects of having a sexual minority orientation has also found differences among this population that are important to note. For example, bi+ persons form relationships based on holistic characteristics (e.g., interest, emotional intimacy personality traits) rather than on specific biological characteristics, sex/gender, or gender expression in a partner (Riggle & Rostosky, 2014; Rostosky et al., 2010). Also, research supports that lesbian women value forming egalitarian relationships that reject societal patriarchal norms (Riggle & Rostosky, 2014; Riggle et al., 2008).

Sexual minority persons who have multiple marginalized identities may develop unique resiliencies, strengths, and resources that support their resilience. Psychologists take into consideration positive aspects of identifying as a sexual minority person and other intersecting identities such as race and ethnicity (Meyer, 2015), Indigenous identity (Elm et al., 2016), disability (Hunter et al., 2020), religion and spirituality (Brennan-Ing et al., 2013; Rosenkrantz et al., 2016; Vaughan et al., 2014), and age (deVries et al., 2017; Fredriksen-Goldsen et al., 2015). In a study of self-identified bi+ and biracial/multiracial persons, Galupo and colleagues (2019) found that participants described ways in which their intersecting identities as bi+ and racial minorities make them unique (i.e., different viewpoints, defying traditional identity categories). Participants identified numerous character strengths through valuing close/intimate relationships, strong social intelligence, and curiosity about self/others and kindness (e.g., self-reflective, more culturally aware, and increased empathy; Galupo et al., 2019; Vaughan et al., 2014). In another study consisting of sexual and gender minority persons living with developmental and physical disabilities, Hunter et al. (2020) found that self-acceptance, advocacy, social support, and the desire to be viewed as fully human maximized their experiences of resilience.

At the community level, there are tangible and intangible resources of resilience (Lytle et al., 2014; Meyer, 2015). Tangible resources refer to having access to community centers and clinics, support groups, information, and laws and policies that support, affirm, and liberate sexual minority persons (Meyer, 2015). Intangible resources include feeling pride, a connection to one's sexual minority community, and feeling that one belongs to that community (de Lira & de Morais, 2018; Meyer, 2015). Due to previous experiences of coping with multiple layers of systemic and structural oppression, sexual minority persons who are exposed to other forms of oppression such as ableism, ageism, racism, and sexism might have access to more resources to help them be more resilient (Bowleg et al., 2003; Meyer, 2015; Moradi et al., 2010). For example, in a study with a sample of Latinx immigrant sexual minority men, Gray and colleagues (2015) found that participants attributed current psychological well-being to successful negotiations of past adversity and connection to communities that shared their intersecting identities as sexual minority Latinx immigrants. In addition, research with sexual minority elders show that belonging to communities (e.g., Services & Advocacy for GLBT Elders [SAGE]) and religion and spirituality serve as sources of resilience (deVries et al., 2017; Swartz et al., 2015).

Application. Psychologists strive to move away from deficit-focused models and use strength-based approaches that increase well-being and resilience at the individual and community levels (Budge et al., 2017; Colpitts & Gahagan, 2016; de Lira & de Morais, 2018; Herrick et al., 2014; Kwon, 2013; Lytle et al. 2014; Meyer, 2015; Rostosky & Riggle, 2017). At the individual level, psychologists affirm sexual minority persons' strengths and positive relationships. They assess and foster individual-level character strengths by utilizing existing measures and adapting empirically-supported interventions centered on common strengths found

within sexual minority persons (See Lytle et al. 2014). Psychological researchers are encouraged to use an intersectional approach that acknowledges the unique experiences of sexual minority persons when developing models to promote resilience (Colpitts & Gahagan, 2016; Lytle et al., 2014; see Meyer, 2015). Although it is important to nurture individual resilient practices, psychologists understand that a "pull yourself up by the bootstraps" mentality may perpetuate victim-blaming ideology, especially when sexual minority persons are having to live in toxic environments that seek to pathologize or marginalize them (Meyer, 2015). At the community levels, psychologists strive to connect sexual minority persons to communities where they are able to have access to role models, form solidarity with others, and have access to resources (Meyer, 2015).

There is a positive relation between engagement in advocacy and well-being in sexual minority persons (Szymanski et al., 2017). Thus, psychologists are encouraged to initiate conversations about ways in which sexual minority persons can engage in advocacy and community activism to resist and combat systems of oppression. Also, there is an association between critical consciousness and increased self-efficacy, and self-esteem and decreased depressed mood among sexual minority persons (Bruce et al., 2015). Therefore, psychologists attempt to help clients develop skills to effectively interrogate systems of oppression. It is important to recognize that because engagement in advocacy and activism could be associated with psychological distress, psychologists discuss diverse ways in which sexual minority persons can engage in activism in order to enact change while taking care of their mental health (Santos & VanDaalen, 2018).

Psychologists examine the various facets of identity (e.g., age cohort, race, gender, ethnicity, culture, socioeconomic class, disability, religion, and spirituality) and how these

intersect with one's sexual identity to promote well-being and resilience. Psychologists understand that not all sexual minority persons (e.g., sexual minority people of color; asexual individuals; bi+ persons; religious individuals) have felt included in sexual minority and gender diverse communities, and thus strive to advocate and create spaces in which sexual minority persons who have historically been marginalized in sexual minority spaces are able to thrive (e.g., bi+ identities and sexual minority people of color).

Relationships and Family

Guideline 9. Psychologists strive to be knowledgeable about and respect diverse relationships among sexual minority persons.

Rationale. Sexual minority persons nurture and sustain meaningful romantic relationships throughout their lifespan, similar to individuals with majority sexual orientations (i.e., heterosexual identified persons). In a review of empirical studies published from 2000 to 2016, Rostosky and Riggle (2017a) identified several positive relationship processes and characteristics associated with relationship strength. Positive relationship processes included respecting partner differences, displaying positivity (e.g., understanding, kindness, and tenderness), reframing stigma and coping with discrimination, and engaging in effective communication and negotiation skills among sexual minority couples. Characteristics of strong relationships included emotional intimacy between partners, being out to others about their sexual minority identities, relationship dynamics, relationship style, emotional and behavioral displays of commitment, and freedom from gender role expectations (Rostosky & Riggle, 2017b). Social support and legal recognition of relationships, including marriage equality, were

also identified as important factors for relationship strength (Riggle et al., 2010; Rostosky & Riggle, 2017b).

Although marriage between same-sex couples has been legalized in many countries, sexual minority persons in romantic relationships continue to encounter stigma and significant hardships (LeBlanc et al., 2018). This stigma creates sexual minority stress for same-sex couples (Dispenza, 2016; Rostosky & Riggle, 2017a). Experiences of discrimination, prejudice, and negative stereotypes impact romantic relationship functioning and quality (Frost, 2013; LeBlanc et al., 2015; LeBlanc et al., 2018; Thies et al., 2018). In one meta-analysis, Doyle and Molix (2015) reported a small but significant effect for social stigma on romantic relationship functioning among sexual minority persons across 35 different studies. A review of empirical studies examined associations between institutional, interpersonal, and proximal minority stressors and relationship-related variables, finding that most studies focus on proximal minority stress (Rostosky & Riggle, 2017a). Internalized stigma (i.e., internalized heterosexism) was inversely related to relationship functioning (Doyle & Molix, 2015; Rostosky & Riggle 2017a). Additionally, depressive symptomatology has been found to mediate the association between internalized heterosexism and relationship quality among sexual minority persons (Frost & Meyer, 2009; Thies et al., 2018), whereas internalized stigma and depression were associated with lower perceptions of relationship quality and higher ratings of relationship dissatisfaction.

Bi+ persons may encounter unique hardships in their romantic relationships. Bi+ persons often experience erasure within the context of romantic relationships because they are assumed to be either heterosexual or lesbian/gay based on the perceived gender of their partner(s). Bi+ individuals may be more likely to be in a mixed-orientation relationship; however, the majority of research in this area has focused on mixed-orientation marriages, with husbands disclosing

same-sex attractions to their heterosexual wives (Vencill & Wiljamaa, 2016). Only a small body of research has explored bi+ experiences within their partner relationships (Hayfield et al., 2018). People in mixed-orientation relationships also experience stigma and issues surrounding disclosure (Bradford, 2012; Buxton, 2004; Schwartz, 2012).

There is a need for research that examines other aspects of diversity within same-sex relationships, including race and ethnicity (Rostosky & Riggle 2017a). Same-sex couples are more likely to be in interracial relationships than different-sex couples, with Asian American sexual minority persons as the highest and White sexual minority persons as the lowest (Kastanis et al., 2014). However, there is a lack of research examining interracial sexual minority relationships. One way that interracial relationships have been studied is in the context of sexual racism. Sexual racism is described as "discriminatory acts carried out against people of color, in particular, in sexual and dating situations on the basis of their ethnicity/race" (Bhambhani et al., 2020, p. 712) and it reflects "… broader systemic racial politics that privilege racial majorities and disadvantage racial minorities." (Thai, 2020, p. 348). Research indicates that sexual minority men perceive a racial hierarchy that privileges White men (Paul et al., 2010; Thai, 2020). Black, Latinx, and Asian American sexual minority men report experiencing both sexual objectification and sexual rejection based on race online (Paul et al., 2010). There is a dearth of research focusing on sexual racism among sexual minority women.

Further, there is diversity among sexual minority persons regarding relationship structure. Similar to heterosexual individuals, some research indicates that sexual minority persons may engage in consensually non-monogamous relationships at similar frequencies as heterosexual individuals (Haupert et al., 2017a; Haupert et al., 2017b). Consensually non-monogamous relationships can take many forms (e.g., polyamory, swinging, open relationships) and generally

encompass relationships in which all partners involved explicitly agree to have multiple intimate partners (Conley et al., 2013).

Evidence suggests that mental health and medical healthcare professionals hold stigmatizing views toward consensual non-monogamy (Schechinger et al., 2018; Vaughan et al., 2019). Clients have described therapists who lack basic knowledge about consensual non-monogamy, pushed them to renounce their relationship(s), or expressed the belief that the clients' relationships were bad, sick, or inferior to monogamy (Schechinger et al., 2018). Given these stigmatizing experiences, sexual minority persons in consensually non-monogamous relationships may choose to not disclose their relationship status (Pallotta-Chiarolli, 2010). A growing body of research suggests that the general public holds erroneous beliefs about consensually non-monogamous relationships. For example, research has generally found that people in consensually non-monogamous and monogamous relationships report similar levels of relationship quality (e.g., trust, commitment, love, sexual satisfaction; Conley et al., 2017; Wood et al., 2018) and psychological well-being (Rubel & Bogaert, 2015). Moreover, people engaged in consensually non-monogamous relationships reported higher levels of attachment security (low avoidance and anxiety) in comparison to the general population and monogamous samples (Moors et al., 2015; Moors et al., 2019).

Some clients may participate in "kink" and/or describe their sexual identities and behaviors that involve engaging in forms of BDSM (i.e., bondage, discipline/domination, submission/sadism and masochism). Clients have often had negative experiences within the mental health and healthcare systems and their communities when disclosing their kink identities (Wright, 2018). Hughes and Hammack (2019) found that sexual minority persons who engaged in kink often shared histories that included concealment of their sexual behaviors and identities,

social isolation and stigma which resulted in psychological distress and negative self-concept. Recent research suggest that treatment strategies should include the clinician's self-awareness regarding kink and BDSM (Pillar-Friedman et al., 2015) in order to assist sexual minority clients in processing feelings related to stigma, isolation, shame and issues of grief and loss (Sprott & Hadcock, 2018; Waldura et. al., 2016).

