AFFECTIONALLY FLUID PERSONS’ BELIEFS ABOUT WELLNESS

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The purpose of this study was to examine affectionally fluid (AF) persons’ beliefs about wellness. A total of 44 participants met the inclusion criteria of identifying as AF for the Q methodology study. These participants sorted 32 statements from most agree with my beliefs about wellness to most disagree with my beliefs, utilizing a response grid to record the sort. In addition, the participants responded to a demographic form including identification of age, gender, race, and other variables. Post-sort written responses were also collected from questions regarding how the participants sorted the statements, serving as qualitative data.

Q sort responses were examined utilizing factor analysis (principal components), resulting in four unique factors. The factors included Intimacy and Self-Acceptance, Openness and Connectivity, Physical Wellness and Self-Care in a Supportive Community, and Acceptance as Unique. Factors were interpreted utilizing factor arrays, distinguishing statements, and post-sort written participant responses. These factors demonstrated the beliefs AF participants had about wellness through themes of connection and personal acceptance, engaged cognitive/emotional openness and interpersonal relationships, physical wellness and prevention occurring within supportive networks, and overall acceptance of unique, deeply personalized wellness models. There was possibility for other perspectives, but they were not noted in this study. By
examining these factors and qualitative data more effective wellness interventions and cultural competence can be developed by counselors, educators, and supervisors for use with the AF population.
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CHAPTER I
INTRODUCTION AND LITERATURE REVIEW

The World Health Organization (1948) defined health as “a state of complete physical, mental and social well-being and not merely the absence of infirmity or disease” (p. 100). Within the U.S. medical system preventative care (termed as “health” care in this review) functions as a secondary concern to treating illness (“sick” care), accounting for only 1% of U.S. federal government expenditures for healthcare (DeVol et al., 2007; Granello, 2013). Concentrating on the treatment of existing illnesses is useful for coping with outbreaks of potential communicable diseases but ineffective on medical and economic levels for consumers and managed care providers (Granello, 2013). This is a relevant issue for those receiving mental health care, one of the most expensive types of care, as several authors note significant co-occurring physical issues up to and including significant decreases in life expectancy of 25 years compared to general populations (Granello, 2013; Parks, Svendsen, Singer, & Foti, 2006). The U.S. population and mental health/medical providers are discovering other options to the pathogenic medical model, defined by a base in illness rather than health (Granello, 2013; Savolaine & Granello, 2002). Preventative healthcare modalities, such as the holistic counseling model of wellness, are suited to both prevent illness and optimize functioning through “salutogenic (health enhancing)” interventions (Granello, 2013, p. 8).

Wellness is a preventative, strength-based, and wellbeing augmenting healthcare model focusing on improving overall physical and mental health through intervention that attend to health rather than illness as an essential element in the practice of mental
health counseling (Granello, 2013; Myers & Sweeney, 2005). Mental health counseling utilizes a developmental, holistic approach to counseling, focusing on evidence-based modalities such as wellness and cultural competent practice (Lee, 2008; Myers & Sweeney, 2008). Cultural competence is defined for this review as recognizing and responding to intersectional elements of culture (race, ethnicity, affectional orientation, ability, etc.) through an evidence-based, cognitive appraisal of differences between client and counselor (Lee, 2008; Sue & Sue, 2008). For the purposes of this review cultural competence and wellness are explored together for marginalized sexual and gender diverse (Moe, Finnerty, Sparkman, & Yates, 2015) populations including bisexual, queer, questioning, and other persons termed as affectionally fluid (AF) individuals. This community manages both chronic and lifestyle conditions, often exacerbated by discrimination, marginalization, and oppression experienced (Carter, Mollen & Smith, 2013).

Affectionally fluid (AF) is a term encompassing all those who identify as bisexual, pansexual, queer, questioning, down-low, and non-identifying others demonstrating fluidity across multiple layers of relationships including sexual/affectional behaviors, spiritual, mental, attractions, and relational patterns not specified within the homosexual/heterosexual binary system (Diamond, 2008a, 2008b; Harper et al., 2013, p. 39; Klein, 1990, 1999). As a term, affectionally fluid is developed from affectional orientation (Crethar & Vargas, 2007; Wells, 1989) defined as “the direction (sex, gender identity/expression) an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally” (Harper et al., 2013, p. 38). This
definition addresses not only behaviors but also attractions and fantasies alongside emotional, relational, and communal factors (Crethar & Vargas, 2007; Klein, 1993). AF persons face specific physical and mental health challenges, as they often exist between heterosexual and lesbian/gay communities (Amola & Grimmett, 2015; D’Augelli, 1998; Mulick & Wright, 2002). These issues are both similar to and differing from the overall LGBTQQIA (lesbian, gay, bisexual, transgender, queer, questioning, intersex and ally) community through exclusion from multiple communities (Harper et al., 2013).

Chronic health conditions, including mental disorders, can be intensified or improved through lifestyle alternatives (Granello, 2013). For example, diet and exercise are responsive to change through utilization of wellness interventions such as self-reflection and encouragement (Myers & Sweeney, 2005). Small shifts towards the integration of prevention and wellness approaches to healthcare demonstrate significant cost-reduction benefits (Granello, 2013) along with enhanced social justice and empowerment for LGBTQQIA communities overall (Prilleltensky, 2005; Savage, Harley, & Nowak, 2005). While there are overarching wellness and prevention concerns in the general population (Myers & Sweeney, 2005), AF persons are more likely to receive inadequate medical (Amola & Grimmett, 2015) and mental health treatment (Page, 2004; Prilleltensky, 2008; Ratts & Hutchins, 2009).

The LGBTQQIA population is disadvantaged regarding wellness because of oppression, discrimination, and lack of pertinent sexual and gender diverse knowledge on the part of healthcare providers (Carter et al., 2013; Dermer, Smith, & Barto, 2010). AF persons are at particular risk due to exclusion from both heterosexual and exclusively
gay/lesbian communities (Ochs, 1996; Rust, 1993) contributing to mental health (D’Augelli, 1998; National Alliance for Mental Health [NAMI], 2007) and physical issues (Amola & Grimmett, 2015; Herek, 2002). Lack of effective mental health care for AF persons presents at a higher rate than lesbian and gay persons as a significant percentage of identities represented by the term AF report limited knowledge and heterosexual bias from mental health practitioners negatively affecting the counseling relationship (Bradford, 2004; Harper et al., 2013). Therefore, mental health counselors must demonstrate informed, culturally competent modalities aligning with the tenets of prevention, developmental growth and wellness the counseling field utilizes to discern clinical practice from other mental health professionals (Lee, 2008; Myers & Sweeney, 2005).

Counselors represent the helping profession basing clinical practice on: philosophies of prevention, lifetime growth, cultural competence and holistic wellness (Myers & Sweeney, 2005) in juxtaposition to the medical model’s illness perspective (Granello, 2013). In fact, Kaplan, Tarvydas, and Gladding (2014) formalized wellness within a diverse society as essential to the revised definition of counseling while noting advocacy as a key element of counseling in an earlier document intended to unite and strengthen the profession (Kaplan & Gladding, 2011). Counselors are active participants in advocating with and for clients to seek personal and systemic changes (Toporek, Lewis & Crethar, 2009) through social justice endeavors for client communities (Prilleltensky & Prilleltensky, 2003). Counselors advocate with/for clients to prevent and combat medical and mental health conditions (Kaplan et al., 2014; Ratts & Hutchins, 2009).
An example of advocacy and cultural competence is an open, affirming approach to clinical work with AF clients (Kort, 2008; McGeorge & Carlson, 2009). The clinician identifies affectional and gender development as continuous, complex and culturally based throughout the lifespan (Moe et al., 2015; Moe, Perera-Diltz, Sepulveda, & Finnerty, 2014). The ACA Code of Ethics (2014) and practices of culturally competent counselors (Lee, 2008) demonstrate how affirming practice is cemented into the counseling framework and describe counselors as allies to the overall sexual and gender diverse community (Finnerty, Goodrich, Brace & Pope, 2014; Poynter, 1999). Effective and ethical treatment in counseling (ACA, 2014; Harper et al., 2013) includes wellness modalities empowering clients to live healthy mental and physical lives (Myers & Sweeney, 2005).

Wellness affects overall health yet is also tied to social justice (Prilleltensky, 2008). When a person, group or community does not possess the knowledge, resources, and/or proficiencies (Sen, 1999) in empowering and advocating for the issues affecting group wellness community members are rendered powerless (Prilleltensky & Prilleltensky, 2003). Marginalized persons are unable to engage decision-makers, create interventions to combat violence, poverty, and other community issues thus cannot foster wellness growth (Prilleltensky, 2003, 2008). Powerlessness connects to an inability to resist political, legal, and institutional policies oppressing the entire LGBTQIA community (Harper et al., 2013; Kitzinger, 1996; Prilleltensky, 2008). Wellness issues connected to marginalization and oppression for AF persons include social isolation (McLean, 2008), minority stress, poverty, and violence (Balsam, Huang, Fieland, Simoni,
& Walters, 2004), hopelessness, and lack of sufficient rest and other self-care behaviors (Moe, Dupuy & Laux, 2008). Wellness issues function as both contributing variables and outcomes predicting powerlessness, showing AF persons’ inability to access resources conducive to reaching high-level wellness (Legate, Ryan, & Weinstein, 2012; Moe et al., 2008).

AF persons often lack personal, group and community wellness (Dew & Newton, 2005; Ketz & Israel, 2002). Prilleltensky (2000, 2008) discussed a person’s inability to attain optimal wellness when not empowered to resist systemic oppressions. Mastery and control of abilities and environment are required to achieve overall wellness while connected to powerlessness as power is gained through access to resources (through mastering one’s environment) and personal characteristics (abilities) combating oppression (Prilleltensky, 2000). AF persons’ struggles to negotiate heterosexist systemic structures (DiPlacido, 1998), patriarchy (Fassinger, 2000; Gonzalez, 2007), and actual discriminatory policies (Israel & Mohr, 2004; Kitzinger, 1996) impact attaining mastery and control of environment (Sen, 1999).

Investigating the beliefs of AF persons about wellness is relevant for mental health counselors as this research can be utilized to implement culturally relevant interventions and techniques for clients seeking optimal wellness and overall physical/mental health (Dew & Newton, 2005). Rather than continuing to subject AF persons to systemic counseling structures not fit for lived experiences, culturally competent (Lee, 2008) and affirmative mental health counselors can address preventative wellness measures; contributing to positive outcomes for clients in optimizing wellness
beliefs about wellness will allow counselors to focus interventions on one or two particular areas pertinent for AF persons, a strategy in wellness counseling recommended by Granello (2013) to create positive growth.

**Purpose and Rationale**

The purpose of the present study is to explore AF persons’ beliefs about wellness. Understanding and conceptualizing these beliefs may assist counselors in developing interventions/techniques optimizing the wellness of the AF population. Exploration of AF beliefs is pertinent as AF persons are wedged between lesbian-gay and heterosexual communities (Macalister, 2003) leading to discrimination, oppression, and marginalization (Balsam et al., 2004) correlating with high rates of anxiety, depression, substance abuse, self-injury, and suicide (D’Augelli et al., 2005). A Q-methodology study (Stephenson, 1953, 1977) explores beliefs (S. R. Brown, 1996, 2008) from diverse AF identities (Boykin, 2005; Firestein, 1996; Gonzalez, 2007) about the elements of wellness (Myers & Sweeney, 2005). An ideal and predicted outcome of the study is knowledge leading to interventions and techniques optimal for AF person’s wellness (Dew & Newton, 2005).

**Definition of Terms**

In the study of AF issues and wellness in counseling, there is an important body of terms to be defined. Language utilized to describe wellness and affectional orientation is in a constant state of flux and development (Granello, 2013; Harper et al., 2013). This list is meant to satisfy the needs for the current study. The author acknowledges many of
these terms may be updated and newer terms may emerge within the timespan of this study. Current terms, including those defined within the context of this study, are referenced in the following section.

**Affectional orientation:** “refers to the direction (sex, gender identity/expression) an individual is predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally” (Harper et al., 2013, p. 38). Utilized as a developed definition from “sexual orientation” more accurately representing (Crethar & Vargas, 2007; Wells, 1989) the “multiple layers of relationships (emotional, physical, spiritual and mental)” while lessening the impact of “sexual behavior as sole means of understanding identity” (Harper et al., 2013, p. 38; Klein, 1990).

**Affectionally fluid:** describes the multiple layers of relationships including sexual/affectional behaviors, spiritual, mental, attractions and relational patterns not specified within the homosexual/heterosexual binary system and includes identities not described as “straight or gay” (Diamond, 2008a, 2008b; Harper et al., 2013, p. 39; Klein, 1990, 1999); including self-identifications of bisexual, queer, questioning, and fluid (Diamond, 2008a, 2008b; Kinsey, Pomeroy, & Martin, 1948; Klein, 1993).

**Ally:** term for person who “provides therapeutic or personal support respectively, to a person or persons who self-identify as lesbian, gay, bisexual, transgender, queer, questioning and intersex (LGBTQQI)” and may include “friends, family, significant others, colleagues/associates, mentors, those who seek counseling before they identify as allies and may be heterosexual and cisgender, and/or members of the” LGBTQQI community (Harper et al., 2013, pp. 38-39; Poynter, 1999; Poynter & Washington, 2005).
**Biphobia**: described as “an aversion, fear, hatred or intolerance of individuals who are bisexual or of things associated with their culture or way of being” (Harper et al., 2013, p. 39).

**Bisexual**: known as a person who “is emotionally, physically, and/or spiritually oriented to bond and share affection” with multiple and/or all genders (Harper et al., 2013, p. 39; Petford, 2005).

**Cisgender**: a person “whose gender identity aligns with the sex and gender they were assigned at birth” (Harper et al., 2013, p. 39).

**Coming out**: defined as both a continual “personal process of understanding, accepting and valuing one’s affectional orientation and gender identity” and “an interpersonal process of sharing that information with others” (Harper et al., 2013, pp. 39-40).

**Down low**: individuals may have opposite gender affectional/sexual relationships but also have sexual and emotional relationships with the same gender yet do not identify as gay or bisexual (Gonzalez, 2007; Harper et al., 2013). Many of these persons may hide sexual behaviors, affections, and so forth, for fear of reprisals in their cultural communities, particularly the Black (Boykin, 2005) and Latino/a populations (Gonzalez, 2007).

**Gay**: a self-identified man “who is emotionally, physically, mentally and/or spiritually oriented to bond and share affection with other men” (Harper et al., 2013, p. 40). This term is also utilized in referring to the entire affectional and gender diverse
community as a political, social, and communal identity (Dew & Newton, 2005; Sue, 2010).

**Gender:** “One’s identity and expression (clothing, pronoun choice, how you walk, talk, carry yourself) as women, men, androgynous, transgender, genderqueer, gender nonconforming, and so on that may or may not line up as socially constructed with one’s biological sex” (Harper et al., 2013, p. 40).

**Gender expression:** physical manifestation of “one’s gender identity through clothing, hairstyle, mannerisms, and other characteristics” through a societal lens of gender based in masculinity/femininity (Harper et al., 2013, p. 40).

**Health:** “is a state of complete physical, mental and social well-being and not merely the absence of infirmity or disease” (World Health Organization, 1948, p. 100).

**Heteronormative:** the prevailing societal bias all persons “follow or should follow traditional norms of heterosexuality” and gender norms of men showcasing masculinity while women display femininity (Harper et al., 2013, p. 41).

**Heterosexism:** an assumption (passed down generationally through socialization) all persons are heterosexual and ought to be, thus silencing or making invisible the lives of LGBTQQIA persons through marginalization, vilification, and stigmatization (Harper et al., 2013). Like racism, sexism, and other “isms,” heterosexism is represented in overt, covert, and subtle forms. An example of overt heterosexism is when assumptions are made that an individual partnered with a person of the opposite gender (Harper et al., 2013; Sue & Sue, 2008).
**Heterosexual:** a term utilized in describing “an individual who is emotionally, physically, and/or spiritually oriented to bond and share affection with those of the opposite sex” (Harper et al., 2013, p. 41).

**Holistic model:** healthcare delivery paradigm focusing on treating the whole individual, community, and/or group including aspects of wellness such as prevention through consideration of activity, alternative treatments (culturally-based), creative outlets, cultural identity and expressions, mental wellbeing, nutrition, social wellness, and so forth. This model extends the medical model’s perspective to include methods of preventative health/wellness care outside of traditional medicine (Granello, 2013).

**Homosexual:** a historical term utilized in description of a man or woman who is “emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with those of the same sex” (Harper et al., 2013, p. 41). It is noted many in the LGBTQQIA community do not utilize this term because of its etymological cousin homosexuality’s derogatory notation as a mental disorder in the *DSM* and other studies (Hooker, 1993).

**Homophobia:** the “aversion, fear, hatred, or intolerance” of LGBTQQIA persons and anything associated “with their culture or way of being” (Harper et al., 2013).

**Internalized homophobia:** occurs when LGBTQQIA persons believe they deserve negative treatment through identifying as part of or associating with the LGBTQQIA community (Sophie, 1987).

**Lesbian:** “a woman who is emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with other women” (Harper et al., 2013, p. 42).
Medical model: “pathogenic, reductionist, and disease focus” healthcare delivery paradigm focused on treatment of existing illnesses (Granello, 2013, p. 8). This model demonstrates great success in drastically reducing and/or eliminating communicable diseases and treating acute trauma yet does not often coordinate prevention for chronic conditions (Granello, 2013).

Microaggressions: term for “brief, everyday exchanges that send denigrating messages” first to persons of certain racial groups (other than White persons) but extended for this review to LGBTQQI persons (Sue et al., 2007, p. 273). These acts are often subtle and noted in verbal, nonverbal, visual, or behavioral realms and conducted routinely and unconsciously (Solorzano, Ceja, & Yosso, 2000).

Omnisexual: similar to identification of bisexual but specifically defined as a person who has sexual/affectional relationships with persons of all gender representations, including persons who identify as transgender and intersex (Harper et al., 2013). Many bisexual persons note having affectional relationships with only men or women (Harper et al., 2013).

Oppression: the blend of prejudice and power affecting dominance of privileged groups over marginalized groups and can include systems such as racism, heterosexism, biphobia, and so forth (ACA, 2010).

Pansexual: similar to identification of bisexual but utilized synonymously with omnisexual as affectional relationships are experienced with all, not only two, genders. A person (regardless of gender identification) who is “emotionally, physically, mentally, and/or spiritually oriented to bond and share affection with any (gender of) person”
regardless of their biological (or assigned) sex, gender expression, or identity (adapted from definition from Harper et al., 2013).

*Privilege:* “social and institutional advantages that dominant groups receive and others do not . . . often invisible to those who have it” (ACA, 2010, p. 159).

*Queer:* generally refers to individuals who identify outside of the heteronormative imperative and/or the gender binary, may also describe the gay community as a whole or denote a political/social affiliation focused upon lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQQI) rights (Dilley, 2002; Harper et al., 2013).

*Questioning:* individuals existing in a state of confusion regarding whether they are “emotionally, spiritually, and/or physically attracted” to multiple genders. Clinicians may identify persons who are questioning by this term but those questioning do not necessarily identify themselves as such (Harper et al., 2013). This term usually refers to the process of coming out where self-identification has yet to occur (Legate et al., 2012).

*Racism:* “oppression, harassment, discrimination, prejudice, microaggressions . . . targeted toward people because of their race or ethnicity . . . includes the belief one race is better than others, historically seen as systemic laws and policies that prefer colonizers and conquerers over Indigenous peoples and other people of color” (Harper et al., 2013, p. 43).

*Sex:* “a person’s sexual anatomy, chromosomes, and hormones . . . determined by the words society” has chosen to represent their assigned sex at birth (Harper et al., 2013, p. 42).
Sexism: Traditionally this is a term defining the unequal and unjust treatment of women (Sue & Sue, 2008) and occurs in overt, covert, and subtle forms (Swim, Mallett, & Stangor, 2004). For this document an expanded enumeration is “oppression, harassment, discrimination, prejudice, microaggressions, and so forth targeted towards people because of their biological sex” (Harper et al., 2013, p. 43).

Two-spirit: persons described by Native Americans who balance gender identifications/roles and/or whose orientation is characterized by affectional and/or gender fluidity (Balsam et al., 2004).

Unidentified: persons encompassed under the varying behaviors of “heterosexually-identified” (Kinsey et al., 1948). These persons demonstrate same-gender attraction/behavior/affectional alignment but do not identify as a member of affectionally diverse communities (Vrangalova & Savin-Williams, 2010).

Wellness: “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving” (Myers, Sweeney, & Witmer, 2000, p. 252).

Wellness model: prevention-oriented, “salutogenic (health enhancing) focus . . . related to constant striving for optimal functioning” for both mental health and medical issues (Granello, 2013, p. 8).

Review of Literature

This chapter reviews the current scholarship involving wellness through the conceptualizations of health, wellness history, models and research followed by literature
involving AF persons, affirmative and culturally competent counseling with AF persons. Intersections between AF persons and wellness in the literature are explored last. The wider range of literature outside of counseling is important for both areas but there is no specific literature for AF persons as this term was created by the researcher for this inquiry (Dew & Newton, 2005). There is limited research regarding wellness for any of the identities and non-identifying individuals termed AF persons. Thus, in order to supplement literature specific to AF persons, the review includes some literature involving the larger LGBTQIA community and identities representing AF persons including bisexual, down-low, queer, and so forth (Harper et al., 2013). In addition wellness is explored through specific literature culturally relevant and affirming for AF persons (Bradford, 2004, 2006).

As noted, there is a need for exploration of AF persons’ beliefs about wellness for several reasons. AF persons are often caught between communities (Macalister, 2003; McLean, 2008), therefore may not exhibit an “out” identity or socially acceptable placement (Griffin, 2009) in either the heterosexual or gay/lesbian communities (Brickell, 2006; Firestein, 1996). The discrimination, oppression, and marginalization experienced by AF persons (Balsam et al., 2004) correlates with high incidences of depression, anxiety, and substance abuse (D’Augelli, 1998; NAMI, 2007), and heightened risk of suicide and self-injury (D’Augelli et al., 2005).

Wellness is impacted by many factors (e.g., a lack of belonging, positive/negative coping skills, inadequate resources; D’Augelli, 1998; Myers & Sweeney, 2005) and contexts (local, communal, systemic, political; Myers & Sweeney, 2008). The
convergence of individual/communal factors and contexts influence subjective perceptions of wellness representation for a diverse community of AF persons (Camarena & Rutter, 2015; Ketz & Israel, 2002; Legate et al., 2012). Wellness as a construct is explored through the contexts of health, models, and relevant literature below.

**Wellness History, Models and Research Pertinent to AF Persons**

The construct of wellness has developed over time, from ancient Greek lore to the philosopher Descartes (Myers & Sweeney, 2005). The concept of wellness is still important today as health care systems can shift towards a preventative tone. A preventative, holistic counseling approach emphasizes wellness as an essential tool, both in assessment and practice for all professionals, especially counselors (Granello, 2013; Myers & Sweeney, 2005). This holistic shift can uncover an opportunity for counselors to develop evidenced-based treatments based upon emotional, physical, psychological, social, and wellbeing.

Evidence-based treatments can assist in providing appropriate wellness modalities through managed-care environments (Granello, 2013) and build upon the counseling profession’s current emphasis on demonstrating concrete support for treatment modalities (Yates, 2013). This shift may be particularly applicable for counselors who desire to provide preventative care while also fostering resiliency and empowerment for AF clients marginalized by society (Granello, 2013; Prilleltensky, 2008).

Wellness has become an instrumental component of differentiating the profession of counseling from other mental health professions. In fact, at pertinent points within the development of the American Counseling Association (ACA), formerly known as the
American Association for Counseling and Development (AACD), wellness has represented the prominent difference between counseling and other mental health professions (Myers & Sweeney, 2005). Wellness is a prominent goal in ACA’s 20/20 definition of counseling (Kaplan & Gladding, 2011). Rationale for its worthiness as a functional modality and/or lens for clinical practice and research is explored concurrently in order to describe the literature in the field.

**Definitions of wellness.** To understand wellness and its connection to counseling, a definition within the context of counseling is needed. As Myers and Sweeney (2005) noted, Aristotle first wrote of finding a balance between “excess and deficiency” in the fifth-century B.C. (p. 7). Various other authors and organizations give reputable definitions based respective to areas of study including: philosophers, physicians, and health associations such as the World Health Organization (WHO, 1948). Many of these definitions represent wellness as a stagnant condition, from which no movement is seen in either direction. According to many non-counseling sources a person is either well or unwell (Granello, 2013). In the counseling sphere this passive definition does not inform a constantly evolving, multidimensional practice based in lifelong growth (Myers & Sweeney, 2005). After analyzing interdisciplinary literature and conducting more research than any other authors in the field of counseling, Myers et al. (2000) described wellness as:

A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the
human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

In effect, this definition suits counselors because it describes wellness not as an inert condition but as a progressive, developmental change in the entirety of the person. Roach and Young (2007) concurred on a counseling definition of wellness that “pervades all aspects of the person” (p. 32).

Myers and Sweeney (2005) noted the counseling profession delineates wellness as a pertinent aspect of how counselors conceptualize, assess, and treat client issues. This stance conflicts with other mental health professions who stress the medical model as central to conceptualization, assessment, and treatment (Granello, 2013). A central theme of the wellness model is how counselors use it to evaluate what is “well” with a client rather than wrong thus shifting assessment dialogue from illness to wellness (Myers & Sweeney, 2005; Myers et al., 2000). This shift localizes and strengthens the tie between wellness and the practice of counseling even as illness model elements such as diagnosing remain prevalent in clinical practice (Myers & Sweeney, 2005).

**Wellness models.** Models of wellness often show a progressive nature denoted within distinguishable figures. According to Myers and Sweeney (2005), interdisciplinary models of wellness became more complex over the years, from wellness pioneer Hal Dunn’s (1961) “interlocking circles of body, mind and spirit of man” to Hettler’s (1984) hexagon that describes six mechanisms of wellness: physical, emotional, occupational, social, intellectual, and spiritual (p. 10). Hettler’s model is used for several
assessment measures (Myers & Sweeney, 2005). Other models denote wellness along a continuum rather than a figure (Travis & Ryan, 1988).

Travis and Ryan (1988) displayed wellness upon a continuum where illness signifies one end with exceptional wellness denoting the other. Illness was defined through utilization of the medical model in which a person usually progresses to debilitating health until death. Exceptional wellness was constituted by attentiveness to health needs, education, and positive personal growth (Travis & Ryan, 1988). The middle of the continuum is a “neutral state wherein illness is absent . . . and so is wellness” (Myers & Sweeney, 2005, p. 10). This model, while providing a continuum, is not effective in delineating a full spectrum of health through a clear health model.

Ardell’s (1977) wellness models represent some of the most detailed representations of wellness, becoming more specific over time. Ardell’s first model was a single circle with self-responsibility in the middle surrounded by four equally contributive elements: nutritional awareness, stress management, physical fitness, and environmental sensitivity. Ardell’s most recent work is characterized by a physical domain, mental domain, and meaning/purpose section (as cited in Myers & Sweeney, 2005). The mental domain is comprised of emotional intelligence, effective decisions, stress management, factual knowledge, and mental health. The meaning and purpose section consists of meaning and purpose subcomponent, relationships, humor, and play. Contained within the physical domain are exercise and fitness, nutrition, appearance, adaptations/challenges, and lifestyle habits (Ardell, 1977).
Ardell’s model hypothesized many of the counseling profession’s conceptualizations of holistic care through the multiple domains noted (Ardell, 1977; Myers & Sweeney, 2005). This attention to detail in several areas represented the most thorough wellness model before Sweeney and Witmer (1991) created the Wheel of Wellness utilizing a meta-analysis of previous literature involving wellness. In an effort to recognize how models directly correlate with client concerns an exploration of counseling wellness models is explored.

Counseling-based wellness models. As often is noted in counseling, a model is useless without application. Sweeney and Witmer (1991) theorized the Wheel of Wellness from an analysis of inter-disciplinary studies in an effort to recognize associates of health, value of life and endurance. After application through empirical study Myers et al. (2000) expanded this Adlerian-based model to greater form with spirituality at its center with 12 spokes originating from the life-task of self-direction. Spokes included cultural identity, gender identity, stress management, self-care, exercise, nutrition, sense of humor, problem solving and creativity, emotional awareness and coping, realistic beliefs, sense of control, and sense of worth. These spokes served to direct a person when responding to the Adlerian life tasks of love, work, and leisure, and friendship. Outside environmental influences, such as: education, religion, family, community, government, media, and business/industry are noted due to inherent ecological influence upon the wellness of the individual (Myers et al., 2000).

The Wheel of Wellness is the foundation of the assessment instrument known as the Wellness Evaluation of Lifestyle (WEL), which has been utilized widely in seminars,
workshops, and empirical research studies (Cox, 2003; Kagee, 2003). Myers and Sweeney (2008) reported the Wellness Wheel is useful both as an assessment tool and in the therapeutic stages of wellness counseling but “statistical analyses failed to support the hypothesized circumplex structure and the centrality of spirituality relative to other components of wellness” (p. 484).

Myers and Sweeney (2008) utilized a meta-analysis of WEL studies in constructing The Indivisible Self (IS-WEL) model to represent the notions of wellness in an effective empirical manner. The researchers rotated back towards Adlerian notions of the self, particularly the unity of the individual (Myers & Sweeney, 2005). The grouping of the 17 factors changed dramatically due to application of empirical data. Findings showed the standardized factor loadings were “statistically significantly different than 0 and quite substantial” (Myers & Sweeney, 2005, p. 272).

