CLINICAL GUIDELINES FOR LGBTQIA AFFIRMING

MARRIAGE AND FAMILY THERAPY

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Erica E. Hartwell, PhD
Christopher K. Belous, PhD
Kristen Benson, PhD
Livingstone Cox, MA
Alex Iantaffi, PhD
Christi R. McGeorge, PhD
Daran Shipman, MA
Markie L. C. Twist, PhD

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Introduction to the Guidelines

Scope of the Guidelines

These guidelines outline how marriage and family therapists (MFTs) practice in an **affirming**, **inclusive**, ethical, and competent way with **lesbian**, **gay**, **bisexual**, **transgender**, **queer**, **intersex**, and **asexual** (**LGBTQIA**) people. In particular, these guidelines provide instructions for what MFTs do or do not do in their clinical practice when working with LGBTQIA clients. These guidelines should be considered a starting point for MFTs (for instance, a glossary of relevant terms can be found in Appendix A), not a comprehensive "how-to" guide. These guidelines do not reflect competences or requirements.

For many MFTs meeting these guidelines may require engaging in additional reading, training, supervision, consultation, and reflection. We have written these guidelines with the hope of illuminating what is possible and necessary in our field. Although we understand that many additional steps are needed for these practices to become commonplace, we hope to provide a vision of what systemic practices with LGBTQIA clients could be if, as a field, we committed ourselves to providing competent and ethical services to all clients.

Who is the target audience?

These guidelines are a call to action for the field and profession of marriage and family therapy (MFT), the American Association for Marriage and Family Therapy (AAMFT), training programs, supervisors, educators, students, scholars, researchers, and clinicians. In addition, these guidelines can and will be helpful for anyone who practices from a systemic therapy lens.

Who are the authors?

These guidelines are written by a team of queer, transgender, and allied MFT scholars and practitioners whose clinical practice, teaching, and research is focused on advancing the well- being of LGBTQIA people, relationships, and families. We are grateful to the LGBTQIA clinicians and scholars who have contributed to the ideas and practices presented in these guidelines. We honor their decades-long commitment to calling the MFT field to do better and to be better. We recognize their sacrifices and experiences of **marginalization** as therapists working in service of LGBTQIA people, while simultaneously navigating their own invisibility and marginalization. These guidelines exist because of them and, at the same time, these guidelines took too long to come into existence. While we celebrate this step forward for affirming and inclusive therapy for LGBTQIA clients, we acknowledge that these guidelines will fall short of what LGBTQIA communities deserve and have come at a personal and professional cost to the LGBTQIA elders who paved the way.

Sociopolitical Context of Writing of the Guidelines

LGBTQIA communities across the world have experienced governmental bodies both granting and denying basic civil rights. These policy decisions impact all aspects of life for LGBTQIA individuals, which include being able to access healthcare, equitable education, the ability to marry, adoption rights, the ability to serve in the armed forces, and housing and employment discrimination protections. The AAMFT Code of Ethics (2015) calls upon MFTs to be informed about laws and policies that impact clients and thus being informed about municipal, state/provincial, and federal governmental policies and laws related to **sexual orientation** and **gender identity** is essential. For instance, in the United States (US), during the 2021 state legislative sessions, hundreds of bills have been introduced limiting the rights of transgender and **nonbinary** individuals, including access to gender-affirming medical care, the ability to play on athletic teams that match their gender identity, and restricting access to official state issued documentation (e.g., drivers licenses) with accurate gender markers (ACLU, 2021). In addition, more states are seeking to enact religious freedom exemptions that would allow medical and mental health providers to refuse to treat members of the LGBTQIA communities based on "sincerely held" personal religious beliefs.

Legislative action further impacts the therapy process through the state, county, and city-wide bans on the practice of **sexual orientation change efforts** (SOCE; i.e., conversion or reparative therapy). These bans prohibit the practice of SOCE with minors; thus, allowing the practice with adults starting at the age of 18 in most jurisdictions. It is important to note that very few of these laws specifically ban the practice of **gender identity change efforts** (GICE).

In addition to the current sociopolitical context that impacts everyday life for LGBTQIA, it is equally important that MFTs acknowledge that the US, along with other western countries, was built on a legacy of genocide and enslavement of Indigenous and African people. The systems of oppression based on race, sexual orientation, and gender are intertwined and interdependent and must both be dismantled. This intersection of oppression is especially dangerous for queer and transgender people of color, who experience oppression and violence at disproportionately high rates.

Guidelines for Clinical Practice with LGBTQIA Clients

The aim of the following guidelines for clinical practice with LGBTQIA clients is to center the experiences of people most impacted by cisheterosexism in the practice of MFT and ensuring that they are treated as fully human by all MFTs.

The guidelines are organized into five pillars:

1. Intersectional: People exist within interlocking and overlapping systems of identity, power, privilege, and oppression that inform their lived experiences. This pillar provides guidance on how to examine, understand, and provide awareness and acceptance of the unique intersectional identities of MFTs and the clients we serve.

2. Systemic: A systemic worldview places the individual and their presenting concerns within the context of important relationships, larger systems, and intersecting power structures. This pillar considers the role of larger systems in the assessment, diagnosis, and treatment of LGBTQIA clients.

3. Relational: Individuals exist in relation to others and relational dynamics are influenced by factors across multiple social systems. This pillar acknowledges the influence of relationships across global, national, community, family, and individual levels.

4. Liberatory: MFTs have engaged in practices that have done great harm to LGBTQIA communities due to the systemic forces of cisheterosexism, and thus this pillar requires that we liberate ourselves as therapists from these systems of oppression in order to provide competent, ethical, inclusive, and affirmative services to members of LGBTQIA communities. This pillar seeks to both acknowledge the important self-of-the-therapist work that all MFTs are called to engage in and discuss the importance of labeling and preventing practices that have and do cause harm to LGBTQIA clients.

5. Transformative: A transformative paradigm is, by its nature, in flux and relational. In this pillar, MFTs are invited to dismantle internalized forms of supremacism through accountability and reflexivity. Because internal change is not sufficient without systemic change, this pillar empowers MFTs to transform the communities we live in, the educational systems we are trained within, and the policies that govern us.