Application. Psychologists are encouraged to consider stigma associated with non-legally recognized family or romantic partners, mixed-orientation relationships, and consensually non-monogamous relationships along with the various forms of stigma and discrimination that sexual minority persons may face (e.g. heterosexism, monosexism, cissexism, racism, ableism). Clinicians working with sexual minority persons on romantic relationship-related concerns may consider eliciting stories of significant relationship events to better assess, comprehend, and ameliorate the impact that stigma and sexual minority stress have on relationship functioning (Frost, 2013; Doyle & Molix, 2015). Further, they may consider working on bolstering relationship functioning processes (e.g., respect, positive reframing) and characteristic factors (e.g., commitment, gender role expectation) to help strengthen relationship quality (Rostosky & Riggle, 2017). Psychologists are encouraged to treat these diverse relationships with the same respect as heterosexual, cisgender, and monogamous identities and relationships.

Psychologists understand that sexual minority stress may uniquely influence diverse relationship and family arrangements. Sexual minority persons in diverse relationships may seek therapy for reasons similar to those of heterosexual people in relationships (e.g., concerns related to communication or sexual satisfaction) or reasons unique to their relationship type (e.g., concerns related to boundaries, emotion management, disclosure or navigating legal systems).

Psychologists should, therefore, strive to be mindful of familial, social, and cultural factors when conducting therapy or counseling with sexual minority people in diverse relationships.

Psychologists attempt to be mindful of the dynamics often faced by individuals in mixed-orientation relationships, such as bi+ erasure (Crofford, 2018; Vencill & Wiljamaa, 2016). These issues may also be present among sexual minority individuals engaged in consensually non-monogamous relationships. For instance, clients engaged in consensual non-monogamy had worse therapeutic outcomes when their therapist was reported to lack or refuse to gather information about consensual non-monogamy, hold judgmental or pathologizing attitudes toward consensual non-monogamy, or blame presenting problems (e.g., depression, anxiety) on consensual non-monogamy (Schechinger et al., 2018). Further, psychologists recognize that both consensual non-monogamy and monogamy are healthy relationship options selected by bi+ individuals. Psychologists validate and attempt not to pathologize bi+ individuals who engage in consensual non-monogamy. No adverse mental health effects are associated with this relationship choice among the small, but significant, proportion of bi+ individuals who engage in consensual non-monogamy (Taylor et al., 2019).

Psychologists are encouraged to reflect on their internalized assumptions and take a non-judgmental, respectful approach to clients engaged in consensually non-monogamous relationships, as these practices are rated as helpful and linked with positive therapeutic outcomes (Finn et al., 2012; Jordan et al., 2018; Moors, 2019; Schechinger et al., 2018). Where there are deficits in knowledge regarding diverse relationship structures, psychologists are encouraged to seek additional education and training to avoid holding stigmatizing attitudes and (unintentionally) engaging in unhelpful practices, which may further contribute to sexual minority stress.

Psychologists are aware that sexual minority persons, particularly sexual minority youth, may be reluctant to disclose their relationship(s) to avoid serious negative events (e.g., family rejection, loss of employment, loss of child custody). Feeling unsafe about disclosing one's sexual orientation or relationship structure can result in emotional distancing from one's family of origin (i.e., family in which one was raised in) and friend network (Ryan et al., 2017; Sheff, 2015). Some families of origin experience difficulty accepting sexual minority family members, especially those in a mixed-orientation or consensually non-monogamous relationship because of cultural, familial, or religious beliefs (Baiocco et al., 2015; Ryan et al., 2009; Schwartz, 2012). Given the stigma and misinformation regarding diverse relationship types, psychologists are encouraged to correct misinformation through their work with clients, community organizations, and legal systems to provide accurate science-based and professionally-derived knowledge. Psychologists also are encouraged to recognize the unique strengths and resilience of sexual minority individuals in diverse relationships (Moors et al., 2017).

Given that diverse types of intimate and family arrangements are often not visible or are rendered invisible with standard forms, psychologists are encouraged to offer the option for clients to self-identify their relationship structure on intake or emergency contact forms. A common harmful practice is assuming heterosexuality and monogamy (e.g., Liddle, 1996; Schechinger et al., 2018); allowing clients to self-identity can help avoid this mistake. To avoid mislabeling, when the preferred term is unknown, psychologists are encouraged to use the term "partner(s)" (instead of, for example, terms like wife, husband, girlfriend, boyfriend that presume gender and/or marital status). Psychologists who have received training on diverse relationship types are encouraged to signal that they are affirming of sexual minority individuals in these

relationships by conveying this on website materials, therapist directory profiles (e.g., APA Psychologist Locator), and in the office (e.g., displaying symbols, relevant brochures).

Guideline 10. Psychologists recognize the importance and complexity of sexual health in the lives of sexual minority persons.

Rationale. Sexual health is a fundamental aspect of overall health and well-being and encompasses physical, mental, and social aspects of sexuality and relationships (Sexuality Information and Education Council of the U.S. [SIECUS], 2015; World Health Organization [WHO], 2006; 2010). Further, sexual health involves the ability to enjoy pleasurable and safe sexual experiences, free from coercion and discrimination (WHO, 2006; 2010). Unfortunately, the sexual health of sexual minority persons has been given scant attention outside the context of HIV and AIDS (National Institutes of Health Sexual and Gender Minority Research Office [NIH SGMRO], 2019). Although the HIV epidemic has had an enormous impact on the sexual health of sexual minority communities, and rates of new infection continue to be highest among sexual minority men, a narrow disease-focused approach has also led to neglect of other important aspects of sexual functioning and health (Hargons et al., 2017). Complicating matters further, psychologists consistently report inadequate training on how to effectively discuss sexual and relationship health topics with their clients (Burnes et al., 2017; Flaget-Greener et al., 2015; Hanzlik & Gaubatz, 2012; Miller & Byers, 2010; 2012; Vencill & Coleman, 2018).

Sexual functioning involves a complex interaction of physiology, sociocultural factors, psychological functioning, and interpersonal relationships (WHO, 2006; 2010). Disruption of one or more of these components can have a negative impact on one's sexual experience and overall sexual health. With regard to the assessment and treatment of sexual functioning

concerns, multiple iterations of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have historically erased or pathologized the sexual activity and functioning of sexual minority individuals. For instance, the Sexual Dysfunction chapter of the *DSM-5* (American Psychiatric Association, 2013) is written from the framework of heterosexual and cisgender sexual health concerns, and does not translate well to the sexual functioning of many sexual minority people (Sungur & Gündüz, 2014; Van Houdenhove et al., 2015). Research focused on the sexual functioning of sexual minority persons is often limited by similar problems, including measurement scales that are heterosexist and cisnormative in nature (Flynn et al., 2017; Peixoto, 2017; Sobecki-Rausch et al., 2017).

Sexual functioning research among bi+ cisgender women, transgender sexual minority persons, sexual minority older adults, and asexual individuals remains in its infancy (Chatterji et al., 2017; Flanders et al., 2017; Fleishman et al., 2019; Vencill et al., 2018; Yule et al., 2017). For gay and bi+ cisgender men, research centers heavily on prostate cancer treatment and resulting sexual functioning concerns, such as erectile dysfunction and sexual pain (Rosser et al., 2016; 2019; Ussher et al., 2016; 2017; 2018). Sexual minority women, especially lesbian women, appear less likely to experience orgasmic dysfunction and difficulties with sexual desire and arousal compared to heterosexual women, although research indicates that they may have comparable rates of genito-pelvic pain (Peixoto, 2017; Peixoto & Nobre, 2015; Sobecki-Rausch et al., 2017). Older adults, including sexual minority older adults, are likely to face age-related changes that can significantly impact their sexual health and functioning. This may include, for example, arthritis or joint pain that can create discomfort during sexual activity, physiologic changes that impact the sexual response cycle, changes to bladder control, and intimacy restrictions in nursing care facilities (Srinivasan et al., 2019). Data on the sexual health needs of

sexual minority older adults remains notably absent in the published scientific literature (Davis & Sokan, 2016; Fleishman et al., 2019; Srinivasan et al., 2019). Asexual individuals typically report little to no interest in partnered sexual activity, although they certainly can and do desire meaningful romantic relationships, and vary widely with regard to sexual fantasy, self-stimulation, and other sexual experiences (Hille et al., 2019; Foster et al., 2019; Rothblum et al., 2020; Yule et al., 2014). Asexuality as an identity has complicated historical *DSM* conceptualizations of sexual desire, with mounting evidence that asexuality represents a unique sexual orientation rather than a sexual dysfunction to be treated (Conley-Fonda & Leisher, 2018; Hinderliter, 2013; Yule et al., 2017).

Sexual minority individuals continue to face negative perceptions and stereotypes about their sexual health and functioning, as well as disproportionate levels of sexual violence. Gay cisgender men and bi+ individuals of all genders have long been stereotyped as hypersexual, promiscuous, and unable to remain faithful in relationships (Bostwick & Hequembourg, 2014; Gleason et al., 2018; Matsick & Rubin, 2018). The sexual behavior of lesbian women is often fetishized or erased (Cohen & Byers, 2014; Peixoto, 2017). Sexual minority people of color often face added levels of stigma and prejudice, due to racialized sexual stereotypes (Calabrese et al., 2018; Rosenthal & Lobel, 2016, 2020; Sung et al., 2015). Compared to heterosexual women, sexual minority women experience significantly higher rates of sexual assault, and may have greater difficulty with post-assault recovery due to reduced social acceptance and support (Canan et al., 2019; Sigurvinsdottir & Ullman, 2016).

HIV prevention efforts for gay and bi+ cisgender men and transgender women have also contributed to stigma (Fitzgerald-Husek et al., 2017; Laing et al., 2015). Mixed findings on the sexual behaviors of bi+ men and subsequent HIV transmission led to a large meta-analysis

(Friedman et al., 2014), which found that men who have sex with both women and men are less likely to be HIV-positive or engage in unprotected sex than men who have sex only with men. This societal-level understanding does not diminish the need for individuals to protect themselves from possible HIV infection, and subgroups of the bi+ population may continue to be at risk of infection (Hoenigl et al., 2016). Refuting harmful stereotypes and providing bi+ clients with accurate, evidence-based sexual health information has been shown to effectively reduce internalized binegativity (Israel et al., 2019).

Sexual health education that is inclusive of sexual orientation diversity remains rare, despite being associated with a number of benefits for sexual minority youth. These include fewer sexual partners and less substance use before having sex, as compared to sexual minority students without inclusive sexual education. Sexual minority-inclusive curricula have also been associated with greater feelings of safety within one's school and less bullying based on sexual orientation and gender expression (Blake et al., 2001; Gegenfurtner & Gebhardt, 2017; Snapp et al., 2015). Several states in the United States do not require sexual health information to be medically accurate and explicitly prohibit teaching sexual and gender minority-related content in schools. Such laws are generally written to apply to sexual health education though are often vague enough to be applied to other areas of school curricula, programs, and activities (SIECUS, 2015). Even in states in which educators are not barred from including health information specific to sexual and gender minority people, this topic is rarely required and not typically included (SIECUS, 2015). In some instances, sexual minority youth living with intellectual and developmental disabilities are excluded from receiving any type of sexual health education (Duke, 2011). Given limited sexual health education in schools, research suggests that online

interventions may be an important adjunctive sexual health resource for sexual minority youth (Mustanski et al., 2015; Widman et al., 2019).