The Indivisible Self Model of Wellness represents the most comprehensive wellness model to date. Five Adlerian parts of self (second order factors) include: essential, creative, coping, social, and physical were developed and are explored through sub-components (Myers & Sweeney, 2005). The essential self is composed of “spirituality, gender identity, cultural identity and self-care” (p. 30). The creative self lists “thinking, emotions, control, positive humor, and work” as sub-factors (p. 31). “Realistic beliefs, stress management, self-worth and leisure” are elements of the coping self (p. 31). The social self has two widely encompassing elements: “love and friendship” (p. 31). “Exercise and nutrition” compose the two elements of the physical self (p. 31). From these factors comes an ecological context, in which a person is both
changed by and creates change to their environment (Myers & Sweeney, 2008). This change the person makes to the environment and the affect on the person is delineated clearly by Prilleltensky (2005, 2008), as part of overcoming oppression and reaching wellness “liberation” (Prilleltensky & Prilleltensky, 2003, p. 273). The environmental contexts in the Indivisible Self Model include “local, institutional and global,” all existing through the developmental “chronometrical” context (Myers & Sweeney, 2005, p. 35).

The most empirically substantial of these contexts is the local, where meaningful results are demonstrated throughout diverse populations (Myers & Sweeney, 2005). The local context includes environments where humans most regularly interact such as family, work, and community. Institutional contexts include “religion, government, business and industry, the media and education” (p. 35). Global contexts consist of current natural environments, politics, and worldwide events, whereas the chronometrical context describes how people progress over time. The local, institutional, and global contexts represent where liberation and social justice efforts combating oppression, discrimination, and subjugation begin but are translated across chronometrical contexts (Prilleltensky & Prilleltensky, 2003). The chronometrical context lends credence of wellness to the counseling profession’s adherence to a lifelong developmental lens (Myers & Sweeney, 2005, p. 35; Myers & Sweeney, 2008). Myers and Sweeney (2008) developed the assessment tool known as the Five Factor Wellness Inventory (5F-WEL) from this new theory. This assessment tool, like its precursor, is utilized often in wellness research (Myers & Sweeney, 2005) and demonstrates empirical viability in
measuring the constructs of wellness (Longborg, 2004) alongside excellent validity and reliability (DeMauro, 2007).

The wellness models above delineate the importance of wellness to counselors and the counseling paradigm, as all components can affect mental health and wellbeing (Myers & Sweeney, 2005). For a more distinct discussion of wellness as worthy and implications for clinical practice and research with AF persons, an exploration of wellness literature is conducted. An important distinction is how most studies in the field of counseling base representations of wellness through Myers and Sweeney’s theoretical models and assessment tools (WEL, 5F WEL; Myers & Sweeney, 2005, 2008). In addition, several studies in counseling comprising wellness definitions and models not informed by the Indivisible Self Model are included due to distinct language and definition similarities.

**Wellness research with undergraduates.** Initial EBSCO searches including keywords of “wellness” and “counseling” elicited over 1,300 articles, many of which did not fit criteria desired for the current review due to limited definitions of either construct and/or limited applicability to the current study. Many studies casually utilize the term wellness without referencing counseling literature, theoretical models, or constructs related to wellness. Thus, limiters including the keywords of “wellness” and “counselors” along with specifiers “peer-reviewed,” “full-text available,” and a publication date within the previous 7 years were utilized in refining results. This refinement of search queries was deemed relevant as most studies were not relevant to counselor education, counseling practice, or wellness practice in counseling (EBSCO, 12-
8-2015). To begin the review several pieces of seminal literature outside the last 7 years are utilized in building the topic of wellness in practice, theory, and study.

Many empirical studies and synthesized literature analyses utilize undergraduate college students, including Osborn’s (2005) review for a chapter in *Counseling for Wellness: Theory, Research and Practice* (as cited in Myers & Sweeney, 2005). Osborn (2005) found spirituality and coping behaviors were realms in which students demonstrated lower wellness scores whereas students scored higher in the physical and social dimensions. These results mirror outcomes from participants in other studies who commonly believe wellness is oriented towards physical but not necessarily spiritual health or the actual self-care strategies predictive of overall physical, mental, spiritual and emotional wellness (Venart, Vassos, & Pitcher-Heft, 2007). Wellness beliefs emphasizing physical health may affect overall conceptions of wellness as participants often demonstrate a lack of awareness of other central tenets including positive coping, cultural, spiritual, and emotional wellness (Osborn, 2005). Certain studies measured nontraditional undergraduate students alongside traditional students, noting nontraditional minority students scored lower on self-care and spiritual measures (Mobley, 2003).

In addition to the differences regarding minority and student status, Mobley (2003) also reported undergraduates consistently scored lower than non-students on overall wellness. Stressors such as balancing school and work may impact undergraduates in these wellness constructs whereas those who return to gain an education later in life are likely balancing family, work, and academics while possibly negotiating systemic marginalization. Both Osborn’s (2005) and Mobley’s (2003)
studies suggest pertinent wellness issues for undergraduate students in several of the areas of wellness measured by the 5F-WEL (Myers & Sweeney, 2005).

Watson and Kissinger (2007) utilized a wellness lens to investigate differences between student-athletes and routine students in psychological adjustment. Previous research showed positive rewards for those participating in collegiate athletes but also demonstrated mental health and wellness issues at a higher rate (10-15%) than non-athletes (8-9%; Watson & Kissinger, 2007). In this study Watson and Kissinger (2007) found student-athletes self-reported lower wellness levels than non-athletes, contradicting previous study. These contradicting studies create confusion regarding student athletes’ wellness but also note issues in measuring college students in general.

**Wellness in counselor education.** In counselor education (CE) wellness is often represented through data concerning counseling students, which correspond with the notions of wellness being paramount to counselor identity and practice (Fetter & Koch, 2009; Hermann & Herlihy, 2006). Counselor education programs stress personal wellness as crucial to the progress of counseling students (CACREP, 2009). Multiple authors noted graduate counseling students demonstrate higher reported wellness levels than other groups (Lambie, Smith, & Leva, 2009) yet many enter with mental health issues and multiple stressors (Longfield, Romas, & Irwin, 2006).

Smith, Robinson, and Young (2007) reported Master’s level counselor trainees demonstrate elevated levels of psychological distress when levels of wellness are low. The authors believed wellness inventories may serve as a “screening tool to identify both strengths and lack of distress in counseling students” (p. 104). Roach (2005) previously
identified how students exposed to wellness in the curriculum demonstrated higher wellness scores. Roach and Young (2007) analyzed results by identifying levels of wellness in students as both a supervision and ethical dilemma, as counselor impairment leads to failure in the counseling relationship. The authors called for “wellness as a unifying philosophy in counselor education” (p. 27). Overall results for counseling students demonstrate the importance of wellness (including self-care; Myers & Sweeney, 2005) for effective clinical treatment of clients (Roach & Young, 2007).

Burck, Bruneau, Baker, and Ellison (2014) utilized focus groups in studying perceptions of wellness among students finding several interesting themes including wellness as: “an important, complex construct . . . unique to the individual (and) an opening of the eyes through awareness, translation, and integration” along with several recommendations from developing counselors (p. 42). These recommendations may serve AF persons well as the focus group participants continually noted individual differences in the definition of wellness with commonalities such as physical (delineated as exercise, nutrition and recreation) and emotional wellness (spiritual, mental health, social, and of “relaxation methods;” Burck et al., 2014, p. 43). These participants reported wellness education and support from faculty and supervisors as pertinent while also utilizing modeling when working with clients during practicum and internship settings. Balance was stressed as an absolutely essential component of a wellness plan, deemed relevant during graduate education and clinical experiences (Burck et al., 2014).

Clinical experiences for students and professionals under supervision impact self-care and overall wellness (Lenz, Oliver, & Sangganjanavanich, 2014). The gatekeeping
role of clinical supervisors is explored through theoretical study integrating wellness into supervision models (Lenz & Smith, 2010). Later this concept was studied through comparative analysis (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012) and qualitative research (Lenz et al., 2014). Results of these studies align with theoretical constructs of wellness found in Myers and Sweeney models (2005, 2008) and complement the supervisory relationship by developing counselors’ training in both qualitative and quantitative research (Lenz et al., 2012, 2014). Supervision research in wellness is paramount in effective preparation of students and new professionals for clinical work. As multiple authors describe clinical experience as frustrating, challenging, and traumatic while also rewarding it is pertinent that self-care is optimized (Lawson, 2007; Lawson & Myers, 2011).

Barden, Conley, and Young (2015) proposed bringing wellness further into the classroom by implementing courses and delineating clear competency for utilization in the curriculum, clinical practice, and counseling field. Current accreditation standards encourage wellness integration into curriculum, but without clear competencies, students may not recognize wellness or when to implement effective interventions (Barden et al., 2015; CACREP, 2009). The issue of well-timed interventions was tackled heavily in two texts from leaders in the wellness counseling literature, Counseling for Wellness: Theory, Research, and Practice (Myers & Sweeney, 2005) and Wellness Counseling (Granello, 2013) but empirical research on actual clinical interventions outside these edited texts is limited.
**Wellness in counselor populations.** Several studies have been conducted in an effort to measure wellness for licensed professional counselors. Mobley (2003) studied wellness in 289 male licensed professional counselors in regards to gender role conflict and training. Findings included better wellness and less gender role conflict than other populations of men (Mobley, 2003). Lawson (2007) surveyed 501 practicing helping professionals, discovering wellness and occupational satisfaction were related to counselors scoring more positively on burnout and fatigue than other professionals (Lawson, 2007). Later, results from Lawson and Myers’ (2011) study of 506 professional members of ACA showed correlations between high wellness and “professional quality of life” scores alongside active engagement in “career-sustaining behaviors” (pp. 167-168).

Literature concerning wellness with practitioners includes theoretical assertions about what counselors can accomplish to maintain wellness (Venart et al., 2007) and inquiry into the power of the counseling relationship in modeling wellness for clients (Neswald-Potter, Blackburn, & Noel, 2013). Tips and techniques are often described including maintaining a reasonable client load, finding moments to relax in between sessions, and fostering effective self-care strategies in and outside the occupational environment (Venart et al., 2007). Modeling a well lifestyle is described as an effective intervention for both clients and counselors as implementation promotes positive outcomes for clients and counselors actually “walk the walk” of a wellness orientation (Neswald-Potter et al., 2013). This modeling becomes practice through wellness
counseling, explored in depth later when crystallized alongside AF literature. In the next section the population under study, AF persons, is explored in depth.

**Literature Involving Affectionally Fluid Persons**

Sexual orientation has historically been described as one’s “physical, emotional and erotic attractions” (Mulick & Wright, 2002, p. 47). The updated term utilized for this study, affectional orientation, exemplifies the “multiple layers of relationships” (Harper et al., 2013, p. 38) in which AF persons invest while rejecting the uninformed stereotype of behavior as the sole means of constructing identity (Crethar & Vargas, 2007; Klein, 1993; Wells, 1989). These definitions inform the contextual literature review below and assist in representing LGBTQQIA persons as a community and AF persons as the specific population within this community under current study.

Within this review a vested pursuit of literature where participants’ personal identifications are valued, as affirmative counselors openly accept a client’s identification rather than positioning their client upon the continuum of orientation (Dillon et al., 2004; Finnerty, Lutes, Kocet, & Yates, 2017b). Unfortunately, many studies delineate orientation identifications based upon behaviors, attractions, thoughts, and so forth, and in order to deliver appropriate review these studies must be utilized (Diamond, 2008b; Harper et al., 2013). In researching this topic the closest and most common identification found in the literature through several searches utilizing the EBSCO search engine was bisexual. Some research includes unidentified persons and those identified by researchers as on the down low (Boykin, 2005; Gonzalez, 2007), fluid (Diamond, 2008a, 2008b) as well as pansexual, queer, and omnisexual (Harper et al., 2013). As such,
literature utilized in the review is theoretical, empirical, and qualitative scholarship involving participants labeled by researchers as bisexual.

In description, AF persons align closely with description provided by the Sexual Orientation Grid constructs noted by Klein (1990, 1993, 1999) which conceptualize orientation as more than sexual behavior by encapsulating emotional attachment, relational status, and community engagement amongst other factors (Klein, Sepekoff, & Wolf, 1985). This developed definition serves to disavow and debunk the common stereotypes of affectionally and gender diverse populations (Moe et al., 2014), particularly AF persons, often represented only by sexual behavior through biphobic notions of promiscuousness, uncommitted to platonic relationships, STD-carrying, and so forth (Bennett, 1992; Herek, 2002; McLean, 2008; Ochs, 1996; Rust, 1993; Spalding & Peplau, 1997). Thus, the term “affectionally fluid” is utilized to paint an accurate picture of orientation involving emotional, sexual, relational, and affectional orientation towards others (Crethar & Vargas, 2007; Diamond, 2008b; Harper et al., 2013). Recognition of the wide spectrum within the population of AF persons, both in the context of the overall LGBTQQIA community and on its own, is explored below.

Population of AF and LGBTQQIA persons. An overall lack of representation of AF persons in population estimates is demonstrated through the major empirical and populations studies (Gates & Newport, 2013; Meyer & Wilson, 2009). This lack of acceptable data transcends studies and minimizes the actual numbers of those who either identify as AF or exhibit concurrent behaviors. Overall, the share of self-identified lesbian, gay, bisexual, and transgender persons in the United States ranges from 3.5–
3.8% to a varied degree between states/territories ranging from 10% in the District of Columbia to 1.7% in North Dakota (Gates & Newport, 2013). Larger empirical studies such as the Center for Disease Control’s *Sexual Orientation and Health Among U.S. Adults: National Health Interview* representing 34,557 adults of whom 1.6% identified as gay/lesbian, 0.7% as bisexual, and interestingly enough, 1.1% identified as “something else,” “I don’t know,” or did not answer (Ward, Dahlhamer, Galinsky, & Joestl, 2014, p. 1). These studies do not take into consideration any self-identifications other than the four noted above.

Those who identified orientation as “something else” or “I don’t know” were dropped from the analyses thus limiting the ability to, at the very least, identify as anything other than lesbian/gay, straight, and bisexual (Ward et al., 2014, p. 3). This limits both the generalizability of the results and demonstrates disinterest from researchers for participants who may not identify directly with the binary terms lesbian or gay while allowing for identification as bisexual (Meyer & Wilson, 2009). Many studies in the past have dropped those who did not identify as heterosexual or gay/lesbian creating more difficulty for AF persons of all identifications or non-identifications to be utilized as effective participants in social science research (Adams & Phillips, 2009; Bennett, 1992; Meyer & Wilson, 2009).

The CDC’s recent *National Health Statistics Report* (2016) regarding sexual behavior, attraction, and orientation (9,175 participants age 18–44) from the data set for the *National Survey for Family Growth* (2011–2013) measured and found an uptick in bisexual identification (5.5% for women and 2% for men) and same-sex sexual behaviors
(CDC, 2016, p. 1). Interestingly, the percentages of persons who noted “don’t know” or “refused” to provide identification were 0.9% for women and 1% for men (CDC, 2016, p. 1), again noting fluidity in respect to orientation and possibly adding to those who do not identify in binary terms (Brickell, 2006; Harper et al., 2013). Heterosexual identification was 92.3% for women and 95.1% for men whereas gay and lesbian identification was 1.3% for women and 1.9% for men (CDC, 2016, p. 1).

Same-gender sexual behavior relates a different storyline as 17.4% of women and 6.2% of men reported “same-sex contact” within “their lifetime” (CDC, 2016, p. 1). Coupled with the results for attraction, which demonstrate many more participants experienced same-gender attraction at some point (nearly 8% for men and “20% for women”); a clear discrepancy between identification and other measures of orientation (attraction, sexual behavior, etc.) are found (CDC, 2016, p. 1). This is similar to findings in several other major findings as far back as the Kinsey et al. studies (1948, 1953), developed further by Klein (Klein, 1990, 1993; Klein et al., 1985). Other interesting findings include differences in ethnicity as 19.6% of White women and 19.4% of Black women note sexual contact with other women but Hispanic women report 11.2%, a marked difference (CDC, 2016, p. 7).

Some pertinent concerns related to question content may explain some of the differences in reporting between men and women as a wider breadth of experiences was asked of women (“any sexual experiences” with another woman) versus men who were asked about specific behaviors (only “anal or oral sex” with another man; CDC, 2016, p. 2). This demonstrates methodological issues the CDC authors admit to, yet the overall
results suggest shifting self-report findings from the last iteration of this report noted in the discussion (CDC, 2016). Usual validity issues for self-report scales are inherent (Heppner, Wampold, & Kivlighan, 2008) yet this study seems to raise the bar slightly in conceptualizing more than binary representations of orientation (Brickell, 2006; Griffin, 2009).

**Self-identification.** Singh and Gonzalez (n.d.) denoted the pertinent structural issue with the above studies and identifying AF persons in counseling generally, whether a person self-identifies as AF. Weinrich (2014) challenged the insinuation regarding self-identity as social science studies researchers estimating the number of AF persons demonstrate limited ability in asking appropriate questions regarding affectional orientation/gender identity. There is often a lack of control and/or accurate description for a myriad of factors purportedly measuring affectional orientation including: sexual behavior, relational/affectional affirmations, attraction, fantasies, and so forth (Singh & Gonzalez, n.d.). Weinrich (2014) recognized issues inherent to inquiry regarding affectional identification including: limited participant understanding of terms, salience and fluctuating of identities over time, participant identification of differential terms, and unsound categorical terms utilized to designate identifications.

Meyer and Wilson (2009) recognized similar concerns in sampling LGB populations, as “the population’s definition is elusive” (p. 23). According to these and other authors, LGBTQIA persons do not identify as such without accomplishing several developmental milestones including coming out to themselves, friends, family, coworkers, and so forth (Cass, 1996; Eliason, 1996; Meyer & Wilson, 2009). On top of
this inherent issue there exists even more variability when cultural mores permeate
descriptions as those who may qualify as participants often will not identify as such due
to ethnic, racial, gender, and other perceptions of LGBTQIA identity (Balsam, Molina,
Beadnell, Simoni, & Walters, 2011; Jamil, Harper, & Fernandez, 2009; Jones &
McEwen, 2000). All of these factors impact how many persons may specifically identify
as AF when being counted by either large public surveying companies (Gates &
Newport, 2013) or social science researchers (Eliason, 1996, Meyer & Wilson, 2009).

**Clarity for populations of AF persons in research.** Seminal work in bisexuality
from Kinsey et al. (1948, 1953), Wolff (1977), Klein (1993), and Firestein (1996)
demonstrated a similar lack of clarity in affectional orientation identification within the
population of AF persons to the overall LGBTQIA community as often mislabeling
occurs. Ketz and Israel (2002) believed this is related to the gender of the current partner
(i.e., woman who is in relationship with woman is presumed to be a lesbian, man in
relationship with woman presumed to be heterosexual). These authors cited
methodological issues with utilizing actual behavior as the primary means of identifying
orientation within participants and then discerning correlation, demographics, and so
forth, based upon those results. These include the previously noted
mislabeled/misidentification issues (Meyer & Wilson, 2009; Weinrich, 2014) leading to
construct validity issues (Ketz & Israel, 2002; Heppner et al., 2008).

If a researcher utilizes singular measures such as self-identification and sexual
behavior to discern orientation other relevant factors such as personal lifestyle, sexual
attraction and fantasies, affections, emotional and/or social/community connections noted
by Klein (1993) in the “Klein Sexual Orientation Grid” are ignored. All of these factors matter for AF persons as they represent a wide variety of actual identifications and perhaps more importantly for those along the continuum, lack of self-identifications (Harper et al., 2013). The limited attention to demographic factors hinders the use of participants who are currently in relationships with the opposite gender as mistakes in labeling lead to what is noted in the literature as “bi-erasure” (Bennett, 1992; Bradford, 2012).

Actual numbers of those representing AF orientations are impacted by the noted factors above and, like other members of the overall LGBTQ community, cultural factors (Adams & Phillips, 2009). Empirical study measuring numbers of, identification as, and corresponding incidences of behavior for AF persons in the community are often mediated by difficulties in accurately measuring sexual/affectional behavior, self-identification, and research methodology not accounting for AF persons in general (Bennett, 1992; Bradford, 2012; Harper et al., 2013). Vrangalova and Savin-Williams (2010) noted culture impedes research on continuums of orientation due to society causing persons to embrace a single of two, maybe three (heterosexual, gay/lesbian, or bisexual) identifications. Research delineating rough estimations and more recent populations size estimates are reviewed below.

The Kinsey et al. studies (1948, 1953) provided estimations of AF attractions, behaviors, and fantasies within a large population of persons. Estimations for men who engaged in or “reacted to” activities with/about both genders was 46% over their lifetimes (Kinsey et al., 1948, p. 656) whereas 11.6% of men from 20–35 years of age
actually subsume a much larger block of the overall community (Kinsey et al., 1948, p. 651). Similar to studies conducted afterwards (Diamond, 2008a), 14% of women in the age bracket of 20–35 years demonstrated more than “incidental homosexual experience” (Kinsey et al., 1953). In the 20–35-age bracket 7% of non-partnered women and 4% previously partnered women were assigned a rating of 3 thus noting clear affectional fluidity (Kinsey et al., 1948).

Results from the 1948 study on 5,300 men and 5,940 women in the 1953 version show most persons under study actually experienced both heterosexual and same-gender activities (Kinsey et al., 1948, 1953; Kinsey et al., 1953). This demonstrates evidence of how self-identification cannot signify the only population representation numerically of the AF population. Most of these persons still identified as heterosexual as is often the case (Gebhard & Johnson, 1979). Kinsey’s research embodied empirical groundwork laid for many seminal theorists and researchers within bisexuality literature (Brickell, 2006; T. Brown, 2002; Diamond, 2008a, 2008b; Firestein, 1996; Klein, 1990, 1993; Klein et al., 1985) and competency (Bennett, 1992; Harper et al., 2013) who came after.

Israel (2015) broke down the binary systems of orientation and gender expression to speak specifically to those who self-identify as bisexual (noting this number is from 1–5% of the U.S. population); while also relating approximately 37% of the population demonstrates bisexual behavior based upon having sexual behavior interactions with both genders, a substantially large reporting difference (Israel, 2015). Behaviors, fantasies, thoughts, and affections demonstrate far more affectional fluidity than static states in the general population (Diamond, 2008b; Ketz & Israel, 2002).
Recently, YouGov.com, a market research organization from the United Kingdom, conducted telephone polling utilizing Kinsey’s scale. Polling indicates 31% of Americans surveyed under 30 years of age position themselves “as something other than heterosexual” (pp. 1–4) with 29% identifying as “somewhere on the category of bisexuality” (Moore, 2015, per OPI_Kinsey_Scale_20150813 report). In the next age bracket up (30–44 years) 24% of respondents positioned themselves somewhere in between heterosexual and gay/lesbian. Overall, the study of 1,000 persons conducted in August 2015 found 16% identified somewhere between completely heterosexual (78%) or gay/lesbian (4%) as they utilized the Kinsey Scale (Kinsey et al., 1948, 1953) to ascertain a person’s orientation status.

Perhaps the most interesting notion within this non-scientific research is that 12% of participants noted previous same-gender sexual behavior yet still identified as exclusively heterosexual, raising the number of respondents who represent affectional fluidity to around 43% when encompassing both identification and behavior (Moore, 2015). There are notable validity concerns with a market research project including validity, lack of a clear scientific methodology, use of simple surveys, and a limited sample (Heppner et al., 2008). Limited information on participant selection or overall research methodology also raises procedural concerns but the use of the Kinsey Scale long after its inception is intriguing, warranting further empirical study on a larger scale (Moore, 2015).

**Kinsey, Wolff and other definition-expanding research.** Alfred Kinsey’s research in the late 1940s through the 1950s and concurrent publications (Kinsey et al.,
1948, 1953) must be explored further as the information gathered here represents some of the first empirical data contradicting the binary system of orientation. Kinsey assigned identities to participants through a rank order system known as the Kinsey Scale, later utilized in many studies (Kinsey et al., 1948). Within a few decades Wolff (1977) demonstrated findings from study on bisexuality with 150 participants evenly split between men and women (75 each) in the text *Bisexuality: A Study*. These major studies informed all studies concerning AF persons for the next several decades up to current research.

Perhaps Kinsey et al.’s (1948, 1953) most valuable contribution to AF research is the Kinsey Scale as the scale differs from all other previous research by emphasizing and normalizing the greater breadth of behaviors and affections represented by AF persons. This scale notates orientation along a continuum with “0” representing “exclusively heterosexual with no homosexual” to “6” operating as “exclusively homosexual” (Gebhard & Johnson, 1979, pp. 5–15; Kinsey et al., 1948, p. 3). The most intriguing points on this scale related to AF persons are those in-between the poles; represented by the ratings “1” (predominantly heterosexual, only incidentally homosexual) through “5” (predominantly homosexual, only incidental heterosexual); informed by urges, experiences, affections, sexual fantasies and/or behavior (Kinsey et al., 1948, p. 3; Kinsey et al., 1953).

There are two notable criticisms of the Kinsey studies. The first is all participants in these two major studies identified as White racially, severely limiting the generalizability of the results to a single racial context. Ironically, these and other
ethnically unrepresentative sexuality studies present support to how identification as LGBT is something occurring solely in the Caucasian community (Chun & Singh, 2010; Jamil et al., 2009) by older Black (Boykin, 2005) or Latino persons (Gonzalez, 2007).

The other main criticism of the studies comes from Kinsey himself who admits a lack of random sampling in his work as all persons volunteered (Gebhard & Johnson, 1979). This obviously limits the representativeness of the sample and external validity associated with the design (Heppner et al., 2008). Lack of random sampling was a design issue Kinsey was willing to work with because otherwise the incredibly large sample for such in-depth interviews would not be possible (Kinsey et al., 1948, 1953).

Other relevant criticisms come from pillars of the sex research community such as Masters and Johnson (1979) for the subjective manner Kinsey placed persons into the 0–7 categories and Klein (1993) who did not believe the scale accurately described the range of affectional, behavioral, fantasy, and attraction qualities of orientation. These authors and others continue to critically develop what is still considered to be preeminent research is sexual behavior and related orientation concepts (Klein, 1993; Vrangalova & Savin-Williams, 2010). Nevertheless, Kinsey and his colleagues (1948, 1953) demonstrated the first empirical representations of the continuum of orientation, followed by Wolff’s extensive mixed methods study (1977).

Wolff (1977) noted how Charles Darwin was the first to utilize the term bisexuality in his 1868 text *The Variation of Animals and Plants under Domestication* as Darwin described how “bisexuality alone could explain hereditary traits” (p. 9). Overall, Wolff offered a contemplative, even controversial, viewpoint on affecional fluidity for
the 1970s; that “homosexuality cannot be isolated from bisexuality” (Wolff, 1977, p. 8). These theoretical determinations based on her major study set a stage for the later period of revolutionary research into affectional fluidity (Diamond, 2003; Firestein, 1996; Klein, 1993, 1996). Overall, Wolff found departures from greater society and exclusively lesbian/gay person for AF persons in concepts of diversity of relationships, participation socially and flexibility for younger AF men and women (1977).

*Recent research based on Kinsey Scale.* Two major peer-reviewed studies were published recently utilizing the Kinsey (Kinsey et al., 1948, 1953) theoretical constructs regarding orientation. These studies measured different particular items; Rieger, Savin-Williams, Chivers, and Bailey (2015) investigated physiological sexual arousal along spectrums of masculinity/femininity while Epstein, McKinney, Fox, and Garcia (2012) utilized an online orientation assessment utilizing both U.S. and international participants to investigate the spectrum of orientation. This recently published research supports previous studies by Kinsey et al. (1948, 1953) and others (Diamond, 2005a, 2005b) by noting sexual arousal (Rieger et al., 2015) and fantasies, thoughts, and overall “flexibility of orientation” is “centered on the continuum” (Epstein et al., 2012, p. 1357).

After demonstrating a strong scholarship review regarding women’s particular tendency to experience fluidity in orientation and bisexual women’s tendencies towards middle of the road scores on both gender expression and sexual arousal, Rieger et al. (2015) explored sexual arousal along the masculinity-femininity continuum. Utilizing the data of two studies (one published and the other unpublished), a self-report of masculine/feminine behaviors with women’s genital arousal alongside observer-rated
behaviors with pupil dilation stimulus interesting results regarding both gender expression and affectional orientation were found (Rieger et al., 2015). Results were similar when compared to previous research the authors conducted on bisexual men’s sexual arousal responses (Rieger, Chivers, & Bailey, 2005).

Rieger et al. (2015) described previous research noting women are more likely to experience arousal evidence by multiple tests (such as pupil dilation and genital arousal) for sexual stimulus images of both men and women than men. Rieger et al. (2015) reported self-identified bisexual women were found to be “in-between straight women and lesbians in their arousal patterns to the same sex or other sex” (p. 2) as well as demonstrating “intermediate” scores in masculinity-femininity behaviors (p. 3). These results were similarly found in the current study alongside findings as women were overall more likely to experience arousal to both sexes, although a difference was found with a group of self-identified lesbians who measured higher on masculine representations (coded utilizing a Kinsey-like scale; Rieger et al., 2015). Results show a wider variance of flexibility not only with orientation but also regarding gender expression and representation, an updated emphasis on what it means to be AF in a society dominated by polarity.

Epstein et al. (2012) utilized the Kinsey scale-based Epstein Sexual Orientation Inventory (ESOI) in measuring 17,785 online participants self-identifications alongside general sexual flexibility, behaviors, affections, fantasies, and attractions. The authors found identification as gay/lesbian, bisexual, heterosexual and non-identifying often linked to wide, slanted distributions; thus the authors insinuated identification terms do
not strongly correlate with actual ways of being. Furthermore, “flexibility . . . in expressing sexual orientation” supports a “fluid-continuum model of sexual orientation” of which “genetic and environmental factors determine both the size of . . . range and point at which an individual’s sexual orientation is centered on the continuum” (Epstein et al., 2012, p. 1356). Both of these studies demonstrate more credence for literature regarding AF persons, which is both evidence-based and connected to actual relational ways of being (T. Brown, 2002; Epstein et al., 2012; Klein, 1993; Weinberg, Williams, & Pryor, 1994). This lack of literature is true for both men and women, identified by specific current literature below.