Pillar 1: Intersectional

In 1989, Kimberlé Crenshaw, a civil rights activist and legal scholar coined the term "**intersectionality**" when examining the overlapping interdependent systems of discrimination and oppression faced by Black women (Bowleg, 2012; Crenshaw, 1989). Since that time, the term has been adapted and expanded by some scholars to not only focus on the intersectional nature of race and gender, but to include all forms of identity, social location, and oppression (Bowleg, 2012; Gangamma & Shipman, 2018; Kulick et al., 2017; Mink, Lindley, & Weinstein, 2014). We acknowledge the roots of intersectionality in the experiences of Black women, and we are grateful for the opportunity to expand this concept to include the diverse range of LGBTQIA people.

As MFTs, we understand that individuals exist within larger systems—families, communities, and societies (Harvey & Stone Fish, 2015). Within these societies are interlocking systems of power, privilege, and oppression, such as **White supremacy**, **patriarchy**, **colonialism**, and cisheterosexism (Addison & Coolhart, 2015; Belous & Bauman, 2017; Blumer et al., 2013; hooks, 2000). These systems create unique experiences of privilege and oppression for individuals based on the assigned value of their socially constructed identities (Austin, 2016; Belous & Bauman, 2017).

Intersectionality posits that all forms of oppression are linked (Bowleg, 2012). Acknowledging the intersectional realities of their clients is a start. However, we need to **center** the lived experiences and identities of LGBTQIA clients and people in order to provide affirmative care (Addison & Coolhart, 2015; Bigner, & Wetchler, 2012; hooks, 2000; McGeorge et al., 2021; McGeorge, et al., 2020). We center marginalized groups by privileging their lived experiences and honoring their knowledge and cultural values. We do not compare them to the dominant norm; instead, we decenter existing norms and work to **deconstruct** beliefs based on these larger systems of power.

Social location. MFTs assess clients' social location at intake and throughout treatment. This may include gender identity, gender expression, sexual orientation and attraction, socioeconomic status, (dis)abilities and health information, genetic and biological components including health, country of origin and citizenship status, religious affiliation, educational attainment or ability, relationship statuses, mental health, trauma histories, and personality characteristics. The client's social location provides context for understanding their lives and presenting issues. However, identities should not be considered the cause of presenting issues. MFTs also consider how their own social location may impact the therapeutic relationship and process.

Fluidity of identities. MFTs recognize and affirm the unique intersectional nature of a person's identity as changing and evolving over time. MFTs validate clients' identities as the client understands them in the present moment, while understanding that they may change in the future. A shift in identity or social location may be due to circumstances (such as gaining citizenship or experiencing a financial loss), learning or deepened awareness (such as discovering a new aspect of ethnic heritage or finding an identity label that resonates more), or natural change over time (such as aging or experiencing shifts in sexual attraction).

Decenter cisnormativity and heteronormativity. MFTs decenter **cisnormativity** and **heteronormativity** in their practice through a lifelong commitment to critical self-reflection, personal and professional development, personal therapy, supervision and consultation. MFTs question assumed norms about gender, sexual orientation, intimate relationships, families, and sex. They examine their clinical practice for the influence and presence of these norms, and they rethink and reimagine any cisnormative or heteronormative practices found.

Center the margins. MFTs center the lived experiences of people marginalized by cisheterosexism, racism, **ableism**, **capitalism**, colonialism, and other systems of oppression by treating their experiences, knowledge, and values as valid and normal.

Pillar 2: Systemic

The field of MFT emerged as a response to the pathologizing of individuals within a linear, medicalized, and modernist worldview. Prior to this, symptoms and illnesses were viewed as stemming from and belonging to the identified patient; subsequently, assessment and treatment focused on the individual. In contrast, a systemic worldview places the individual and their presenting concerns within the context of important relationships, larger systems, and intersecting power structures. Subsequently, assessment and treatment consider and, to the extent possible, include the systems in which the client is embedded.

Nonpathology. MFTs do not pathologize individuals, relationships, or systems (Blumer et al., 2013). They acknowledge that all clients do family, gender, and sexual orientation differently and can determine for themselves what constitutes healthy relationships (McGeorge et al., 2020; Oswald et al., 2005). Rather than determining health or functionality based on relationship structures, roles, or formation, MFTs look for adaptability as a sign of systemic health.

Diagnosing. MFTs recognize that psychiatric diagnoses such as Gender Dysphoria (DSM-5), Gender Identity Disorder (DSM-III through IV-TR), and homosexuality (DSM-II) can and have pathologized and harmed LGBTQIA individuals (Giammattei & Green, 2012). MFTs use diagnoses such as Gender Dysphoria only as needed to assist transgender, nonbinary, and gender expansive clients in accessing care through the current **medical industrial complex**. MFTs discuss the use of diagnoses with clients and locate the source of this pathology in a hetero- and cis- normative society.

Multiple realities. MFTs acknowledge the existence of multiple realities. Like balancing multiple perspectives among family members, MFTs hold tension between opposing viewpoints and diverse experiences (McDowell, 2015). For example, MFTs work to end oppression based on gender identity and sexual orientation, while also working to dismantle the socially constructed categories of gender identity and sexual orientation (Hudak & Giammattei, 2014).

Power structures. MFTs recognize that power structures underly and inform all systems, including the profession of MFT, by granting privilege to some and oppression to others (hooks, 2000; McGeorge et al., 2020). They attend to and deconstruct heteronormativity, cisnormativity, patriarchy, and White supremacy in their daily lives and in their practice.

Larger systems. MFTs acknowledge that power structures are enacted through larger systems that impact the lives and well-being of LGBTQIA people. This includes government-sanctioned oppression of LGBTQIA people, violence toward LGBTQIA people that is permitted by cultural and legal norms, and discrimination in schools, health care, housing and employment, and parental and marital/relationship rights (Giammattei & Green, 2012). MFTs are aware of local, state, federal, and international laws and policies that impact LGBTQIA people (Bordoloi et al., 2013).

Minority stress. MFTs assess for minority stressors that can impact a person's mental health and well-being. **Minority stress** is the added daily stress that marginalized individuals experience based on systems of power and oppression, and can include microaggressions, discrimination, violence, rejection, expectations of rejection, internalized stigma, and the need to conceal one's identity to preserve safety (Meyer, 2003).

Pillar 3: Relational

MFTs recognize that they exist in relationship to others and their relational dynamics are influenced by factors across multiple social systems. They also recognize that understanding these factors is vital to strengthen the quality of relationships in their clients' lives. Research consistently shows that supportive relationships buffer against negative mental and physical health outcomes for LGBTQIA youth and adults (Fuller & Riggs, 2018; Ryan et al., 2010; Stone et al., 2020b). However, there may be differing levels of support and rejection across multiple systems that LGBTQIA individuals, intimate partner(s), and families can experience. MFTs must therefore be prepared to both examine for resilience and risk and intervene at all levels.

