When Identities Collide:

Identifying Best Practices for Family Therapy with LGBTQ+ Young People in Mormon Families

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Dissertation submitted to the faculty of Virginia Polytechnic Institute and State University in partial fulfillment of requirements for the degree of

Doctor of Philosophy

In

Human Development

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February 15, 2023
Blacksburg, VA

Keywords: LGBTQ+, Mormon, family therapy, best practices, intersectionality

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ABSTRACT

This study investigates the best-practice guidelines for family therapists working with LGBTQ+ young people and their Latter-day Saint families. Through a modified Delphi method, the study employs a mixed-methods approach to identify the expert consensus on best practices in the field. The study was framed using an intersectional modification of Bronfenbrenner's ecological framework. This study fills several significant gaps in the literature, as it is the first to specifically examine (a) family therapy best practices, (b) LGBTQ+ youth and young adults, and (c) their LDS families. The results of this study will contribute to the advancement of best practices in the field of family therapy, particularly for therapists working with LGBTQ+ young people and their Latter-day Saint families.

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ABSTRACT FOR GENERAL AUDIENCES

This study aimed to identify the best-practice guidelines for family therapists working with LGBTQ+ young people and their families who follow the Latter-day Saint faith. The study was conducted using a mixed-methods approach, which included qualitative interviews and surveys, and framed within an ecological framework. This is the first study to examine family therapy best practices specifically for LGBTQ+ youth and young adults and their LDS families, filling a significant gap in the literature. The results of this study will help therapists provide better support to LGBTQ+ young people and their families.

DEDICATION

I dedicate this dissertation to LGBTQ+ young people and their LDS family members whose courage, resilience, and commitment to navigating complex family dynamics have been a constant inspiration to me. I hope that this work will contribute to a better understanding of your experiences and ultimately lead to improved mental health outcomes for you and your families.

I also dedicate this dissertation to the therapists who work with LGBTQ+ young people and their families. Your dedication to your clients and your commitment to lifelong learning have been a source of inspiration to me. I hope that this work will provide you with useful insights and tools to better serve this population and that it will encourage ongoing reflection and growth in your practice.

ACKNOWLEDGEMENTS

I begin by reflecting on why I embarked on this dissertation journey in the first place. As a new family therapist in my master's program, I suddenly went from having done no therapy before in my life to having a caseload of LGBTQ+ young people in Latter-day Saint families, nearly half of whom were experiencing active suicidality. When I looked for existing research to guide me, I couldn't find any resources that addressed the tricky nuances of this work. Even after I compiled all the resources I could find, there were important gaps in information for how to best navigate such nuanced sessions. I knew the research needed to be done, but I had no desire to pursue a doctoral degree.

Having had an extremely difficult experience as a Master's student, I felt resistant to remaining in the power structure of academia for several additional years. Present, too, was the cultural rhetoric that as a single, Mormon woman, choosing to move to the east coast to continue my education was, in essence, also a choice not to get married and have a family. Despite these challenges, I remained committed to this important work, and the last five years have--though often draining and sometimes painful-- have been some of the most formative of my life. I'm grateful to say that I still believe I would make the choice again.

I would like to extend my heartfelt thanks to my chair, Dr. Erika Grafsky, for empowering my autonomy and providing a non-judgmental approach that has been critical to my success. I am also grateful to my dissertation committee members, Dr. Jody Russon, Dr. Tyler Lefevor, and Dr. Megan Dolbin-MacNab. Dr. Russon, thank you for seeing and validating my strengths as an academic and clinician. Your letter of recommendation for me still serves as a source of inspiration and confidence. Dr. Lefevor, your cultural expertise and feedback have

been instrumental in making this study possible. Your contributions to this field have helped scaffold the literature at this intersection. Dr. Dolbin-MacNab, your methodological and academic expertise has been invaluable to me, and your lecture on qualitative methods in our mixed-methods research class was instrumental in my thematic analysis process.

My sincere gratitude goes out to, Michael, for his endless support throughout this process. Your care and attention to detail in feeding me every meal during the times I was in the throes of writing my prelims and dissertation study were critical to my success. Thank you for taking such good care of Albie, our pup, so that I could direct more energy to completing my formal education journey. Your patience, comfort, and love through my many moments of overwhelm and self-doubt have been invaluable.

I am deeply appreciative of Dr. Lisa Tensmeyer Hansen for being my mentor and friend. Lisa, you have been an important example to me of how to facilitate a healing environment for both clients and clinicians. Without your years of laying the foundation of this work, your warm approach to leadership, your collaborative heart, and your fierce advocacy, I likely would not have pursued my dissertation or doctoral degree. Your guidance, mentorship, and support have been instrumental in my success. I am grateful for your unwavering belief in me and for how you have challenged and inspired me. Thank you for being an integral part of my journey.

I would like to express my profound gratitude to the members of the pup pic group, Drs. Allie King and Jessica Resor. Allie, you have been the best doggie co-parent I could have asked for. Your unwavering support and encouragement throughout our program have been invaluable to me. You and Huck have been a constant source of comfort and joy. Jessica, I am grateful that of all people, I was able to be quarantined with you and Albie. Your presence in my life has been

a saving grace. Your friendship, kindness, and generosity have touched me deeply. Thank you both for your unwavering support and for being a part of my life.

I would like to express my heartfelt appreciation to my mentor and friend, Brian Huwe. Brian, I am so grateful that we met before I left Virginia. Our frequent meetings have been instrumental in helping me expand my mind and attune with my heart. The lessons I have learned from you have greatly informed my conceptualization of this study. Your wisdom, guidance, and support have been invaluable to me. I am grateful for your unwavering belief in me and for how you have challenged and inspired me. Thank you for being an integral part of my journey.

I want to acknowledge and thank my family members, especially my mom, Alison, and Lily. Your help with formatting when my deadline was closing in was immensely helpful. I appreciate your willingness to help me in any way possible, no matter how big or small the task. Your support, love, and encouragement have been a constant source of strength and motivation for me. I am truly blessed to have such a wonderful and supportive family. Thank you for being on my team and for believing in me even when I doubted myself.

I would like to extend a heartfelt thank you to my friend Andres Larios Brown. Andres, thank you for being just as obsessed as I am with intersectional therapy processes with LGBTQ+ young people raised in Mormon families. Our discussions have deeply influenced the thought processes behind this study, and our friendship has felt meant to be. Your insights, wisdom, and support have been invaluable to me. Thank you for being a part of my journey.

Finally, I would like to express my sincere gratitude to the therapists who participated in this study, whether through interviews or surveys. Your willingness to share your experiences

and insights has been invaluable to this research. I appreciate your dedication to this work and your commitment to serving LGBTQ+ young people and their LDS families. Thank you for your time and expertise. I am honored to have had the opportunity to conduct this research, and I hope that it will contribute to the growing body of knowledge in this field.

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CHAPTER 1. INTRODUCTION

This study is designed to identify best practices for family therapists serving LGBTQ+ young people in Latter-day Saint (also known as "Mormon" or "LDS") families. The following chapter provides the background and significance of why a study examining the unique considerations family therapists must make when working with LGBTQ+ youth and young adults in Latter-day Saint families is warranted. Specifically, this chapter will address (a) the background of this study, (b) a statement of need for this study, (c) the purpose and significance of this study, (d) the research design, (e) the research questions, (f) the assumptions and limitations of this study, and (g) definitions and terms used in this study.

Background of the Study

Family therapists may at any moment find themselves working with LGBTQ+ young people and young adults in families who subscribe to the beliefs of the Church of Jesus Christ of Latter-day Saints (LDS Church). The LDS Church centers much of its doctrines on the importance of family, and great emphasis is placed on heterosexual marriage and a binary gender construct (i.e., church doctrines, policies, etc.). Heteronormative and cisnormative doctrines and policies can create dissonance within LGBTQ+ young people and also among and between family members who may be trying to reconcile their religious beliefs with the love they have for their child.

Studies have shown that those holding both sexual minority and Mormon identities face negative impacts on their mental health such as mood disorders, self-worth issues, suicidality, and a need for mental health recovery (Jacobsen & Wright, 2014). Minority stress has been identified as a major factor in these mental health outcomes by researchers (Crowell et al., 2015;

Grigoriou, 2014), who cite social constraint (Grigoriou, 2014), internalized homophobia, the need for privacy and acceptance, difficult processes, and identity confusion as contributing factors (Crowell et al., 2015). Lefevor et al. (2019) further support these findings by showing that authentic expression of sexuality, openness about same-sex attraction experiences, and positive identity feelings positively correlated with well-being for LGBQ/SSA Mormons. Framed within the context of an LDS family, together these findings suggest that LGBTQ+ young people in LDS families may experience negative mental health effects related to minority stress, but that authentic expression of sexuality, positive feelings about one's sexual attractions, and social support can help improve their mental health.

Need for the Study

Currently, the literature at the intersection of LDS and LGBTQ+ identities focuses almost entirely on the experiences of LGBTQ+, Latter-day Saint adults. There is a dearth of research, however, focused on adolescents and young adults, specifically. Further, there is a need for more clinical research about the nuances of therapy with LDS LGBTQ+ youth and young adults in a clinical mental health setting, especially when their family members may be involved in therapy. Thus, this study seeks to build upon existing literature by contributing concrete recommendations for therapists who include family members in their interventions or who see the family system as their primary client when working with LGBTQ+ youth and young adults and their LDS families.

Purpose of the Study

The purpose of this mixed-methods Delphi study is to (a) identify guidelines of best practice for family therapists working with LGBTQ+ young people and their LDS families and

(b) determine areas of practice where additional training may better support therapists who are conducting this clinical work. This inquiry seeks to provide therapists with culturally responsive, ethical considerations and strategies to scaffold the complex processes LGBTQ+ young people and their LDS families must navigate in family therapy. Such strategies and considerations examined include decision-making processes, cultural considerations, appropriate goals for family therapy, strategies for who participates in each session, etc. The field of LGBTQ+/Mormon Studies is relatively new, and very little of it currently focuses on clinical practice. In fact, no previous study has yet investigated clinical practices with LDS families and their LGBTQ+ child. These research gaps indicate a need for concrete guidelines of best practice so that therapists serving this population are better equipped to expertly navigate the nuances that accompany this work.

Significance of the Study

There are several important areas where this research makes an original contribution. Previous studies, for example, have produced research at the intersection of LGBTQ+, LDS-affiliated individuals, and mental health factors (see the individual work of Drs. Tyler Lefevor, Renee Galliher, and John Dehlin). While several have provided implications for clinical practice, no studies to my knowledge have examined clinical processes with LGBTQ+, LDS-affiliated people. Additionally, the only study I know of that has examined clinical experiences focused primarily on LGB adults—there was no inclusion of transgender clients, nor was there any focus on youth or young/emerging adults (Jacobsen & Wright, 2014). Most clinical research at this intersection focuses on clients' experiences of conversion therapy (Beckstead & Morrow, 2004) and sexual orientation change efforts (Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015).

Finally, only one study has included family as a significant factor, focusing on experiences of family support of “GLBQ Latter-day Saints”, but the authors did not approach the topic of clinical practice (Mattingly, 2016). Therefore, this study fills several significant gaps, as it is the first to specifically examine (a) family therapy best practices, (b) LGBTQ+ youth and young adults, and (c) their LDS families.

While there is existing research on how to conduct family therapy for LGBTQ+ young people, there is a need for similar research specific to Latter-day Saint families, as well as research that focuses on LGBTQ+ young adults. LDS families not only strongly subscribe to deeply held belief systems, but they also belong to a tight-knit cultural community. In other words, therapists working with these families are entering a complicated family system that is influenced by predominant doctrines and cultural practices—among a plethora of other factors that impact many families (i.e., social location, family history, etc.). One example of an influential doctrinal factor is *The Family: A Proclamation to the World* document (1995, aka *The Family Proclamation*) published by the LDS Church, which states: “We declare that God has commanded that the sacred powers of procreation are to be employed only between man and woman, lawfully wedded as husband and wife.” This heterocentric belief, compounded by cultural mentalities such as “Love the sinner, hate the sin,” indicate that existing literature on family therapy for LGBTQ+ youth and young adults may not be sufficiently nuanced or culturally mindful enough to translate to similar work among Latter-day Saint families and their LGBTQ+ loved one.

Research Questions

Given that the risk for mental health distress is high among LGBTQ+ young people within Latter-day Saint families (Ryan & Rees, 2012), and that a family approach has been established as a helpful approach for LGBTQ+ young people in therapy (Diamond, et al. 2013), this study aims to establish an expert consensus on guidelines of best practices for family therapy this population. This mixed-methods study will explore the considerations therapists must make as they navigate therapeutic processes with LGBTQ+ young people in LDS families. To develop concrete best-practice recommendations that take into consideration the intersectional needs of LGBTQ+ young people and their LDS families, the research questions posed in this study were:

R1: What is the expert consensus on best practices for family therapists working with LGBTQ+ young people and their Latter-day Saint families?

R2: How do family therapists with intermediate experience working with LGBTQ+ young people and their Latter-day Saint families perceive their self-efficacy in implementing the best-practice recommendations identified in R1?

Definitions of Terms

LGBTQ+

The acronym LGBTQ stands for lesbian, gay, bisexual, transgender, and queer/questioning. This acronym represents the various sexual orientations and gender identities of individuals who do not conform to traditional heterosexual and cisgender norms. The term LGBTQ+ can also include other identities such as intersex, asexual, and pansexual, among others. The "+" symbol represents the diverse and inclusive nature of the LGBTQ+ community.

When used in this paper, the term LGBTQ+ is an acronym meant to include the identities of all individuals who identify as non-heterosexual and/or non-cisgender. This term includes but

is not limited to lesbian, gay, bisexual, asexual, pansexual, and queer individuals (sexual minority identities), as well as transgender, non-binary, gender-queer, and intersex individuals (gender/sex minority identities).

Young People

This study examines family therapists' work with LGBTQ+ individuals in LDS families. Nearly all research on LGBTQ+ Mormons is centered on adults, but no studies thus far have explored clinical work with adolescents and young adults. Given that there are clear developmental markers within the LDS Church structure that are dependent on age, gender, and Church "worthiness," this study focuses on family therapy processes with young people between the ages of 12-25 years old.

Latter-day Saint

Language around the identity of the Church of Jesus Christ of Latter-day Saints and its members is complicated. Historically, members of the Church have been referred to, both by self and others, as "Mormon" (likely in reference to *The Book of Mormon*). In addition, because of the lengthy name of the Church, "LDS" has been a common short-hand description of the Church and its members. However, the president of the Church recently released a statement that they now discourage the use of the colloquial terms "Mormon" and "LDS", and created a style guide on the preferred Church-approved terms. When referring to Church members, the guide states that the terms "members of The Church of Jesus Christ of Latter-day Saints," "Latter-day Saints," "members of the Church of Jesus Christ" and "members of the restored Church of Jesus Christ" are preferred" (Church Newsroom, 2018). When referring to the name of the Church, the

Church's full name or "the Church", "Church of Jesus Christ," and the "restored Church of Jesus Christ" are also endorsed in the style guide.

However, the terms "Mormon" and "LDS" are still commonly used in conversation among Church members, and many prefer to hold on to their identity as "Mormons." "Mormon Studies," for example, is a field of research that continues to utilize these terms despite recent Church statements. Thus, with the intent to respectfully include the spectrum of identities related to the Church of Jesus Christ of Latter-day Saints, this paper will include all of these terms interchangeably.

Family Therapy

Within the context of this study, family therapy will be defined as therapy that (a) views the family system as the client and (b) involves at least two family members or family-equivalent relationships. Additionally, because panelists in this study may not all have family-specific clinical training, the term "family therapist" will be used to describe any therapist conducting family therapy as described here.

Research Design

This mixed-methods study employed a modified Delphi method with four rounds of data collection and analysis. Round I involved qualitative interviews with family therapists (core field experts; CFEs) who had extensive expertise working with LGBTQ+ youth and their LDS families. In Round II, a survey compiling the findings from interviews was returned to core field experts, inviting CFEs to endorse which best-practice recommendations they deemed important. Endorsed recommendations from Survey I were used to create Survey II. Round III entailed sending Survey II to a panel of peripheral field experts (PFEs), who then rated their perceived

self-efficacy for each of the best-practice recommendations previously endorsed in Round II. Finally, Round IV entailed the compilation of this study's findings into a brief document of concrete best-practice recommendations for family therapy with LGBTQ+ young people and their Mormon families. The document was distributed to all participants who had indicated a desire to receive the completed study's findings. See Figure 2 in Chapter 3 for a full procedural outline of this study.

Researcher Positionality, Assumptions, and Limitations

Researcher Positionality

This study, like all research, is impacted by the knowledge, experiences, and perspectives of the researcher. I currently identify as a born-and-raised Mormon who has gone through an extensive, ongoing critical investigation of my theological beliefs. The result has been a long-term deconstruction process of internalized fundamentalism, heteronormativity, cisnormativity, and patriarchy. I was led to this work as I experienced loved ones coming out as LGBTQ+ in a predominantly Mormon area, witnessing and listening to ways both they and their families often felt helpless in knowing how to navigate this new information within the context of their relationships. Additionally, as a bisexual family therapist raised in a Latter-day Saint family, there are clear personal connections to this research endeavor.

I situate myself in this work as a constructivist researcher in that I believe research, especially qualitative research, is inherently influenced—and can benefit from—the knowledge and experiences of the researcher. I lean away from the assumptions of "an objective external reality, a passive neutral observer, or a detached, narrow empiricism" (Charmaz, 2006, p. 13) and lean instead toward an approach that takes "the researcher's position, perspective, and

interactions into account as an inherent part of the research reality" (p. 13). In other words, my "self" as a researcher and all I bring into the research process will be part of the construction of this study and its resulting best-practice guidelines. A constructivist approach is ideal for my research question because of the insider perspective, knowledge, and experience I bring with me into my work with this population. To conduct this study under the pretense that I am unbiased, objective, or an outsider would be to cheapen the rich, iterative process that can manifest through the co-construction of meaning in the development of new research.

Assumptions

All research studies are based on basic assumptions. One such assumption of this study is that there is salience to examining a family approach for this population. Along the same lines, in conducting this research I am assuming that with enough clinical experience doing family therapy with this population, the panelists have enough expertise to co-create guidelines of best practices for working with LGBTQ+ young people in Latter-day Saint families. It is also assumed in this study that there are unique considerations for working with one and/or all of the following: LGBTQ+ individuals, adolescents, young adults, and Latter-day Saint families.

Limitations

While this study's limitations will be explored in more detail in Chapter 5, I will outline several limitations anticipated for this project. First, it is difficult to determine exactly who qualifies as an expert on this topic. There are very few therapists who have dedicated their careers to serving and/or researching LGBTQ+ Mormons. Even fewer are conducting a family-based approach and may not self-identify as "family therapists." Given that panelists were distinct in their training backgrounds, agency settings, years of experience, and hours committed

to family therapy with this specific population, the classic Delphi method has been altered to include several interviews with “true experts,” from which the Delphi questionnaire was based. Second, while family therapists dedicated to this population are needed, they are few. As such, the community of applicable therapists is small, and I had some measure of a personal relationship with several of these experts. Thankfully, this limitation was mitigated by the anonymous co-creative process of the Delphi method. Thirdly, given that this study focused on such a specific population and process, findings may not be transferable for all therapists. Readers should use their own knowledge and circumstances to determine how this study's findings are best applied to their work.

Delimitations

Because this study aims to create specific guidelines for family therapists working with LGBTQ+ young people in Latter-day Saint families, various topics lie beyond the scope of this project. For example, this study engages only with the therapist’s perspective and does not explore the experiences of the family members in therapy. Further, while a brief conversation on the prevalence of suicidality and the need for suicide prevention among LGBTQ+ youth and young adults in LDS families is necessary, a full discussion of this topic lies beyond the scope of this study.

The reader should also bear in mind that while I consider myself a feminist researcher and see a need for critical analysis and deconstruction of the many systems of power and privilege at play for LGBTQ+ young people within the LDS Church, LDS families, family therapy, and in LGBTQ+ communities, it is beyond the scope of this study to employ a truly intersectional, feminist analysis and deconstruction. I acknowledge a need for research at this

intersection that embodies Kimberlee Crenshaw's framework of intersectionality (1989) by explicitly examining the systems of power at play, how they are used, who is impacted, and the influences of power on those possessing more than one marginalized identity. For example, I have worked with LGBTQ+ young people in LDS families who also identified as racial minorities, as disabled, as different variations of LGBTQ+ identities—each of whom has been impacted by systems of power differently. Thus, due to practical constraints, this paper cannot address all the issues of power and identity that will be present in the therapy room.

Design Flaw Limitations

While there are many advantages to the Delphi method, there are also several limitations to this approach. First, regression towards the mean can occur when participants alter their responses (consciously or unconsciously) to closer align with consensus. This particular limitation does not apply to my modified Delphi model, because the other participants will only be able to see the best-practice items in Survey I and Survey II— not the responses of other participants. Second, because panelists will likely share similar backgrounds and credentials, responses may embody a limited, narrow perspective on the research topic (also impacted by the researcher's choice of questions). Accordingly, I have added qualitative interviews with experts in Round I of this study to avoid starting the Delphi study with too narrow a viewpoint. Third, this four-stage approach is time-intensive for both the panelists (especially those being interviewed) and the researcher; thus, attrition is a risk. To diminish the risk of attrition, I plan to highlight the participants' expert role in my communications with them (Stone Fish & Busby, 2005), provide financial incentives throughout the study (Berger, Begun, & Otto-Salaj, 2009,

Striley et al., 2008), and, most importantly, establish rapport and relational engagement through expressing empathy, compassion, and understanding to panelists (Miller & Johnson, 2014).

Organization of the Remainder of the Study

This chapter provides an introduction describing the background of this study, a statement of why this study is needed, the purpose and significance of this study, an outline of the research design, the research question, a definition of key terms, and the assumptions and limitations of this study. From this point, Chapter 2 will give a comprehensive review of literature relevant to this topic, Chapter 3 will more thoroughly describe the methodology for this study, Chapter 4 will present the results of all four rounds of the study, and Chapter 5 will discuss the implications of my findings and suggest areas for potential future research.

CHAPTER 2: LITERATURE REVIEW

This review of literature will provide a foundation of understanding for the present study by outlining existing research at the intersection of family therapy, LGBTQ+ young people, and Latter-day Saint families. This chapter will discuss three primary points: (a) the methods and procedures used to search for sources, (b) a review of the research literature, and (c) a synthesis of the findings.

Methods of Searching

In preparation for a comprehensive review of literature, I operated first from my knowledge of current pioneers in the field of "LGBTQ+ Mormon Studies." Authors I began with included Drs. Tyler Lefevor, John Dehlin, and Renee Galliher. Databases utilized include Google Scholar, the Virginia Tech Library, and a Dropbox that has been created for and shared among scholars studying the mental health of LGBTQ+ individuals with backgrounds in the Church. Search terms in such databases included combinations of the following: "LGBT," "LGBTQ+," "transgender," "gender minority," "sexual minority," "youth," "adolescents," "family therapy," "sexual/religious identities," "family acceptance," family rejection," "family nonacceptance," "identity conflict," "identity conflict," "lesbian, gay, bisexual youth," "Latter-day Saint families," "Family Proclamation," "LDS Doctrine," "Mormon," "LDS," "Exclusion Policy," "Minority Stress Model," "mental health," and "suicide prevention." Because no articles currently exist that include the topics of family therapy, LGBTQ+ youth, and Latter-day Saint families together, articles were selected for review depending on their relevance to the specific topics of mental health, LGBTQ+ identities, Latter-day Saint identities, family therapy, and family acceptance processes.

An Intersectional Ecological Framework

The research questions and subsequent methodologies were conceptualized within an ecological framework. Bronfenbrenner's ecological theory (Bronfenbrenner, 1979) is a framework for understanding the multiple systems that shape human development. It posits that individuals exist within and are shaped by multiple levels of influence, including the microsystem (e.g., family and peers), mesosystem (e.g., school and community), exosystem (e.g., media and government), and macrosystem (e.g., cultural norms and values). This theory provides a systems perspective that recognizes the interconnectedness of individuals, families, and communities and the importance of considering multiple levels of influence in understanding the experiences and challenges of LGBTQ+ young people and their Mormon families.

Strengths of an Ecological Framework

The strengths of Bronfenbrenner's ecological theory make it appropriate for this research. Such strengths include its ability to provide a systems perspective, recognize the interconnectedness of individuals and families, contextualize the experiences of individuals within larger systems and structures, and provide a holistic approach to understanding human experiences and challenges. These strengths make the ecological framework well-suited for understanding the experiences of marginalized groups like LGBTQ+ young people and their Latter-day Saint families in the context of family therapy. The overall conceptualization of ecological theory offers a helpful way to conceptualize research at this intersection.

Addressing Weaknesses of an Ecological Framework

Bronfenbrenner’s ecological theory also has weaknesses, however, several of which are particularly relevant to research at this intersection and have been modified to better suit this research.

Linearity

First, Bronfenbrenner's theory is often criticized for presenting a linear model of development, implying a one-way influence of the different systems on the individual, rather than recognizing the reciprocal relationships between the individual and their environment. To address this weakness, my modification of the framework includes, highlighting bi-directional processes within, between, and around systemic levels.

Limited Attention to Cultural Diversity

Bronfenbrenner's theory has been criticized for not adequately considering cultural diversity, as it is largely based on research with Western samples and does not address how cultural values and norms shape development. Given that my research question is highly related to the intersections of specific cultures, my model addresses this weakness by incorporating an intersectional feminist lens to highlight larger power structures at play in the lives of LGBTQ+ young people and their families, including their experiences within the context of their cultural background.

My model addresses this weakness by incorporating an intersectional feminist lens to highlight larger power structures at play in the lives of LGBTQ+ young people in Mormon families in the context of their cultural background and larger power structures. Specifically, my addition of social structures to the model adds the consideration of unique cultural factors that can impact this population, including religious beliefs and values, widespread attitudes and

beliefs about LGBTQ+ individuals that perpetuate discrimination, and media representation that may amplify harmful stereotypes or lack LGBTQ+ visibility. Thus, my modified model provides a more inclusive and culturally responsive understanding of client experiences and development.

Lack of Attention to Agency

Bronfenbrenner's theory is often criticized for not adequately taking into account the role of individuals' agency in shaping their own development and experiences (Darling, 2007). The theory primarily focuses on the relationship between individuals and their environment and does not fully consider how individuals can actively shape and transform their experiences through their thoughts, beliefs, and emotions. This weakness can lead to a reductionist understanding of human development and experiences that does not fully capture the complexity of human behavior and resilience.

By adding "internal systems" within each individual to the model, you are addressing this weakness and recognizing the role that individual factors, such as thoughts, beliefs, and emotions play in shaping development and experiences. This addition provides a more comprehensive understanding of the interplay between the individual and their environment and recognizes that people are not simply passive recipients of environmental influences, but active agents who can shape and transform their experiences through their thoughts, beliefs, and emotions. The inclusion of an internal system also provides a framework for considering how individual agency and resilience can play a role in overcoming challenges and promoting well-being.

My inclusion of time in the model also addresses the weakness of lacking attention to individual agency. By considering time, the model can account for how individuals and systems may change and adapt over time in response to different life events and experiences, including

changes in attitudes, beliefs, and behaviors, as well as changes in the larger social, political, and cultural contexts in which individuals and systems operate. Furthermore, the inclusion of time in the model can also provide a more nuanced understanding of how agency and experiences are influenced by historical and cultural contexts, as well as current events and trends. Including time in the model can be particularly important for understanding the experiences of LGBTQ+ young people and their families in the context of family therapy, where the larger cultural, historical, and political contexts in which individuals and families operate can play a significant role in shaping their experiences.

Lack of Attention to Power Imbalances

Bronfenbrenner's theory does not explicitly address power imbalances and their impact on development, which is a limitation for understanding the experiences of marginalized populations, especially in specific cultural contexts with unique power dynamics. To address this weakness and make the model more intersectional, I added the constructs of power, social structures, economic structures, and political structures.

The inclusion of these constructs recognizes how power imbalances, such as those based on race, gender, sexuality, and class, play a role in shaping development and experiences. These additions highlight the larger societal and systemic factors at play in the lives of LGBTQ+ young people and their Mormon families. By addressing larger societal and systemic factors, this model can inform more effective and empowering family therapy practices that can promote greater equality and well-being for LGBTQ+ young people in LDS families.

In conclusion, incorporating Bronfenbrenner's ecological theory and a focus on power structures provides an intersectional and nuanced understanding of the factors and processes that

influence LGBTQ+ young people and their families in the context of family therapy. This understanding can inform best practices for supporting these families and promoting their well-being.

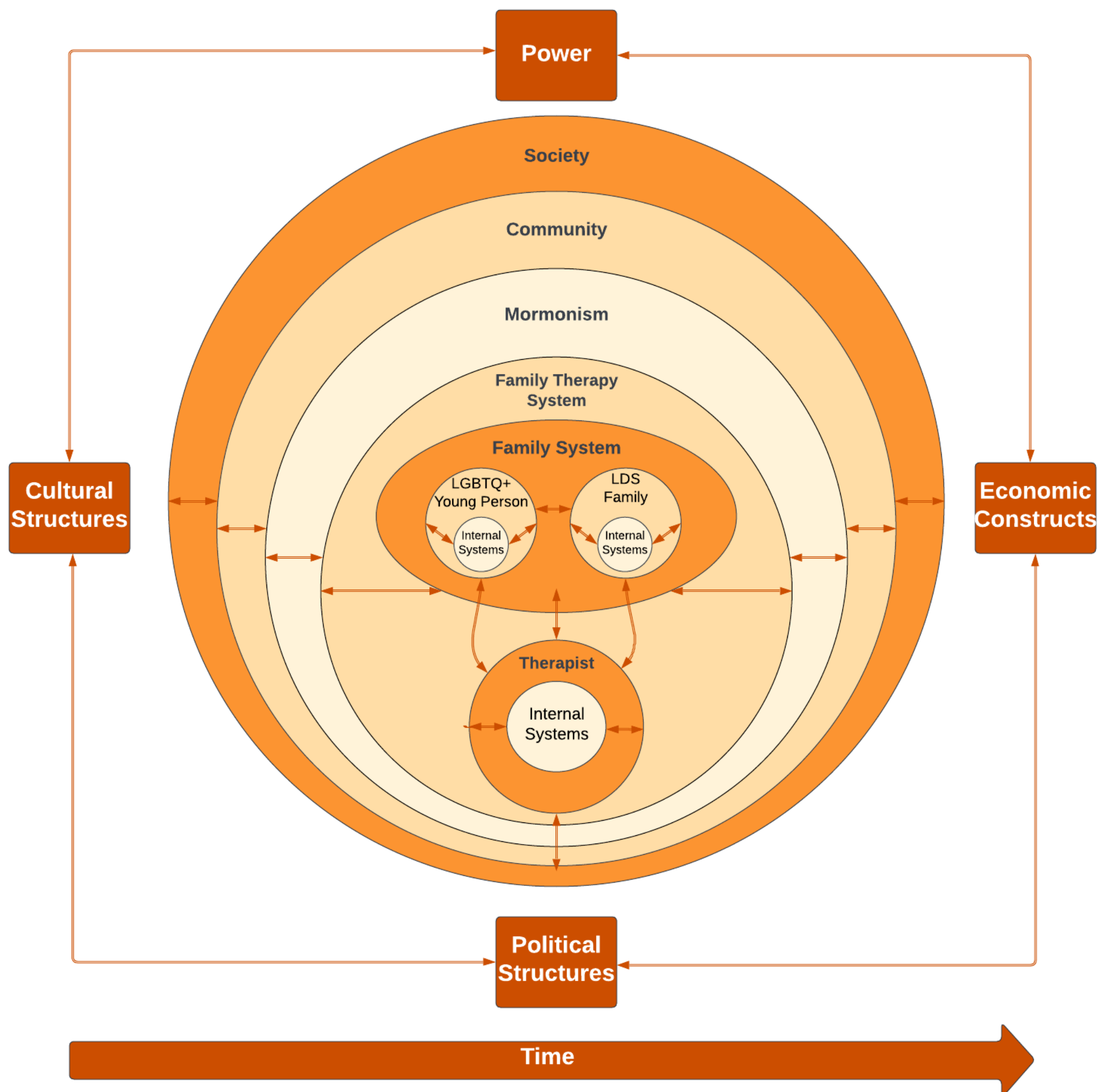

Figure 1.

Visual Model of the Intersectional Ecological Framework.

Review of the Literature

There is currently a shortage of research specific to understanding the experiences of LDS families with LGBTQ+ youth and young adults, and very little of the existing research explicitly addresses their experiences in therapy settings. Because of the lack of research on this population, it can be challenging for therapists to find empirical resources to help them in working with these families. The purpose of this section is to provide a comprehensive review of existing literature. In this section, I will (a) situate existing research in the context of the LDS Church's doctrines and influences, (b) discuss the unique language around identity labeling among sexual minority individuals in the LDS Church, (c) highlight literature on transgender and gender-diverse (TGD) individuals in the Church, (d) review research on the intersection of religious, spiritual, and sexual identities, (e) outline research findings on mental health in LGBTQ+ Mormons, and (f) examine the state of clinical literature among this population and its support for a family-based approach.

A New Field of Research

Current literature about LDS families and their LGBTQ+ children is severely lacking—and could even be considered nonexistent, given that there is but one study, to my knowledge, that specifically examines LGBTQ+ youth or adults in the context of LDS families (Mattingly, 2016). There is also no research on their clinical experiences in family therapy, or even in individual therapy for that matter. In order to capture a solid summary of what research tells us about LGBTQ+ young people in LDS families and how to work with them in family therapy, we must take a comprehensive look at the many facets that have been studied concerning this population. Nearly all research at this intersection has been conducted on individual adults, and almost none of it focuses on the experiences of transgender and gender-diverse (TGD)

individuals within the LDS Church. This synthesis will summarize existing research relevant to these young people and families (though by necessity will focus largely on adults and individuals), will identify gaps in the existing literature, and highlight how this study will address said gaps.

A Context of Mormonism

The relationship between the LDS Church and LGBTQ+ individuals has been described as one with “intended actions, unintended consequences” (Prince, 2019). Theologically, the LDS Church is rooted in doctrines that endorse heterosexual marriage and discourage same-sex relations (CJCLDS, 2008). The Church also holds rigid stances on gender, believing that gender is biological, binary, and eternal (CJCLDS, 1995; 2019). Furthermore, the LDS Church has been actively engaged in political endeavors to prevent the legalization of same-sex marriage. As such, it has been suggested that:

> The primacy of family in Mormon theology, as a unit that will endure into a post-mortal existence, raises the stakes for LGBT children. By condemning their homosexuality as evil, self-inflicted, and impossible in post-mortal existence, the church has opened the door to draconian behavior by parents, peers, and congregations. (Prince, 2019, p. 3-4)

Scholars have argued that the robust theological and political declarations of the Church have had both direct and indirect negative impacts on the well-being and mental health of LGBTQ+ individuals in the LDS Church—youth especially (Prince, 2019, p. 3, Lefevor et al., 2019). It has been suggested that beyond the national oppression of LGBTQ+ individuals, the greater and deeper effect on LGBTQ+ Latter-day Saints has been “at the hands of their own

church" (Prince, 2019, p. 3). The population of Utah, where LDS Church headquarters are located, is made up of approximately 62% who are LDS Church members (Canham, 2017). At least 40% of Utah's homeless youth are LGBTQ+ (Adler, 2018; Barker, Parkinson, & Knoll, 2016), which is on the higher end of the national estimates between 20%-40% (National Conference of State Legislatures, 2016). Further, a majority of these homeless LGBTQ+ youth come from religious and socially conservative homes, with 60% coming from Mormon homes (Fletcher, 2014). Perhaps even more tragically, teen suicide rates doubled between 2011 and 2016 and became the leading cause of death among teenagers in Utah (Utah Department of Human Services, 2015). These staggering statistics demonstrate a need for further inquiry into the impacts of the Church's doctrines, policies, and political action on LGBTQ+ youth.

Teachings on "Same-Sex Attraction"

The LDS Church's teachings on sexual minority members have fluctuated in general over time, but the Church has always maintained that (a) all same-sex sexual behavior is sinful, (b) that same-sex marriage is not approved by God, and (c) that violations of Church policies around same-sex relationships are subject to Church discipline (CJCLDS*,* 2014). Additionally, because LDS doctrine has consistently indicated that only Church members that enter into heterosexual, temple marriages can obtain residence in the highest tier of heaven (i.e. exaltation, Celestial Kingdom), even celibate sexual minority members have been canonically prevented from obtaining exaltation unless they enter into what has been coined a "mixed-orientation marriage" (Legerski et al, 2017), which is a marriage between a cisgender heterosexual and cisgender non-heterosexual individual. Indeed, there have been many statements made by Church leaders to condemn what has often been termed "a gay lifestyle."

In his book *Gay Rights and the Mormon Church: Intended Actions, Unintended Consequences* (2019), Gregory Prince posits that the policies and attitudes of the LDS Church and its members toward same-sex attraction have been shaped by three basic tenets: "homosexuality . . . is a grievous 'sin' that requires 'punishment' by the church (often excommunication in earlier times) and is caused by a conscious 'choice' of the LGBT individual rather than being biologically determined" (p. 15). The following section will outline the LDS Church's teachings, describing them within the three tenets that Prince (2019) has suggested.