Application. Psychologists strive to acquire basic knowledge about human sexuality, including diversity in sexual functioning, sexual orientation, and sexual behaviors (Buehler, 2016; Foster & Scherrer, 2014). Psychologists strive to be inclusive of all sexual orientations (e.g., bi+, asexual) and consensual practices (e.g., kink/BDSM, abstinence), and take care not to pass judgment regarding the sexual behaviors of sexual minority groups. Because of their roles in consultation, supervision, assessment, prevention, and intervention, psychologists are in a crucial position to raise questions about sexual health and functioning which, depending upon the setting, minimally should include a discussion about sexual satisfaction and pleasure. As sexual health not only involves intrapersonal aspects, but often also relational processes, psychologists strive to address sexual health concerns within all relevant contexts (Cruz et al., 2017).

Psychologists strive to examine their own values and biases regarding human sexuality, sexual minority orientations, and diverse sexual and relationship practices. Additionally, to work effectively with clients presenting with a broad range of sexual health concerns, psychologists should seek ongoing education and, as needed, supervision or peer consultation. Psychologists are encouraged to develop working knowledge about how sexual health and functioning may be impacted by various biopsychosocial factors (e.g., medical conditions, disability, race and ethnicity, religious and cultural beliefs) and, if not capable of providing sexual health-focused care, should have or identify referrals to healthcare providers who can competently provide such services (Vencill & Coleman, 2018).

During clinical assessment activities, psychologists are encouraged to avoid assumptions pertaining to a sexual minority client's sexually transmitted infection (STI) history or status,

including their HIV serostatus. By broaching the subject of sexual health openly, psychologists create an opportunity to offer accurate and potentially preventive educational information on STIs for all clients, as well as to provide support to those who have been or are currently diagnosed with an STI (e.g., encouraging clients to seek or continue medical care). Psychologists endeavor to obtain the requisite information from credible sources (e.g., WHO, SIECUS, Centers for Disease Control and Prevention) to accurately discuss STI prevention strategies with their clients in a culturally affirmative manner. In particular, psychologists strive to be cognizant of how communities of color and various age cohorts may have had unique experiences with the HIV epidemic. For example, many sexual minority persons in the 1980s and 1990s experienced significant loss, including concomitant grief or guilt, due to the AIDS-related deaths of their friends and partners, and may need continued support in the face of these losses (Bristowe et al., 2016).

Given that sexual minority clients, particularly women, are at greater risk of sexual assault, psychologists should be aware of current best practices in trauma-informed care. Psychologists are encouraged to become knowledgeable about social media, online networking sites, and geosocial mobile applications (i.e., smartphone apps) that may be utilized by sexual minority clients and inform their sexual health, behaviors, and practices (Badal et al., 2018; Johnson et al., 2017). Psychologists attempt to remain aware of the impact of sex work and underground economy work, beyond a concern for safety and STIs. Psychologists are encouraged to support sexual minority clients engaged in sex work in accessing medical and mental healthcare that validates their sexual autonomy and involves awareness of the particular experiences (e.g., food or housing insecurity, financial instability, structural racism) that may shape their sexual needs and practices (Bloomquist & Sprankle, 2019; Sprankle et al., 2018).

Psychologists understand that many sexual minority youths do not have access to inclusive sexual health education, and strive to connect youth to resources with accurate and inclusive information about sexual health.

Guideline 11. Psychologists strive to understand sexual minority persons' relationships with their families of origin, as well as their families of choice.

Rationale. The coming-out process (i.e., the practice of revealing of one's sexual minority orientation) can occur at various time points in one's lifespan (e.g., adolescent years, adulthood, older adulthood), and can be met with varying degrees of acceptance or rejection by members of one's family of origin (family in which one was raised in). Coming out to family members can be associated with parent-child conflict, compromised well-being, internalized stigma, emotional distress, suicidality, and poorer overall psychological outcomes for sexual minority persons (Hall, 2017; Needham & Austin, 2010; Pistella et al., 2016; Roe, 2017). In contrast, there are also sexual minority persons who experience affirmation and acceptance from their family members. Family acceptance is associated with lower risk of substance use and abuse, depression, risky sexual behaviors, and suicidal behavior (Bouris et al., 2010; Hall, 2017; Institute of Medicine, 2011; Katz-Wise et al., 2017; Ryan et al., 2010; Snapp et al., 2015), and higher rates of self-esteem (Roe, 2017).

In some cases, family acceptance or rejection may be nuanced by factors associated with race and ethnicity (Gattamorta & Quidley-Rodriguez, 2018; Greene, 2008; Pastrana, 2015; Potoczniak et al., 2009). Cultural significance of family involvement, as well as gender role expectations, could all contribute to whether and how families accept one's sexual minority orientation (Bates, 2010; Pastrana, 2015). Family religious beliefs also play a significant role in

the lives of sexual minority persons (Bridges et al., 2019; Roe, 2017). For instance, Bridges and colleagues (2019) found that religiosity and church attendance were associated with lower levels of acceptance of a family member's sexual minority orientation. Sexual minority persons who also identify as persons of color, and who come from religious backgrounds, may find it more difficult to come out due to perceived and real issues of discrimination, rejection and further marginalization from both their families of origin and their ethnic/racial communities (Bates, 2010)

Sexual minority youth, adults, and older adults may create their own families of choice or chosen family in response to rejection from their family of origin and community or because of shared common experiences that arise from their marginalized status (Connolly, 2005; Fredriksen-Goldsen et al., 2014; Lytle et al., 2014). Families of choice often include non-biological relationships, including other sexual and gender minority friends and allies, as well as romantic partners. Often, chosen families provide significant social and emotional support for sexual minority persons, and in some instances constitute intimate connections that resemble biological family connection (Hammack et al., 2019; Levitt et al., 2015).

Although religion may serve as a possible risk factor in the coming-out process when there are lower levels of family acceptance (e.g., Bridges et al., 2019), there is also evidence that religion may serve as a protective factor when sexual minority people participate in congregations that are affirming of sexual minority persons (Boppana & Gross, 2019; Gattis et al., 2014; Hamblin & Gross, 2013). Therefore, participation in religious organizations may provide additional sources of social support, acceptance, and family of choice that may be protective against the development of psychological problems.

Sexual minority youth are overrepresented in the foster care system and are more likely to be rejected by families of origin, run away from home because of abuse, and experience homelessness (Fish et al., 2019). Sexual minority youth in foster care may be at more risk of developing depressive and anxiety disorders, and engaging in risky behaviors because of their status as sexual minority persons, rejection or distance from their biological families, and the stigma associated with being in foster care (Gallegos et al., 2011). Some may seek to create families of choice within their out-of-home placements (Gallegos et al., 2011; Mallon & Woronoff, 2006) as well as with supportive adults in their school environments (Resnick, 2006). Additionally, some sexual minority youth may create additional families of choice within youth organizations (Gamarel et al., 2014). For example, some may participate in activities that are geared toward sexual minority youth, which may create a sense of community and emotional and psychological support (Resnick, 2006). Some sexual minority youth, particularly Black young men who have sex with men, may also form families of choice within House Ball communities (Kubicek et al., 2013; Telander et al., 2017; Wong et al., 2014). These youth may have experienced rejection from their family of origin and come to redefine family through the development of "…close familial-type networks within their House structure" (Kubicek et al., 2013, p. 1537).

Sexual minority persons encounter unique family issues and concerns as they age into older adulthood. For instance, they may maintain relationships with former spouses, children from previous partnerships or marriages, and establish new relational bonds with grandchildren. They may navigate these familial dynamics, while simultaneously nurturing new relationships with their families of choice. Older and aging sexual minority adults also are at risk of isolation,

stigma, and discrimination (Rogers et al., 2014), and may experience estrangement or rejection from their family of origin in their later years (Putney et al., 2019).

Massini and Barrett (2009) found that older sexual minority adults who received support from their family of choice reported lower instances of depression, anxiety, and internalized heterosexism when compared to those who received care from biological family members. Croghan et al. (2014) found that sexual minority older adults were more likely to either be a caregiver, or, more likely to have a caregiver who they were not biologically or legally related to when compared to their heterosexual counterparts. As such, some older sexual minorities may find themselves seeking long-term care in residential facilities. In those facilities, sexual minority older adults may face additional difficulties including apprehension about possible discrimination, rejection by assisted living staff and heterosexual residents, fears about being forced back into the closet (Stein & Beckerman, 2010) and poor-quality care from staff and program administrators (Putney et al., 2019; Sullivan, 2014).

Application. Psychologists do not urge or pressure sexual minority clients to disclose their sexual minority identities to their families, friends, or loved ones (Legate et al., 2012). Instead, they empower and respect a sexual minority client's decision to disclose (or not disclose) their sexual minority identities. Psychologists understand that sexual minority persons might not disclose their sexual minority orientation to family members or friends in order to minimize interpersonal rejection, threat, or violence. Psychologists also take the time to understand intersecting cultural contexts (e.g., race, ethnicity, gender, religion, disability status) that may influence factors associated with sexual minority identity disclosure.

Sexual minority persons engage in a wide array of family and close relationships across their lifespan. Diverse family and intimate arrangements may include family of origin, blended

family, and chosen family structures. Many sexual minority individuals establish a chosen family network, often to mitigate the effects of alienation by biologically or legally related family members and to develop sources of social support (Lee & Quam, 2013; Oswald, 2002; Sheff, 2011). Psychologists strive to recognize the importance of families of choice, especially with sexual minorities whose families of origin may have been rejecting, unsupportive or not affirming of their sexual minority identities. As families of choice may serve to counter experiences of discrimination and marginalization, and mitigate psychological distress, psychologists may wish to inquire about significant friendships and connections that may not be based on biological ties. Some examples of those considered members of an individual's family of choice may include sexual minority role models, advisors, mentors, and other allies. Psychologists recognize that some sexual minority persons may choose to continue to have close relationships with family members who are less accepting or affirming. Psychologists create room to explore these complex relationships if they emerge in the context of counseling and psychotherapy.

Given the associations between family and religion (Bridges et al., 2019; Roe, 2017), psychologists consider exploring the role and function of religion, spirituality, family history, and family dynamics in the lives of their sexual minority clients. Psychologists also understand that participation in sexual minority-affirmative churches may serve as a protective factor in the prevention of psychological distress (Boppana & Gross, 2019; Gattis et al., 2014; Hamblin & Gross, 2013), and thus, do not shy away from exploring or discussing the role of religion and spirituality in the lives of their sexual minority clients.

Guideline 12. Psychologists strive to understand the experiences, challenges, and strengths faced by sexual minority parents and their children.

Rationale. As of 2016, there were more than 700,000 cohabitating same-sex couples, with an estimated 114,000 raising children (Goldberg & Conron, 2018). These figures are likely an underestimation of the total number of sexual minority parents in the United States, given that asexual, bi+ persons in different-sex partnerships, polyamorous parents who choose to raise children with more than two parents, and single sexual minority parents are not included in these numbers. The experience of sexual minority grandparents is also often overlooked (Fruhauf et al., 2019). Despite sexual minority parenting becoming a common practice and consistent research outcomes demonstrating positive adjustment of their children, parenting by sexual minority persons continues to receive scrutiny (Fedewa et al., 2015). For instance, controversy often focuses on the developmental and psychological outcomes of children (Patterson, 2017). Dominant cultural discourse on family frequently de-centers and de-legitimizes sexual minority persons as parents, subsequently reinforcing heteronormative narratives around family and parenthood (Fish & Russell, 2018).

Although the academic literature on sexual minority parents often focuses on highly educated, White, high SES, urban-dwelling parents and their families (Holman, 2018; Moore, 2011; van-Eeden et al., 2018; Wright & Wallace, 2016), sexual minority parents represent diverse races, ethnicities, religions, geography, education, and SES (Calzo et al., 2019). Indeed, sexual minority parents are a diverse and heterogeneous group that exists across the lifespan, including sexual minority grandparents (Allen & Lavender-Stott, 2020). High rates of parenting exist among sexual minority people of color. Among sexual minority communities, Black, Indigenous, and Latinx people are most likely to be raising children (Brainer et al., 2020). Sexual

minority parents are also more likely to be interracial couples and more likely to create multiracial families (Kastanis & Wilson, 2014).