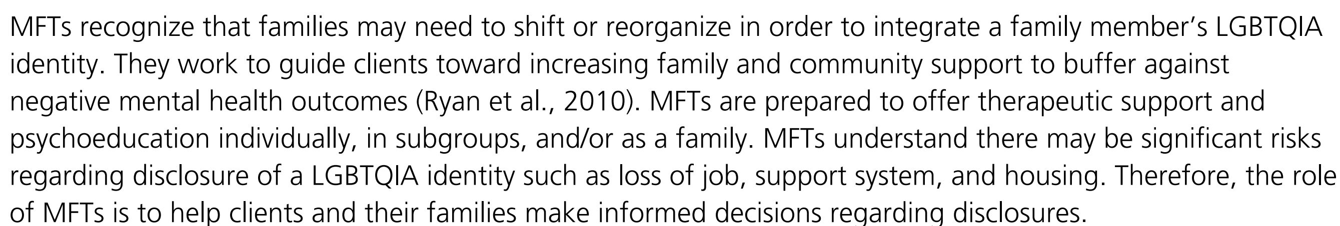
National and global relationships. MFTs seek to understand diverse contexts of LGBTQIA clients. For instance, immigrant LGBTQIA clients may simultaneously experience the consequences of differing social contexts, norms, and laws in the United States and their country of origin (McGeorge et al., 2020). In this instance, the MFT must consider the simultaneous influence of this context on the client's life (Gangamma & Shipman, 2018). They understand the importance of ongoing advocacy, education, and training (Goodman et al., 2018). MFTs recognize that professional relationships are bridges to significant sources of support and information that may be cultivated both nationally and globally to include mentors, colleagues, and organizations.

Community relationships. MFTs recognize that LGBTQIA clients may experience support and lack of support simultaneously depending on the client's intersecting identities. They understand that increasing community supports buffers against negative mental health outcomes (Fuller & Riggs, 2018; Ryan et al., 2010; Stone et al., 2020a). For example, in-person and/or virtual support groups for LGBTQIA adults or youth, gender and sexuality alliances in schools (GSAs), and gender inclusive sports. Although a spiritual or religious belief system and/or affiliation may be a significant source of support (Rosenkrantz et al., 2016), MFTs acknowledge the possible relational and/or personal conflict between one's LGBTQIA identity and religious/spiritual belief system (Coburn & McGeorge, 2019b).

MFTs recognize advocacy as included in the therapist's role in working with LGBTQIA youth andadults. Therapists may need to advocate for youth in schools and/or support students and parents in self-advocating (i.e., use of name and pronouns, access to safe bathrooms and locker rooms, implementing anti-bullying policies, LGBTQIA inclusive sports and curricula; Coolhart & Shipman, 2017; Kull et. al., 2016). MFTs also understand the importance of developing collaborative relationships in the community. For instance, a collaborative network of health care professionals will bridge the LGBTQIA individual with other affirmative care providers.

Family relationships. MFTs model an affirming stance regarding family member's LGBTQIA identity(ies) throughout the therapeutic process (Bigner & Wetchler, 2012). For instance, MFTs normalize and depathologize diverse gender identities and sexual orientations, while also dismantling heteronormativity, cisnormativity, patriarchy, and White supremacy. MFTs recognize the harm caused by family-of-origin rejection (Koken et al., 2009; Ryan et al., 2010; Schmitz & Tyler, 2018), and work to help families move to places of fully accepting and celebrating LGBTQIA members (McGeorge et al., 2020).

MFTs recognize that LGBTQIA clients may have a "family of choice" in addition to families of origin which may be more salient in some cases. They also understand and acknowledge that LGBTQIA families already have strengths and resiliencies from which to draw on in the therapeutic process (e.g., relationship/community building skills, a parent's protectiveness of their LGBTQIA child, determination, and transparency; Moradi & Budge, 2018). MFTs recognize disclosure of a LGBTQIA identity as a process of identity management that occurs over the lifespan and may differ across contexts, change over time, or not occur at all (Twist et. al., in press). However, they are aware that disclosure may not be the current goal of therapy.



MFTs recognize that families may need to shift or reorganize in order to integrate a family member's LGBTQIA identity. They work to guide clients toward increasing family and community support to buffer against negative mental health outcomes (Ryan et al., 2010). MFTs are prepared to offer therapeutic support and psychoeducation individually, in subgroups, and/or as a family. MFTs understand there may be significant risks regarding disclosure of a LGBTQIA identity such as loss of job, support system, and housing. Therefore, the role of MFTs is to help clients and their families make informed decisions regarding disclosures.

Parenting and co-parenting relationships. MFTs recognize that parenting and co-parenting arrangements may have similarities and differences from cisnormative and heteronormative expectations and structures (Hammack et al., 2019). They also acknowledge that family and parenting structures vary across cultures, ethnicities, and other intersectional identities. For example, a Black, same-gender couple may share parenting resources and responsibilities across generations in their family. MFTs recognize that children of LGBTQIA parents have similar outcomes as compared to cisgender and heterosexual parents (Patterson, 2017).

However, the rights of LGBTQIA parents and co-parents to adoption, custody, and visitation are deeply impacted by systems of power and oppression (Farr et al., 2020). MFTs remain aware of current laws and policies affecting LGBTQIA families and offer advocacy and support as needed.

Intimate partner(s) relationships. MFTs understand that relationship structures of LGBTQIA individuals are diverse. Relational structures and patterns may include many different types of consensual nonmonogamy and **monogamy**. They acknowledge that there are multiple ways to engage in healthy, fulfilling and functional intimate relationships. MFTs assess for strengths, as well as challenges in relational structures. They understand that a person's current relationship(s) does not determine or define a person's sexual orientation. Therefore, MFTs avoid assumptions regarding sexual orientation, gender identities, expressions, experiences, and pronoun use. MFTs understand that coming into an LGBTQIA identity may occur at any time over the life span (Twist et al., in press). They acknowledge that relational scripts for LGBTQIA people are lacking and partners may need support to negotiate and adopt new roles and rules that affirm their identity(ies).

Intimate partner(s) seen as existing outside of cisgender and heterosexual identities may face stigma and marginalization whether or not they claim a LGBTQIA identity. MFTs understand and assess the impact of marginalization on the relational dynamics of intimate partners (Hammack et al., 2019). For example, current policies and laws may separate or limit access to partners in settings such as hospitals or assisted-living facilities.

