The American Occupational Therapy Association, Inc.

POLICY E.17

Subject: Affirming Sexual Orientation

PURPOSE: The purpose of this policy is to articulate the Association's commitment to the affirming care, safety, and inclusion of sexual minority clients and colleagues across occupational therapy education, practice, and advocacy.

RATIONALE:

The occupational therapy profession is grounded in client-centered, occupation-based practice that at its core addresses occupational justice for all individuals. As a profession, we affirm that:

- Occupational therapy practice supports and recognizes justice, equity, and diversity, which are integral in creating a transformative profession.
- American Occupational Therapy Association (AOTA) seminal documents, including the Occupational Therapy Practice Framework: Domain and Process, 4th edition (*OTPF-4*; 2020b) and the AOTA Occupational Therapy Code of Ethics (2020a), outline the process and standards for providing affirming care for sexual minorities.
- Sexual orientation is not an issue of morality; care that aligns with one's sexual orientation is ethical and inclusive.
- Sexual orientation exists as a natural part of the human experience; as such, one's orientation experience influences and impacts occupation. In the United States, there are an estimated 20 million lesbian, gay, bisexual, transgender (LGBT) adults (Human Rights Campaign Foundation, 2021).
- Sexual minority individuals engage in occupation in meaningfully unique and specific ways.
- Historical and contemporary traumas have shaped the experience of sexual minority individuals in the United States.
- Ongoing, widespread discrimination and stigma against those of diverse sexual orientations exist in mainstream society and contribute to occupational deprivation and injustice.
- Documented health disparities among sexual minorities is the result of the United States' environmental context being constructed in a way that traumatizes, harms, and excludes those with non-majority sexual orientations and identities.
- Approximately 70% of lesbian, gay, bisexual, transgender, queer, intersex, asexual, etc. (LGBTQIA+) individuals have had at least one negative encounter with a health care provider, including misgendering, inappropriate questions, and outright physical assault (Radix & Maingi, 2018). Practitioners may consciously or subconsciously play a role in replicating or disrupting sexual orientation narratives that harm sexual minority individuals.
- Support and relationships exist in all facets of an individual's life and provide practical

support, nurturing, protection, assistance, and affection. Families may be biologically related or constructed (not biologically related).

- *Chosen* family may be more common for sexual minorities due to prevailing homophobic social attitudes. These found or constructed families may differ from heteronormative assumptions of *family*, such as chosen family, multiple adults sharing a household, non-blood family, or blood family outside the nuclear family (e.g., being raised by affirming uncle vs. by biological parents).
- Affirming care and inclusive environments are critical to improving health, occupational engagement, and quality of life. These have an impact not just on clients but also on colleagues, peers, professional partners, and stakeholders.
- High quality occupational therapy services include a comprehensive understanding of personal and contextual factors related to sexual orientation. "Practitioners recognize that for people to truly achieve full participation, meaning, and purpose, they must not only function but also engage comfortably within their own distinct combination of contexts" (AOTA, 2020b, p. 9). Sexual orientation is one of many personal factors that occupational therapy practitioners must recognize when considering a person's context.
- There is a documented gap in research and content pertaining to sexual minorities in occupational therapy education, continuing competence, and practice.

THE FOLLOWING COMPONENTS CONSTITUTE THE ASSOCIATION'S POLICY IN REGARD TO AFFIRMING SEXUAL ORIENTATION

I. TERMS & DEFINITIONS

A note on terminology & definitions: Terminology and definitions evolve and change over time as people and society evolve. Labels and terms also have different definitions among the individuals who use them. Therefore, the definitions within and outside of this document and between people will vary. These definitions are operational for the purposes of unifying an understanding among those referencing and working under this policy for clear expectations of practice.