Sexual minority persons become parents through varied pathways, including private domestic or international adoption, fostering publicly (via child welfare), in the context of a previous or current different-sex relationship(s), through assisted reproductive technologies such as use of donor sperm or eggs, or surrogacy (Goldberg, 2010). However, such parenting pathways are notably shaped by racially unjust systems (e.g., economic, social, legal) and impact the opportunities available to parents of color (Brainer et al., 2020).

The process of building families for sexual minority parents often includes navigation of non-biological relatedness (e.g., adoption stigma, bionormativity) and kinship care. Although this is similar to non-biologically-related families with heterosexual parents, sexual minority parents must navigate an additional layer of complexity by doing so in a heteronormative context (Davies, 2020). Like their heterosexual counterparts, sexual minority parents of color are likely to be involved in the multigenerational, extended family, and kinship care networks that are common among communities of color (Brainer et al., 2020). These parents may also be providing financial, emotional, and logistical support to extended family and/or other children within their racial community. For example, Black sexual minority parents are twice as likely to be parenting a non-biological and/or non-legally connected child, including children of relatives (Moore & Stambolis-Ruhstorfer, 2013). Such family arrangements are rarely included in research that often narrowly defines parenthood in ways that are Eurocentric.

Children of sexual minority and heterosexual parents are similarly well adjusted (Calzo et al., 2019; Farr, 2017; Fedewa et al., 2015; Patterson, 2017). There are few differences in developmental, social, and psychological outcomes between children raised by sexual minority

parents and those raised by heterosexual parents (Calzo et al., 2019; Farr, 2017; Fedewa et al., 2015; Gartrell et al., 2018). Although research has failed to identify any disadvantages to children raised by sexual minority parents, there are certain unique strengths of these families (Miller et al., 2017). Children raised by sexual minority parents may have lower levels of internalizing (e.g., depression, anxiety) and externalizing (e.g., aggression, hostility) symptoms, and higher social and academic competence compared to their counterparts raised by heterosexual parents (Gartrell & Bos, 2010; Gartrell et al., 2018; Green et al., 2019; Golombok & Badger, 2009; Miller et al., 2017). These outcomes are hypothesized to be due, in part, to primarily surveying sexual minority parents with greater economic and social resources and privilege—a confound in research design but a reflection of the resources that it takes for some sexual minority persons to become parents. Other strengths of children belonging to sexual minority parents include less gender-stereotyped play (Goldberg et al., 2012) and gender attitudes (Sutfin et al., 2008), allowing children less hindrance by traditional gender expectations and more flexibility to explore a greater array of interests. Such flexibility in gender and sex roles benefits all children and adults, regardless of sexual orientation or family structure, because socialization of rigid traditional gender roles limits development (Eisenberg et al., 1996).

Sexual minority parents who create families in the context of a same-sex relationship may also demonstrate more preparedness for parenthood as a result of often requiring extensive and purposeful planning to create a family, as well as anticipating, planning, and managing stigma and scrutiny directed at sexual minority parents (Goldberg et al., 2012; Miller et al., 2017). Experiences of stigma and discrimination, as well as institutionalized and structural stigma, remain common for sexual minority parents and their children (e.g., remaining legal barriers to foster care and adoption in certain states, conscience clauses; NCLR, 2019). Sexual

minority parents may experience less support from families of origin (Sumontha et al., 2016) and in the workplace (Holman, 2018). Like others, sexual minority parents and their children fare better when they have greater access to supportive resources and live in affirming environments (Farr et al., 2019).

After reaching the milestone of parenthood, sexual minority parents continue to face unique stressors. "Conscience laws" allow for the denial of services by both institutions and individual providers based on "strictly held beliefs" resulting in "religious or conscience" objection (Anastas, 2013). Conscience clauses are still prevalent throughout the United States and impact sexual minority parents in multiple ways (Kazyak et al., 2018). Such exemptions leave all sexual minority persons vulnerable to discrimination, but are particularly problematic and relevant for sexual minority individuals wishing to become parents, given the need to interact with medical providers and agencies when engaging in surrogacy, egg or sperm donation, or adoption agencies. In at least nine states, private adoption agencies are protected by conscience clauses that legally allow agencies to refuse to place children in homes with sexual minority parents solely due to their sexual orientation (NCLR, 2019).

In conjunction with stigma and discrimination based on sexual orientation, sexual minority persons who engage in diverse types of relationships may also experience stigma unique to their relationship arrangement. For example, individuals with chosen family members or romantic partners with whom they have no legally recognized relationship may experience barriers to participating in childcare and healthcare decisions (Stinchcombe et al., 2017). Sexual minority persons in consensual non-monogamous relationships raising children commonly experience microaggressions intended to question the legitimacy of their family or relationship arrangement (Haines et al., 2018; Schechinger et al., 2018). People in consensual non-

monogamous relationships (regardless of gender or sexual orientation) are perceived as possessing low relationship quality (e.g., trust, satisfaction, commitment) and being harmful to children compared to people engaged in monogamous relationships (Hutzler et al., 2016; Moors et al., 2013). Children raised in families with parents who are involved in consensually monogamous relationships appear to fare no better or worse than children in monogamous relationships (Pallotta-Chiarolli, 2010; Sheff, 2011; 2015). Relatedly, Sheff (2015) suggests that children with parents engaged in consensual non-monogamy may benefit from having additional parental or familial figures to offer support and resources.

Despite the additional challenges sexual minority parents navigate, positive outcomes for children indicate that sexual minority parents engage in successful parenting practices in preparing children to navigate stigma and discrimination. Similar to ways in which racial and ethnic minority parents prepare their children for encountering racism and racially-based discrimination as part of familial racial socialization practices, sexual minority parents promote resilience by socializing their children to anticipate and manage heterosexism and homonegativity (Battalen et al., 2019; Goldberg et al., 2016; Oakley et al., 2017; Ollen & Goldberg, 2015; Prendergast & MacPhee, 2018).

The method of family building used impacts subsequent legal challenges of sexual minority parents (Farr & Goldberg, 2018; Goldberg, 2019). For example, with regard to surrogacy, newer laws restrict citizenship of children born abroad (e.g., through surrogacy), necessarily leaving some sexual minority parents legally vulnerable (NCLR, 2019). For couples utilizing assisted reproductive technology (e.g., sperm or egg donors where one parent is biologically related to the child), in some states, a non-biological (or “second”) parent is not automatically considered a legal parent (Maxwell & Kelsey, 2014). This means the second

parent has no legal rights to the child until a second parent or stepparent adoption is completed, leaving many parents in legal limbo until such processes can be completed. Biological and legal connections (or lack thereof) can have profound implications for couples who separate (Kim & Stein, 2018). Additionally, sexual minority parents seeking to adopt internationally face a common preference to place children with married heterosexual couples and often must have one partner pose as a single heterosexual parent (Farr & Grotevant, 2019). Further, sexual minority parents of color may face additional legal stressors and challenges if involved with the courts system, given the additional hurdle of systemic racism. The immigration system in the United States continues to be a source of oppression for sexual minority parents and their children. For example, a child of a same-sex binational couple who is not biologically related to their U.S. citizen father has been denied citizenship by the U.S. government (Adams, 2019). In addition to these legal vulnerabilities, sexual minority parents must manage decisions and dynamics related to how their families were created. For example, families formed through assisted reproductive technology (e.g., sperm and egg donors) or adoption must navigate complex issues related to disclosure of donor identification and birth family (Farr & Grotevant, 2019) or donor contact (Golombok, 2013), regardless of parent sexual orientation. Other notable concerns specific to sexual minority parents include heterosexist and homonegative reactions from pediatricians, daycare providers, school personnel, and others who may interact with the child directly or through the parents (Goldberg, 2010).

Application. Psychologists strive to recognize the multitude of ways that sexual minority persons become parents, including through sex with a different-sex partner. Given that some sexual minority persons may be in mixed-orientation relationship structures (e.g., a bi+ woman partnered with a heterosexual man), psychologists should not assume that parents in different-sex

partnerships are heterosexual. Relatedly, psychologists should not assume that all sexual minority persons desire to pursue parenthood.

Psychologists attempt to recognize that sexual minority parents may be "invisible," since sexual minority persons in mixed-orientation relationships (e.g., bi+ individuals) are often regarded as heterosexual. Other sexual minority groups may also be less visible, such as sexual minority parents living in non-metropolitan areas, sexual minority parents of color, asexual parents, single sexual minority parents, sexual minority parents with disabilities, and those with other intersecting minority identities. Psychologists are encouraged to examine the various facets of identity (e.g., race and ethnicity, culture, socioeconomic class, disability, age, religious or spiritual traditions) that intersect in creating the experiences of sexual minority parents.

Psychologists strive to recognize the challenges faced by sexual minority parents and are encouraged to explore these issues with their clients. Psychologists recognize the stress that parents in diverse family arrangements (e.g., multiple co-parents) may endure, especially around visibility management and disclosure. For instance, parents in mixed orientation and consensually non-monogamous relationships have to decide when, how, and if to come out to their children, knowing that being out may subject them or their children to discrimination. At the same time, psychologists are urged to recognize and celebrate the resilience of families with sexual minority parents. Psychologists endeavor to highlight sexual minority parents' strengths and build upon these factors to bolster resilience across family members.

Psychologists strive to recognize the impact of discrimination in any matter of adoption, child custody and visitation, foster care, and reproductive health services. Although bias and misinformation continue to exist in the educational, legal, and social welfare systems, psychologists also are encouraged to correct this misinformation in their work with parents,

children, community organizations, and institutions and to provide accurate information based upon scientifically and professionally derived knowledge. Where appropriate, psychologists may work with policy makers to develop policies that reduce stigma and discrimination. When working with sexual minority parents, psychologists should consider the impact of everyday discrimination coupled with legal and structural inequalities and make efforts to help sexual minority parents navigate these biased societal systems.

Education and Vocational Issues

Guideline 13. Psychologists strive to understand the educational and school system experiences that impact sexual minority students in K-12 and college/university settings.

Rationale. Schools and educational systems are often hostile environments where sexual minority students feel unsafe and threatened. Research shows that sexual minority students in K-12 settings are victimized in schools at disproportionate rates as a result of their actual or perceived sexual identity or gender expression (Espelage et al., 2017; Kann et al., 2016; Kosciw et al., 2018; National Association of School Psychologists [NASP], 2017; Tucker et al., 2016). According to GLSEN's latest national climate survey, approximately 95% of sexual minority K-12 students reported hearing expressions such as "dyke" and "faggot" (Kosciw et al., 2018). Students also reported experiencing verbal harassment, being physically or sexually harassed, and being assaulted (Kosciw et al., 2018). When compared to their heterosexual counterparts, sexual minority high school students reported higher levels of violence and bullying, sexual assault, sexual and physical dating violence, in-person bullying, and online bullying (Kann et al., 2016). Further, over 40% of these students reported considering suicide and approximately 30% reported attempting suicide in the last year (Kann et al., 2016). It is not surprising that schools

that enact and enforce anti-harassment and anti-bullying policies protecting sexual minority youth are the schools where students report the lowest rates of bullying and victimization (Kosciw et al., 2012).