Therapeutic relationship. MFTs recognize social locations and intersecting identities of both the therapist and client(s) as significant factors that impact the relational dynamic and therapeutic process. This may include consideration of therapist self-disclosure of gender identity and/or sexual orientation to a client (Addison & Coolhart, 2015; Shipman & Martin, 2019). While a client's LGBTQIA identity is important to the therapeutic process, MFTs understand that the client's primary or presenting concern may not be related to their LGBTQIA identity (Benson et al., n.d.). MFTs acknowledge that mental health professionals have historically played a role in perpetuating discrimination against LGBTQIA clients such as pathologizing the individual versus acknowledging pathology as existing in societies oppressive systems (e.g., DSM diagnoses, assessment, lack of education and training, etc.; McGeorge et al., 2020). MFTs also understand client's unique dependence on mental health professionals to access gender affirming medical care (Benson, 2013; Coolhart & Shipman, 2017). Based on current and historical roles of MFTs in the lives of LGBTQIA clients, MFTs consider and attend to the impact on the therapeutic relationship.

Pillar 4: Liberatory

The AAMFT Code of Ethics and the MFT field are based on the notion that all people deserve access to just, ethical, and competent therapy services. Those who provide therapy must do so with a commitment to do no harm and to engage in intentional practices that support all clients in reaching their fullest potential. Due to the systemic forces of cisheterosexism, MFTs have engaged in practices that have done great harm to LGBTQIA communities, and thus this pillar requires that we liberate ourselves as therapists from these systems of oppression in order to provide competent, ethical, inclusive, and affirmative services to members of LGBTQIA communities. This pillar seeks to both acknowledge the important self-of-the-therapist work that all MFTs are called to engage in and discuss the importance of labeling and preventing practices that have and do cause harm to LGBTQIA clients.

Examine biases and assumptions. MFTs engage in an active process of self-exploration of their own heteronormativity, cisnormativity, and cisheterosexism. MFTs work to make their unconscious biases and assumptions conscious so that they can deconstruct these biases and assumptions and decrease their influence on the therapy process, clinical decision making, and LGBTQIA clients (McGeorge & Carlson, 2011; McGeorge et al., in press).

Root out internalized superiority. MFTs who hold dominant identities (e.g., heterosexual, cisgender, White, etc.) seek to name and decrease the influence of their own **internalized superiority**, which is often reinforced by unearned societally granted privileges, namely heterosexual and cisgender privilege. This process of rooting out internalized superiority often begins with MFTs with societal sanctioned dominant identities learning about how they came to hold these dominant identities. Specifically, this involves learning how they came to hold heterosexual and/or cisgender identities (Hoffman, 2004; McGeorge & Carlson, 2011; McGeorge et al., in press; Mohr, 2002; Worthington et al., 2002). Once MFTs understand their identity development process, they can move to engaging in self-of-the-therapist work to explore the privileges they experience on a moment-to-moment basis based solely on holding these dominant identities. The purpose of this self-of-the-therapist work is for MFTs to work to deconstruct and diminish these unearned advantages (McGeorge & Carlson, 2011; McGeorge et al., in press).

Protect people from harmful practices. MFTs do not engage in practices that are harmful to LGBTQIA individuals, relationships, and communities. MFTs do not practice, for any reason, sexual orientation change efforts (SOCE; also referred to as conversion or reparative therapy) and gender identity change efforts (GICE), nor do they make referrals to other clinicians who practice SOCE and/or GICE (Bradshaw et al., 2015; Cyphers, 2014; Dehlin et al., 2015; Haldeman, 2002; McGeorge et al., 2015; Serovich et al., 2008; Shidlo & Schroeder, 2002; Tosh, 2011; Turban et al., 2019; Wallace & Russell, 2013). Moreover, MFTs do not refer (or refuse to see) clients based solely on the client holding a marginalized sexual orientation and/or gender identity, such referrals are considered discriminatory (Coburn & McGeorge, 2019a; Corey et al., 2015; Kaplan, 2014; McGeorge et al., 2015; McGeorge et al., 2016; McGeorge et al. 2017; Nguyen et al., 2016; Serovich et al., 2008; Shidlo & Schroeder, 2002; Shiles, 2009).

Create collaborative therapeutic relationships. MFTs actively seek to foster collaborative therapeutic relationships with LGBTQIA community resources and local and national LGBTQIA communities. MFTs work to be informed about inclusive and affirming LGBTQIA resources within their local community in an effort to provide appropriate resources for LGBTQIA clients and to seek out connections and educational opportunities for themselves.

Pillar 5: Transformative

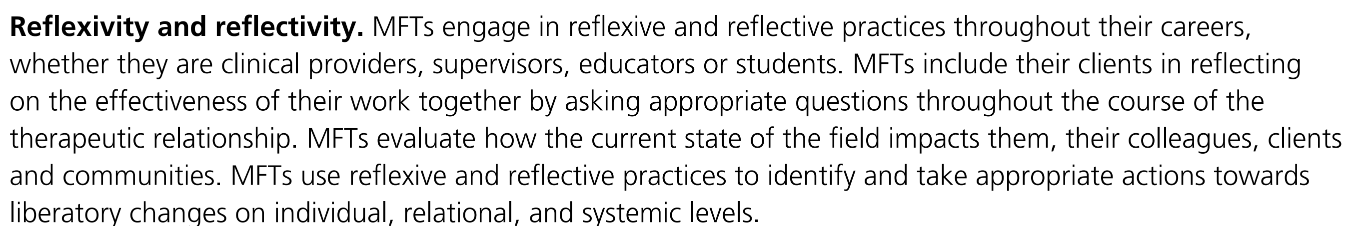
Given that MFTs are concerned about their clients' well-being, this commitment to well-being must extend beyond the therapy room and into the community and legislative structures.

Although, at first glance, these might seem beyond the scope of MFT, the reality is that, as systemic providers, MFTs understand that individual and familial experiences are in relationship to communal and legislative structures. Policies are both a reflection of communal and cultural values and shape those values through a synergetic relationship. For example, policies governing who can use a bathroom, who can participate in league sports, how someone can change their gender marker on legal documentation, who can get married, who can adopt children, and so on, shape the lives of the people most impacted by cisheterosexism (Iantaffi, 2015; Marzullo & Herdt, 2011; Mills, 2018; Ullman, 2018).