1. Sexual Orientation
    a. Sexual orientation refers to emotional, romantic, and/or sexual attraction toward another person. This is a distinct client factor different from one's sex assigned at birth, gender identity, gender expression, and attributed gender.
    b. Individuals who are exclusively attracted to one gender may be labeled as *monosexual*.
    c. For monosexual individuals who are exclusively attracted to people of a gender different from their own, labels may include *heterosexual* or *straight*.
    d. For monosexual individuals who are exclusively attracted to people of their same gender, labels may include *gay* or *lesbian*.
    e. Individuals who are attracted to people of a variety of genders, both

similar to and different from their own, include individuals who are *bisexual*, *pansexual*, or *queer*, among others.

f. Some individuals do not experience physical, emotional, and/or sexual attraction as a primary motivation for engaging in relationships. This can include individuals who are *asexual*, *demisexual*, or *aromantic*, among others, depending on the individual's experiences of attraction in social relationships.

2. Sexual Minority
    a. This term is more often used by the National Institutes of Health, and the Centers for Medicare & Medicaid Services, among other regulatory bodies, than among individuals.
    b. Non-majority sexual orientations include lesbian, gay, bisexual, pansexual, queer, and asexual, among others. These are frequently referred to under the umbrella term "LGBTQIA+". Please note that the "T" & "I" (transgender & intersex) describe sex & gender identity–related terms; please refer to AOTA's policy on *Affirming Gender Diversity and Identity* for more information.
    c. *Same gender loving* or SGL is a related term that comes from the African American community as an Afrocentric alternative to the Eurocentric "LGBT" frame of reference.

3. Heteronormativity
    a. This is the concept, belief, or attitude that heterosexuality is the preferred or "normal"sexual orientation. It assumes that there are only two distinct, opposite genders (referred to as *gender binary*) and that sexual relations are most appropriate or "normal" between people of "opposite" sex.
    b. Heteronormativity is a pervasive belief system in the United States and creates conditions of heterosexual or straight privilege, and marginalizes lesbian, gay, and bisexual individuals.
    c. Compulsory heteronormativity refers to the pressures and influences of individuals and society to uphold the ideology of heteronormativity (e.g., "homosexuality is a disease," "legal marriage is inappropriate for same-sex couples," "lesbians don't have 'real' sex").
    d. Cisnormativity is a related concept that holds that gender is determined by genitalia, chromosomes, and sex assigned at birth. This belief system erases transgender and gender-diverse individuals, and it reinforces binary gender ideology (such as heteronormative relationship structures). Additional information on managing cisnormativity can be found in AOTA's Policy E.15, *Affirming Gender Diversity and Identity*.
    e. Heteronormative (and cisnormative) ideology is used to justify systemic oppression and other instances of harm. Examples include the history of *homosexuality* being labeled as a mental illness in previous versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (*DSM I-III)*, refusing to serve sexual minority individuals, and the lack of legal protections for LGBTQ+

individuals.

f. The idea that certain genders are "most appropriate" or assumed to be attracted to other genders (such as men being attracted to women).

4. Sexuality is a state of mind that represents how individuals feel about themselves, how they relate to others, how relationships are established, and how they express themselves (AOTA, 2013).

5. Affirming Care for Sexual Minorities
    a. Affirming care for sexual minorities is health care that respectfully affirms sexual minority individuals' sexual orientation while holistically meeting their physical, mental, and social health needs and well-being.
    b. Affirming care is defined and informed first and foremost by the needs of each individual client.
    c. Affirming care includes evidence-informed practice.
    d. Affirming care for sexual minorities aligns with occupational therapy's client-centered focus on the person, their environment, and their occupations.