**Fluidity and men.** Several authors note how persons who may fit the AF paradigm/definition may not actually be counted in or necessarily identify with the limited number of options given (Harper et al., 2013). This seems to be especially true with men (Boykin, 2005; Brickell, 2006; T. Brown, 2002). Bagley and Tremblay (1998) utilized a randomly selected study with perhaps the largest North American men’s participant pools examining same-gender orientation. These authors found at least 15.3% of men demonstrated at least “some degree” of gay/bisexual behaviors although only fractions of those surveyed identified as gay or bisexual (Bagley & Tremblay, 1998, pp. 7–9). This estimate may be not characteristic of current populations as this study was published in 1998 and conducted in a major city, Calgary, rather than rural areas. Another issue in the study was limited representation of minorities including Black and Latino men (Bagley & Tremblay, 1998).
Recognizing most Latin American men do not self-identify as gay, bisexual, or queer, Gonzalez (2007) investigated Latino men whose behaviors and identifications represent being “on the down low.” Gonzalez reported Latino men participate in the communal (nightclubs, bars, and particular meet-up interactions), behavioral (sex with both men and women, sometimes concurrently), fantasies, thoughts, and sharing of affection characterized by affectional fluidity (Boykin, 2005; Diamond, 2005a). Gonzalez (2007) and other researchers (Boykin, 2005; Jamil et al., 2009) noted how bisexual, pansexual, or other identifications along the spectrum of affectional fluidity are not personally ascribed by many persons of color, especially given ethnic and spiritual mores of respective communities.

In several studies of “men who have sex with men” (MSM), men of varying ethnicities subscribe to and participate in both same and opposite-gender sexual and affectional interactions (Camarena & Rutter, 2015; Jamil et al., 2009). Many studies regarding these non-identifying men are from medical or mental health journals focused nearly exclusively on HIV transmission, an important issue especially for AF men regarding physical wellness, yet these studies do little other than describe the risk behaviors inherent with AF behaviors (Storholm et al., 2013). Only a few articles reference mental health counseling within the parameters of unidentified and HIV issues (Amola & Grimmett, 2015).

Dilley (2002) explored a long history of college-age men who may or may not identify within LGBTQ spheres, speaking to the varying degrees and means of associating with others on campuses where AF persons are not welcomed. Often
identification is irrelevant within these circles and often represents an underground conceptualization of behaviors, affections, and other representations of AF definition (Dilley, 2002; Fairyington, 2008). Brickell (2006) elaborated on this concept noting many men reject the “homo/hetero binary” in behaviors, affections, attractions, fantasies, and so forth; yet do not choose to identify even as bisexual as this term carries a historical connotation often inaccurate and unsafe (p. 424).

Brickell (2006) recognized a long history of AF conceptualization for men, extending far back into the Asian and Roman empires. Similar to Foucault’s (1976) conceptualizations about sexuality, Brickell critiqued the “social constructionism” demonstrated in 18th and 19th century sexology in which a “homo/hetero binary system” was established through a “medicalized homosexuality . . . minoritizing homosexuals” while erasing AF persons (pp. 425-427). Brickell (2006) utilized several texts from 18th, 19th, and 20th century sexologists to track the historical progress and commonly accepted notations of AF sexualities in men, albeit noting acceptance comes as a product of diversion to and from binary constructs of homosexuality and heterosexuality.

As the 20th century began, homosexuality became pathologized, provoking both societal and legal repercussions such as bans on sodomy aimed particularly at men (Brickell, 2006; Foucault, 1976). The effects of these policies laid the groundwork for damaging male gender role expectations leading to minority stress (Carter et al., 2013; DiPlacido, 1998), victimization (D’Augelli, 1998), internalized homophobia (Eliason, 1996), prejudice, discrimination, and oppression (Dermer et al., 2010) for AF person and gay/lesbian persons as well. Many recent empirical and popular culture articles speak to
the qualitative experiences of young men from high school to old age that experience sexual interactions and play with both men and women (Boykin, 2005). As is noted by the research above, more research concerning the wellness of and developmental considerations for AF men is needed (Dew & Newton, 2005). Literature regarding AF women shows similar findings but also demonstrates differences in flexibility sexually below.

**Fluidity and women.** Diamond’s longitudinal study and corresponding research (2008a, 2008b) notate a clear fluid developmental nature to women’s sexual desire and orientation from adolescence well through womanhood. These studies open dialogue on the gender-based notations of affectional fluidity in how women often demonstrate more fluidity outwardly through behavior and/or identification than men (Diamond, 2008a). By the end of her longitudinal study, Diamond refuted the “transitional stage model” of affectional orientation (i.e., from heterosexuality to lesbianism), moving towards the “distinction between lesbianism and bisexuality (as) a matter of degree rather than kind” (2008a, p. 5). Diamond’s research challenged the use of overall LGBTQQIA community models of development for AF lifelong growth.

Diamond (2008a) reported several participants in her study explained:

their sexual identity using alternative identity labels, such as ‘queer,’ ‘pansexual,’ or ‘polyamorous’ . . . when asked to describe what these labels meant, each of these women indicated that her underlying attractions were bisexual, but expressed reservations about the bisexual label because (a) it did not adequately
describe the fluid and changing nature of their sexual feelings, and/or (b) it was associated with negative stereotypes, such as promiscuity. (p. 122)

Although Diamond (2008a) considered these participants as bisexual for categorization, she duly noted the difference in description of orientation seen in many other studies of both women (Bennett, 1992; Kinsey et al., 1953) and men (Boykin, 2005; Gonzalez, 2005; Kinsey et al., 1948). Fluidity in orientation is heavily represented by the identity shift over the years of the study (Diamond, 2008a, 2008b) through differences in behavior, relationships, and the fact a significant percentage of participants during the timespan of the study (25% at inception to 26% at termination) identified as “unlabeled” rather than heterosexual, lesbian, or bisexual.

The main result Diamond reported was how over a period of a decade 2/3 of participants shifted identifications with a third doing so multiple times (Diamond, 2008a). Diamond (2008b) noted this may not be simply experiential but based in societal mores corresponding to gender expression and expectations. To date Diamond’s longitudinal research (2008a) represents the best methodological lens to view development of AF women’s orientation. Diamond’s studies demonstrated women demonstrate a wider range of affectional fluidity, even in self-identification and can be described outside of the lesbian, heterosexual or bisexual realms as “woman-loving-woman,” “woman who has sex with women,” and so forth. Although there seems to be more societal acceptance of affectional fluidity in women, there are still limited differences in identifying exclusively (Vrangalova & Savin-Williams, 2012; Weinrich & Klein, 2002). This may relate to the skepticism and outright biphobia perpetrated by self-identified lesbians
towards those who share relationships, sex, and affection with both genders (Ochs, 1996; Rust, 1993).

Ketz and Israel (2002) noted behavior is often isolated from identification in wellness research concerning women who have relationships with both men and women and identify as bisexual or heterosexual. The authors noted how women may continue to identify as heterosexual even while having affectional relationships with other women (Ketz & Israel, 2002). This phenomenon may relate to retention of privilege (McIntosh, 1998), internalized biphobia (Rust, 1996), and/or discrimination (Ketz & Israel, 2002). Israel (2015) reported how more young persons, especially women, identify as bisexual than lesbian/gay while others do not identify at all which again may signify a more complex, multidimensional affectional orientation identity (Harper et al, 2013; Israel, 2015).

As noted both men and women demonstrate far more AF behaviors, affection, and traits than previously delineated but these representations from general study are not often noted in the training of counselors, much less represented in building a strength-based wellness modality to treat AF persons (Dew & Newton, 2005). The negative situations and systemic issues faced by AF men and women indicate need for informed wellness interventions. In essence and substance this exploration leads into a discussion regarding oppression and the effects of marginalization for AF persons.

**Base of power, privilege and oppression for AF persons.** Fassinger and Arseneau (2007) extended dialogue concerning identity philosophies when describing how the acronyms meant to describe the sexual and gender diverse population do not
effectively account for individual differences or the essentialist versus social-constructionist perspectives regarding affectional orientation. Foucault (1976) utilized a critical lens in theoretically and philosophically exploring the concept of one’s sexuality being labeled and/or categorized and how this identification became a powerful element of a person’s identity in the 19th and 20th centuries. Labeling can be particularly problematic for the AF population, whose members often live both within and in-between communities (Fairyington, 2008; Griffin, 2009; Israel & Mohr, 2004). AF persons are a present yet invisible minority who may not identify with current identifications and/or represent a breadth of identifications not readily embodied by the terms gay/lesbian and heterosexual (Fassinger, 2000; Fassinger & Arseneau, 2007; Petford, 2005).

Foucault (1976) demonstrated how power plays into the concept of sexuality by relating how it was represented during feudal times (of historical Europe). For those identified as “sinners” by religious and/or governmental authorities, it was not uncommon to be scorned, vilified, and killed (Foucault, 1976). This concept of law intruding upon one’s sexuality continues today, as gay rights advance in both the courts and public opinion through the overturn of government bans of same-sex marriage and adoption as well as with the continual fight to end SOCE (sexual orientation change efforts) practices (Chaney, Filmore, & Goodrich, 2011). The scorn and violence continue as evidenced by terrorism movements such as Daesh torturing and killing suspected LGBTQ persons (Associated Press, 2015).

W. Brown (2001) described the base of power in regards to sexual identity politics by referencing Freud’s “A Child is Being Beaten” in her text, Politics Out of
History. She questioned whether politicization of identity occurs when a person “pejoratively marked along lines of gender, sexuality, or race” awakens to the concept that the “universal personhood” prescribed by the system they desire to be part of does not “hold them in esteem” (W. Brown, 2001, p. 52). Instead, society “spurned their expectations of belonging and protection,” therefore demeaning LGBTQIA and more specifically, AF persons in their wants (p. 53).

Ironically, this analogy to Freud’s article concerning desire may explain how AF identities become politicized (W. Brown, 2001; Bennett, 1992) particularly for this study as AF persons represent the unseen (McLean, 2008) and oppressed majority (in population; Fairyington, 2008; Israel, 2015). This politicization of identity is noted as a routine, natural tendency given the consistent reminders of AF persons’ confrontations with heterosexism, sexism, and blatant biphobia (Brickell, 2006; Carter et al., 2013). W. Brown argued identity often grows from struggle, as AF persons experience struggle and privilege in a simultaneous fashion (W. Brown, 2001; Macalister, 2003; McLean, 2008).

Many researchers of the connections between wellness, social justice, and empowerment note how wellness cannot be unaffected, in either positive/negative directions, by struggles caused by oppression and the advocacy conducted with/for marginalized yet empowered AF persons (Harley, Stebnicki, & Rollins, 2000; Prilleltensky, 2008; Savage et al., 2005; Sen, 1999). Struggle, of course, is not only represented in the orientation of AF persons but also incorporated into the multiple marginalizations faced through intersecting identities of ability, education, ethnicity, religion/spirituality, socioeconomic status, and other cultural variables (Collins, 2004).
Intersecting identities of AF persons. Identities are not developed from one relevant component. Abes, Jones, and McEwen (2007) argued meanings are derived from a multitude of “dimensions” within identity impacted by contextual, cultural, and relational variables (p. 2). Meanings are a function of the sum of interactions between dimensions of overall identity and created in usually supportive contexts of race, ethnicity, spirituality, class, and so forth (Collins, 2004). AF persons reside in often-unsupportive familial, local communal, gay/lesbian, and heterosexual communities (Brewster, Moradi, DeBlaere, & Velez, 2013; Harper et al., 2013). Thus those sympathetic to the oppressions of race, ethnicity, spirituality, and so forth, are not as often caring when persons come out as AF due to uninformed conceptualizations of identifying as LGBTQIA being a choice (Harper et al., 2013).

Salience of identity is noted as relevant to clinical counseling work with AF persons of color by several researchers (Chun & Singh, 2010; Moe et al., 2014; Yakushko, Davidson, Williams, 2009). When certain aspects of identity are more germane to contextual variables, such as in the case of religion and/or spirituality (Wilcox, 2003), orientation may become less salient or at the very least take a lesser role in negotiating familial or community environments (W. Roscoe, 1995; Wilcox, 2003). Moe et al. (2014) noted how salience alongside context and other variables reverberates for LGBTQ youth in determining needs of these young people in school settings. The authors demonstrated how AF persons may cede orientation identity for academic, ethnic, religious, or peer group depending on how orientation factors into scholastic, interpersonal, and communal settings (Moe et al., 2014). Similarly, Chun and Singh
Collins (2004) began a relevant review of the limited research on intersectionality between affectional orientation/gender expression and race, ethnicity, spirituality, socioeconomic status, and so forth, by noting how most literature on LGBTQIA issues is conducted on “white, middle-class” lesbians and gay men (p. 101). Collins also noted how research on cultural populations rarely includes affectional orientation or gender expression as demographic data points, much less factors. This is especially true for bisexuals (by definition, persons who may be AF), where no suitable research was found at the point of her review (Collins, 2004). Later research, correlating into identity models, such as Chun and Singh’s “Bisexual Youth of Color Intersecting Identities Model” (2010, p. 429), demonstrate how far research has developed since Collins’ review.

Collins utilized a literature review to discover the impact of ethnicity specifically on bisexual development coining the term for persons of color who demonstrate AF identities/behaviors as the “borderlands” (Collins, 2004, p. 101). She cited Census Bureau (1995) statistics showing how U.S. population will diversify to “50% people of color” by 2050 (U.S. Bureau of the Census, 1995) with these changes already having taken place in Western states such as New Mexico and the country’s most populous state, California, where, as of 2014, the Latino/a or Hispanic population is now the largest
ethnic group overall (Lopez, 2014). According to Lopez of the Pew Research Center, the only other state where this is true is in Hawaii where the population majority is Asian/Pacific Islander.

Brewster et al. (2013) fostered an updated context of the “borderlands” encompassing the impact of “minority stress, bicultural self-efficacy and cognitive flexibility” upon mental wellness of AF persons of color. With 411 self-identified bisexual persons the authors found correlations between minority stress and mental suffering, with greater anguish adversely affecting mental wellness scores. “Cognitive flexibility” demonstrated a positive effect upon mental health and wellness but this effect was shattered in “high prejudice” environments (p. 543). The effect of prejudice on wellness of AF persons is noted in research by scales such as the LGBT People of Color Microaggressions Scale (Balsam et al., 2011), multiply marginalized communities such as Native Americans (Balsam et al., 2004) and for LGBTQQIA persons on the whole (Herek, 1998, 2002; Meyer, 1995, 2003).

Many authors note particular cultural concerns for AF persons who may obtain some relevance and support within the AF community but receive little support and often discrimination and oppression through connections with ethnic, racial (Boykin, 2005; Gonzalez, 2007; Balsam et al., 2004) or spiritual groups (Wilcox, 2003). Variables of identity also represent particular 2nd order factors of wellness included in the IS-WEL model (Myers & Sweeney, 2005, 2008). These pertinent factors affect lifelong development explored in depth through multiple models below.
**Contextual research and identity models for AF persons.** Vivienne Cass (1979) was the first theorist to create an identity development (so-called coming out) model designed exclusively for gay and lesbian persons. The six stages of the *Homosexual Identity Formation: A Theoretical Model* (HIF) include identity: confusion, comparison, tolerance, acceptance, pride, and synthesis. Although this model has been criticized for the lack of recognition of those along the continuum of orientation (affectionally fluid, bisexual, etc.; Klein, 1993), the model delineates some important developmental notations relevant to many LGBTQIA persons (Cass, 1984). Relevant expansion and literature concerning the HIF for ethnic and racial minorities underscores both the utility and shortcomings of the model (Adams & Phillips, 2009; Eliason, 1996).

The HIF is critiqued for a linear nature limiting applicability for diverse experiences (Troiden, 1989). Areas of critique include the “fit” for lesbians (Sophie, 1987), limited scope regarding diversity (Adams & Phillips, 2009), and dependence upon Caucasian, educated, middle-class lesbian and gay persons (Eliason, 1996) while ignoring persons along the continuum such as AF individuals (Klein, 1993). Other models represent the development of LGBTQIA persons in succinct and specific ways, including models more appropriate to the experience of AF persons.

Sophie (1987) researched women’s development of orientation longitudinally, including concepts from Cass’s 1979 model. This integrated model showed most women were involved in relationships with other women well before identifying or even questioning orientation thus challenging the sequential alignment of the Cass model (Cass, 1979; Sophie, 1987). Several other studies did not find such disorder in linear
progression (Walters & Simoni, 1993). Substantial differences are represented in identity development, especially concerning intersectionality of diversity (Adams & Phillips, 2009; Eliason, 1996), differential patterns resolving the HIF stages, and how empowerment strategies such as LGBTQIA social justice advocacy conflict with completion of HIF stages (Eliason, 1996; Kitzinger, 1996). Studies below noting the intersection of cultural factors with lifelong development offer even more relevance to the growth of AF persons.

Adams and Phillips (2009) utilized a grounded theory analysis in studying identity development of two-spirit, lesbian and gay (TsLG) Native Americans. The authors noted two thematic routes to synthesis of identity, one of which was delineated along the CIF model while the other lacks resolute aspects of the CIF including self-perceptions of: defect (described as “discomfort” with orientation); isolation from family, friends, and/or society; and most namely the distinct experience of “passing” where a TsLG person is perceived by others as heterosexual (Adams & Phillips, 2009, p. 970). Incidentally the lack of these situations begat the lack of resolution cited continuously in the CIF model. Thus the experiences of at least Native American TsLG’s do not match with those of majority Caucasian groups (Adams & Phillips, 2009). L. B. Brown (1997) also noted issues inherent to developmental models, as any such model does not appropriately affirm the fluid nature of both orientation and gender expression represented by TsLG’s.

Eliason (1996) also identified the “narrow samples,” often not representing intersectionality, found in most studies regarding identity development models. The term
narrow describes the sense of most studies; including those of Cass (1979, 1984) as all feature participants who are overwhelmingly White and well-educated and self-identify as lesbian or gay. Participants who are not firmly situated in one binary orientation are often removed from the sample or not represented as a significant portion. Eliason’s concerns regarding Cass’s insistence upon identity synthesis as de facto termination of identity development are not surprising given LGBTQQIA persons’ participation in social justice advocacy for and with the community (Eliason, 1996; Savage et al., 2005). As AF persons often exist on the “borderlines” between communities, specific advocacy efforts may not fit or appear welcoming (Collins, 2004).

If synthesizing orientation is a part of the overall self-identity does that entail AF and other LGBTQQIA-identified advocates have not synthesized given advocacy’s promotion in the stage of identity pride? Kitzinger (1996), offering a cutting review of previous LGBTQQIA research and a model built from the current study’s methodological lens (Q-sort), criticized the HIF for refuting the exchanges possible through social justice because the HIF delineates this as lack of progression to synthesis. A likely outcome for those who align accordingly with the HIF model is less engagement in advocacy and LGBTQQIA identity described as apolitical (Eliason, 1996; Kitzinger, 1996).

Inherent issues with the HIF and other stage models noted above include the limited applicability to AF persons and those who represent intersectionality of diversity in regards to ethnicity, ability, gender expression, and so forth (Bilodeau & Renn, 2005; L. B. Brown, 1997). As these models are mostly tested on lesbian women and gay men integration into counseling paradigms for work with AF persons is discouraged at best or
demonstrating a startling lack of cultural competence at worst (Bilodeau & Renn, 2005; Dworkin, 2012; Lee, 2008). As culturally competent counseling methods for AF persons’ development are not satisfactorily met by stage models, inclusion of approaches which relate life-span development are helpful (Bilodeau & Renn, 2005) and encouraged by the growth-centric counseling sphere (see 20/20 Consensus Definition of Counseling, ACA, 2010). Wellness constructs and the IS-WEL Model (Myers & Sweeney, 2005) correspond to effective models of lifespan development allowing for multiple routes, backtracking, and appropriate movement for AF persons through multiple environmental contexts (Myers & Sweeney, 2008).

**Lifespan and Developmental Models**

D’Augelli (1994) proposed a lifespan model, identified only for lesbian, gay, and bisexual persons (LGB), contextualizing social constructs to diverse, intersectional experiences (Bilodeau & Renn, 2005; D’Augelli, 1994). This model offers six “identity processes” not necessarily in sequential order including: exiting heterosexuality, developing a personal LGB identity, developing an LGB social identity, becoming an LGB offspring, developing an LGB intimacy status and entering an LGB community (D’Augelli, 1994, as cited in Bilodeau & Renn, 2005). D’Augelli’s model allows for more flexibility as these processes need not be in order and some may be true in certain situations but not in others (i.e., Be “out” to family but not outside the home thus have become “LGB offspring” but not yet “entered the LGB community;” D’Augelli, 1994, as cited in Bilodeau & Renn, 2005, pp. 28-29). Flexibility and multifaceted growth is
featured heavily in the following developmental models, which demonstrate saliency for
AF persons more than others, as each is more specific than the previous.

**Identity and development models appropriate for AF persons.** Klein (1990,
1993, 1999) and his colleagues (Klein et al., 1985; Weinrich & Klein, 2002) built upon
previous research to build the comprehensive Sexual Orientation Grid, serving elements
noted as part of one’s affectional identity. These elements include sexual behavior,
attraction, and fantasies along with emotional preference, social preference, a continuum
of heterosexual-homosexual lifestyle, and self-identification (Klein, 1999). The grid also
utilized “time” as an indicator of identity development by examining each of the elements
by past, present and preferred connotations (Klein, 1993). These notations were made as
Klein wrote of persons of a bisexual nature (1993), extending the grid to AF persons’
opens doors for those who do not identify concretely as bisexual (Crethar & Vargas,
2007).

In addition, Klein’s work heavily informed the previous culturally incompetent
models relating gay/lesbian models as sufficient for AF persons (Macalister, 2003).
Klein’s (1993) and Kinsey’s (Kinsey et al., 1948, 1953) previous studies set precedent for
continuum models such as Epstein et al.’s (2012) Fluid-Continuum Model of Sexual
Orientation, theorized after a large (over 14,000 participants) study was conducted to
measure constructs of both Kinsey’s (Kinsey et al., 1948, 1953) and Klein’s (Klein, 1990,
1993, 1999; Klein et al., 1985) models. The Fluid-Continuum Model of Sexual
Orientation, which supports both “genetic and environmental factors” influences in
description of identity within multiple contexts over the lifespan, is useful (Epstein et al.,
Klein’s work also assisted in defining T. Brown’s (2002) model of “bisexual identity development” focusing on the practical variances for men and women (p. 68). Practicality is featured in the following model, which theorizes specific differences in bisexual development from gay/lesbian growth.

Bleiberg, Fertmann, Todhunter Friedman, and Godino (2005) developed the Layer Cake Model of Bisexual Identity Development in order to debunk stereotypical notions of bisexuality within the student affairs setting. This bisexual-specific standard speaks to AF persons far more than most models as the layers demonstrate the multiple components of identity. To create the model Bleiberg et al. (2005) utilized a grounded theory qualitative methodology, gaining a total of eight participants from contacts with the LGBT Student Services at New York University along with several other regional academic institutions. These students represented a younger generation of AF persons as their ages ranged from 19–21 years. Bleiberg et al. (2005) noted interviews to include “open-ended” items regarding “sexual orientation and experiences related to their bisexuality” along with questions regarding roommates, friends, and family (p. 54). The following theory was created utilizing the thematic elements found in these original interviews.

Bleiberg et al. (2005) fostered a unique determination not noted in many other theories of affectional development, theorizing a part of one’s original identity is never left behind. Thus the Layer Cake Model builds from one’s “development of a heterosexual identity” (Layer 1) to Layer 5’s “identification as bisexual” with each layer the same size as the previous as identity builds towards bisexuality (Bleiberg et al., 2005,
Layer 1 is cemented in the development of “an assumed heterosexual identity” where heteronormative behavior (getting married, having children, etc.) is promoted through socialization and the family unit. Once the “experience of homosexual thoughts, feelings and/or behaviors” begins a person begins adding Layer 2 (Bleiberg et al., 2005, p. 56). Within this layer one’s original heterosexual identity is examined because of same-gender feelings, thoughts, attractions, relationships, or sexual behavior. Often a person recognizes previous incidences of the above, accepts these incidences and integrates same-gender notations into their identity. For others, especially those raised in conservative backgrounds, this layer may represent a time of anxiety, doubt, and suppression. More time in this layer for these persons is possible, sometimes represented through “experimentation in order to further solidify” same-gender reflections (Bleiberg et al, 2005, p. 56).

Layer 3 is built on “acceptance of homosexual attraction while maintaining heterosexual identity,” representing a period of accommodating same-gender thoughts, leanings and conduct but not including outright identification as bisexual (Bleiberg et al., 2005, p. 56). The lack of identification springs from the heteronormative world, where unless it is absolutely needed, one will not identify as bisexual as the world does not often accept the affectional ambiguity. As noted in most LGBTQIA literature, coming out is cumbersome and often dangerous socially, emotionally, and/or physically (APA, 2000; Carter et al., 2013) but can be more difficult for AF persons (Bradford, 2012).
Concerns over coming out as AF result from fear neither the heterosexual or gay/lesbian communities will be welcoming, a substantive common issue reported in research (Fairington, 2008; Firestein, 1996; Fox, 1996; Ketz & Israel, 2002).

The fourth layer focuses on “integration and assimilation of heterosexual and homosexual identities” thus persons no longer identify as heterosexual or even gay/lesbian (Bleiberg et al, 2005, p. 57). Within this layer persons now demonstrate active attraction to both genders and often angrily reject relentless efforts to be labeled by those who lack understanding of bisexuality. There is also exploration of identity labels affiliated with affectional fluidity (bisexual, queer, etc.) through associating with persons whom they share aspects of orientation. Depending on how supportive environments and persons around are these budding bisexual persons will also begin to come out to family and friends (Bleiberg et al., 2005).

Layer 5 (Bleiberg et al., 2005) is comprised of space where persons will be content in subscribing to bisexual identification. This may consist of multiple identities corresponding to both the term bisexual and personal representations of what such individual identification means. Often this means being attracted to the person rather than the gender of said person.

Overall, the Layer Cake Model of Bisexual Development demonstrates relevance on individual, intrinsic, and holistic levels (Bleiberg et al., 2005), corresponding to research regarding growth with AF persons (Bradford, 2012; Fox, 1996). Inherent methodological issues with a lack of significant quantitative research as follow-up to this one small qualitative study demonstrate limited generalizability to the AF population.
Research on individual layers, how each relates to the others, and whether AF persons relate to the model is pertinent to continued development. This model matches with assessment of wellness issues through the multifaceted approach corresponding with several areas of wellness including social, physical, and communal (Moe et al., 2015; Myers & Sweeney, 2005). A review of the existing models and overall issues for the AF community logically follow this exploration.

**Review of relevant issues in models for AF persons.** As noted above, theoretical rubrics for counseling with AF persons are molded after lesbian and gay research, not accounting for the fluid nature of AF persons’ sexuality. AF person’s experiences are often demoted to a “phase” before settling upon a homosexual or heterosexual identity (Klein, 1993). In fact, the lesbian/gay population and the heterosexual community often believe this assumption as representing fact. In addition, the multiple identities under the AF umbrella describing non-binary (not strictly hetero/homo) activities and fantasies are not represented accurately or at all in most multicultural and supervision models (Dew & Newton, 2005; Macalister, 2003). A rich description of AF persons and the community’s overall issues and demographics can assist counselors to understand the unique needs of this population, often marginalized between and within the heterosexual and gay communities (Dilley, 2002; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Israel & Mohr, 2004).

Models such as Klein’s Sexual Orientation Grid (1985, 1993), Epstein’s Fluid-Continuum (Epstein et al., 2012), and the Layer Cake of Bleiberg et al. (2005) conceptualize AF persons’ growth to a culturally competent degree. After exploring
these models it is pertinent to review cultural competence and affirmative therapy when counseling AF persons, two elements tied to effective treatment and wellness (Moe, 2016).

Culturally Competent Counseling

Lee (2008) summarized the elements of cultural competence in the field of counseling by noting several concepts inherent to proper practice. Perhaps one of the most pertinent aspects is to place the counseling relationship within the constraints of a “social and historical context” which inherently speaks to each person’s lived experience (p. 1). A recent flagpole experience for many LGBTQQIA persons, the U.S. Supreme Court decision in Obergefell v. Hodges (2015), granting marriage equality to all U.S. citizens regardless of state residence, demonstrates the cultural significant context Lee noted. Lee noted many marginalized groups began to “demand inclusion” through social/political struggles creating change in society. AF persons are actively engaged in these demands yet still receive less than stellar respect for such efforts (Bradford, 2012).

A moving inclusion for AF persons was the first “out” bisexual governor, Kate Brown, taking power in Oregon in early 2015 (State of Oregon, 2015). A counselor who does not study these histories misses a great deal of “attitudes, values and behaviors” of their clients (Lee, 2008, p. 1). This is especially true within the LGBTQQIA community as historical events including homosexuality’s previous inclusion as a mental disorder in the Diagnostic Statistical Manual (DSM) has pathologized AF persons and the overall LGBTQQIA community (Harper et al., 2013; Hooker, 1993).
Lee and Diaz (2009) delineated another major facet of cultural competence with the “cross-cultural zone.” In this zone a competent counselor scrutinizes differences in culture between client and counselor. Counselors, supervisors, and consultants must appreciate cultural differences involve a convergence of factors and thus must create effective and culturally sound interventions to suite clients (Robinson & Howard-Hamilton, 2000). These can include but are not limited to: ethnicity and race, affectional orientation, gender expression, ability and socioeconomic status, class, religion and/or spirituality, education level, and so forth (Harper et al., 2013; Lee, 2008).

For clinical work with AF persons, counselors (especially those who identify as heterosexual) must analyze and begin to discard ingrained heterosexist societal norms (Israel, 2015; Israel et al., 2008). Counselors can then take collaborative steps in empowering wellness through a cultural lens accomplished through elements often seen as contradictory and contributing to internalized homophobia for AF persons such as spirituality/religion (Moe, 2016; Wilcox, 2003).

Lee (2008) linked spiritual wellness as a prospective strength for culturally diverse persons and an essential element of optimal wellness while also paramount to integrating multiple identities within the counseling process (Gill, Barrio Minton, & Myers, 2010; Wilcox, 2003; Yakushko et al., 2009). Integration of multiple identities has led to higher levels of wellness for both heterosexual and AF clients (Granello, 2013; Ketz & Israel, 2002; Myers & Sweeney, 2008; Moe, Perera-Diltz, & Rodriguez, 2012) and engaged counselors in critical internal dialogue regarding assumptions about cultural differences (Griffith, 2004; Wilcox, 2003). Lee (2008) noted the empowerment
occurring as a result of integration of spirituality and orientation is necessary for both counseling process and outcome for culturally diverse clients.