As stated earlier in this document, MFTs do not currently live in a geopolitical, social, and cultural context that is supportive of people whose identities, experiences, relationships, and families exist outside of cisheterosexism. This means that policies at local, state, and federal levels are often counter to client well-being. While MFTs acknowledge that some progress in this area has been made, MFTs have also witnessed how conditional any progress is, and how it can be quickly dismantled by a change in governance. As systemic providers, it behooves MFTs to not only address discrimination and oppression in the therapy room. In fact, if MFTs are not careful, MFTs end up reproducing the same systems of power and oppression within their therapy rooms, supervisory relationships, and educational programs, as Hare-Mustin (1994) pointed out when talking about therapy as a mirrored room that reflects the dominant discourses of society.

This is an aspect of what it means to work within a transformative paradigm. MFTs need to transform themselves—by dismantling their internalized superiority—and to transform the communities they live in, the educational systems they are trained within, and the policies that govern society and each person's life, if MFTs are to be effective in their work with LGBTQIA clients and supportive of LGBTQIA practitioners. What does this mean in practice? A transformative paradigm is, by nature, always in flux as it adapts to the currents of change and keeps pushing MFTs forward towards greater liberation. However, for the purposes of this document, there are four identified components of this pillar: accountability, reflexivity and reflectivity, neurodecolonization, and advocacy.

Accountability. MFTs acknowledge their positionality within the therapy room and throughout their careers. MFTs recognize how their identities and perceived identities are connected to systemic power structures. MFTs who hold supervisor, institutional and organizational leadership positions, and other leadership roles create and maintain platforms that allow people with marginalized LGBTQIA identities to have influence, and shape policies and procedures. MFTs acknowledge when they have participated in discriminatory practices, albeit unintentionally, and seek appropriate consultation and work to remedy and correct wrongdoings. MFTs acknowledge that their identities may play a part in establishing a sense of trust, especially with clients who experience marginalization. MFTs recognize that lived experiences have value in the therapy room, as well as when teaching, supervising, and in leadership positions. MFTs seek to be transparent and accountable in all their professional roles. MFTs engage in accountability practices by actively seeking out opportunities to continually reflect and learn about their privilege, such as attending ongoing trainings, reading current literature, and being aware of social and legislative issues related to sexual orientation and gender identity.



Reflexivity and reflectivity. MFTs engage in reflexive and reflective practices throughout their careers, whether they are clinical providers, supervisors, educators or students. MFTs include their clients in reflecting on the effectiveness of their work together by asking appropriate questions throughout the course of the therapeutic relationship. MFTs evaluate how the current state of the field impacts them, their colleagues, clients and communities. MFTs use reflexive and reflective practices to identify and take appropriate actions towards liberatory changes on individual, relational, and systemic levels.

Neurodecolonization. MFTs acknowledge that the current understandings of gender and sexual orientation are shaped by colonial values and, as such, erase and exclude Indigenous values, identities, and experiences. MFTs recognize that the field, including its past and continuing education, is deeply steeped in and influenced by the ongoing colonization in the United States and globally. MFTs are willing to center Indigenous voices and acknowledge that the current way of working is not the only pathway to healing. MFTs recognize that several Western-based therapeutic modalities often appropriate Indigenous healing practices and traditions, repackaging them for clients' consumption under capitalism. MFTs understand that the field has historically excluded and underserved many of the same populations whose cultures have been mined for 'new' approaches to healing. MFTs are willing to do the relational repair work needed to better serve all communities, including Indigenous communities, which continue to be impacted by colonialism.

Advocacy. MFTs are willing to contact regional, state, and federal elected officials to advocate for legislation and policies that improve the lives of clients. MFTs are willing to speak up against legislation and policies that limit the freedoms, access to resources, and rights of LGBTQIA people with regional, state, and federal elected officials. MFTs know that any conversion, change or reparative efforts in relation to gender and sexual orientation are not only ineffective but also deeply unethical and actively advocate against them. MFTs advocate for the inclusion of LGBTQIA people in AAMFT, COAMFTE, and other professional organizations charged with training and advocating for the profession. MFTs support LGBTQIA representation and leadership within the profession at local, state, and federal levels.

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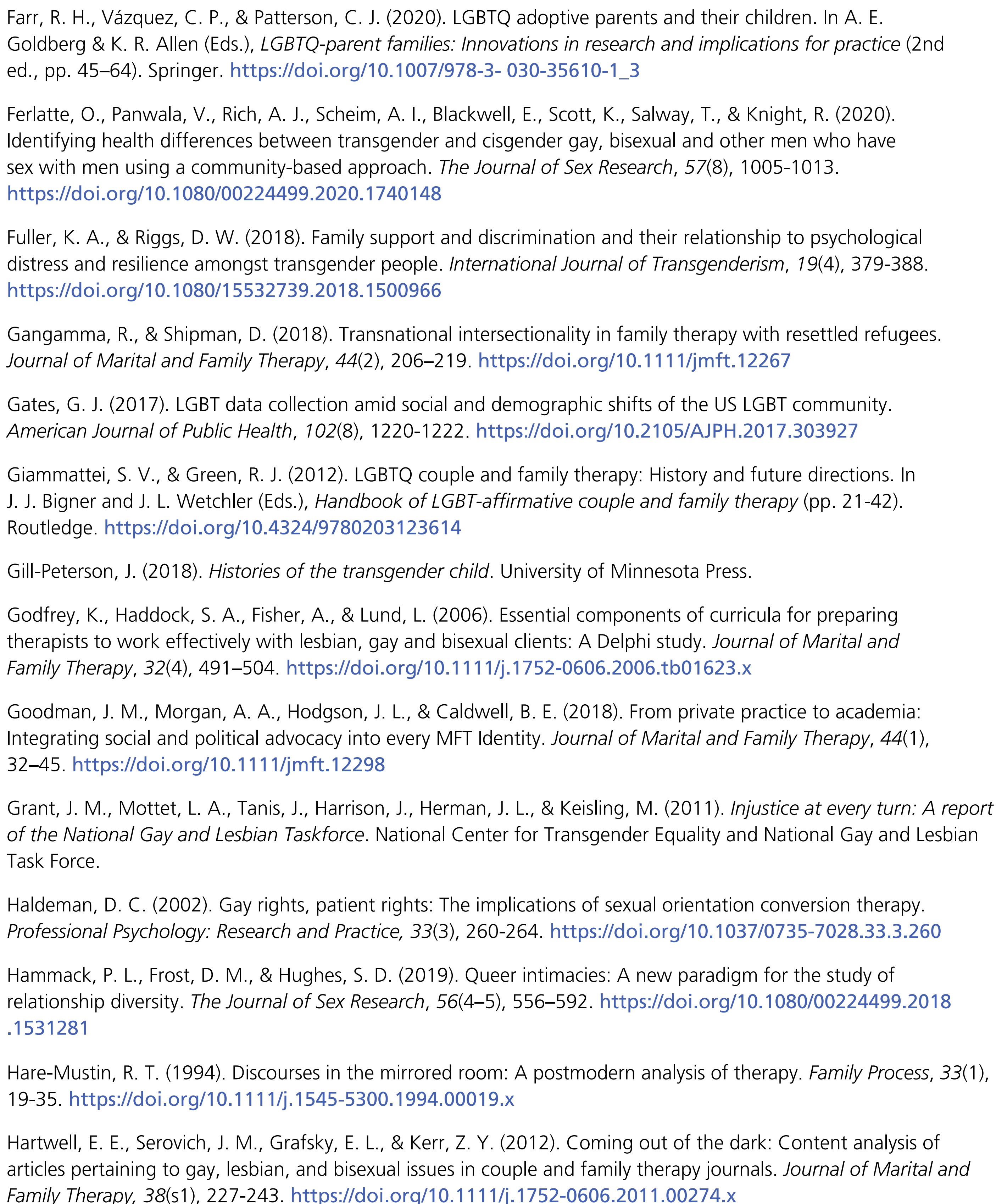