Sin. Though the LDS Church was not very vocal about same-sex relations and LGBQ individuals before 1968, the institution has never wavered from its position that "homosexual relations" are "grievous sins" (Hinckley, 1987). In early addresses on "homosexuality" (the term utilized by the Church at the time), Church leaders spoke harshly on the topic. For example, one discourse in the Church's 1954 semiannual General Conference condemned "that filthy crime of homosexuality" (CJCLDS, 1954, p. 79). Other leaders followed suit, including one report of Church President Spencer Kimball stating that "homosexuality was worse than immorality, that it is a filthy, unnatural habit" (Wilkinson, 1959).

The first mention of same-sex attraction in the Church's *General Handbook of Instructions* made the distinction between attraction and behavior by utilizing the phrase "homosexual acts" (Bush, 1981; CJCLDS, 1968, p. 122). In other words, same-sex attraction on its own was not considered by the Church to be sinful—but acting upon it was. The next iteration of the *General Handbook*, however, reverted the language to refer to same-sex attraction itself as a sin, listing "homosexuality" as grounds for church court to be held (Bush, 1981, p. 84; CJCLDS, 1976, p. 71). An unfortunate result of this language was that being gay, even if the

individual was celibate, was cause enough for church disciplinary action (further discussed later in this chapter)—often ending in excommunication, meaning termination of Church membership. Later versions of the *General Handbook* even equated same-sex attraction with the sins of adultery, fornication, and child molestation (CJCLDS, 1983, p. 51). Currently, the Church differentiates carefully between behavior and attraction, though there continue to be anecdotal reports of harsh treatment from LDS leadership based in a remaining belief that same-sex attraction is among the most grievous of sins.

Since the early iterations of the *General Handbook,* the LDS Church seems to have softened its stance in several ways. In recent years, Church leaders have called for Church members to treat LGBTQ+ individuals with love, kindness, and sensitivity. More concretely, in 2012 the LDS Church released a new website called *Mormon and Gay*, with the apparent goal to increase a sense of belonging and comfort for LGBQ Church members. To be clear, same-sex sexual behaviors are still considered among the most serious sins in LDS doctrine, but there seem to be increasingly tolerant attitudes toward LGBQ Church members—especially those who are not engaged in same-sex sexual relationships.

Punishment. Before 1968, the term "homosexuality" had not yet been part of any canonical LDS law. Thus, there was no standardized approach to LGBQ issues and the discretion to make disciplinary decisions was left to local leaders. As such, disciplinary actions by local church leaders covered a broad spectrum in severity for many years. The 1983 *General Handbook,* for example, indicated that "Church courts may be convened to consider . . . homosexuality." However, just three years earlier, Church president David McKay was cited saying that "they should be excommunicated without any doubt, that the homosexual has no

right to membership in the Church . . . I said I think they should be dealt with immediately if they are guilty" (Prince, 2019, p. 17). Official Church discipline of LGBQ Church members has ranged from acquittal to excommunication; "more serious transgressions," such as same-sex sexual behavior, are often addressed through a church court process called a disciplinary council. Whatever the disciplinary decision, it has been common practice for LDS Church leaders to punish both same-sex attraction and same-sex sexual behaviors.

Choice. Historically, the LDS Church's position on same-sex attraction has been that it is just that—an attraction. Indeed, some Church leaders have implied that to be attracted to the same sex is a choice, and therefore something that can be changed. In one General Conference address, then apostle Boyd Packer forcefully emphasized:

> "Homosexuality . . . is learned behavior. . . There is a falsehood that some are born with an attraction to their own kind, with nothing they can do about it . . . While it is a convincing idea to some, it is of the devil. No one is locked into that kind of life." (CJCLDS, 1976, p. 101)

Even as evidence suggests otherwise, Church leaders have emphasized the "temporary nature" of homosexuality, highlighting it as an adjective, a condition, a struggle—rather than an identity, an orientation, or a salient part of the individual. In doing so, Church leaders have simultaneously implied that same-sex attraction is something that can be altered. Accordingly, many LGBTQ Church members have gone to great lengths to change their sexual orientation, a topic that will be further addressed later in this chapter.

Teachings on Gender

The LDS Church has historically said very little about transgender issues. Indeed, the word “transgender” had never been mentioned in any of the Church’s semiannual General Conference addresses until 2019 and did not appear in the *General Handbook* until 2020. *The Family: A Proclamation to the World* (1995*)*, a document to be further discussed in a following section, is viewed as the Church’s most central teaching on gender, stating that:

> “All human beings—male and female—are created in the image of God. Each is a beloved spirit son or daughter of heavenly parents, and, as such, each has a divine nature and destiny. Gender is an essential characteristic of individual premortal, mortal, and eternal identity and purpose.” (p. 1)

As transgender issues became a topic more commonly discussed, the Church clarified this stance, stating in the *General Handbook* (2020, section 38.6.23), “The intended meaning of gender in the family proclamation is biological sex at birth. Some people experience incongruence between their biological sex and their gender identity. As a result, they may identify as transgender. The Church does not take a position on the causes of people identifying themselves as transgender.”

The 2020 edition of the Church’s *General Handbook* was the first in which TGD issues were addressed directly for the first time. Firstly, a policy of good will is outlined, acknowledging that “Transgender individuals face complex challenges. Members and nonmembers who identify as transgender—and their family and friends—should be treated with sensitivity, kindness, compassion, and an abundance of Christlike love” (section 38.6.23). The *General Handbook* (2020) goes on to dictate new policies specific to transgender members, unveiling several unexpectedly progressive guidelines. It indicates that transgender members (a)

can be baptized and confirmed, (b) may partake of the sacrament and receive priesthood blessings, (c) may receive Church callings, temple recommends, and temple ordinances (as long as they do not pursue “medical, surgical, or social transition to the opposite gender and are worthy”), and (d) may have their preferred name and pronouns noted in their Church membership record and may be addressed by their preferred name in their local congregation.

In contrast, however, policies are also outlined in the same section of the *General Handbook* (2020) that restrict the self-expression of transgender members, in that they (a) can only receive priesthood ordination and temple ordinances according to their biological sex at birth, (b) are counseled against “elective medical or surgical intervention for the purpose of attempting to transition to the opposite gender of a person’s biological sex at birth (“sex reassignment”),” (further endorsing a binary view of sex through the use of the phrase “opposite gender”), (c) are counseled against “social transitioning,” including “changing dress or grooming, or changing a name or pronouns, to present oneself as other than his or her biological sex at birth”. Consequences for violating these policies may involve restrictions around “receiving or exercising the priesthood and receiving some Church callings.”

History of the Mormon Church and LGBTQ+ Individuals

Above, I described the LDS Church’s historical teachings around LGBTQ+ identities. In this section, I will discuss concrete instances in which the Church has taken intentional action based on the teachings described above. For brevity’s sake, this compilation includes only several of many examples of religious and political action relevant to LGBTQ+ youth in Latter-day Saint families, and thus relevant to the therapists who serve them.

Sexual Orientation Change Efforts. The notion that one's attraction to the same sex is "curable" has long been held by the LDS Church. The *Bishop's Training Course and Self-Help Guide* (1975) indicated that "Though many have been told it is incurable, that is not true." Although many iterations of this teaching have been proclaimed over the years (CJCLDS, 1973, p. 18; 1975; 1992b, p. 4), instruction from Church leaders as to how to change one's sexual orientation has covered a broad spectrum, including: to replace pornographic materials with scriptures and other distractions, to "flee from other gays even if it contradicted their responsibility to 'guide those who stumbled'" (Winkler, 2008, p. 44), and repentance of the "sin of homosexuality" (CJCLDS, 1973, p. 18). Essentially, the early stance taken by the Church was one common across conservative religions—that one can "pray the gay away."

As same-sex-attracted (SSA) Church members began to take on this counsel, it became apparent over time that individuals' efforts to change their own attractions were not working. Indeed, the futility of sexual orientation change efforts (SOCE) in the LDS Church has been supported by recent research (Dehlin, Galliher, Bradshaw, Hyde, & Crowell; 2015) in which a sample of 1,612 non-heterosexual individuals affiliated with the Church reported private efforts (personal righteousness, ecclesiastical counseling, and individual efforts) to be the most commonly used change efforts (utilized by more than 85% of those attempting SOCE and reported by at least 70% of those individuals as ineffective or even harmful). Additionally, personal righteousness was the most common SOCE attempted, reported by 76% of participants—and was also reported as the most harmful SOCE, with 45% of participants describing it as moderately to severely harmful (p. 100). In sum, the LDS Church began to see

the ineffective nature of personal efforts at sexual orientation change and began to look for more effective alternatives.

Thus began the implementation of outside intervention for changing one's sexual orientation. Church leaders began referring non-heterosexual members to licensed clinicians and often unlicensed entrepreneurs in the practice of "repair" or "conversion" meant to change one's sexual attractions (Prince, 2019). A number of LDS-affiliated organizations have provided conversion therapy, including LDS Family Services, Brigham Young University (BYU), and Evergreen (an organization meant to be a resource for non-heterosexual LDS men). In a study of LGBQ, Mormon-affiliated adults who had engaged in psychotherapy to change their sexual orientation, 42% reported it was not at all effective, and 37% found it to be moderately to severely harmful (Bradshaw et al., 2015). In contrast, those in the same study who had received affirming therapies reported it reduced their depression, increase self-esteem, and improve family relationships.

One significant initiative endorsed by the Church was employing a variety of aversion therapies executed by BYU therapists, including electric shock therapy. In a 1976 university-approved dissertation study of 17 male participants, doctoral student Max McBride would attach a pressure cuff around a participant's penis to measure sexual arousal and attach an electrode to their bicep. Nude photographs of cisgender men and women were projected. If the participant became aroused by a nude male image, an electric shock would be administered, gradually increasing in voltage to create an aversion to homosexual arousal (McBride, 1976). Although the dissertation was never published in a peer-reviewed journal, electric shock therapy was performed at BYU for several years afterward (Prince, 2019, p. 91). The personal accounts of

BYU's electric shock practices emphasize negative long-term impacts and illustrate both psychological and physical harm. Connell O'Donovan, an LGBTQ+ Mormon historian describes a harrowing encounter with one recipient:

> I spoke with him, but he requested that I remain at least six feet in distance away from him. He then rolled up his shirtsleeves and showed me his arms. The deeply scarred skin on the inside of his arms looked like raw hamburger and I almost vomited… The results were badly burned arms and a complete inability to come physically close to any male without him emotionally breaking down from the trauma. His homosexual desires were as strong as ever, but he was unable to touch another man even for a simple hug, he had no heterosexual desires whatsoever and he was constantly on the verge of suicide (O'Donovan, 1994).

Mixed-Orientation Marriages

Another approach the LDS Church took was to direct same-sex attracted individuals to partner romantically with someone of "the opposite sex" (another illustration of a binary view of gender). In the words of Gregory Prince (2019, p. 27), "For decades, countless numbers of men [in the LDS Church] have been counseled to marry a woman, with the implied or expressed promise that this would 'cure their homosexuality.'" Thus, mixed-orientation marriages became a prominent option for non-heterosexual Mormons.

While there is much we do not know about the outcomes and experiences of those in LDS mixed-orientation marriages, there are several things researchers have learned. First, although mixed orientation-marriages were taught for decades as a viable option for either "curing one's homosexuality" or simply providing a way to maintain Church membership status

and “worthiness privileges,” their rate of success has been very low. One study on the matter showed a 51% divorce rate at the time of the survey, with a projected 69% divorce rate (Dehlin, Galliher, Bradshaw, & Crowell, 2015). Second, some individuals in LDS mixed-orientation relationships are satisfied with their relationship choice. Lefevor et al (2019) assessed the satisfaction and health of same-sex attracted and LGB participants in four different relationship categories: single and celibate, single and not celibate, in a mixed-orientation relationship, and in a same-sex relationship. Among the participants, 69% were raised in the Mormon faith and 54% were Mormon-affiliated at the time of the survey. Those in same-sex relationships reported the highest levels of some amount of satisfaction with their relationship status (95%), followed by those in mixed-orientation relationships (80%), those who were single and celibate (42%), and those who were single and not celibate (40%). Third, some LDS mixed-orientation marriages end in devastation. One such account is that of a gay bishop who faithfully served the Church, his wife of many years, and his eight children:

> “The damage there was enormous when he came out. He and his wife divorced, and then the kids looked at him and said, ‘You hypocrite!’ But he did what the church wanted him to do. So it’s just been really fractured. They don’t even want him to be around the grandchildren” (Prince, 2019, p. 28).

The Church later took steps to discourage mixed-orientation marriages as a way to change one’s sexual orientation, implementing in a 1992 policy that:

> Marriage should not be viewed as a way to resolve homosexual problems. The lives of others should not be damaged by entering a marriage where such concerns exist. Encouraging members to cultivate heterosexual feelings as a way

to resolve homosexual problems generally leads them to frustration and discouragement (CJCLDS, 1992, p. 4).

1995 - "The Family: A Proclamation to the World"

In 1995, the LDS Church released a document called "*The Family: A Proclamation to the World*," which outlined marriage as being ordained of God and "between a man and a woman" and publicly declared that "gender is an essential characteristic of individual premortal, mortal, and eternal identity and purpose" (CJCLDS, 1995). These two teachings from the *Proclamation* are ever-present in the Mormon Church and culture, to the extent that a framed copy can be found in thousands, perhaps millions, of Latter-day Saint homes. Interestingly, although it is often treated as canonized doctrine among Church members, the *Proclamation* has never been canonized in the LDS Church. One thing was made certain in the creation of the *Proclamation*—LGBTQ+ individuals and their LDS families now had a published document to which they could refer should there ever be confusion on the Church's stance on same-sex marriage, gender, and sex outside the binary.

2008 – Proposition 8

California's Proposition 8 was perhaps the LDS Church's most public instance of fighting the legalization of same-sex marriage. Although the Church had been involved in several other court cases regarding marriage equality (Prince, 2019), this time the Church issued a letter to all LDS Californians with a call to action: "We ask that you do all you can do to support the proposed constitutional amendment by donating of your means and time to assure that marriage in California is legally defined as being between a man and a woman" (CJCLDS, 2008). While some members and leaders reported feeling conflicted about the instruction

(Prince, 2019, p. 131), many others took to door-to-door canvassing, phone banks, and public demonstrations in support of Proposition 8. It is estimated that nearly half of the $40 million raised to bolster Proposition 8 was contributed by LDS Church members (McKinley & Johnson, 2008). Ultimately, Proposition 8 passed and same-sex marriage was not legalized in California for several more years.

2015 – The Exclusion Policy

In November of 2015, LDS Church leaders updated *Handbook 1* for those in leadership roles, implementing a church-wide policy regarding same-sex marriage that considered entering into a same-sex marriage as "apostasy" and something that would require a Church disciplinary council. As discussed previously, such councils often end in terminating one's church membership. Additionally, the policy would prohibit the baptisms of children under the age of 18 whose parents were in a same-sex marriage. This policy was retracted in March 2019, but with a statement from LDS Church leaders that the changes "do not represent a shift in Church doctrine to marriage or the commandments of God in regard to chastity or morality" (Weaver, 2019).

Identity Labeling: LGBQ vs. Same-Sex-Attracted

Within the Church of Jesus Christ of Latter-day Saints, the language describing same-sex sexual attraction, same-sex sexual behavior, and sexual orientation are carefully differentiated. Whereas outside of an LDS Church context one might identify as gay, lesbian, bisexual, or queer (LGBQ), the same individual within the LDS Church might reject these or similar identity labels in favor of saying that they experience same-sex attraction (SSA), as other identity labels may imply same-sex sexual behavior (CJCLDS, 2017). The use of this language may be, in part, due

to LDS Church leaders periodically warning against viewing oneself as gay. In a 1992 *Manual on the Ecclesiastical Support of Gay Members*, LDS apostle Boyd Packer was quoted, as saying:

> Be careful not to label the person as homosexual or gay. Such labels can undermine the person's belief that change is possible and may communicate the mistaken notion that a man or woman is born with a homosexual identity that cannot be changed. Although some struggle with unwanted homosexual thoughts and feelings, there is no conclusive evidence that anyone is born with a homosexual orientation. (p. 3)

In a more recent account, LDS apostle David Bednar was cited, proclaiming, "There are no homosexual members of the Church. We are not defined by sexual attraction. We are not defined by sexual behavior. We are sons and daughters of God." (Bednar, 2016). Such statements have indicated an attempt by LDS Church leaders to separate attraction from personal identity.

Existing literature about identity labeling among LGBQ Mormons and ex-Mormons has mixed findings regarding the impact of how the way someone self-identifies may impact their personal experiences as a sexual minority in a religious upbringing. Some research indicates that the decision to self-identify as either LGBQ or not can influence one's well-being and health. For example, participants from a non-LDS-specific study who adopted an LGBQ identity and found support around said identity demonstrated decreased mental health problems (Legate, Ryan, & Rogge, 2017).

In contrast, a study by Lefevor et al. (2020) examined the relationship between Mormons rejecting an LGBQ identity and religiousness, attitudes toward sexuality, and health outcomes.

They found that Mormons who rejected an LGBQ identity were significantly more religious, less content with their sexual attractions, and less "out" in their lives. This finding makes sense considering that SSA is the term most often utilized in connection to the LDS Church (Brown, 2015). They also found, however, no significant differences between SSA and LGBQ Mormons on any health outcome that they studied, which contrasts with much of the research centering the experiences of LGBQ Mormons. Lefevor et al. (2020) proposed that the conflict between these findings "may indicate that SSA and LGBQ Mormons experience similar minority stressors; however, given the difference observed in religion and sexuality variables, it seems more likely that SSA and LGBQ Mormons experience different minority stressors and engage in different ways of navigating these stressors" (p. 17).

Transgender and Gender-Diverse Individuals in the LDS Church

While there is little research examining the identities and experiences of sexual-minority individuals and families in the LDS Church, there is even less literature about TGD individuals and families in the Church. There is only one study, to my knowledge, that focuses on the experiences of TGD individuals and couples in the LDS Church, a doctoral dissertation (Mansfield, 2017). Mansfield's phenomenological study explored the personal narratives and negotiating processes around the congruence of members of the LDS Church in the context of marital relationships, in which one partner identified as "MtF [male-to-female] gender-variant." One strength of this study is that it provided both individual and relational insights, looking at experiences between partners as well as within each person—a dyadic approach most of the literature on these types of families is lacking.

The lack of research on TGD Mormon individuals and families, in a sense, mirrors the absence of attention to TGD Mormons by the LDS Church as an institution. As noted previously, the Church only recently made its first statement regarding any official stance on TGD individuals in the release of an updated *General Handbook* (CJCLDS, 2020). In said handbook, the Church equated gender with "biological sex at birth;" counseled against medical, surgical, and social transitioning; and restricted some privileges of Church membership such as ordination to the priesthood. Cisnormative positions like these may help explain why research regarding TGD individuals in other Christian upbringings indicates common experiences across studies, such as isolation (Kidd & Witten, 2008) and a need for personalized faith (Wilcox, 2002). Overall, however, there is a glaring need for studies that focus on the specific experiences of TGD individuals in the LDS Church, rather than research that lumps a few TGD individuals into a larger sample of sexual minorities and proposes a generalized understanding of gender minority experiences (see Buser, Goodrich, Luke, & Buser, 2011, as an example).

The Intersection of Religious, Spiritual, and Sexual Identities

Research regarding the integration of identities and/or the conflict between them is one of the more saturated corners of the literature on LGBTQ+ individuals in the LDS Church—though still very little of it seems to focus on young people, families, or clinical practice. Additionally, many of the publications at this intersection come from a single dataset (see Bradshaw et al., 2015a; 2015b; 2020; Crowell et al., 2015; Dehlin et al., 2014; 2015a; 2015b; 2019). While some in the Church seek to integrate both their religious and sexual identities, existing literature indicates that most individuals ultimately reject one or the other (Dehlin et al., 2015a), 2015) for the sake of mitigating the internal and external conflict that comes with holding both a Mormon

and sexual minority identity (Dahl & Galliher, 2012). Dehlin et al. (2015a) examined the navigation of sexual and religious identity conflict among LGB current or former members of the LDS Church. The authors found that rejection or compartmentalization of sexual identity (as compared to rejecting religious identity or integrating religious and sexual identities) may be difficult to sustain over time and likely comes at a significant psychosocial cost.

In contrast, however, some research points to the positive aspects of having intersecting religious/spiritual and LGBTQ+ identities. One qualitative study (Rosenkrantz, Rotosky, Riggle, & Cook, 2016) examined religious LGBTQ participants who described the positive aspects of identifying as both religious/spiritual and LGBTQ. Participants described (a) love and acceptance for one's LGBTQ identity, (b) deeper meaning and purpose due to having an LGBTQ perspective, (c) empathy, openness, and compassionate action rooted in LGBTQ identity and a passion to actively live religious/spiritual values, (d) positive relationships with families, partners, and communities based in a shared religious/spiritual identity and authentic expression of LGBTQ identity, and (e) spiritual strength for coming out and coping with sexual or gender identity stigma and prejudice.

These themes seem to indicate that religious, spiritual, and LGBTQ identities can interact in ways that synergistically enhance each other and may even provide an important source of strength and support that can be mobilized in clinical practice. Still, additional research is needed to assist families and clinicians in mitigating psychosocial costs and enhancing the positive aspects of holding both identities. Finally, it is important to note here that there are few studies concerning the intersection of TGD individuals and religious/spiritual identity (and none on TGD Mormons), and a call has been made by researchers for studies that provide models "by which

individuals resolve conflict between gender identity and a Christian upbringing" (Levy & Edmiston, 2014, p. 67).

Mental Health and LGBTQ+ Mormons

Religiosity is generally a robust protective factor against negative mental health outcomes among adolescents and young adults (Gibbs & Goldbach, 2015). For LGBTQ+ individuals, however, religiosity may instead contribute to increased mental distress. Studies on sexual minority Mormons and their experiences in the LDS Church indicate negative effects on their mental health, such as mood disorders, self-worth concerns, suicidality, and a need for "mental health recovery" (Jacobsen & Wright, 2014). Researchers in this area have identified minority stress as a primary contributor to these negative mental health outcomes, (Crowell, Galliher, Dehlin, & Bradshaw, 2015; Grigoriou, 2014). More specifically, their research highlights specific aspects of minority stress such as social constraint (Grigoriou, 2014), internalized homophobia, the need for privacy, the need for acceptance, difficult processes, and identity confusion (Crowell et al., 2015).

Findings by Lefevor et al. (2019) further support this literature around minority stress and LGBQ/SSA Mormons in their discovery that authentic expression of sexuality, openness about experiences of same-sex attraction, and positive feelings toward their identity were positively related to well-being. Together, these studies suggest that authentic expression of sexuality, positive feelings about one's sexual attractions, and social support can help LGBQ/SSA Mormons in their mental health. Again, however, the research on mental health among TGD Mormons is virtually nonexistent, and studies on their experiences and mental health needs are imperative.

Suicide

Research connecting the religious experiences of LGBTQ+ people and suicidal ideation is mixed. Some individuals, for example, have endorsed the suicidal ideation related to their identity as partly due to denominational teachings against their same-sex attractions or behaviors (Dahl & Galliher, 2012). There is other research, however, that suggests religious affiliation is a significant predictor of LGBT individuals' happiness, with no significant differences found between churches whose doctrine often accepts same-sex relations and those who condemn them (Barringer & Gay, 2017). Further, there is additional research on the influences of sexual and religious identity on mental health that indicates that heterosexual individuals report lower psychological distress than do their sexual minority counterparts, but also that those identifying as Judeo-Christian report less psychological distress than those identifying with non-dominant religions or who here religiously unaffiliated (Lefevor, Park, & Pederson, 2018). There is a need for more nuanced research that can parse out when religion may be helpful to well-being and a protective factor against suicidal ideation, and when it may be a contributing factor to psychological distress and suicidality.

There is enough data to illustrate a need for suicide research and prevention among LGBTQ+ people who are affiliated with the LDS Church (Barker et al., 2016; Simmons, 2017). Although the LDS Church does not collect data on suicidality and sexual minority identities, there is evidence that the leaders acknowledge a need for suicide prevention, in that they recently released a series of suicide prevention resources and have made donations to support suicide prevention training in an organization for LGBTQ+ people who are current and former members of the LDS Church (Stephenson, 2018). Utah is consistently in the top 10 states for suicides

every year for both adolescents and adults. Additionally, suicide is the leading cause of death for Utahns ages 10-17, and the second leading cause for Utahns ages 18-44 (Annor et al., 2018). Within scholarly literature, there have been no direct links published to indicate that LGBTQ+ individuals with LDS backgrounds have higher rates of suicidality than their heterosexual, cisgender, LDS peers. There is a need not only for research that examines the relationship between LDS-raised sexual minorities and suicidality but also for more nuanced findings that can differentiate what processes around LDS affiliation act as protective vs. contributing factors for suicidality.

Affirmative Best-Practice for LGBTQ+ Clients

Mental health organizations across the globe are now implementing ethical standards in their fields that mental health professionals must engage in affirmative practices with LGBTQ+ clients (Pillay, Ntetmen, & Nel, 2022). Affirmative therapy initially emerged in the 1980s and 1990s to challenge the assumption that "homosexuality" was inherently pathological (Harvey, et al., 2022, p. 9). Since then, it has been evolving and becoming more focused in its efforts to advocate for LGBTQ+ individuals and families and protect their well-being (Johnson, 2012). The Handbook of LGBTQ Affirmative Couple and Family Therapy makes a call for such advocacy, stating that "it is imperative that clinicians are able to navigate outside of the traditional confines of a patriarchal, heteronormative gender binary" (Harvey, et al., 2022, p. 10).

The American Association for Marriage and Family Therapy (2022) is an organization at the center of family therapy as a field. They recently released clinical guidelines for affirmative therapy with LGBTQIA+ individuals and families. Their guidelines of affirmative practice are organized into five pillars. They propose that affirmative practice with these clients must be (a)

intersectional, (b) systemic, (c) relational, (d) liberatory, and (e) transformative. More and more, researchers and therapists are integrating intersectional feminism (Crenshaw, 1989) into their operationalization of what affirmative practice means.

Many organizations include in their definition of affirmative practice a condemnation of any kind of conversion therapy (AAMFT, 2022; APA, 2015)—also referred to in this paper as sexual orientation change efforts (SOCE) and gender orientation change efforts (GICE). Given the research indicating that such practices are not uncommon for LGBTQ+ Church members, whether they seek it out personally or not, discourse among therapists working with this population is not without tension. The Reconciliation and Growth Project (n.d.), for example, is a committee of therapists from diverse backgrounds and political leanings who have worked hard to create a set of culturally responsive clinical recommendations for therapists working with sexual or gender minority people from faith-based backgrounds. In their guide, they state:

> We advocate moving beyond terminology such as ‘reparative,’ ‘conversion,’ ‘sexual orientation change efforts,’ and ‘affirmative’ therapies because they fuel adversarial tensions and foster misunderstanding. Instead, we favor language that focuses on reducing the distress associated with same-sex attractions and non-traditional gender.

Although all organizations listed above verbalize support for the principles of “do no harm” and “facilitate self-determination,” there is clear disagreement among mental health professionals at the LGBTQ+/religious intersection regarding just how to define what affirmative practice means when working with LGBTQ+, LDS-affiliated individuals.

Clinical Practice with LDS-Affiliated, LGBTQ+ Individuals

Research on the clinical experiences of LGBTQ+ young people in LDS families has yet to be conducted. However, some studies highlight the clinical experiences of sexual minority adult Mormon individuals. One phenomenological study (Jacobsen & Wright, 2014) has examined the therapy experiences of adult Mormon women with SSA. The authors emphasized that when working with women who experience internal conflict such as these participants, it is essential that therapists assess self-worth, suicidality, and one's level of community and family support. Most of the research at this intersection focuses on clients' experiences of conversion therapy (Beckstead & Morrow, 2004) and sexual orientation change efforts (Bradshaw et al., 2015). Literature on these topics indicates that both conversion therapy and personal efforts to change sexual orientation are both ineffective and have deleterious effects on one's mental health (Beckstead & Morrow, 2004; Bradshaw et al., 2015).

Little to no inquiry has been performed regarding the clinical experiences of TGD Latter-day Saints, though Mansfield's (2017) dissertation provides some insight into the experiences of TGD Latter-day Saints in individual and couples therapy. He found that most participants did not see a therapist until they were an adult, and then typically saw more than one. Some participants sought therapists who were not LDS because they did not want therapists to impose religious values. Others sought out LDS therapists who shared their faith-based values and whom they thought might not push for transition but often found that they were not knowledgeable enough about gender identity to be helpful. This unpublished study gives insight into the need for therapists who work with TGD Latter-day Saints and their families to be knowledgeable about gender identity, respectful of client autonomy, and understanding of the values clients bring into the therapy room.

The Salience of the Family

Given the emphasis of LDS Doctrine on the importance of eternal family relationships, combined with empirical research in support of a family-based approach for LGBTQ+ youth in distress (Coolhart, 2017; Diamond et al., 2013), an inquiry into a family approach for LGBTQ+ youth and young adults in Latter-day Saint families is merited. This section will review existing literature about (a) LGBTQ+ young people in LDS families (and the lack thereof), (b) the impacts of family support and identity acceptance on LGBTQ+ young people, and (c) family therapy approaches utilized among LGBTQ+ young people.

LGBTQ+ Youth and Adolescents in LDS Families. It should be noted here that only one study has examined the experiences of LDS families with LGBQ adult family members (not including TGD individuals; Mattingly et al., 2016). All other research on LGBTQ+ Mormons focuses on adult individuals. Mattingly et al. (2016) found that in response to one's coming out, there was a continuum of responses from family members, including hostility, a sense of being conscience-stricken (blaming oneself), avoidance, conditional positivity, and positive affirmation (p. 397). Moreover, only one study has examined LDS LGBTQ+ adolescents and young adults, but that study also included youth of other Christian faiths and was not LDS-specific (Dahl & Galliher, 2012). The authors found that a religious context was connected to depressive symptoms, social strain, increased sense of self, acceptance of others, incorporation of religious values into their identity, and a sense of surprise when they were met with social support from childhood religious contexts. Given the sparsity of research about young people and families at this intersection, especially pertaining to family therapy, this study focuses on family therapists' work with LGBTQ+ young people and their LDS families.

Family Support and Identity Acceptance. Research overwhelmingly shows that family support acts as a protective factor against youth suicide behaviors and can even be a stronger predictor of attempts than support from peers or social support in general (Flouri & Buchanan, 2002). Research has indicated, for example, that family acceptance of youths' sexual orientation or gender identity can predict better health outcomes, higher self-esteem, increased social support, and decreased suicide risk for those youth (Bauer et al., 2015; Ryan et al., 2010). Moreover, similar findings demonstrate that family rejection of youth and their LGB identity is linked to poorer health outcomes and increased risk for attempted suicide, depression, illegal drug use, and unprotected sexual intercourse (Ryan, Huebner, Diaz, Sanchez, 2009). Indeed, some youth exhibit distress around the feeling that they face a decision between their religious and sexual identities and by extension a decision between their needs for friends, family, and community, as well as their needs for intimacy, emotional fulfillment, and sexual expression (Anderton, Pender, & Asner-Self, 2011). Still, there remains a need for nuanced research to examine how family therapists working with LGBTQ+ youth and young adults in LDS families can facilitate increased supportive/accepting behaviors and reduce rejecting behaviors.

Family-Based Interventions. As LGBTQ+ youth in LDS families navigate the challenges that accompany identity formation and religious conflict, they must usually do so within the context of their family relationships, which may not be supportive of their LGBTQ+ identities. While individual therapy with these young people may benefit them, involving family members in therapy can address the relationships that have the greatest potential for providing LGBTQ+ youth with the help and connection they need most. In family therapy, for example,

young people are more likely than in individual therapy to have an opportunity to directly address family dynamics that may contribute to the distress that is bringing them to therapy.

The Church's focus on family relationships can be a resource for clinicians working with this population. There are various doctrines, beliefs, and cultural practices specific to the Church that can aid clinicians in understanding and intervening with families in the Church. Unfortunately, as mentioned previously, clinicians working with such families will find a dearth of research about best therapeutic practices for families with LGBTQ+ and LDS intersecting identities. Although empirical evidence supports a family-based approach for therapy among LGB (Diamond et al, 2013) and TGD youth (Russon, Smithee, Simpson, Levy, & Diamond, in press), no research exists to address the nuances of family therapy with Mormon families and their LGBTQ+ youth and young adults. As such, my study will seek to fill this gap by identifying concrete guidelines of best practices for family therapy among LGBTQ+ young people in LDS families.

Synthesis of Research Findings

This literature review intentionally began by providing a broad overview of the teachings and dealings of the LDS Church concerning LGBTQ+ individuals. Within the LDS Church, it has been common rhetoric to attribute the distress among LGBTQ+ Mormons to their own attractions, internal identity conflicts, and/or "sinful behaviors." In essence, a Church-wide lack of understanding around sexual and gender identity has resulted in the pathologization of LGBTQ+ youth and adults.

An extensive review of the Church's teachings, political endeavors, and disciplinary history have served here to highlight an important insight that is foundational to the aim of this

study: The distress that Mormon LGBTQ+ young people are experiencing is more likely a response to the pathologization of their identity than an inherent dysfunction of their sexual or gender identity. Clinically, such a distinction is essential, as it moves therapists away from understanding a young person's identity as the presenting problem (as is the case in conversion therapy) and toward a more systemic understanding of contextual factors contributing to young people's distress.

Unfortunately, there is still a general lack of research regarding LGBTQ+ individuals affiliated with the LDS Church. A newer body of research, reviewed above, has emerged to highlight the experiences of sexual and gender minority individuals in the Church. There is even an area of research focused specifically on the mental health of LGBTQ+ individuals associated with the LDS Church, all of which indicates a need for identity affirmation and acceptance to mitigate negative mental health impacts. However, a severe lack of clinically-focused research among this population makes it difficult for clinicians to employ empirically-supported interventions that are also culturally sensitive to those with LDS backgrounds.

Research indicates that family often plays a salient role in the mental health outcomes of LGBTQ+ youth. Behaviors of family acceptance have predicted better mental health outcomes in LGBTQ+ youth (Ryan et al., 2010), whereas family rejection behaviors have been shown to have deleterious mental health impacts (Ryan et al., 2009). Outside of LDS-focused literature, a family approach to therapy with LGBTQ+ youth has been effective in minimizing negative mental health outcomes (Diamond et al., 2013; Russon et al., in press). Furthermore, the LDS Church's emphasis on family relationships makes a family approach well-suited for LDS-affiliated LGBTQ+ young people in distress.

Family therapists who have worked with LGBTQ+ young people and their LDS families have had to do so with no established guidelines for best practice. Presumably, much of the literature on clinical, family-based interventions for LGBTQ+ young people will be applicable. Still, the complex context of Mormonism's doctrines and culture can create unique challenges for family therapists working with young people and parents who feel torn between their loyalty to each other and their beliefs. As such, this study aims to fill a critical gap by learning from therapists experienced in family-based approaches with this population and obtaining consensus among them in the identification of best-practice guidelines for family therapy with LGBTQ+ young people and their Latter-day Saint families.

Summary

This chapter reviewed the existing literature relevant to family therapy practices with LGBTQ+ young people and their Latter-day Saint families. Given that LGBTQ+ research on LDS-affiliated adults is a new area of research, there are still numerous studies needed to build upon existing knowledge. More research is needed, for example, specific to LGBTQ+ young people and young adults in the LDS Church and their mental health. Additionally, there is a severe lack of clinical literature for LGBTQ+ young people in LDS families, and no guidelines for best practice have been identified for family therapy among this population. As such, this study seeks to answer the question, "What is the expert consensus on best practices for family therapists working with LGBTQ+ young people and their Latter-day Saint families?" The following chapter will describe in detail how the methods of this study addressed this research question.

CHAPTER 3: METHODS

In Chapter 1, I described my basic research design and my research questions. In Chapter 2, I presented the need for my study through an analysis of related literature on this topic. In Chapter 3, I describe step-by-step the methods and procedures used in my study in a way that will allow researchers to replicate this study. Specifically, I outline (a) the purpose of the study, (b) the research questions, (c) the research design, (d) the target population and participant selection, (e) the procedures I used to conduct the study, (f) the instruments utilized in data collection, and (g) ethical considerations for this study.

Purpose of this Research

The purpose of this mixed-methods Delphi study was to (a) identify guidelines of best practice for family therapists working with LGBTQ+ young people and their LDS families and (b) determine areas of practice where additional training may better support therapists who are conducting this clinical work. Family therapists may at any moment find themselves in the therapy room with such families, and there is no literature on best-practice guidelines for serving this population. Thus, this study seeks to fill a gap in the literature by being the first to examine the intersection of (a) family therapy practices, (b) LGBTQ+ young people, and (c) their LDS families.

Research Questions

In an effort to develop concrete best-practice recommendations that take into consideration the intersectional needs of LGBTQ+ young people and their LDS families, the research questions posed in this study are:

R1: What is the expert consensus on best practices for family therapists working with LGBTQ+ young people and their Latter-day Saint families?

R2: How do family therapists with intermediate experience working with LGBTQ+ young people and their Latter-day Saint families perceive their self-efficacy in implementing the best-practice recommendations identified in R1?