In addition to being victimized in person at school, sexual minority youth are also victims of cyberbullying, a form of aggression performed through the use of digital media or technology with the goal of inflicting harm in a person or a group of peoples (e.g., Hinduja & Patchin 2014; Pham & Adesman 2015). Sexual minority youth report cyberbullying at higher rates than their heterosexual counterparts (Abreu & Kenny, 2017; Hatchel et al., 2017; Kann et al., 2016). Hostile school climates have a significant negative impact on sexual minority students' mental health and academic performance (Abreu & Kenny, 2017; Espelage et al., 2017; Kosciw et al., 2018; Poteat et al., 2017). For example, sexual minority students who are victimized in schools have poorer academic-related outcomes (e.g., achieve lower grade point averages, have higher absenteeism, withdraw from involvement in extracurricular activities, and are twice as likely to report not planning to pursue post-secondary education; Kosciw et al., 2015) as well as have poorer mental health outcomes (e.g., report lower self-esteem, more hopelessness, and increased rates of suicidal ideation and suicide attempts; Abreu & Kenny, 2017; Kann et al., 2016; Kosciw et al., 2018).

Scholarship about the experiences of sexual minority youth in schools has documented the difficult experiences of sexual minority students who share other vulnerable intersecting identities such as minority race and ethnicity, low SES, disability (e.g., intellectual, developmental, physical, and mobility related), certain geographical locations (e.g., rural communities), and nonbinary or transgender identities (Abreu & Kenny, 2017; Duke, 2011; Kosciw et al., 2018). According to GLSEN's 2018 climate survey, Black/African American

sexual minority students were more likely to experience out-of-school suspension or expulsion than White students and other sexual minority students of color. Further, Arab/Middle Eastern sexual minority students were more likely than their Hispanic/Latinx, Multiracial, Native American, and White counterparts to feel unsafe due to their racial/ethnic identity (GLSEN, 2018). In addition, sexual minority students from rural areas report greater rates of victimization and lack of anti-LGBTQ school policies (Kosciw et al., 2018).

Public campaigns (Hatzenbuehler et al., 2019), commitment of national organizations (e.g., NASP, APA; Anhalt et al., 2016), and school policies affirming of sexual and gender diversity are important for the well-being of sexual minority students (Day et al., 2019). Although some recent national and state policies have been put in place to protect sexual minority youth (e.g., state laws banning sexual orientation change efforts), there are still laws and policies in schools that continue to promote oppressions and put at risk the well-being of sexual minority youth in schools (Barrett & Bound, 2015; Kull et al., 2015; GLSEN, 2018; Russell et al., 2016). For example, as of 2018, approximately 10 million public school students are affected as a result of laws forbidding the inclusion of diverse sexualities across several states (e.g., Alabama, Arizona, Louisiana, Mississippi, Oklahoma, South Carolina, and Texas; GLSEN, 2018). These laws either direct schools to take a neutral position about sexual minority orientations or entirely prohibit discussions about health and sexuality that promote the well-being of sexual minority students. According to GLSEN, sexual minority students who attend public school in states that have these laws face more hostility, have less access to inclusive curricula, have less access to inclusive school clubs such as Gender and Sexualities Alliance (GSA), have less access to health resources, and feel less supported by educators, among other negative outcomes (GLSEN, 2018). Research also shows that these students do not always feel

supported by school staff (e.g., teachers, counselors, administrators) and often do not report incidents of bullying and harassment because they do not trust that school personnel will intervene, fear that they will be blamed or asked to change their behavior, and their sexual identity will be outed (Abreu & Kenny, 2017; Kosciw et al., 2018).

Schools also have the potential to serve as a protective factor, helping to buffer against bullying and the consequences of bullying toward sexual minority students (Dessel et al., 2017; Espelage et al., 2018; Johns et al., 2019). The presence of school-based extracurricular groups fostering social support for sexual minority students not only function as a source of explicit support for sexual minority students, but also serve to foster school-wide cultural competence in sexual and gender diversity (Baams et al., 2018; Ioverno et al., 2016; Marx & Kettrey, 2016; Poteat et al., 2017). Such groups are associated with lower levels of harassment and bullying, higher levels of school belonging, lower emotional distress, higher perceived safety at school (Goodenow et al., 2006; Heck et al., 2011; Kosciw, 2004), as well as reduced drug use (Heck et al., 2014).

Sexual minority students have negative experiences related to their identities while studying at colleges and universities in the United States (Greathouse et al., 2018; Miller et al., 2017; Moran et al., 2018; Pitcher et al., 2018; Rankin et al., 2019; Sevecke et al., 2015). In an analysis of seven national studies across the United States, findings revealed that sexual minority college students were more likely than their heterosexual counterparts to take leave from school for at least one semester and submit work late due to lack of belonging to their college or university community (Rankin et al., 2019). Also, compared to their heterosexual counterparts, sexual minority college students reported below average emotional health, feeling isolated on campus, engaging in self-injurious behavior in the last year, and suicidal ideation. In addition,

sexual minority college students reported higher rates of depression, drug use, and discrimination than their heterosexual counterparts (Rankin et al., 2019). These negative experiences and outcomes may be worse for sexual minority college students who share other oppressed identities (e.g., racial, ethnicity, international students). For example, sexual minority international students attending U.S. colleges and universities often feel excluded and experience difficulties accessing culturally appropriate services within their campus and the surrounding community (Nguyen et al., 2017; Oba & Pope, 2013). It should be noted that most of the available research about the experiences of sexual minority students in educational settings focuses on K-12, with less attention geared toward sexual minority students in college/university settings.

Application. Interventions aimed at targeting bullying are not effective without specific considerations for protecting sexual minority students from bullying and aggression in schools (Kull et al., 2015). Psychologists working in schools are encouraged to establish and deliver school-wide interventions to target homonegative bullying and victimization (Abreu & Kenny, 2017; Espelage et al., 2018). Psychologists working in schools are encouraged to contribute to developing interventions that target students' aggressive behaviors toward sexual minority students (e.g., Espelage et al., 2015), including peer-led programs (e.g., Palladino et al., 2016). Psychologists also want to consider programs that train teachers and other school personnel on how to intervene when homonegative aggression is taking place (e.g., Stonewall, 2011), and parent-school collaborations (e.g., educating parents about the dangers of cyberbullying; Abreu & Kenny, 2017; Schneider et al., 2015). Where appropriate, psychologists may consult with school personnel on inclusive curricula, affirming policies, and access to services (mental health, behavioral, or educational) that affirm sexual minority students.

Psychologists acknowledge and strive to work toward making systemic impact by educating themselves, students, school personnel, parents, and other stakeholders about the negative consequences of laws prohibiting the inclusion of sexual diversity among sexual minority youth. Given research about the importance of involving parents in reducing bullying (e.g., Simmons & Bynum 2014), psychologists strive to provide psychoeducation and other direct services (e.g., family therapy) in order to create a safe environment for sexual minority youth beyond the school setting. Psychologists recognize the importance of engaging in interdisciplinary work with other professionals (e.g., administrators, public health workers, nurses) to promote the well-being of sexual minority students at an individual, local, state-wide, and national level. Psychologists are advised to recognize that no two students are the same and actively acknowledge and consider the importance of intersectionality (e.g., being a Black sexual minority student) when creating and delivering interventions at the school, community, and national level. Also, psychologists strive to help sexual minority youth explore their identities, as well as feelings and thoughts associated with their identities. Psychologists endeavor to empower and respect sexual minority students' decision-making process in disclosing (or not disclosing) their identities (e.g., coming out).

Psychologists are encouraged to advocate on behalf of sexual minority students by providing support for more inclusive school policies and resources, as well as enforcing anti-harassment and anti-bullying. Psychologists can consider functioning as allies to sexual minority students and set examples for the entire school to emphasize the negative consequences of harassment and bullying. Psychologists working in schools endeavor to train teachers, professors, student personnel staff, and administrators to make changes in the curriculum to weave topics of sexual and gender diversity into other lessons such as history, diversity, and civil

rights in an effort to increase school-wide dialogue on topics pertinent to sexual orientation. School environments that are characterized by positive comments about and portrayals of diverse sexual identities go beyond just protecting sexual minority students to also nurture them to facilitate a sense of comfort and belonging (McCabe, 2014). If no GSA or other school-based group exists, psychologists working in school settings consider starting one. If one does exist, psychologists are encouraged to take an active role as an ally and advocate by serving in a formal role (e.g., advisor).

Psychologists working at colleges and universities are encouraged to provide psychological services through already established systems within their colleges or universities (e.g., counseling centers) and strive to facilitate more inclusive policies across different aspects of on-campus life including housing and athletics, among others. Psychologists look to connect sexual minority studies with campus resources (e.g., LGBTQ resource centers, multicultural centers), as well as community resources when these students' needs are not met on campus or as additional sources of support. Also, psychologists are aware of the extra layers of stress experienced by sexual minority students who share other oppressed identities experience and strive to provide services, or connect these students to services, that take an intersectional approach.

Guideline 14. Psychologists strive to understand career development and workplace issues for sexual minority persons.

Rationale. Factors associated with having diverse sexual minority orientations could influence or restrict various career choices, interests, aspirations, decision making, and other career development-related processes across the lifespan for sexual minority persons (Fisher et al., 2011; Lyons et al., 2010; Schmidt & Nilsson, 2006; Winderman et al., 2018). Perceived

discrimination, sexual minority stress, and decreased perceptions of social support correspond with difficulties in career decision-making and vocational maturity among sexual minority youth, adolescents, and young adult (Lyons et al., 2010; Schmidt et al., 2011; Schmidt & Nilsson, 2006; Winderman et al., 2018). Sexual minority youth and young adults are at risk for not completing high school or post-secondary education as a result of stigma and sexual minority stressors (Kosciw et al., 2015), impacting their long-term career possibilities. Alternatively, encouragement and support from family and friends lead to higher career aspirations among sexual minority women (Fisher et al., 2011).

Sexual minority persons encounter high rates of distal stressors (e.g., harassment, discrimination, microaggressions) when navigating the workforce throughout adulthood. Distal stressors hinder their capacity to attain work, address occupational constraints (e.g., coping with workplace stressors), and earn sustainable income (Douglass et al., 2017; Resnick & Galupo, 2018; Velez & Moradi, 2012). Sexual minority adults and older adults report significantly higher lifetime rates of job discrimination, being fired, denied employment, denied job promotions, and they more frequently report receiving negative job evaluations from employers when compared to cisgender, heterosexual persons (Fredriksen-Goldsen et al., 2017; Harley & Teaster, 2016; Meyer, 2019; Sears & Mallory, 2011). Additionally, sexual minority persons living in rural areas experience more employment discrimination than those who live in urban areas (Swank et al., 2013).

Sexual minority persons are socioeconomically diverse, and some may experience a variety of socioeconomic inequities despite the inaccurate myth that sexual minority persons are affluent (McGarrity, 2014). Poverty rates are collectively higher among sexual minority adults than their cisgender, heterosexual counterparts, threatening the economic well-being of sexual

minority persons in and out of the workforce (Badgett et al., 2019). Additional disparities exist when race is examined within sexual minority communities. For instance, Badgett et al. (2019) found that cisgender, Black and Latinx sexual minority women and men have higher poverty rates than cisgender, White sexual minority women and men. Sexual minority women also struggle with the burden of higher unemployment rates, and are more likely to receive public assistance (e.g., welfare payment or food stamps) when compared to heterosexual women (Conron et al., 2018). Similarly, sexual minority men are more likely to report lower income levels and financial hardships when compared to heterosexual men of comparable educational levels (Conron et al., 2018; McGarrity, 2014).