Client empowerment is an ideal and expected outcome of culturally competent counseling and also leads to higher levels of wellness on individual, communal and systemic levels (Lee, 2008; Prilleltensky, 2003). This tie of client empowerment to wellness is explored further later in the chapter. As empowerment relates to assisting clients in countering internalized perceived inferiority “in societal relationships with powerful others” (Lee, 2008, p. 1; see also, Harley et al., 2000). Savage et al. (2005) denoted empowerment as an essential tool for development of positive coping skills and optimal wellness along with the resisting of societal discrimination, oppression, and violence LGBTQQIA persons experience daily (Kitzinger, 1996). Empowerment is tied to ethical treatment and cultural competence as well (ACA, 2014).

Lee (2008) contextualized cultural competence as being based in ethical practice. The updated ACA Code of Ethics (2014) describes knowledge of culturally relevant, strength-based approaches developed from both empirical and qualitative research as crucial to the process of informed, ethical practice. Lee (2008) furthered the Code’s language by noting all research must explore culture as multidimensional when exploring inter and intra-group differences and announcing how cross-cultural study advances treatment. Ethical and affirmative treatment for AF and other LGBTQQIA persons is explored through the contextual lens formulated by cultural competence and ethical practice below (Finnerty et al., 2017b). To ascertain affirmative treatment a short
conceptualization of the history of AF and LGBTQQIA persons served by mental health professionals is included.

**History of AF and LGBTQQIA Mental Health Services**

Some counselors may wonder why elucidating a clear perspective on AF affirmative therapy is important. An appropriate answer is found in how AF and other LGBTQQIA persons have been treated historically by society at large and the mental health field. Katz (1976) and other authors relate a history of discrimination, inequity and oppression in housing, the workplace, and legal system (Dermer et al., 2010). AF persons and the entire LGBTQQIA community face violence, marginalization, homelessness, and abuse (Gay, Lesbian and Straight Education Network [GLSEN], 2009; Herek, 1998; Kitzinger, 1996).

In addition to the above issues, marginalization within the overall LGBTQQIA community is a significant stressor for AF persons as noted by many authors and professional mental health organizations (American Association for Marriage and Family Therapy [AAMFT], 2014; APA, 2009; Balsam et al., 2011; Brewster et al., 2013; D’Augelli, 1998; Firestein, 1996; Harper et al., 2013; Herek, 2002). Without recognizing and combating these historical and current stressors wellness within the AF community will not improve and counselors cannot develop affirming practice (Finnerty et al., 2017b; Moe, 2016).

Once the removal of “homosexuality” from the *DSM* occurred in 1973 demonstrative progress was made in removing heterosexual bias and prejudice from the counseling profession. The continual growth of research demonstrating equivalency for
heterosexual and LGBTQIA persons on measures of emotional/psychological wellbeing (Freedman, 1971; Gonsiorek, 1991; Hart et al., 1978) assisted in ending a pathologizing period of LGBTQIA persons by mental health professionals (Finnerty et al., 2017a). These studies and meta-analyses led to many statements affirming LGBTQIA persons’ orientations and gender expressions as equal to those of heterosexuals by mental health professional organizations such as the American Counseling Association (1998), American Psychiatric Association (1973, 2000), the American Psychological Association (1975, 2009), and National Association of Social Workers (1998; all as cited in Harper et al., 2013).

**AF Affirmative Therapy**

Malyon (1982) began the process of developing affirmative methodologies for counseling with LGBTQIA when he recognized the need during research for a modality that affirmed his gay male participants’ personhood and demonstrated cultural competence. Affirmative therapy grew from marriage and family therapy literature and practice, including research being conducted by members of the American Association of Marriage and Family Therapy (AAMFT). While not a theoretical orientation, affirmative therapy is a lens to view counseling through in work with AF and other LGBTQIA persons (AAMFT, 2014).

Kort (2008) and AAMFT (2014) demonstrated core elements conducive to practicing affirmative therapy explored below. The first two demonstrate the importance of understanding and combating heterosexism and heterosexual privilege. Part of this process is moving beyond tolerance to affirmation of all diverse orientations and gender
expressions (AAMFT, 2014). Previous statements by the American Counseling Association (2014), American Psychological Association (2000; 2009) and many other health organizations echo sentiments of affirmation as extending tolerance to celebration of the experiences of AF and LGBTQIA persons (Finnerty et al., 2014). Singh and Gonzalez (n.d.) focused on the challenging of heterosexism by the counselor, a type of advocacy pursued by counselors each meeting with a client. This micro-level process that combats microaggressions found in everyday life is delineated in the ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2002).

Addressing homophobia and biphobia in everyday life, as AF and other LGBTQIA clients often present with internalized versions of both, is essential practice for affirmative counselors (Kort, 2008). Bradford extended affirmative therapy to the AF “experience” (2004, p. 8) by noting specific issues in serving AF persons individually (Bradford, 2006) and in couples/families (Bradford, 2012). Identifying as an affirmative counselor also denotes identification as an ally for AF persons and the overall LGBTQIA community (Finnerty et al., 2014; Poynter, 1999). Identification as such aligns with notations of affirmative counseling through exhibiting support in a holistic manner through affirmative assessment, treatment and research in addition to advocacy efforts both in and outside the office (Finnerty et al., 2017b; Harper et al., 2013).

**Affirmative assessment with AF persons.** Conducting appropriate, affirmative mental health assessments is important for counselors as often presenting concerns are not related to one’s orientation and/or gender expression (Harper et al., 2013; Singh & Gonzalez, n.d.). As there are significant mental health issues tied to the constant
microaggressions, discrimination, and often violence experienced by LGBTQ persons, one might believe symptomology is a result of identity but this sentiment is critiqued heavily by multiple authors (D’Augelli, 1998; Harper et al., 2013; Moe et al., 2015; Singh & Gonzalez, n.d.). Providing a strength-based approach delineated by the IS-WEL Model (Myers & Sweeney, 2005) is pertinent to both affirmative treatment and holistic care (Moe, 2016).

Moe et al. (2015) critiqued assessment measures and counselors for often focusing on one’s affectional orientation and gender identity as a sole contributor to presenting issues. These and other authors demonstrate counselors must be aware of assessment biases as in many cases one’s orientation and gender expression may inform treatment but not demonstrate the focus of treatment as other issues (relationship, depression, anxiety, etc.) may represent presenting concerns (Harper et al., 2013; Kort, 2008; Moe et al., 2015). In effect, counselors must be aware of countertransference, systemic heterosexism and other biases presenting in the counseling relationship by the counselor (Moe et al., 2015).

Several authors and the 2014 ACA Code of Ethics speak to the significance of countertransference as affirmative counselors must examine and overcome discomfort, biases, and even previous experience working with AF persons (ACA, 2014; Kort, 2008; Moe et al., 2015). This process involves assessing one’s biases regarding gender expression, orientation, relationships, and sexuality (AAMFT, 2014) and then bracketing those biases in an effort to limit negative impact on clients (ACA, 2014; Kocet & Herlihy, 2014). An example of addressing counselor bias is Dworkin’s growth through
expanding “ideas about relationships” when she worked with a bisexual woman who lived with and carried on romantic relationships with a married husband and female partner simultaneously (2012, p. 129). Addressing bias must begin before one enters the counseling profession and as gatekeepers’ supervisors and educators can address this process (Frank & Cannon, 2010; Phillips & Fischer, 1998).

**Affirmative supervision.** Kort (2008) noted specialized training and affirmative supervision as particularly relevant in developing affirmative practitioners. Phillips and Fischer (1998) noted how many multicultural and feminist counseling leaders embrace the applicability of concentrated training and information for counselors in order to deliver culturally competent services. As supervision is generally assumed as pertinent to the development of counselors through the challenging of counselor’s and theoretical modalities’ heterosexist assumptions and biases the providing of affirmative supervision is absolutely necessary (Phillips & Fischer, 1998).

Research in clinical supervision exposes concerns regarding “heterosexual bias and discrimination” on the part of clinical supervisors (Burkard, Knox, Hess, & Schultz, 2009, p. 177), creating adverse outcomes for supervisees and clients served (Rose, Moore, Kautzman-East, & Burton, 2015). Fortunately, these issues can be mediated by well-trained and experienced supervisors, which translate to positive personal attitudes, clinical approaches, and counseling outcomes (Moe et al., 2014). Affirmative supervision is critical to combat the biases, assumptions and negative attitudes towards AF persons noted in the literature (Rainey & Trusty, 2007), often exposing heterosexual bias (Dillon et al., 2004). Overall, authors in both counseling and psychology fields note
affirmative supervision as an imperative in appropriately serving AF persons and the entire LGBTQIA community (Aducci & Baptist, 2011; Halpert & Pfaller, 2001; Halpert et al., 2007).

**Affirmative counselor training.** Several authors recognized training of counselors to be particularly important in providing effective and affirmative therapy (Frank & Cannon, 2010; Matthews, 2005). In general, counselor education programs demonstrate a concerning lack of training in affirmative modalities (Matthews, 2005). Matthews noted cultural diversity courses often include one lesson on working with the overall LGBTQIA community even though accreditation standards demonstrate a need for inclusive training for counselor education students (CACREP, 2009).

Wells (1989) was one the first counselor educators to describe teaching general gay and lesbian issues by expressing the use of “explicit films” to decrease bias and homophobia (p. 19). This exposure methodology is an example of how progressive efforts to teach AF and LGBTQIA issues are fostered throughout the years. Frank and Cannon (2010) described the utilization of Queer theory as both a critique of current education standards and as a curriculum for teaching AF and LGBTQIA issues moving forward. Queer theory is optimal for teaching when utilized as a critical lens to view counseling process, assessment protocols and theoretical assumptions. Utilized to deconstruct biases due to heterosexism, biphobia and other systemic pressures Queer theory is noted as an ideal instrument in the development of critical analysis (Frank & Cannon, 2010). Outside of these articles there is a noticeable gap in literature referencing
the teaching of affirmative modalities for LGBTQIA persons, with none targeting AF issues (Matthews, 2005).

**Discrimination and Oppression of AF Persons**

The pressure of the homo/hetero binary often turns to discrimination, oppression and prejudice from both the “straight” and “gay/lesbian” communities (Brickell, 2006; Israel & Mohr, 2004). Often AF individuals exist in between communities; therefore the persons may not exhibit an open identity or socially acceptable placement in either community (Brickell, 2006; Zaylia, 2009). High risk for suicide, self-injury, and substance abuse is common for lesbian, gay, and transgender individuals because of societal pressures, discrimination, and the supposed “unnatural” identity these persons may project (D’Augelli et al., 2005). In the case of AF persons, there is not a succinct community/identity to “belong to” therefore these persons may demonstrate heightened risk factors (Griffin, 2009; Klein, 1993). Wellness levels of AF persons are affected negatively by intra/inter community resentment and discrimination impacting personal power, wellbeing, self-care strategies, physical health, and so forth (Ketz & Israel, 2002; Moe et al., 2008).

Sen (1999) spoke to the relationship between power and wellbeing through the concepts of capabilities and entitlements. Prilleltensky (2008) developed this argument noting, “capacities and resources are at once intrinsically meritorious and extrinsically beneficial” (p. 124). In an often-overlooked result of living in both the heterosexual and gay communities AF persons experience the paradox of both detriments and privileges from both communities simultaneously (McIntosh, 1998; McLean, 2008). Detriments
including harassment and physical/emotional abuse leading to traumatization and the wellness interventions to combat such trauma are explored further below.

Due to well-documented harassment, emotional and physical abuse/violence (GLSEN, 2009; Moe et al., 2014) trauma and victimization are common issues AF persons seek counseling for, even if not originally listed as a presenting concern (Moe et al., 2015). Employing wellness techniques are helpful in treating trauma and related issues according to Moe et al. (2008), as wellness constructs such as “hope, optimism and life engagement” correlated with adequate LGBQ (lesbian, gay, bisexual and queer) identity development and by extension, overall wellness (p. 211). Attitudes, discrimination, and oppression towards AF persons from both communities can negatively affect wellness (Moe, 2016) and contribute to negative coping skills including suicide and substance abuse (D’Augelli et al., 2005).

Israel and Mohr (2004) specifically focused on attitudes of students towards persons who are bisexual. Findings were consistent with previous research reporting AF persons to be stigmatized and discriminated against by both the heterosexual and lesbian/gay community (D’Augelli et al., 2005; Diamond, 2008a). Specific results were representative of similar research, suggesting AF persons are marginalized and left out of communal activities and advocacy by both the heterosexual and lesbian/gay communities yet may “pass” as heterosexual or lesbian/gay thus may retain privilege depending upon situational and environmental factors (Macalister, 2003; McLean, 2008). Results also point to the connotation of AF persons as both privileged and unprivileged, depending upon activities, the gender of partners and surrounding environments (McLean, 2008).
Privileged and Non-Privileged

Peggy McIntosh, through seminal words on White and male privilege (1998), noted several relevant concepts for the discussion of privilege and lack of privilege for AF persons. McIntosh referenced “denials” which are applicable to both the heterosexual and gay/lesbian communities as neither fully indicate an understanding nor resolve that AF persons live in-between communities and can at any moment be both privileged and unprivileged (Macalister, 2003; McIntosh, 1998; McLean, 2008).

McIntosh noted most oppression from those privileged is “unconscious” as is true with White privilege described as “an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks” (1998, p. 148). Ironically, while lesbian/gay persons are customarily unprivileged in a heterosexist society they have developed privilege within LGBTQQIA communities, especially in comparison to the AF identities of bisexual, queer, questioning, and so forth (Firestein, 1996; Israel & Mohr, 2004). Common stereotypes note AF persons as fence-jumpers, going through a phase of attraction or orientation towards multiple genders, or denying being “fully” lesbian or gay prevail in both heterosexual and lesbian/gay communities (Firestein, 1996; Mulick & Wright, 2002). These fear and ignorance-based representations Bennett (1992) noted as constituting biphobia, the “prejudice against bisexuality” (p. 205), underscore the privilege both heterosexual and exclusively lesbian/gay persons experience in different settings.

In the creation and testing of an instrument Mulick and Wright (2002) found evidence of biphobia (relevant to AF persons’ experience) as a construct existing in both
the lesbian/gay and heterosexual populations. Bennett (1992) had earlier noted biphobia as “denigration of bisexuality as a valid life choice” (p. 207). As this statement implies orientation to be a choice we shall recognize affectionally fluid persons to represent a valid affectional orientation based upon bisexuality and fluidity of orientation research over decades (Kinsey et al., 1948; Klein, 1993; Diamond, 2008a, 2008b; Vrangalova & Savin-Williams, 2012).

An often-unnoticed contributing factor to lower wellness levels for AF persons are microaggressions. These routine and often unconscious acts communicate negative messages to AF persons through subtle verbal, nonverbal, visual or behavioral acts (Solorzano et al., 2000; Sue et al., 2007). An example of a microaggression for an AF person could include the following scenario:

Jess, a self-identified bisexual, cisgender woman, is married to Ken, a cisgender, heterosexual-identified man. She is having a conversation with her female friend Irene, a heterosexual, cisgender-identified woman. Irene asks what it is like being married to a man “when it could be so much easier being with a woman because men are so difficult.” Irene then states, “Well I guess you made the choice to be with a man instead of a woman so that must mean you are really straight but maybe he’s okay with you having a lady on the side too.”

This encounter is representative of the “brief, everyday exchanges that send denigrating messages” to AF persons (Sue et al., 2007). These acts are often subtle and noted in verbal, nonverbal, visual or behavioral realms and conducted routinely and unconsciously (Solorzano et al., 2000). The impacts of stressful events such as
microaggressions along with larger systemic heterosexism, discrimination, and oppression affect the wellness of AF persons (Moe, 2016). Wellness research connected to lived experiences of AF persons and direct wellness research including AF persons is explored below. This literature focuses on implementation of wellness modalities counteracting stressors from systemic pressures in ways conducive to the AF experience.

**Wellness Counseling and Recent Wellness Research Pertinent to AF Experiences**

Granello (2013) defined wellness counseling as noting the modality “may deal with all of the body, including the brain, consciousness, and essential personhood” (p. 61). Granello (2000) noted approaches to wellness counseling vary with multiple theoretical approaches and interventions utilized commonly including assessment of and skill training in social development, psychoeducation (including familiarizing clients with wellness models), goal development, and specific interventions such as relaxation or stress management. This holistic model is represented best through the use of the Transtheoretical Model (TTM) and quality goal development (Granello, 2013; Prochaska & DiClemente, 1982). The TTM’s five stages of precontemplation, contemplation, preparation, action, and maintenance are an ideal method to measure goal development, attainment, and progress (Prochaska & DiClemente, 1982).

Changing one’s lifestyle and behaviors through a collaborative, prevention-oriented client/counselor plan and effective formal/informal assessment (including utilizing the WEL/5F-WEL conducted by the counselor represent the most successful wellness plan) is a daily endeavor (Myers & Sweeney, 2003; Myers et al., 2000). This plan is undertaken by pursuing a couple specific areas of wellness identified by the client
such as pursuing a more active lifestyle or reconceptualizing spirituality (Granello, 2013; Myers & Sweeney, 2005). Finnerty and Jencius (2011) described similar connotations, including daily rituals and activities such as the use of technology in developing personal models of wellness. These models include education, encouragement, feedback from counselors, and small goals to sustain substantive progress (Finnerty & Jencius, 2011).

In addition to reviewing the notations above, relevant literature in wellness counseling are explored below.

Recent counseling literature (2007-2015) has studied or conceptualized the varied modalities of wellness counseling. Statistically significant improvement of 5F-WEL scores (within-subjects ANOVA, pre to post-test) in all but one of the 2nd order factors (Essential, Social, Physical, Creative and Coping) of the Indivisible Self Model were demonstrated utilizing wellness counseling with law enforcement officers (Tanigoshi, Kontos, & Remley, 2008). Wellness counseling and interventions are also noted in treating veterans effectively and competently (Carrola & Corbin-Burdick, 2015).

Strength-based wellness counseling techniques utilized in an approach to counseling adult women sexually abused as children was recently explored by Hodges and Myers (2010) through a case study, suggesting these holistic interventions can lead to resiliency and assist in addressing past trauma.

Lenz and Roscoe (2011) utilized a “personal wellness card sort” intervention, to “promote relational healing” (pp. 70-71). This methodology is close to the Q-method explained in the next chapter as it asks for the participant to recognize constructs of wellness, which constitute meaning for the participants, rather than constructed meanings.
from researchers (Lenz & Roscoe, 2011). This suits AF persons as empowerment is absolutely essential to developing skills needed in establishing individual, group, and community wellness (Harley et al., 2000; Legate et al., 2012; Prilleltensky, 2008; Savage et al., 2005).

Recent wellness research with the general population, including literature concerning marginalized groups, where wellness descriptions are related to overall wellbeing, occupation, or other significant variables have demonstrated noteworthy results. In subject areas from pet-owner wellness (Chandler, Fernando, Barrio Minton & Portrie-Bethke, 2015) to “eco-wellness” as a theoretical construct delineating the natural world as essential to personal wellbeing (Reese & Myers, 2012) wellness modalities and constructs demonstrate intriguing quantitative, qualitative and theoretical literature. Other relevant wellness studies in the general population include criticisms of current models/definitions (L. J. Roscoe, 2009) along with study utilizing wellness modalities with special populations such as persons with mobility impairments (Snook & Oliver, 2015).

The subject areas of pet-owner (Chandler et al., 2015) and eco-wellness (Reese & Myers, 2012) are relevant to current study as they delineate the construct in specialized social and ecological enumerations found to be pertinent in experiential notations of wellness (Myers & Sweeney, 2005). Through qualitative inquiry Chandler et al. (2015) identified eight domains of wellness corresponding to pet owners: “emotional and physical nurturance, sense of family, sense of responsibility and purpose, friendship or
companionship, social interaction and connections, personal values and spiritual meaning, fun and play, and physical health” (p. 268).

Many of these themes, including those based in social wellness such as family alignments, friendship, and social connection align with prevailing issues for marginalized populations such as AF persons (Dew & Newton, 2005). Physical wellbeing is also a pertinent issue for AF persons and influenced socially and through stigmatization (Meyer, 1995, 2003). Although Chandler et al. (2015) did not note direct thematic implications referring to reduction of social stigma effects experienced by participants, the authors suggest (noting research by Plakey & Sakson, 2006) pets provide “non-judgmental acceptance” counteracting “social stigma or total rejection” (p. 269). Chandler et al. (2015) noted the study is limited in scope given the qualitative nature and lack of diverse participants (mostly married, heterosexual Caucasians) but the themes found align with 1st and 2nd order factors of the Indivisible Self Model developed by Myers and Sweeney (2005, 2008).

Pets can provide a needed boost in connection with others and provide important stress management (IS-WEL-Coping Self) and self-care (Essential Self) for AF persons struggling with Social Self factors of friendship and love (Myers & Sweeney, 2005). The study below concerning integration of nature into counseling also provides for social interaction amongst other relevant wellness factors (Reese & Myers, 2012).

Although experiencing the natural world has long thought to be part of optimal wellness, Reese and Myers (2012) described “EcoWellness” as “the missing link in wellness models and counseling” (p. 400). These authors called for inclusion of nature in
counseling practice, as there is a developing interdisciplinary set of literature connoting “viewing and being in nature . . . contribute to positive effects” (p. 401). Greenleaf, Bryant, and Pollock (2014) echoed this call for “nature-based approaches” in the practice of counseling, noting the interdisciplinary research supporting such modalities in heightening wellness (p. 162).

Reese and Myers’ (2012) theorized concepts are relevant in counseling the AF population in accessibility, spirituality/connecting, and identity formulation. This includes: issues of “access to nature” for often economically marginalized AF persons (p. 402; Bradford, 2004), “spirituality and community connectedness” as part of what the authors noted as “transcendence” (p. 403) and the concept of identity as pertinent to one’s wellness. Here more aspects of the Essential (spirituality, self-care), Social (friendship, love,) and Physical (exercise; Myers & Sweeney, 2005), 1st order factors can be addressed to combat environmental issues for AF persons (Herek, 2002). This allows AF persons to seek spiritual connections with the natural world rather than or in addition to often-discriminatory organized religious services (Reese & Myers, 2012; Wilcox, 2003).

Spirituality and a sense of connection can also be pertinent to community building (Lee, 2008; Prilleltensky, 2003) and combating social stressors for AF persons (Brewster et al., 2013). Purdy and Dupey’s (2005) Holistic Flow Model of Spiritual Wellness embodies these sentiments through recognition of “a universal force, making meaning of life . . . death, connectedness, faith, and movement toward compassion” (p. 95). This integrated framework can assist with existential issues faced due to the coming out and community-building process (Legate et al., 2012; Wilcox, 2003). All of these aspects
integrate for AF persons who can utilize support for the convergence of multiple identities as they build community in environments wrought with stress and marginalization (Balsam et al., 2004).

Meyer (1995, 2003) noted how social stress and a lack of a supportive community can impact availability and access to functional/safe environments (Brewster et al., 2013). With the EcoWellness elements of “environmental identity” and “community connectedness” one develops or strengthens sense of identity based upon interest in/concern for the environment around them, leading to a symbiotic relationship between person and environment (Reese & Myers, 2012, pp. 402-403). AF persons can create a strengthened sense of identity, community connection, and overall wellness through such an alignment as noted by other researchers who studied social stress (Meyer, 2003), the invisibility/erasure of AF persons (Macalister, 2003). AF persons demonstrate similar results in wellness scores as many marginalized persons of color, ability, and other non-majority persons (Dew & Newton, 2005).

**Diversity and wellness.** Research conducted on the general population for diverse persons shows significant differences regarding wellness from majority to minority populations. Rayle and Myers (2004) demonstrated noteworthy wellness differences across ethnicities. Crose, Nicholas, Gobble, and Frank (1992) explored wellness differences in gender, finding men and women demonstrate notable distinctions on 1st and 2nd order factors of wellness. Wellness within the specific group of AF persons is very difficult to find, thus literature with participant pools including bisexual or queer
persons is utilized in describing the AF wellness experience (Dew & Newton, 2005; Moe, 2016).

There is a continued need for research on wellness with AF persons of color (and other tenets of diversity such as orientation, gender expression and ability as examples). According to Myers and Sweeney (2005), wellness resounds across the globe, especially since spiritual wellness is a major focus. As instruments designed to measure wellness, the WEL and 5F-WEL have been utilized in studying numerous populations across the country and world including Southeast Asia (Myers & Sweeney, 2005). Without including intersectionality in these studies one cannot fully represent the extent multiple marginalization has on wellness. Balsam et al.’s (2004) study examining “culture, trauma, and wellness” (p. 287) with multiply marginalized Native American lesbian, gay, bisexual and Two-spirit persons is one of the first to do so finding wellness is constructed differently by AF persons of color through the lens of trauma. Balsam et al. (2011) later created the LGBT People of Color Microaggressions Scale to measure multiple marginalization while Brewster et al. (2013) studied bicultural bisexual individuals’ ability to cope with minority stress through utilization of coping mechanisms, “cognitive flexibility, and bicultural efficacy.” This study is emphasized later in final review of AF persons in wellness research.

**Wellness within the AF population.** Very few empirical studies or theoretical articles describe AF persons’ wellness in counseling or within the LGBTQQIA at-large (Dew & Newton, 2005). At this time the limited literature regarding wellness within the entire LGBTQQIA community describes how coming out relates to wellness (Legate et
al., 2012), how internalized homophobia impacts wellness (Dew, Myers & Wightman, 2006), and comparisons between sub-group members (lesbians/bisexual women vs. gay/bisexual men) on correlates of stigmatization, “well-being,” and identity (Luhtanen, 2003, p. 86).

Specific studies regarding wellness for AF persons are even less common. Ketz and Israel (2002) studied the relationship between women’s affectional identity and “perceived wellness” (p. 229) whereas Brewster et al. (2013) assessed relationships between “minority stressors . . . as well as posited mental health promoters” alongside indicators of mental distress and wellness in “bicultural” bisexuals (p. 543). Ketz and Israel (2002) described identity and subsequent levels of wellness as correlated to the gender of the current partner (i.e., woman who is in relationship with woman is presumed to be a lesbian, man in relationship with woman presumed to be heterosexual). Another result from this study is how behavior was found to be isolated from affectional orientation identification as women may continue to identify as heterosexual even while having affectional relationships with other women.

Ketz and Israel (2002) believed this may have to do with retaining privilege, internalized bifobia, and/or discrimination. The overall results showed no statistically significant differences between “women who sex with both women and men and identify as bisexual or women who have sex with both women and men and identify as heterosexual or lesbian/gay” (Ketz & Israel, 2002, p. 229), but this study still did not include wellness models from the counseling field. Sheets and Mohr (2009) later examined the similar construct of “perceived social support” for bisexual college
students, demonstrating a link to less mental distress (p. 152). Although this study also did not utilize the specific Social Self construct formulated in the IS-WEL, social connection is again correlated with optimized health (Moe, 2016; Myers & Sweeney, 2005).

Brewster et al. (2013) found variables associated with minority stress were correlated with distress while “mental health-promoting variables” connected to heightened wellness for 411 bisexual persons (p. 552). Wellness in the participants was found negatively connected to internalized prejudice and biphobia whereas “outness was linked with some costs and benefits” (p. 543). The authors suggest results trend towards cognitive flexibility as a protective factor but this effect is shattered in environments of extreme prejudice. These results note how functional, safe environments alongside resilience through cognitive flexibility can foster substantive impacts on the overall wellness of AF persons (Brewster et al., 2013). This study did not utilize the IS-WEL model but many of the descriptions of wellness may corroborate to the 2nd order factors of coping, essential and social selves. Positive social connection is noted yet again in the study below.

Legate et al. (2012) also found significant relationships between positive support, being out and wellness but noted these correlations were dependent upon positive coming out experiences, suggesting wellness concerns for AF persons who may come out to both the heterosexual and gay/lesbian communities (Legate et al., 2012; Macalister, 2003). As the AF population lives between communities minority stress may also be present.
Balsam et al. (2004) also found stress in the form of trauma to be correlated with constructs of wellness.

Balsam et al. (2004) contrasted the interactions between “culture, trauma and wellness” between Native American lesbian, gay, bisexual, and Two-spirit persons (LGBTs). The generalizability of this study is in question as the authors explored differences between Native American LGBTs and heterosexual populations but only included 25 LGBTQQIA participants against 154 heterosexuals. Results did point to issues related to wellness including higher substance abuse rates, physical concerns and traumatic experiences over their lifetimes (Balsam et al., 2004).

Degges-White (2003) studied several factors including wellness in “women at midlife.” This study included self-identified lesbian, gay, and bisexual participants but did not delineate on identities assumed by AF persons. There were no demonstrable differences between heterosexual and bisexual (AF) women in correlates of wellness (Degges-White, 2003). Degges-White and Myers (2006) later recognized correlations between total wellness and life satisfaction for lesbian women. Degges-White (2003), Degges-White and Myers (2006), and Dew et al. (2006) represent the only studies investigating wellness with LGBTQQIA identities through usage of the IS-WEL (Moe, 2016; Myers & Sweeney, 2005). No study conducted with only AF persons has been undertaken utilizing the IS-WEL Model.

Moe (2016) conducted the first major meta-analysis (8,499 total participants from 25 studies) regarding wellness of LGBTQQIA persons contextualized through the construct of distress, including two utilizing the IS-WEL model (Myers & Sweeney,
2005). Studies with results correlating to constructs of the IS-WEL were utilized from multiple counseling and psychology journals transposed alongside “psychosocial distress” (Moe, 2016, p. 119). Results from this analysis found 27 effect sizes including 13 grounded in relational constructs describing the “lived experience (e.g., internalized homoprejudice)” of LGBTQIA (including AF) persons (p. 119). Moe (2016) coded “wellness-related variables” utilizing the IS-WEL model finding 11 studies examined coping self variables, “eight studies of the social self, six studies the essential self, three studies the creative self, one the physical self, and one study the first-order, general wellness factor identified by Myers and Sweeney” (2005, pp. 119-120).