Research Design

This mixed-methods study employed a modified Delphi method with four rounds of data collection and analysis. The study followed a traditional Delphi technique, which seeks to reach a consensus among field experts. The modification of this study is slight, as it (a) uses two samples instead of one and (b) the peripheral field experts (PFEs) in Round III have less experience than the core field experts in Rounds I and II, but still have expertise in family therapy with LGBTQ+ young people and their LDS caregivers.

Round I involved qualitative interviews with six family therapists (core field experts; CFEs) who have extensive expertise working with LGBTQ+ young people and their LDS families. The interviews explore best practices for working with this population in the context of family therapy sessions from the perspective of therapists. The qualitative data collected in Round I was analyzed through a process of thematic analysis, and the findings inform the development of Survey I. In Round II, Survey I is distributed, inviting core field experts (CFEs) to endorse which best-practice recommendations they deem important. Endorsed recommendations from Survey I are used to create Survey II.

Round III involved sending Survey II to a panel of PFEs on conducting family therapy with this population. In Survey II, the PFEs rate their perceived self-efficacy for each of the best-

practice recommendations previously endorsed in Round II. Finally, Round IV entails the compilation of this study's findings into a brief document of concrete best-practice recommendations for family therapy with LGBTQ+ young people and their Mormon families. The document was distributed to all participants who indicated a desire to receive the completed study's findings. See Figure 2 for a full outline of the procedural steps of this study.

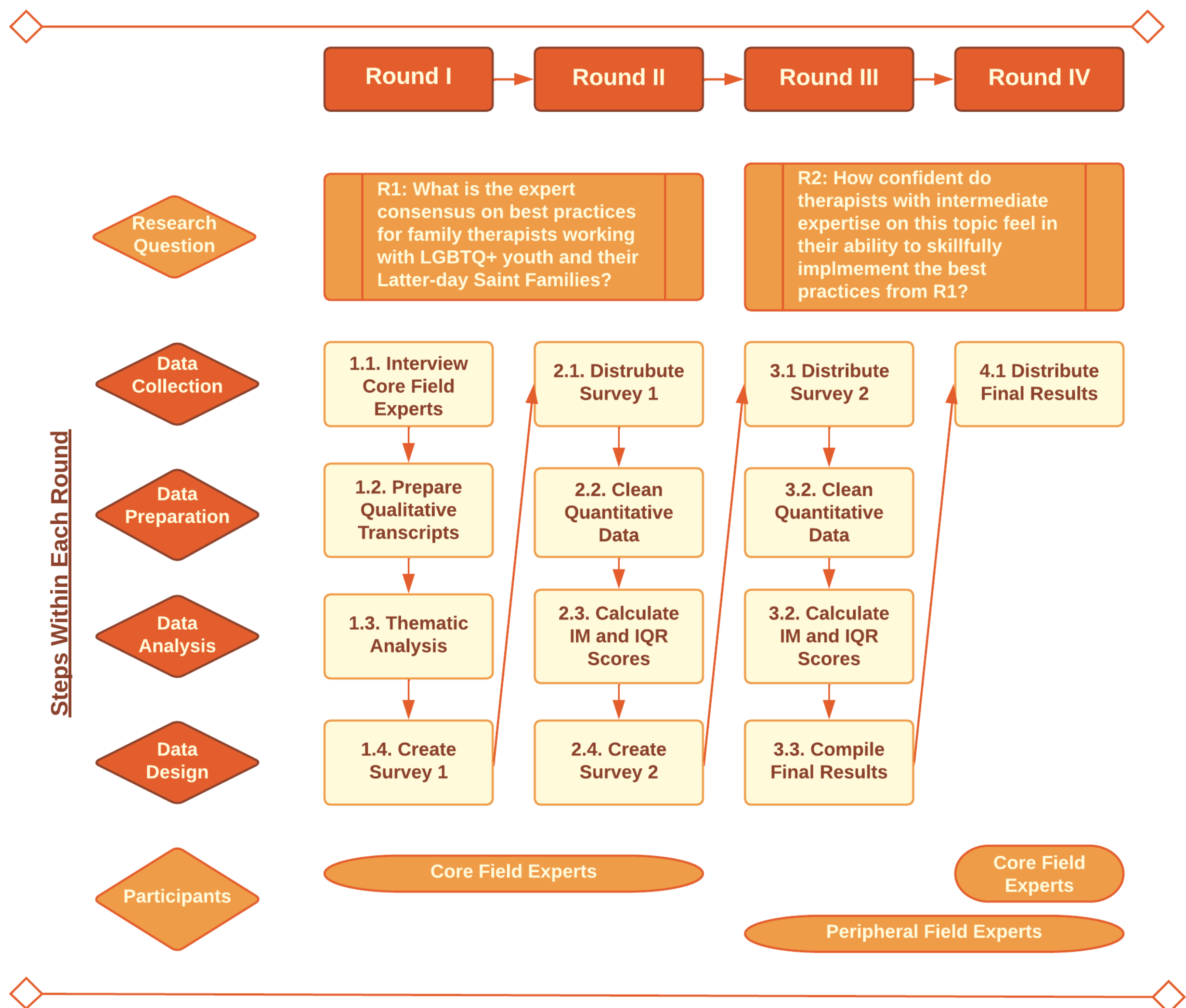

Figure *2.*

Procedural Flow Chart of this Modified Delphi Study.

Exploratory Design with an Embedded Convergent Component

This mixed-methods modified Delphi study employed an exploratory design with an embedded convergent component (Archibald, et al., 2015). The Delphi method provides a structured and systematic approach to collecting data (Stone Fish & Busby, 2005), allowing me to gather information and reach a consensus on best practices from a group of experts in the field (Round II). The use of multiple rounds of data collection and identifying expert consensus provides a rigorous and reliable method for collecting data.

However, the Delphi method alone may not provide a comprehensive understanding of the nuances of the work done by family therapists working with LGBTQ+ young people and their families. That is why I incorporated an exploratory component into my study (Round I). The exploratory component allows me to generate new insights and hypotheses about best practices by exploring the topic in a more open-ended manner. This provided a deeper understanding of the perspectives and thought processes of participants. Finally, I have included an embedded convergent component in my study to validate and refine the insights generated from the exploratory component (Round III). By triangulating data from multiple sources and methods, the convergent component provided a more robust and comprehensive understanding of best practices for family therapists working with LGBTQ+ young people and their LDS families.

Community-Based Participatory Research

Round I of this study was guided by the principles of community-based participatory research (CBPR) in that I involved community stakeholders and integrated their feedback for the

design of Round II. I hold the perspective that participatory research involves three interconnected goals: research, action, and education (Hall, 1992), and have designed my study accordingly. This research was conducted with the input of community stakeholders for the explicit purpose of creating actionable guidelines that will serve in the education of family therapists serving LGBTQ+ young people and their LDS families.

More of a process and approach than a methodology, CBPR utilizes collaboration to facilitate the negotiation of information between researchers and community experts (Wallerstein et al., 2008, p. 27). In my study, this approach allowed community stakeholders to transfer their "expert content and meaning" to inform my research and facilitated a transfer of actionable tools from my research to the community experts. The result is mutual knowledge and the application of such knowledge for the benefit of the community (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993). The final product of this research is a document containing the study's results, which were compiled and sent to all participants who had expressed interest in receiving them (Round IV).

The Delphi Method

The Delphi technique is a commonly used method of collecting "group consensus from a panel of knowledgeable persons" (Stone Fish & Busby, 2005). In the case of studying best practices for family-based treatment among LDS families with LGBTQ+ young people, the Delphi method offers the opportunity to obtain expert consensus from family therapists who have been pioneering this clinical work for the last few decades. A classical Delphi method is characterized by four main features (Rowe & Wright, 1999): (a) the anonymity of panelists allows them to freely express their opinions without social pressures to conform to the ideas of

others in the group, (b) the iterative nature of the process allows panelists to refine their opinions as the study goes through each round, (c) controlled feedback informs panelists of other panelists views, thus providing the opportunity for panelists to evolve or clarify their positions, and (d) statistical aggregation of responses allows for quantitative analysis of qualitative data.

This study is a mixed-methods Delphi study with four rounds of data collection and analysis. The goal of the study is to reach expert consensus on best practices for family therapists working with LGBTQ+ young people and their LDS families. The study involves qualitative interviews with six core field experts (Round I), a survey of the same experts to endorse best-practice recommendations (Round II), a survey of 29 peripheral field experts to rate their perceived self-efficacy for each recommendation (Round III), and finally, the compilation of findings into a document of best-practice recommendations (Round IV).

Philosophical Assumptions of the Delphi Method

The Delphi method is based on the assumption that "*n* heads are better than one" (Dalkey, 1972, p. 15). Indeed, the often too-vast separation between researcher and researched individuals is bridged in the Delphi method's attempt to reach consensus through a collective human intelligence process (Linstone & Turoff, 1975). While other methodologies may set out to find or define "truth," the Delphi method concerns itself more with identifying shared knowledge and applying it in useful ways (Mitroff & Turoff, 1975). As such, the principles of a CBPR paradigm described above are especially applicable in conjunction with the Delphi methodology for this study.

Background of the Delphi Method

The Delphi method was first utilized in the 1950s as the U.S. Air Force sought to learn what U.S. experts thought Soviet Union leaders might consider the ideal industrial U.S. target and how many A-bombs it would take to reduce munitions outputs (Linstone & Turoff, 1975). It later grew beyond defense research and ventured into forecasting long-range trends in science and technology and their impact on society (Gordon & Helmer, 1964). Through the 1960s and 1970s, the Delphi method became more prolific as it was used in numerous fields to find applications for various complex problems facing society (Stone Fish & Busby, 2005, p. 240). The Delphi technique was first utilized in the family therapy field in the early 1980s and is slowly becoming more widely used as researchers become more aware of this approach and how it can assist in developing direct applications of expert knowledge.

Strengths of the Delphi Method

The Delphi approach is well-suited for this study on creating best practices for family therapists working with LGBTQ+ young people because this study is (a) exploratory in nature, (b) situated within an area of research that is still emerging, and (c) builds consensus among a group of experts. According to Stone Fish and Busby (2005), when utilized for these purposes, few weaknesses exist in the Delphi technique. Still, there are particular strengths of this method that merit review, which are outlined below:

Accessibility. The Delphi method is a particularly accessible method for researchers. First, it does not require significant statistical or clinical expertise, financial resources, or large sample sizes (Stone Fish & Busby, 2005). Second, the results from Delphi questionnaires are accessible in that they utilize the language of the respondents, rather than being "shrouded in excessive theory or statistical jargon" (p. 251). Third, the Delphi method allows researchers to

extend their reach to a wider variety of experts. Another format, such as focus groups or in-depth interviews, would require a greater time commitment for participants than a few questionnaires. Additionally, for panelists located far from one another, the ease of an emailed questionnaire means researchers can include more panelists than they would be able to reach locally.

Applicability. The nature of the Delphi method means it is well-suited to bridge the gap between research and practice. My study seeks to embody CBPR's principles of research, application, and education through the use of the Delphi method—from this research will come immediately applicable guidelines meant to educate practitioners. In the case of family therapists working with LGBTQ+ young people and their Latter-day Saint families, the results of this study will be immediately educational and applicable to any family therapist doing this work.

Reciprocity. The Delphi method engages both the researcher and panelists in a rich, reciprocal process of exchanging knowledge and ideas. The anonymity of respondents, too, allows for panelists to review and respond to other respondents, minimizing any power dynamics that may be present among them. The iterative nature of the Delphi method also allows for the flexible input of information and knowledge gleaned along the way, which can be reflected to respondents before results are finalized. The final product is a full-bodied consensus of experts that can be readily put into practice.

Weaknesses of the Delphi Method

While the Delphi technique facilitates the creation of robust findings and applications, there are also limitations to this method. These limitations, as well as how I addressed them in this study, are outlined below:

Regression to the Mean. Respondents may change their answers to align closer with the group consensus if too many rounds of surveys are distributed. The traditional Delphi study is conducted with at least three rounds of surveys (Linstone & Turoff, 1975). I mitigated this limitation by first implementing a preliminary qualitative portion interviewing only a few experts, thus allowing for the flexibility of only two rounds of surveying among the final panelists. Thus, I hoped to minimize the potential for regression to the mean.

Minimization of Diversity. Within the Delphi method, diversity is sometimes sacrificed for consensus. If there are outliers in responses or bimodal trends of panelists splitting into distinct groups, these findings may only manifest if the researcher relaxes the standard of small interquartile ranges (IQRs.) To assess for the diversity of thought among panelists, I created a scatter plot to determine whether non-normal distributions of opinions are present.

Attrition. One of the challenges of utilizing the Delphi method is that of retaining panelists long enough for follow-up analysis of consensus. Indeed, recruitment and retention have been coined "a constant challenge to the success of clinical research" (Gul and Ali, 2010, p. 228). I understood that upon recruiting panelists, I had to make sustained efforts to retain them in the study. My strategies for retention were to offer financial incentives, highlight the expert role of the participant in my communications with them, and build an engaging rapport with each participant (Stone Fish & Busby, 2005, p. 249).

Procedures

Sampling and Recruitment

A critical component of this mixed-methods study is the selection of core field experts (CFEs) and peripheral field experts (PFE), as it is directly connected to the validity of the results.

According to Dalkey (1969), panelists' knowledge of the topic being examined is the most important element of high-quality results when executing the Delphi method. As such, I utilized purposive sampling to recruit core field experts for Rounds I and II of data collection.

Core Field Experts

In recruiting for Rounds I and II, I first met with a primary stakeholder within the intersection of family therapy, LGBTQ+ young people, and Latter-day Saint families. The primary stakeholder recommended eight potential CFEs, six of whom participated in and completed the study. Round I included interviews with field experts who meet the following criteria: (a) have five years or more experience working with LGBTQ+ individuals and their LDS families, (b) possess a qualifying degree in a mental health discipline, and (c) identify as LGBTQ-affirming therapists.

Peripheral Field Experts

Round III recruitment aimed to obtain 20-30 PFEs who had some experience with family therapy with LGBTQ+ young people in LDS families, but who did not necessarily have as much experience as the CFEs. Originally, I had set the criteria that participants must have conducted at least 10 family therapy sessions with LGBTQ+ young people and their Mormon family members to be eligible to participate as a PFE. Only five participants met that requirement, however, so the criteria to be a PFE were adjusted. The final criteria to participate as a PFE were that the therapist must (a) have conducted or observed at least three sessions of family therapy with this population, (b) possess a qualifying degree in a mental health discipline, and (c) identify as LGBTQ-affirming therapists.

Snowball Sampling. PFEs were recruited primarily through snowball sampling, followed by a round of convenience sampling. At the end of each interview in Round I, I asked each CFE to list up to 10 names of individuals whom they believed had conducted at least 10 sessions of family therapy with an LGBTQ+ young person and at least one Mormon family member. Of the 13 therapists recommended by the CFEs, all 13 were invited to participate, and 5 completed the study.

Convenience Sampling. To obtain the rest of the 20-30 PFEs required for Round III, I contacted several organizations adjacent to the work of therapy, LGBTQ+ people, and Mormonism. I emailed or posted an electronic recruitment flier on Facebook pages for the following organizations: Flourish Therapy, Encircle Therapy, the LGBTQ+ Guild of Utah Therapists, and the Utah Pride Center.

Round I

Data Collection

Interviews with Core Field Experts. Semi-structured interviews provided the foundation for this study. Interviews were the primary source of data used to answer R1: "What unique considerations must family therapists make when working with LGBTQ+ young people and their Latter-day Saint families?" I conducted six interviews using a secure online video platform. Each interview was one-on-one to maintain participants' confidentiality. I obtained participant permission to video- and audio-record all interviews. Participants were told to expect a 60- to 90-minute interview but were told that they could extend the interview if they had more they wished to express on this topic.

Trustworthiness. To ensure trustworthiness, I engaged in member checking both throughout and at the end of each interview by sharing my interpretations with the interviewees. I reflected on my interpretation of the interview content with each participant to ensure that it was reflective of their experiences and invited the participant to correct or clarify my interpretations of their words. Immediately following each interview, I reviewed my notes and impressions, following the recommendations of Sprenkle and Piercy (2005).

Data Preparation

To ensure completeness and accuracy, I utilized automated transcribing software to create initial transcripts of the interviews and sent them to be 'cleaned up' and edited by a professional transcription service company, TranscriptionWing.com. The recorded interviews resulted in a total of 194 pages of transcripts, saved as Microsoft Word files. The average length of an interview was 1 hour and 38 minutes. The average number of pages of transcription from each participant interview was 25 pages.

Data Analysis

Braun and Clarke's (2006) thematic analysis is a widely used method for analyzing qualitative data. I followed their recommended steps, which are outlined in this section.

Familiarization with the Data. This step involves reading through the data several times to get a general sense of the content and to identify any patterns or themes that may be emerging. I familiarized myself with the data by reading through it several times for these purposes. To immerse fully in the interviews, I listened to the audio recording of each interview while concurrently following along in the transcripts.

Generating Initial Codes. This step involves breaking down the data into smaller pieces and assigning codes to each piece that capture its main meaning or content. These codes are then used to identify patterns or themes that emerge across the data. I reread each interview transcript line by line in Microsoft Word, then generated initial codes and their line numbers in a Microsoft Excel sheet. I noted similarities between coded passages and commonalities across participants and began considering potential themes across codes.

I then reviewed the transcripts line by line for a second time, repeating the coding process to ensure that all meaningful words and passages were coded based on their relationship to the research question. A total of 245 initial codes were identified, each noted in Microsoft Excel with a brief, descriptive title passage related to potential best-practice recommendations for family therapists conducting sessions with LGBTQ+ young people in Latter-day Saint families. Table 1 presents an example of how passages were coded.

Table 1.

Example Passages with Initial Codes

Raw data	Code
"Without symbolic interactionism framework, we can kind of view labels as stagnant. Something like gay, just like it's just there, gay is gay, but understanding that in my family, gay has a certain symbol and a certain meaning that I bring in by how I understand gayness and how my family understands gayness. So, we cocreate how gayness exists in our family. It isn't just a definition in a dictionary." (CFE 04)	Symbolic Interactionism framework Co-created family meaning of constructs
"I want to meet with them on their own for a while, so, just so I can form like the therapeutic alliance, first and foremost, with my client." (CFE 01)	Meet first with the young person

Searching for Themes. The third step in thematic analysis is to examine the codes for themes (Braun and Clarke, 2006). In this step, I further reduced data into larger categories of similar codes. To complete this step, I reviewed all of the initial codes and determined relationships among them. Codes that were related to each other were joined into larger categories that were used to form themes.

Reviewing Themes. The fourth step of Braun and Clarke's thematic analysis requires the researcher to review the passages again to ensure that all codes are moved into larger themes. I examined the 245 initial codes again and determined that 27 of them were either not present enough in the transcripts or were not sufficiently related to the research question, leaving a total of 218 individual codes that were formatted as recommendations for best practice pertaining to family therapy with LGBTQ+ young people and their LDS families. I then reviewed the themes to ensure that they were clearly defined and accurately reflected the data.

Defining and Naming Themes. The fifth step involves conducting further analysis of the placement of all codes and categories into a thematic structure that addresses the research question. The themes that best represented the data and supported the aim of answering the research question were 13 distinct treatment categories. I assigned names and descriptions to each treatment category to give them meaningful, clear definitions. Round I theme descriptions can be found in Appendix A.

Producing the Report. This step involves writing up the analysis and describing the themes that have been identified, along with any subthemes or variations that have been found. The results section for Round I in this chapter presents the qualitative findings from this study.

Reflexivity. Researchers need to reflect on their own positionality and the ways it may have influenced the analysis and interpretation of the data. Although reflexivity was employed throughout the study, in this step I spent intentional time considering my own questions, thoughts, concerns, and emotional reactions that had come up throughout the interviewing and coding processes.

In particular, I noticed within myself a sense of cognitive dissonance and a feeling of "unsettledness" after an interview with one participant. Leaning into the social constructivist paradigm of this study, I worked consciously to utilize my positionality to enhance the richness of the qualitative findings, rather than allowing it to take away from them. I revisited the data to employ a more global view of the perspectives expressed by the CFEs.

Closer observation indicated that although I had observed a consensus of content and recommendations across CFE interviews, I had missed a subtle outlier. I noted that all CFEs but one had discussed a need for therapists to conceptualize family members and their identities working within and between larger systems of power, and to be attentive to power dynamics throughout family therapy. That CFE was also the only one who did not explicitly highlight the role of power in the work of family therapy with LGBTQ+ young people and their Mormon family members. Further, the other CFEs all recommended that (a) the LGBTQ+ young person is the client with less power than their caregivers in family therapy sessions and that (b) therapists must act as advocates and protectors for the LGBTQ+ young person in family sessions. This reflexivity process led me to add the construct of power to the intersectional ecological framework guiding this study.

Data Design

Following a thorough process of thematic analysis in Round I, I gathered the identified 13 treatment categories and 218 codes to create Survey I. An email was sent to CFEs that included a summary of results from Round I, a link to the QuestionPro survey for Round II, and the CFE's unique identification number. Participants were given two weeks to complete Survey I, and an email was sent to remind them of the deadline as it approached.

Round II

The purpose of Round II was to identify convergence as well as variation of the CFEs' opinions regarding the importance of each best-practice recommendation identified in Round I. Upon completing a thorough thematic analysis of transcripts of the qualitative interviews, the identified individual codes were used to create Survey I to send back to all six CFEs who had participated in the expert interviews.

Data Collection and Preparation

CFEs from Round I were invited to rank each identified best-practice recommendation by how important they perceived it to be to the work of family therapy with LGBTQ+ young people and their Latter-day Saint family members. Items were ranked on a Likert Scale (1-5) of perceived importance (1 = Not at All Important, 5 = Always Important). Survey I was distributed to all CFEs who had been interviewed in Round I. All six CFEs completed Survey I, achieving my goal of 0% attrition from Round I to Round II. There was no missing data or incomplete responses, thus the data was ready to be analyzed.

Data Analysis

I calculated the interpolated median (IM) and interquartile ranges (IQRs) of CFE scores of perceived importance for each best-practice recommendation. Items with an importance IM of

at least 3.50 and an IQR of 1.50 or below were considered highly endorsed by the CFEs as important. I calculated the interpolated median because it adjusts the median slightly upward or downward to indicate whether there were more responses above or below the median score. For example, in the case of CFE importance ratings on a 1-5 scale, an IM between 4.0 and 4.5 would indicate that there were more ratings above 4 than below 4. Similarly, an IM between 2.5 and 3.0 would indicate that there were fewer ratings above 3 than below 3.

A total of 176 items were endorsed as important, which were then compared with the original 13 treatment categories to assess for appropriateness. Given that 42 items were not highly endorsed by CFEs, I determined that the categories needed to be reworked to accurately reflect the content of items that CFEs considered important. The finalized 176 best-practice recommendations were compiled and utilized to create Survey II, which would be distributed in

Round III

Data Design

To create Survey II, I compiled the 176 best-practice recommendations endorsed by CFEs in Survey I and reorganized them into eight categories, after 42 recommendations were not highly endorsed by CFEs. An email was sent to PFEs that included a link to the QuestionPro survey for Round III and the PFE's unique identification number. Participants were given two weeks to complete Survey I, and an email was sent to remind them of the deadline as it approached.

Round III

The purpose of Round III in this modified Delphi study was to assess the level of self-efficacy perceived by peripheral field experts (PFEs) concerning each best-practice

recommendation that had been endorsed by CFEs in Round II. As such, the research question guiding Round III was:

> R2: How do family therapists with intermediate experience working with LGBTQ+ young people and their Latter-day Saint families perceive their self-efficacy in implementing the best-practice recommendations identified in R1?

Data Collection and Preparation

PFEs were advised that all best-practice recommendations had been identified and endorsed by CFEs in Rounds I and II. PFEs were invited to rate each proposed best-practice recommendation on a Likert Scale (1-5) of perceived self-efficacy pertaining to each best-practice recommendation (1 = Highly Uncertain, 5 = Highly Certain). PFEs were asked to "please rate how certain you are in your ability to skillfully" implement each best-practice recommendation.

Data Analysis

First, I calculated the IM and IQRs of PFE perceived self-efficacy scores for each best-practice recommendation. Second, I calculated that the mean of IMs across all best-practice recommendations was (m = 3.68) and implemented that as the cutoff for which items were considered rated for low levels of self-efficacy. Thus, recommendations with an IM of 3.68 or below and an IQR of 1.5 or less were considered recommendations that PFEs as a group did not feel certain about being able to implement skillfully. Each treatment category also received a self-efficacy score which was determined by calculating the mean of all items' IMs in that category.

Summary

In this chapter, I outlined in detail how the following research question was to be answered: "What is the expert consensus on best practices for family therapists working with LGBTQ+ young people and their Latter-day Saint families?" I discussed the purpose of this study, the research questions, the research design, the target population and participant selection, and the procedures I used to conduct the study. Chapter 4 will highlight the findings of this study and provide a detailed description of the results.

CHAPTER 4: RESULTS

This chapter presents the procedures and results from all four rounds of this modified Delphi study. The chapter includes a description of the participants, as well as a detailed overview of the study's qualitative and quantitative findings.

Purpose of this Research

The purpose of this mixed-methods Delphi study was to (a) identify guidelines of best practice for family therapists working with LGBTQ+ young people and their LDS families and (b) determine areas of practice where additional training may better support therapists who are conducting this clinical work. This inquiry sought to provide therapists with culturally responsive, ethical considerations and strategies to scaffold the complex processes LGBTQ+ young people and their LDS families must navigate in family therapy. Such strategies and considerations examined included decision-making processes, cultural considerations, appropriate goals for family therapy, strategies for who participates in each session, etc. In an effort to develop concrete best-practice recommendations that take into consideration the intersectional needs of LGBTQ+ young people and their LDS families, the research questions posed in this study were:

R1: What is the expert consensus on best practices for family therapists working with LGBTQ+ young people and their Latter-day Saint families?

R2: How do family therapists with intermediate experience working with LGBTQ+ young people and their Latter-day Saint families perceive their self-efficacy in implementing the best-practice recommendations identified in R1?

Results from Round I

Core Field Experts

The sample of six core field experts in this study consisted of two cisgender women (50.00%), two cisgender men (33.33%), and one non-binary individual. CFEs self-identified across a range of sexual orientations and pronouns. The majority of CFEs had completed a Ph.D. (66.67%) and all of them were raised in the LDS/Mormon religion (100.00%). In terms of their clinical practice settings, all CFEs' practices were located in Utah. Half of them worked in private practice and half worked in non-profit organizations. Years of experience doing therapy with LGBTQ+, Mormon-affiliated people ranged between 5 to 15 years.

Initial Thematic Structure

A total of 218 potential best-practice recommendations across 13 distinct treatment categories were found from the interview data after Round I's thematic analysis. Table 2 below outlines the identified treatment categories, their descriptions, and the number of potential best-practice recommendations that fit within each category. A list of all 218 codes from Round I can be found in Appendix A.

Table 2.

Thematic Structure Following Round I Thematic Analysis

Treatment Category	# of Codes	
Self of the Therapist	16	
Cultural Knowledge and Humility	14	
Intersectionality and Attentiveness to Power	16	
General Therapy Skills	23	
Theories, Frameworks, and Therapy Models	25	
Assessment	11	

Treatment Category	# of Codes	
Client Self-Examination and Belief Deconstruction	6	
Psychoeducation	13	
Goals of Family Therapy	21	
Appropriateness and Timing of Involving Family Members	9	
Alliance with the Young Person	21	
Alliance with Caregivers	19	
Skills for Family Sessions	24	

Note: Following Round II, categories were reworked and refined from 13 treatment categories to 8, using only items endorsed by CFEs as important.

Finalized Thematic Results

Quantitative results from Round II will be described later in this chapter. It should be noted here, however, that the thematic structure of this study's qualitative results was not finalized until after Round II. The results of Survey I indicated that a total of 176 items were endorsed as important by core field experts, and 42 were not. These items were compiled into a final list of 176 best-practice recommendations, which were then compared again with the original 13 treatment categories to assess for appropriateness. I determined that the categories needed to be reworked to accurately reflect the content of items that CFEs considered important. Final refinement of the codes resulted in 8 treatment categories that housed 23 themes and 47 subthemes. Table 3 below outlines the finalized treatment categories and themes.

Table 3. Finalized Thematic Structure

Treatment Category	Themes
1. Self of the Therapist	1.1 Self-Reflection and Emotional Management in Therapy
	1.2 Personal Identity and Its Impact on Therapy

Treatment Category	Themes
	1.3 Authenticity and Self-Disclosure in Therapy
2. Cultural Knowledge and Humility	2.1 Cultural Knowledge Relevant to LGBTQ+ Young People in LDS Families 2.2 Cultural Humility & Responsiveness
3. Intersectionality and Attentiveness to Power	3.1 Conceptualization of Families within Interlocking Systems of Power 3.2 Attentiveness to Power within Family Therapy 3.3 Adherence to Ethical Standards of Care.
4. Theories, Frameworks, and Therapy Models	4.1 Moving Beyond Approaches Rooted in Cisheteronormativity 4.2 Implementing a Trauma-Informed Approach 4.3 Utilization of Relational, Attachment-Focused Approaches
5. Assessment	5.1 Young Person's Risk for Self-Harm and Suicidality 5.2 Relational Dynamics in the Family System 5.3 Acceptance and Rejection within the Family 5.4 Appropriateness of Family Therapy
6. Skills for Building Therapeutic Alliances	6.1 Alliance with the Young Person 6.2 Alliance with Caregivers
7. Equipping Family Members for the Work of Relational Repair	7.1 Self of the Family Member 7.2 Psychoeducation
8. Skills for Family Sessions	8.1 Beginning with a Baseline of Hope 8.2 Establishing "Enough" Emotional Safety

Treatment Category	Themes
	for Relational Repair
	8.3 Directively Orchestrating Constructive Interactions
	8.4 Navigating Obstacles in Family Sessions

Self of the Therapist

All six core field experts seemed to agree that the "self of the therapist" is a key factor when conducting family therapy with LGBTQ+ young people and their LDS families.

Self-Reflection and Emotional Management in Therapy. All CFEs emphasized that a great deal of internal inquiry around one's experiences, biases, and beliefs is required of therapists before, throughout, and after interactions with clients. In the words of one CFE:

> I feel like if I haven't really wrestled with, well, what if the Church is true? What if I've just made the biggest mistake of my existence and chosen a path that is selfish, wrong, all of these things? If I myself haven't really interacted with that and aren't continually interacting with that, then I think that there's an area that the family can't go because I'm nervous, I'm too scared to hold or contemplate the nuances of some of those areas, if that makes any sense. (CFE 04)

Personal Identity and its Impact on Therapy. There was consensus across CFEs, too, that one's own experiences and interactions with LGBTQ+ identities and religion—specifically Mormonism— are important to acknowledge and be aware of. One participant said:

> [My story] is more of a tragedy… of this human that was so in it to win it, that went to the temple multiple times a week, that prayed and believed so profoundly in God and eternal families, and then got kicked out… I think it's required me to also do a lot of work in my own healing to not be just antagonistic. To hold nuance for these belief systems, even though they've harmed me … I think in some ways, I do have a bias against the church… And so, my familiarity with my own lack of feeling resolved, my own triggers, my familiarity with my own, like, my own making sense of myself, then allows me more space and openness for whatever they're experiencing. (CFE 04)

Another CFE emphasized the use of their own emotions to assist clients in identifying their own:

> I talk about my own emotions when it's relevant, not to make it about me, but again, I say, 'I'm feeling this emotion, and this is what I'm feeling in my body.' I call it an emotional tuning fork like if it's resonating within me and I make my resonance louder, it also brings out the emotions within them, if I'm right. If I'm wrong, then we can clarify it… Then the resonance can be refined to the right note for that tuning fork to then connect (CFE 03).

Authenticity and Self-Disclosure in Therapy. Where some CFEs differed in opinion was how and when to utilize self-expression and self-disclosure most appropriately. Some CFEs highlighted that the use of self in therapy sessions is different from self-disclosure, as self-disclosure involves explicit information communicated to clients, whereas the use of self is more of an experiential practice, focusing on the therapist's decisions around "how much of [themselves] to bring into the therapeutic relationship." (CFE 01)

One CFE, for example, reported that they both present and disclose only what feels helpful to the goals of family therapy and that for them it does not always mean absolute transparency about their own identities or experiences. They stated:

> I mean, I'm constantly drawing on different aspects of self and life experience, but not in, like, a uniform way, if that makes sense. There's research that says clients feel safest with people who they see as being like them. And so, if I'm working with parents straight up, guess what? Maybe that day I just need to be straight [laughter]. And, you know what? That is a part of my background because I had to be straight for a lot of years... So, I understand. And even to this day, as a gay person, at any given moment you get to decide whether you are coming out or not. So, if I need to show up that day as not gay, then that's what I'll do… And actually, that is an example of using privilege, especially with parents, you know, in terms of - of, you know, knowing, knowing where they feel safest. (CFE 01)

Another CFE presented a different perspective, indicating that "I think authentic disclosure is key here." They suggested that a therapist's self-expression is, in and of itself, a form of self-disclosure, saying:

> I think that for those who are LGBTQIA+ from the Church of Jesus Christ of Latter-day Saints, there is real reason for us to distrust therapists. That position, that space, has been used against us, and we put lots of energy and effort into trying to reduce who we are in order to maintain membership. We were told by somebody who was in a position of power that was an okay and acceptable thing to do. So to interact with that I think it's essential for us as clinicians… to get comfortable with self-disclosure. Because our

identities show up, our histories show up, and our biases show up—whether we are talking about them or not.

Sometimes we have this myth that we get to opt in or opt out of self-disclosure, but we're self-disclosing constantly. My gender presentation is an aspect of self-disclosure. When parents interact with a full-grown human or an ever-growing human, that has experienced this, that identifies as nonbinary…. I think it also solidifies identity, right, that non-binary-ness isn't a phase, that identity is fluid. If a grown professional can identify as nonbinary and have varying levels of presentation, that makes it less silly than a 12-year-old also doing that. I get to utilize my identities as maybe a mirror for some of these belief systems… I might say something like, 'What's it like to tell a nonbinary human that you don't believe that like nonbinary really exists? How does that feel in this space?' …Usually, they are talking about their child, and then bringing me into the room works as, maybe like a canvas to kind of play around with and paint with some of the different things. (CFE 04)

Cultural Knowledge and Humility

All CFEs who were interviewed expressed that gaining fundamental knowledge of Latter-day Saint theology, policy, and culture is important to implementing a culturally competent approach to working with LGBTQ+ young people and their LDS families. There was less consensus, however, regarding just how much cultural knowledge is sufficient for therapists to be adequately equipped for conducting family therapy sessions. One CFE discussed:

I think [therapists] who were raised in the church, or at least have some familiarity with the church, are going to inherently be more equipped. Because I think one of the really

> important pieces is I think as therapists we need to, again, have that respect for the belief system, for some of the really quirky things that Mormons do, the really damaging, maybe even objectively toxic things that we do, understanding where that comes from and why that comes at play energetically, emotionally, I think, is essential…
>
> How do you do that in a training? How do you really get that complexity of why parents are so heartbroken, so distraught, so confused? I have yet to figure it out fully. I think we can get a general understanding in trainings… But I don't know if it's complete, right? Because there's so many of these things, and so many of the smaller things, right, like - like Sunbeams, or Primary, or the Sacrament, or mission farewells, or old missions versus new missions and patriarchal blessings…There are so many nuances to, I think, our identity as queer humans within the church that I don't know how to train somebody for that so that they feel prepared. (CFE 04)

In sum, CFEs expressed that they wrestle with what elements of working with this population can be taught to clinicians, and which may require some form of lived experience. Even still, they reported that knowledge at the intersections of LGBTQ+/Mormon identities is essential, as well as knowledge of their potential impacts on families.

Knowledge Around the LDS Doctrine of Binary Gender. CFEs agreed that among the most important LDS teachings for therapists to understand is the conceptualization of gender as a fixed, eternal, binary construct. Several CFEs discussed "*The Family: A Proclamation to the World*" (1995), a document that they said contains the theologies that come up most often in family therapy with LGBTQ+ young people and their Mormon family members. "*The Family Proclamation*," as they called it, states that "Gender is an essential characteristic," and suggests

that one's gender is fixed, remaining constant before, during, and after one's 'earthly life.' CFEs indicated that although it is not considered canonized LDS doctrine, the *Proclamation* on the family is a document upon which many Latter-day Saints base their religious beliefs regarding the definitions of family, marriage, and gender. One CFE described:

> *The Family Proclamation* is now quite old, and it was - it was clarified that it was not scripture, it was not doctrine, but parts of it have actually been spoken over the pulpit by leaders that are considered to be prophets, seers, and revelators, so they are - are becoming doctrine. The gender binary, for example, and that… the gender that's assumed at birth is their eternal gender, [laughter] whatever gender a baby can have, [laughter]. Which to me, as a social constructionist for gender, seems like an odd juxtaposition or an odd assignment to a baby, but the sex assigned at birth is assumed to be their gender for eternity. (CFE 02)

CFEs were in agreement that the LDS theology and policies around "the gender binary" are important for therapists to understand because they will be very present in family sessions with LGBTQ+ young people in Mormon families. One CFE indicated the loss of access to religious rituals that many transgender and non-binary young people experience, stating:

> So if [the young person] has a belief that the covenant path is something they want to follow and now they don't have access to it, like they don't have access because of the policies of the church right now, they don't have access to attend the temple because they're transgender. And so then what does that mean about the beliefs that they have if they aren't able to participate and engage with them in ways that they would have typically? (CFE 05)

One CFE recounted an experience utilizing psychoeducation about the Family Acceptance Project (Ryan, et al., 2009; 2010) to navigate the theology of binary gender in family therapy. They stated:

> I'm thinking of one specific experience where I had a nonbinary human whose parents were having a really hard time using they/them pronouns. And it was because of gender being an 'essential characteristic', a divine characteristic. And 'they/them,' and 'nonbinary-ness' doesn't fit in this. And that thing that we were able to do was to draw from the Family Acceptance Project, which is like do we want this child to live? If we want this child to live, we've got to use they/them pronouns… respecting their pronouns, respecting their name. (CFE 04)

Awareness of the Collectivistic LDS Doctrine of the Eternal Family. Several CFEs indicated that family therapists working with LGBTQ+ young people in LDS families must understand the collectivistic nature of Mormonism's doctrine on eternal families. According to CFEs, LDS theology preaches that only devout LDS individuals who live a cisgender, heterosexual 'lifestyle' will be permitted to enter the highest tier of heaven, as well as to maintain their family relationships after death. Thus, Mormon doctrine teaches that the only families that will remain intact after death are those in which all family members have diligently believed in and followed the teachings of the LDS church. As such, one CFE argued that the LDS concept of salvation could be considered a "team sport" (CFE 03). Because family members' personal salvation is tied up in the salvation of the family unit, CFEs expressed that although Mormonism's collectivistic theologies and culture often enhance family members' sense of community and belonging, they can also complicate family therapy processes. Thus,

CFEs expressed that Mormon caregivers often perceive the young person's "decision" to adopt an LGBTQ+ identity as one that comes with "really profound religious losses" (CFE 01).