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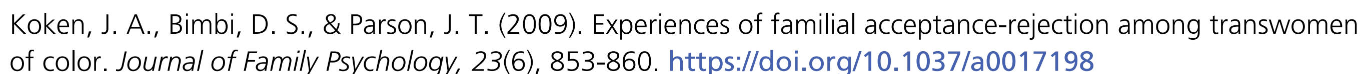

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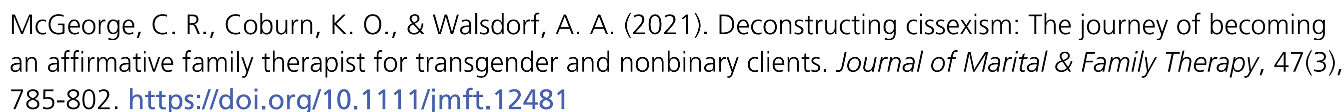

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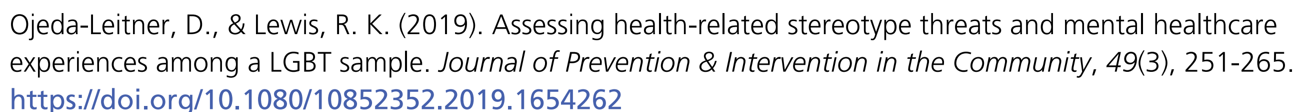

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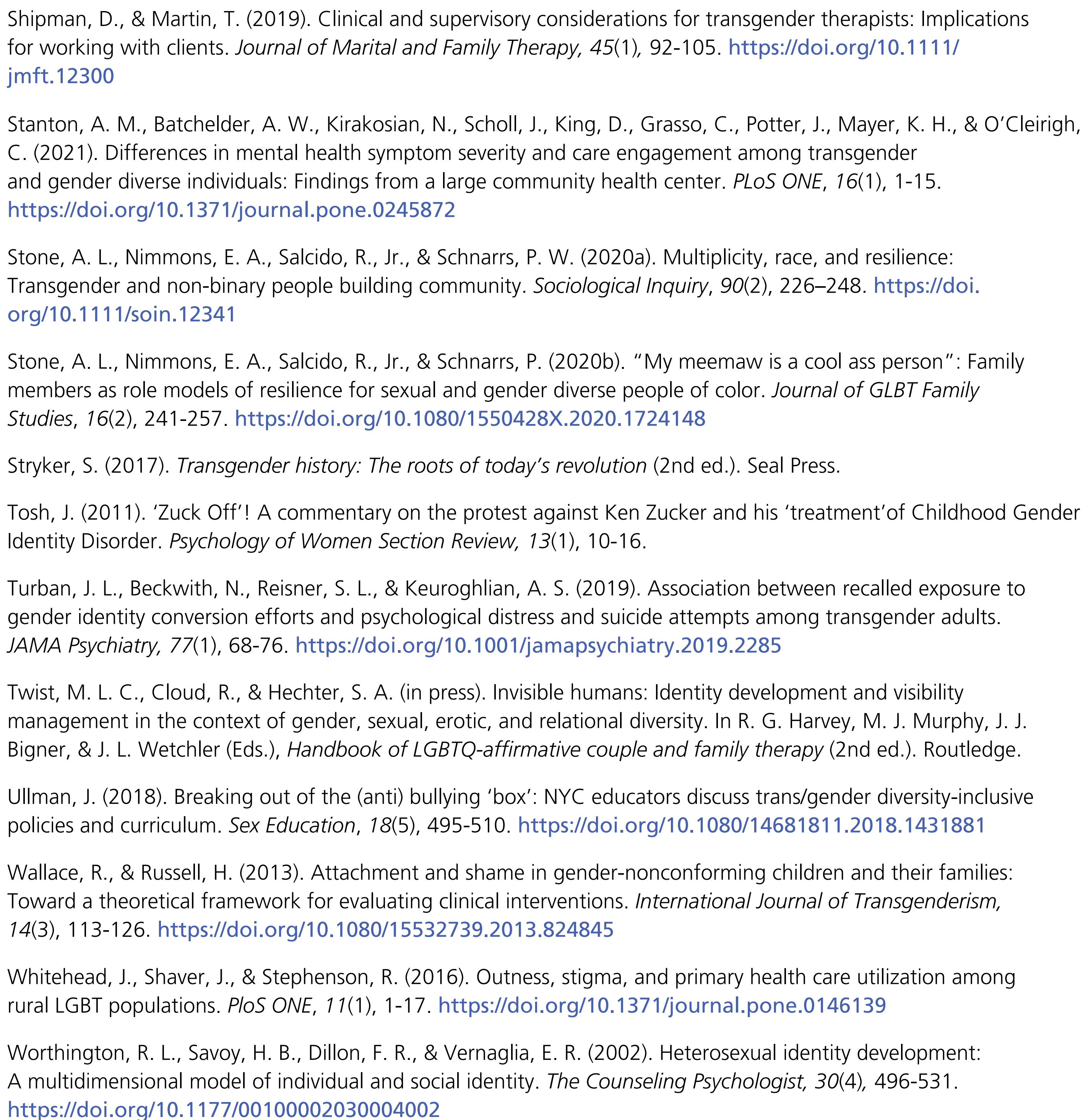

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Appendix A. Glossary

Ableism. A system of oppression that marginalizes and devalues people with disabilities or who are perceived to be disabled.