Further, some sexual minority persons may continue to work past the age of retirement. This may be the result of not accumulating enough financial resources due to workplace discrimination, or being denied a surviving spouse's pension (Choi & Meyer, 2016; Harley & Teaster, 2016; Fredriksen-Goldsen et al., 2017). Other identity-related factors, including chronic illness, disability, race, gender, and socioeconomic status intersect with the workplace experiences and career development trajectories of sexual minority persons (Badgett et al., 2019; Dispenza et al., 2019; Harley & Teaster, 2016; Harris, 2014). These identities nuance the experiences of discrimination, marginalization, and stress for sexual minority persons across their career trajectory and in the workforce.

Sexual minority persons also contend with proximal minority stressors as part of their career development and vocational trajectory, including internalized heterosexism, expectations of stigma, and identity concealment (Winderman et al., 2018). Proximal minority stressors negatively interfere with job and career satisfaction (Tatum, 2018), sexual identity management strategies (Velez et al., 2013), work-life interface for dual-earner couples (Dispenza et al., 2016;

Goldberg & Smith, 2013; Williamson et al., 2017), and increase psychological distress for sexual minority persons in the workplace (Corrington et al., 2018; Velez et al., 2013). Alternatively, results from a meta-analysis indicated that formal policies and practices, supportive workplace climate, and supportive interpersonal workplace relationships were significantly associated with workplace attitudes (e.g., job satisfaction and organizational commitment), psychological strain (e.g., anxiety, depression, and emotional exhaustion), disclosure of sexual minority identity, and perceived discrimination for sexual minority adults (Webster et al., 2018).

Sexual minority working adults may be more likely to disclose (whether implicitly or explicitly) their identities when they perceive the workplace environment to be more affirming of sexual minority individuals (Tatum, 2018; Webster et al., 2017). This is especially important for persons who identify as bi+, as their identities are less apparent in the workplace, and they may feel less supported or affirmed by colleagues (Corrington et al., 2018). In some instances, bi+ persons are less likely to disclose their identity at work when they perceive non-affirmative attitudes from heterosexual, gay, and lesbian coworkers (Arena & Jones, 2017). Asexual persons may also encounter workplace environment concerns, but no research to date has examined the career development and vocational-related experiences of asexual persons.

Legislative and organizational policies influence the work-lives of sexual minority persons. Sexual minority persons have not been historically protected in certain ways by legislation in the United States, as a majority of states did not have policies that prohibited employment-related discrimination on the basis of sexual orientation. In June 2020, the U.S. Supreme Court ruled that sexual and gender minority persons were protected under Title VII of the Civil Rights Act of 1964. Under this ruling, sexual and gender minority persons cannot be fired from the workplace on the basis of their sexual orientation, gender identity, or gender

expression. Additionally, corporate organizations in the United States that provide supportive workplace policies toward sexual minority persons benefit from increased financial profitability and work productivity when compared to organizations that do not provide supportive policies (Pichler et al., 2018). Supportive workplace policies also are associated with lower ratings of workplace harassment, lower feelings of isolation, and higher ratings of wellness at work among sexual minority persons (Lloren & Parini, 2017). Relatedly, countries that offer more legislative rights and recognition to sexual minority persons report significantly higher per capita global domestic product, benefitting their economies by being more inclusive of sexual minority persons in the workforce (Badgett et al., 2019).

Application. Psychologists understand that sexual minority persons may anticipate stigma and minority stress as barriers throughout the length of their career trajectory (Parnell et al., 2012). Psychologists are encouraged to assess how distal and proximal minority stressors impact one's vocational interests and values, employment and career prospects, ability to make career decisions, work-life interface concerns, and capacity to cope with employment-related barriers across the lifespan (Dispenza et al., 2016; Lyons et al., 2010; Parnell et al., 2012; Schmidt et al., 2011). Psychologists are especially encouraged to assess instances of perceived and actual workplace discrimination, experiences of marginalization throughout a person's career trajectory, and the impact that these experiences have had on work functioning, satisfaction, and mental health (Velez et al., 2013; Velez et al., 2018). Psychologists look to understand how these experiences impact results on career-related assessments (e.g., assessments of vocational interest, values, personality, and skills to suggest a few; see Swanson, 2020).

As a result of their evaluation, psychologists may find it beneficial to help clients increase their use of social supports, help youth and young adults identify positive sexual

minority role models, enhance adaptive coping strategies and self-esteem, and further bolster empowerment and resilience strategies when providing vocational-based interventions (e.g., career counseling or psychotherapy; Dispenza et al., 2019; Tatum, 2018; Velez et al., 2018). Psychologists factor in the contextual role that socioeconomic status has on career development and work when providing services to sexual minority persons. Additionally, psychologists consider how to best assist older sexual minority adults transition out of the workplace and into retirement as part of the career development trajectory.

Psychologists also attempt to advocate for organizational and policy changes that help reduce and ideally eliminate discrimination and oppression rooted in ableism, ageism, cisgenderism, classism, heterosexism, racism, and sexism (Dispenza et al., 2019; Douglass et al., 2017; Velez et al., 2018). Psychologists consider utilizing psychological consultation with firms, organizations, and places of employment to help raise critical consciousness around workplace issues and environments (Velez et al., 2018). Psychologists consider how to incorporate policies that promote inclusion and affirmation of culturally diverse sexual minority persons in the workplace (Pichler et al., 2018; Tatum, 2018). Psychologists consider helping organizations develop means and strategies of assessing workplace climate for heterosexism and other forms of prejudice. In doing so, psychologists consider assessing for workplace contextual supports that may help contribute to productive and positive work environments (Webster et al., 2017).

Professional Education, Training, and Research

Guideline 15. Psychologists strive to educate themselves and others on psychological issues relevant to sexual minority persons, and to utilize that knowledge to improve training programs and educational systems.

Rationale. Becoming competent at psychological practice with members of any sociocultural group is a lifelong process that requires continued self-reflection, education, professional development, supervision, and consultation. There has been increased attention to sexual orientation-related topics, including the content and climate of training programs (at the doctoral, internship, and postdoctoral levels), as well as the requisite knowledge and skills that psychology trainees and practicing psychologists need to interact sensitively and competently with others (Burnes & Stanley, 2017). At present, the field of professional and applied psychology lacks evidence-based educational practices needed to ensure that the requisite knowledge and skills for working with sexual minority clients are imparted effectively (Moss-Racusin et al., 2014). Most psychologists are heterosexual (Callahan et al., 2018; Newell et al., 2010), and training more sexual minority psychologists will be an important way to shape the field. It is important to keep in mind that sexual minority psychologists have unique training needs when working with sexual minority clients, since a shared identity is not necessarily a proxy for competence (Pantalone et al., 2019).

Curricular elements broadly related to diversity are required for training programs accredited by the Commission on Accreditation of APA (APA, 2015c). Cognate data from other health professions, including counseling (Graham et al., 2012), social work (Logie et al., 2007), and nursing (Strong & Folse, 2015) suggests the need for more content and skills-based curricular elements. In psychology training, inclusion of content related to assessment and intervention with sexual minority persons is lacking. Without published research in this area, it is impossible to accurately portray the state of the curricular offerings. A likely result of this training omission is that many psychologists lack basic scientific knowledge and comfort in

addressing the unique sociocultural context and life experiences of sexual minority clients, let alone a more advanced understanding of intersectionality or within-group diversity of sexual minority communities.

Failure to include sexual minority-relevant content in training settings has implications beyond simply the ability of trainees—and, later, the psychologists they become—to work competently with sexual minority persons. Absent training in this area may lead psychologists to perpetuate, rather than attenuate, identity-related health disparities facing vulnerable sexual minority clients by perpetrating harmful stereotypes (Alessi et al., 2015). Exclusion of sexual minority-focused training content may imply to trainees that those identities are invalid or not valued, and that the skills needed to work productively with sexual minority clients are identical to those for working with heterosexual clients. Lack of representation of sexual minority-focused training content in itself can be considered a microaggression.

There has been increasing empirical attention to determining the most effective constellation of knowledge and skills for sexual minority cultural competence. Most of the extant literature on which the recommendations are based are studies of expert therapist descriptions of the components of treatment that they believe are most helpful (e.g., Boroughs et al., 2015). Relatively few include first-hand reports from current and former psychotherapy clients reporting on what elements they experienced as helpful (e.g., Quiñones et al., 2017). There have been some efforts to describe and measure cultural competence, including some work to develop measures in this area (e.g., Bidell, 2017).

The recommendations offered by scholars and clinicians have not been tested using randomized controlled trials (e.g., Pantalone, 2015). The field has generated a long list of

potential teaching points and skills and the next generation of research has been tasked with determining which elements are truly required and which are optional. Boroughs and colleagues (2015) appear to provide the most comprehensive coverage of sexual and gender minority cultural competence, enumerating 28 recommendations that they construe as the minimum standards needed to signify baseline competence. These recommendations include being aware of the sociohistorical context of sexual minority individuals, especially as they have been treated by the healthcare system, as well as sexual minority-specific content, attention to the potential for an increased desire for confidentiality, and more. More research is needed to determine the most effective ways to incorporate sexual orientation diversity into training programs at all levels (Pantalone, 2015)—including coursework, practicum, internship, postdoctoral, and continuing education (CE) efforts—given that a unified conceptual model for training (in terms of duration, content and training methodology) has yet to be identified (Sekoni et al., 2017).

After completion of the required training elements, clinicians have the opportunity to engage in CE programs to enhance their knowledge in areas of interest or those commonly present in their practice settings. However, clinicians who most need training on sexual minority-related topics may not seek it out. Another problem with CE programs is that they differ markedly in their content, and have uncertain effectiveness at training providers, let alone important downstream outcomes like sexual minority client satisfaction, retention, or improvement of psychological functioning (Matza et al., 2015). Although empirical evidence supports the utility of diversity trainings for increased content learning, the data are limited for the ability of minimal intensity trainings (such as CE programs) to impact behavioral skills or attitudinal learning (see a meta-analysis of 260 samples by Bezrukova et al., 2016). Thus, CE

programs can have a limited role in psychology training and cannot be considered a replacement for a more substantial experience as part of primary in-person training (e.g., Forsetlund et al., 2009).

As of this guideline's writing (August 31, 2020), in at least one state, California, the psychology licensure process includes as a requirement the completion of coursework in human sexuality. Other states' psychology licensure process may have similar requirements. Although these requirements are helpful for increasing the attention to this important topic, it is not possible to determine the utility of such training on psychology skills or on patient outcomes without further adequate study.

Application. Psychologists strive to understand the necessity of having substantial knowledge about and skills in working successfully with sexual minority clients in an affirmative manner. Psychologists consider identifying gaps in their knowledge or skills regarding sexual minority clients and take initiative to engage in education and training activities to improve their cultural competence. Ideally, psychologists strive to approach their practice with clients of diverse sexual orientations from the standpoint of cultural humility (Davis et al., 2016). Cultural humility is the practice of continually examining one's own power and privilege, as well as committing to a lifelong process of responsiveness and self-reflection, espousing the desire to fix power imbalances, engaging in actions to improve the lives of their clients (e.g., anti-oppression efforts), and by making changes to the systems that have given rise to sexual orientation-related health disparities. Psychologists understand that their own and others' training needs may differ based on that individual's sexual orientation, and aim to provide tailored training to maximize success in working with clients of diverse sexual orientations.

Psychologists use an intersectional lens when training and providing educational services. Psychologists understand that the psychological evidence base related to diverse sexual orientations changes over time. Revisiting established and new scholarship is needed to maintain up-to-date cultural competence and practice consistent with the tenets of affirmative psychological practice and cultural humility. Psychologists understand that, because they exist in the same heteronormative world as sexual minority clients, they are also susceptible to internalized negative beliefs, attitudes, and biases about sexual minority individuals. Psychologists should work to identify and neutralize the impact of such internalized bias on clients, students, trainees, colleagues, and educational programs or systems (Alessi et al., 2015).