CFEs indicated that family therapists must conceptualize Mormon caregivers' responses to their LGBTQ+ children within the context of a deeply internalized "eternal responsibility to have their children live a particular kind of life… and how that impacts their standing in the community… and the power they have to have relationships within families" (CFE 02). One CFE highlighted a common perspective that LDS caregivers hold concerning their LGBTQ+ children, stating that, "It's like they're really, really saying, 'I am choosing to defy these teachings,' which comes with all of these punishments, and losses of rights, and blessings, and privileges, and salvations" (CFE 01). One CFE's personal experience punctuated the complexity and necessity for therapists to understand the internal conflict of many LDS caregivers of LGBTQ+ young people, saying:

> When my - when I came out and my mom said, like you destroyed our eternal family, I think [family therapists] need to understand why a single mother who comes from Church roots—who had invested all of her energy and time into being a good Mormon mom and taking care of her children, and believed that her prize was coming in the afterlife—why me coming out was such a big distraction from that. Why she would care so much, why she felt like a failure, and why she maybe even continued to feel like a failure because her job as a Mormon mom is to make sure that her children go back to heaven. (CFE 04)

Intersectionality and Attentiveness to Power

Conceptualization of Families within Interlocking Systems of Power. All but one CFE emphasized the need for family therapists to conceptualize the family within the context of larger systems of power, and how such power can create both privilege and oppression. One CFE articulated that without such a lens, therapists can miss the fact that family members' own layers of identity can simultaneously increase their power in some contexts and decrease it in others. They described this phenomenon as the ability of all participants in the family therapy process "to be both the oppressed and the oppressor."

One CFE highlighted the need for therapists to be aware of how larger systems of power interact so they can utilize their own positionality within those systems to perpetuate healing, rather than harm. They stated,

> It's a delicate balance, and something I think is even more difficult for me as a [LDS-affiliated university] faculty member … But also, honestly, there's probably some privilege there because I have some moral authority being a [LDS-affiliated university] faculty member even though it's totally unjustified. But there is, there is some religious authority that is ascribed, I think (CFE 03).

Another CFE emphasized the utility of implementing an intersectional approach, stating that, "I think intersectional feminist family therapist framework is also really important, understanding identities and the interplay of identities within a system of oppression, how that may show up, what that means for people who are marginalized with their identities" (CFE 04).

Attentiveness to Power within Family Therapy. Again, all but one CFE discussed a need for family therapists to be aware of and carefully navigate power dynamics within the family therapy system.

Consider the Age of the Young Person. Several CFEs highlighted that the age of the young person, and specifically whether they are legally considered a minor, impacts the power dynamics of family therapy. One CFE described:

> Having a relationship with an adult child is a privilege, because legally they, you know - it's not like that role of dependence. And so, again, I don't have concrete ideas of how that's shaping things, but it's certainly shaping things in the room in terms of like a young person who's not a minor has a lot more power to end the relationship. For someone who is a minor, the parents have a lot more power to punish, shape, or restrict behavior…If they're feeling unsafe with their parents, they just, obviously, they just spend less and less time with them, right? And that relationship becomes estranged, and parents know that, right? So, the power dynamics, essentially, is what we're talking about. The power dynamics are really shifting between that, that legal age (CFE 01).

Consider Families' Living Arrangements. CFEs also emphasized that whether the young person lives at home or not greatly impacts power dynamics in family therapy. One CFE articulated:

> It seems like youth who are living outside the home feel a lot more empowered to potentially explore, or… to move in different directions than parents might wish, right? They're just having more space and more freedom to do that… But to share that movement, to share that direction, that new direction with their parents, you know, is still so vulnerable, even though they're not living at home…. Like, they might not be punished for it, but, you know, they're anticipating their parents' disappointment or disapproval. (CFE 01)

Adherence to Ethical Standards of Care. All CFEs in this study expressed that no matter their personal perspectives, family therapists have an obligation to adhere to the ethical standards of one's clinical and professional field. CFEs recommended that family therapists working with LGBTQ+ young people and their Mormon family members enhance clients' sense of self-determination. All CFEs self-identified as "LGBTQ+ affirming," in their approach to family therapy, but there was a diversity of opinion about (a) defining what it means to be affirming, (b) what is and is not considered conversion or reparative therapy.

Enhance Clients' Sense of Self-Determination. All CFEs saw value and importance in implementing practices that enhance clients' sense of autonomy and self-determination but had differing perspectives about just how to do that. The use of language, for example, was one area where CFEs' approaches to client self-determination differed. The term, "same-sex attraction," for example, is a term that many LDS church leaders use to describe what those outside of Mormonism might equate with possessing a "gay identity." One CFE expressed that regardless of any common labels and/or their history, therapists should reflect clients' own use of self-describing language. They stated that therapists should, "[be] careful not to assume labels, not to assume identities. Just be very open, letting the client lead the way on that; because there are too many therapists that just don't, right" (CFE 06)?

In contrast, another CFE stated that "This is probably where my intersectional queer feminist lens comes in. 'Same-sex-attracted' is an oppressive label. It's a reductionistic label, in my opinion. So, if we're using those labels… what are my considerations on what could be influencing this young human to be using or not using that label, for family members using those labels?" (CFE 04). This CFE expressed that while client self-determination is an essential ethical

principle in working with these families, many therapists fail to acknowledge the socialization and power structures that have influenced the decisions LGBTQ+ young people have made around how to describe themselves.

Do Not Conduct Reparative or Conversion Therapy. CFEs agreed that therapists should not engage in any version of conversion or reparative therapy—even if clients are asking therapists to help diminish the LGBTQ+ parts of themselves. There was some lack of consensus, however, on how to define exactly what it means to perform conversion therapy.

One CFE reported that given the collectivistic nature of Mormon salvation, it is not uncommon for LGBTQ+ young people and/or their family members to request some version of conversion therapy. They stated that:

> The vast majority of the people that I work with have experienced some form of conversion or reparative therapy. Even things like…when I feel I'm being told by somebody in a position of power to pray when I start feeling inclinations of my queerness. That has a real, detrimental impact on us, and on our clinical work. (CFE 04)

That same CFE outlined some reasons why LGBTQ+ young people may seek out reparative therapy practices, including wanting to maintain religious membership and participation, increasing a sense of belonging in their family, aiming for religious salvation and exaltation, and enhancing a sense of community belonging. They indicated that:

> To seek belonging is a survival strategy for a lot of us, right? We don't know what it's like to not be in community, and we've been taught that our existence is in community. And so understanding that there is real survival energy behind some of these conversion and reparative practices [is important] (CFE 04).

Acknowledge Differing Definitions of the Term "Affirming". Several CFEs highlighted that the term "LGBTQ-affirming" is a point of disagreement among therapists engaged in family therapy with LGBTQ+ young people in LDS families, and one even reported that the word "affirmative" is a "polarizing word" (CFE 06). The CFEs, though all self-identifying as "LGBTQ-affirming" therapists, reported subscribing to their own interpretation of what it means to be an affirming therapist. The majority of CFEs seemed to employ a perspective that encouraging LDS family members' acceptance and even celebration of the young person's LGBTQ+ identity is part of what it means to be an affirming therapist, and that identity acceptance and celebration encourage positive mental health and relational outcomes.

In contrast, one CFE reported that they believe that more Latter-day Saint families could "get on board with" the term "affirmative" if they were to implement a definition that emphasizes the affirmation of all family members' experiences. The CFE said they prefer to use the word "affirmative" in messages to clients, saying, "Affirming means I'm affirming your experience. I'm affirming your distress. I'm affirming your ability to navigate the world and know what's best for you" (CFE 06).

CFEs reported, too, that one area where such a distinction around affirmative family therapy is in whether a goal of family therapy with LGBTQ+ young people in LDS families is to change the behavior of family members or to change family members' beliefs around the morality of their child's LGBTQ+ identity. One CFE, for example, talked about the internal wrestle they experience personally around wanting to respect the beliefs of Mormon family members while also believing that behavior alone may not be enough to repair relational wounds between family members.

The CFE clarified that although they doubt whether the job of family therapists is to change family members' beliefs, they still believe that caregivers need to engage in the experience of examining their beliefs around LGBTQ+ identities to facilitate relational repair and secure attachment. They reported that the principle of faith, in fact, has served them in supporting caregivers whose religious beliefs feel deeply dissonant with their child's LGBTQ+ identity. In such cases, the CFE stated that:

> When we can tap into kind of the love, the desire for wellbeing, the desire for celebration, that then takes root and kind of supersedes maybe a lot of the, like, whatever. Though it's interesting, as I'm - as I'm talking, I'm reminded that sometimes what ends up happening [for parents] is strengthening a trust in God and a faith in God. That 'I as the parent don't have to have it all figured out. I don't have to understand the complexity of gender in gospel doctrine. I can rest on my job is to love, is to support, is to celebrate my child, and I can actually give up to God my child and their salvation, and their eternal wellbeing.' And that actually strengthens a family's relationship with God, right? Because like my mom is like, "God, I'm actually trusting you way more than I thought I would, right, because I don't know what to do and I'm confused, but like I'm going to trust you, God, that even if my child wears heels that – that you'll figure it out" (CFE 04).

This CFE reported that their current approach to the "behavior vs. belief" dilemma is to focus family therapy sessions on behavioral interventions, such as using their transgender child's requested pronouns, with the intent that such behavioral changes can prepare the way for appropriate belief work to take place during future individual sessions with family members.

Theories, Frameworks, and Therapy Models

CFEs as a group expressed that family therapists must be knowledgeable about conceptual frameworks and evidence-based practices relevant to therapy with LGBTQ/LDS families. Although not all CFEs recommended the same models with which therapists should be familiar, there were certainly some that were mentioned more than others. Still, CFEs as a group indicated that no single model or framework in and of itself attends to the unique needs and nuances of family therapy with this population. Thus, this section begins with a critique from CFEs regarding existing approaches but also outlines the existing approaches that came up most often in the interviews.

Moving Beyond Approaches Rooted in Cisheteronormativity. CFEs as a group postulated that no existing models for family therapy sufficiently address the needs of LGBTQ+ young people and their Mormon families. Several CFEs reported that they pick and choose principles and interventions from various family therapy approaches in order to provide a culturally responsive, catered approach. One CFE, for example, reported that they utilize a mix of attachment-based family therapy (ABFT), experiential family therapy, and "like 20% of strategic in there" (CFE 03).

Other CFEs expressed that they have not found any models that address some specific aspects of family therapy with LGBTQ+ young people in LDS families. One CFE expressed, "I don't know what model there is that understands patriarchal culture, but I think being aware of what families are up against with an eternal responsibility to be parents" (CFE 02). Another CFE identified a lack of models addressing the particulars of spiritual trauma.

Consensus across participants indicated a need for a catered, culturally informed approach for this work. One CFE suggested that "there is a need for approaches that are not just

adapted for work with LGBTQ+ humans with LDS backgrounds, but for approaches that are born from the needs of these specific humans" (CFE 04). They expressed that:

> All of our models are going to be insufficient because they're heteronormative and cisnormative. Family therapy is rooted in this, right? So, even Satir, right? Even Satir has some of that what am I doing? I can't just fall back on, 'Oh, I'm a structural therapist.' Like, all of these things are rooted in the very same systems that are causing us harm as queer humans. And so, can we feel comfortable in that? Can we feel comfortable that we're going to have to relearn lots and lots and lots of things and unlearn lots and lots and lots of things? (CFE 04)

Implementing a Trauma-Informed Approach. CFEs highlighted the need to implement a trauma-informed approach, both with young people and caregivers. They emphasized that there are several areas where these families experience trauma most often, naming spiritual and relational trauma, specifically. Regarding young people's experiences with spiritual trauma, CFEs indicated that what seems to be most traumatic for LGBTQ+ young people in LDS families is the messaging from the Church that their identity is something that they should hide or be ashamed of, and then having such messages confirmed through interactions with their caregivers at home—even when their intentions are good. In the words of one CFE:

> It's so not uncommon for parents, say, out of goodwill, to not realize that saying, 'Yeah, we shouldn't tell aunt so and so, or we should,' and them not realizing that's a - that's actually a rejecting behavior that it sends the message, right, that - that the problem is the

young person rather than taking the role of advocate and saying, 'If aunt so and so gives you a problem, ever, let us know. We have your back,' right (CFE 01)?

CFEs also reported that although parents have more power in the caregiver/child relationship, their own experiences of spiritual trauma may be impeding their ability to empathize and connect with their LGBTQ+ child. One CFE reported that:

> I mean, like I have had parents ultimately decide to come in and do EMDR on the moment when their child came out because it was so rocking of their world that it just flipped everything upside down. They didn't know how to handle it. I mean, that's sometimes how culturally hurt [they are], like because there is so much misunderstanding in LDS culture about what it means to be LGBTQ…
>
> Sometimes their own dissonance between what the church is teaching and how they're wanting to show up for their child or - or wondering about that question, bringing up all kinds of dissonance and existential crisis for a parent, and them experiencing that themselves is quite traumatic. So, I mean, some of the other forms of like spiritual trauma for queer people are probably easier to assume, right, in terms of internalized homophobia, and all the messages of potentially being evil if you are gay, or if you transition, and like loss of blessings and loss of salvation, right? I mean, that trauma, I think, is something that we're all more familiar with, but obviously…parents are having their own journey, and their own experience (CFE 01).

Utilization of Relational, Attachment-Focused Approaches. Despite expressing that no existing models are sufficient to fill the needs of this population, all CFEs signaled a need for family therapists to have a solid foundation in relational, attachment-focused interventions.

Though each reported different relational therapy models that they utilize, they all made an argument that therapists must maintain a focus on improving the caregiver/child relationship. This section outlines the main relational approaches the CFEs recommended for use with this population.

Experiential Family Therapy. Several CFEs indicated that they lean into the experiential work of family therapist Virginia Satir when working with LGBTQ+ young people and their Latter-day Saint family members. One CFE expressed that,

> The experiential model is what I'm aiming for here; that the parents have a different experience with their child… Yes, experiencing that emotion in the session, deepening it in session, absolutely, is the goal... And not even just feeling it and experiencing it, expressing it—but allowing the parent or the kid, like the other parties to clarify their understanding of the emotion (CFE 03).

Another CFE expressed a similar sentiment, reporting that "When parents… find in this session that their young person wants to turn to them, it shifts something in their mind that then shifts things outside of session" (CFE 02).

Attachment-Based Family Therapy. Another model that was recommended specifically by several CFEs was that of attachment-based family therapy (ABFT). One participant described it as "a beautiful guide in working with families, structuring family therapy sessions, and staying client-centered" (CFE 05). Another participant clarified their position on the model, stating that:

> I mean, I'm biased. Attachment-based family therapy strongly informs what I do… but if I'm being totally honest… it is not a unique model. I think it's just a group of best practices of having good family therapy. I ultimately think that's what ABFT is and - and

> the whole function of that is you are trying to set up a place – you're trying to set up this experience where the kids can talk to their parents and – and feel accepted by their parents in a way they have never felt before (CFE 03).

Identity Development Frameworks. A few CFEs also suggested that family therapists should have an understanding of developmental theories. One CFE indicated that although identity development is an internal process that is most commonly explored with LGBTQ+ young people in individual therapy, family therapy is also an appropriate setting for such conversations, noting that, "identity development is really difficult to do alone" (CFE 05). One therapist reported using Erik Erikson's psychosocial theory of development to outline the need for young people to experience a period of safe exploration and self-discovery. They emphasized that as LDS caregivers and their LGBTQ+ children have conversations about healthy exploration and appropriate boundaries, together, they are also doing relational work that will benefit the family system as a whole.

Assessment

CFEs reported that when conducting family therapy with LGBTQ+ young people and their Mormon family members, therapists should be sure to assess for a few specific things, including (a) the young person's risk for self-harm and suicidality, (b) the presence of relational and spiritual trauma in the family system, and (c) family members' levels of acceptance vs. rejection of the young person's LGBTQ+ identity.

Young Person's Risk for Self-Harm and Suicidality. CFEs reported that because of the systems of power and dynamics of marginalization at play for LGBTQ+ young people in LDS families, it is important to assess for any risks to their safety. Specifically, CFEs recommended

assessing for, “the frequency of suicidal ideation, the likelihood that the young person thinks that they might take their own life, and…what I called earlier the affinity of a young person – the likelihood that they would talk to their parent” (CFE 02).

CFEs suggested a multifaceted approach to safety assessments, which may include written assessments and more informal, discussion-based assessments. Although CFEs reported implementing a variety of written assessments, the strongest argument was made in favor of the Depression Symptom Inventory Suicide Subscale (DSI-SS). In the words of one CFE,

> It’s just four items, but its four items are about four specific different domains of suicidality. So, it has one about suicide ideation, one about suicide plans, one about impulses or suicidal impulses, and then one item about how much control you have over suicidal impulses. And I think that’s a very clinically-useful measure because most people that have a suicide - have suicidal ideation and a suicide plan don’t attempt suicide, but when you have these impulses, even most people that have an impulse don’t attempt suicide because most people are able to control their impulses. But when you’re not able to control these intrusive thoughts, that gets really worrisome (CFE 03).

Regarding less formal assessments for suicidality, CFEs recommended that therapists utilize what they observe in sessions to make decisions regarding the best way to navigate continued assessment for the young person’s safety. One CFE, for example, emphasized the ongoing nature of assessment:

> I am always assessing. [laughter] Always. When I work with queer individuals and families, every session in some way, shape, or form, asks highs and lows from your week. Were there any moments where, if they report a low, of like not wanting to get out

of bed, then that's an indicator that I need to ask about suicidal ideation? Like, “Was your depression so low where you’re having any thoughts of suicide?” And then like continuing the assessment from there depending on their answer.

Same thing with self-harm, I will have assessed for a history of self-harm in the first session, and then I’ll continue to assess throughout every session… I’m listening for those flags that indicate I need to maybe ask some more questions, and also watching for some other behavior cues. So, if it’s like a 95-degree day and someone comes in in long sleeves, then I’ll ask about self-harm (CFE 05).

Relational Dynamics in the Family System. Several CFEs highlighted the importance of therapists assessing the relational dynamics within the family. They also recommended supporting each family member as they begin to notice and acknowledge their contributions to their relational cycles. Thus, it can be beneficial to help them understand their “emotion-driven, relational cycles.” One CFE outlined how they assist family members in outlining relational cycles with them:

Kind of – kind of the bread and butter here is that kids are gonna express something really deep like this, ‘You don’t like who I am.’ And often the parents are gonna just fall on the sword, [saying] ‘I’m not good enough for you no matter - it doesn’t matter what I do. Nothing is like good enough. I just wish you didn’t have this failure of a parent.’

That’s a typical response, which is essentially, playing up being a burden. Like ‘You are telling your kid that they’re a burden, but I mean, maybe you’re also acting a little bit emotionally immature as a parent.’ There’s guilt within that. Again, I’m not

trying to blame everybody, but like there is this stereotype that you just can't tell your mom how you really feel because she'll feel like a failure...

Well, I believe that builds up the sense that you're a burden, which is funny like that you're - you're a burden to your parent, so you have to be strong because you can't be weak because if you're weak, that's - that's a burden to your parent. So you have to be over-functioning where they're under-functioning. I mean, there's that systemic pattern. So you don't share that deep emotion and then when you - when you start to - then somebody leaps and falls on the sword and says they're just a terrible parent...

Well, that's why it's great doing therapy because you as – you – you step in and you help clarify this. 'This is exactly what we're talking about and what's it like when your mom does this?' [They'll say,] 'That makes me never want to tell you anything again.' I'll ask, 'Mom, what's that like when your kid says they never wanna tell you anything ever again?' And they'll say, 'That's the opposite of what I want,' essentially. See this is the pattern that we're talking about (CFE 03).

Acceptance and Rejection within the Family. Family therapists working with LGBTQ+ young people in LDS families can assess for accepting and rejecting behaviors within the family system through collaboration with the young person. One CFE described what guides their assessment for such behaviors, stating that first, they identify the feelings related to them. They stated:

I do a lot of work to find the acceptance, to find the hope, and then really hone in on that….I think that's maybe the important thing is really creating that baseline of what acceptance feels like—what celebration feels like— to know that something's rejecting…

> And then as we go along, things that knock [us] from that feeling are the rejecting behaviors or rejecting experiences (CFE 04).

CFEs also indicated that therapists can also use psychoeducation to help the young person understand the difference between parental rules and rejecting behaviors. For example, a young person may feel that being grounded from their friends is a rejecting behavior because their friends are queer, but the therapist can help them understand that it may not be the case. By creating a sense of security and safety for the young person and their sense of self, the therapist can help identify rejecting behaviors. The therapist should note that there is some subjectivity in this process, as acceptance and rejection are defined by how it feels to the young person.

Appropriateness of Family Therapy. All CFEs agreed that the decision of if, when, and how to involve family members in the therapy of LGBTQ+ young people and their LDS family members is an important one. Several of them differed, however, in their perspective on who should first be involved in said assessment. Whereas most CFEs expressed that the decision is best made after having individual sessions with the young person and/or their family members separately, one CFE reported seeing the benefit of meeting with the family all together first. They reported:

> Sometimes, I'll first meet with them all together just to feel it out. And it's kind of like this with couples therapy, too. Depending on how that goes, I may want to do an individual session with each of them, especially if there's a feeling that there's not a lot of openness in the family. I want to be with them individually because I want to get more history that they may not feel comfortable sharing together. But if there's a feeling

there's a lot of openness, and that it's kind of clear that this is all out on the table, I might sometimes do that, probably just as often I don't (CFE 06).

CFEs reported that this decision is based on the individual client's preferences and safety concerns. CFEs prioritize the young person's autonomy and allow them to set the tone and pace of how involved they want their family to be in their therapy. They also provide psychoeducation to help all family members understand the process and potential benefits of involving family members in therapy.

Safety is a primary concern for therapists when deciding whether or not to involve family members in therapy, reported CFEs. One CFE stated

> So, the baseline is safety. So, is family a safe place for the child to work with? So, are parents safe, or are they going to be combative or abusive in the therapy room? If so, then I can advocate and say like, 'No, we're not going to include family right now,' or 'We're gonna pause the session and come back to this when people are ready' (CFE 05).

Taking such measures shows that the therapist is aware of and sensitive to the potential for family sessions to feel unsafe or harmful to the client and that they prioritize the young person's safety and well-being above all else. CFEs also indicated that if there are severe mental health symptoms, such as psychosis, that may make the therapy sessions volatile, the therapist might make the decision not to involve the family members in therapy altogether.

Skills for Building Therapeutic Alliances

Alliance with the Young Person. CFEs agreed that family therapists' ability to build a relationship of trust with the LGBTQ+ young person is essential to family therapy with them and their LDS families. CFEs recommended that family therapists build such an alliance by (a)

implementing a collaborative approach, (b) establishing clear boundaries around confidentiality, and (c) acting as an advocate for the young person.

Implement a Collaborative Approach. One strategy that CFEs reported for building a trusting alliance with LGBTQ+ young people in LDS families is to utilize a collaborative approach. One phrase that came up frequently in CFE interviews was that therapists should aim to “empower” the young person. One described how they approach facilitating such empowerment, saying:

> Everything [should be] collaborative… So I like asking the young person, you know, ‘What do you think about that? If we were to reach out to your parents, what would be the best way? Would you want to talk to them? Would you want me to text them and talk to them?’ … So, you know, I’m really just caretaking the therapeutic alliance like through the process of a collaborative assessment (CFE 01).

Establish Clear Boundaries around Confidentiality. CFEs indicated that establishing boundaries around confidentiality is one of the first things a therapist must do to build rapport with LGBTQ+ young people in family therapy with their LDS family members. They emphasized that because LGBTQ+ young people are typically the person in family therapy with the least amount of relational power, it is crucial that they know exactly what to expect from the family therapist. One CFE described a strategy they have found helpful, reporting that:

> So, I let the child know ahead of time like, ‘The things that I will need to talk with your parents about are safety-related. Like that's my boundary as a therapist. So, if you are self-harming to the extent where you're like in danger, and then we have to get your parents involved. And I'll let you know when we reach that line. Like you can let me

know, and I can let you know when we're reaching that line, and then we'll both talk together about it' (CFE 05).

CFEs indicated that this process takes effort and intentionality on the part of the family therapist. One CFE reported:

> [There's a lot of] Being really, really careful not to reveal to the parents things that the young person has said but just supporting the young person at whatever it is they want to have said in that moment, that the words come out of their mouth unless they've explicitly told you, 'Here's what it is I want you to share with my parents. I can't use the words myself,' being really careful that what you create in session is not going to create a problem for the young person afterward (CFE 02).

Act as an Advocate for the Young Person. Most of the CFEs described their perceived role in their relationship with the LGBTQ+ young person as that of an advocate. One stated, "I do have a bias that I prioritize the needs of the child in a family system because they are a marginalized member of the family. And so, I'm gonna act as an advocate for them" (CFE 05). CFEs indicated that their role as advocates for the LGBTQ+ young person stays constant, regardless of who is present in each session. They highlighted a need for therapists to have a clear understanding of how the young person feels about involving family members, what they hope to see a change in their relationship with caregivers, and what the young person needs from the therapist during family sessions. One therapist reported that:

> Sometimes I'll have the youth come in before a family session and say, "Okay, let's debrief this. What do you hope comes out of this? What do you need to feel supported?" So, I want to get really clear about what they need to feel supported because I want them

to know - again, some of this depends - sometimes it depends on where the parents are. But I want them to know that they’re not going to be ganged up on (CFE 06).

Alliance with Caregivers. CFEs stressed the importance of building a strong therapeutic relationship with caregivers by validating their emotions and emphasizing their strengths as parents. One CFE emphasized one way they try to start off on the right foot when meeting with LDS caregivers of an LGBTQ+ young person for the first time:

> Because I work with primarily LGBTQ people, I'm usually working with an individual that's bringing in parents. So, parents, oftentimes, are just collateral to their individual therapy. And so, I will only have – so, for bringing parents in for one to three sessions, I’ll only have like 10 to 15 minutes to join those parents. And I have to let them know that they’re also safe in this environment. And that I'm going to ask a lot of them, but I also support them in showing up for their child, validating their child, and pausing to like regulate emotions, right? That I'll be in it with them. So, I have to bring myself into that space to say, ‘You - you are also safe here,’ and get like 10 to 15 minutes to make that happen. So, it's very quick (CFE 05).

Validate Caregivers’ Emotions. While individual and family sessions are meant to focus on the emotional experience of the LGBTQ+ young person, CFEs did propose that family therapists should provide a therapeutic space where caregivers can express and process their emotions—without the young person present. One CFE emphasized the importance of such a space for caregivers, saying:

> They may benefit more from a therapist meeting with them separately holding space for where they’re at until you know - until they’ve maybe learned some skills about how to

> create more space, how to listen to their child, you know, how to empower the child's voice where the child is feeling hurt or worried or concerned, how they can process their stuff enough to be able to actually hold that in ways that the session doesn't actually become about the parent, [laughter] right (CFE 01)?

CFEs reported that the most common experience that LDS caregivers may need space to process is grief. CFEs argued, however, that caregivers' grief is not always an indicator of rigidity and/or rejection of their child's LGBTQ+ identity. CFEs validated that even parents who are intentionally moving towards a space of acceptance and affirmation of their loved one's queer identity may experience a sense of loss when the life they had originally imagined for their child is no longer their trajectory. CFEs reported that parents often feel guilt for feeling grief and that it is imperative for them to have a safe place to process whatever feelings come up so that they don't do so in the presence of their LGBTQ+ loved one.

In fact, one CFE argued that therapists can do damage if they do not approach caregivers' emotions with compassion. They critiqued the field of LGBTQ+-affirmative family therapy, arguing that "It is kind of the norm within affirming therapy practice to just be angry at parents…. But not many people have ever changed just when they have been told they need to change…I think it's setting families up for failure because you have to acknowledge the grief that parents have" (CFE 03).

One participant described one way they work with caregivers to normalize their feelings of grief as follows:

> It's grief when your child goes through something - something painful because you're sad for your kid. I mean, I often tell parents and we talk about like 'I would be so sad if

> my kid was gay or trans. Not because I'm sad that they're gay or trans. Just 'cause I'm sad that I know the experiences that they're gonna have being in this culture. Like I'm sad about the pain that they're going to experience' … We have to be - we have to be witnessing and encouraging that emotion even when parents are being unaffirming, 'cause there is emotion there. The best way that I've seen to move parents to be more accepting is to validate that emotion--- because it is valid (CFE 03).

Highlight Caregiver Strengths. When building alliances with caregivers, CFEs emphasized the importance of "honoring that they're showing up for something hard and vulnerable for them" (CFE 01). One participant said that parents "generally are terrified of this journey. That's why they are in your office. If they thought they could take it alone… they wouldn't be there" (CFE 01). CFEs also indicated that many Mormon parents fear that family therapists will judge their parenting or misunderstand their intentions, and thus need to be made to feel at ease with the family therapist. The key, in the words of one CFE, is that "When you help, like, the parents see their strengths in this, they- they need that as much as anyone in this journey" (CFE 01).

One CFE reported that they sometimes utilize self-disclosure to accentuate the positive contributions that parents are making as they wrestle with how to best show up for their LGBTQ+ child. In their words:

> I will tell parents over and over and over again, 'You know what? Once upon a time, I asked my own mom to come into therapy with me, and she just - she wouldn't in this journey. And the fact that you are here like wanting, wanting to show up in this journey

with your child, even though the two of you are starting from different places, like that, that is beautiful. Like, your child is so lucky to have you' (CFE 01).

Equipping Family Members for the Work of Relational Repair

Self of the Family Member. Experts expressed that, just as therapists in this work must do internal work to become more self-aware and to examine their assumptions, so must family members. Themes within this category center around the co-creation of meaning within families, supporting clients in examining and deconstructing their beliefs, and assisting family members in developing relational skills.

Explore Families' Co-Created Meaning Around Relevant Constructs. Another theme that emerged from the data is the importance of assisting family members in acknowledging that their understandings of important constructs (i.e. Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions. CFEs reported that they often work to help family members recognize that their understanding of these constructs is reciprocally shaped by the interactions and relationships within the family and by the culture, religion, and society they are in. One participant expressed:

> And I think part of this, right, with the co-creation is the bidirectional influence. That it's not just one-directional. We are being acted upon, but also acting. So, anyway… our role is helping [family members] understand those mechanisms of acting upon something, our empowered stance, and also some of the systems that are acting upon us. I think both are really helpful in our work (CFE 04).

CFEs emphasized that this process allows family members to have a better understanding of the issues related to the LGBTQ+ young person and to have more empathy and acceptance.

Support Clients in Examining and Deconstructing Personal Beliefs. CFEs identified a need for family therapists to invite caregivers to deconstruct and examine their spiritual beliefs and how they impact their relationship with the young person. Many of the CFEs reported that caregivers often come to therapy with a sense that something has failed when their child identifies as LGBTQ+. One CFE reported that, "This sense of failure is often rooted in the belief that parents are supposed to mold children to live a heterosexual, cisgender life, and that when that fails, it is a failure of the molding, the parenting, or the peer group" (CFE 02). CFEs emphasized the importance of helping caregivers to re-evaluate these beliefs and see that their child's LGBTQ+ identity is not a failure, but rather a natural aspect of human diversity.

Assist Family Members in Building Relational Skills. Family therapy sessions can be emotionally charged, particularly when issues of identity are at play. To help manage these emotions, CFEs recommended teaching relational skills such as active listening and validation to family members. Another relational skill that CFEs expressed is helpful to teach family members is emotional validation, which involves being able to sit with and validate someone's emotions without necessarily agreeing with them. One CFE explained that many LDS caregivers feel a need to make sure their child knows that they don't agree with their beliefs about their identity. The participant reported preparing caregivers with approaches to help them empathize with their LGBTQ+ young person. "You don't have to say 'I love you, but I don't agree with you,' but you can say 'I love you and I'm sad that you're going through this'" (CFE 03).

CFEs indicated that these skills should be taught separately to caregivers and LGBTQ+ young people in individual sessions, and then put into practice during family sessions. One CFE

highlighted the importance of explaining to young people and caregivers why these skills are important:

> I'll tell parents, 'You know, I've seen this go a couple of different ways… Like, [with] parents who want to impose a very rigid path for their kids, then the child just hides the journey, the authentic journey, from the parents; and the relationship becomes more estranged. Or, with parents who are like willing to listen and be open, who like really listen and are open to really trying to understand what [their kids] are going through…. They create a space of safety for that young person' (CFE 01).

Psychoeducation. Experts identified the importance of psychoeducation in their work with LGBTQ+ young people and their Latter-day Saint family members. They emphasized a need for therapists to educate all family members about (a) queer identity development, (b) LGBTQ+ educational resources, and (c) local community resources.

Educate Clients About Queer Identity Development. CFEs expressed that adolescence and young adulthood are important times for families to think about "allowing developmentally appropriate exploration, potentially within their value system" (CFE 01). They indicated that because young people are experiencing the developmental processes of puberty, sexual maturation, and making decisions about their adult life trajectory, families need a therapist who will help them understand the salience of identity development. One therapist stressed the need to teach parents that any identity development that does not occur during adolescence and young adulthood will by necessity happen later in life:

> That's just what we've seen over and over and over again in our adult population in the LDS community, or in conservative communities where, you know, you have entire

> generations of people who didn't get that chance. And now families are really, really being impacted, or things are having to be explored in really ethically messy ways. And so, helping parents understand that, developmentally, [laughter] the time is now… Sometimes I work with people who are like in their 50s having to figure this out and have to be 15 all over again. [laughter] Like, you really do want your child to be able to explore this to some degree or another right now (CFE 01).

Provide Research-Based LGBTQ+ Educational Resources. CFEs discussed the need for LDS caregivers to have at the ready an arsenal of LGBTQ+ educational resources with correct, research-based information. CFEs reported that LDS caregivers, and even sometimes their LGBTQ+ child, often begin therapy with drastic misconceptions and incorrect information about Queer communities that can impede their ability to move forward in their acceptance journeys in family therapy. Several CFEs recommended educating caregivers about the Family Acceptance Project (Ryan et al., 2009; 2010), which outlines accepting and rejecting behaviors that impact the mental health outcomes for LGBTQ+ young people. Additionally, CFEs recommended that family therapists educate caregivers about the mechanisms of secure attachment, as well as the World Professional Association for Transgender Health (WPATH) *Standards of Care for Transgender Clients* and the minority stress framework.

Inform Clients of Local Community-Building Resources. CFEs pointed out the importance for family therapists to educate parents about local resources and ways they can expand their support system. Many LGBTQ+ community centers provide support groups for caregivers of Queer youth and/or group therapies where young people can connect with others. Additionally, CFEs recommended that the therapists do some research into LGBT-affirming

local healthcare providers, so they have collaborative-care connections to whom they feel comfortable sending families for additional help with healthcare and consultations around gender-affirming care.

CFEs also emphasized that LGBTQ+ youth centers are a source of connection for many LGBTQ+ young people in LDS families. They recommended that therapists educate LDS parents that when LGBTQ+ young people feel a sense of belonging, their risk for suicide decreases. CFEs indicated that some Mormon parents respond to their child's coming out by limiting their access to other LGBTQ+ peers. One participant stated:

> And with regard to - to gender, it's usually, 'I don't like your nonbinary friends. They're not good for you.' They tend to be those that have mental health issues. As we know, transgender and nonbinary young people have more suicidal ideations, so families tend to resist you hanging out with other people who are like this, and families tend to blame the friends for the "contagion" of why you're thinking about gender issues. And so, families tend to resist hanging out with nonbinary and transgender people. So, they don't want them going to a GSA [Gender-Sexuality Alliance] or they tend to restrict certain kinds of friends (CFE 02).