II. DEFINED OUTCOMES

A. Safety

1. Safety is necessary for all sexual minority individuals whether they are a client, colleague, or other stakeholder in practice, education, and research.
2. Trauma-informed care (TIC) provides the minimal base for creating safety for all individuals regardless of age, particularly sexual minorities, who are more likely to have experienced trauma in a health care setting. Universal precautions, consistent with Level 1 TIC approaches, should be integrated into all settings and contexts.
3. Occupational therapy practitioners and students should engage in the purposeful critical examination of compulsory heteronormativity to create safer contexts and settings for sexual minority individuals.
4. At minimum, all settings should adopt a zero-tolerance policy for homophobic, heterosexist, queerphobic, homo-antagonistic, queer-antagonistic, or other sexual orientation-based harassment or violence.
5. Occupational therapy practitioners' and students' verbal and written communication should consistently affirm sexual orientation through recognizing all found and constructed families as an inherent part of an individual's identity, contexts, and roles, while recognizing the trauma endured due to heteronormative assumptions.
6. Occupational therapy practitioners and students should be aware of organizational, local, state, and national laws and policies, or lack thereof, that may not provide explicit legal or non-discrimination protections for sexual minority individuals. The lack of policies or legal

protections may limit the ability to report instances of bias, harm, and human rights violations.

7. Occupational therapy practitioners and students are bound by the AOTA Code of Ethics to provide high quality, non-discriminatory care to sexual minorities.

B. Education
    1. Occupational therapy education programs should explore the complex relationships of sexual orientation to all areas of occupation, with special emphasis on sexual minority individuals.
    2. Occupational therapy curricula should include education on care for sexual minority individuals as it aligns with current education standards including, but not limited to:
        a) Ethical decision making
        b) Sociocultural, socioeconomic, and diversity factors
        c) Trauma-informed care
        d) Social determinants of health
        e) Upbringing and life experiences
        f) Therapeutic use of self.
    3. Educational environments should be inclusive and equitable for sexual minority students, faculty, and staff, and should strive to create safe educational contexts and systems (e.g., inclusive documentation, forms, and language).
    4. Occupational therapy research should further develop the evidence base for providing affirming care for sexual minorities.
    5. Occupational therapy educators are encouraged to examine the impact of underlying heteronormative & cisnormative assumptions and biases impacting the content and methodology of what they are teaching as it pertains to sexual minorities, including, but not limited to:
        a) Accessibility of education for students who are excluded by heteronormative and cisnormative systems and structures (e.g., discriminatory attitudes, lack of representation, safe housing)
        b) Assessments and evaluations (i.e., examining standardized assessments for language that may exclude same-gender relationships, such as forms defining intimate partner relationships as between a "boyfriend & girlfriend"; identifying opportunities to include gender-inclusive language in the evaluation process such as asking, "are you dating?" vs "do you have a boyfriend?"; "who do you consider family?" vs assuming their bio-family[1] is their family)
        c) Intervention strategies (e.g., using social stories that provide both mixed-gender and same-gender relationships, instead of assuming

[1] "Bio-family" is shorthand for "biological family". This refers to someone's blood relatives, who may be discriminatory towards your LGBTQIA+ client. "Bio-family" may or may not be the primary social support or "family" for some LGBTQIA+ individuals.

heterosexual relationships)

d) Therapeutic use of self (e.g., recognizing your positionality related to the sexual majority and how it may help or hinder your relationship with your client. Understanding that family & social relationships may vary greatly, and taking care not to assume that their bio-family relationship is a positive one).

6. Occupational therapy education programs are encouraged to cultivate strong self-reflection skills in their students and faculty to understand implicit bias and its impact on their conduct.
7. Occupational therapy programs are encouraged to actively dismantle oppressive systems to create a space for faculty and students to advocate for their safety and wellness within the classroom and fieldwork settings.

C. Continuing Competency

1. Occupational therapy practitioners will critically examine and self-reflect upon implicit biases toward sexual minority individuals and how bias unconsciously shapes actions that may exclude, invalidate, or harm clients.
2. Occupational therapy practitioners should actively develop, maintain, and update competence, as well as pursue continuing competence opportunities, to provide high-quality sexual minority affirming care to sexual minority clients.
3. Occupational therapy practitioners should develop and maintain competency regarding current terminology and vernacular utilized by sexual minority individuals.
4. Occupational therapy practitioners should be familiar with current AOTA Official Documents and Professional Policies as well as legislative, legal, and regulatory requirements to provide affirming care.
5. Occupational therapy practitioners should systematically re-examine previous assumptions and revise decisions to incorporate new evidence, research findings, and outcome data as they relate to sexual orientation and sexual minorities.
6. Occupational therapy practitioners must critically self-reflect based upon feedback provided by sexual minority individuals, adapting one's professional behavior and clinical reasoning to foster therapeutic and professional relationships.
7. Occupational therapy practitioners are encouraged to seek out and allocate resources toward LGBTQIA+ affirming training to facilitate and foster safe and accessible care for sexual minority populations.