Within this meta-analysis one study included only bisexual (one identification of AF) persons, thus Moe’s (2016) results cannot generalize to the specific AF population under study in the current research. The author noted “the trait of social support” as the most evidenced correlate in reduction of psychosocial distress and discusses wellness interventions aimed to “increase social support may help foster this important wellness component” (Moe, 2016, p. 124). Moe (2016) indicated strength-based approaches such as the IS-WEL model must become more attuned to the lived experiences of the overall LGBTQIA community, in extension research investigating the use of such modalities with AF persons is essential. Moe (2016) noted fostering a deeper understanding of LGBTQIA experiences with IS-WEL “wellness traits is warranted,” therefore investigating AF beliefs about these traits in particular is necessary (p. 126).
Conclusions

As noted above, there is a paucity of literature measuring AF persons' beliefs about wellness and AF literature related to wellness as a counseling construct (Dew & Newton, 2005; Moe, 2016). In order to effectively serve AF persons through a strength-based wellness modality, it is pertinent to understand the beliefs of the population about wellness elements. AF beliefs are useful for counselors treating clients but perhaps most useful to counselor educators in the development of suitable supervision and multicultural instruction suiting the ambiguity of affectional fluidity.

Effective, culturally competent, and affirmative treatment is provided through utilizing a wellness approach focused on the resilience of AF clients (Kort, 2008; Lee, 2008). Individual and community wellness is developed through empowering with/for diverse AF communities served (Prilleltensky, 2003; Ratts & Hutchins, 2009). As there are even less studies (Balsam et al., 2004; Brewster et al., 2013) measuring wellness with a diverse set of AF persons fostering an intersectional sample is ideal. A Q-methodology study can recognize the beliefs of AF persons about wellness factors and practices.

Research Questions

Q1: What is the nature of subjective beliefs about wellness that emerge from the studied population?

Q2: How will AF persons rank order statements emanating from IS-WEL 2nd and 3rd order factors of wellness such as social self, physical self, essential self, and so forth?
CHAPTER II

METHODOLOGY

This chapter contains an overview of Q methodology, the justification for utilizing Q to measure AF persons’ beliefs about wellness, processes followed in the completed investigation, and data analysis. Q method may not necessarily utilize research hypotheses, thus this study was guided by the research questions: What is the nature of subjective beliefs about wellness that emerge from the studied population? How will AF persons rank order statements emanating from IS-WEL 2nd and 3rd order factors of wellness such as social self, physical self, essential self, and so forth?

Q Methodology

Q methodology is scientific study of subjectivity, first presented by William Stephenson. Through subsequent publications, Stephenson (1953, 1977) noted how the inversion of factor analysis is useful in investigating relationships among persons, thereby establishing the Q approach (McKeown & Thomas, 2013). Shinebourne and Adams (2007) reported Q demonstrates a “powerful capacity for thematic identification and analysis” (p. 103).

Stephenson (1953) noted the concept of human subjectivity, which is the communication of personal point of view, inherently focused in self-reference (McKeown & Thomas, 2013). Q methodology affords a systematic process to measure and better understand the subjective experiences of participants, relating subjectivity as an aspect of human behavior (McKeown & Thomas, 2013). These opinions are the main consideration with Q, thus researchers utilize this modality not to prove these opinions
but instead find the configuration representing perspectives (S. R. Brown, 1996). In methodological practice this allows the participant to model perspectives through the use of a Q sort (McKeown & Thomas, 2013).

According to McKeown and Thomas (2013), the Q method process begins with researchers sampling statements that form an extensive scope of perspectives, gathered from relevant literature, media, and previous interviews or pilot studies. Statements are transcribed to cards and numbered. This leads to the Q sort where participants are instructed to order cards by preference from agree to disagree. Once completed, the researcher records the sort for analysis by observing statement card placement. Participants are interviewed regarding the placement of the statements (S. R. Brown, 1986).

The results of this process are factors representing different human subjectivities within the participant pool. S. R. Brown (1996) noted subjectivity in Q can communicate a participant’s appraisal, attitude, experience, interpretation, judgment, perception, or standpoint. Instead of communicating precise perceptions of a single participant, results represent an apex of commonalities for a specific belief (S. R. Brown, 1996). The remainder of the chapter is concentrated on Q methodology and the approach to the study conducted.

**The Current Study**

The current study utilized Q methodology to understand AF persons’ beliefs about wellness. Q method was an appropriate approach due to its focus on the subjective beliefs of participants and interrelation of these beliefs. Other research methodologies
were pondered to investigate AF beliefs about wellness, including phenomenological inquiry. This branch of qualitative research emphasizes persons’ lived experiences and the meaning, structure, and essence derived from said experiences (Moustakas, 1994). Phenomenological data gathering involves deep interviews with participants regarding beliefs and perceptions (Schram, 2006). This related to the current study in learning about the beliefs of AF persons about wellness.

Phenomenological inquiry was not chosen for several reasons, most namely due to the limited scope this modality provides, as the intent of this study was to recognize a range of beliefs communicated by AF persons instead of individual beliefs. Q methodology allowed for various perspectives to be considered alongside a correlation analysis explaining relationships in singular perspectives and emergent factors (S. R. Brown, 1996). As phenomenological inquiry does not allow for multiple viewpoints or statistical analysis, Shinebourne and Adams (2007) recommended Q methodology as it can deliver phenomenological information from many more participants via correlational analysis. In extension of delivering participant experiences, Brown noted how Q methodology is efficacious when utilized with marginalized groups such as AF persons as it empowers said persons’ subjective voices to be heard rather than devalued (S. R. Brown, 2005). In effect, both minority perceptions and the Q sort interviews provide a medium for marginalized participants to voice their concerns, which then enter the data set (S. R. Brown, 2006).

As the current study was focused upon wellness, which requires significant with/for advocacy and empowerment through counseling for marginalized AF persons in
clinical practice, utilizing the Q method created actionable research (Granello, 2013; S. R. Brown, 2005). Q offered this by empowering AF persons to express subjective beliefs with limited bias or imposition from external forces (S. R. Brown, 2005). These beliefs, represented after analysis as factors, informed clinical interventions for this misunderstood population.

Baltrinic, Waugh, and Brown (2013) utilized Q methodology in processing and building strategies for successful completion of doctoral counselor education programs. The researchers utilized the emergent and “distinguishing perspectives” emerging from analysis to focus recommendations for both faculty and students in program progression. For this study, emergent factors, the relationships within and between these factors, and statistical information informed future wellness interventions for clinical work with AF persons.

The sections below include procedural descriptions followed in the study. Construction and sampling of the concourse and Q sample, participant selection, data collection, and the data analyses are explored.

The Concourse

The concourse is an assortment of statements surrounding a specific topic (Stephenson, 1978). It characterizes the total summation of subjective communicability associated with a specific topic (Baltrinic et al., 2013). Statements are utilized from a collection of literature including texts, journal articles, interviews with persons and/or groups, and so forth (S. R. Brown, 1996). The concourse for this study was generated
through review of wellness and AF literature with particular attention given to the IS-WEL Model (Myers & Sweeney, 2005) described in the literature review.

As the concourse was created utilizing relevant literature in the field, many journal articles and texts describing wellness in counseling were used. Impressions were developed from existing wellness and AF literature in counseling and related fields. Chapter 1 delineated the limited research on the intersection of AF persons with wellness. The IS-WEL Model provided most of the material for wellness statements (Myers & Sweeney, 2005). For functional application with AF persons the \textit{ALGBTIC Competencies} (Harper et al., 2013), Moe’s (2016) synthesis of LGBTQQIA wellness research, and Moe et al.’s (2015) article stressing affirmative assessment with the LGBTQQIA community were utilized to craft culturally competent and AF affirming wellness statements. These three articles were helpful in screening the questions for cultural and identity/behavior-affirmation issues. In addition the Moe et al. (2008) article concerning “LGBQ identity development and hope, optimism, and life engagement” was utilized to format identity concerns related to wellness (p. 199).

The material developed into 48 statements (noted in Appendix A) shaped from the 2\textsuperscript{nd} and 3\textsuperscript{rd} order factors of wellness delineated within the IS-WEL Model (Myers & Sweeney, 2005). In addition, the AF literature above deemed relevant assisted in “queering” the statements for use by a group of AF persons, recommended in various LGBTQQIA publications regarding clinical practice, teaching, and/or research with AF persons (Frank & Cannon, 2010; Harper et al., 2013; Moe et al., 2015).
The Q Sample

A representative subset of the concourse is known as the Q sample. The most common elements utilized for this subset are statements (Watts & Stenner, 2012). The Q sample for this study was a set of 32 statements (Appendix B) from the concourse to be sorted by participants in a rank-order fashion (S. R. Brown, 2008). The statements were based upon 2nd and 3rd order factors of the IS-WEL Model, thus statements emphasized elements of theoretical model of wellness (Myers & Sweeney, 2005). The researcher, under direction from an advisor (Brown, personal communication, 10-12-16) chose items demonstrating significance to the study, culminating in the table and content below.

As the IS-WEL Model of Myers and Sweeney (2005) provided the basis for categorizing and selecting statements, the main components (and sub-components) are shown in Table 1. The Creative self was specified in terms of five sub-components—thinking, emotions, control, work, and humor—and among the statements selected for these sub-components were as follows:

3. Is mentally active and open-minded. (thinking)
4. Aware of and in touch with feelings. (emotions)
10. Demonstrates planfulness in life. (control)
32. Finds satisfaction with work. (work)
21. Can laugh at mistakes and unexpected things that happen. (humor)
Table 1

*Q-Sample Structure*

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<th>Main Effect</th>
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<td>Creative</td>
<td>Coping</td>
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<tr>
<td>Components</td>
<td>Creative</td>
<td>Thinking, emotions, control, work, humor</td>
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The same strategy was adopted in selecting statements for the other selves, the following being illustrative (for all Q sample statements, see Appendix B):

*Coping (leisure, stress, self-worth, realistic beliefs)*

23. Is satisfied with leisure activities.


27. Acknowledges positive qualities and imperfections within self.

14. Understands that perfection and being loved by everyone are impossible goals.

*Social (friendship, love)*

1. Enjoys social relationships involving a connection with others, individually or communally, but without marital, sexual, or familial commitment.

12. Is able to be intimate, trusting, and self-disclosing with another person.
Essential (Spirituality, gender identity, cultural identity, self-care, physical)

29. Holds/practices personal beliefs that allow for recognition of self as more than just a material being.

26. Feels satisfaction with existing gender.

8. Feels supported in a cultural identity.


25. Engages in sufficient activity to stay in good physical condition.

A subset of \( n = 8 \) statements was selected from each of the 4 Self-categories in Table 1 for a Q-sample size of \( N = 32 \) statements, all of which are shown in Appendix B with the response grid utilized to rank the statements.

From a methodological standpoint, it is important to note the statements above are not conceived of as variables, as in the case of scaling theory; that is, they are not considered as measures of a creative, coping, social, essential, or any other “self” in any substantive sense. Rather, the framework advanced by Myers and Sweeney (2008) was adopted for pragmatic purposes, as a device that provides the basis for winnowing down the concourse (which is theoretically infinite in magnitude) into a Q sample of manageable size for the purpose of carrying out the empirical study. The goal of the study was to approximate representativeness (Brunswik, 1947) in the Q sample comparable to the range of diversity in the parent concourse, in the same way that a sample in survey research is comparable in its representativeness to the breadth of the population.
Participants (P set)

To foster a diverse participant set (P set) a $3 \times 3$ factorial structure of age brackets (young, middle age, and older) across gender identification (man, woman, transgender/androgynous) was utilized (S. R. Brown, 1986). An effort to gain a blend of AF persons through age brackets and gender identification was made to create a P set of at least 5-6 per cell (Figure 1). Major sources on Q methodology recommend a P set reaching 30 to 50 participants for a suitable representation (S. R. Brown, 1980, 2008; McKeown & Thomas, 2013).

![Figure 1. 3 × 3 Factorial Structure for AF-Wellness Sample](image)

As noted above, identification as one of the many identities associated with AF persons (bisexual, down-low, fluid, omnisexual, pansexual, queer, etc.) or noting lack of identity with either of the binary identifications along the continuum of affectional orientation (heterosexual and gay/lesbian) was the major inclusion criterion for the study.
As wellness is developmental and continual over the lifespan for every person no ability, age, educational, ethnic, spiritual, or other demographic constraints were needed (Myers & Sweeney, 2005).

Solicitation of participants occurred through use of personal/professional contacts, direct emails, online counseling/AF persons-related list serves, and social media sites. The online counseling list serves included the Association of LGBT Issues in Counseling (ALGBTIC), Counselor Educators (CESNET), and Counselors for Social Justice. The social media posts were conducted within the Facebook groups and/or pages of the Association of LGBT Issues in Counseling, Counselors for Social Justice, the researcher’s personal page, the Counselor/Therapist Networking/Consultation Group, Association of Multicultural Development, BiNet USA, Queer PhD Network, North Central Association of Counselor Education and Supervision (NCACES), LGBTQ Research and Researchers in Higher Education and Student Affairs, People Against Biphobia, and Professional Mental Health Counselors/Social Workers/Psychologists. The researcher utilized the snowball technique (Goodman, 2011) by asking participants to recommend others for the study. An example of the recruitment letter/email/posting was provided in Appendix C.

**Procedure**

The Q sort was completed by participants either in-person or via mail. For those who completed the sort in person, a large table (with room to sort) was utilized, away from others or in more private locations at the participant’s request. The researcher
explained the consent form (Appendix D), basic sort, and Q procedure by utilizing a brief script (Appendix E).

In addition, background information and the Q sort interview was collected through a form (Appendix F) presented with the rest of the packet. This background information form included questions on relevant aspects of the participant’s age, gender expression/identity (both pertinent to the P set recruitment noted above), and the inclusion measure of affectionally fluid identity. In addition, the form also included markers of identity relevant to recognizing the type of population recruited (ethnicity, identified racial group, assigned sex, education level, relational status, employment status, and spiritual/religious affiliation or beliefs).

In addition to the forms above the Q sort materials (statements and numbers corresponding to grid) were explained for in-person participants. If the sort was completed remotely a packet was sent with directions/brief script to introduce the study (Appendix E), informed consent form (Appendix D), Q sample materials, a response grid included in Appendix B, and the background information/Q sort interview form (Appendix F).

Both in-person and mail-in participants received 32 Q sort cards, each card with a printed statement from the Q sample. The participants completed the Q sort by sorting statements by preference. First, participants separated cards into three groups: agree, neutral, and disagree. Participants then placed statement cards under the response grid, which ranged from 4 to -4, and recognized gradations of agreement with individual statements (McKeown & Thomas, 2013). The positive end of the rankings (4)
represented agreement, whereas the negative end of the rankings (-4) recognized disagreement with the statements. The mid or zero point represented neutral conceptualization of the statement. Participants navigated back and forth, placing statements under the positive, then negative columns, of the grid until all statements were utilized. The participants then had the opportunity to shift statements from original placements as necessary.

Q researchers often tend towards a forced distribution as it demands participants demonstrate preference of one statement over another. A forced distribution is created by allowing for a certain number of statements to be placed under each marker on the positive, neutral, negative parts of the response grid (S. R. Brown, 1980). This study utilized the Q method’s common standard curve in distribution of statements, although, there were no recognizable impact of distribution on factor loadings. Instead, the arrangement of card placement was pertinent to factor loadings (S. R. Brown, 2008).

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*Figure 2. Distribution shape. The first row of numbers was the scale for ranking of 32 statements. Each X represented a statement for the ranking.*

After completion of the card sort for in-person participants the researcher recorded the card numbers of the sort on the grid utilized while participants completed the background information and Q sort questionnaire. Mail-in participants recorded the
card numbers, completed the questionnaire, and returned completed materials via mail. Developed from Schermer (2010), questions on the Q sort questionnaire included:

- Describe how the statements you ranked at 4 (Most agree with your beliefs about wellness) are essential to your beliefs.
- Describe how the statements you ranked at -4 (Most disagree with your beliefs about wellness) are most inessential to your beliefs.
- Describe other statements you believe assist in defining your beliefs (either positive, negative, or neutral rankings).
- What statements were difficult to place? Please note the difficulty in placing.
- Are there any other beliefs or concepts about wellness which materialized during the sort?

**Analyses**

Correlation and factor analysis of complete sorts were conducted utilizing PQMethod (Schmolck, 2014). This program computes a by-person correlation matrix where the coefficient expresses the degree of similarity among the various Q sorts (Schmolck, 2014). As S. R. Brown (1996) noted, the matrix provides information about the relatedness of subjectivity, but Q researchers are not interested in these results. Once the correlation matrix was defined, a factor analysis through principal components method (with varimax rotation) was conducted. Factors resulting from this analysis were groups of participants who ranked statements similarly. The degree of relation between single Q sorts and factor arrays comprised a factor loading, which was significant (i.e., significantly different from 0.00) when in excess of ±1.96 times standard error (SE).
Standard error was calculated utilizing the equation \( SE = \frac{1}{\sqrt{N}} \), where \( N \) represented the number of statements in the Q sample (McKeown & Thomas, 2013). The matrix of factor loadings was included in Appendix G.

**Interpretation of Factors**

Factor scores are emphasized more than factor loadings in Q methodology (McKeown & Thomas, 2013). Scores represented the averages of statements for those Q sorts loaded on each factor (S. R. Brown, 1996). Factor arrays were calculated utilizing PQMethod (Schmolck, 2014). Each factor in this study represented a result of highly correlated Q sorts instead of any single participant’s sort (Brown, 1993).

Similarities and differences among factors were assessed utilizing factor arrays and analysis of said arrays guided by the placing of statements. In addition, the ranking of statements statistically was utilized (Watts & Stenner, 2005). Underlying factor connotations were interpreted through analysis of factor arrays.

S. R. Brown (1996) noted participants could assist the researcher with factor interpretation when the researcher asks questions concerning placement of statements. In this study particular assessment of meaning was focused on the poles of the rankings (4 and -4). Other important statement placements and struggle with statements were also noteworthy. Participants with strong factor loadings (noted in Appendix G) were focused upon to elicit wellness beliefs in an appropriate manner and the interview answers utilized for clarification (McKeown & Thomas, 2013). Open-ended clarifications were utilized to understand participants’ Q sorts in this study as the content, wellness,
represented in different ways to a range of culturally different subjects (Lee, 2008; Watts & Stenner, 2012).

**Delimitations**

The P sample of AF persons may have embodied the main limitation for the study as this population represented an intersection of ethnic, spiritual, ability, and other demographic factors (Harper et al., 2013). The intersections of diversity in the population created an inherent range of beliefs about wellness, which can be seen as useful for the study but may have limited findings. In addition, AF persons who demonstrated an interest in wellness could have been more likely to participate, thus interested parties may also limit findings.

As S. R. Brown, Danielson and van Exel (2015) described, Q methodology offers no intention of relating all possible or incidence of beliefs. This concern has represented a common misconception and denigration of Q by critics (Kampen & Tamás, 2014). As S. R. Brown et al. (2015) and Stephenson (1953) noted, the worth of perceptions are not lessened or heightened by inclusion in the greater community. Instead, results can showcase particular sub-sections of AF persons’ beliefs. As noted above, different beliefs for those who did not participate in this study are not only possible, but also probable.

**Summary**

The current study attempted to add to the literature about wellness beliefs of AF persons. The dearth of information on AF beliefs about wellness or literature regarding wellness for AF persons at all is concerning at best, exhibiting a lack of cultural
competence in wellness practice at worst (Dew & Newton, 2005; Harper et al., 2013). To foster more affirmative and culturally competent counseling services, practitioners must demonstrate more awareness and knowledge regarding coping activities and overall wellness of AF persons (Moe, 2016). Developing literature on AF beliefs about wellness can assist practitioners in implementing specific wellness and mental health interventions in an affirming, client-focused manner.
CHAPTER III

RESULTS

The current study utilized Q methodology to assess affectionally fluid (AF) persons’ beliefs about wellness. This chapter includes the demographics of the participants, the statistical data analysis, and post-sort Q responses. The beliefs of the participants emerging from the data are presented in greater detail in Chapter 4. The research question of the study was: *What is the nature of subjective beliefs about wellness that emerge from the population of AF persons?*

Data collection occurred over a six-week period from late December 2016 to February 1, 2017. As noted in Chapter 2, participants were recruited through use of personal/professional contacts, direct email, online counseling/AF persons list servs, and social media sites. The online counseling list servs utilized included Association of LGBT Issues in Counseling (ALGBTIC), Counselor Educators (CESNET), and Counselors for Social Justice. The social media posts utilized within the Facebook groups and/or pages included Association of LGBT Issues in Counseling, Counselors for Social Justice, the researcher’s personal page, the Counselor/Therapist Networking/Consultation Group, Association of Multicultural Development, BiNet USA, Queer PhD Network, North Central Association of Counselor Education and Supervision (NCACES), LGBTQ Research and Researchers in Higher Education and Student Affairs, People Against Biphobia, and Professional Mental Health Counselors/Social Workers/Psychologists.
The snowball technique (Goodman, 2011) proved effective as many prospective participants from states as far as California responded noting referral from a colleague. Professional contacts referred quite a few prospective participants through sharing the recruitment email about the study resulting in contact from interested parties.

Prospective participants agreed via electronic communication to either be sent a packet by mail or meet in person to conduct the sort. Ten of the 45 participants met in person for the sort and completed it after reading the directions (Appendix E) and having any questions answered verbally, signing and keeping the informed consent (Appendix D) for their records, thereby giving consent to participate per IRB stipulation. The participants who completed and returned packets by mail gave consent to participate by signing and retaining the informed consent as designed per IRB stipulation.

A total of 45 packets were sent back by participants but a response grid in one packet was completed incorrectly and deemed inappropriate for inclusion in the study. With the exclusion of those who participated in person (all residents of Northeast Ohio), data on participants’ states of residence were not available due to confidential nature of materials sent back (participants were asked not to provide return addresses or leave any identifying information on forms). However, emails were exchanged with prospective participants from 16 states including Arizona, California, Colorado, Connecticut, Idaho, Illinois, Michigan, Nevada, New York, North Carolina, Ohio (10 in-person participants), Oklahoma, Pennsylvania, South Dakota, Texas, and Virginia.

A total of 44 responses were considered for use in the study. As noted in Chapter 2, Q researchers recommend a P set of 30 to 50 participants as a suitable representation
The demographic information for participants included in the analysis is summarized below and by participant in Appendix G.

**Participants**

In order to gain a diverse P sample the notations of age (in three ranges beginning at 18 years old) and gender identity (man, woman, and non-binary identifications such as genderfluid, genderqueer, transgender, etc.) were utilized (as noted in Chapter 2). Affectional orientation represented through identification and/or description corresponding to the AF definition noted in Chapter 1 set inclusion criteria. The mean age of the 44 participants was 32.8 years old. In the 18–39-age bracket 13.6% identified as men ($n = 6$), 43.2% as women ($n = 19$), and 27.3% self-identified as “genderqueer,” “genderfluid,” “transgender,” “transmasculine,” “two-spirit,” or “gender flexible” ($n = 12$) in the 18–39 age bracket. Between the ages of 40 and 60, 4.5% identified as men ($n = 2$), 6.8% as women ($n = 3$), and 2.3% as one of the representations outside of the gender binaries, noted above, in this case “gender flexible” ($n = 1$).

After continual efforts to reach out to the 61 years and above age group, one participant, a self-identified man, participated, representing 2.3% of the overall P sample ($n = 1$). No self-identified AF women or non-binary gender identities were represented in this age bracket. Several outreach efforts, including a “senior” group at the local LGBTQ center, did not result in more participants from this age bracket. The leader of this group noted, “Some of our members were interested but did not feel they belonged to the population you were looking for” (confidential personal communication, 1-8-17).
In Tables 2 and 3 the main inclusion criterion, affectional orientation identity, was represented along with ethnic identity as both consisted of many identifications. Several other demographic representations are noted and Table 4 for spiritual/religious identification demonstrated the wide variation of belief in the sample.

Table 2

*Affectional Orientation Identification in P Sample*

<table>
<thead>
<tr>
<th>Affectional Identity</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>43.2</td>
<td>19</td>
</tr>
<tr>
<td>Pansexual</td>
<td>20.5</td>
<td>10</td>
</tr>
<tr>
<td>Queer</td>
<td>20.5</td>
<td>10</td>
</tr>
<tr>
<td>Heterosexual w/ same gender attraction</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Attraction via intelligence</td>
<td>6.8</td>
<td>3</td>
</tr>
<tr>
<td>Fluid</td>
<td>2.7</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>2.7</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 3

*Ethnic Identification in P Sample*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian/White, European</td>
<td>61.4</td>
<td>27</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Biracial-White/Native American</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>African-American</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>English/Jewish</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Hmong</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Mixed-White/Hispanic</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Polish</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Russian</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>2.3</td>
<td>1</td>
</tr>
</tbody>
</table>

In identification of racial group, 84.1% noted an identity of White or Caucasian (*n* = 37), 4.5% as Asian (*n* = 2), and 4.5% as Black (*n* = 2). One participant each (2.3%) identified as Native American/White, Hispanic, or Latina. In regards to assigned sex, 72.7% of participants identified as female (*n* = 32), 25% as male (*n* = 11), and one participant (perhaps confused about the difference between gender and sex) identified as “man” (2.3%, *n* = 1). Educational level was particularly high for this population as 20 participants completed a master’s degree (45.5%, *n* = 20), 22.7% reported a bachelor’s
degree \( (n = 10) \), and 10 participants held a PhD \( (22.7\%, n = 10) \). Three participants reported “some college” \( (6.8\%, n = 3) \) and one held an associate’s degree \( (2.3\%, n = 1) \).

Twenty-one participants reported current relationship status as married \( (47.7\%, n = 21) \), 25% reported being single \( (n = 11) \), and 4.5% utilized “married/partnered” to describe their relationship \( (n = 2) \). One participant each \( (2.3\%) \) reported being “engaged,” “partnered,” “in a relationship-monogamous,” and “dating/LTR (long-term relationship).” Diversity of relational styles within the AF community was established in this sample through 9% of participants describing a status of “non-monogamous with a primary partner” \( (n = 4) \) and two participants reported an open relationship within marriage \( (4.5\%, n = 2) \).

Full-time employment was reported by 20 participants \( (45.5\%) \), 12 reported employed \( (27.3\%) \), and one participant each noted “self-employed/disabled” \( (2.3\%) \), and “part-time self-employment” \( (2.3\%, n = 1) \). Two participants noted part-time employment \( (4.5\%) \) and one noted “unemployed but not seeking” \( (2.3\%) \). The student population in the sample reported variations of employment including student \( (4.5\%, n = 2) \), student/part-time employment \( (6.8\%, n = 3) \), and graduate assistant \( (2.3\%, n = 1) \).

Table 4 denotes spiritual/religious beliefs and demonstrated the large number of non-religious persons alongside the variance of spiritual identities in the study.
Table 4

*Spiritual/Religious Identification in P Sample*

<table>
<thead>
<tr>
<th>Spiritual/Religious Beliefs</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheist</td>
<td>18.2</td>
<td>8</td>
</tr>
<tr>
<td>Spiritual</td>
<td>16.0</td>
<td>7</td>
</tr>
<tr>
<td>Agnostic</td>
<td>16.0</td>
<td>7</td>
</tr>
<tr>
<td>Agnostic Humanist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Agnostic but spiritual</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Agnostic-Unitarian Universalist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Very spiritual/Unitarian Universalist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Catholic</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Christian</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Methodist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Protestant</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Lutheran</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Pagan</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Buddhist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Hindu</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Humanistic</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Judaism</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Shamanism</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Taoist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Witch</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Nontheist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>No affiliations but many beliefs</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Not a materialist</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Illegible response</td>
<td>2.3</td>
<td>1</td>
</tr>
</tbody>
</table>

Q methodology data analysis includes both statistical and qualitative elements.

Statistical analysis involves factor analysis revealing associations that can remain unseen without the entirety of such analyses (S. R. Brown, 1996). These statistical analyses are
not the only aspects of data representation as qualitative input from post-sort Q responses is combined to interpret factors. Statistical analyses and representation of post-sort responses are reported below.

**Statistical Data Analysis**

Factor analysis is the statistical method utilized to group similar Q sorts together. The current study’s analysis was conducted using PQMethod (Schmolck, 2014). The sorting of statements, encapsulated in response grids, were entered and analyzed using the PQMethod software. The specifics of the factor analysis are interpreted below.

**Factor Analysis**

Factor analysis is completed to statistically characterize how participant beliefs group together. Participant sorts of 32 statement cards and similarities between those sorts organized these groupings (McKeown & Thomas, 2013). Factor analysis denotes distinctive factors existing within the P sample, these factors representing different attitudes occurring within the sample. Highly correlated sorts share similar structure thus interconnected beliefs. Each sort represents individual beliefs whereas multiple participants combine to foster the attitudes representing each factor (S. R. Brown, 1996). For the current study the factors represent AF persons’ attitudes about wellness.

Participant data were factor analyzed utilizing a principle components analysis (PCA). This approach was chosen due to the precise statistical nature and the common usage for factor analysis within and outside Q methodology (Watts & Stenner, 2012). Watts and Stenner (2005) previously noted PCA as offering “equally satisfying” results when compared to other factor analytic techniques (p. 81).
**Factor rotation.** The PQMethod program automatically provides eight factors from PCA analysis for prospective rotation. Utilizing the rule of thumb of an Eigenvalue of 1.00 or greater as the starting point of extraction, all eight factors demonstrated statistical significance, although this does not signify meaningful factors (McKeown & Thomas, 2013).

The Varimax rotation attempts to find simple structure through maximizing loadings on one factor and minimizing loadings on others (Watts & Stenner, 2012). The researcher examined the data by conducting three, four, five, six, seven, and eight factor solutions, weighing the total number of sorts represented in the solution alongside between-factor correlations. In the current study, the solution representing the highest number of sorts (38/44) and lowest between factor correlations (highest = 0.39) was a four-factor solution. Correlations did not improve and there were fewer defining sorts for three- and five-factor solutions.