Skills for Family Sessions

Beginning with a Baseline of Hope. When first starting family sessions with LGBTQ+ young people and their Latter-day Saint family members, CFEs reported that starting off "on the right foot" is essential. CFEs indicated that if family therapy—both across and within each session—begins with a tone that fosters hope and connection, it is more likely to continue in the direction of connection. One participant stated:

> I think so much of it is really, again, trying to tap into the hopes of the family. So, maybe engaging mom with like, what is her hope for the session, what is her hope for her family, and what are her hopes for her child? Doing the same for dad and doing the same for the child. And so, maybe getting a general - again, maybe that baseline and really looking for that connective piece. And then really being able to go back to that connective piece throughout the session. Is this moving us towards or against (CFE 04)?

Invite Hope-Centered Mindfulness. Inviting family members to practice a moment of hope-centered mindfulness at the beginning is one strategy CFEs recommended to help clients tap into the hopes they have both for the session and for their relationship with the other party:

> I will start with saying, 'I'd like to have a start and just get into a place where we are really mindful of what we most hope will happen in this session and see if you can identify it and put it into words. So, I'll give you a few minutes to think on that and I'll ask everybody to speak to what you most hope will happen in this session.' And then after a few moments of mindfulness, and I'll make sure everybody's got something before we start, and then I will say, 'I don't care who starts but I would love to hear what you most hope will happen in this session' (CFE 02).

Assist Family Members in Reframing Concerns as Hopes. CFEs also pointed out that family members will often express concerns—usually out of habit—rather than hopes. They reported that family members often need support from therapists as they transform their concerns or complaints into wishes and hopes, and will likely feel vulnerable practicing new skills. One participant outlined their approach, saying:

> And then I will sort of guide it and tweak it so that it's hopeful and encouraging rather than, 'Well, usually what happens is…' [laughter] I will say then, 'I want you to speak to what you hope for rather than what usually happens,' that kind of thing, and then everybody gets a chance to say something that they hope will happen in the session, tweaked and supported by me.
>
> Then I will invite probably the young person – whoever I think is most likely to say something that will be productive [laughter]. In the next part of it, I will say, 'So, now I hope each of you is thinking about what it is that you want to talk about in this session, and I'll invite you to just sort of bring it up as simply as you can, then I will help you turn it into a wish that you hope will occur in this session.' So we establish it that way (CFE 02).

CFEs indicated that therapists can normalize family members' challenges in finding the language to express their hope by validating their efforts and the ways they are showing up. CFEs expressed that even when family members "stumble through" this exercise, they are also showing one another from the start of the session that they are willing to try new ways of thinking and interacting. Such new experiences early in a session open opportunities for family members to surprise each other in positive ways, which CFEs argued is important.

Establishing "Enough" Emotional Safety for Relational Repair. CFEs collectively endorsed a need to establish a sense of emotional safety for all family members in order to have successful relational interactions. They emphasized a few recommendations for how to do so, including (a) prioritizing the voice of the young person, (b) maintaining attunement to family members' emotions, and (c) diffusing potentially high-barrier emotions.

Prioritize the Voice of the Young Person. Many of the CFEs emphasized the importance of prioritizing the needs and voice of the young person in family sessions and establishing that expectation early on. One CFE described their main goal for family sessions:

> It's to advocate for the child so that their voice can be heard. So, I really am mediating that session to hold space with the child and for the child, ask them if they're ready to move forward, remind the parents to just listen, to validate, to affirm, and then ask like, 'Are we ready to move on to the next topic?' and yeah, just fully advocate and empower them to share what they want to share with their family (CFE 05).

Build Structure for the Session. CFEs recommended having a specific conversation at the start of a family session to help everyone get "on the same page" about what the session is expected to look like. In the words of one CFE, "Because parents often worry that I'm suggesting that their child is gay and/or trans, and children are worried that their parents aren't gonna be able to hold space for them… I keep family therapy sessions really structured." (CFE 05) One CFE reported leaning on ABFT's approach of preparing family members for family sessions beforehand and discussing what they can expect in family sessions. They stated:

> I'll say something like, 'Parents, I'm gonna do some coaching with you, and I want you to just sit and listen, and when you feel reactive, we could pause, or we can just note that and come back to it, but focus on holding space for your child. And child, I have worked with your parents. You and I have worked together to talk about the items that we're going to specifically focus on in this session. So, let's take it just like one by one, and you get to set the pace and the tone of this session, and if we need to stop, we can stop' (CFE 05).

CFEs indicated, too, that sometimes there will be a need for therapists to directly set some rules or boundaries for the session. They recommended being specific and clear in setting such boundaries in order to increase the likelihood of productive interactions between family members. One CFE gave an example of some of the language they have used when a young person has expressed a desire for specific boundaries for family sessions. They reported:

> Sometimes we'll actually say, 'Young person wants to talk about this today but they do not want to talk about it after session. So, whatever the issue is that they want to bring up, they want to be really clear they don't want to be asked about this after session. Next session we get together, if you have questions, we can ask about it, but before we start, how do you feel about that, mom and dad?" I might say that before I even say what the issue is (CFE 02).

Maintain Attunement to Emotional Responses. CFEs emphasized a need for family therapists to be acutely attuned to both their own emotional responses within the room, as well as those of family members. Scanning for signs of distress, within the LGBTQ+ young person especially, was something CFES identified as important to preventing interactions from being re-traumatizing. One CFE recommended:

> Pay close attention to the child's signals of distress. They're more important than the parents' signals of distress, although the parents' signals of distress may mean you don't do therapy [laughter] with them anymore. I have missed a couple of parental signals of distress that have resulted in therapy stopping, but paying close attention to the young person's signals of distress when a parent says something because they will perhaps feel less empowered to speak to it (CFE 02).

Defuse Potentially High-Barrier Emotions. CFEs emphasized that for families to establish a sense of emotional safety necessary to promote parent/child connection, family therapists must be skilled in diffusing intense emotions that could lead the session away from the goal of connection. In the words of one CFE, “I’m trying to think of like a – a generality for like across the board. Maybe engage and defuse would be two important pieces, engaging those who are disconnected and defusing really high potentially barrier emotions, responses.” (CFE 04) Therapists’ approaches to diffusing such emotions depend on how much conflict there is in the space, the CFE reported:

> So, that we can hold maybe a little bit more grace, if mom is getting activated to say, ‘Oh, mom, yeah, I’m getting the sense that you’re getting kind of really activated. This is a really scary place for you, isn’t it?’ And then to like bring that down as opposed to kind of catch or go more into maybe the darts that mom is throwing (CFE 04).

Directively Orchestrating Constructive Interactions. CFEs reported that family sessions are those in which therapists “have to really be on their ‘A game.’” They reported that therapists must be “at the ready” to spot and slow down interactions that are headed in a direction of disconnection.

Coach Family Members Through Enactments. As such, CFEs indicated a need for family therapists to be able to skillfully facilitate enactments. One CFE highlighted that “We’re developing these experiences to have them come in together and then have an enactment where we really get into some of the—that deep emotional stuff and have them respond to one another.” (CFE 03) As such the CFE stressed a need to be directive during enactments, saying, “We are setting clients up for success, not setting them up for failure” (CFE 03). CFEs expressed

that one of the main reasons for recommending so much preparatory work to be done during individual sessions before holding family sessions is to help make sure that enactments can move family members toward connection, rather than furthering disconnection. One expert explained:

> My goal is to have family members turn toward each other. So, I'd be asking the child to turn toward parents and let them know what they want to talk about, and parents to turn toward the child to validate and assure them, and I would like coach them as the therapy session goes on, but if the emotion starts to rise to where the people are becoming dysregulated, we'll pause and I'll have them turn toward me instead. And I'll monitor that a bit more until the emotion comes back down and they're able to face each other (CFE 05).

CFEs indicated that many family therapists struggle to facilitate successful, connecting enactments. This difficulty can occur for several reasons, they expressed, including (a) a lack of preparation and expectation-setting, (b) missing emotional cues of distress or activation, and (c) difficulty setting and maintaining boundaries for the session. One CFE described their approach:

> I will say to the young person, 'Can you turn to your parent and tell him that you feel this way? Can you tell them the three words that this feels like when they barge in your door? Can you?' And - and I will tell the parent, 'When you tell me you didn't know they felt that way, can you actually turn to your young person and say 'I didn't know you felt that way?' So, yes, there's a lot of the conversation that I'm orchestrating, but then also as soon as they say words that I want them to say to one another, [laughter] I will invite them to say them to each other ... Right to one another. And it's amazing the impact it has

when it’s to the other person, to the child, or to the parent, and not to me. So, I think it’s a really essential piece. (CFE 02)

Facilitate Renegotiation of Boundaries Around Autonomy. CFEs emphasized the importance of renegotiating appropriate boundaries around autonomy when working with LGBTQ+ young people in LDS families. CFEs indicated that two influential factors in this process are the age of the young person (i.e., whether they are of legal adult age or not), and whether they live with the family or not. They expressed that it is often helpful for therapists to facilitate a conversation between LDS caregivers and their LGBTQ+ child around what is working in their relationship and what is not, and whether the current boundaries feel developmentally appropriate. One CFE stated:

> Even when a young person is like 16 or 17 and we’re talking issues of respect within the family, I will still say to the parents, ‘It’s probably only a matter of X number of months or whatever until your young person is on their own, and I think you would love for them to still have a relationship with you and want to come back and visit with you and talk things over with you.
>
> ‘At some point, you will want to make that shift in your mind where your child is like a neighbor, and the kinds of things, the comments you make about them, and their choices, and their spiritual life will probably want to resemble more of how you would treat a neighbor who moved in and is a different religion, or has a partner of the same sex or is a nonbinary person, that the comments you would make to them are ones that might inform how you treat your child so that your child would want to come and spend time with you’ (CFE 02).

In cases where family members feel that they cannot trust the other party, CFEs reported that this process becomes both more essential and more complicated. One CFE recounted an experience in which boundaries had to be renegotiated, which meant that family sessions first needed to be used to repair trust. They stated:

> Yeah, I'm thinking of a family, and I'm trying to think of, like, specifically that we were repairing trust—and still are actually—but part of the trust is, 'I trusted you to take care of me, parents, and you indoctrinated me with a belief system that actually causes me to, like, hate myself. So, I don't trust you. I don't trust that you can set rules for me. I don't trust that you can guide me. So, I'm not going to follow your rules. I'm not going to do the things that you need me to do' (CFE 04).

Navigating Obstacles in Family Sessions. Therapists highlighted a few scenarios to watch for that demonstrate a need for the therapist to step into and slow down an interaction. They presented three common obstacles that can arise in this work, including (a) needing to reinforce the parent/child boundary, (b) respecting the young person's boundaries if they disengage from family therapy, and (c) intervening when caregivers begin to prioritize their own voice in the session rather than the young person's.

Reinforce Boundaries Around Parent/Child Roles. CFEs highlighted that there is often a dynamic within the relationship between LGBTQ+ young people and their LDS caregivers in which the young people begin taking care of their caregivers' emotions when they don't feel able to talk with caregivers about things they are struggling with. One CFE expressed that one contribution to this dynamic is that "just about any religion has a belief about respecting parents

and honoring parents… But I think it's a misinterpretation of this parental hierarchy to say that it is the kid's job to take care of their parents' emotions" (CFE 03).

Several CFEs emphasized that such a shift in dynamic requires therapists to be confident and prepared for in-the-moment intervention. One CFE stated that,

> When emotion comes up and a kid starts to take care of their parent, shut it down. Like, 'Hey, no. This is you expressing your love to your mom or your dad. They are big. They're adults. They can do it themselves.' What I try is to encourage the parents to say to their kid, 'Thank you so much. It means you love me. It means you care about me. It is not your job to take care of my emotions. You are my child. It is my job to take care of your emotions and help you to learn how to take care of your own emotions' (CFE 03).

Another CFE shared a specific strategy that has aided their work in reinforcing the caregiver/young person hierarchy:

> It seems like parents have to be in a place where they are ready to what I call 'fire their children from taking care of their feelings'. Parents seem to especially feel like the young people have in their mind made a decision to be [LGBTQ+], and that those children need to know what the cost to the parent is…like, for some parents, this is the cost and the child needs to understand the cost in order to fully appreciate the journey that the parent is making. And that has to be dealt with - with parents to the point where the parent can say, 'Okay, it's not my child's burden to hold this. This is something other parents can hold for me, or my therapist can hold for me, but I will not give this burden to my child' (CFE 02).

Intervene when Caregivers Prioritize Their Own Voice. CFEs highlighted that one scenario where enactments can go wrong is when LDS caregivers shift the focus of the session from prioritizing the young person's voice and instead begin to amplify their own. One CFE said that one indicator for therapists to get ready to slow down an interaction is when "the parent comes into session and for whatever reason, the parent makes it all about them" (CFE 02). They report:

> That is, as the young person tries to say, 'Hey, I've got these feelings,' and the parent is, 'Well, that's disrespectful,' or 'You're ungrateful,' or 'If you knew all the things that I've done,' or 'I don't know why you would feel that way…' (CFE 02).

This CFE reported two reasons that such an interaction might occur: "Perhaps the parent has been insufficiently prepared, or their amygdala is in charge [laughter] and they can't remember anything that you prepared, and they're just having a difficult time" (CFE 02).

CFEs indicated that in such instances—when caregivers are having a difficult time making space for the young person's voice and experience—it may be helpful to shift the focus of the session to helping them see positive things about one another or to separate the family members with the hope of trying again later. One participant presented language they sometimes use in such circumstances:

> In those cases, it may be helpful for therapists to say something like, 'Let's just slow this down and maybe let's do an exercise here, and then we'll do something separate. I'm wondering if in this exercise we can all get in touch with our own feelings of fear and what it is that keeps us from connecting. Just sort of sit with that for a moment and breathe, and know that we're loved and that we're enough,' you know, do that kind of

> exercise, 'and then maybe speak one positive thing about the relationship that you have with the other person, and then we'll have a separate session…' (CFE 02).

Respect Boundaries of Disengaged Young People. CFEs also reported that there may also be circumstances in which the young person is disengaged in family therapy and remains so even when caregivers are receptive and supportive. One CFE reported that "there are some young people who have turned off completely and who won't even try anymore… [who] want to maintain a shallow relationship with parents" (CFE 02). One CFE gave an example of such disengagement:

> I do have one high school youngster who… I worked them to a point of having mom come in the session, and they did not say a word, and it took two or three sessions after that before they would start talking even with [just] me again. Even though they wanted to meet with me, there was something about their relationship with their parents that just shuts them down completely (CFE 02).

In such instances, the CFE recommended "So, when it doesn't go well, sometimes you muddle along and keep hoping that it will work. That's one where the session, I didn't see any overt harm to the young person in session" (CFE 02). They reported that in that particular case, the young person requested to continue therapy without the participation of their caregivers in session to which the CFE and family members agreed. The CFE reported, "It's probably been a year since I had the parents in…in the back of my mind, still, I wish I could have them chat with the parent. I wonder if they're emotionally ready to do that in session again." (CFE 02) They indicated that "those parents really often feel like a failure, and it's helpful to them just to let them know that the young person is still working on their identity and cocooning, in order to

create that identity and be able to come out and be a fully formed human. So, that's good parenting, to not poke the cocoon, [laughter] right" (CFE 02)?

Summary

The exploratory, qualitative portion of this study highlighted a total of 218 best-practice recommendations across 13 treatment categories. Core field experts highlighted the complex nature of family therapy processes when working with LGBTQ+ young people and their Mormon families. These qualitative findings lay a foundation for a thorough quantitative inquiry regarding CFEs' perceived importance of each best-practice recommendation for work with this population.

Results from Rounds II and III

To make the quantitative results of this study easier to read, and to facilitate a comparison of responses from both CFEs regarding importance and PFEs regarding self-efficacy, the results from Rounds II and III are combined.

Peripheral Field Experts

The final sample of PFEs consisted of 29 therapists. Each participant completed an eligibility survey, provided their informed consent to participate, and completed a demographic survey. In terms of sex, the majority identified as female (58.62%, n = 17), with 37.93% (n = 11) identifying as male, and one participant (3.45%, n = 1) identifying as intersex. The participants used different pronouns with the majority of the participants using she/her/hers (41.14%, n = 12), 34.48% (n = 10) using he/him/his, 10.34% (n = 3) using they/them/theirs, and the rest using a combination of those three (13.79%, n = 4). In terms of sexual orientation, the majority identified as straight or heterosexual (41.14%, n = 12), while 13.79% (n = 4) identified as

lesbian, and 10.34% (*n* = 3) identified as bisexual or queer. The majority of the participants were between the ages of 20 and 29 (41.14%, *n* = 12), while 34.48% (*n* = 10) were between the ages of 30 and 39.

In terms of race or ethnicity, the majority of the participants identified as Caucasian or white (48.28%, *n* = 14), while 31.34% (*n* = 9) identified as African American. Most participants held a master's degree (44.83%, *n* = 13) and were currently in a clinical field, such as marriage and family therapy (48.28%, *n* = 14). Most of the participants were raised in the LDS/Mormon Church (48.28%, *n* = 14) and currently identified with Christianity (37.93%, *n* = 11). See Appendix A for a complete breakdown of descriptive statistics about the PFEs who participated.

Overview of Quantitative Results

Across the eight treatment categories, all were rated fairly high by CFEs for importance and consensus. The category with the highest importance IM, as well as the highest level of consensus from CFEs, was "Intersectionality and Attentiveness to Power," (IM = 4.88; IQR = .23). On the other hand, the category with the lowest importance IM, as well as the lowest level of consensus from CFEs, was "Theories, Frameworks, and Therapy Models."

Interestingly, although all treatment categories were rated highly for importance, PFEs reported low levels of self-efficacy for five of eight categories (indicated in the table below with two asterisks). PFEs reported feeling least confident in their ability to implement "Theories, Models, and Frameworks," (IM = 3.54) and most confident in their ability to implement "Self of the Therapist" practices (IM = 3.75). "Self of the Therapist" also had the highest level of consensus (IQR = 0.81). There was less consensus across PFEs than across CFEs, indicating a variance in confidence levels across PFEs. Rated least for consensus around self-efficacy was

"Cultural Knowledge and Humility" (IQR = 1.35). Of the 176 recommendations, 33 items were identified as having low levels of self-efficacy. A table of those items and their self-efficacy ratings can be found in Table 6 in the appendices.

Table 4. Mean Ratings for Each Treatment Category

Category of Treatment	**Importance IM**	**Importance IQR**	**Self-Efficacy IM**	**Self-Efficacy IQR**
1.. Self of the Therapist	**4.83**	**0.32**	**3.75**	**0.81**
**2. Cultural Knowledge and Humility	**4.55**	**0.60**	**3.66**	**1.35**
**3. Intersectionality and Attentiveness to Power	**4.88**	**0.23**	**3.63**	**1.17**
**4. Theories, Frameworks, and Therapy Models	**4.50**	**0.64**	**3.54**	**1.18**
**5. Assessment	**4.65**	**0.46**	**3.63**	**1.28**
**6. Skills for Building Therapeutic Alliances	**4.78**	**0.32**	**3.70**	**1.18**
7. Equipping Family Members for the Work of Relational Repair	**4.63**	**0.55**	**3.69**	**1.15**
8. Skills for Family Sessions	**4.80**	**0.43**	**3.69**	**1.12**

**Categories for which, on average, PFEs rated low for perceived self-efficacy

Quantitative Results by Treatment Category

Self of the Therapist

This category holds three themes: "Self-Reflection and Emotional Management in Therapy," "Authenticity and Self-Disclosure in Therapy," and "Personal Identity and Its Impact

on Therapy." The participants rated all recommendations within these three themes with a high level of importance and consensus around importance. Regarding self-efficacy, this category was rated with moderately high levels of self-efficacy among PFEs. Self-efficacy IM scores for each theme ranged from 3.62 – 3.85. The consensus around self-efficacy was moderately high, with IQR scores ranging from 0.48 to 1.00.

Self-Reflection and Emotional Management in Therapy. The recommendation with the highest importance IM in this theme was that therapists "Are engaged in a continuous process of self-reflection around their own beliefs, biases, and how they may impact therapy," with a rating of 5.00 and an IQR of 0.00, indicating high consensus. Regarding self-efficacy, the recommendation to "continuously self-reflect" had the highest rating within this theme (IM = 3.78, IQR = 1.00 indicating moderate consensus among PFEs around their confidence to implement this recommendation.

Personal Identity and Its Impact on Therapy. The recommendation rated highest for importance in this theme was that therapists "Have examined their own layers of privilege and marginalization, and how those may impact therapy," with an importance rating of 5.00 and an IQR of 1.00, indicating moderate consensus. Regarding self-efficacy, the recommendation for therapists to "Examine their own privilege and marginalization" had the highest rating within this theme (IM = 3.58, IQR = 2.00), indicating low consensus among PFEs around their confidence to implement this recommendation.

Authenticity and Self-Disclosure in Therapy. In this theme, the recommendation rated highest for importance was that therapists "Are mindful to only use self-disclosure if they feel it

will be helpful to the client," with an importance rating of 4.75 and an IQR of 0.48, indicating high consensus around importance. In terms of self-efficacy, the recommendation for therapists to "Be mindful to only use self-disclosure if it will be helpful to the client" had the highest rating within this theme (IM = 3.82 IQR = 0.00) indicating unanimous consensus among PFEs around their confidence to implement this recommendation.

Cultural Knowledge and Humility

The findings for this treatment category show that cultural knowledge and humility are important themes in the treatment of LGBTQ+ young people in LDS families. Across both themes, the highest scores for importance IM were in the 4.50 - 4.90 range, indicating that participants believed these best-practice recommendations to be highly important. Similarly, the lowest scores for importance IQR were in the 0.00 - 0.75 range, illustrating a high level of consensus among participants regarding the importance of these best-practice recommendations. In terms of self-efficacy IM, the highest scores were in the 3.70 - 3.90 range across all themes, showing that participants believed they were able to effectively implement these best-practice recommendations. However, the self-efficacy IQR scores were generally higher, with a range of 1.00 - 2.00, demonstrating a lower level of consensus among participants regarding their ability to implement these best-practice recommendations.

Cultural Knowledge Relevant to LGBTQ+ Young People in LDS Families. These findings suggest that the theme of "Cultural Knowledge Relevant to LGBTQ+ Young People in LDS Families" had high ratings of importance for best-practice recommendations related to having a fundamental knowledge of gender identity and related issues and being engaged in

continuous education on these topics. The lowest-rated recommendations within this theme were related to knowing the history of the relationship between LGBTQ+ people and the LDS Church.

Cultural Humility and Responsiveness. The theme of "Cultural Humility & Responsiveness" had high ratings of importance for best-practice recommendations related to respecting family members' belief systems, seeking to understand their values, and demonstrating foundational respect for their religion. The lowest-rated recommendations for importance within this theme were related to understanding the significance of faith deconstruction and faith transitions.

The overall suggestions of these findings are that therapists should focus on obtaining fundamental knowledge of gender identity and related issues, engaging in continuous education, demonstrating respect for family members' belief systems and values, and seeking to understand their religion. Additionally, lower importance was placed on knowing the history of the relationship between LGBTQ+ people and the LDS Church and understanding the significance of faith deconstruction and faith transitions.

Intersectionality and Attentiveness to Power

The findings for this treatment category show that the themes of conceptualizing families within interlocking systems of power, attentiveness to power within family therapy, and adherence to ethical standards of care are important for family therapy with LGBTQ+ young people and their LDS families. There is a high level of consensus among participants on the importance and self-efficacy of these best-practice recommendations. However, there were some variations within each theme, particularly in items related to enhancing clients’ sense of self-determination and being attentive to power within family therapy.

Conceptualization of Families within Interlocking Systems of Power. In this theme, the best-practice recommendations related to conceptualizing family dynamics within the context of systems of power, privilege, and oppression received the highest scores for importance IM (4.92), and self-efficacy IM (4.39). Within this theme, the recommendation to "Conceptualize family therapy with LGBTQ+ young people and their LDS families within the contexts of interactive systems of power, privilege, and oppression" received the highest scores for both importance IQR (0.75) and self-efficacy IQR (0.00).

Attentiveness to Power within Family Therapy. In this theme, the best-practice recommendations related to balancing power dynamics in family therapy, considering the age of the young person and being mindful of power as an authority figure in therapy received the highest scores for importance IM (4.95) and self-efficacy IM (4.32). Interestingly, the recommendation to "Take on a role as the young person's advocate to improve the balance of power dynamics in family therapy" received the highest level of consensus for importance (IQR = 0.00), and the lowest level of consensus for self-efficacy (IQR = 2.00).

Adherence to Ethical Standards of Care. In this theme, the best-practice recommendations related to assessing for and obtaining family members' informed consent throughout the therapy process, increasing family members' sense of "agency" and ability to make informed choices, and promoting client self-determination and autonomy received the highest scores for importance IM (4.86) and self-efficacy IM (3.88). Within this theme, the recommendation to "Promote client self-determination and autonomy" received the lowest score for self-efficacy IQR (1.06).

These findings suggest that there is a consensus around the importance of best-practice recommendations related to knowledge of LGBTQ+ issues, cultural humility and responsiveness, power dynamics, and ethical standards of care in family therapy for LGBTQ+ young people in LDS families. The highest scores for both importance and self-efficacy were received by recommendations related to conceptualizing family dynamics within systems of power, balancing power dynamics in therapy, and promoting informed consent and client self-determination. However, there were some differences in the level of self-efficacy for the different themes and recommendations, with the lowest scores for self-efficacy being related to faith deconstruction and transitions, taking on a role as the young person's advocate, and promoting client self-determination.

Theories, Frameworks, and Therapy Models

The theme of Utilization of Relational, Attachment-Focused Approaches includes the recommendation that therapists competently use "theories, frameworks and therapy models relevant to family therapy with LGBTQ+ young people and their Latter-day Saint families." The findings across these themes are generally similar, with most of the recommendations receiving high scores for importance, with a median score of 4.75. There was also a high degree of consensus among participants, with a median score of 0.75 for importance IQR.

Family Systems Theory received the highest score of importance IM of all the theories suggested by CFEs (4.88), with a high level of consensus (IQR = 0.00). The recommendation with the lowest score for importance IM is Bowenian Family Therapy (4.00), endorsed with a high level of consensus by CFEs (IQR = 0.00). The Family Resilience model received the lowest level of consensus of all frameworks with an importance IQR of 1.50, but with a moderately high

score for importance IM (4.00). Several CFEs scored this model at a high rate of importance, with a couple of CFEs rating it as not very important in this work.

The best-practice recommendation with the highest score for self-efficacy IM was knowledge about LGBTQ+ topics, queer identity development, healthy exploration, etc. (4.57). The best-practice recommendation with the lowest score for self-efficacy IM was that therapists should strive for systemic, relational changes in the family system, even in individual sessions (2.63). The best-practice recommendation with the highest measure of consensus in PFEs' perceived self-efficacy (IQR = 0.00) was Family Systems Theory. The best-practice recommendation with the lowest measure of consensus in PFEs' perceived self-efficacy was the Interpersonal Theory of Suicide (IQR = 2.00).

In conclusion, the theme of Utilization of Relational, Attachment-Focused Approaches has a high degree of importance and consensus among participants. Overall, the results suggest that the core field experts (CFEs) deemed "Family Systems Theory" and "Have fundamental knowledge of trauma-informed best practices" as the most important recommendations. They felt most confident in their ability to implement the experiential practice "To create new emotional experiences together as family members." and the theoretical framework of "Identity Development." However, there was a lower level of consensus among PFEs on certain recommendations, such as "LGBTQ+ topics, queer identity development, healthy exploration, etc." and "Interpersonal Theory of Suicide" in terms of importance and "Attachment-Based Family Therapy" and "Emotionally Focused Therapy" in terms of self-efficacy.

Assessment

The findings across the themes within the assessment category are similar in that they all focus on assessing the young person's risk for self-harm and suicidality, relational dynamics in the family system, assessing for accepting and rejecting behaviors, and assessing the appropriateness of family therapy.

Young Person's Risk for Self-Harm and Suicidality. Within this theme, the recommendations for the frequency of suicidal ideation in the young person and the likelihood that a young person experiencing suicidal ideation will turn to family members for help have the highest scores for importance IM (5.00) and consensus around importance (IQR = 0.00). The involvement of caregivers in any safety-planning processes with the young person has the lowest score for importance IM (4.00) and importance IQR (0.75).

Relational Dynamics in the Family System. The best-practice recommendations for family members' history of relational trauma with one another and the presence of grief and/or loss in the family system have the highest scores for importance IM (4.90) and importance IQR (0.00). The best-practice recommendation for rigidity and flexibility within the family system has the lowest score for importance IM (4.50) and importance IQR (1.00).

Acceptance and Rejection within the Family. The best-practice recommendation for the level of caregiver acceptance around their young person's LGBTQ+ identity has the highest score for self-efficacy IM (5.00) and self-efficacy IQR (0.00). The best-practice recommendation to assess the young person's sense of their caregivers' level of acceptance vs. rejection of their LGBTQ+ identity has the lowest score for self-efficacy IM (4.22) and self-efficacy IQR (2.00).

Appropriateness of Family Therapy. Within this theme, the best-practice recommendation for assessing how a young person feels about involving family members in

sessions has the highest score for self-efficacy IM (4.90) and self-efficacy IQR (0.00). The best-practice recommendation to meet first with caregivers and the young person separately and to not hold family sessions until family members are prepared "enough that it's likely to go well" has the lowest score for both the self-efficacy IM (4.40) and self-efficacy IQR (1.00).

In conclusion, the findings for the assessment category show that there is a high importance placed on assessing the young person's risk for self-harm and suicidality, relational dynamics in the family system, accepting and rejecting behaviors, and the appropriateness of family therapy. Additionally, there is a high level of consensus among participants on the importance of these best-practice recommendations.

Regarding self-efficacy, however, there were some variations in self-efficacy scores, indicating that some participants feel more confident in their ability to implement certain assessment recommendations than others. These findings show that best-practice recommendations related to assessing young person's risk for self-harm and suicidality, as well as the frequency of suicidal ideation, were rated highly in both importance and self-efficacy. On the other hand, best-practice recommendations related to the appropriateness of family therapy were rated as lower in importance and self-efficacy.

Skills for Building Therapeutic Alliances

This treatment category is divided into two themes, "Alliance with the Young Person" and "Alliance with Caregivers." Across both themes, all best-practice recommendations have similar scores for importance IM and importance IQR, with all scores being high (4.90 or 5.00) and IQR scores being 0.00. These scores suggest that there is a high level of agreement among experts about the importance of these recommendations for building therapeutic alliances.

There is some variation, however, in the scores for self-efficacy IM and self-efficacy IQR, indicating that there may be less consensus among experts about the ability to implement these recommendations effectively. For example, the best-practice recommendation "Help the young person to prepare for the possibility of negative responses from their caregivers in family sessions" has a high self-efficacy IM score of 3.83, but a low self-efficacy IQR score of 1. These scores suggest that while some experts may feel confident in their ability to implement this recommendation, others may not.

Alliance with the Young Person. Within this theme, best-practice recommendations "Clarify what the young person needs in order to feel supported by the therapist in family sessions" and "Collaborate with youth to identify what behaviors from family members feel accepting vs rejecting to them" have the highest scores for importance IM and self-efficacy IM, both with 5.00. The lowest score is for "Highlight the young person's strengths" with 3.34 for self-efficacy IM.

Alliance with Caregivers. Within this theme, the best-practice recommendation "Follow-up with caregivers about their experience of any recent family sessions" has the highest score for importance IM, with 4.90, and self-efficacy IM, with 4.20. The lowest score is for "Work hard to build an alliance with caregivers and increase caregiver buy-in" with 3.65 for self-efficacy IM.

In conclusion, the theme of "Skills for Building Therapeutic Alliances" highlights the importance of collaboration, clear boundaries, and advocacy for building effective therapeutic alliances with both the young person and their caregivers. However, there is a lack of consensus among experts about their ability to effectively implement these recommendations. The next

treatment category discusses how, after building a strong therapeutic alliance with the LGBTQ+ young person and their LDS caregivers, family therapists can help them prepare for family sessions.

Equipping Family Members for the Work of Relational Repair

This treatment category focuses on addressing the family members' internal self, and how their internal self affects the relationships within the family. Overall, the findings for this treatment category suggest that equipping family members for the work of relational repair by addressing self-of-the-family-member is important and that participants feel capable of implementing this category's best-practice recommendations in their work with families.

Self of the Family Member. Within this theme, there are three subthemes: exploring families' co-created meaning around relevant constructs, supporting clients in examining and deconstructing personal beliefs, and practicing dialectic skills with family members. The findings across these subthemes are similar in that they all focus on the importance of self-reflection and understanding one's own beliefs and assumptions in order to better help the LGBTQ+ loved one. However, the specific recommendations within each subtheme differ, with some focusing on exploring and deconstructing beliefs and others focusing on practicing dialectic skills.

In terms of importance IM, the highest score goes to the recommendation to "support clients in examining and deconstructing personal beliefs" with a score of 5.00. The lowest score goes to the recommendation to "support the young person as they wrestle with dissonance around seemingly contradicting realities" with a score of 4.90. In terms of importance IQR, the highest score goes to the recommendation to "support clients in examining and deconstructing

personal beliefs" with a score of 0.00. The lowest score goes to the recommendation to "assist family members in seeing that their understandings of important constructs (i.e., Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions" with a score of 1.00.

In terms of self-efficacy IM, the highest score goes to the recommendation to "encourage caregivers to be honest with themselves about their opinions and emotions" with a score of 3.93. The lowest score goes to the recommendation to "support the young person as they wrestle with dissonance around seemingly contradicting realities" with a score of 3.52. In terms of self-efficacy IQR, the highest score goes to the recommendation to "support clients in examining and deconstructing personal beliefs" with a score of 1.00. The lowest score goes to the recommendation to "support the young person as they wrestle with dissonance around seemingly contradicting realities" with a score of 2.00.

These findings imply that self-reflection and understanding of one's own beliefs and assumptions are crucial in better supporting the LGBTQ+ loved one. The recommendation to "support clients in examining and deconstructing personal beliefs" is deemed to be the most important and easiest to implement. Meanwhile, "encouraging caregivers to be honest with themselves about their opinions and emotions" is considered to be important for self-efficacy.

Psychoeducation. The theme of psychoeducation involves educating family members about LGBTQ+ issues and providing them with research-based educational resources. The findings suggest that equipping family members with education and resources is crucial for their work of relational repair with their LGBTQ+ loved ones. The best-practice recommendations within this theme received high scores in terms of importance IM, with a majority of the

recommendations receiving scores of 4.75 or higher. There was also a high level of consensus among experts, as indicated by the scores for importance IQR, which were mostly 0.75 or lower. The findings suggest that there is room for improvement in PFEs feeling confident in guiding family members on how to connect their new understanding to their belief systems and expanding the young person's social support system.

Educating Clients About Queer Identity Development. In terms of specific best-practice recommendations, "Situate unfamiliar concepts within the belief systems of family members to help them relate and understand" and "Help the young person distinguish between healthy caregiver/child boundaries and rejecting behaviors from caregivers" received the highest scores in the “Psychoeducation” theme for both importance IM and IQR, as well as self-efficacy IM and IQR. Within this subtheme, the best-practice recommendation of "Developmental theories and age-appropriate exploration" has the lowest score for importance IM at 4.00 and for self-efficacy IM at 4.52.

Providing Research-Based LBGTQ+ Educational Resources. In this subtheme, the best-practice recommendation of "Address misinformation and misconceptions family members have about LGBTQ+ individuals” has the lowest score for importance IQR at 0.00 and for self-efficacy IQR at 1. The best-practice recommendation of “Educational resources” has the highest score for importance IQR at 0.75 and for self-efficacy IQR at 1.

Inform Clients of Local Community-Building Resources. This subtheme received the lowest scores for both self-efficacy IM and IQR, indicating that experts believe it to be more difficult to implement. In the subtheme of informing clients of local community-building resources, the best-practice recommendation of "Encourage the young person in expanding and

deepening their social support system" has the lowest score for self-efficacy IM at 3.13, while the best-practice recommendation of "Assist families in expanding the young person's treatment team when collaborative care is appropriate" has the highest score for self-efficacy IM at 3.80.

In conclusion, the psychoeducation theme in the category of equipping family members for the work of relational repair includes several subthemes that focus on providing education and resources to family members to help them understand and support their LGBTQ+ loved ones. These findings suggest that the importance and self-efficacy scores vary depending on the specific focus and emphasis of the education and resources provided. Practitioners need to consider the specific needs and concerns of their clients and their families when implementing these best-practice recommendations.

Skills for Family Sessions

The findings for this category were generally considered important by the participants, with an average importance IM score of 4.68. The importance IQR scores for the recommendations were relatively low, with an average score of 0.69, indicating a high level of consensus among CFEs regarding the importance of the recommendations.

Beginning with a Baseline of Hope. The two subthemes within this theme indicate that beginning family therapy sessions with a focus on hope-centered mindfulness and reframing concerns as hopes are deemed important by the experts. The recommendation with the highest score for importance IM is to "Tap into" family members' feelings of love and longing for connection at 5.00, while the best-practice recommendation with the lowest score for importance IM is “Begin each family session by inviting each family member to voice their hopes and wishes for the session” at 4.50. The best-practice recommendation with the highest score for

importance IQR is “Encourage openness, flexibility, and curiosity in the family system” at 0.00, indicating strong consensus across core field experts.