Psychologists involved in professional education and training activities for any audiences (i.e., counselors, mental health providers, teachers, social service workers, or community members), even when not specifically focused on the experiences of sexual minority clients, consider the diversity of sexual orientations and highlight the links between the identity and experiences of sexual minority persons as relevant to the topic at hand. Psychologists involved in professional education and training activities make an explicit commitment to include in their programs a focus on current, evidence-based, ethical content of relevance for psychological practice with sexual minority clients. Psychologists teaching psychology and diversity-focused content help their students and trainees to see the detrimental effects of the heteronormative assumptions and systems that pervade the scientific and clinical literatures, as well as academic and service delivery settings. Psychologists and trainees engage in expert consultation, if needed, or work to develop expertise in competent treatment of sexual minority clients among their

colleagues, and then acknowledge the value of that expertise in the personnel review process. They include acknowledgement of the importance of sexual minority persons, and psychologists' sexual minority cultural competence, in public materials, such as websites, and in guiding documents, such as mission statements (Yeo et al., 2017).

Psychologists or psychology trainees who are in the process of developing competence to work successfully with sexual minority clients may be assigned to treat such clients in their workplace or training settings. For psychologists who believe that they cannot affirm clients' sexual minority orientations in alignment with the *APA Ethical Principles of Psychologists and Code of Conduct* (2017) and other relevant APA position statements (e.g., APA Policy Statement on Prejudice, Stereotypes, and Discrimination; APA, 2006) for religious or other reasons, they should follow relevant ethical procedures including seeking consultation and working to mitigate harm to the client. Guidance is provided by the APA Council of Representatives Resolution on Religious, Religion-Based, and/or Religion-Derived Prejudice (2007), which "encourages individuals and groups to work against any potential adverse psychological consequences to themselves, others, or society that might arise from religious or spiritual attitudes, practices, or policies." Further, it resolves that "psychologists are careful to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists." In some cases, it may be prudent to refer a sexual minority client to another practitioner who can provide affirming care. Referral because of client characteristics should be a strategy of last resort, however, and the psychologist

should take proactive steps to explore possible sources of bias and work to develop competence at working successfully and affirmatively with sexual minority clients.

If a psychology trainee, based on their religious or other personal beliefs, determines that they cannot provide affirmative treatment to a client based on the client's sexual orientation, the trainee should abide by the ethical imperative to mitigate any negative impacts on the client of their beliefs or nascent competence. An ethically-informed resolution process should include engagement in self-reflection to consider how their personal views might impede successful treatment and seeking supervision or consultation (Wise et al., 2015), both in the context of a specific case of a given sexual minority client as well as in their approach to and competence with treating sexual minority clients overall. Attaining competence to work with a diverse public is not optional, as noted by the APA Board of Educational Affairs Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education: "Ultimately all trainees (and trainers) must develop the cognitive complexity and flexibility to hold their own personal beliefs in a way that allows them to be able to serve a diverse clientele in a beneficial, non-harmful manner" (Wise et al., 2015, p. 265). In some cases, a supervisor may choose to reassign the sexual minority client to another trainee who can provide affirming care. Reassignment should be an infrequent (and not systematic) recourse, and should be accompanied by a clear plan for the trainee to increase cultural competence in this domain so that reassignment of potential clients in the future is no longer needed.

Psychologist-educators understand that training in psychological assessment and intervention activities that is based on reductionistic views or stereotypes about sexual minority

individuals can further stigmatize and harm vulnerable individuals in their care (e.g., Burnes & Stanley, 2017). For example, including content narrowly focused on gay men or lesbians fails to consider the similarities and differences in the experiences of bi + persons.

Psychologist-educators use the best available evidence from rigorous scientific journals to determine the minimum content needed for trainees in psychological practice with sexual minority persons (e.g., Boroughs et al., 2015). Psychologists strive to recognize the importance of presenting content about sexual minority cultural competence from a strengths-based rather than a deficit-focused model. Psychologists acknowledge that there is not yet a well-developed empirical literature about the optimal ways of infusing a focus on sexual minority cultural competence into training programs (e.g., Sekoni et al., 2017). However, there exist some clearly articulated activities from the general (Newell, 2010) and sexual minority-specific (Hope & Chappell, 2015) cultural competence literatures that could be implemented, evaluated, and shared with the discipline.

Psychologists working in education and training make themselves familiar with and promote adherence to the relevant content in the current *Standards of Accreditation for Health Services Psychology*, regardless of their specific site's accreditation status. These standards reflect field-wide minimums of competence. In addition to the content within their curricula, psychologists affiliated with educational or training programs attend specifically to the climate at their sites for sexual minority persons, identify areas for improvement, and promote an affirming environment. Creating an inclusive and equitable learning environment is a goal to pursue, which may require taking actions to precipitate change in the educational system and not just individual-level changes (e.g., *Guidelines on Race and Ethnicity in Psychology*; APA, 2019b).

Psychologists acknowledge the importance of having sexual minority trainees (and, thus, a future psychologist workforce), as well as faculty and supervisors, to enrich the experiences of everyone at their site. In addition, training programs take proactive steps to increase the level of sexual minority cultural competence of the staff at their site, which can include hiring psychologists with relevant experience and engaging in site-wide training efforts. Producing psychologists with expertise in sexual minority mental health is an important need in the field and psychologists engage in actions within their scope of practice to improve the field in this regard.

Finally, sexual minority cultural competence must be understood to include sexual orientation as just one salient identity among many potential identities held by a given individual. One significant element of working successfully with sexual minority clients is acknowledging that their experiences of any given sexual minority person differs by, and is shaped in part by, the other identities the individual holds. Thus, sexual minority cultural competence must encompass an intersectional approach.

Guideline 16. Psychologists strive to take an affirming stance toward sexual minority persons and communities in all aspects of the planning, conduct, dissemination, and application of research to reduce health disparities and promote psychological health and well-being.

Rationale. The U.S. National Institutes of Health (NIH, 2016; 2019) officially designated sexual and gender minority individuals as a health disparities population for the purposes of federal healthcare research and policymaking. This designation gives priority status to funding research focused on understanding and ameliorating sexual orientation-related health disparities.

This designation is helpful, but there continues to be insufficient or inadequate epidemiologic data collected on sexual minority communities. For example, many nationally representative studies do not measure sexual orientation, removing the possibility of gaining that level of knowledge about sexual minority persons, which could be used to plan future studies (IOM, 2011). Although there have been some strides to recruit and measure sexual orientation in research, political pressures have rolled back some of those gains (Wang et al., 2016). Another limitation of research on sexual orientation and psychological practice with sexual minority persons is that it has focused disproportionately on White gay men and intersections between sexual minority populations and the HIV epidemic. Further research is needed to fully understand the extent and causes of additional identity-based health disparities within sexual minority populations, especially for bi+ individuals and sexual minority people of color, and to identify effective intervention mechanisms (IOM, 2011).

Some research on sexual orientation and sexual minority populations has been harmful (e.g., sexual orientation change efforts; APA, 2009a, 2009b). Some studies have been conducted or their results publicized with the intent to communicate the belief that sexual minority sexual orientations are inherently pathological (Herek, 2010). Studies of this type are predicated on the belief that a sexual minority orientation can and should be altered through intervention, despite a sizable body of literature concluding that sexual minority sexual orientations are healthy variants of human functioning.

There is now a large volume of empirical research to draw from in an attempt to understand and reduce sexual minority-related health disparities, and a substantially improved understanding of the best practices for conducting such research. There are entire scientific journals whose editorial scope is devoted to increased understanding of sexual orientation and

sexual minority populations, and research reports on sexual orientation and sexual minority populations have increasingly appeared in scientific journals that have a more general editorial scope. Additionally, researchers have employed an array of quantitative, qualitative, and mixed methods to understand the lives, health, and well-being of sexual minority populations. There are a variety of detailed sources that offer important reflection questions for prospective researchers, as well as suggestions for conducting both affirming and rigorous research on topics of relevance to sexual minority persons (e.g., IOM, 2011).

Although the increased empirical attention has yielded many significant insights, there exist many open research questions related to the psychological and physical health of sexual minority persons and communities. Some questions remain because of the difficulty of conducting research with "hidden" and stigmatized populations, over and above more general challenges that arise in research related to resource limitations. Obtaining highly representative samples has been one of the primary challenges to research with sexual minority persons and communities. Poorly planned or executed sampling strategies can result in biased findings that mislead stakeholders (Meyer & Wilson, 2009).

Because of the history of pathologizing and marginalizing sexual minority populations, psychologists who plan and conduct research on sexual minority participants and communities have a heightened responsibility to protect not only the sexual minority research participants, but also sexual minority persons more generally who might be impacted directly or indirectly by the dissemination and application of their findings. Ethical issues that are especially salient for sexual minority participants include invasions of privacy, breaches of confidentiality, or distress or embarrassment resulting directly from the experience of participating in research (Price, 2011). Because of the pervasive societal bias against sexual minority persons, the feared

consequences of the loss of privacy or confidentiality include discrimination, which could result in physical harm or threats of violence, as well as the loss of housing or employment (Price, 2011). By virtue of their socially stigmatized identities, sexual minority persons are especially vulnerable to harms inflicted purposely or unwittingly by individuals in positions of power, which includes psychologists serving in their professional capacities as researchers or consumers of psychological research.

Application. Psychologists adhere to relevant requirements of the APA (2017a) *Ethical Principles of Psychology and Code of Conduct* when conducting research. Psychologists consider an affirming stance in their research activities (i.e., planning, conducting, disseminating and applying results) related to sexual minority individuals and communities, and formulate research studies that aim to reduce sexual minority identity-based health disparities (Chan & Henesy, 2018; Griffith et al., 2017). Psychologists understand that approaches to research that pathologize sexual minority orientations or sexual minority persons and communities, or research that aims to change a person's sexual orientation, have been deemed harmful and unethical by the APA and other credible medical and mental health professional organizations and should be avoided (APA, 2009a). Psychologists strive to be aware of the potential influence of overt and covert bias on the planning, implementation, and application of research involving sexual minority persons. Psychologists consider the range of political and scientific features that may influence the research questions asked, samples recruited, and implications presented in research on sexual orientation and on psychological practice with sexual minority participants (Griffith et al., 2017). Psychologists recognize that certain research methods, such as qualitative methods, mixed methods, and community-based participatory approaches may be useful for centering the voices of sexual minority individuals, especially those who possess marginalized

intersecting identities or experiences and who have not been represented as well in prior work (Chan & Henesy, 2018; Collins et al., 2018; Johnson & Parry, 2016). Qualitative, mixed methods, and community-based participatory approaches may be especially suitable when studying daily, lived experiences of sexual minority individuals across the lifespan, as well as diverse sexual minority communities (Singh & Shelton, 2011; Orel, 2014).

Psychologists acknowledge that the scientific and professional literature focused on sexual orientation and psychological practice with sexual minority persons is consistently growing, and it is essential to rely on current scholarship when planning research projects (Griffith et al., 2017). Psychologists recognize that the challenges inherent in conducting research on sexual minority persons has resulted in a literature that tends to over-represent younger, urban dwelling, White, middle-class gay men, who do not represent the breadth of sexual minority communities (Price, 2011). Psychologists recognize the urgent need to conduct and disseminate research on other sexual minority populations, and especially on members of marginalized groups of sexual minority individuals, such as trans and nonbinary persons; sexual minority older adults (American Geriatrics Society, 2015; Harley & Teaster, 2015; Orel, 2014); sexual minority persons of color (Barnett et al., 2019; DeBlaere et al., 2010); individuals who identify on the bi+ spectrum (Singh & Shelton, 2011); sexual minority persons with disabilities (Dispenza et al., 2019); and those in more than one of these marginalized groups, such as transgender bi+ persons or bi+ persons of color.