**Factor loadings.** Level of agreement each sort has with each factor is demonstrated by factor loadings (McKeown & Thomas, 2013). Significant ($p < 0.05$) factor loadings in the current study are greater than ±1.96 (SE). Thus, loadings needed to be greater than ±1.96 (.18) = ±0.35 in order to significantly load on one of the four factors. Factor loadings were the outcome of the rotated four-factor PCA solution.

Twenty-one participants including one inverse loaded at a defining level on Factor I: *Intimacy and Self-Acceptance*; nine on Factor II: *Openness and Connectivity*; six on Factor III: *Physical Wellness and Self-Care in a Supportive Community*; three on Factor IV: *Acceptance as Unique* including an inverse of the main factor; and six
participants did not load significantly on any factor \( (p < .05; \text{Appendix G}) \). Sort number 32 loaded on Factor IV in an inverse fashion (-0.744), suggesting this participant demonstrated a negative endorsement of the factor. This was the only such occurrence of an inverse loading. Typical factor selection requires two or more sorts to load significantly on it alone. Thus, all 4 of the factors selected had at least nine significant loadings after removing other factors with limited loadings (from the 8 automatically created by PQMethod for PCA).

**Post Q-Sort Responses**

Q methodology encompasses more than the sorting of cards and subsequent analysis. Participants usually complete a post-sort interview or questionnaire fostering deeper recognition of participant beliefs while enriching data interpretation (Watts & Stenner, 2012). The researcher in this study asked participants to answer five questions (Appendix F) developed from Schermer (2010). Participants were asked to describe how the statements ranked at the extremes (4 and -4) were essential or inessential to their beliefs about wellness, other statements that assisted in defining beliefs, the statements difficult to place, and if any other beliefs or concepts about wellness materialized during the sort. In addition there was a section entitled “additional comments” on the response grid (Appendix B) where participants could choose to leave any other commentary.

Due to the nature of the study, where packets were most often sent out to participants, each was asked to deliver written responses. This was also true of those participants who completed the study in person. From 44 total participants, 90.9% \( (n = \)
40) answered each question, whereas 9.1% \( (n = 4) \) partially completed the questions. The answers completed by these participants were included in factor interpretation.

**Factor Interpretation**

Interpretation is based on the rankings of statements via factor scores, distinguishing statements among factors, post Q-sort responses, and demographic data of participants (Watts & Stenner, 2012). Interpretation of the four factors and inverse started with factor scores through a composite sort to recognize the perspective of participants on each. In the current study four different factors and an inverse of one factor emerged.

Participants ranked statements from *most agree with my beliefs* to *most disagree with my beliefs*: these extremes fostered the most meaningful areas of interpretation (S. R. Brown, 1996). This area, ranging from ±4 to ±3, was deemed most relevant and studied first due to statements either noting *most agree* or *most disagree* participant beliefs. The middle of the array was studied second, ranging from ±2, and provided added material regarding distinction when paired with distinguishing statements. These statements allow for determination of relational importance among multiple factors. All factor scores are reported in Appendix B.

Following the study of factor scores, interpretations were contextualized through use of post Q-sort responses. Further distinctions of the perspectives were afforded through this additional qualitative data. Afterwards, demographic information was utilized, when applicable, in marking possible differences in relevant sub groups.
Factor names were constructed to recognize the intricate perspectives through utilization of factor scores, distinguishing statements, and post Q-sort responses. The researcher recognized the inability for these titles to reveal a full amalgamation of distinctions within perspectives but instead to comprise the main theme of the factors. Special consideration was given to the polar extremes of the factor arrays.

**Factor 1: Intimacy and Self-Acceptance**

The *Intimacy and Self-Acceptance* factor (1) was defined by 20 sorts. Participants who shared this perspective noted intimacy, trust, self-disclosure, and acceptance of self as crucial to beliefs about wellness. *Intimacy and Self-Acceptance* suggested a focus on self-acceptance and effective interpersonal skills key to fostering positive relationships. The name given to the factor reflects agree loadings of positive relational contexts and acceptance of intersectional identities (the convergence of multiple identities through orientation, gender, race, spirituality, etc.) as the main thematic elements for *Intimacy and Self-Acceptance*. As nearly half of the total P sample loaded on this factor there was considerable variety regarding demographics but as noted many participants were White, not religious, and women. Further notation of demographics can be found in Appendix G.

Themes were also demonstrated by statements from the disagree end of the array. In this case, a lack of support for both financial security and minimization of environmental pollution showcased how much participants believed non-material, internal, and relational characteristics are key to wellness. The ranked statements from the composite Q sorts (the overall rankings from most agree to most disagree of statements on the factor) below demonstrated the themes of the factor. The
demonstration below was utilized for each set of Q sample statement rankings for each factor with the factor score to the right notating the rankings within the composite factor sort.

12. Is able to be intimate, trusting, and self-disclosing with another person.  
27. Acknowledges positive qualities and imperfections within self.  
2. Demonstrates adequate financial security.  
28. Attempts to minimize harmful effects of pollution and stress in the environment.

As demonstrated, a theme recognizing the elements of positive relational constructs and self-acceptance emanated from the rankings and was demonstrated further by post Q-sort responses patterned on the interplay of internal and interpersonal elements. Interpersonal relationships (often with a non-biological family chosen by the participant) built on trust, empathy, and authenticities were reported as crucial to wellness.

Participants who sorted the above Q sample statements similar to the most agree (+4) rankings of the composite Intimacy and Self-Acceptance sort responded in post-sort questions with the following narratives. Participant identification numbers are included in parentheses after the responses.

It has been vital to my personal development to understand and accept myself as a complex person. When I did not accept my intersecting identities and both positive aspects and imperfections I was depressed and had thoughts of suicide. (4)

Interpersonal relationships are paramount for health... must be intimate, authentic, and built on trust but do not have to be with family or partners to be intimate. (19)
I put importance on humanity and caring about others beyond ourselves... human connection and especially the quality of it due to negative experiences within my own family. (21)

I identify as polyamorous and as such feel that being intimate, trusting, self-disclosing and respectful [in] conflict resolution to be key parts of both my personality as well as beliefs. (23)

As noted by participants, the importance of positive relationships and self-acceptance are described in the responses. Several participants reported positive communication and other relational characteristics were conducive to wellness in several areas including the resolution of conflict within interpersonal relationships. Many participants alluded to experiencing mental and emotional struggle before attaining improved wellness through social connections and full recognition of self. The responses gathered from disagree rankings were just as important in relating the themes of this factor. Participants (identification numbers in parentheses) who sorted the above Q sample statements similar to the most disagree (-4) composite Intimacy and Self-Acceptance rankings responded in post-sort questions with the following narratives.

Financial security is not a requirement for wellness. It’s capitalism that penalizes poor people & creates them. Baby boomers fucked the economy over, we younger people will not get financial security. (20)

While taking care of the environment contributes to the wellness of the world, I don’t see it as important to my personal beliefs of wellness. (33)

We are not defined by what we do for money, even if we are informed by what we’re willing to do. (3)

One participant’s response (20) suggested financial security was tied to further marginalization. In addition, an adverse reaction in responses was expressed for minimizing effects of pollution and stress in the environment as many participants noted
this statement as not conducive to personal wellness but rather health of the planet. These responses suggested items such as wealth and the environment are not as pertinent to personal wellness as self-acceptance, personal characteristics, and interpersonal relationship themes of the overall perspective.

Five additional statements below focused *Intimacy and Self-Acceptance* by recognizing internal and interpersonal development. These rankings further elucidated the theme of *Intimacy and Self-Acceptance* through relational and internal characteristics alongside denial of importance of transcending cultural identities and “physical wellness” elements. The denial of physical wellness elements created distinctions from Factor 3 (*Physical Wellness and Self-Care in a Supportive Community*) and to a lesser extent Factor 2 (*Openness and Connectivity*). Further agree and disagree rankings from the composite *Intimacy and Self-Acceptance* sort (with factor scores to the right) are noted below and connected the themes below.

4. Aware and in touch with feelings. 3
20. Is able to solve conflict in a mutually respective way. 3
11. Values self as a unique individual through multiple elements of identity. 3
31. Transcends cultural identifications. -3
7. Maintains a nutritionally balanced diet. -3

Statement 11 fostered the most discussion of any statement outside of the most-agree statements as placing great value upon the multiple identities the participants were made up of (intersectional identities) was expressed by a majority of participants on *Intimacy and Self-Acceptance* as essential. Statement 11 was referenced strongly in the
post Q-sort responses whether participants had placed it in the most agree column or not, demonstrating the theme of self-acceptance of multiple, intersectional identities. In addition, the post-sorting interview responses noted connection with cultural identities, mature judgment, and emotional/mental health as precursor to physical wellness as pertinent. The following post-sort responses (participant numbers in parentheses) demonstrated how the rankings above corresponded with wellness.

I find great value in cultural identity. (4)

Intersectionality is crucial . . . maturely handling conflict is necessary. (20)

I noticed an emphasis on mental and emotional health for me because physical health often follows from that. If our minds and hearts aren’t healthy it’s difficult to [take] care of ourselves physically. (43)

I find great value in cultural identity and while I recognize there is more beyond cultural identity I have little connection to “transcending” it. More interested in connecting with it. (4)

Statements related to physical wellness were difficult because I felt like they seemed out of place amongst the other internal wellness statements. (19)

Transcending cultural identification sounds a lot like colorblindness to me. I think being aware and proud of our various identities are essential. (42)

Participants on Intimacy and Self-Acceptance suggested multiple identities are embraced and these response narratives demonstrate how participants reacted negatively to the terminology noted in statement 31. These responses suggested acceptance of intersectional identities, positive internal characteristics, and achieving each of these elements must come before physical wellness can be realized.

Intimacy and Self-Acceptance suggested further depth of themes explored above through several other statements and corresponding responses, which recognized
awareness and openness. In addition, statements expressing cognitive and emotional
flexibility added depth to the interpersonal characteristics and self-acceptance
participants described as helpful to interpersonal relationships. Negative rankings (and
responses) substantiated the importance delegated to personal characteristics for
relational wellbeing and self-acceptance. This importance of personal traits, rather than
utilization of spirituality, was recognized by participants as meaningful to relationships.
The ranked statements from the composite sort below (factor scores delineated by the
number to the right) further demonstrated the themes of the factor.

3. Is mentally active and open-minded. 2
17. Has trustworthy friends. 2
30. Demonstrates a health communication style. 2
24. Views change as an opportunity for growth. 2
1. Enjoys social relationships involving connection with others, 1
   individually or communally, but without marital, sexual, or familial
   commitment.

15. Is able to solve problems. 0
22. Has a family or family-like support system characterized by shared
   spiritual and/or ethical values. −2
29. Holds/practices personal beliefs that allow for recognition of self as
   more than just a material being. −2

Rankings above and responses below added more depth how personal characteristics,
self-acceptance, and positive relational contexts were important to wellness. The
responses below suggested that relationships with people, rather than spirituality, were
key to wellness. The responses below were narratives given for questions related to
rankings closer to the middle of the composite sort (with participant numbers in parentheses).

It is vitally important to connect with other people because we are social creatures descended from social creatures. (3)

Solving problems and being honest about self is essential. (6)

I live far from family... growing up Jewish family is often a priority, comforting value. Hence, when I moved creating a “family of choice” became imperative. (22)

We are material beings there is nothing else. (3)

I do not feel one must have religion/spirituality in order to be happy. (37)

But I don’t believe that an exclusive group has to have the same spiritual values in order to be supportive of each other and be mutually healthy. If that were true, I think my choices in friends would be very limited, especially since open-mindedness and cultural exchange is so important to me. (41)

Statement rankings and post-sort responses continued to suggest participants put more importance on activities involving relationships and internal processes. Two participants described support for acceptance of intersectional aspects of self and social support (22 and 41). Two participants (3 and 37) described lessened importance of spirituality and participant 3 noted, “there is nothing else,” demonstrating the demographic characteristic of limited spiritual/religious belief within the P sample. A number of participants identified as atheist, agnostic, not religious, or several other aspects of non-religious identification. Twenty-two participants (50%) did not subscribe to a specific religion or noted described themselves as atheists.

Intimacy and Self-Acceptance suggested connecting with others and self-acceptance is pertinent to living a well life. Post-sort responses focused on the
development of positive internal characteristics helpful for self-acceptance and connected to social skills necessary for adequate relationship building and maintenance. Participants suggested one must first accept personal strengths and weaknesses before developing strong, sustaining relationships and a social network. The response below (with participant number) summarized what participants who loaded on *Intimacy and Self-Acceptance* believed must occur first and foremost.

Wellness begins with accepting and loving yourself. Embracing multiple identities and your imperfections allow for a more appreciating point of view. (29)

**Factor 2: Openness and Connectivity**

*Openness and Connectivity* was defined by 9 sorts and named for the open engagement leading to and part of connecting with others. The *Openness and Connectivity* perspective shared some similar statement rankings with *Intimacy and Self-Acceptance* yet suggested an engaged and open mind alongside strong interpersonal connections developed through tools such as effective communication most conducive to participant wellness. These notations of openness in mind, feelings, and sustainable connection with others as themes throughout informed the title of the factor.

An overall emphasis through rankings and post-sort responses suggested physical activity and minimization of stressors as important but only after mental and emotional needs are met. In addition, rankings and responses represented differentiation from other factors as cultural, gender, and intersectional identities were not recognized as pertinent to wellness. Significant rankings and responses, with interpretation of the factor, begins
below with most agree and disagree statements from the composite sort (with factor scores to the right) alongside connected responses.

3. Is mentally active and open-minded. 4

12. Is able to be intimate, trusting, and self-disclosing with another person. 4

17. Has trustworthy friends. 3

30. Demonstrates a health communication style. 3

4. Aware of and in touch with feelings. 3

The statements above demonstrated the importance of mental and emotional acuity and flexibility, especially within relationships, a theme present throughout rankings and responses for this factor. Participant responses describing effective interpersonal functioning and flexibility on personal and interpersonal levels were common, emphasized as “the heart of wellness & life satisfaction.” These narratives represented answers to the agree rankings of statements above and include the participant number in parentheses.

I believe connection with others & keeping a working mind/open to others’ beliefs + ideas are essential for wellness. (17)

I regard mental health as the biggest fortune in life. Mentally active & open-mindedness is important, this leads to pursuit of happiness. Further, open-mindedness allows to base your choices on facts, allows for discussion, learning new things. (18)

I believe that love for the self & for others is at the heart of wellness & life satisfaction. (14)

I noticed a pattern with healthy relationships/friendships and achieving wellness. (15)
These participants summarized *Openness and Connectivity* through recognition of healthy connections with self and others, differentiating from *Intimacy and Self-Acceptance* through a focus on mental and emotional flexibility. Substantial differences from the 3rd and 4th factors are obvious due to the focus of relationships and internal development. Other differences between *Openness and Connectivity* and the other factors were found through statement rankings on the most disagree end of the factor array. The statement rankings (below with factor scores from the composite sort to the right) and responses reflected the lack of importance of intersectional identity to wellness.

26. Feels satisfaction with existing gender. -4

8. Feels supported in a cultural identity. -4

These two statement rankings suggested interesting nuance for the theme of the factor. A possible lack of identification with demographic groups, in regards to culture, gender, and orientation, as one participant (2) suggested below, added description to *Openness and Connectivity*. If a participant does not identify with any marginalized group, the salience of these identities may not demonstrate relevance to wellness. Responses below may have been affected by the demographics of this factor. Almost all of the participants were White and cisgender. Responses to the most disagree rankings are below (with participant numbers in parentheses).

Cultural identifications and satisfaction with gender: I feel these are fluid and change over time or can change over time. Identity and culture sometimes depends on environment. Change environment = get wellness. (15)

Feeling satisfaction w/ existing gender is not so much on my mind because my assigned gender and sexual identity are in sync. Feeling supported in a cultural
identity is not important to me, b/c culture is something one can acquire and change and move past. (18)

I do not feel like I identify as a member of any particular group. I’m female and married to a woman but don’t consider myself a lesbian or monogamous, despite my current status and behavior. (2)

The responses above suggested privileged cisgender, White, AF persons are less likely to consider these statements as vital to wellness, to the point one participant simply noted how she is “in sync” (18). One response suggested further thought on this subject through expressing the fluidity of gender and cultural identity (15) but this participant also related how one’s environment can be changed. A change in environment is possible for those who can afford such a change through adequate financial, social, and pragmatic means. The rejection of gender and cultural identity as germane to beliefs of wellness differentiates Openness and Connectivity from Intimacy and Self-Acceptance. Intersectional identities were important aspects of wellness in ranking and responses for participants on Intimacy and Self-Acceptance whereas the current perspective suggests little relevance for participants. Demographics may explain these results and represent privilege in action. Most participants who loaded on this factor were White, cisgender, identified as bisexual over pansexual/queer and agnostic/atheist/nonreligious, and considered these statements as irrelevant to personal experience through the narratives above. This suggested participants with the above demographics were more likely to agree with the Openness and Connectivity including the lack of relevance for accepting and embracing intersectional identities.

Major differences between the first two factors continued to present on the disagree side of the array. The first two of the statement rankings below echoed most
disagree rankings for *Openness and Connectivity* in the rejection of statements describing cultural identification (31 and 11). The rejection of statement 10 was consistent with the openness and flexibility demonstrated by participants who loaded on *Openness and Connectivity*. Disagree rankings of statements follow with the factor scores from the composite factor sort to the right.

31. Transcends cultural identifications.  -3

11. Values self as a unique individual through multiple elements of identity.  -3

10. Demonstrates planfulness in life. -3

As noted for previous most disagree statements, the rejection of cultural/intersectional identities as crucial to wellness suggested influence of participant demographics, as all but one person identified as cisgender (see Appendix G for more demographic information). These results are consistent with privilege being a component of *Openness and Connectivity*. When a person does not experience marginalization due to an identity, it is likely the impact associated with this identity will be lessened. The post-sort responses corresponding to rankings above demonstrated the narratives of this mostly white, privileged group of participants who loaded on *Openness and Connectivity* (with participant numbers in parentheses).

I found it difficult to place the cards regarding identity. While I spend quite a bit of time examining how my whiteness, queerness, “femme-ness” shapes my “being in the world,” I’m not sure how this process interacts with my personal wellness. I do find great meaning in being an ally & advocate to/with marginalized folks, which is essential to my sense of self, for sure. (14)

The response above noted how one participant spends time studying aspects of identity but does not recognize this “process” as relating to wellness. This response
suggested recognition of the importance multiple identities had to lived experience but not to wellness. This response again suggested the influence of privilege, but for this participant the lack of importance to wellness was owned at the same time, a thoughtful recognition of personal privilege indicative of cultural competence (Lee, 2008). The latter sentence of the response suggested the participant is active in advocating and representing ally behaviors for marginalized communities while recognizing personal privilege (Finnerty et al., 2014; Sue & Sue, 2008). This suggested social justice advocacy is essential to the participant’s identity. The same participant offered a response representative of the openness recognized by participants in the overall perspective below (participant number in parentheses). While this particular description was not found in most other participants, the participant’s response (followed by participant number) further informed the theme of openness through a description of flexibility.

I tend to find that spontaneity & flexibility, rather than planfulness, best support my wellness. (14)

As this perspective places value on openness, correlated strongly with flexibility, planfulness may represent the antithesis to the theme for Openness and Connectivity, therefore the negative ranking continues to project the beliefs noted. Continued focus on open, engaged growth, connection with others, and the addition of physical beliefs supportive for wellness are noted in selected agree rankings below (with factor scores to the right) further the description of Openness and Connectivity.

22. Has a family or family-like support system characterized by shared spiritual and/or ethical values.
28. Attempts to minimize the harmful effects of pollution and stress in the environment. 2

27. Acknowledges positive qualities and imperfections within self. 2

25. Engages in sufficient activity to stay in good physical condition. 2

1. Enjoys social relationships involving a connection with others, individually or communally, but without marital, sexual, or familial commitment. 1

Although factor scores are significantly less for statements 22, 27, and 1, the rankings demonstrated consistency with and refined overall perspective themes of social connection/support and open engagement and development. The rankings further differentiated the perspective from *Intimacy and Acceptance* through support for physical and environmental contexts as relevant to wellness but post-sort responses suggested this only occurred after mental, emotional, and social wellness was solidified. A response below clarified this interaction by noting the detrimental effects of limited mental and emotional health to overall wellness, suggesting physical wellness “as a waste” without the former factors. This interaction was described further through post-sort responses including participant concerns regarding other aspects deemed pertinent to physical wellness not included in any of the statements.

In addition, participant 44 gave an interesting response below after ranking the minimization of negative effects from pollution and stress in the environment (statement 28) in an agree column. The narrative created context for how participants may have ranked statement 28, as several contextualized the wording as “environmentalism” but this participant believed it to be functional for overall, holistic health. For many other participants, this was not part of personal wellness so the polar response is notable. Post-
sort responses corresponding to less significant agree rankings of statements from the composite sort are noted below with participant numbers in parentheses.

These were the clearest answers for me because I make decisions daily that affirm these beliefs. My wife and I own one car, a Prius. I ride my bike to work daily. This also supports daily exercise + I practice yoga daily. (1)

I find physical/nutritional/sexual health to be as important to my life satisfaction as anything else. I’m surprised that sexuality & eroticism were not available components of wellness! (14)

For me- mental & emotional factors are more detrimental than physical, its not that physical is unimportant but without mental & emotional wellness, physical wellness is sort of a waste. (17)

Minimizing harm and stress to the environment is essential to my beliefs of wellness, as I believe it is my responsibility as a human and inhabitant of this planet to act as a caretaker. How can I be well if the planet is not? (44)

These individual responses, transposed as everyday actions, may also foster important communal connectivity and a sense of spiritual flow for an overall P sample that displayed atheist, agnostic or non-religious tendencies (Moe et al., 2008; Purdy & Dupey, 2005). Often connections to something more than self (religion, environment, etc.) and physical activity represent self-care and stress management modalities (Myers & Sweeney, 2005). For this perspective, the spiritual and physical were much more pertinent together than the other factors’ representations. Other descriptions of stress management loaded on the disagree end of the array, demonstrating particular nuance in how participants recognized wellness. These rankings from the composite sort are noted below with factor scores to the right.

6. Utilizes self-care when dealing with daily stress. -2

7. Maintains a nutritionally balanced diet. -1

These rankings, along with the following response, demonstrated how *Openness and Connectivity* suggested a nuanced perspective through endorsement of particular elements such as physical activity and reduction of environmental harm alongside rejection of nutrition components. The response below (with participant number in parentheses) suggested the participant valued a “healthy diet” but does not participate in healthy eating. This response was captured in a follow-up question asking participants to reflect upon the sort and post-sort response process.

For example, I agree that a healthy diet is important for maintaining wellness, however, I know my eating habits need improvement. I completed this survey from the perspective of my own experiences. So the statement regarding nutrition/diet was placed further to the center-left of the grid. (38)

A brief review of the rankings from the middle of the composite sort can assist in further describing themes of *Openness and Connectivity*. Statements describing leisure activities (No. 23), resolution of conflict (20), expression of needs (18), problem solving (15), satisfaction with self-management and regulation (16), and balancing giving and receiving support (9) were all ranked at the neutral position (score 0). These rankings created context for the perspective as previous notations were made about the selected self-care and stress-management statements. Satisfaction with management of self-care and stress-management items were noted as neutral to wellness, suggesting participants may not know whether what they are doing currently is helpful to regulating their systems or not. Many of the other statements describe cognitive, emotional, and interpersonal beliefs, which may be better conceptualized by similar statements ranked in agree or disagree regions.
A pattern of social connections and healthy relationships represented *Openness and Connectivity*, similar to a trend in *Intimacy and Acceptance* suggesting similarity, but there was significant difference in how the rest of the array was ranked. Major differences in agree and disagree rankings alongside post-sort responses demonstrated independence of *Openness and Connectivity* from other factors while solidifying the attitude as unique.

**Factor 3: Physical Wellness and Self-Care in a Supportive Community**

Six sorts defined *Physical Wellness and Self-Care in a Supportive Community*. Participants who shared this perspective endorsed physical activity, proper nutrition, and other self-care strategies as occurring within a supportive network. As the title of the factor suggested, physical wellness and self-care occurred within a supportive network as noted by both statement rankings and descriptive responses. Most-agree and disagree statements from the composite sort below (with factor scores to the right) informed this nuanced attitude and were also distinguishing statements within data analysis for this factor.

25. Engages in sufficient activity to stay in good physical condition.  
   7. Maintains a nutritionally balanced diet.  
   28. Attempts to minimize the harmful effects of pollution and stress in the environment.  
   10. Demonstrates planfulness in life.

Physical wellness was previously explored within the agree columns (2 and 1) of *Openness and Connectivity* but was ranked higher by participants who loaded on *Physical Wellness and Self-Care in a Supportive Community*. Responses demonstrated a
focus on physical activity, nutrition, and openness first and foremost for change to occur. This was in contrast to *Openness and Connectivity*, where physical wellness was noted as occurring after mental, emotional, and interpersonal growth. The first response below succinctly summarized the “physical” aspect of the factor title as the participant noted it as “the basis for whole body, mind, and soul wellness.” In addition, environmental concerns were noted as important, just not for personal wellness. Responses below represent both most agree and most disagree statement rankings from the composite sort (participant numbers are in parentheses).

Physical well-being, for me personally, is the basis for whole body, mind, and soul wellness. So I find physical activity and a nutritional diet to be the most important part of body wellness. In my own experience, I find that when I’m not physically well my mind isn’t well either. (36)

When I think of wellness it usually starts w/these & continues w/other areas of life. (16)

The statements I disagreed with the most were focused on planning for life and I believe that wellness is an open-minded process where change happens and changes are seen as opportunities for growth. The other statement was focused on the world in terms of environmental justice work and, although important, just not as important to my beliefs on wellness. (31)

After learning more about recycling recently, I feel that one’s attempts are a very minimal piece of wellness. Also, I don’t feel that ability to plan is of high, if any, importance. I think being organized is important to wellness, but sometimes people don’t need a plan to be successful in life. (36)

Openness, rather than planfulness, was represented as functional to growth and change. This notation of flexibility as pertinent to wellness was also strongly endorsed in *Openness and Connectivity*. A theme of physical activity, nutrition, openness and self-care represented an intersection of beliefs supported by social connections noted in ranked statements below. Several more pertinent statements (and their respective
numbers to the left) are presented below with the factor scores from the composite sort to the right.

1. Enjoys social relationships involving a connection with others, individually or communally, but without marital, sexual, or familial commitment.  
31. Transcends cultural identifications.  

Connection with others and self-care articulated further nuance into the perspective. While connection with others was strongly regarded within previous factors, self-care measures (including physical activity and proper nutrition as most agree statements) continued to demonstrate the distinguishing rankings and theme of *Physical Wellness and Self-Care in a Supportive Community*. In addition, the negative ranking of statement 16 demonstrated participants were still not satisfied with self-care measures, suggesting continual development of self-maintenance strategies was key. Another negatively ranked statement, 31, when coupled with positively ranked statement 11, suggested intersectional cultural identifications are pertinent to wellness. Demographics of participants on this factor included the only two Asian participants and two persons who were outside the gender binary (gender queer and genderfluid) but otherwise many similarities to participant on other factors were found (white women who reported agnostic or spiritual notations). For a further review of the demographics please see Appendix G. Responses from questions related to agree and disagree areas of the
composite sort further framed the themes of this factor. Participant numbers are included in parentheses.

I find social relationships to be of very high importance and someone’s social support is usually how they learn wellness and/or are exposed to elements of wellness. This leads to the importance of healthy communication styles so that you can create social relationships. (36)

I ranked most of the statements as what I believe is connected to wellness. The statements were a balance of connecting to self, being surrounded with a community that supports my intersectionalities, and also having and utilizing the skills to create opportunities of wellness that includes doing a physical activity, enjoying leisure activities, and finding satisfaction in work. (31)

These responses further contextualized the perspective through recognition of intersectionality and utilization of self-care modalities as occurring within a supportive network. Therefore, the convergence of identities into a healthy whole and self-care measures occur within a supportive community. The agree ranking of statement 22 below added to this general theme (with factor score to the right).

22. Has a family or family-like support system characterized by shared spiritual and/or ethical values.  2

The ranking of statement 22 and the statements below (disagree rankings with column numbers to the right) aligned with similar aspects of self-care, social connection, and prominence of intersectional identity noted above. Such rankings assert the imprint of social connections, noted in previous factors as important. The personalized development of overall wellness described in previous responses showcase wellness as an ongoing process resultant of many variables, not an eventual endpoint. Demographics may have informed some of the statement disagree rankings from the composite sort below (with column numbers to the right) as traditionally collectivistic Asian cultures
consider assertiveness to not be pertinent to either communal or personal wellness (Sue & Sue, 2008). Participant 31, who identified as Asian, supplied the narrative below statements, which supported this notion. To sum up the perspective several selected statements are demonstrated with factor scores to the right and corresponding post-sort responses below.

2. Demonstrates financial security. -2
8. Feels supported in a cultural identity. -1
18. Assertive in expressing needs. -1

Culturally, being assertive in expressing needs is not highly important because it seems more of an individualistic aspect where it could disrupt the harmony of a community. (31)

Adequate financial security was difficult because it is a programmed stressor (especially in the Western world). I wanted to rank it higher but then remembered you can’t pay for love, support, friendship, and growth. All of which I feel largely contribute to a sense of wholeness within the self. (39)

The responses above represented the overall context of the perspective, self-care measures heightened by a community supportive of cultural intersectionality, and themes found across all factors (rejection of financial security). Physical, self-care, interpersonal connection, intersectional identity awareness, and personal characteristics informed Physical Wellness and Self-Care in a Supportive Community while differentiating it from all other factors.

Factor 4: Acceptance as Unique

Acceptance as Unique was defined by 3 sorts with one sort emerging as the inverse of the factor. As the title suggested three participants loaded on Acceptance as Unique, which described wellness in a “unique” manner differentiated from the other
factors by an emphasis on acceptance of self as intersectional and recognition as more than a material being. In addition, the sort from participant 32 represented the inverse of *Acceptance as Unique*, thus creating an additional perspective within the factor. This sort was determined as a true inverse rather than participant error in completing the sort (i.e., reversing the score scale) through concordance between the participant sort and post-sort qualitative responses. In effect, the responses matched with the participant’s sort.