The best-practice recommendation with the highest score for self-efficacy IM and a high level of consensus (IQR = 0.00) is "Tap into family members' feelings of love and longing for connection” at 3.75. In contrast, the best-practice recommendation with the lowest score for self-efficacy IM is “Begin each family session by inviting each family member to voice their hopes and wishes for the session” at 3.47. Overall, these findings show that the work of family therapy with LGBTQ+ young people in LDS families should prioritize hope and mindfulness in order to create a positive and open environment for the family members.

Establishing “Enough” Emotional Safety for Relational Repair. The main findings within this theme demonstrate that establishing emotional safety is crucial for the healing process for LGBTQ+ young people in LDS families. The subthemes within this theme include prioritizing the voice of the young person, building structure for the session, and maintaining attunement to emotional responses.

The best-practice recommendations in this theme received high ratings of importance IM, with scores ranging from 4.50 to 5.00. The two recommendations with the highest scores were to "Reduce the young person's sense of perceived burdensomeness" and to "Develop a relationship in which the young person can turn to their caregivers for support", both receiving a score of 5.00. In terms of importance IQR, the recommendations with the highest scores were to increase the young person's feelings of belonging and to reduce their sense of perceived burdensomeness, both receiving a score of 0.00. The recommendation with the lowest score for importance IQR was to obtain family members' consensus for language and labels, with a score of 1.50.

The best-practice recommendations in this theme received varying ratings of self-efficacy IM, with scores ranging from 3.12 to 4.46. The recommendation with the highest score for self-efficacy IM was to "Develop a relationship in which the young person can turn to their caregivers for support", with a score of 4.46. In terms of self-efficacy IQR, the recommendations with the highest scores were to increase the young person's feelings of belonging and to reduce their sense of perceived burdensomeness, both receiving a score of 1.00. The recommendation with the lowest score for self-efficacy IQR was to obtain family members' consensus for language and labels, with a score of 1.50.

Together, these findings indicate that establishing emotional safety is crucial for the healing process for LGBTQ+ young people in LDS families and that a structured and attuned approach is necessary to protect vulnerable family members and prevent re-traumatization. Therapists should prioritize the voice of the young person, be intentional and thoughtful in their implementation of interventions, and obtain family members' consensus for the language and labels used. In conclusion, these findings highlight the importance of establishing emotional safety in family therapy for LGBTQ+ young people in LDS families.

Directively Orchestrating Constructive Interactions. The recommendations in this theme received high ratings of importance with an average of 4.67 and an IQR of 0.83, indicating moderately high consensus across items. Ranked highest for importance in this theme is the recommendation to "Interject during interactions that feel unhelpful to the goal of increasing feelings of safety and connection (IM = 5.00; IQR = 0.00). Ranked lowest for importance was 4.50 and an IQR of 1.00, "Support youth as they engage in age-appropriate exploration within the constraints of their environment."

Self-efficacy ratings were moderately low, with a wide spread of consensus (IM = 3.47, IQR = 2.00). In fact, all four recommendations in this theme had an IQR of 2.00, indicating quite a large spread across PFEs' confidence in their ability to implement these interventions. Highest in self-efficacy was the recommendation to "Actively coach family members through interactive enactments." Ranked lowest for self-efficacy was to "Invite family members to address each other directly only when they are expressing primary emotions," with an IM of 3.51.

Navigating Obstacles in Family Therapy. The items in this category were ranked high in importance, all with high rates of moderately high to high levels of consensus. The average importance IM for this theme was 4.63, with an IQR of 0.46, indicating high consensus across CFEs. The item ranked highest in importance as well as consensus was therapists' ability to "Redistribute responsibility for taking care of caregivers' emotions away from the young person and back onto the caregivers and the therapist (IM = 5.00; IQR = 0.00). Lowest in importance was the recommendation of "Do not hold family sessions if the young person doesn't want to.

In terms of self-efficacy, PFEs rated this theme as moderately low, with a moderate spread in consensus (IM = 3.67; IQR = 1.33). The item ranked highest in self-efficacy was "Do not hold family sessions if the young person doesn't want to," with an IM of 4.01 and an IQR of 1. Lowest in both self-efficacy and consensus around self-efficacy was therapists' ability to "Reinforce the boundary between the caregiver and child roles," with an IM of 3.23 and an IQR of 2.00.

CHAPTER 5: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This study aimed to identify best practices for family therapists serving LGBTQ+ young people in Latter-day Saint (LDS) families. The research addressed the unique considerations that family therapists must make when working with LGBTQ+ young people in LDS families The study also aimed to contribute specific recommendations for therapists who include family members in their interventions, or who see the family system as their primary client when working with LGBTQ+ LDS youth and young adults.

Summary of the Findings

This study on family therapy with LGBTQ+ young people and their LDS families found 218 potential best-practice recommendations across eight distinct treatment categories. These recommendations were rated by core field experts (CFEs) in terms of importance, with a total of 176 items being considered highly important. These items were then used to create Survey II, which was distributed in Round III. The study also looked at self-efficacy, or the level of confidence that peripheral field experts (PFEs) had in their ability to implement best-practice recommendations. Of the 176 recommendations that emerged from Survey I, 33 items were identified in Survey II as having low levels of self-efficacy. Overall, the study was successful in providing important insights into best practices for family therapy with LGBTQ+ young people and their LDS families, as well as highlighting areas where therapists may need additional training or support.

Given the scope of the findings, this discussion will highlight the unique contributions of this study. Many of the best practices identified are consistent with existing literature that describes the necessary components of good therapy, as well as the characteristics of LGBTQ+

affirmative therapy. Therefore, what do the findings suggest beyond being a good family therapist and beyond being an affirmative therapist?

Interpretations of Findings

Self of the Therapist

The findings of this study indicate that therapists' internal self-work is not only essential but also lies at the core of providing competent and ethical therapy to LGBTQ+ young people and their families in a Mormon context. The intersectional ecological framework used in this study highlights how intrapersonal processes at the center of the model impact interpersonal processes occurring in more distal systems. Given that all the CFEs interviewed for this study were raised in Mormon families and the majority of them identify as LGBTQ+, the findings and framework from this study together suggest that therapists need to engage in a thorough and deep internal inquiry into how their own experiences, beliefs, assumptions, and social location may impact their work with LGBTQ+ young people in LDS families.

Self-Reflection and Emotional Management in Therapy

The results within this theme emphasize the importance of therapists' in-the-moment self-reflection and emotional management during therapy sessions with LGBTQ+ young people and their families in a Mormon context. Findings suggest that therapists need to be aware of their own emotional responses during sessions and consider what personal experiences may be at the root of their emotional reactions throughout family sessions. In-the-moment assessments of what they are feeling, why they might be having that feeling, and how to best utilize it as the conductor of family sessions is essential to the work of helping move these families to a place of growth and connection.

The person-of-the-therapist framework (Hardy, 1992) also aligns with these findings. This framework recognizes the impact that a therapist's personal beliefs, values, and experiences can have on the therapy process and the therapeutic relationship. According to this framework, it is crucial for family therapists to be self-aware and understand how their own biases and assumptions may influence their therapy practices. Given that most of the therapists doing this work have themselves had a plethora of experiences at the intersection of queerness and Mormonism, their internal work becomes especially crucial. They must be able to identify areas where their experiences are similar to those of their clients, as well as areas where their experiences differ.

Authenticity and Self-Disclosure

The findings of this study support existing literature that underscores the importance of therapists' mindful use of self and self-disclosure in family therapy with LGBTQ+ young people and their LDS families. Guidelines for family therapists emphasize the need to recognize the social locations and intersecting identities of both the therapist and the client as significant factors that impact the relational dynamic and therapeutic process. This includes considering therapists' self-disclosure of gender identity and/or sexual orientation to a client (AAMFT, 2022).

Self-disclosure can be a tricky tool for therapists at this intersection to utilize effectively and appropriately, as the information they disclose to clients could either increase the strength of the therapist-client relationship or damage it. For example, one of the CFEs in this study identified as a post-Mormon lesbian woman who indicated that it is sometimes necessary for her to be more transparent about her identity when talking with the LGBTQ+ young person, and less

transparent about it when working with highly rigid LDS caregivers. Thus, therapists need to be thoughtful and intentional about how and when they disclose personal information to build rapport and trust with their clients (Budge et al., 2021; AAMFT, 2022).

Personal Identity and Its Impact on Therapy

The study highlights the importance of family therapists working with LGBTQ+ young people in LDS families being self-aware and having a deep understanding of their own privileges and internalized superiority. Guidelines established by the American Association for Marriage and Family Therapy (AAMFT) stress the need for therapists, especially those with dominant identities such as being heterosexual, cisgender, White, or able-bodied, to engage in self-reflection and explore their own heteronormativity, cisnormativity, and internalized cisheterosexism (AAMFT, 2022). Regarding work with Mormon families specifically, this finding implies that the social location of the therapist matters. For example, three of the six CFEs interviewed for this study considered themselves believing Latter-day Saints and were able to maintain, at the time of data collection, the privileges and credibility that come with being a "card-carrying Church member" (referring to an LDS temple recommend, which is obtained only by individuals deemed worthy of temple participation by Church leaders). Based on their social location, those three therapists may have an easier time earning the trust of caregivers who deeply believe in the teachings of the Mormon Church. In contrast, the two therapists who did not identify as believing Latter-day Saints may more easily build trust with an LGBTQ+ young person who may feel misunderstood within a family of "card-carrying" Church members.

Cultural Knowledge and Humility

Knowledge Relevant to LGBTQ+ Young People in LDS Families

Knowledge Around the LDS Doctrine of Binary Gender. The findings within this theme highlight the importance of family therapists working with LGBTQ+ young people and their families in Latter-day Saint (LDS) context to have a foundational understanding of the implications of the doctrine of binary gender in LDS theology. The doctrine of binary gender is at the very root of Mormon teachings and has extensive ramifications for Church members, impacting their participation in every ordinance and milestone throughout a Mormon's lifespan as well as the level of decision-making power within the Church. According to Mormon doctrine, ordinances are the vessels through which individuals can access the saving power of Jesus Christ's salvation. While some ordinances typically occur only once or a few times across the lifespan (i.e., baptism, confirmation, priesthood ordination, temple endowments, and temple sealing ceremonies), others take place on a weekly or even daily basis (i.e., partaking of the sacrament during church services, priesthood blessings of healing or comfort). One's sex and gender impact who can receive each ordinance, who is authorized to perform it, and even which classes they are permitted to attend during weekly services.

In addition to the impact of gender and sex on LDS ordinances, the LDS Church has explicit policies that restrict the self-expression of transgender members, further emphasizing the need for therapists to understand the cultural, religious, and familial context of their clients. The policies are outlined in the Church's *General Handbook* (CJCLDS, 2020) that restricts the self-expression of transgender members, in that they (a) can only receive priesthood ordination and temple ordinances according to their biological sex at birth, (b) are counseled against "elective medical or surgical intervention for the purpose of attempting to transition to the opposite gender of a person's biological sex at birth ("sex reassignment")," (further endorsing a binary view of

sex through the use of the phrase “opposite gender”), (c) are counseled against “social transitioning,” including “changing dress or grooming, or changing a name or pronouns, to present oneself as other than his or her biological sex at birth”. Consequences for violating these policies may involve restrictions around “receiving or exercising the priesthood and receiving some Church callings.” This approach to gender and sex is especially problematic for transgender and gender-diverse (TGD) members who may experience significant mental health challenges and may need professional support from therapists who understand their unique challenges.

In sum, this study’s findings suggest that therapists working with LGBTQ+ young people and their families in an LDS context need to have a thorough understanding of how the LDS Church views gender and sex and how it shapes the lived experiences of its members. Furthermore, they need to be knowledgeable of the specific challenges faced by TGD individuals in this context and be prepared to offer support that is both culturally sensitive and affirming. The importance of this study's findings cannot be overstated and should be taken seriously by therapists who work in this unique and complex environment.

Awareness of the Collectivistic LDS Doctrine of the Eternal Family. The intersectional ecological framework of this study highlights the collective nature of Mormonism's doctrine of eternal families and its potential impact on family therapy with LGBTQ+ young people and their LDS families. This doctrine asserts that if all family members are “true and faithful to their covenants,” family relationships do not end at death, but instead continue into the afterlife. LDS parents are taught that it is their primary responsibility and divine calling as a parent to ensure the salvation not only of each family member under their

stewardship but also the salvation of the family as a unit. This means that any action or decision that could be perceived as endangering the eternal salvation of the family, including a child coming out as LGBTQ+, may be met with resistance and even rejection.

The element of the "family system" in the intersectional ecological framework nods to the collectivistic nature of Mormon families in that it seeks to capture that family therapy impacts the entire family system, even though not all family members may be participating in the family therapy process. This means that therapists working with LDS families must be attuned to the potential impact of the doctrine of eternal families on the family dynamics, even if not all family members are present in the therapy room. In particular, therapists must recognize that the emphasis on the eternal nature of the family unit may create additional pressure on family members to conform to societal and religious expectations, including expectations around gender and sexual orientation.

Cultural Humility and Responsiveness

The present study emphasizes the necessity of cultural humility and responsiveness in family therapy with LGBTQ+ young people and their LDS families. The results of this study align with AAMFT clinical guidelines, which prioritize the centrality of clients with marginalized identities by "privileging their lived experiences and honoring their knowledge and cultural values" (2022, p. 4). Culturally humble therapists explicitly value their clients' expertise, recognize the power imbalances that exist in therapist/client relationships, and commit to ongoing self-examination and critique (Vaughan, et al., 2019). Additionally, culturally responsive therapists can adapt their approaches and techniques to meet the cultural needs and experiences of their clients, ensuring that therapy is culturally relevant and respectful. These

qualities are particularly crucial in working with underrepresented groups such as LGBTQ+ young people and their families, as they promote trust, understanding, and the potential for therapeutic success. Family therapists who cultivate cultural humility and responsiveness can establish a sense of safety and trust with LGBTQ+ clients and their LDS families, which can ultimately lead to more effective treatment outcomes.

Intersectionality and Attentiveness to Power

Conceptualization of Families within Interlocking Systems of Power

Core field experts recommend that family therapists working with LGBTQ+ young people and their LDS family members should conceptualize families within interlocking, larger systems of power (Wolfe et al., 2021). This finding aligns closely with the AAMFT guidelines for clinical practice with LGBTQIA individuals, which emphasize the systemic nature of therapy and the importance of recognizing and deconstructing power structures that affect the lived experiences of LGBTQ+ people (AAMFT, 2022).

Attentiveness to Power within Family Therapy

This research highlighted a need for family therapists to attend carefully to power dynamics in their work with LGBTQ+ young people and their LDS family members (Wolfe et al., 2021), indicating the need for therapists to be mindful of their role and the impact they can have on the therapy process, especially when working with vulnerable populations (Baima & Sude, 2020).

Adherence to Ethical Standards of Care

Family therapists working with LGBTQ+ individuals in LDS families must adhere to ethical standards of care, which include enhancing clients' sense of self-determination, refraining

from conducting reparative or conversion therapy and acknowledging the differing definitions of affirmative care among clinicians.

Do Not Conduct Reparative or Conversion Therapy. Experts in this study emphasized that family therapists should not participate in any form of conversion or reparative therapy, even if clients request it. This finding is supported by research that has shown both the ineffectiveness and harm of sexual orientation change efforts (SOCE) in the LDS Church (Dehlin, Galliher, Bradshaw, Hyde, & Crowell; 2015). Clinical guidelines for family therapists, too, highlight that family therapists “do not practice, for any reason, sexual orientation change efforts (SOCE) and gender identity change efforts (GICE), nor do they make referrals to other clinicians who practice SOCE and/or GICE” (AAMFT, 2022)

The study also highlighted that LGBTQ+ individuals in the church often feel pressure to change their sexual orientation and/or gender identity to find belonging and feel valued within their closest relationships and communities. This recommendation aligns with Dehlin et al.'s (2015) findings that among non-heterosexual, LDS-affiliated individuals, private efforts to change their sexual orientation were the most common and harmful. Additional research confirms that conversion therapy and personal efforts to change sexual orientation are both ineffective and can negatively impact one's mental health.

The juxtaposition of CFEs’ condemnation of conversion therapy practices with their endorsement of client self-determination as an essential part of this work brings up questions about how family therapists can implement both best-practice recommendations harmoniously. Additionally, this study proposes a need for therapists to engage LGBTQ+ young people in the work of self-acceptance, to support families in the work of acceptance– even celebration. When

LGBTQ+ young people and/or their family members ask for help changing their identity, for example, therapists may feel that denying clients' requests could be a violation of their right to self-determination. Further inquiry is needed to understand how these recommendations can synchronize, if at all, in the work of family therapy with LGBTQ+ young people and their LDS families.

Acknowledge Differing Definitions of the Term "Affirming." The present study highlights a need for family therapists to be very intentional and communicative about what they mean when they describe themselves to clients as LGBTQ-affirming therapists. The CFEs, though all self-identifying as "LGBTQ-affirming" therapists, reported subscribing to their own interpretation of what it means to be an affirming therapist. Most CFEs therapists expressed a hope and goal to move Mormon families toward a place of acceptance around their young person's LGBTQ+ identity and indicated that a neutral approach would not be considered affirmative practice. Existing guidelines for family therapy with LGBTQ populations, however, suggest that the definition of "affirmative practice" as proposed by the majority of CFEs in this study is the standard for the field of marriage and family therapy. The clinical guidelines outline a duty for family therapists to "recognize the harm caused by family-of-origin rejection and work to help family move to places of fully accepting and celebrating LGBTQIA members" (AAMFT, 2022, p. 6). In contrast, other CFEs indicated a belief that if they are affirming the experiences and emotions of LGBTQ+ young people and their LDS family members, they are implementing affirmative practices.

The differing opinions on what it means to be an LGBTQ+-affirming therapist have significant implications for the practice of family therapy with LGBTQ+ young people in Latter-

day Saint families. Therapists who hold the view that being affirming simply means acknowledging the experiences and emotions of LGBTQ+ young people and their families may not be equipped to address the power imbalances present in these families. On the other hand, therapists who believe in the more widely held view of affirmative practice as involving advocacy and political activism are more likely to be able to address power imbalances and promote change in the families they work with.

Theories, Frameworks, and Therapy Models

Moving Beyond Approaches Rooted in Cisheteronormativity

Experts in this study highlighted that the frameworks and clinical models in the field of family therapy are rooted in cisheterosexism and are thus inefficient for working with LGBTQ+ young people in Mormon families. These findings align with existing research, which shows that the current frameworks and clinical models in family therapy are rooted in cisheteronormativity and therefore inadequate for working with LGBTQ+ young people in Mormon families. Hartwell et al. (2018) found that most MFT models "were created in a heteronormative context that assumes cisgender, heterosexual, child-bearing monogamous partners who are white and middle-class" (Hartwell, et al., 2018, p.100).

To address this issue, the CFEs in this study recommend that therapists move beyond approaches rooted in cisheternormativity, supporting AAMFT's call for family therapists to decenter cisnormativity and heteronormativity in their practice through a "lifelong commitment to critical self-reflection, personal and professional development, personal therapy, supervision, and consultation. This approach involves "questioning assumed norms about gender, sexual orientation, intimate relationships, families, and sex; as well as examining their clinical practice

for the influence and presence of these norms” (AAMFT, 2022, p. 4). Such critical self-reflection offers therapists the opportunity to experience liberation from such norms themselves as they rethink and reimagine those practices. This statement also agrees with the findings in this study indicating that self-of-the-therapist work is an important, ongoing process.

Utilization of Relational, Attachment-Focused Approaches

This study revealed that utilizing a relational, systemic approach is crucial for family therapists working with LGBTQ+ young people and their LDS families. Research has shown that LGBTQ+ young people who feel accepted and supported in their families experience better mental health outcomes, while those who feel rejected or unsupported are at a higher risk for mental health issues (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Furthermore, studies have found that family acceptance can have a protective effect against suicide attempts and substance abuse among LGBTQ+ young people (Ryan et al., 2010; The Trevor Project, 2021). Therefore, it is critical for family therapists at this intersection to focus on strengthening attachment and relationships within the family, particularly for LGBTQ+ young people who may feel disconnected or rejected.

Therapists can lean on Mormonism’s emphasis on the importance of family relationships and strengthening attachments. LDS teachings emphasize the importance of love, acceptance, and forgiveness within families. Given these doctrines, family therapists working with Mormon families can use attachment-focused interventions that align with these teachings, such as enhancing communication skills, promoting emotional expression, and emphasizing shared values and goals.

Furthermore, Mormon families may face unique challenges in accepting and supporting their LGBTQ+ young people due to the Church's teachings that (a) all same-sex sexual behavior is sinful, (b) that same-sex marriage is not approved by God, and (c) that violations of Church policies around same-sex relationships are subject to Church discipline (CJCLDS, 2014). Family therapists can work with Mormon families to navigate these challenges and promote family acceptance and support of their LGBTQ+ young people. By focusing on attachment and relational interventions, family therapists can help families maintain strong relationships while also promoting acceptance and understanding of their LGBTQ+ family members.

A relational, attachment-focused approach is crucial for family therapists working with LGBTQ+ young people in Mormon families. Such an approach can promote positive mental health outcomes and align with Mormon doctrines on the importance of family relationships. By strengthening attachments and promoting family acceptance, family therapists can help LGBTQ+ young people and their families navigate the challenges of coming out and finding acceptance in their faith communities.

Assessment

Young Person's Risk for Self-Harm and Suicidality

Experts in this study unanimously agreed on the importance of assessing LGBTQ+ young people in Mormon families for safety risks, particularly self-harm and suicidal ideation. The experts reported various methods for formal and informal assessments, emphasizing the importance of such assessments. The literature on sexual minority Mormons and their experiences in the LDS Church highlights negative effects on their mental health, including mood disorders, self-worth concerns, suicidality, and a need for mental health recovery

(Jacobsen & Wright, 2014). The mechanism behind these negative outcomes is primarily minority stress, driven by factors such as social constraint, internalized homophobia, and identity confusion (Crowell et al., 2015). Research suggests that religious affiliation may be either helpful to well-being and a protective factor against suicidal ideation or a contributing factor to psychological distress and suicidal ideation (Barringer & Gay, 2017).

The LDS Church has acknowledged the need for suicide prevention and released resources to support it (Stephenson, 2018). Utah has high rates of suicide, particularly among adolescents and young adults (Annor et al., 2018), but there are no direct links published to indicate that LGBTQ+ individuals with LDS backgrounds have higher rates of suicidality than their heterosexual, cisgender, LDS peers. Further research is needed to examine the relationship between LDS-raised sexual minorities and suicidality and to differentiate protective vs contributing factors for suicidality.

Involving LDS caregivers in the assessment process can promote the well-being of LGBTQ+ young people in Mormon families. According to the Doctrine and Covenants, a fundamental scripture in the LDS faith, members should "love one another" and "bear one another's burdens" (Doctrine and Covenants 88:123). It is the responsibility of LDS caregivers to support and provide a safe and inclusive environment for their children, regardless of their sexual orientation or gender identity. Therefore, it may be helpful for family therapists to involve LDS caregivers in the assessment process to promote the safety and support of LGBTQ+ young people in Mormon families.

Acceptance and Rejection within the Family

The experts in this study emphasized the importance of therapists conducting assessments for accepting and rejecting beliefs and behaviors during therapy with LGBTQ+ young people and their families affiliated with the LDS Church. Research has shown that LGBTQ+ youth who experience rejection from their families are at increased risk for mental health issues, including depression, anxiety, and suicidal ideation. According to a study published in the Journal of Homosexuality, family rejection is a significant predictor of suicidal ideation and attempts among LGBTQ+ youth (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In addition, a report by the Family Acceptance Project found that LGBTQ+ youth who experienced high levels of family rejection were more than eight times as likely to have attempted suicide (Ryan, Russell, & Toomey, 2018).

While the Church of Jesus Christ of Latter-day Saints has not historically been affirming of LGBTQ+ individuals and has opposed same-sex marriage, the Church has more recently made statements condemning bullying and discrimination against LGBTQ+ people (CJCLDS, 2019). However, despite these teachings, some families may struggle to accept their LGBTQ+ children due to cultural and religious beliefs. Family therapists need to approach their work with sensitivity and understanding of the unique challenges faced by LGBTQ+ youth in Mormon families. By assessing for acceptance and rejection, therapists can better understand the family dynamics and work towards creating a more supportive and accepting environment for LGBTQ+ youth.

Appropriateness of Family Therapy

CFEs in this study indicated that although a family-based intervention is often helpful for LGBTQ+ young people in LDS families, therapists must take great care in assessing whether

there is enough emotional safety to do so. This finding supports existing research about family therapy with transgender and gender-non-conforming youth which has proposed a need to assess the level of support and/or opposition to their child's gender identity and expression (Coolhart & Shipman, 2017). Research has also shown that family therapy sessions can retraumatize young people who have experienced relational ruptures with their caregivers, particularly when their caregivers are unsupportive of their gender identity and expression (Ryan, et al., 2009).

Additionally, in Mormon families, where there may be strong cultural and religious beliefs about gender and sexuality, family therapy may be particularly challenging if not carefully assessed and prepared for. Separating family members for therapy sessions may be a more appropriate approach for some families where emotional safety is not yet established. Separating family members may also provide a safe space for LGBTQ+ youth to express themselves without fear of judgment or rejection from family members and for caregivers to process their emotional reactions without the risk of further damaging the relationship with their LGBTQ+ loved one. However, the decision to separate family members or to engage in family therapy should be based on an assessment of the family's emotional safety and readiness for therapy.

The consistent LDS mandate for family members to "love one another" supports the importance of family relationships and may motivate families to engage in therapy to improve relationships. However, LDS doctrines also emphasize the importance of respecting agency and recognizing individual differences. As such, therapists working with Mormon families should be mindful of these doctrines and tailor their approach to the unique needs of each family.

Skills for Building Therapeutic Alliances

Alliance with the LGBTQ+ Young Person

The findings of this study emphasize the importance of building a strong therapeutic alliance with LGBTQ+ young people in family therapy with their LDS families, involving three key strategies: (a) establishing clear boundaries around confidentiality, (b) acting as an advocate for the young person, and (c) implementing a collaborative approach. CFEs reported that these strategies are crucial in establishing trust, which is essential to a strong therapeutic alliance. However, the study's quantitative results suggest that there may be some variability in therapists' confidence in their ability to implement these strategies.

Although Mormonism teaches that parents should be kind and loving to their children, the commandment that children should "honor their father and mother" is often implemented hierarchically. In some instances, such as when an LGBTQ+ young person feels at risk for judgment from their caregivers or fears burdening them, CFEs indicated that the collectivism within Mormon families may make the young person less likely to voice their experience to caregivers. The findings of this study indicate that, certainly, the boundary between the caregiver/child roles should be emphasized in this work. However, because of the inherent power imbalance created by the parent/child hierarchy, the findings of this study suggest that empowering the LGBTQ+ young person is imperative to building trust and rebalancing power dynamics within the family system.

Implementing a Collaborative Approach. This study's findings show that family therapists working with LGBTQ+ young people and their Latter-day Saint family members should utilize a collaborative approach when building a trusting alliance with LGBTQ+ young people. Given the explicit caregiver/child hierarchy outlined in Mormon doctrine, a collaborative

approach with the young person may help the therapist address power imbalances present within the family therapy subsystem of this study's intersectional ecological model. This finding confirms the recommendations in existing literature that highlight the importance of a collaborative approach in family therapy with LGBTQ+ young people. For example, according to the handbook of LGBTQ affirmative couple and family therapy (Baldwin & Carson, 2022), a collaborative approach can help create a safe and welcoming environment for LGBTQ+ young people and their families and enhance the therapeutic alliance between the therapist and the client.

Establishing Boundaries of Confidentiality. This study's results showed that it is important for family therapists to establish clear boundaries around confidentiality when building a trusting alliance with LGBTQ+ young people in LDS families. These findings validate existing research findings that maintaining confidentiality is crucial for building trust and a therapeutic alliance with LGBTQ+ youth in therapy (Ryan, Huebner, Diaz, & Sanchez, 2009). According to Diamond et al. (2013), therapists need to hold the tension of keeping the young person's confidence until the youth and caregivers are prepared to have conversations about these issues together. Confidentiality helps to create a safe space for young people to freely express their thoughts and feelings without fear of judgment or stigma (Diamond et al., 2013). In therapy, confidentiality also helps to protect LGBTQ+ youth from potential harm from family, peers, or the larger community (Ryan et al., 2009). Therapists must thus be proactive in explaining why confidentiality is critical and be prepared to address any concerns that either the young person or their caregivers may have.

Act as an Advocate for the LGBTQ+ Young Person. The findings of this study suggest that family therapists working with LGBTQ+ young people and their Latter-day Saint family members should act as an advocate for the young person, both within and outside of therapy. This study supports existing literature (AAMFT, 2022; Ackerman & Newton, 2019) that recognizes advocacy as a crucial part of the family therapist's role when working with LGBTQ+ individuals and their families. In a family therapy context, study participants indicated that they prioritize the needs of the marginalized LGBTQ+ young person and act as their advocate, regardless of who is present in the session. This finding confirms the need for family therapists to have a clear understanding of the young person's needs, desires, and goals for family therapy.

The addition of power constructs (i.e., social, economic, and political structures) to the intersectional ecological model used in this study is particularly relevant here. This finding again calls for therapists to examine how they operationalize their conceptualization of what it means to practice "affirmative therapy." Those who take a more neutral stance would likely not put as much effort into advocating for the LGBTQ+ young person. Those with a more intersectional lens, however, might insist that advocacy is a necessary part of addressing power imbalances in family therapy. This application of the intersectional ecological framework acknowledges that therapists who take a neutral approach are inherently perpetuating power imbalances that can impede relational safety within the family.

Furthermore, family therapists must be aware of the political and social context in which they are working and understand the unique challenges faced by LGBTQ+ young people and their families. Advocacy for LDS-affiliated LGBTQ+ adolescents is especially relevant right now, given that this study's findings are emerging just after the governor of Utah passed a bill

that will ban gender-affirming healthcare for TGD young people, including hormone treatments and gender-affirming surgeries (CBS News, 2023, January 28). Therapists need to be aware of the resources and support groups available to these individuals and be prepared to act as an advocate for the young person.

Alliance with Caregivers

Validate Caregivers' Emotions. The findings of this study regarding the need for family therapists to validate caregivers' emotions when working with LGBTQ+ young people in LDS families support existing literature (e.g., Bos, Hughes, & Johnson, 2015; Riggle, Olson, & Rostosky, 2008); and are consistent with the AAMFFT clinical guideline that family therapists "understand and acknowledge that LGBTQIA families already have strengths and resiliencies from which to draw on in the therapeutic process" (AAMFT, 2022, p. 6).

Moreover, despite the negative mental health outcomes associated with the experiences of LGBTQ+ individuals in LDS contexts (Lefevor, et al., 2019), there may be aspects of family members' spiritual identities that therapists can utilize in promoting a more loving, compassionate relationship between LDS caregivers and their LGBTQ+ children. One particular best-practice recommendation found in this study suggests that therapists "utilize caregivers' spiritual beliefs to encourage softness and connection," highlighting a specific strength of LDS caregivers that may be therapeutically helpful in bonding with their LGBTQ+ young person. By validating caregivers' emotions and highlighting their strengths, family therapists can improve the therapeutic alliance and promote positive outcomes.

Equipping Family Members for the Work of Relational Repair

Self of the Family Member

Explore Families' Co-Created Meaning Around Relevant Constructs. The present study found that family therapists working with LGBTQ+ young people and their LDS families should explore the co-created meaning around relevant constructs within each family system. This approach is consistent with clinical guidelines inviting therapists to acknowledge that all clients do family, gender, and sexual orientation differently" (AAMFT, 2022, p. 5). This finding also supports postmodern approaches that highlight the importance of considering the social construction of reality within family systems and how these constructions shape the experiences and beliefs of individuals within the family.

In the context of working with LGBTQ+ young people in Mormon families, the intersectional ecological framework that guided this study can be helpful for understanding the impact of microsystems (e.g., family, peer groups), mesosystems (e.g., community and cultural norms), and macrosystems (e.g., laws and policies) on the experiences and perspectives of the young people and their families. Specifically, the addition of various power structures to the model can assist family therapists and family members to conceptualize their current challenges within the context of the oppressive forces they may not contemplate otherwise. By considering the complex interplay of these systems, therapists can better understand the ways socially constructed realities influence the experiences of LGBTQ+ young people and their families and tailor their interventions accordingly. In this way, the intersectional ecological model can help therapists to work collaboratively with families to co-create new realities and experiences that elevate the well-being of LGBTQ+ young people.

Support Clients in Examining and Deconstructing Personal Beliefs. Family therapists should support their clients in examining and deconstructing their personal beliefs when

conducting family therapy with LGBTQ+ young people and their LDS families. This finding confirms previous research that suggests that affirmative therapists should help clients challenge heteronormative beliefs by deconstructing and subverting these external beliefs (Green & Mitchell, 2015). This study extends this literature by specifically focusing on family therapy with LGBTQ+ young people and their LDS families and the need to address the religious beliefs that may contribute to the pathologization of LGBTQ+ identities.

Therapists at this intersection face an interesting dilemma. They must consider how much of their role should be to address the beliefs vs. the behaviors of family members. Further, when family therapists do feel that the caregiver/child would benefit from an examination of beliefs, how can they do so while still demonstrating appropriate respect for the beliefs they currently hold? Several in this study indicated that although a focus on behaviors can help reduce the amount of relational conflict in the family system, true relational repair is likely only possible once family members have done an internal inquiry around their beliefs regarding other family members (i.e. the pathologization of LGBTQ+ identities, assuming caregivers do not care about their young person if they experience distress around their loved one's disclosure of LGBTQ+ identity, etc.).

Practice Dialectic Skills with Family Members. This study highlighted that at the heart of family therapy with LGBTQ+ young people in LDS families is an ever-present tension of holding multiple truths at once—even when those truths seem to contradict one another. For therapists to enhance the dialectic skills of family members, they must first develop those skills themselves. Experts in this study highlighted an absolute need for family therapists to be able to "sit in the tension" of this work. They indicated that such dialectic practices are difficult

processes to describe, but even more difficult to do. Experts described this phenomenon as a "delicate dance," a "push and pull," a practice of "distress tolerance" and "holding the 'both/and.'" This finding is supported by existing guidelines for clinicians working with LGBTQ+ people and their families that point out a need for therapists to first "acknowledge the existence of multiple realities…. Like balancing multiple perspectives among family members, MFTs hold the tension between opposing viewpoints and diverse experiences (AAMFT, 2022, p. 5). One major area where this tension must be navigated expertly is to invite family members to examine their internalized assumptions and beliefs while also demonstrating respect for the beliefs and experiences they presently carry.

Skills for Family Sessions

Beginning with a Baseline of Hope

The results of this study highlight the importance of starting family therapy sessions with a sense of hope and longing for connection when working with LGBTQ+ young people and their LDS families. By inviting a moment of hope-based mindfulness at the beginning of each session, therapists can help create an encouraging environment for family members, which can be especially valuable for families who may be struggling with conflict and tension related to issues of sexuality and identity.

Such emphasis on hope is one way that family therapists at this junction can utilize LDS teachings as a helpful tool for facilitating change within the family. Focused on the lifespan of one's spirit, Mormon teachings are largely "future-focused." As such, LDS doctrines invite Church members to seriously consider the long-term costs and benefits of short-term decision-making processes. As such, the Church teaches that the "first principle of the Gospel is faith"

(CJCLDS, 2013, p. 67). Therapists can thus utilize family members’ core values around faith and familial love to encourage them to be open to being surprised by one another.

This finding confirms existing literature endorsing a solution-focused approach to assist LGBTQ+ individuals and their families in moving toward a space of hope and resilience (Ouer, 2015). Solution-focused approaches emphasize the importance of creating a positive and solution-focused environment in therapy. Additionally, a strength-based approach has been shown to be effective in working with families who are dealing with issues related to sexuality and identity (Buckner, 2013; Jordan, 2011). Our findings extend existing research by specifically highlighting the need for therapists to start family sessions with a tone of hope and longing for connection. By starting each session with a focus on hope and connection, therapists can help families to identify and build on their strengths, as well as work towards finding solutions to the challenges they face.

Establishing “Enough” Emotional Safety for Relational Repair

The findings of this study highlight the importance of establishing emotional safety between family members to effectively engage in relational repair work in family therapy with LGBTQ+ young people and their LDS families. Emphasizing emotional safety aligns with the principles of solution-focused and strength-based family therapy, which prioritize the development of a safe and supportive therapeutic environment (Miller & Rollnick, 2013). However, these findings go beyond the existing literature by specifically emphasizing the need for therapists to explicitly and intentionally establish the structure and guidelines for the session, prioritize the voice of the LGBTQ+ young person, maintain attunement to family members' emotional states, and diffuse emotions that present barriers to connection. The importance of

establishing emotional safety in family therapy with LGBTQ+ young people and their LDS families is also supported by previous research on the challenges faced by this population. For example, studies have shown that LDS families often struggle with accepting their LGBTQ+ children, which can lead to feelings of rejection and alienation (Johnson, 2016). These feelings can escalate into high levels of emotional distress, making it difficult for the family to engage in productive therapeutic work (Steele & Eldridge, 2018). By prioritizing emotional safety and implementing specific interventions to establish it, therapists can create an environment that is conducive to effective relational repair work.