Asexual (ace). People who do not experience sexual attraction.

Bisexual (bi). People who are attracted to more than one gender.

Capitalism. A form of economic structure in which a societies' trade and markets are controlled by private citizens instead of the government. This allows private citizens to make decisions that may have substantial monetary impact on those who may be less privileged.

Center(ing). The process through which the margins of social identities are brought to the forefront of awareness and effort, dismantling the oppressive or marginalization standards of the status quo.

Cisgender (cis). Someone whose sex assigned at birth and gender identity align. For example, someone assigned male at birth who identifies as a man.

Cisheterosexism. A system of oppression that marginalizes and devalues people who are not cisgender or heterosexual.

Cisnormativity. The assumption that people are usually cisgender and that their gender assigned at birth aligns with their gender identity.

Colonialism. The occupation and oppression of a native or less powerful population through the assimilation of dominant concepts from the social group that holds the most power. This term relates to the historical oppression of indigenous persons through the expansion of power by invading and controlling or oppressing existing societies and countries throughout the world.

Consensual nonmonogamy. Having multiple close romantic and/or sexual relationships, typically with the knowledge and consent of all partners.

Deconstruct. The act of examining all parts of an idea, theory, or behavior to uncover any implicit and/or hidden assumptions, biases, values, and ideas.

Dominant. Social norms established by the populations who maintain power and privilege.

Equity. A system of resource management in which persons are afforded similar or the same opportunities regardless of social location, ability, or status.

Fluid. Changing over time.

Gay. A person who is attracted to people of the same gender as themselves.

Gender. A biopsychosocial construct that refers to the complex interaction of biology, psychology, and social and cultural norms governing identities, roles, and expressions of what is 'appropriate' for men, women, trans, nonbinary, and gender expansive people.

Gender expression. The way in which a person shows and displays their gender identity.

Gender identity. A term used to indicate an inner sense of who we are in relation to gender.

Gender identity change efforts (GICE). Methods and interventions to try to change someone's gender identity to conform to cisnormativity. These methods have not been corroborated by credible studies and have been condemned by most reputable healthcare professional organizations.

Heteronormativity. The assumption that people are usually heterosexual, and that heterosexuality is the only natural and normal sexual orientation.

Heterosexuality. Someone who is only attracted to people of the 'opposite' gender. This is an identity label so people may identify as straight but still have sex with people of different genders.

Internalized superiority. Process by which those who hold the most societal power come to believe that they are inherently deserving of it and, as such, superior to others.

Intersectionality. Black feminist Kimberlé Williams Crenshaw's term for overlapping social identities, and the related systems of privilege and oppression that impact our lives.

Intersex. A person has been born with indistinct or more than one distinct set of biological sexual/ genital constructs.

Lesbian. A woman who is attracted to people of the same gender as herself.

LGBTQIA. Lesbian, gay, bisexual, transgender, queer, intersex, asexual.

Macroaggression. Overt acts of discrimination against a marginalized individual or group.

Marginalization (margins). People who are outside of dominant norms and experience oppression due to some aspect of body, identity, and/or experience.

Medical industrial complex. The complex web of corporations within the healthcare industry that provide services and goods for profit.

Microaggression. As defined by Derald Wing Sue, microaggressions are everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.

Minority stress. The additional (added, moment by moment) stress experienced by LGBTQIA persons because of cisheterosexism that is in addition to the normative life stress experienced by all individuals.

Monogamy. Having only one close romantic and sexual relationship, to the exclusion of other romantic or sexual relationships.

Neurodivergence. A term used to indicate how someone's brain might process, learn, and function in a way that is not considered typical within current cultural and social norms. It is often used to refer to autistic people, people with ADHD, and conditions such as complex PTSD that can change the way our brain works.

Nonbinary (genderqueer). People who exist outside of the gender binary.

Oppression. The systematic discrimination and disempowerment of a group of people or persons by those who hold more power.

Patriarchy. A system of oppression in which male identified persons are afforded more power and privilege in society.

Power. The socially granted ability to hold influence and control over decisions, and/or various systems to the exclusion of others.

Privilege. Unearned societal benefits and advantages granted to people based solely on their socially dominant identities.

Queer. Sometimes used as a catch-all term for people who are not heterosexual or cisgender. Also used for any (sexual, gender, or relationship) experience outside of normativity.

Racism. The belief that there are inherent differences between racialized groups of people, and that those differences give one group the right to dominate other groups that are deemed inferior. Racism is institutionalized into norms, policies, and laws.

Sex. Sex can be used to indicate physiological aspects of ourselves, such as our sex assigned at birth. These aspects can be external or internal and may or may not change over time (e.g., sexual characteristics such as beards and breasts; hormone levels; chromosomes)

Sexual orientation. The kinds of people, roles, or experiences someone is sexually attracted to, or oriented towards.

Sexual orientation change efforts (SOCE). Methods and interventions to try to change a person's sexual orientation or attraction to conform to heteronormativity. These methods have not been corroborated by credible studies and have been condemned by most reputable healthcare professional organizations. Also known as conversion therapy or reparative therapy.

Transgender. An umbrella term for people whose sex assigned at birth differs from their gender identity.

White supremacy. The belief that White people are inherently superior to all other racial and ethnic groups, especially Black people, and are rightfully dominant and centered in any society.

Appendix B. Author Position Statements

Erica E. Hartwell, PhD, LMFT (she/her)

I am a White, cisgender, bisexual/queer, mostly-able-bodied woman, a citizen of the US and the El Nu Abenaki tribe, and a native English speaker. I was raised by divorced working class parents in Massachusetts. I currently identify as middle class and live in southern Connecticut (ancestral home of the Norwalke, Quiripi, Siwanoy, and Wepawaug peoples).

I am an Associate Professor of Marriage and Family Therapy at Fairfield University and the Program Director and creator of the Sexual and Gender Minority Mental Health program. I have served AAMFT as Chair of the Queer and Trans Advocacy Network, Chair of this CEO Workgroup, and now as Board member. My personal mission is to embody and inspire compassion. I work towards this mission in my professional life as an educator, supervisor, therapist, activist, and scholar whose work focuses on increasing access to inclusive and affirmative health care for all people.