D. Practice

1. Occupational therapy practitioners must acknowledge, incorporate, and respect sexual orientation to provide holistic, evidence-based, trauma-informed, and client-centered care across the lifespan.
2. Occupational therapy practitioners are encouraged to examine the impact of underlying heteronormative and cisnormative assumptions and biases impacting the process and domain of occupational therapy practice, including:
    a) Accessibility of care for sexual minority clients (e.g., recognizing that previous negative or traumatic experiences may prevent individuals from seeking care; addressing how the clinic environment may be exclusionary or unsafe)
    b) Assessments and evaluations (e.g., maintaining an affirming and inclusive mind during the initial interview, such as asking open-ended questions about household labor instead of making assumptions based on gender roles; allowing a client to define their own family and social supports rather than focusing solely on biological & legal relationships)
    c) Goal setting and intervention strategies (e.g., including goals enabling the client to attend groups at a local LGBT center, recognizing that electronic health record information may incorrectly categorize a client's partner as solely an instrumental caregiver)
    d) Therapeutic use of self (e.g., providing support and autonomy to clients regarding disclosure of their sexual orientation as it relates to occupational choices, partner/caregiver relationships, and their experience in the health care system)
3. The use of functional and occupation-based assessments and interventions by occupational therapy practitioners is critical in developing, executing, and affirming plans of care while avoiding heteronormative assessments and interventions based on the gender binary.
4. Occupational therapy practitioners are encouraged to help create safe work environments for sexual minority colleagues, staff, administrators, and volunteers (e.g., providing support to coworkers who are being targeted by clients or other coworkers, or systemic policies that impact their safety and well-being).
5. Occupational therapy practitioners are encouraged to connect with their local sexual minority–serving organization (i.e., LGBT Center) as a resource for their clients and for their own professional development.
6. Occupational therapy practitioners shall not engage in practice aimed at changing or denying an individual's sexual orientation.

E. Advocacy
    1. Occupational and social justice are core values of the profession and should be a central focus of occupational therapy advocacy efforts in

alignment with the *OTPF-4* and the AOTA Occupational Therapy Code of Ethics.

2. AOTA advocates for:
   a) An individual's right to self-identify their sexual orientation, no matter the age, ability, or context
   b) The deconstruction of compulsory heteronormativity
   c) Inclusive and safe work, home, education, and community environments for sexual-minority individuals
   d) Equitable health care access for sexual-minority individuals
   e) Trauma-informed care integrated into policies and procedures across all settings and contexts
   f) Policies, laws, and regulations at the local, state, and national levels that support sexual minorities including, but not limited to, anti-discrimination laws (e.g., family rights, housing, employment, and public accommodations such as access to services offered by private businesses and health care providers)
   g) Organizational, operational, and procedural changes, including, but not limited to, health care, education, community, and other settings to make them more inclusive for sexual-minority individuals (e.g., modifications to heteronormative language in electronic medical records, intake forms, marketing and promotion of services, etc.)
   h) Increased research and evidence including sexual orientation and its relation to occupation
   i) Diversity in our settings, contexts, and the profession at large.
3. AOTA advocates against:
   a) Policies with negative impacts on sexual minorities including, but not limited to, restrictions to health care decision making and information sharing, employee benefits, and adoption policies for individuals and their partners or spouses
   b) Systemic barriers to health care utilization by sexual-minority individuals
   c) The practice of conversion therapy[2] and other efforts to change an individual's sexual orientation.

References

[2] Conversion (or *reparative*) therapy is the harmful practice of attempting to change an LGBTQIA+ individual's gender identity or sexual orientation

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