Implications

When Identities Collide

CFEs emphasized that the most distressing elements of holding multiple realities at once are most often those that pertain to one's sense of identity. Indeed, this suggestion supports the findings in existing literature (Dehlin et al., 2015a; Dahl & Galliher, 2012) that the integration of religious and sexual identities can be challenging for individuals and may come at a significant psychosocial cost. They found, too, that most LDS-affiliated, nonheterosexual people who attempt to integrate their religious and sexual identities, ultimately reject one or the other (Dehlin et al., 2015a, 2015b) for the sake of mitigating the internal and external conflict that comes with holding both a Mormon and sexual minority identity (Dahl & Galliher, 2012). Other research, however, has indicated that some religious, LGBTQ individuals experience positive aspects of identifying as both religious/spiritual and LGBTQ (Rosenkrantz et al., 2016). The present study extends this literature by highlighting the positive aspects of holding both identities—such as empathy, compassion, and spiritual strength—that can be mobilized in clinical practice. The

findings of this study validate the importance for family therapists to (a) educate family members about queer identity development, (b) encourage all family members to engage in a process of self-examination and belief deconstruction, and (c) encourage acceptance of the young person's LGBTQ+ identity both within and between family members.

These findings suggest that identity integration is not solely an internal process within individuals. This study's findings invite family therapists to conceptualize identity integration more expansively; acknowledging it as a process that is simultaneously internal, relational, familial, and intersystemic. It involves processes within, between, and around family members in the family system. For example, these findings imply that family therapists at this intersection can help LDS caregivers and adjacent family members understand that the protective factor of family acceptance (Ryan, et al., 2010) will grow as family members integrate their LGBTQ+ family member's queer identity into the family system—both conceptually and behaviorally. Clinicians can invite Mormon family members to "make space for" and adapt around the LGBTQ+ identity of their loved one, thus inviting the hope and flexibility that experts who participated in this research endorsed as essential to this relational work. These findings support and amplify the call previously made by researchers for studies that provide models "by which individuals resolve the conflict between gender identity and a Christian upbringing" (Levy & Edmiston, 2014, p. 67), mitigate the psychosocial costs, and enhance the positive aspects of holding both identities.

Differing Definitions of Affirmative Practice

This study identified a disparity across participants in how each therapist was conceptualizing the terms "affirmative practice" and "affirming therapy," even as self-identified

affirming therapists. This finding matches literature at this intersection that indicates a polarization of views on how to define affirmative practice, especially among LGBTQ+ people from religious backgrounds (RGP, n.d.). Interestingly, a distinction in the literature that I noticed was that the organizations who define affirmative practice as a work of advocacy and protection for LGBTQ+ people also included in their arguments a need for an intersectional framework (Crenshaw, 1989) that attends to power structures and power imbalances (AAMFT, 2022; Harvey, et al., 2022).

In contrast, other mental health professionals have created guidelines for clinicians to "do no harm" and "facilitate self-determination" when working with individuals to "resolve distress between faith-based values and sexual and gender diversity" and have advocated "moving beyond terminology such as 'reparative,' 'conversion,' 'sexual orientation change efforts,' moving beyond terminology such as "reparative," "conversion," "sexual orientation change efforts," and "affirmative" therapies because they fuel adversarial tensions and foster misunderstanding" (RGP, n.d., p.1).

The findings from this study validate the existence of such differing perspectives among therapists working with LGBTQ+, LDS-affiliated people—but they do not resolve it. All 38 participants in this study self-identified as LGBTQ+-affirming therapists, and they all endorsed with consensus the harmful nature of conversion therapies, SOCE, and GICE. They also held perspectives on affirmative practice that are nearly as polarized as those described in the literature above. Indeed, these findings indicate that therapists doing family therapy with LGBTQ+ young people and their families truly do practice the dialectic skills of holding the "both/and."

The conversation on how to approach affirmative practice is one where the tenets of Crenshaw's intersectional feminist framework provide important context. There are structures of power that influence such processes as client self-determination and identity development. When we as systemic clinicians fail to acknowledge and address the way clients must interact with such power structures, we miss crucial contributions to the barriers and negative mental health outcomes experienced by many LGBTQ+ individuals in LDS contexts.

A Foundation for Queer Mormon Family Therapy

The experts in this study expressed that although many helpful family therapy models can support therapists in their work with LGBTQ+ young people in LDS families, no existing approach is culturally attuned to the needs of this population. Specifically, CFEs indicated a need for an approach that understands the role of patriarchy in LDS culture, the collectivistic nature of Mormonism's concept of "eternal family," the theological implications of challenging the Church's gender binary, and the impacts of spiritual trauma. Indeed, in the words of one participant, "there is a need for approaches that are not just adapted for work with LGBTQ+ humans with LDS backgrounds, but for approaches that are born from the needs of these specific humans" (CFE 04).

This study not only highlights the clinical implications of the development of these best practices but also lays the foundation for the development of a therapeutic approach that has been culturally tailored from the bottom up. The development of a culturally tailored therapy approach for LGBTQ+ young people in LDS families not only addresses the needs of the client but also requires a deep examination of the therapist's own beliefs and assumptions. Working with families in this context requires a sensitivity to the complex dynamics of patriarchal culture,

collectivism, and spirituality, and the impact these have on family relationships. By acknowledging and examining their own biases and assumptions, therapists can approach this work with a level of cultural humility that will allow them to provide effective and empathetic care to their clients. By committing to this type of internal work and training, therapists can create a more inclusive and equitable therapy experience for all families, regardless of their background or identity.

Limitations

The purpose of this section is to identify the limitations of this study and to explain their impact on the findings. This section will discuss the limitations that have been identified in this study and their implications for the interpretation of the results. Additionally, suggestions for future research will be presented.

One of the main limitations of this study is its generalizability. The results may not be statistically representative of the larger population of family therapy with LGBTQ+ young people in Mormon families, making it difficult to generalize the findings. In addition, the modification to the Delphi method in this study meant that participants did not have the opportunity to elaborate on their views after the interview was completed. This modification may have limited the depth of information obtained and the ability to reach consensus. Moreover, the consensus reached by the participants does not necessarily mean that their perspectives, opinions, or judgments are correct, highlighting the importance of considering alternative perspectives. The limitations of generalizability and the modification of the Delphi method may have had an impact on the validity and reliability of the findings. These limitations should be considered when interpreting the results of this study. Additionally, the possibility that the consensus

reached by participants may not represent the best practices highlights the importance of considering alternative perspectives and evaluating the limitations of this study. Future research could address the limitations of this study by utilizing a larger and more diverse sample, increasing the depth of information obtained through qualitative research methods, and considering alternative perspectives and opinions. Furthermore, it would be valuable to explore the effectiveness of the best-practice recommendations identified in this study through systematic evaluation. This could provide a more comprehensive understanding of the best practices for family therapy with LGBTQ+ young people in Mormon families.

Future Directions

This study has opened new avenues for future research regarding family therapy with LGBTQ+ young people in Mormon families. Rooted in an intersectional ecological framework, this study intentionally examined the internal processes of therapists, filling a major gap in literature by being the first in Mormon Studies to (a) highlight family therapy processes, (b) explore the perspectives of clinicians, and (c) examine LGBTQ+, LDS-affiliated individuals within a family context. An intersectional ecological model aligns with the goals of this research, as it emphasizes that therapists must engage in their own healing to avoid perpetuating harmful power dynamics with their clients. Given the harm that mental health professionals have caused for LGBTQ+ young people and their LDS family members, this study highlights the importance of advocacy work that begins with self-awareness and healing.

The principles of intersectionality rooted in Black feminism (Crenshaw, 1989) are largely missing from current literature at the LGBTQ+/Mormon intersection. While some research in this field implements systemic frameworks, such as minority stress theory, to highlight the

experiences of marginalized groups, previous efforts to employ an intersectional framework to LGBTQ+/Mormon literature have departed from the core concepts of Black feminism. We as researchers fall short in practicing decolonized research when we apply systemic frameworks without contextualizing the findings within the larger power structures (i.e., capitalism, White supremacy, cis heterosexism, ableism) and the dynamics of oppression within and between such structures. The findings of this study present a call to action for researchers at this intersection to revisit their attempts to operationalize the change-promoting tenets of an intersectional approach.

Finally, this study's findings suggest a clear need for future research in several areas, including:

- Family therapy practice from the perspectives of LGBTQ+ young people and their LDS family members.
- Studies employing dyadic or other relational approaches to data collection to capture interpersonal processes that individualized approaches often miss.
- The expansion of individualized frameworks (such as identity development) to capture the relational nature of social construction and symbolic interaction.
- The exploration of identity integration as a collection of processes both within and between interacting systems.
- The role of community support, connection, and belonging in the healing process.
- Additionally, conducting studies that examine family therapy with LGBTQ+ youth and young adults in other religious contexts could increase the generalizability of the results.

These future studies could contribute to the development of evidence-based practices that better serve the needs of LGBTQ+ individuals in Mormon communities.

Conclusion

In conclusion, this study highlights the complex nature of family therapy at the LGBTQ+/Mormon intersection and provides a systemic, dynamic perspective of how various systems interact and influence one another. With a feminist socio-ecological framework and a mixed methods approach, this study aimed to identify best practices for family therapy with LGBTQ+ young people in Mormon families and to highlight areas where therapists need more training. The results of this study underscore the importance of critically examining the internal processes of therapists and filling a major gap in literature by being the first in Mormon Studies literature to explore the perspectives of clinicians in this context. The best-practice recommendations identified through this study provide a valuable starting point for further research and practice in this field.

The findings of this study serve as a call to action for therapists to engage in self-awareness and healing, and for researchers to revisit the application of an intersectional approach rooted in Black feminism when examining the experiences of marginalized identities at the LGBTQ+/Mormon intersection. We must continue to critically examine and challenge power dynamics within therapeutic practices to promote justice and equity for all individuals, regardless of their identities. The complex nature of family therapy at this intersection requires a systemic, dynamic perspective that recognizes the interplay of various systems of power and their influence on one another. This study provides a valuable step towards creating a more inclusive and equitable therapeutic landscape for LGBTQ+ young people and their families in Mormon communities.

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APPENDICES

Appendix A. Phase I Qualitative Interview Protocol

Thank you for participating in this study. Your input is essential to the process of creating guidelines of best practice for this population. Please feel free to ask questions at any time.

Do you have any questions before we begin?

The following questions will be presented in one-on-one interviews with three to five identified experts in performing family therapy with LGBTQ+ youth (ages 12-25) and their LDS families.

1. Please describe key characteristics and elements of working with LGBTQ+ youth and their LDS families.
2. What should be the goals of family therapy with LGBTQ+ youth and their LDS families?
3. What theoretical stances/models/frameworks inform your work with LGBTQ+ youth and their LDS families?
4. How do you make decisions around when and when not to involve LDS family members in treatment with LGBTQ+ youth?
5. In what ways do you involve family members in the therapy process when working with LGBTQ+ youth in Mormon families?

a. Probe: What distinctions do you make between a family-centered/family-oriented approach vs. a family therapy approach?

6. How do you assess for rejecting and accepting behaviors of the youth's identity among family members?
7. What are unique challenges family therapists may encounter in treatment with LGBTQ+ youth and their LDS families, and vice versa?
8. What considerations must be made that are specific to working with *sexual minority* youth and their LDS families?
9. What considerations must be made that are specific to working with *gender minority* youth and their LDS families?
10. What considerations must be made when building therapeutic alliance with these youth? With their LDS family members?
11. What elements of LDS doctrine come up in your sessions with LGBTQ+ youth and/or their LDS family members? How do you navigate these?
12. If LGBTQ+ youth or young adults have not yet "come out," either to themselves or their families, how do you navigate this?
13. How do you navigate issues of parental consent and youth assent when working with *minor* LGBTQ+ youth in LDS families?

14. When LGBTQ+ youth are of minor status vs. adult status, how does that impact your work with them and their families?
15. When LGBTQ+ youth and young adults are living at home with their LDS family vs. living outside the home, how does that impact family therapy?
16. How is your work with these families impacted when the LGBTQ+ young person has rejected Mormon doctrine vs. wants to integrate their identities vs. rejects their queerness?
17. How do you navigate issues of safety when working with LGBTQ+ youth and their LDS families?
18. How do you use self-disclosure (i.e., personal experiences, own sexual/gender identity, religious background) in your work with LGBTQ+ youth and their LDS families?
19. How does your own social location impact your work with LGBTQ+ youth and their LDS families?
    i. Probe: How does your religious identity impact this work?
    ii. Probe: How do your gender identity and/or sexual orientation impact this work?

Post-Interview Questions:

20. I want to make sure I have interpreted your responses in a way that accurately represents what you have hoped to convey. I will now reflect some of my interpretations back to you to give you the opportunity to clarify anything that may have been lost in translation.
    i. Probe: After hearing these reflections, are there any clarifications you would like to make about your responses?
21. The second phase of this study requires a panel of 20-30 field experts on the topic of family therapy with LGBTQ+ youth and young adults in Mormon families. Our primary recruitment method is to ask core field experts, such as yourself, to identify other therapists whom they perceive to be experts in this area. Can you list up to 10 names of individuals whom you believe have done at least 10 sessions of affirmative family therapy with LGBTQ+ youth in Mormon families?
22. I have a list of mental health resources that I will send to you after we hop off our call, should you feel any distress following the interview. Are you experiencing any distress right now?

Appendix B. Demographic Survey for Core and Peripheral Field Experts

When referring to youth, this survey is asking about clients between 12-25 years old.

Clinician Information

What is your first and last name? ____________

How old are you? Enter number in years. ____________

How do you identify your gender? Please list all terms that apply. ____________

What is your sex?

- Male
- Female
- Intersex
- Not listed: ___________

What are your pronouns? __________

How do you currently describe or label your sexuality to others? Please list all terms that apply. ____________.

What is your race/ethnicity? ______________

At what age did you start referring to yourself with this sexual identity? ____________

What is the highest level of education you have completed?

- Master of Science
- Master of Art
- PhD
- PsyD
- Not listed: ____________

What is your current religious affiliation? ____________

What religion/faith were you raised in? ____________

Please enter the 5-digit zip code for where you currently live. ____________

Please enter the 5-digit zip code for where your most recent clinical practice is located.
____

What type of clinical training did you receive for your master's degree?

- Marriage and Family Therapy
- Professional Counseling
- Clinical Social Work
- Mental Health Counseling
- Clinical Psychology
- Not listed: _______________

In what type of clinical setting do you practice? (Check all that apply).

- Private Practice
- Non-Profit Organization
- LGBTQ+ Community Resource Center (provides services beyond therapy sessions)
- LGBTQ+ *Youth* Resource Center
- LGBTQ+ Therapy Center (therapy only, no additional resources)
- Not Listed: ______________

How much LGBTQ-specific training did you receive in your clinical program?

- I received no LGBTQ-specific clinical training
- Minimal LGBTQ-specific training was integrated into our courses, but was not a course I took.
- Substantial LGBTQ-specific training was integrated into our courses, but no LGBTQ-specific courses were offered.
- Substantial LGBTQ-specific training was integrated into our courses, but I did not take any of the LGBTQ-specific courses that were offered.
- I have completed one or more LGBTQ-specific courses in my clinical training.

Clinical Practice

How many cumulative *years* of experience do you have performing therapy with LGBTQ+ youth (ages 12-20 years-old) in Latter-day Saint families?

- _______ years

In how many of the *last five years* have you performed at least one family therapy session with LGBTQ+ youth in Latter-day Saint Families?

- _______ years

What percentage of your sessions *with LGBTQ+ youth in Latter-day Saint families* in the last year have *involved at least one family member or family-member equivalent*? _______________.

What percentage of your sessions with LGBTQ+ youth in LDS families in the last year have employed a *family-centered approach,* but did not involve a family member in-session? (i.e, individual sessions with family-centered approach, etc.) ___%.

What percentage of your current cases include LGBTQ+ youth? ___%

What percentage of *those* LGBTQ+ youth are members of Latter-day Saint or LDS-affiliated families? ___%

Table 5. Core Field Expert Demographics

Variable	*n*	%
Gender (open response)		
“Cisgender Woman”	3	50.00
“Cisgender Man”	2	33.33
“Non-Binary, Gender-Queer, Queer”	1	16.67
Sex		
Female	3	50.00
Male	3	50.00
Intersex	0	0.00
Pronouns (open response)		
She/Her/Hers”	3	50.00
“He/Him/His”	2	16.67
“They/He/Elle”	1	16.67
Sexual Orientation (open response)		
“Lesbian”	1	16.67
“Straight”	1	16.67
“Queer; mostly-straight”	1	16.67
“Queer”	1	16.67
“Bisexual/queer”	1	16.67
“Sexual minority, unlabeled”	1	16.67
Race or Ethnicity (open response)		
“Caucasian or White”	5	33.33
“Multi-racial”	1	16.67
Highest Education Level Completed		
Master’s	2	33.33
PhD	4	66.67
Current Religious Affiliation		
LDS/Mormon	4	66.67
Christian	1	16.67
Non-Religious	1	16.67

Raised-In Religious Affiliation		
LDS/Mormon	6	100.00
Clinical Practice Settings		
Private Practice	3	50.00
Non-Profit Organization	3	50.00
LGBTQ+ Therapy Center (therapy only)	2	33.33
LGBTQ+ Community Resource Center (services beyond therapy sessions)	2	33.33
Location of Clinical Practice Utah	6	100.00
Years Working with LGBTQ+ Mormons		
5 – 7 years	3	50.00
8 – 10 years	2	33.33
15 years	1	20.00

Note: CFE descriptive statistics are broken down as a group rather than by each individual CFE to better ensure the anonymity of each participant.

Table 6. Round I Arrangement of Initial Codes into Treatment Categories

Item #	Category of Treatment	Best-Practice Recommendation
1	**Self of the Therapist**	Are engaged in a continuous process of self-reflection around their own beliefs, biases, and how they may impact therapy.
2		Have already begun working to identify and heal their own experiences of trauma.
3		Are able to differentiate between their own emotional reactions and those of family members in session.
4		Have wrestled with their own questions of faith and identity.
5		Are aware of their own emotional triggers and can manage them appropriately during therapy sessions.
6		Accept the inevitability of biases and agendas, and work to be aware of an accountable for their own.
7		Presents an authentic self to all family members.
8		Are mindful of their own sense of marginalization and safety in their relationships with each family member.
9		Are open to sharing elements of their own experiences.
10		Are mindful to only use self-disclosure if they feel it will be helpful to the client.

11		Use self-disclosure to establish credibility as someone with an "in-group" understanding of family members' experiences.
12		Are transparent about their own feelings and opinions surrounding the intersection of LGBTQ+ and Latter-day Saint identities.
13		Are strategic about which elements of their own identity they present in therapy.
14		Understand why their own identities and beliefs may increase buy-in for some families and reduce buy-in for others
15		Utilize their positionality to model healthy emotional and communicative processes.
16		Identify when their own feelings of discomfort arise and work to deconstruct what is coming up for them.
17	**Cultural Competence**	Have contemplated the complexity and nuance that exist at the intersection of Mormonism and queerness.
18		Have a fundamental knowledge of Mormon doctrine/theology.
19		Have a fundamental knowledge of Mormon culture.
20		Have a fundamental knowledge of gender identity, gender expression, pronouns, and gender identity development.
21		Have knowledge about the Mormon Church's conceptualizations and policies around queer identities.
22		Knowledge of the history of the relationship between LGBTQ+ people and the LDS Church
23		Are engaged in continuous process of educating themselves on issues and treatments relevant to LGBTQ+ young people in LDS families.
24		Understand the spiritual, familial, and social significance of faith deconstruction and faith transitions.
25		Understand the emphasized role of family in Latter-day Saint theology and culture.
26		Understand the implications of Mormonism's empHaveis on eternal life, eternal families, and the covenant path.
27		Acknowledge the religious consequences of celebrating Queer identity.
28		Conceptualize family members' relational behaviors and response within the context of the various systems contributing to the family dynamic.
29		Have a foundational respect for the origin, theology, and framework of the family's religion.
30		Have fundamental knowledge about spiritual trauma.
31	**Intersectionality and Attentiveness to Power**	Conceptualize family therapy with LGBTQ+ youth and their LDS families within the contexts of interactive systems of power, privilege, and oppression.
32		Understand and acknowledge that existing family therapy models and frameworks have roots in heteronormativity and cisnormativity.
33		Understand the interplay of identities within a system of oppression, especially when marginalized identities are present.
34		Have examined their own layers of privilege and marginalization, and how those may influence therapy.
35		Are aware of the ways that the young person's age and living circumstances

		impact power dynamics in family therapy.
36		Take on a role as the young person's advocate to improve the balance of power dynamics in family therapy.
37		Promote client self-determination and autonomy.
38		Avoid filling the role of a spiritual guide/leader for family members, while allowing space for spiritual deconstruction.
39		Are aware of how therapists working with LGBTQ+/LDS families can and have perpetuated harm.
40		See the most vulnerable and or marginalized family member as their primary client.
41		Intentionally align with the most vulnerable family member in the session.
42		Acknowledge their power as an authority figure in therapy, and are mindful of how they use that power.
43		Follow guidelines of affirmative best practices as established by professional mental health organizations.
44		Do not participate in reparative or conversion therapy practices.
45		Do not encourage sexual orientation change efforts (SOCE) or gender identity change efforts (GICE).
46		Are transparent with families about their own conceptualization of "affirmative therapy."
47	**General Therapy Skills**	Establish clear expectations and boundaries around confidentiality.
48		Assess for and obtain family members' informed consent throughout the therapy process.
49		Be intentional and thoughtful in their implementation of interventions.
50		Match the language that family members use to describe their experiences and identities.
51		"Tap into" family members' feelings of love and longing for connection.
52		Be attuned to subtleties within interactions between family members in sessions.
53		Make family dynamics explicit.
54		Help families unpack the messages being communicated and received in their interactions.
55		Root their interventions in a robust, systemic framework.
56		Tune into their intuition during sessions and utilize it to make in-the-moment clinical judgement calls.
57		Embrace the "delicate dance" of validating family members' experiences while also challenging rigidity within the family.
58		"Sit" with the family in the discomfort of holding multiple realities and dissonant truths.
59		Encourage openness, flexibility, and curiosity in the family system.
60		Meet family members "where they are" while also encouraging continuous self-reflection and evolution.
61		Seek to understand the family's values and what is most important to family members.
62		Conceptualize the caregiver/young person-relationship as the primary client.

63		Conceptualize the family system as the primary client.
64		Strive for systemic, relational changes in the family system, even in individual sessions.
65		Understand that family members' rigidity or unwillingness to change is most often rooted in fear.
66		Assist families in expanding the young person's treatment team when collaborative care is appropriate.
67		Consistently reassesses and recalibrates throughout the therapy process.
68		Have fundamental knowledge of trauma-informed best practices.
69		Are attuned to responses of family members that may be rooted in their own experiences of trauma.
70	**Theories, Frameworks, and Therapy Models**	Identity Development
71		Family Systems Theory
72		Attachment-Based Family Therapy
73		Intersectional Feminism
74		Bowenian Family Therapy
75		Attachment Theory
76		Family Processes
77		Symbolic Interactionism
78		Eye-Movement Desensitization & Reprocessing (EMDR)
79		Internal Family Systems Therapy
80		Sue & Sue's Tripartite Model for Culturally Competent Therapy (i.e. Awareness, Knowledge, Skills)
81		The Family Acceptance Project
82		Social Constructivism
83		Structural Family Therapy
84		Narrative Therapy
85		Somatic Experiencing
86		Emotionally Focused Therapy
87		Humanistic Framework
88		Experiential Family Therapy
89		Ambiguous Loss Framework
90		Cognitive Dissonance Theory
91		Family Resilience Model
92		Queer Theory
93		Minority Stress Model
94		Interpersonal Theory of Suicide
95	**Assessment**	Level of caregiver acceptance around their young person's LGBTQ+ identity
96		Family members' interactional, relational dynamics
97		Rigidity and flexibility within the family system
98		Mental health of all family members
99		Frequency of suicidal ideation in the young person

100		Likelihood that a young person is to take their own life
101		Likelihood that a young person experiencing suicidal ideation will turn to family members for support
102		Presence of grief and/or loss in the family system
103		Family members' history of spiritual trauma
104		Family members' history of relational trauma with one another
105		General history of trauma among family members
106	**Self-Examination and Belief-Deconstruction**	Invite caregivers to deconstruct and examine their spiritual beliefs and how they impact their relationship with the young person.
107		Assist family members in seeing that their understandings of important constructs (i.e. Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions.
108		Help the young person distinguish between healthy caregiver/child boundaries and rejecting behaviors from caregivers.
109		Invite family members to willingly enter the tension that accompanies unlearning internalized assumptions and the experience of tolerating uncertainty.
110		Situate unfamiliar concepts within the belief systems of family members to help them relate and understand.
111		Support family members in identifying their own assumptions, examining them, and reconceptualizing them in a way that promotes connection.
112	**Psychoeducation**	Misinformation and misconceptions family members have about LGBTQ+ individuals.
113		LGBTQ+ topics, queer identity development, healthy exploration, etc.
114		Developmental theories and age-appropriate exploration.
115		General mental health principles and practices
116		Local support resources
117		Educational resources
118		Emotional regulation practices
119		Active listening skills
120		The Family Acceptance Project
121		Mechanisms of secure attachment
122		WPATH Standards of Care for Transgender Clients
123		Minority Stress Framework
124		Interpersonal Theory of Suicide
125	**Goals of Family Therapy**	To improve the overall well-being of individual family members.
126		For family members to be able to navigate crises together, while maintaining connection.
127		For family members to examine their own assumptions and beliefs, and assess for how they align with their personal values.
128		To create new emotional experiences together as family members.
129		To develop a relationship in which the young person can turn to their caregivers for support.
130		For family members to examine their own behaviors and the impacts they

		have on family relationships.
131		To increase family members' curiosity about one another's experiences, perspectives, and emotions.
132		To increase family members' sense of "agency" and ability to make informed choices.
133		To reinforce the boundary between the caregiver and child roles.
134		To redistribute responsibility for taking care of caregivers' emotions away from the young person and back onto the caregivers and the therapist.
135		To increase family members' openness to being surprised by one another.
136		To foster a therapeutic environment in which all family members feel a sense of emotional safety.
137		To decrease family members' sense of needing to hide parts of their identity in their relationships with one another.
138		To help family members accept differences in belief systems and values.
139		To increase family members' capacity for perspective-taking.
140		To foster identity development of the young person.
141		To increase levels of differentiation within individual family members.
142		For the young person to be able to own and feel confident about their story and experience.
143		To increase the young person's feelings of belonging.
144		To reduce the young person's sense of perceived burdensomeness.
145		For caregivers to "accept what is" when a goal of celebrating their young person identity is a goal that feels incongruent for them.
146	**Appropriateness and Timing of Involving Family Members**	Meet first with family members all together.
147		Meet first with caregivers and young person separately and does not hold family sessions until family members are prepared "enough that it's likely to go well."
148		Work with young person for a while to assess for appropriateness of family therapy.
149		Offer young person the option to involve family in therapy as soon as they start talking about the role of family members in their experiences.
150		Employ a collaborative approach with all family members to determine if, when, and how family members will participate in therapy.
151		Allow the young person to decide if, when, and how family members will participate in therapy.
152		Therapist makes the decisions around involvement of family members, depending on how therapy begins, how involved caregivers are already, and how the young person feels about involving family members in therapy.
153		Encourage the young person to be the one who invites their caregivers to participate in family therapy.
154		Involve family members in every session, even if the time is split between caregiver/young-person subsystems.
155	**Alliance with the Young Person**	Understand that young people typically have a good idea of how their caregivers will respond.
156		Meet with the young person before meeting with any other family members.

157		Work with the young person "for a while" before holding any family sessions.
158		Support youth as they engage in age-appropriate exploration within constraints of their environment.
159		Without caregivers present, assess young person's risk for suicidal ideation and self-harm.
160		Without caregivers present, assess young person's sense of their caregivers' level of acceptance vs. rejection of their LGBTQ+ identity.
161		Assess for how young person feels about involving family members in sessions.
162		Employ a collaborative approach with the young person.
163		Reassure youth of therapist's role as their advocate.
164		Collaborate with youth to identify what behaviors from family members feel accepting vs rejecting to them.
165		Obtain a clear understanding of young person's expectations and concerns about family therapy before bringing everyone together.
166		Allow the young person to set the pacing of the course of therapy.
167		Highlight the young person's strengths.
168		Clarify what the young person needs in order to feel supported by the therapist in family sessions.
169		Encourage the young person in expanding and deepening their social support system.
170		Encourage the young person's self-acceptance.
171		Encourage the young person in moving their life forward, regardless of caregivers' level of support or readiness for change.
172		Help the young person to prepare for the possibility of negative responses from their caregivers in family sessions.
173		Follow-up with the young person about their experience of any recent family sessions.
174		Assume that the young person has "really tried" to engage their caregivers and has likely been through a lot.
175		Support the young person as they wrestle with dissonance around seemingly contradicting realities.
176	**Alliance with Caregivers**	Work hard to build alliance with caregivers and increase caregiver buy-in.
177		Prepare caregivers for family sessions.
178		Wait until caregiver sessions to hold space for their concerns and emotions without the young person present.
179		Utilize caregivers' spiritual beliefs to encourage softness and connection.
180		Support caregivers as they wrestle with dissonance around seemingly contradicting realities.
181		Encourage caregivers to "rest in their job" to love, support, and keep their child safe.
182		Acknowledge that most caregivers are doing the best they can and have good intentions in their interactions with their young person.
183		Act as a consultant to caregivers.

184		"Tap into" caregivers' caregiving and nurturing instincts.
185		Involve caregivers in any safety-planning processes with the young person.
186		Help caregivers understand that young people often perceive family sessions as "tests" for their caregivers.
187		Coach caregivers in nonjudgmental listening skills.
188		Support caregivers in processing emotions of grief and/or loss that may be present
189		Encourage caregivers to be honest with themselves about their opinions and emotions.
190		Advise caregivers that the therapist will be taking a stance as the young person's advocate in family sessions.
191		Clarify what caregivers need to feel supported by the therapist in family sessions.
192		Follow-up with caregivers about their experience of any recent family sessions.
193		Help caregivers to aim for a morally neutral, nonjudgmental approach if they do not do not feel ready to take an accepting, affirming, or celebratory approach to their young person's LGBTQ+ identity.
194		Encourage caregivers to be advocates and allies for their young person in outside systems such as school, church, and family gatherings.
195	**Skills for Family Sessions**	Begin each family session by inviting each family member to voice their hopes and wishes for the session.
196		Obtain family members' consensus for language and labels to be used that feel congruent for all family members.
197		Prioritize the needs and voice of the young person in family sessions.
198		Consistently scan for signs of emotional activation in family members, especially the young person.
199		Invite family members to address each other directly only when they are expressing "connecting primary emotions" instead of "protective secondary emotions."
200		If therapist is not yet confident that enactments will go well, therapist "interviews" the young about their experience and invites caregivers only to listen and summarize what they are hearing.
201		Engage family members who are disconnected or disengaged in the session.
202		Defuse intense secondary emotion responses.
203		Watch for and "catch the darts" that family members may verbally throw during sessions.
204		Interject during interactions that feel unhelpful to the goal of increasing feelings of safety and connection.
205		Actively coach family members through interactive enactments.
206		Deepen and heighten expressions of primary emotion.
207		Invite family members to turn to one another to express primary emotions when they are present in the room.
208		Invite family members to check in with their bodies and emotions, and to work to stay connected to them throughout the session.

209		Do not hold family sessions if there is clear risk of re-traumatization or abuse.
210		Do not hold family sessions if the young person doesn't want to.
211		Do not hold family sessions when high levels of rigidity are still present in the family system.
212		Do not hold family sessions when they feel a risk to their own emotional or physical safety.
213		Are strategic and intentional in deciding what to address in the moment and what should be saved for individual sessions.
214		Utilize a highly structured approach in family sessions in order to protect vulnerable family members and prevent re-traumatization.
215		Position themselves as a buffer between caregivers and the young person when talking with each other presents a clear risk for harmful interactions.
216		Don't intervene in family sessions unnecessarily, allowing the family to navigate their interactional processes when risk for emotional harm is relatively low.
217		Are confident in their ability to manage a family session in a way that does not hurt clients.
218		Are prepared to slow down unhelpful family interactions.

Table 7. Best-Practice Recommendations Rated Low in Self-Efficacy

Treatment Category	Best-Practice Recommendation	IM	IQR
Self of the Therapist	Have already begun working to identify and heal their own experiences of trauma.	3.40	1
Cultural Knowledge & Humility	Have contemplated the complexity and nuance that exist at the intersection of Mormonism and queerness.	3.62	1
Intersectionality and Attentiveness to Power	Conceptualize family members' relational behaviors and response within the context of the various systems contributing to the family dynamic.	3.47	1
	Assess for and obtain family members' informed consent throughout the therapy process.	3.40	1
Theories, Frameworks, and Therapy Models	Family Systems Theory	3.10	1
	Attachment Theory	3.68	1
	Family Processes	3.62	1
	Family Resilience Model	3.16	1
	Somatic Experiencing	3.20	1
Assessment	Family members' history of spiritual trauma	3.62	1
	Involve caregivers in any safety-planning processes with the young person.	3.66	1
	Make family dynamics explicit.	3.53	1
	Offer young person the option to involve family in therapy as soon as they start talking about the role of family members in their experiences.	2.50	1
Skills for Building Therapeutic Alliances	Clarify what the young person needs in order to feel supported by the therapist in family sessions.	3.64	1
	Obtain a clear understanding of young person's expectations and concerns about family therapy before bringing everyone together.	3.61	1
	Reassure youth of therapist's role as their advocate.	3.63	1
	Assume that the young person has "really tried" to engage their caregivers and has likely been through a lot.	3.58	0

Treatment Category	Best-Practice Recommendation	IM	IQR
Equipping Family Members for the Work of Relational Repair	Work hard to build alliance with caregivers and increase caregiver buy-in.	3.65	1
	Assist family members in seeing that their understandings of important constructs (i.e. Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions.	3.63	1
	Help families unpack the messages being communicated and received in their interactions.	3.62	1
	"Sit" with the family in the discomfort of holding multiple realities and dissonant truths.	3.65	1
	Support caregivers as they wrestle with dissonance around seemingly contradicting realities.	3.66	1
	To help family members accept differences in belief systems and values.	3.65	1
	Prepare caregivers for family sessions.	3.25	1
Skills for Family Sessions	Emotional regulation practices	3.66	1.25
	Situate unfamiliar concepts within the belief systems of family members to help them relate and understand.	3.64	1
	Misinformation and misconceptions family members have about LGBTQ+ individuals.	3.68	1
	Begin each family session by inviting each family member to voice their hopes and wishes for the session.	3.47	1
	To decrease family members' sense of needing to hide parts of their identity in their relationships with one another.	3.25	1
	To foster a therapeutic environment in which all family members feel a sense of emotional safety.	3.68	1
	Do not hold family sessions when they feel a risk to their own emotional or physical safety.	3.65	1.5
	Utilize a highly structured approach in family sessions in order to protect vulnerable family members and prevent re-traumatization.	3.66	1.5
	Defuse intense secondary emotion responses.	3.59	1
	Engage family members who are disconnected or disengaged in the session.	3.60	1.5

Treatment Category	Best-Practice Recommendation	IM	IQR
	Do not hold family sessions if there is clear risk of re-traumatization or abuse.	3.65	1.5

Note. Self-Efficacy was rated on a 1 – 5 Likert scale. The cutoff for self-efficacy was an IM of 3.68 and an IQR of 1.5.

Table 8. Peripheral Field Expert Demographics

Variable	*n*	%
Gender (open response)		
“Female”	10	34.48
“Male”	6	20.69
“Cisgender Male”	3	10.34
“Transgender Male”	2	6.90
“Cisgender Female”	1	3.45
“Cisgender Woman”	1	3.45
“Feminine”	1	3.45
“LGBTQ+”	1	3.45
“Man, Male”	1	3.45
“Non-binary”	1	3.45
“Transgender Female”	1	3.45
“Woman”	1	3.45
Sex		
Female	17	58.62
Male	11	37.93
Intersex	1	3.45
Pronouns (open response)		
“She/Her/Hers” or “She/Her”	12	41.14
“He/Him/His” or “He/Him”	10	34.48
“They/Them”	3	10.34
“She/They”	1	3.45
Sexual Orientation (open response)		
“Straight” or “Heterosexual	12	41.14
“Lesbian”	4	13.79
“Bisexual” or “Bisexual or Queer”	3	10.34
“Gay”	3	10.34
“Gay/Lesbian”	1	3.45
“Lesbian, Gay, Queer”	1	3.45

“Gay, homosexual, homoromantic”	1	3.45
“Heterosexual but always open to growth and discovery!”	1	3.45
“Sapphic/Queer”	1	3.45
“Queer”	1	3.45
“LGBTQ+”	1	3.45
Age in Years		
20 - 29	12	41.14
30 - 39	10	34.48
40 – 49	4	13.79
50 – 59	2	6.90
60 – 69	1	3.45
Race or Ethnicity (open response)		
“Caucasian” or “White”	14	48.28
“African American”	9	31.34
“Asian”	2	6.90
“Black”	1	3.45
“White-Hispanic”	1	3.45
“Pasifika (Native Polynesian and Caucasian”	1	3.45
"Pacific Islander”	1	3.45
Clinical Degree		
Marriage and Family Therapy	14	48.28
Mental Health Counseling	6	20.69
Clinical Social Work	5	
Professional Counseling	3	10.34
Clinical Psychology	1	3.45
Highest Education Level Completed		
Master’s degree	13	44.83
PsyD	6	20.69
PhD	5	17.24
Currently in a doctoral program	4	13.79

Currently in a master's program	1	3.45
Current Religious Affiliation		
Christianity	11	37.93
Non-religious	9	
LDS/Mormonism	3	10.34
Islam	2	6.90
Protestantism	1	3.45
Catholicism	1	3.45
Belief in a higher power	1	3.45
Paganism	1	3.45
Raised-In Religious Affiliation		
LDS/Mormon	14	48.28
Christianity	11	37.93
Converted to Mormonism in Teens	1	3.45
Non-religious	2	6.90
Islam	2	6.90
Protestantism	1	3.45
Catholicism	1	3.45
Clinical Practice Setting (could choose more than one)		
Private Practice	10	34.48
LGBTQ+ Community Resource Center (provides services beyond therapy)	11	37.93
LGBTQ+ Youth Resource Center	10	34.48
LGBTQ+ Therapy Center (therapy only)	10	34.48
Non-profit Organization	5	13.79
Location of Clinical Practice		
Utah	17	58.62
California	3	10.34
Georgia	2	6.90
Indiana	1	3.45

Michigan	1	3.45
Ohio	1	3.45
Tennessee	1	3.45
Texas	1	3.45
Washington	1	3.45
Wisconsin	1	3.45
Completed one or more LGBTQ-specific courses	12	41.14
Minimal LGBTQ-specific training integrated into courses	7	24.14
No LGBTQ-specific training	7	24.14
Substantial LGBTQ=specific training integrated into courses	2	6.90

Note: Percentages in table may not add up to 100% due to rounding.