Christopher K. Belous, PhD (he/him)

As a white, cisgender male I am the face of multiple layers of oppression; in addition, I am also well-educated with secure employment. Holding these positions of power has afforded me intense unearned privilege in the world. As a person, I constantly try to deconstruct hierarchical injustice using a queer feminist lens of advocacy, activism, and representation. I strive to dismantle the systems of oppression in our society and culture through introspective conversations with myself and those I have the honor to work with, and doing research and engagement to inspire insight for social justice issues.

I currently live in Northwest Indiana, where I teach and do research at Purdue University Northwest, serving as an Associate Professor and Program Director for the Couple & Family Therapy Graduate Program. My work has focused on sex and sexuality – broadly defined to include and be representative of sexuality and sex therapy. I am a Certified Sex Therapist, Certified Sex Educator, Certified Family Life Educator, and hold a Certification in Gay Affirmative Psychotherapy. I actively serve on national boards for associations, journals, and in other capacities across the nation and internationally.

Kristen E. Benson, PhD (she/her)

I am a white, able-bodied, middle class, queer, cisgender woman who is first-generation college educated. I serve as Program Director and Associate Professor of Marriage and Family Therapy at Appalachian State University. I earned my B.S. in Family Science from Florida State University, M.A. in MFT from Appalachian State, and Ph.D. in Human Development from Virginia Tech. I am a licensed marriage and family therapist and AAMFT Approved Supervisor. I reside in Boone, NC on the ancestral, traditional, and contemporary Lands of the Tsalaguwetiyi (Cherokee, East) and Moneton peoples. I joined the AAMFT LGBTQ Caucus in 1999, served as Moderator 2009-2011, and Chair of the AAMFT Queer Affirmative Caucus 2011-2018. I am involved in queer and trans advocacy and organizing in my community, university campus, professional organizations, and scholarship. My focus as an educator, therapist, and scholar centers on social justice and systemic inequality accountability.

Livingstone Cox, MA

Alex Iantaffi, PhD (they/them)

I am an Italian immigrant, trans masculine, bi queer, disabled, nonbinary, Pagan, polyamorous person who has been living, working, and parenting on Dakota and Anishinaabe territories, currently known as Minnesota (US) since 2008.

I am a family therapist, AASECT certified sex therapist, Somatic Experiencing® practitioner, WPATH certified gender specialist, clinical supervisor, author, public speaker, and independent scholar. I co-run a group practice, Edges Wellness Center LLC, which centers both providers and clients who have been historically marginalized and underserved. In 2019 I was honored to be the recipient of the MAMFT Distinguished Service Award. I was the Editor-in-Chief for the journal of *Sexual and Relationship Therapy* for eleven years and have researched, presented, and published extensively on gender, disability, sexuality, relationships, and HIV. I am honored to be part of the CEO Workgroup tasked with co-creating these guidelines and I feel that, in many ways, it is the culmination of 20 years of systemic training, research, and practice across two countries as well as community organizing. You can find out more about my work at www.alexiantaffi.com

Christi R. McGeorge, PhD (she/her)

I am a White heterosexual cisgender woman with an immense amount of privilege. My life and sense of self were changed many years ago when I learned about damali ayo's anti-racism work calling for White individuals to embrace a dual identity as a racist and someone who is trying to be anti-racist. Each day I try (and regularly fail) to embrace a series of dual identities as a racist and anti-racist, heterosexist and anti-heterosexist, cissexist and anti-cissexist, etc.

Since 2003, I have been a professor at North Dakota State University (NDSU) in Fargo, ND (which is located on *the traditional lands of the Oceti Sakowin (Dakota, Lakota, Nakoda) and Anishinaabe Peoples)* in the Department of Human Development and Family Science. Research is an important form of my advocacy work. My research focuses on the influence of heterosexism and cissexism on clinical practice and training, the intersection of religion and affirmative therapy with LGBTQ communities, promoting LGBTQ ally behavior in collegiate athletics, and gender equity in higher education.

Daran Shipman, MA, LMFT (he, him)

I am a white, queer, trans man in an interracial marriage residing in Upstate New York from a middle class, non-religious background. I grew up in a rural community without access to positive language or representation for my trans or queer identities. My lived experiences and the stories told by my community and by my clients, bring me to the work of building affirming places each day.

I am a licensed Marriage and Family Therapist with a private practice where I specialize in affirming care with transgender and gender expansive individuals and their families. I am an adjunct Instructor at Fairfield University where I teach a course on Transgender and Gender Expansive Affirmative Care. I am also part of the leadership team at Camp Aranu'tiq, a summer camp for transgender and nonbinary youth. I have published and presented on the topic of affirming care nationally and locally through my practice.

Markie Louise Christianson (L. C.) Twist, Ph.D. (they/she)

I was born in Anchorage and raised in a village (Houston) on the road system in Alaska. I am an androgynous, bisexual, kinky, polyamorous human in transition from early to mid-life, who is the parent of a Generation Z young teen. I reside in what colonizers call Las Vegas, Nevada, but what was and is Nuwu (Southern Paiute) land.

I am teaching faculty in the Doctor of Philosophy and Master of Arts in Couple and Family Therapy programs in the Department of Applied Psychology at Antioch University New England. I am an LMFT and LMHC, an AAMFT clinical fellow and approved supervisor, and an AASECT certified sexuality educator and supervisor. Recently, I co-authored *The Internet Family: Technology in Couple and Family Relationships* and *Focused Genograms: Intergenerational Assessment of Individuals, Couples, and Families* (2nd ed.). I am Editor of the AAMFT QTAN Newsletter and the Editor-in-Chief of *Sexual and Relationship Therapy.* I co-edited *Eco-Informed Practice: Family Therapy in Age of Ecological Peril*. For more about me, visit: drmarkie.com.

Teneo is AAMFT's online education platform and provides clinical training on various topics with a focus on systems and relational therapies, offering continuing education credits for mental health professionals. Explore our course catalog at www.aamft.org/learning and use code TENEO10 for 10% off your purchase.

The Queer and Trans Advocacy Network (QTAN) is a topical interest network of AAMFT with the mission to increase professional competency, enable peer support, and advocate for sexual and gender minority health and well-being. Join QTAN at www.aamft.org/qtan.

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