*Acceptance as Unique* was appropriately titled as it described a functional manner of relating to the self and world amidst the lack of significant support from others. In the case of participant 32 the near opposite was true as these statements were ranked as disagree on the array (at -3 and -4, respectively). As multiple perspectives informed this factor, the interpretation is discussed by describing an overall perspective, followed by the inverse. The ranked statements from the composite Q sorts (overall rankings from most agree to most disagree of statements on Factor 4) below demonstrated the main themes of *Acceptance as Unique*. Factor scores are to the right notating the ranking of these statements within the composite sort.

11. Values self as a unique individual through multiple elements of identity. 4

29. Holds/practices personal beliefs that allow for recognition of self as more than just a material being. 4

31. Transcends cultural identifications. 3

8. Feels supported in a cultural identity. -4

22. Has a family or family-like support system characterized by shared spiritual and/or ethical values. -4

12. Is able to be intimate, trusting, and self-disclosing with another person. -3
17. Has trustworthy friends. -3

26. Feels satisfaction with existing gender. -3

The rankings of statements above included several distinguishing this factor from all others while establishing a coherent theme, thus each was noted in this first part of exploration (29, 31, 22, and 12). These statement rankings differentiated *Acceptance as Unique* from all other factors through the emphasis of accepting self without the use of supportive networks. Unlike previous factors *Acceptance as Unique* noted both recognizing and cherishing an intersectional identity while pushing past the boundaries created by such an identity. The building of intersectional identities in a unique manner while demonstrating struggle in intimacy and interpersonal aspects was also noted in post-sort responses. The narratives from the post-sort responses corresponding to most agree and most disagree statement rankings are shown below with participant numbers in parentheses.

I had a good connection and felt no indecisiveness when placing these as important to me. (28)

Believes being open-minded & unique makes the human experience interesting & worthwhile. Also believes in order to grow & gain knowledge an open mind & unique perspective are necessary. (11)

As someone who is more attracted to someone’s mind, it is somewhat difficult to be in intimate relationships, because sexual participation is expected; even when I am not always (rarely) interested. So often times I do not express my desires; or lack of desires. (11)

I am most comfortable in relationships in which there are not any sexual expectations, rather there is intellectual connectedness. In a society where traditional lifestyles & sexual roles are the norm I am striving to own my uniqueness & help others who are outside of the box (be) comfortable w/themselves. (11)
Being raped . . . demoralization from family . . . made me probably inept to be close to others . . . so yeah, six years of celibacy. (28)

The post-sort responses added significant detail to the rankings of statements. In particular, the descriptor “unique” served as an effective component of the title as participant 11, a 30-year-old pansexual agnostic/atheist, reported “an open mind & unique perspective as necessary” for heightened wellness. The same participant expanded upon concepts regarding relationships as she noted disinterest in sexual intimacy, an “expectation” she believed hinders her development of relationships “in a society where traditional lifestyles & sexual roles are the norm.” This description may have informed rankings of statement 26 and 31 as gender role expectations have shown to affect satisfaction negatively, with gender thus creating a need for these participants to transcend this aspect of identity (Mobley, 2003; Rieger et al., 2015).

The other participant, a 49-year-old gay-bi agnostic/Buddhist man, was also not interested in sexual intimacy, reporting “celibacy” for six years prior due to traumatic experiences including denying affectional identity with subsequent punishment when he was found out (in the military), early Catholic education, family strife, and traumatic rape. The personal experiences of each participant subscribed to the theme of acceptance of one’s unique method for wellness. In addition, these experiences shaped a theme characterized by internal foci of wellness such as self-acceptance rather than those concordant with relationships. The demographic measures collected outside of inclusion criteria of orientation did not relate nearly as much as the additional information supplied by these two participants in post-sort interviews. As can be viewed in Appendix G, these
participants shared similarities on other demographics but one demographic shared was the general sense of spirituality, rather than a concrete religion or practice (Appendix G).

Another element of the theme suggested the influence of demographic similarities (spirituality, race, and lack of sexual interest) between the two participants focused the perspective not in religion but a general sense of spirituality. Personal strengths such as open-mindedness previously noted by participant 11 and respect for the natural world also informed concepts surrounding spirituality as a deeply personal journey. Several more statement rankings from the composite sort are demonstrated through factor scores to the right of statement number and description.

3. Is mentally active and open-minded. 3
28. Attempts to minimize the harmful effects of pollution and stress in the environment. 3
5. Engages in mutual appreciation. -2
18. Assertive in expressing needs. -2

These statement rankings continued to display concordance with Acceptance as Unique as each related to factor themes of internal mental stimulation, beliefs in something higher than self (minimizing pollution), and difficulty in relational components due to unique experiences of the world.

One sort loaded in an inverted fashion, revealing another perspective. Demographics demonstrated difference from other participants as participant 32 was a 25-year-old African American genderqueer female who identified as panromantic and spiritual but non-religious (see Appendix G for demographic differences between participants).
The inverse was characterized by how statements 1, 3, 22, 26, and 29 were ranked on the polar opposite columns from the overall Acceptance as Unique array. These differences reflect how an inverse loading occurs. Positive rankings including satisfaction with gender and cultural identity, a family system with mutual values, and detailed responses recognizing a need to “live your truth” demonstrated a specific personal model of wellness. In addition, the negative rankings distinguishing difference from Acceptance as Unique and other factors demonstrated low support of social relationships, open-mindedness, and practicing beliefs. In essence the theme was further individualized, as the participant did not look to social relationships, mental activation, and spiritual practices as foundational to wellness. All of the above elements are best described in participant 32’s post-sort response to agree rankings below.

To live your truth and feel happy and fulfilled, it is necessary to not only have a support system, but to feel close and trusting enough to share intimate life details without great fear of losing support. We need close relationships and genuine support to thrive in life. (32)

This participant identified a complex approach focused on personal truths inherent to an individual model of wellness. This personalized recognition suggested the participant has developed a wellness style over a long period of time, instilling aspects of familial and cultural concepts alongside functional additions. The gender identity of participant 32 may relate to the ranking above and response below as she identified as genderqueer, an identification noted in the research as someone who rejects the binary systems of gender (Harper et al., 2013). This rejection of binary gender and individualized self-care systems may further personal wellness as noted by the responses to subsequent post-sort questions below.
Having self acceptance and feeling comfortable in your body, including gender, is necessary to experience wellness…as well as self-care are all important to wellness in whole sense. I do believe however you can be well even in compromising situations such as an illness. The spiritual wellness may account for the lack of physical wellness. (32)

Self-care beliefs. I know the importance of self-care in an individual context, but it is greater impacted within a social context. Feeling supported in cultural identity I believe the personal impact of the level of support determines the impact of this belief. (32)

These responses best defined the inverse while further informing the overall factor. The participant developed an effective personal model of wellness for self, incorporating many different items handpicked and contextualized for use as a person of multiple identities. The dialogue regarding how both cultural identity and self-care “is greater impacted within a social context” suggested the perspective was formulated through multiple contexts: the individual, the self within supportive community, and then the greater community. Operating from a positive intersectional identity where awareness and use of personal and communal advantage personal abilities/skills and supportive networks was essential.

Other rankings conceptualized the inverse by recognizing spiritual or deeper connections to the world through the environment or “material” connotations were not demonstrated, instead connections with particular people may be present. The narrative below represented a post-sort response to a question regarding the disagree rankings of her sort.

When I think of wellness, I think of a personal experience, not environmental. I also think you can be well and not believe in a spiritual way of being more than a physical body. If anything, this belief could lead to some leading a more prosperous and thriving life. (32)
Again, a “personal experience” informed the rankings and connected response here. In addition, the participant cleared up the question of spirituality by noting a specific relationship to spirituality that may reside in nothing more “than a physical body.” This may relate to the multiple perspectives regarding the physical body genderqueer persons’ express, as they exist outside the binary gender identifications. A pick and choose methodology for internal and interpersonal considerations, cultural/spiritual/relational expression, and recognition of societal impact was contextualized through a subjective lens more likely to disconfirm than accept the norm.

In concluding results for this perspective, it was appropriate to utilize the final response from participant 32. The post-sort question was, “Are there any other beliefs or concepts about wellness that materialized during the sort?”

How the beliefs are connected. Whatever will keep you from having internal peace will impact all other areas of wellness. With factors like acknowledging imperfections or knowing you can’t please everyone, understanding and internalizing these concepts are different. You can know and understand this information, but unless it impacts your feelings it is not aiding to greater wellness. That being said, you cannot come to be impacted without the acknowledgement first. (32)

The response above summarized the theme of the inverse suggested throughout the sort and responses. Notation of the beliefs (statements) being “connected” and how through interaction with other beliefs an individual develops a personal model of wellness seemed to symbolize Acceptance as Unique. According to participant 32, a person must first be aware and then “internalize” a belief before it becomes action. It must “impact your feelings” to foster “greater wellness.” Overall, participant 32 endorsed personalized experiences/attributes of wellness, emphasized
emotional/cognitive connection, and utilized individual, intersectional characteristics in building a complex, personal model. The inverse provided further detail along with counterpoints to *Acceptance as Unique*, as the overall factor included distinct themes of self-acceptance as an intersectional, self-sufficient person without supportive networks.

**Summary**

This chapter reviewed the statistical data analysis and factor interpretation conducted in the current study. This analysis consisted of factor loadings, factor scores, factor interpretation, and post-sort responses. Factor loadings suggested sort similarity/dissimilarity to each other. Factor loadings of $\pm 0.35$ or greater ($p < .05$) were considered significant for the current study. The results suggested 38 out of the 44 participants loaded significantly on at least one of four factors.

The factor arrays from the output of PQMethod were represented as composite sorts of the participant sorts that loaded meaningfully on the four factors (Schmolck, 2014). Details from the arrays were crucial for factor interpretation. The resultant factors represented some AF persons’ beliefs about wellness. The statistical results were merged with post-sort participant responses to interpret the factors. Discussion of results, implications, and future research direction are explored in Chapter 4.
A Q methodology approach was utilized in investigating AF persons’ beliefs about wellness. Forty-four AF persons completed the Q sort. Statistical analysis suggested the participants sorted the cards in several different ways, resulting in four factors. Discussion of the resultant factors is represented in this chapter and findings explored within current literature. The implications, limitations, and possibility for future research are explored.

Discussion of Factors

The four factors resultant from the analysis share some thematic material yet all differed with enough significance clear boundaries emerged. In the following sections, each factor is discussed within the lens of previous research. An overall emphasis of the current study adding to the relevant literature on this topic is presented as there was no research regarding wellness with AF persons previous to this research (Dew & Newton, 2005; Moe, 2016).

Factor 1: Intimacy and Self-Acceptance

Intimacy and Self-Acceptance suggested a focus on wellness beliefs of self-acceptance, interpersonal skills key to fostering positive relationships, and how these social connections are pertinent to beliefs about wellness. As difficulty exists for AF persons to create community due to stigmatization, biphobia, and marginalization from both heterosexual and gay/lesbian populations this theme seemed to align with a desire to build a chosen family (McLean, 2008; Mulick & Wright, 2002). Building a supportive
network to combat minority stress encountered utilizing cognitive flexibility and bicultural self-efficacy has been demonstrated in previous research but *Intimacy and Self-Acceptance* demonstrated a specific method absent in the literature (Brewster et al., 2013). This method included internal working models that recognize inner growth in self-acceptance supporting overall wellness (Griffith, 2004). An emphasis on acceptance of self through recognition of and valuing intersectional identities demonstrated similar results to previous literature focused on developmental models but added new research in beliefs of wellness for AF persons (Jamil et al., 2009; Jones & McEwen, 2000). These main themes, along with several interesting demographic and other details of the results, are discussed below.

Interpersonal relationships (often with a chosen family) built on trust, empathy, and authenticity are effective in heightening wellness (Moe et al., 2008; Myers & Sweeney, 2005). The current study suggested the relationship among the factors above was more complex than previous incarnations regarding support and outness (Legate et al., 2012), personal characteristics such as hope and life engagement (Moe et al., 2008), and stigma management (Luhtanen, 2003). *Intimacy and Self-Acceptance* demonstrated a complex interplay between wellness, interpersonal relationships, social support, and the characteristics needed to develop said relationships unlike any previous research. This complexity was informed in particular by present qualitative data limited in previous studies of wellness with LGBTQ persons but absent altogether for AF persons (Dew & Newton, 2005).
These essentials of positive relational constructs correlated with building AF community and empowerment noted in previous research (Harley et al., 2000; Prilleltensky & Prilleltensky, 2003). Prilleltensky (2008) suggested development of empowerment within marginalized communities was key in optimizing wellness for both communities and individuals. Participants in the current study demonstrated a process of developing wellness out of marginalization. Savage et al. (2005) demonstrated the most similar results in noting social empowerment as an effective tool for the marginalization that AF persons often encounter. The current study furthered these concepts by spelling out particular personal characteristics found in previous research such as self-acceptance as an intersectional person (Brewster et al., 2013) and development of social skills needed for interpersonal connecting such as intimacy, trust, and effective communication (Degges-White & Myers, 2006).

Brewster et al. (2013) represented how AF persons can utilize “bicultural self-efficacy” and cognitive flexibility to combat minority stress. Results from Intimacy and Self-Acceptance suggested the use of both intersectional self-acceptance and efficacy in mental/emotional flexibility and interpersonal skills as foundational for wellness, thus creating an added roadmap towards living a more well life. Many participants added how positive internal development of accepting the intersectional elements (of non-binary orientation, gender representation, ethnicity, spirituality/religion, and relational style) impacted both overall wellness and relationships with others (Jamil et al., 2009). Intimacy and Self-Acceptance results also suggested it was not important for AF persons to “transcend” cultural identifications but to embrace the intersectionality present within
each aspect of identity, a result backed by multiple authors (Gill et al., 2010; Harper et al., 2013; Myers & Sweeney, 2008). Cultural identity demographics may have played a role. Acceptance of an intersectional self rooted in personal strengths is well established in wellness literature (Eliason, 1996; Fetter & Koch, 2009).

The use of strengths-based approaches is common in general wellness literature (Myers & Sweeney, 2005), but the current study demonstrated further considerations for a process relevant to AF development (Finnerty et al., 2017b). This thoughtful and often internal process led to positive beliefs about self and interacted with relevant areas of wellness noted by researchers including spirituality (Wilcox, 2003), emotions (Myers & Sweeney, 2005), and thinking (Brewster et al., 2013). These beliefs were essential to construction of a personal model of wellness rooted in introspection and connection to others (Finnerty & Jencius, 2011). Particular data points reviewed below may hold worth for researchers and practitioners as they reaffirmed the root of this theme, internal characteristics and interpersonal relationships as conducive to wellness.

One participant’s response (20) suggested financial security was tied to further marginalization, which aligned with previous research as many AF persons experience socioeconomic issues due to marginalization, discrimination, and lack of opportunities and/or resources (Carter et al., 2013; Storholm et al., 2013). A similar reaction in responses was expressed for minimizing effects of pollution and stress in the environment as many participants noted it as not conducive to personal wellness but rather health of the planet.
Considering both elements are inherently parts of the Western world for most AF persons but also strongly influenced by contextual variables (e.g., business/industry, economy, and environment), it was interesting to review responses describing lower importance when compared to internal and interpersonal variables of wellness (Moe et al., 2008; Myers & Sweeney, 2005). This does configure appropriately with *Intimacy and Self-Acceptance* themes and previous wellness counseling literature, as material items such as money and sustaining the environment have demonstrated limited empirical support for personal wellness compared to non-material elements (Gill et al., 2010; Myers & Sweeney, 2008).

Regardless, there is an argument for consideration of the relationship between material items and wellness. Although previous studies reported a higher likelihood that AF persons are marginalized socioeconomically due to many factors, there has been no research demonstrating lack of belief in financial security and/or maintenance of pollution/stressors in personal environments (Harper et al., 2013; Storholm et al., 2013). This is true for general knowledge and wellness concerns alike. Due to marginalization affecting economic and wellness issues alongside the higher homelessness rate for the overall LGBTQIA community, *Intimacy and Self-Acceptance* suggested a complex interaction for the AF community (Firestein, 1996). This new information can be explored by future AF wellness study.

The drive for interpersonal connection and social support as protection from the harm caused by stigmatization, discrimination, oppression and prejudice experienced by AF persons was both rational and conducive to building wellness (Carter et al., 2013;
Sheets & Mohr, 2009). Thus, social support fostered through an emphasis on internal and relational growth may carry enough weight for marginalized AF persons the importance of material items lowers. These findings corresponded to previous literature and suggest AF persons must combat the negative effects of discrimination, oppression, and marginalization due to orientation, gender identity, ethnic background, relational style, ability, etc. or the composite of these identities through emotional, cognitive, resilience, and social development (Chun & Singh, 2010; Brewster et al., 2013).

*Intimacy and Self-Acceptance* included the most persons of color in the study, many who came from either traditional religious and/or ethnic backgrounds (Boykin, 2005; Gonzalez, 2007). These persons may not receive support of multiple identities from several communities (Camarena & Rutter, 2015; Jamil et al., 2009). In essence and substance, certain cultural communities’ lack of acceptance of AF orientation and gender expression may be a negative component to overcome (Gonzalez, 2007). The overcoming of societal obstacles through personal and interpersonal skill speak to the resilience and negative mental health effects present in the AF population overall and within this small sample (Carter et al., 2013; D’Augelli, 1998). Social connections and the characteristics assisting in building a reflexive network of friends, colleagues, and allies are paramount to optimizing AF wellness and providing safe space for growth (Bradford, 2012; Finnerty et al., 2014).

Overall, *Intimacy and Self-Acceptance* adds new information to the literature through recognition of wellness aspects pertinent to AF persons, as this literature was not present in any definitive form or through utilization of an evidence-based model (Dew &
Newton, 2005; Moe, 2016). The themes of *Intimacy and Acceptance* align with literature on resilience, stressors, and coping but now add wellness and affective coping into the fold, establishing the first research of this kind for AF persons. The perspective beliefs of emotional, cognitive, cultural, interpersonal, and relational development offer intriguing new possibilities for wellness and overall counseling practice. A similar yet independent factor, *Openness and Connectivity,* exhibited qualities of openness and relationships yet without an emphasis on cultural identities.

**Factor 2: Openness and Connectivity**

*Openness and Connectivity* suggested an engaged and open cognitive process alongside strong relational connections as most conducive to participant wellness. These processes occurred without the influence of an intersectional self noted in *Intimacy and Self-Acceptance,* suggesting a method towards wellness found in similar mostly Caucasian samples of non-AF persons (Myers & Sweeney, 2005, 2008). Research involving transitions and wellness for queer women were similar to the relational processes the responses describe. Degges-White and Myers (2006) reported maintaining active, open minds and healthy communication allowed queer women to sustain wellness through life and relational transitions. *Openness and Connectivity* suggested these beliefs are consistent with living a well life (Degges-White & Myers, 2006). The perspective also added a process of wellness to the literature promoting the establishment of mental and emotional needs before integration of physical wellness. This process had been previously alluded to but not defined descriptively (Myers & Sweeney, 2005).
One participant described social connections and mental/emotional engagement as the “heart of wellness and life satisfaction.” Several wellness theorists have drawn similar connections from research involving social connections based in trust and empathy alongside personal mental and emotional stability (Granello, 2013; Griffith, 2004; Myers & Sweeney, 2005). The importance of these aspects represented a starting point for further development of wellness as evidenced-based studies and models such as the IS-WEL Model demonstrated stronger empirical evidence for these areas than material (i.e., financial security) and physical (i.e., activity) components (Myers & Sweeney, 2005). The factor analytic and qualitative methodology applied in the current study added a descriptive process not found in previous wellness inquiry, much less investigation with AF persons. As noted above, Degges-White and Myers (2006) represented positive relational functioning as applicable to life transitions resulting in positive wellness outcomes but the actual descriptive process was not defined.

Lenz and Roscoe (2011) also reported relational healing as an outcome for a wellness card sort, demonstrating the most similar methodological process to the current study and the power of positive relationships to wellness. *Openness and Connectivity* added a prospective step-by-step process detailed by qualitative description of interpersonal connection and open mental/emotional engagement as occurring before physical aspects of wellness can be integrated. These results did match with models present while adding qualitative detail to the journey to wellness (Dew & Newton, 2005; Granello, 2013). Overall, the statements describing positive interpersonal relationships and mental/emotional openness suggested similar connotations that previous study
outlined, as vital for AF persons’ overall health and wellness (Legate et al., 2012; Sheets & Mohr, 2009).

*Openness and Connectivity* also promoted the relevant finding of how a homogenous Caucasian sample may not find intersectional cultural identities as related to wellness (see Appendix G for further demographic information). This result was an interesting dynamic with some specific responses demonstrating further interest. The lack of identification to demographic groups, both in gender and culture often found in Caucasian populations, may reduce the impact upon wellness (Degges-White & Myers, 2006; Diamond, 2008b). If a participant does not identify as any of the demographic groups the salience of personal identity likely affects the importance of feeling supported or satisfaction (McIntosh, 1998). Moe et al. (2014) theorized salience of identity changes over time, which may mean most participants sharing *Openness and Connectivity* who expressed satisfaction with gender and support for cultural identity also found these aspects to be less important for wellness. Demographics may have played a role as only one participant from *Openness and Connectivity* identified as between binary genders and all identified as white or Caucasian. Power and privilege may explain why these statements were not salient to a mostly cisgender, white group as these issues are not everyday concerns (McIntosh, 1998; Moe et al., 2014).

One response suggested further thought on this subject, noting the fluidity of gender and cultural identity reported by previous study but also how one’s environment can be changed (Diamond, 2008b; Moe et al., 2014). The concept of changing one’s
environment is not possible for many marginalized AF persons; therefore, an ironic
demonstration of privilege juxtaposes thoughtful intention (Sue & Sue, 2008).

One response suggested the influence of privilege but also noted the impetus to
advocate for marginalized persons. For this participant, the limited importance of
intersectionality to wellness was owned, a thoughtful recognition and indicative of
cultural competence (Lee, 2008). The latter sentence of the response suggested the
participant was active in advocating and representing ally behaviors for marginalized
communities while recognizing personal privilege (Poynter, 2005; Sue & Sue, 2008).
This suggested social justice advocacy was essential to the participant’s identity, a
component not represented in counseling-based wellness models but recognized as
essential by other wellness and social justice researchers (Myers & Sweeney, 2005;
Prilleltensky & Prilleltensky, 2003; Toporek et al., 2009). This result can be served by
further investigation to uncover what ways social justice advocacy assists in optimizing
wellness and whether this process can be optimized for both those serving and served by
advocacy (Toporek et al., 2009).

Openness and Connectivity suggested the importance of physical aspects to
wellness but only after the mental efficacy (openness and cognitive engagement) and
relational connections solidified. This conceptualization was demonstrated by previous
evidence during factor analytic reconstruction of the Wheel of Wellness to the current IS-WEL Model, as the authors reported the Physical factor did not demonstrate loadings as
high as other second-order factors (Myers & Sweeney, 2005). Several participants noted
physical and environmental wellness components such as exercise, riding a bike rather
than driving, sexual health and eroticism, and advocacy for the planet through “act(ing)
as a caretaker” as important. Reese and Myers (2012) reported similar connotations
through “eco wellness” as functional for building community connectedness and concern
for the natural world. Little to no previous research has covered these areas with AF
persons; thus, utilizing current results, in particular the qualitative responses, can spur
additional inquiry into areas functional to developing personal models of wellness (Dew

The additional areas described by participant 14 (sexuality and eroticism) are
noted within conceptualizations of physical health by researchers but not directly in
wellness models for some reason (Granello, 2013). Myers and Sweeney (2005) reported
other factors concerning physical wellness were present in data but did not load high
enough for inclusion as third-order factors for the Physical domain of the IS-WEL.
Further inquiry into the sexual health and eroticism areas as each correlates with physical
wellness may serve AF populations in particular, as sexual behavior of this group is
ostracized by both heterosexual and gay/lesbian communities (DiPlacido, 1998; Ochs,
1996). Development of these areas may add to knowledge regarding the connection of
sexual health and eroticism to overall wellness. Further reviews of qualitative
implications of Openness and Connectivity continue below.

The emphasis on minimizing pollution through utilization of alternative modes of
transportation and daily exercise offer concrete examples of stress management,
environmental caretaking, and physical wellness promotion relevant to wellness literature
but not found in AF research (Dew & Newton, 2005; Fetter & Koch, 2009). These
examples may serve practitioners when working with AF persons as they suggest participant-integrated activity with concern for the environment by noting use of a bicycle and car sharing as tools relevant to both beliefs. These activities also demonstrate meaning making, intentional conceptualization of larger forces than self, and fostering community wellness through liberation from societal constraints (Frankl, 1962; Prilleltensky & Prilleltensky, 2003; Reese & Myers, 2012). These individual beliefs, transposed as everyday actions, may also foster important communal connectivity and a sense of spiritual flow within a P sample that endorsed atheist, agnostic, or non-religious tendencies (Moe et al., 2008; Purdy & Dupey, 2005). Granello (2013) reported these types of integrated activities as realistic and measured when creating wellness treatment plans as they represent small, incremental change. Incremental change was one similarity between Openness and Connectivity and Physical and Self-Care in a Supportive Community.

**Factor 3: Physical Wellness and Self-Care in a Supportive Community**

The Physical and Self-Care in a Supportive Community factor was focused on physical activity, proper nutrition, and other specific self-care strategies occurring in a supportive network. This supportive network provided flexibility desired by and emanating from the participants through post-sort responses along with previous research (Brewster et al., 2013; Legate et al., 2012). Previous clinical research demonstrated tendencies for clients to focus on physical aspects when practitioners suggest wellness practice even as theoretical inquiry demonstrated many other wellness domains discussed earlier (Granello, 2013; Myers & Sweeney, 2005). Disconnect between clinical and
research participants may be mended by this perspective’s distinctions of a process toward and context where wellness can occur. This process was different than previous factors, therefore establishing multiple routes to optimized wellness (Granello, 2013).

*Physical and Self-Care in a Supportive Community* aligned with previous study through activity and nutrition representing what one participant reported as “the basis for whole body, mind, and soul wellness” (Fetter & Koch, 2009; Moe, 2016). This represented common perceptions of clinical populations but the perspective also added some further description to the process of developing a personal model with physical wellness at the center (Granello, 2013). *Physical and Self-Care in a Supportive Community* formed the physical as foundation for the holistic wellness theorized in older, non-counseling wellness models (Hettler, 1984; Travis & Ryan, 1988). Participants from several factors and those who did not load on any one factor noted importance of physical activity benefits to mental and emotional growth, self-care, and stress management (Burck et al., 2014; Granello, 2013). A connection between body and mind through qualitative responses was also recognized by limited AF wellness literature and general wellness scholarship (Granello, 2013; Ketz & Israel, 2002; Moe, 2016; Myers & Sweeney, 2005). Development of this connection between mind and body can continue to be investigated with AF populations as limited qualitative data within the current study provides just a surface understanding. The connection between environment, mind, and body was another intriguing result of the current study.

*Physical and Self-Care in a Supportive Community* suggested that minimizing negative effects of pollution/stress and planning are not beliefs of wellness for AF
persons, an interesting result not explained by any current or past literature (Dew & Newton, 2005; Myers & Sweeney, 2005). Wellness practitioners and health care researchers often expect those who utilize and recognize physical wellness as pertinent will also believe other stress management, control, and overall positive coping strategies are functional (Granello, 2013). Usually researchers find the four foci of nutrition, physical activity, self-care, and minimizing negative effects of pollution/stressors in the environment correlating either positively or negatively together, rather than on opposite poles (DeVol et al., 2007). Future research can explore this complex interaction as this result seems counterintuitive yet may speak to the personal models of wellness espoused in the data (Finnerty & Jencius, 2011).

Participants who loaded on Physical Wellness and Self-Care in a Supportive Community may represent the social support, self-care, and flexibility noted by researchers as vital to overall wellness and resilience (Brewster et al., 2013; Luhtanen, 2003). Previous research related the essential quality of positive communication and building networks to combat marginalization and foster wellness (Moe, 2016; Savage et al., 2005). The supportive environment recognized by previous researchers consisted of positive relationships and openness where self-care can occur within the current perspective (Legate et al., 2012; Moe, 2016). The social connectivity and skills required to communicate effectively were noted on other factors to differing degrees but the utilization of self-care as pertinent to wellness was a new development and aligned with previous meta-analyses of wellness research (Myers & Sweeney, 2005, 2008).
As self-care has often been conceptualized differently from study to study the inclusion of mixed self-care elements including physical activity, nutrition, prevention, leisure, and making time for each within busy schedules on *Physical Wellness and Self-Care in a Supportive Community* demonstrated specific methods toward optimized wellness. These results again suggested multiple descriptive and personal paths towards wellness, a notation found in previous research but not to the detailed degree found before (Griffith, 2004; Myers & Sweeney, 2008). These results can be explored further through Q samples investigating specific self-care techniques and interventions within marginalized communities (S. R. Brown, 2006; Myers & Sweeney, 2005). Another functional characteristic of self-care was how cultural and intersectional identity was embraced on this factor by certain participants, granting voice and demonstrating empowerment to those marginalized by other aspects of identity (Collins, 2004; Harley et al., 2000).

Cultural differences may have been a factor for a participant who noted transcending identities is “not the work I care to do” as he also gave responses indicative of the crucial interplay of collectivism and intersectional identities as a marginalized person (Eliason, 1996). This demonstrates what Sue and Sue (2008) described as retaining one’s collectivistic cultural identities while existing in Western culture, a dynamic found in persons with elevated wellness (Myers & Sweeney, 2005). These responses further contextualized the perspective as focused on intersectionality and community empowerment, aspects reported by researchers as essential to wellness (Prilleltensky, 2008; Prilleltensky & Prilleltensky, 2003).
The convergence of identities into a healthy whole was nuanced within *Physical and Self-Care in a Supportive Community* as occurring within a supportive community, a perspective anchored in multicultural AF literature (Adams & Phillips, 2009; Boykin, 2005; Lee, 2008). The personalized development of overall wellness described in responses showcased wellness as an ongoing process resultant of many variables, not an eventual endpoint (Griffith, 2004; Jones & McEwen, 2000). This sentiment is evidenced by the continual wellness research of Myers and Sweeney (2005, 2008). The ongoing process inherent continued to represent a unifying theme in Factor 4, discussed at length below.