Table 9. Quantitative Results of Rounds II and III

Best-Practice Recommendation	Importance IM	Importance IQR	Self-Efficacy IM	Self-Efficacy IQR
***1. Self of the Therapist**	**4.69**	**0.25**	**3.69**	**1.00**
1.1 Self-Reflection and Emotional Management in Therapy	***4.92***	***0.38***	***3.62***	***1.00***
Are engaged in a continuous process of self-reflection around their own beliefs, biases, and how they may impact therapy.	5.00	0.00	3.78	1
Have wrestled with their own questions of faith and identity.	4.75	0.75	3.68	1
Accept the inevitability of biases and agendas, and work to be aware of an accountable for their own.	5.00	0.00	4.00	1
Are aware of their own emotional triggers and can manage them appropriately during therapy sessions.	5.00	0.00	3.90	0
Are able to differentiate between their own emotional reactions and those of family members in session.	5.00	0.00	3.94	1
Identify when their own feelings of discomfort arise and work to deconstruct what is coming up for them.	5.00	0.00	3.81	1
1.2 Authenticity and Self-Disclosure in Therapy	***4.98***	***0.00***	***3.85***	***0.96***
Are mindful to only use self-disclosure if they feel it will be helpful to the client.	4.75	0.75	3.82	0
Are open to sharing elements of their own experiences.	4.00	0.00	3.84	0
Are strategic about which elements of their own identity they present in therapy.	4.17	0.75	3.88	1
Presents an authentic self to all family members.	4.00	1.50	3.71	1.75
1.3 Personal Identity and Its Impact on Therapy	***4.58***	***0.58***	***3.78***	***0.48***
Utilize their positionality to model healthy emotional and communicative processes.	4.50	1.00	3.74	1.5
Understand why their own identities and beliefs may increase buy-in for some families and reduce buy-in for others	5.00	0.00	3.56	2

Are mindful of their own sense of marginalization and safety in their relationships with each family member.	4.75	1.50	3.80	1
Have examined their own layers of privilege and marginalization, and how those may influence therapy.	5.00	0.00	3.58	2
*Have already begun working to identify and heal their own experiences of trauma.	4.90	0.00	3.40	1
***2. Cultural Knowledge and Humility**	**4.55**	**0.60**	**3.66**	**1.35**
2.1 Cultural Knowledge Relevant to LGBTQ+ Young People in LDS Families	***4.43***	***0.63***	***3.69***	***1.25***
Have a fundamental knowledge of gender identity, gender expression, pronouns, and gender identity development.	4.90	0.00	3.71	1.75
Engage in continuous process of educating yourself on issues and treatments relevant to LGBTQ+ young people in LDS families.	4.75	0.75	3.77	1
Understand the implications of Mormonism's emphasis on eternal life, eternal families, and the covenant path.	4.17	0.75	3.58	1.75
Understand the emphasized role of family in Latter-day Saint theology and culture.	4.00	1.50	3.77	1
*Have contemplated the complexity and nuance that exist at the intersection of Mormonism and queerness.	4.90	0.00	3.62	1
Knowledge of the history of the relationship between LGBTQ+ people and the LDS Church	3.83	0.75	3.68	1
****2.2 Cultural Humility & Responsiveness***	***4.55***	***0.60***	***3.66***	***1.35***
Understand the spiritual, familial, and social significance of faith deconstruction and faith transitions.	4.17	0.75	3.25	1.75
Seek to understand the family's values and what is most important to family members.	4.90	0.00	3.63	2
Have a foundational respect for the origin, theology, and framework of the family's religion.	4.75	0.75	3.70	1
Match the language that family members use to describe their experiences and identities.	4.17	0.75	3.81	1
Acknowledge the religious consequences of celebrating Queer identity.	4.75	0.75	3.93	1

***3. Intersectionality and Attentiveness to Power**	**4.88**	**0.23**	**3.63**	**1.17**
****3.1 Conceptualization of Families within Interlocking Systems of Power***	***4.85***	***0.38***	***3.74***	***1.00***
*Conceptualize family members' relational behaviors and response within the context of the various systems contributing to the family dynamic.	5.00	0.00	3.47	1
Conceptualize family therapy with LGBTQ+ youth and their LDS families within the contexts of interactive systems of power, privilege, and oppression.	4.75	0.75	4.03	0
Understand the interplay of identities within a system of oppression, especially when marginalized identities are present.	4.75	0.75	3.41	2
See the most vulnerable and or marginalized family member as their primary client.	4.90	0.00	4.04	1
****3.2 Attentiveness to Power within Family Therapy***	***4.95***	***0.00***	***3.60***	***1.00***
Take on a role as the young person's advocate to improve the balance of power dynamics in family therapy.	4.90	0.00	3.11	2
Are aware of the ways that the young person's age and living circumstances impact power dynamics in family therapy.	5.00	0.00	3.70	1
Acknowledge their power as an authority figure in therapy, and are mindful of how they use that power.	5.00	0.00	3.78	1
Intentionally align with the most vulnerable family member in the session.	4.90	0.00	3.82	0
****3.3 Adherence to Ethical Standards of Care.***	***4.84***	***0.33***	***3.56***	***1.50***
*Assess for and obtain family members' informed consent throughout the therapy process.	5.00	0.00	3.40	1
To increase family members' sense of "agency" and ability to make informed choices.	4.90	0.00	3.71	2
Promote client self-determination and autonomy.	4.75	0.75	3.88	1
Consistently reassesses and recalibrates throughout the therapy process.	4.75	0.75	3.76	1

Avoid filling the role of a spiritual guide/leader for family members, while allowing space for spiritual deconstruction.	4.75	0.75	3.15	2
Do not encourage sexual orientation change efforts (SOCE) or gender identity change efforts (GICE).	4.90	0.00	3.35	2
Do not participate in reparative or conversion therapy practices.	4.90	0.00	3.58	2
Follow guidelines of affirmative best practices as established by professional mental health organizations.	4.90	0.00	3.70	1
Are aware of how therapists working with LGBTQ+/LDS families can and have perpetuated harm.	5.00	0.00	3.33	2
Are transparent with families about their own conceptualization of "affirmative therapy."	4.50	1.00	3.70	1
***4. Theories, Frameworks, and Therapy Models**	**4.50**	**0.64**	**3.54**	**1.18**
4.1 Moving Beyond Approaches Rooted in Cisheteronormativity	***4.50***	***0.75***	***3.71***	***1***
Acknowledge that MFT models are rooted in cisheteronormativity and may not be sufficient for the needs of this population.	4.50	0.75	3.71	1
****4.2 Utilization of Relational, Attachment-Focused Approaches***	***4.49***	***0.63***	***3.58***	***1.16***
*Family Systems Theory	4.88	0.00	3.10	1
Conceptualize the caregiver/young person-relationship as the primary client.	4.75	0.75	3.52	2
Root their interventions in a robust, systemic framework.	4.75	0.75	3.55	2
*Attachment Theory	4.75	0.75	3.68	1
*Family Processes	4.75	0.75	3.62	1
Strive for systemic, relational changes in the family system, even in individual sessions.	4.75	0.75	2.63	2
To improve the overall well-being of individual family members.	4.75	0.75	3.97	0
LGBTQ+ topics, queer identity development, healthy exploration, etc.	4.50	1.00	3.81	1
Interpersonal Theory of Suicide	4.25	1.00	3.11	2
Bowenian Family Therapy	4.00	0.00	3.75	1
Emotionally Focused Therapy	4.00	0.00	3.33	2

*Family Resilience Model	4.00	1.50	3.16	1
Ambiguous Loss Framework	3.75	1.00	3.68	1
*Somatic Experiencing	3.75	1.00	3.20	1
To create new emotional experiences together as family members.	4.90	0.00	4.01	0
Experiential Family Therapy	4.17	0.75	3.78	1
Attachment-Based Family Therapy	4.67	1.00	3.48	2
To foster identity development of the young person.	4.75	0.75	3.82	1
Identity Development	4.17	0.75	3.95	1
Have fundamental knowledge of trauma-informed best practices.	5.00	0.00	3.89	0
Have fundamental knowledge about spiritual trauma.	4.90	0.00	3.34	2
*Family members' history of spiritual trauma	4.75	0.75	3.62	1
5. Assessment	**4.65**	**0.46**	**3.63**	**1.28**
5.1 Young Person's Risk for Self-Harm and Suicidality	***4.76***	***0.15***	***3.83***	***1.20***
Frequency of suicidal ideation in the young person	5.00	0.00	4.26	1
Likelihood that a young person experiencing suicidal ideation will turn to family members for support	5.00	0.00	3.71	1
Likelihood that a young person is to take their own life	4.90	0.00	3.63	2
Without caregivers present, assess young person's risk for suicidal ideation and self-harm.	4.90	0.00	3.91	1
*Involve caregivers in any safety-planning processes with the young person.	4.00	0.75	3.66	1
****5.2 Relational Dynamics in the Family System***	***4.76***	***0.57***	***3.55***	***1.43***
Family members' history of relational trauma with one another	4.90	0.00	3.60	2
Presence of grief and/or loss in the family system	4.90	0.00	3.71	1
General history of trauma among family members	4.75	0.75	3.33	2
Mental health of all family members	4.75	0.75	3.71	1
*Make family dynamics explicit.	4.75	0.75	3.53	1
Rigidity and flexibility within the family	4.50	1.00	3.68	1

system				
Family members' interactional, relational dynamics	4.75	0.75	3.33	2
5.3 Acceptance and Rejection within the Family	***4.88***	***0.38***	***3.67***	***1.50***
Level of caregiver acceptance around their young person's LGBTQ+ identity	5.00	0.00	3.82	1
Without caregivers present, assess young person's sense of their caregivers' level of acceptance vs. rejection of their LGBTQ+ identity.	4.75	0.75	3.52	2
****5.4 Assessing Appropriateness of Family Therapy***	***4.23***	***0.75***	***3.46***	***1.00***
Assess for how young person feels about involving family members in sessions.	4.90	0.00	3.95	1
*Meet first with caregivers and young person separately and does not hold family sessions until family members are prepared "enough that it's likely to go well."	4.17	0.75	3.67	1
Meet with the young person before meeting with any other family members.	4.00	1.50	3.74	1
*Offer young person the option to involve family in therapy as soon as they start talking about the role of family members in their experiences.	3.83	0.75	2.50	1
6. Skills for Building Therapeutic Alliances	**4.78**	**0.32**	**3.70**	**1.17**
6.1 Alliance with the Young Person	***4.81***	***0.19***	***3.67***	***1.18***
*Clarify what the young person needs in order to feel supported by the therapist in family sessions.	5.00	0.00	3.64	1
Collaborate with youth to identify what behaviors from family members feel accepting vs rejecting to them.	5.00	0.00	3.86	1
Employ a collaborative approach with the young person.	5.00	0.00	3.52	2
Help the young person to prepare for the possibility of negative responses from their caregivers in family sessions.	5.00	0.00	3.83	1
Highlight the young person's strengths.	5.00	0.00	3.34	2
Follow-up with the young person about their experience of any recent family sessions.	4.90	0.00	4.04	1

Establish clear expectations and boundaries around confidentiality.	5.00	0.00	3.91	1
Encourage the young person's self-acceptance.	4.90	0.00	3.22	2
*Obtain a clear understanding of young person's expectations and concerns about family therapy before bringing everyone together.	4.90	0.00	3.61	1
*Reassure youth of therapist's role as their advocate.	4.90	0.00	3.63	1
*Assume that the young person has "really tried" to engage their caregivers and has likely been through a lot.	4.17	0.75	3.58	0
Encourage the young person in moving their life forward, regardless of caregivers' level of support or readiness for change.	4.00	1.50	3.83	
6.2 Alliance with Caregivers	***4.75***	***0.46***	***3.74***	***1.17***
Follow-up with caregivers about their experience of any recent family sessions.	4.90	0.00	3.50	2
*Work hard to build alliance with caregivers and increase caregiver buy-in.	4.90	0.00	3.65	1
Act as a consultant to caregivers .	4.75	0.75	3.63	2
Advise caregivers that the therapist will be taking a stance as the young person's advocate in family sessions.	4.75	0.75	3.77	1
Clarify what caregivers need to feel supported by the therapist in family sessions.	4.90	0.00	3.74	1
Wait until caregiver sessions to hold space for their concerns and emotions without the young person present.	4.75	0.75	3.90	0
Support caregivers in processing emotions of grief and/or loss that may be present	4.50	1.00	3.93	1
Help caregivers understand that young people often perceive family sessions as "tests" for their caregivers.	4.00	0.75	3.74	1
"Tap into" caregivers' caregiving and nurturing instincts.	5.00	0.00	3.74	1
Acknowledge that most caregivers are doing the best they can and have good intentions in their interactions with their young person.	4.90	0.00	3.55	2
Encourage caregivers to "rest in their job" to	4.90	0.00	3.93	1

love, support, and keep their child safe.				
Utilize caregivers' spiritual beliefs to encourage softness and connection.	4.75	1.50	3.83	1
7. Equipping Family Members for the Work of Relational Repair	**4.63**	**0.55**	**3.69**	**1.15**
7.1 Self of the Family Member	***4.75***	***0.40***	***3.69***	***1.15***
*Assist family members in seeing that their understandings of important constructs (i.e. Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions.	4.50	1.00	3.63	1
Support family members in identifying their own assumptions, examining them, and reconceptualizing them in a way that promotes connection.	5.00	0.00	3.79	1
*Help families unpack the messages being communicated and received in their interactions.	5.00	0.00	3.62	1
For caregivers to "accept what is" when a goal of celebrating their young person identity is a goal that feels incongruent for them.	4.75	0.75	3.74	1
Encourage caregivers to be honest with themselves about their opinions and emotions.	4.50	1.00	3.83	1
For family members to examine their own assumptions and beliefs, and assess for how they align with their personal values.	4.50	1.00	3.48	2
Invite caregivers to deconstruct and examine their spiritual beliefs and how they impact their relationship with the young person.	4.50	1.00	3.71	1
Meet family members "where they are" while also encouraging continuous self-reflection and evolution.	5.00	0.00	3.87	1
Support the young person as they wrestle with dissonance around seemingly contradicting realities.	4.90	0.00	3.52	2
Embrace the "delicate dance" of validating family members' experiences while also challenging rigidity within the family.	4.90	0.00	3.79	1
*"Sit" with the family in the discomfort of	4.90	0.00	3.65	1

holding multiple realities and dissonant truths.				
*Support caregivers as they wrestle with dissonance around seemingly contradicting realities.	4.88	0.00	3.66	1
Invite family members to willingly enter the tension that accompanies unlearning internalized assumptions and the experience of tolerating uncertainty.	4.75	0.75	3.84	0
*To help family members accept differences in belief systems and values.	4.17	0.75	3.65	1
*Prepare caregivers for family sessions.	5.00	0.00	3.25	1
Encourage caregivers to be advocates and allies for their young person in outside systems such as school, church, and family gatherings.	4.90	0.00	3.63	2
For family members to examine their own behaviors and the impacts they have on family relationships.	4.90	0.00	3.99	1
To increase family members' capacity for perspective-taking.	4.90	0.00	3.76	1
To increase family members' curiosity about one another's experiences, perspectives, and emotions.	4.90	0.00	3.83	1
Active listening skills	4.90	0.00	3.77	1.25
Coach caregivers in nonjudgmental listening skills.	4.75	0.75	3.35	2
For family members to be able to navigate crises together, while maintaining connection.	4.75	0.75	3.83	1
*Emotional regulation practices	4.00	1.50	3.66	1.25
7.2 Psychoeducation	***4.52***	***0.69***	***3.70***	***1.14***
*Situate unfamiliar concepts within the belief systems of family members to help them relate and understand.	4.75	0.75	3.64	1
Help the young person distinguish between healthy caregiver/child boundaries and rejecting behaviors from caregivers.	4.75	0.75	3.70	1
Developmental theories and age-appropriate exploration.	4.00	0.00	3.77	1
*Misinformation and misconceptions family	4.90	0.00	3.68	1

members have about LGBTQ+ individuals.				
Interpersonal Theory of Suicide	4.75	1.50	3.58	2
Mechanisms of secure attachment	4.50	1.00	3.94	0.25
Educational resources	4.00	0.75	4.01	1
Encourage the young person in expanding and deepening their social support system.	4.75	0.75	3.13	2
Assist families in expanding the young person's treatment team when collaborative care is appropriate.	4.25	0.75	3.80	1
8. Skills for Family Sessions	**4.80**	**0.43**	**3.69**	**1.12**
***8.1 Beginning with a Baseline of Hope**	***4.80***	***0.33***	***3.61***	***1.33***
"Tap into" family members' feelings of love and longing for connection.	5.00	0.00	3.75	1
*Begin each family session by inviting each family member to voice their hopes and wishes for the session.	4.50	1.00	3.47	1
Encourage openness, flexibility, and curiosity in the family system.	4.90	0.00	3.60	2
8.2 Establishing "Enough" Emotional Safety for Relational Repair	***4.73***	***0.54***	***3.78***	***1.15***
To increase the young person's feelings of belonging.	5.00	0.00	3.83	1
To reduce the young person's sense of perceived burdensomeness.	5.00	0.00	3.41	2
To develop a relationship in which the young person can turn to their caregivers for support.	5.00	0.00	4.47	1
*To decrease family members' sense of needing to hide parts of their identity in their relationships with one another.	4.50	1.00	3.25	1
*To foster a therapeutic environment in which all family members feel a sense of emotional safety.	4.50	1.00	3.68	1
Are confident in their ability to manage a family session in a way that does not hurt clients.	4.75	0.75	3.96	1
*Do not hold family sessions when they feel a risk to their own emotional or physical safety.	4.75	0.75	3.65	1.5
For the young person to be able to own and feel confident about their story and	4.90	0.00	3.78	1

experience.				
*Utilize a highly structured approach in family sessions in order to protect vulnerable family members and prevent re-traumatization.	4.75	0.75	3.66	1.5
Obtain family members' consensus for language and labels to be used that feel congruent for all family members.	3.83	1.50	3.68	1
Consistently scan for signs of emotional activation in family members, especially the young person.	4.90	0.00	3.73	1.5
Be intentional and thoughtful in their implementation of interventions.	5.00	0.00	3.90	1
Are attuned to responses of family members that may be rooted in their own experiences of trauma.	4.90	0.00	3.74	1
Invite family members to turn to one another to express primary emotions when they are present in the room.	4.90	0.00	3.83	1
Be attuned to subtleties within interactions between family members in sessions.	4.75	0.75	3.93	0
Tune into their intuition during sessions, and utilize it to make in-the-moment clinical judgement calls.	4.75	0.75	3.91	1
Are strategic and intentional in deciding what to address in the moment and what should be saved for individual sessions.	4.75	1.50	4.00	0
Are prepared to slow down unhelpful family interactions.	4.90	0.00	4.58	2
Deepen and heighten expressions of primary emotion.	4.75	0.75	3.89	1
*Defuse intense secondary emotion responses.	4.75	0.75	3.59	1
Invite family members to check in with their bodies and emotions, and to work to stay connected to them throughout the session.	4.75	0.75	3.12	2
Watch for and "catch the darts" that family members may verbally throw during sessions.	4.75	0.75	3.70	1.5
*Engage family members who are disconnected or disengaged in the session.	4.00	0.75	3.60	1.5

8.3 Directively Orchestrating Constructive Interactions	***4.67***	***0.83***	***3.47***	***2.00***
Interject during interactions that feel unhelpful to the goal of increasing feelings of safety and connection.	5.00	0.00	3.57	2
Actively coach family members through interactive enactments.	4.75	0.75	3.57	2
Invite family members to address each other directly only when they are expressing "connecting primary emotions" instead of "protective secondary emotions."	4.75	0.75	3.51	2
Support youth as they engage in age-appropriate exploration within constraints of their environment.	4.50	1.00	3.33	2
****8.4 Navigating Obstacles in Family Sessions***	***4.63***	***0.46***	***3.67***	***1.33***
To redistribute responsibility for taking care of caregivers' emotions away from the young person and back onto the caregivers and the therapist.	5.00	0.00	3.89	0
To increase levels of differentiation within individual family members.	4.50	1.00	3.55	2
To reinforce the boundary between the caregiver and child roles.	4.50	1.00	3.23	2
*Do not hold family sessions if there is clear risk of re-traumatization or abuse.	4.90	0.00	3.65	1.5
Do not hold family sessions if the young person doesn't want to.	4.00	0.75	4.01	1
Position themselves as a buffer between caregivers and the young person when talking with each other presents a clear risk for harmful interactions.	4.90	0.00	3.70	1.5

Note. Recommendations rated low in self-efficacy are indicated with an asterisk.

Appendix C: Final Compilation of Best-Practice Recommendations

1 Self of the Therapist

1.1 Self-Reflection and Emotional Management in Therapy

1.1.1 Self-Reflection and Self-Awareness in Therapy

Therapist(s):

Are engaged in a continuous process of self-reflection around their own beliefs, biases, and how they may impact therapy.

Have wrestled with their own questions of faith and identity.

Accept the inevitability of biases and agendas, and work to be aware of an accountable for their own.

1.1.2 Emotional Management in Therapy

Therapist(s):

Are aware of their own emotional triggers and can manage them appropriately during therapy sessions.

Are able to differentiate between their own emotional reactions and those of family members in session.

Identify when their own feelings of discomfort arise and work to deconstruct what is coming up for them.

1.2 Authenticity and Self-Disclosure in Therapy

Therapist(s):

Have already begun working to identify and heal their own experiences of trauma.

1.2.3 Self-Disclosure and Authenticity in Therapy

Therapist(s):

Are mindful to only use self-disclosure if they feel it will be helpful to the client.

Utilize their positionality to model healthy emotional and communicative processes.

Are strategic about which elements of their own identity they present in therapy.

Are open to sharing elements of their own experiences.

Present an authentic self to all family members.

1.3 Personal Identity and its Impacts on Therapy

1.3.1 Personal Identity and Its Impact on Therapy

Therapist(s):

Understand why their own identities and beliefs may increase buy-in for some families and reduce buy-in for others.

Are mindful of their own sense of marginalization and safety in their relationships with each family member.

Have examined their own layers of privilege and marginalization, and how those may influence therapy.

2 Cultural Knowledge and Humility

2.1 Cultural Knowledge Relevant to LGBTQ+ Young People in LDS Families

2.1.1 Knowledge Around the LDS Doctrine of Binary Gender

Therapist(s):

Have a fundamental knowledge of gender identity, gender expression, pronouns, and gender identity development.

Are engaged in a continuous process of educating themselves on issues and treatments relevant to LGBTQ+ young people in LDS families.

2.1.2 Awareness of the Collectivistic LDS Doctrine of the Eternal Family

Therapist(s):

Understand the implications of Mormonism's emphasis on eternal life, eternal families, and the covenant path.

Understand the emphasized role of family in Latter-day Saint theology and culture.

Understand the spiritual, familial, and social significance of faith deconstruction and faith transitions.

2.1.3 Acknowledgement of the Significance of Embracing LGBTQ+ Identities

Therapist(s):

Have contemplated the complexity and nuance that exist at the intersection of Mormonism and queerness.

Value knowledge of the history of the relationship between LGBTQ+ people and the LDS Church

2.2 Cultural Humility & Responsiveness

2.2.1 Respect for Family Members' Belief Systems

3 Intersectionality and Attentiveness to Power

3.1 Conceptualization of Families within Interlocking Systems of Power

Therapist(s):

Conceptualize family members' relational behaviors and responses within the context of the various systems contributing to the family dynamic.

Conceptualize family therapy with LGBTQ+ youth and their LDS families within the contexts of interactive systems of power, privilege, and oppression.

Understand the interplay of identities within a system of oppression, especially when marginalized identities are present.

3.2 Attentiveness to Power within Family Therapy

Therapist(s):

Take on a role as the young person's advocate to improve the balance of power dynamics in family therapy.

3.2.1 Consider the Age of the Young Person.

Therapist(s):

Are aware of the ways that the young person's age and living circumstances impact power dynamics in family therapy.

3.2.2 Consider Families' Living Arrangements.

3.3 Adherence to Ethical Standards of Care.

3.3.1 Enhance Clients' Sense of Self-Determination.

Therapist(s):

See the most vulnerable and or marginalized family member as their primary client.

Acknowledge their power as an authority figure in therapy, and are mindful of how they use that power.

Intentionally align with the most vulnerable family member in the session.

Assess for and obtain family members' informed consent throughout the therapy process.

Seek to increase family members' sense of "agency" and ability to make informed choices.

Promote client self-determination and autonomy.

Consistently reassess and recalibrate throughout the therapy process.

Avoid filling the role of a spiritual guide/leader for family members, while allowing space for spiritual deconstruction.

3.3.2 Do Not Conduct Reparative or Conversion Therapy.

Therapist(s):

Do not encourage sexual orientation change efforts (SOCE) or gender identity change efforts (GICE).

Do not participate in reparative or conversion therapy practices.

Follow guidelines of affirmative best practices as established by professional mental health organizations.

3.3.3 Acknowledge Differing Definitions of the Term "Affirming."

Therapist(s):

Are aware of how therapists working with LGBTQ+/LDS families can and have perpetuated harm.

Are transparent with families about their own conceptualization of "affirmative therapy."

4 Theories, Frameworks, and Therapy Models

4.1 Moving Beyond Approaches Rooted in Cisheteronormativity

4.2 Utilization of Relational, Attachment-Focused Approaches

Family Systems Theory

Conceptualize the caregiver/young person-relationship as the primary client.

Root their interventions in a robust, systemic framework.

Attachment Theory
Family Processes
Strive for systemic, relational changes in the family system, even in individual sessions.
Improve the overall well-being of individual family members.
LGBTQ+ topics, queer identity development, healthy exploration, etc.
Interpersonal Theory of Suicide
Bowenian Family Therapy
Emotionally Focused Therapy
Family Resilience Model
Ambiguous Loss Framework
Somatic Experiencing

4.2.1 Experiential Family Therapy
Create new emotional experiences together as family members.
Experiential Family Therapy

4.2.2 Attachment-Based Family Therapy
Attachment-Based Family Therapy

4.2.3 Identity Development Frameworks
Foster identity development of the young person.
Identity Development

4.2.4 Trauma-Informed Interventions
Therapist(s):
Have fundamental knowledge of trauma-informed best practices.
Have fundamental knowledge about spiritual trauma.
Value family members' history of spiritual trauma

5 Assessment

5.1 Young Person's Risk for Self-Harm and Suicidality
Frequency of suicidal ideation in the young person
Likelihood that a young person experiencing suicidal ideation will turn to family members for support.
Likelihood that a young person is to take their own life
Without caregivers present, assess young person's risk for suicidal ideation and self-harm.
Involve caregivers in any safety-planning processes with the young person.

5.2 Relational Dynamics in the Family System
Family members' history of relational trauma with one another
Presence of grief and/or loss in the family system
General history of trauma among family members

Mental health of all family members
Make family dynamics explicit.
Rigidity and flexibility within the family system
Family members' interactional, relational dynamics

5.3 Acceptance and Rejection within the Family
Level of caregiver acceptance around their young person's LGBTQ+ identity
Without caregivers present, assess the young person's sense of their caregivers' level of acceptance vs. rejection of their LGBTQ+ identity.

5.4 Appropriateness of Family Therapy
Therapist(s):
Assess for how young person feels about involving family members in sessions.
Meet first with caregivers and young person separately and do not hold family sessions until family members are prepared "enough that it's likely to go well."
Meet with the young person before meeting with any other family members.
Offer the young person the option to involve family in therapy as soon as they start talking about the role of family members in their experiences.

6 Skills for Building Therapeutic Alliances

6.1 Alliance with the Young Person

6.1.1 Implement a Collaborative Approach.
Therapist(s):
Clarify what the young person needs in order to feel supported by the therapist in family sessions.
Collaborate with youth to identify what behaviors from family members feel accepting vs rejecting to them.
Employ a collaborative approach with the young person.
Help the young person to prepare for the possibility of negative responses from their caregivers in family sessions.
Highlight the young person's strengths.
Follow-up with the young person about their experience of any recent family sessions.

6.1.2 Establish Clear Boundaries around Confidentiality.
Establish clear expectations and boundaries around confidentiality.

6.1.3 Act as an Advocate for the Young Person.
Therapist(s):
Encourage the young person's self-acceptance.
Obtain a clear understanding of young person's expectations and concerns about family therapy before bringing everyone together.
Reassure youth of therapist's role as their advocate.

Assume that the young person has "really tried" to engage their caregivers and has likely been through a lot.
Encourage the young person in moving their life forward, regardless of caregivers' level of support or readiness for change.

6.2 Alliance with Caregivers

Therapist(s):
Follow-up with caregivers about their experience of any recent family sessions.
Work hard to build alliance with caregivers and increase caregiver buy-in.
Act as a consultant to caregivers.
Advise caregivers that the therapist will be taking a stance as the young person's advocate in family sessions.

6.2.1 Validate Caregivers' Emotions.

Therapist(s):
Clarify what caregivers need to feel supported by the therapist in family sessions.
Wait until caregiver sessions to hold space for their concerns and emotions without the young person present.
Support caregivers in processing emotions of grief and/or loss that may be present
Help caregivers understand that young people often perceive family sessions as "tests" for their caregivers.

6.2.2 Highlight Caregiver Strengths.

Therapist(s):
"Tap into" caregivers' caregiving and nurturing instincts.
Acknowledge that most caregivers are doing the best they can and have good intentions in their interactions with their young person.
Encourage caregivers to "rest in their job" to love, support, and keep their child safe.
Utilize caregivers' spiritual beliefs to encourage softness and connection.

7 Equipping Family Members for the Work of Relational Repair

7.1 Self of the Family Member

7.1.1 Explore Families' Co-Created Meaning Around Relevant Constructs.

Therapist(s):
Assist family members in seeing that their understandings of important constructs (i.e. Queerness, faith, acceptance, worthiness) are co-created within family systems, family relationships, and family interactions.

7.1.2 Support Clients in Examining and Deconstructing Personal Beliefs.

Therapist(s):
Support family members in identifying their own assumptions, examining them, and reconceptualizing them in a way that promotes connection.

Help families unpack the messages being communicated and received in their interactions.

For caregivers to "accept what is" when a goal of celebrating their young person's identity is a goal that feels incongruent for them.

Encourage caregivers to be honest with themselves about their opinions and emotions.

For family members to examine their own assumptions and beliefs, and assess for how they align with their personal values.

Invite caregivers to deconstruct and examine their spiritual beliefs and how they impact their relationship with the young person.

7.1.3 Practice Dialectic Skills with Family Members

Therapist(s):

Meet family members "where they are" while also encouraging continuous self-reflection and evolution.

Support the young person as they wrestle with dissonance around seemingly contradicting realities.

Embrace the "delicate dance" of validating family members' experiences while also challenging rigidity within the family.

"Sit" with the family in the discomfort of holding multiple realities and dissonant truths.

Support caregivers as they wrestle with dissonance around seemingly contradicting realities.

Invite family members to willingly enter the tension that accompanies unlearning internalized assumptions and the experience of tolerating uncertainty.

Help family members accept differences in belief systems and values.

7.1.4 Assist Family Members in Building Relational Skills.

Therapist(s):

Prepare caregivers for family sessions.

Encourage caregivers to be advocates and allies for their young person in outside systems such as school, church, and family gatherings.

For family members to examine their own behaviors and the impacts they have on family relationships.

To increase family members' capacity for perspective-taking.

To increase family members' curiosity about one another's experiences, perspectives, and emotions.

Active listening skills

Coach caregivers in nonjudgmental listening skills.

For family members to be able to navigate crises together, while maintaining connection.

Emotional regulation practices

7.2 Psychoeducation

Therapist(s):
Situate unfamiliar concepts within the belief systems of family members to help them relate and understand.
Help the young person distinguish between healthy caregiver/child boundaries and rejecting behaviors from caregivers.

7.2.1 Educate Clients About Queer Identity Development.
Developmental theories and age-appropriate exploration.

7.2.2 Provide Research-Based LGBTQ+ Educational Resources.
Misinformation and misconceptions family members have about LGBTQ+ individuals.
Interpersonal Theory of Suicide
Mechanisms of secure attachment
Educational resources

7.2.3 Inform Clients of Local Community-Building Resources.
Therapist(s):
Encourage the young person in expanding and deepening their social support system.
Assist families in expanding the young person's treatment team when collaborative care is appropriate.

8 Skills for Family Sessions

8.1 Beginning with a Baseline of Hope

8.1.1 Invite Hope-Centered Mindfulness.
Therapist(s):
"Tap into" family members' feelings of love and longing for connection.
Begin each family session by inviting each family member to voice their hopes and wishes for the session.

8.1.2 Assist Family Members in Reframing Concerns as Hopes.
Therapist(s):
Encourage openness, flexibility, and curiosity in the family system.

8.2 Establishing “Enough” Emotional Safety for Relational Repair
To increase the young person's feelings of belonging.
To reduce the young person's sense of perceived burdensomeness.
To develop a relationship in which the young person can turn to their caregivers for support.
To decrease family members' sense of needing to hide parts of their identity in their relationships with one another.
To foster a therapeutic environment in which all family members feel a sense of emotional safety.
Therapist(s):

Are confident in their ability to manage a family session in a way that does not hurt clients.

Do not hold family sessions when they feel a risk to their own emotional or physical safety.

8.2.1 Prioritize the Voice of the Young Person.

For the young person to be able to own and feel confident about their story and experience.

8.2.2 Build Structure for the Session

Therapist(s):

Utilize a highly structured approach in family sessions in order to protect vulnerable family members and prevent re-traumatization.

Obtain family members' consensus for language and labels to be used that feel congruent for all family members.

Consistently scan for signs of emotional activation in family members, especially the young person.

8.2.3 Maintain Attunement to Emotional Responses.

Therapist(s):

Are intentional and thoughtful in their implementation of interventions.

Are attuned to responses of family members that may be rooted in their own experiences of trauma.

Invite family members to turn to one another to express primary emotions when they are present in the room.

Are attuned to subtleties within interactions between family members in sessions.

Tune into their intuition during sessions and utilize it to make in-the-moment clinical judgement calls.

Are strategic and intentional in deciding what to address in the moment and what should be saved for individual sessions.

8.2.4 Diffuse Potentially High-Barrier Emotions.

Therapist(s):

Are prepared to slow down unhelpful family interactions.

Deepen and heighten expressions of primary emotion.

Defuse intense secondary emotion responses.

Invite family members to check in with their bodies and emotions, and to work to stay connected to them throughout the session.

Watch for and "catch the darts" that family members may verbally throw during sessions.

Engage family members who are disconnected or disengaged in the session.

8.3 Directively Orchestrating Constructive Interactions

8.3.1 Coach Family Members Through Enactments.

Therapist(s):

Interject during interactions that feel unhelpful to the goal of increasing feelings of safety and connection.

Actively coach family members through interactive enactments.

Invite family members to address each other directly only when they are expressing "connecting primary emotions" instead of "protective secondary emotions."

8.3.2 Facilitate Renegotiation of Boundaries Around Autonomy.

Therapist(s):

Support youth as they engage in age-appropriate exploration within constraints of their environment.

8.4 Navigating Obstacles in Family Sessions

8.4.1 Reinforce Boundaries Around Parent/Child Roles.

To redistribute responsibility for taking care of caregivers' emotions away from the young person and back onto the caregivers and the therapist.

To increase levels of differentiation within individual family members.

To reinforce the boundary between the caregiver and child roles.

8.4.2 Respect Boundaries when Young People Disengage.

Therapist(s):

Do not hold family sessions if there is clear risk of re-traumatization or abuse.

Do not hold family sessions if the young person doesn't want to.

8.4.3 Intervene when Caregivers Prioritize Their Own Voice.

Therapist(s):

Position themselves as a buffer between caregivers and the young person when talking with each other presents a clear risk for harmful interactions.