Psychology researchers are encouraged to review critical published scholarship that offers suggestions for high-quality methodologic practices for investigators planning to engage in sexual minority focused research. There are examples of published resources that provide useful insights into the conduct of psychological research with sexual minority populations (e.g.,

Bostwick & Hequembourg, 2013; Chan & Henesy, 2018; DeBlaere et al., 2010; Fassinger & Morrow, 2013; Fredriksen-Goldsen & Kim, 2017; Griffith et al., 2017; Moradi et al., 2009; Parent et al., 2013; Singh & Shelton, 2011). Psychologists aim both to use as well as to create scholarship that advances research methods to reduce health disparities and promote psychological health and well-being of sexual minority persons (e.g., surveying intersectional microaggressions; Fattoracci et al., 2020).

Psychologists strive to demonstrate foundational knowledge and basic research competencies for the planning, conduct, dissemination, and application of research on sexual orientation or psychological practice with sexual minority persons. Regardless of research design or methodology used, psychologists can consider engaging in a transparent process of critical self-reflection about their positionalities and motivations for conducting research on sexual orientation or psychological practice with sexual minority persons. This may help psychologists enhance their methodological integrity (Levitt et al., 2018), "especially as they relate to power and privilege" and are "prepared to honor the strengths and support the needs of that community as they become manifested during the course of the research" (Fassinger & Morrow, 2013, p. 73).

Psychologists look to understand the inherent challenges in sampling a stigmatized, hidden population, such as sexual minority persons, and engage in efforts to maximize the diversity of their sexual minority samples in terms of other demographic or identity characteristics (e.g., recruiting from both urban and rural locations). General studies of sexual minority populations should break down participants into specific groups, such that the proportion of the samples that represent each group, and the outcome differences between lesbians, gay men, and bi+ persons, can be examined explicitly (Ghabrial & Ross, 2018).

Psychologists should clearly represent all characteristics of sexual minority samples to facilitate accurate interpretation of generalizability (DeBlaere et al., 2010) and transferability (Levitt et al., 2018).

Psychologists acknowledge the potential impact of the language used in recruitment materials, study documents, data collection instruments, publications, and presentations that affirm or invalidate diverse sexual minority orientations, individuals, and communities (Griffith et al., 2017). Further, in applying this knowledge, psychologists measure relevant constructs and experiences of sexual minority persons in ways that accurately reflect the state of knowledge in the field and that acknowledge the within-group diversity of this population. For example, psychologists consider continuous measures of sexual orientation, use open-ended questions to allow for self-identification by participants, assess multiple dimensions of sexual orientation (identity, attraction, behavior), and explore cultural variations in sexual orientation identification, as appropriate (DeBlaere et al., 2010; Griffith et al., 2017). Psychologists acknowledge that scientific terminology related to sexual minority individuals often do not match the labels used colloquially by community members, and should be aware of the implications of this disconnect between scientific and community understandings of sexual minority identity. Lastly, psychologists recognize that, when conducting any research that could potentially include sexual minority participants, it is important to review all measures to remove language indicative of heterosexist bias, binary conceptualizations of gender and sexual orientation, and other sexual minority relevant issues. Psychologists follow the rules set forth in the APA Style Guide (APA, 2019a), especially the elements of style related to reducing bias in language.

Psychologists look to understand the inherent and unique challenges that arise when working with sexual minority youth, including the potential variability in sample characteristics

that can result from an institutional review board decision to require parental consent. There can be considerable variability in sexual minority youth's outness, and the degree of parental support toward a child's sexual minority orientation. As a result, this could influence youth participation in research (Griffith et al., 2017). With youth, seeking parental consent is inadvisable when potential participants are not out to their parents because of the potential harms that could result from the inadvertent disclosure. Thus, psychologists conducting research with sexual minority youth must plan study procedures in close consultation with institutional review boards to maintain compliance with local guidelines, state laws, and the APA (2017a) *Ethical Principles of Psychology and Code of Conduct*. Additionally, psychologists seek to understand the unique and inherent challenges in working with older sexual minority persons, particularly in terms of identity concealment, assumptions about heterosexuality, and difficulty accessing this population via probability sampling (Fredriksen-Goldsen & Kim, 2017; Teaster & Harley, 2015).

Psychologists take proactive steps to enhance the representativeness, generalizability, and transferability of their research, even in studies with limited resources, and to be transparent in the strengths and limitations in diversity of a given study's sample (Meyer & Wilson, 2009). Psychologists understand that traditional sexual-minority focused recruitment efforts are insufficient to recruit substantial proportions of diverse samples of sexual minority individuals, especially sexual minority persons of color (DeBlaere et al., 2010), and study recruitment efforts should not unduly infringe upon private or safe affinity spaces (Griffith et al., 2017). Psychologists provide sexual minority research participants accurate assurances about the privacy and the confidentiality of their data, especially in terms of the participants' outness, the study procedures, data storage, and publication and presentation of findings (Price, 2011; Griffith

et al., 2017). Providing this information as part of the informed consent process allows a prospective participant to accurately evaluate the study's risk-benefit ratio.

Psychologists who conduct research on sexual minority orientations, individuals, or communities recognize that they may face discrimination for engagement in that type of work, as well as potentially experience vicarious traumatization, depending on the topic under study (Griffith et al., 2017). Thus, psychologist researchers look to understand that they may need personal or professional support to manage the pressures of conducting sexual minority-focused research. Further, psychologists acknowledge that any cultural competence they experience must be understood through a lens of cultural humility, such that they must engage in a continuous and proactive process of self-reflection and professional development to enhance their personal and professional growth (Griffith et al., 2017).

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Appendix A: Terminology

Affirmative psychological practice considers the role of stigma and oppression throughout various aspects of psychological practice, and approaches sexual minority identities as a normative aspect of human sexuality, rather than pathologizing sexual minority persons.

Asexual is a sexual minority orientation that refers to individuals who do not experience sexual attraction or desire. Those who identify as asexual often experience marginalization and discrimination related to their sexual orientation.

Bi+ pronounced as "bi plus" is an umbrella term used to capture multiple sexual orientations that involve having an attraction to more than one sex or gender. Bi+ persons include those who identify as bisexual, pansexual, demisexual, or queer. Another term for this is plurisexual.

Binegativity is a prejudicial belief that marginalizes, stereotypes, and stigmatizes bi+ individuals. The belief contends that bi+ orientations are illegitimate and unstable, and assume bi+ people to be confused about their "true" sexual orientation.

Cisgender refers to an individual whose gender identity and expression corresponds with their sex assigned at birth.

Coming out refers to the process in which one acknowledges and accepts one's own sexual orientation. It also encompasses the process in which one discloses one's sexual orientation to others. This term can also apply to gender identity.

Consensual non-monogamy constitutes intimate and romantic relationships in which all involved partners explicitly understand and agree to have multiple concurrent emotional or sexual partners (i.e., polyamory, swinging, and open relationships)

Demisexual refers to a person who experiences sexual attraction for another person after an emotional or intellectual bond has been developed.

Families of choice are non-biological support systems that are often created as a result of rejection from one's family of origin or community.

Gender refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex.

Gender expression refers to the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person's gender identity.

Gender identity is a person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Since gender identity is internal, a person's gender identity is not necessarily visible to others.

Gender minority refers to a group of individuals whose gender identity or gender expression differs from the social norms that are associate with their sex assigned at birth. This is separate and distinct from sexual minority, as gender identity differs from sexual orientation.

Gender nonbinary and gender diverse is a more inclusive terms that refer to those that identify themselves as outside of the male-female binary, including those who identify as both or neither gender. This term includes those who identify as nonbinary, genderqueer, bigender and pangender.

Heterosexism refers to the notion or the idea that being heterosexual is the norm, rendering other sexual orientations (i.e., lesbian, gay, or bi+) as outside the norm. It is also a system that privileges heterosexual norms and ideals over other equally valid sexualities.

Homonegativity is a term that is used to describe negative societal reactions and views reactions, as well as discrimination sexual minority persons. Homonegativity can be found both outside the LGBTQ community and inside through means of internalized homonegativity or targeted homonegativity toward certain groups within the LGBTQ community

Mixed-orientation relationship refers to a relationship where partners in a romantic relationship identify with differing sexual orientations (e.g., a cisgender bi+ woman who is married to a cisgender heterosexual man).

Monosexism refers to the assumption that people are, or can be, only either heterosexual, lesbian, or gay, and attracted to only one sex/gender. This minimizes bi+ sexualities, and the idea that sexuality exists on a continuum.

Pansexual refers to those whose sexual or romantic attraction is not defined by gender.

Plurisexual is a term used to refers to sexual minority orientations that are not explicitly based on attraction to one sex, and leave open the potential for attraction to more than one sex/gender.

Queer is a formerly pejorative term for LGBT individuals. It has now been reclaimed and operates as an umbrella term for any nonheterosexual identity. It allows for more inclusivity, particularly for those whose sexuality is more fluid or shifts over time.

Sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex with the aim of assigning a sex that is most likely to be congruent with the child's gender identity (MacLaughlin & Donahoe, 2004). For most people, gender identity is congruent with sex assigned at birth (see cisgender); for transgender and gender nonbinary individuals, gender identity differs in varying degrees from sex assigned at birth. Sex is typically categorized as male, female, or intersex (i.e.,

sexual anatomy that combines or is atypical of male and female characteristics). There are a number of indicators of biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia.

Sexuality refers to a broad dimension of human sexual behavior, including sexual values, needs, preferences, and preferred modes of sexual expression, intimacy, and affect.

Sexual fluidity refers to changes in attraction, sexual identity, or orientation over time. It is bi-directional, which means it can mean a change toward or away from same-sex/gender attraction.

Sexual identity refers to the action of claiming through recognition, acceptance, or self-labeling one's sexual orientation as it is relevant to the self.

Sexual minority constitutes a group of individuals whose sexual and affectual orientation, romantic attraction, or sexual characteristics differ from that of heterosexuals. Sexual minority persons are inclusive of lesbian, gay, bi+, and asexual identified individuals.

Transgender is an adjective that is an umbrella term used to describe the full range of people whose gender identity or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term "transgender" is commonly accepted, not all transgender and gender nonconforming people self-identify as transgender.

Appendix B: Resources

An increasing number of resources exist for clinical psychologists with clients who identify as gender diverse (e.g., APA, 2015a; Burnes et al., 2010; Chang & Singh, 2016; Chang et al., 2017; Chang et al., 2018; Coleman et al., 2012; dickey, 2017; Kimmel, 2014; Lev, 2004; Porter et al., 2016; Rider et al., 2019; Singh, 2016a; 2016b; Singh & dickey, 2017). Psychologists who work with sexual minorities who also identify as gender diverse are encouraged to utilize the emerging professional literature as well as online resources to keep abreast of the changing context for this population. Useful websites include those of the American Psychological Association (http://www.apa.org/topics/lgbt/index) and related Guidelines for the Psychological Practice with Transgender and Gender Nonconforming People (https://www.apa.org/practice/guidelines/transgender.pdf), the World Professional Association of Transgender Health (http://www.wpath.org), the National Center for Transgender Equality (http://www.transequality.org), the Trans People of Color Coalition (https://transpoc.org/), the Sylvia Rivera Law Project (http://www.srlp.org), and the Transgender Law Center (http://www.transgenderlawcenter.org).