**Factor 4: Acceptance as Unique**

The unique nature of both poles of Factor 4 followed from specific personal wellness journeys each had to load on *Acceptance as Unique* (Factor 4), with *An Individualized Model* representing the inverse of Factor 4. *Acceptance as Unique* demonstrated the power of intersectionality for AF persons who also recognized the self as more than a material being without the support that other factors and previous literature suggested as essential (Gonzalez, 2007; Sheets & Mohr, 2009). Within this approach, recognition of the many identities, and thus contexts, that a person inhabits demonstrated significant influence upon how participants lived well (Chun & Singh, 2010).

Previous research recognized spirituality as part of intersectional identities yet no other factor demonstrated recognizing the self as more than a material being (Gill et al., 2010; Myers & Sweeney, 2005, 2008; Wilcox, 2003). The most interesting phenomenon
was how few participants emphasized a specific religion but instead represented the self as more than a material being through contact with the physical world or through pure spirituality (see Appendix G for further representation of religion/spirituality demographics). Purdy and Dupey (2005) recognized these elements of identity in the Holistic Flow Model of Spiritual Wellness, a focused rubric for developing one’s spirit. The Holistic Flow Model is utilized for meaning-making and connection, two elements described in participant responses as reactive and attentive to multiple identities (Purdy & Dupey, 2005, p. 95).

Valuing multiple identities was noted as conducive to wellness on other factors, but not to the extent recognized here, even with ample research support (Gonzalez, 2007; Jamil et al., 2009; Jones & McEwen, 2000). For one participant, continual trauma seemed to shape an intersectional identity, which also included a non-existent sexual desire, framed as “celibacy,” seen in other studies as a reaction to similar severe circumstances (Carter et al., 2013; D’Augelli, 1998). Previous research by Carter et al. (2013) demonstrated similar shifts to internal foci of wellness rather than those concordant with relationships for LGBTQ persons experiencing minority and/or psychological distress. This internal locus of control, including celibacy, demonstrated a unique path to wellness while also registering coping mechanisms for trauma (Harper et al., 2013; Storholm et al., 2013). Similar marginalization occurred for the other participant due to a lack of sexual desire, but she related the societal implications of sex as an issue within relational contexts.
The participant noted comfort within relationships where sexual expectations are mute and “intellectual connectedness” is preferred, but reported sexual expectations often interfere in connecting with others. This way of relating to others was not within the stereotypes of AF sexual behavior as often both heterosexual and gay/lesbian persons believe AF persons are hypersexual (Israel & Mohr, 2004; Ochs, 1996). Klein’s (1990) Sexual Orientation Grid, describing a multi-variable process of orientation, rang true for interactional styles on *Acceptance as Unique* as these were impacted by many factors and demonstrated unique relationships to wellness. The considerations of celibacy and/or intellectual connection as recognized within wellness are not found in current research, offering a new paradigm to view wellness from marginalized perspectives (Myers & Sweeney, 2005).

Marginalization may also have affected an interaction seen with transcending identifications as unlike other factors, *Acceptance as Unique* did not demonstrate support for cultural and gender identity while also reporting transcendence of said identities as functional to wellness. The description of issues within intimate relationships due to lack of sexual desire may have affected the negative rankings and qualitative data as gender role expectations have been shown to negatively affect satisfaction with gender (Mobley, 2003; Rieger et al., 2015). This describes the unique manner in which participants approached a personal model of wellness through how they grappled with identities, support for this process is found in some assimilation research (Sue & Sue, 2008). It is possible this interaction was a particular acculturation experience for those who do not conform to societal expectations regarding sex due to trauma and/or lack of sexual
interest as noted by previous research (Harper et al., 2013). Future research can gather more information or identify particular non-sexual populations for wellness inquiry, as these issues most likely create significant obstacles to overcome in affirmative counseling even for the most resilient AF persons (Finnerty et al., 2017a).

The inverse of Factor 4 noted a complex personal wellness approach. This perspective demonstrated how an intersectional genderqueer person of color might socialize, utilize family and values, and express gender in a positive manner to foster greater wellness. Previous research for AF persons has not demonstrated the rich detail of how this participant lived her “truth” through acceptance of gender, culture, family (the positives and negatives), positive relationships and not positioning herself as needing social relationships, but utilizing the positive people around to elevate wellness (Harper et al., 2013; Jamil et al., 2009). The rejection of binary gender representation may have assisted the participant to feel satisfaction with gender and utilize this acceptance of self to further wellness (Bradford, 2004; Harper et al., 2013; Moe et al., 2014). Further research on androgynous, non-binary, and genderqueer persons can serve to develop greater detail about the experiences of wellness for these groups, as little to no research exists (ACA, 2010).

The participant seems to have developed an effective personal model of wellness for self, incorporating many different items handpicked and contextualized for use as a person of multiple identities (Finnerty & Jencius, 2011; Gill et al., 2010). The responses regarding culture and self-care are “greater impacted within a social context” suggested her perspective was formulated through the multiple contexts AF genderqueer persons
live, noted with extensive description in the literature (ACA, 2010; Harper et al., 2013). This suggested that the participant operates from a positive intersectional identity where one is both aware of and utilizes to personal and communal advantage personal abilities/skills and supportive networks (Eliason, 1996; Fassinger & Arseneau, 2007; Griffith, 2004).

Persons who have solidified a personal model of wellness alongside a healthy sense of self may find intersectionality not as essential to personal wellness, a connotation found in the literature through often opposing lenses (Camarena & Rutter, 2015; Eliason, 1996; Granello, 2013). This represents the highly functional personal wellness model utilized and an established sense of intersectional self (Eliason, 1996; Griffith, 2004).

The response regarding how wellness beliefs are connected and interact summarized how an individual develops a personal model of wellness (Finnerty & Jencius, 2011). The awareness and internalizing of a belief before it can impact behavior and change has continuously fermented within the counseling literature as it symbolized stages of change (Prochaska & DiClemente, 1982). One must first be aware of the issue, and then can move towards change (Griffith, 2004). As Granello (2013) reported, these changes occur one or two at a time.

**Implications**

The current study has prospective benefit to three different areas: (a) counselors, (b) counselor educators and supervisors, and (c) researchers of affectionally fluid persons and/or wellness. The perspectives that emerged in the current study hold substantial
worth to each area. As many particular themes were discussed in the sections above, general connotations are covered below.

**Mental Health Counselors**

The current results can assist mental health counselors in wellness practice and overall affirmative counseling with AF persons. The results indicated that there are several different perspectives of wellness beliefs, each impacted by multiple demographic and lived experience variables. Each perspective’s themes are explored in context to how counselors can effectively integrate new material, ways of being, and knowledge in providing holistic, affirmative treatment.

*Intimacy and Self-Acceptance* added a great deal of new material to AF wellness literature. Although the themes supported previous research on resilience, stressors, and coping, counselors now have some specificity to beliefs of wellness, which can assist in creating effective wellness interventions (Brewster et al., 2013; Granello, 2013). Several major trends can be focused upon in delivering effective, affirmative counseling services. The major themes of self-acceptance and interpersonal skills as beliefs of wellness demonstrated the need for wellness intervention affirming the intersectional identities AF persons embrace and consideration of techniques designed to foster positive identity development (Eliason, 1996; Finnerty et al., 2017b; Jamil et al., 2013).

By affirming these identities, counselors can begin to mend the internal pain caused by marginalization, discrimination, and lack of support (Carter et al., 2013; McLean, 2008). Building trust, empathy, and authenticity in the counseling relationship can serve as a model for AF persons creating reflexive and supportive interpersonal
relationships of their own, building individual and community wellness through personal and communal empowerment (Harley et al., 2013; Prilleltensky, 2008). Interventions such as Lenz and Roscoe’s (2011) wellness card sort, group advocacy events, and involving allies in community engagement can be functional in developing identity through social engagement (Jones & McEwen, 2000; Legate et al., 2012).

Openness and Connectivity suggested several wellness areas to explore in addition to the relational and internal aspects. Findings of cognition, open-mindedness, and flexibility in handling experiences as relevant to optimizing wellness can be utilized in crafting culturally competent wellness intervention (Granello, 2013; Lee, 2008). Fostering the development of cultural awareness through cognitive and empathic appraisal of personal identity can be helpful in trending towards social justice advocacy and wellness for privileged members of the AF community and counselors alike (McIntosh, 1998; Myers & Sweeney, 2005; Ratts & Hutchins, 2009). Utilizing an affirmative counseling relationship for co-creation of open-ended interventions with small, incremental goals to develop positive schemata regarding wellness activities such as physical and social justice advocacy (Granello, 2013; Lewis et al., 2002). According to findings, counselors can integrate physical and social justice activities once internal and interpersonal wellness beliefs are thoroughly engaged to further the reach and wellness potential of AF persons (Halpert et al., 2007; Ratts & Hutchins, 2009).

Although the current study’s sample is not to be taken as an overall representation of the AF community, it may be functional to recognize how 50% of participants identified as atheist, agnostic, or non-religious in some form. This difference in
spirituality relates to some uncertainty in spiritual wellness that counselors will likely grapple with in work with AF persons (Purdy & Dupey, 2005; W. Roscoe, 1995). Findings noted the utilization of physical wellness activities and reduction of negative effects of pollution and stress in the environment may be helpful for meaning making and conceptualization of forces greater than self (Frankl, 1962). When suggested or conceptualized in counseling as wellness interventions, these everyday actions, such as riding a bike or joining a community organization, can increase community connectivity and develop a sense of spiritual flow without the need for organized religion (Purdy & Dupey, 2005).

*Physical and Self-Care in a Supportive Community* offered several items for counselors to consider in affirmative wellness practice. The first was how physical activity and good nutrition can add to a personal model of wellness rooted in internal acceptance and functional characteristics, intersectional identity development, and interpersonal connectivity (Myers & Sweeney, 2008). In addition, counselors must recognize that AF persons may share certain beliefs regarding self-care strategies with the overall community, but wellness practice must be based upon individual client strengths to build the best personal model (Finnerty et al., 2017b; Granello, 2013). The myriad of differences among perspectives on this domain of wellness demonstrates how intersectional elements of identity and experience affect beliefs of what is or can be helpful in maintenance of self (Storholm et al., 2013).

*Acceptance as Unique* suggested counselors recognize how previous trauma and differences in relational styles (e.g., celibacy and/or lack of interest in sex) can impact
how clients pursue interpersonal connections and conceptualize wellness practices (D’Augelli, 1998; Finnerty et al., 2017b; Meyer, 2003). Without a proper knowledge base of those who prefer less or no sexual contact, it is difficult to provide affirming wellness interventions, especially when it comes to optimizing social connectivity and identity development (Eliason, 1996; Harper et al., 2013; Moe, 2016). The inverse within *Acceptance as Unique* demonstrated how personal wellness truly is and how practitioners must recognize the subjective nature of wellness beliefs with which an AF client will present (Finnerty & Jencius, 2011). The number and nature of factors that contribute to each client’s case must be assessed in a functional, multidisciplinary, and affirmative manner (Finnerty et al., 2017b; Moe et al., 2015). In order to serve clients in an ethical and affirmative manner, practitioners must educate themselves to be culturally competent (in all senses) and affirmative of all senses of the word (Camarena & Rutter, 2015; Kort, 2008).

Another item to consider with AF persons is the number of persons who reported polyamorous relational styles in the current study. These findings suggest counselors continue to develop affirmative wellness practice through education, supervision/consultation, and experience of different relational practices as each person may represent differentially in the practice of wellness (Firestein, 1996; Harper et al., 2013). These differences in relational styles impact wellness and practitioners must be ready to grapple with shifting societal norms, particularly among younger populations (Dworkin, 2012).
For all the perspectives explored there were some common themes noting rejection of statements connected to wellness beliefs. Financial security was consistently rejected as a pertinent wellness belief for AF persons although many noted how this is important, just not as much as interpersonal, emotional/cognitive, intersectional identity, and physical wellness. Relevant literature on multiple marginalizations experienced suggested that socioeconomic issues negatively affect AF persons more than heterosexual and gay/lesbians but the position of demonstrating financial security does not secure wellness (Chun & Singh, 2010; Granello, 2013; Meyer, 2003). The recognition that certain wellness beliefs are impacted by the systemic contexts AF persons come into contact with daily suggested counselors consider many different factors and always approach wellness practice as allies from an affirmative stance (Finnerty et al., 2014).

The overall lesson from these findings for counselors was to continue developing cultural competence and affirming practice with AF persons through education and internal bias reduction (Finnerty et al., 2017b). This affirmative wellness practice is functional to the current group in particular through the modeling utilized in the counseling relationship. Wellness beliefs are interconnected and counselors can benefit from the realization that clients must become aware and internalize a belief before it turns into action (Prochaska & DiClemente, 1982).

Counselor Educators and Supervisors

Counselor educators and supervisors can utilize these findings in the classroom and supervision session through conceptualization of wellness treatment plans and added content areas on AF persons in discussions of culture. One of the larger issues the
counseling field encounters is how to incorporate both wellness and AF issues into the curriculum (Frank & Cannon, 2010; Wells, 1989). Through effective curriculum development utilizing the core wellness themes of social connectivity, internal development, physical wellness, and unique perspectives educators and supervisors can develop affirmative wellness content and teaching/supervision styles (Frank & Cannon, 2010; Lenz et al., 2014).

Educators and supervisors can utilize information provided to develop cultural competence and wellness modalities suiting AF persons so students and seasoned counselors can attain ally status and practice wellness excellence (Moe et al., 2014; Myers & Sweeney, 2005; Poynter & Washington, 2005). Blending the use of affirmative AF counseling/supervision models with wellness supervision models in teaching students about the current findings can be effective in creating knowledgeable allies and advocates (Halpert et al., 2007; Lenz et al., 2014; Lewis et al., 2002). In addition, educators can frame queer theory through the intersectional AF lens reported in the study (Frank & Cannon, 2010). By doing so educators can assist students in recognizing personal bias and strengths in both AF and wellness issues (Kort, 2008; Lenz et al., 2012). Supervisors can model affirmative wellness practice in supervision to promote beginning counselors and students’ use of modeling in counseling sessions with AF clients (Moe et al., 2014; Moe et al., 2015; Lenz et al., 2014). These experiences can assist in recognizing bias, learning affirmative wellness therapeutic modalities, and developing cultural competence to combat the assumptions and negative attitudes toward AF persons (Lenz et al., 2010; Moe et al., 2014; Rainey & Trusty, 2007).
Researchers of Affectionally Fluid Persons and Wellness

As this study constitutes some of the first wellness research through use of an evidence-based model with AF persons, both AF and wellness researchers can benefit from the conceptualizations and overall perspectives included (Dew & Newton, 2005; Moe, 2016). For both types of researchers, information about wellness beliefs and lived experiences of AF persons through both the sorts and responses provided a great deal of intriguing information on intersectional identity, considerations regarding trauma, relational patterns, descriptions of identifications, and demographic points including those of spirituality. Coupling this information with previous empirical, qualitative, and theoretical research can assist in informing best practices of AF affirmative wellness counseling (Finnerty et al., 2017b; Granello, 2013; Myers & Sweeney, 2008).

For AF researchers, the findings allow for concepts regarding health, wellness, identity, lived experiences, and connotations regarding intersections of these elements to be explored in more depth and compared to results from larger quantitative and richer qualitative studies (Moe, 2016). All of these items are pertinent as the limited current knowledge on AF wellness can be developed through functional recreation of studies designed to investigate the current study’s perspectives further (Dew & Newton, 2005; Moe, 2016). All of these elements can be investigated in counseling, supervision, and multicultural areas of research.

Wellness researchers can benefit further by utilizing findings to investigate the perspectives with large, norming groups and qualitative studies to tease out rich detail behind the sorts and responses in the current study. This can refresh the IS-WEL Model
with a more AF affirmative position in the counseling literature for usage with multiple affectional populations (Finnerty et al., 2017b; Myers & Sweeney, 2005). In specific terms, wellness researchers can utilize perspectives to create new treatment plans, interventions, and techniques with intersectional AF and other cultural groups (Granello, 2013; Moe et al., 2015).

**Limitations**

The largest limitations to the study resulted from the types of AF persons who responded. An initial factorial structure called for gaining adequate participant numbers from 3 age brackets across 3 gender identifications from a maximum of 45 participants (S. R. Brown, 1986). This would mean 30 participants would come from the age brackets of 40-60 years and 61 years and older spread across the genders of man, woman, and gender queer/androgynous. In the end only 13.6% of participants came from the 40-60 year age bracket \( (n = 6) \) and 2.2% from the 61 years and older bracket \( (n = 1) \). The \( 3 \times 3 \) factorial structure was not met in each of these cells as 84% of the participants came from the 18-39-age bracket \( (n = 37) \). Of this group, all cells contained at least 5 participants but most participants identified as women for the entire P sample \( (50\%, n = 22) \). In addition, gender queer/androgynous persons made up 31% of the P sample, a rather large number when compared to the 2-10% of the total population most studies find (ACA, 2010). In addition, 27 participants identified as Caucasian, white, or European creating a rather large ethnicity concern to perspectives (61.4%).

These demographic concerns of gender and age were likely a product of women identifying much more often as affectionally fluid than men and older persons usually
taking up a binary identity due to a myriad of reasons (Diamond, 2008b; Harper et al., 2013). This participant sample does not seem reflective of the larger population due to participant totals in age, ethnicity, and gender identification noted. It is possible such a homogenous population did not capture sufficient diversity as outlined by the factorial structure to foster other perspectives. The demographics of the sample likely limited the four main factors revealed and an effort to gain a sample with more men and gender flexible or genderqueer persons can be useful. There is also the possibility seeking participants with a clear description of AF identity gave the most representative sample possible due to the constraints of selecting a refined definition.

Another concern for the study was couched in description of the Q sort task. Although the researcher believed directions were concise, several participants noted confusion in the additional comments section about how they were not sure whether to sort based on their personal beliefs of wellness, how they personally practiced wellness day to day, or what was considered functional to any person’s wellness. The first description was italicized as it was the correct manner to sort but nevertheless this may have affected the sorts of participants. Some of those who commented upon this concern reported they went through with the sort utilizing the correct method. Researchers should consider direct, concise description of how to sort if this study is replicated in the future.

One participant noted an additional issue related to the mail-in version of the sort. He stated in the “additional comments” section (after agreeing to complete the task by hand) how sorting by hand and writing out responses was “perfunctory and ill conceived” as disability involving hand movement was an issue. This is something to consider for
future researchers, as there may be options to utilize Skype or computer-based programs available to complete the study.

Q methodology has traditionally used post-sort in-person or telephone interviews to better recognize the perspectives of the participants (McKeown & Thomas, 2013). For the purposes of this sensitive study the researcher chose to utilize written responses. The short responses possibly impeded the complexity of the interpretation, but it is unclear whether more depth would be possible with interviews. However, interviews may have allowed for elucidation of responses and the sort in general.

**Future Research**

The most obvious question that remains from this study is, are there any other perspectives? Q methodology does not claim to find all prospective perspectives; therefore, the current study cannot claim to be all encompassing (Watts & Stenner, 2012). As such, future research endeavors must pursue and document other probable perspectives. These perspectives emerged in the current study, where several principal components were completed representing up to eight factors with at least one significant loading. There may be other factors, but due to the tidy nature of the PCA four-factor solution, comprised of the most defining sorts, these other possibilities were not pursued. Future research may pursue these other specific perspectives. This includes utilizing intensive single-case Q method studies to investigate the rich details afforded by participants in this study further (Goldstein & Goldstein, 2005).

Possible other areas of inquiry may include asking counselors practicing from a wellness perspective to consider what beliefs of wellness emerge from work with AF
As there has been little to no research conducted on AF wellness, adding in the perspective of a counselor on AF wellness may showcase both biases on part of the counselor and an external perspective on client wellness. Utilizing a Q methodological or qualitative approach to investigate AF wellness may spawn richer detail. Other possible research endeavors include empirical research utilizing the perspectives for wellness intervention with AF clients. Creating studies to measure the effectiveness of both affirmative wellness practices and particular techniques informed by the findings can extend research into treatment protocols. Overall, conducting more research as a follow up to the current study is essential.

The researcher is interested in gaining more participants above the age of 40 as there was significant difficulty representing middle age and older adults in this P sample. The same is true with gaining more men and gender queer/androgynous persons. To explore these concerns, it may be helpful to investigate the motivations behind participation, efficacious methods of recruitment, and interests regarding wellness for AF persons. There may also be benefits to investigating the personality characteristics and interest in research of AF persons who actively participate in research. Recognizing the differences between these persons and those in the larger population can assist researchers in gaining a strong representation of the AF community.

**Conclusion**

The current study utilized Q methodology to investigate AF persons’ beliefs about wellness. Forty-four participants sorted 32 statements from most agree with my beliefs about wellness to most disagree with my beliefs. The responses were analyzed utilizing
factor analysis (principal components) resulting in four factors and an inverse, constituting five total perspectives.

The researcher interpreted the factors by using factor arrays, distinguishing statements, and post-sort written responses of participants. The factors included *Intimacy and Self-Acceptance*, *Openness and Connectivity*, *Physical Wellness and Self-Care in a Supportive Community*, and *Acceptance as Unique*. These factors related the beliefs that these AF persons had about wellness through themes of connection and personal acceptance, engaged cognitive/emotional openness and interpersonal relationships, physical wellness and prevention in supportive networks, overall acceptance of unique wellness models. There is possibility for other perspectives, but they were not noted in the current study. This chapter described the meaning of the perspectives and the responses shared by the participants.
APPENDICES
APPENDIX A

AF-WELLNESS CONCOURSE
Appendix A

AF-Wellness Concourse*

Creative Self

Thinking
Is mentally active and open-minded.
Is able to be creative and experimental.
Demonstrates a sense of curiosity: seeks knowledge and learning.
Is able to solve problems.

Emotions
Aware of and in touch with feelings.
Recognizes differences, similarities, and connections between negative emotions and
cognitions.
Experiences and expresses both positive and negative feelings appropriately.

Control
Usually achieves personal goals.
Demonstrates planfulness in life.
Assertive in expressing needs.

Work
Satisfied with work.
Demonstrates adequate financial security.
Utilizes skills appropriately.
Is able to cope with workplace stress.

Positive Humor
Can laugh at mistakes and unexpected things that happen.
Utilizes humor to accomplish even serious tasks.
Utilizes humor in interpersonal relationships, even in difficult moments.

Coping Self

Leisure
Is involved in activities during free time.
Is satisfied with leisure activities.
Has at least one activity in which “time stands still.”
Makes time for activities not connected to work or long-term goals.

Stress Management
Views change as an opportunity for growth.
Can continually self-monitor.

Assesses coping resources.
Utilizes self-care when dealing with stress daily.

**Self-Worth**
Accepts the “who” and “what” of self.
Acknowledges positive qualities and imperfections within self.
Values self as a unique individual through multiple elements of identity (ethnicity, orientation, gender expression, ability, etc.).
Recognizes intersections of identity and how these elements inform experiences.

**Realistic Beliefs**
Understands perfection and being loved by everyone are impossible goals.
Demonstrates courage to be imperfect.
Recognizes a balance must be struck between goals and self-care.

**Social Self**

**Friendship**
Enjoys social relationships involving a connection with others, individually or communally, but that do not have a marital, sexual, or familial commitment.
Has trustworthy friends.
Recognizes balance between giving and receiving support.
Receives emotional, material, or informational support when needed.
Can provide emotional, material, or informational support to others when needed.

**Love**
Is able to be intimate, trusting, and self-disclosing with another person.
Has a family or family-like support system characterized by shared spiritual and/or ethical values.
Is able to solve conflict in a mutually respective way.
Demonstrates a healthy communication style.
Engages in mutual appreciation.
Is able to compromise and grow within significant relationships.

**Essential Self**

**Spirituality**
Holds/practices personal beliefs that allow recognition of self as more than just a material being.
Behaves in an adept and skilled way, not just mechanically in mind and body.

**Gender Identity**
Feel satisfaction with my gender.
Feel supported in my gender.
Able to transcend gender identity and expression.
Able to be androgynous.

**Cultural Identity**
Express satisfaction with the intersecting elements of my cultural identity.
Feel supported in my cultural identity.
Transcends cultural identifications.
**Self-Care**
Takes responsibility for wellness through self-care.
Engages in preventative self-care strategies.
Attempts to minimize the harmful effects of pollution and stress in my environment.

**Exercise**
Engages in sufficient physical activity to stay in good physical condition.
Maintains flexibility through stretching.

**Nutrition**
Able to eat a nutritionally balanced diet.
Maintain a healthy weight.
Avoids over-eating.

(Note: The Physical Self has been compressed into the Essential Self for this inquiry.)
APPENDIX B

Q SAMPLE/FACTOR SCORES AND RESPONSE GRID
Appendix B

Q Sample/Factor Scores and Response Grid

<table>
<thead>
<tr>
<th>Factor Arrays</th>
<th>1</th>
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<th>3</th>
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</tr>
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<tbody>
<tr>
<td>+1</td>
<td>+1</td>
<td>+3</td>
<td>+2</td>
<td></td>
</tr>
<tr>
<td>-4</td>
<td>-1</td>
<td>-2</td>
<td>-1</td>
<td></td>
</tr>
<tr>
<td>+2</td>
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</tr>
<tr>
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<td>-3</td>
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<td>0</td>
<td></td>
</tr>
<tr>
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<td>-3</td>
<td>+1</td>
<td>+4</td>
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<td>+4</td>
<td>0</td>
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<tr>
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<td>-2</td>
<td>+2</td>
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<tr>
<td>+1</td>
<td>-2</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>-3</td>
<td>+1</td>
<td></td>
</tr>
</tbody>
</table>

1. Enjoys social relationships involving a connection with others, individually or communally, but without marital, sexual, or familial commitment.
2. Demonstrates adequate financial security.
3. Is mentally active and open-minded.
4. Aware of and in touch with feelings.
5. Engages in mutual appreciation.
7. Maintains a nutritionally balanced diet.
8. Feels supported in a cultural identity.
9. Recognizes balance between giving and receiving support.
10. Demonstrates planfulness in life.
11. Values self as a unique individual through multiple elements of identity.
12. Is able to be intimate, trusting, and self-disclosing with another person.
14. Understands that perfection and being loved by everyone are impossible goals.
15. Is able to solve problems.
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>-2</td>
<td>0</td>
<td>-2</td>
<td>-2</td>
<td>(17) Has trustworthy friends.</td>
</tr>
<tr>
<td>+2</td>
<td>+3</td>
<td>0</td>
<td>-3</td>
<td>(18) Assertive in expressing needs.</td>
</tr>
<tr>
<td>+1</td>
<td>0</td>
<td>-1</td>
<td>-2</td>
<td>(19) Makes time for activities not connected to work or long-term goals.</td>
</tr>
<tr>
<td>0</td>
<td>+1</td>
<td>+1</td>
<td>0</td>
<td>(20) Is able to solve conflict in a mutually respective way.</td>
</tr>
<tr>
<td>+3</td>
<td>0</td>
<td>-1</td>
<td>0</td>
<td>(21) Can laugh at mistakes and unexpected things that happen.</td>
</tr>
<tr>
<td>+1</td>
<td>-2</td>
<td>-1</td>
<td>+2</td>
<td>(22) Has a family or family-like support system characterized by shared spiritual and/or ethical values.</td>
</tr>
<tr>
<td>-2</td>
<td>+2</td>
<td>+2</td>
<td>-4</td>
<td>(23) Is satisfied with leisure activities.</td>
</tr>
<tr>
<td>-1</td>
<td>0</td>
<td>-2</td>
<td>0</td>
<td>(24) Views change as an opportunity for growth.</td>
</tr>
<tr>
<td>+2</td>
<td>-1</td>
<td>+1</td>
<td>+2</td>
<td>(25) Engages in sufficient activity to stay in good physical condition.</td>
</tr>
<tr>
<td>-3</td>
<td>+2</td>
<td>+4</td>
<td>+2</td>
<td>(26) Feels satisfaction with existing gender.</td>
</tr>
<tr>
<td>-1</td>
<td>-4</td>
<td>0</td>
<td>-3</td>
<td>(27) Acknowledges positive qualities and imperfections within self.</td>
</tr>
<tr>
<td>+4</td>
<td>+2</td>
<td>+2</td>
<td>+1</td>
<td>(28) Attempts to minimize the harmful effects of pollution and stress in the environment.</td>
</tr>
<tr>
<td>-4</td>
<td>+2</td>
<td>-4</td>
<td>+3</td>
<td>(29) Holds/practices personal beliefs that allow for recognition of self as more than just a material being.</td>
</tr>
<tr>
<td>-2</td>
<td>+1</td>
<td>0</td>
<td>+4</td>
<td>(30) Demonstrates a health communication style.</td>
</tr>
<tr>
<td>+2</td>
<td>+3</td>
<td>+3</td>
<td>0</td>
<td>(31) Transcends cultural identifications.</td>
</tr>
<tr>
<td>-3</td>
<td>-3</td>
<td>-3</td>
<td>+3</td>
<td>(32) Finds satisfaction with work.</td>
</tr>
</tbody>
</table>
### Response Grid/Additional Comments

<table>
<thead>
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<th>Most Disagree</th>
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<td></td>
<td>+4</td>
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<tr>
<td>+2</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>+3</td>
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<td></td>
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<tr>
<td>+4</td>
<td></td>
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</tr>
</tbody>
</table>

(2)  (2)  (3)  (3)  (4)  (4)  (4)  (4)  (6)

### Additional Comments

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________________________________________________________________________
________________________________________________________________________
APPENDIX C

RECRUITMENT LETTER/EMAIL/POSTING
12-15-16

Re: Affectionally Fluid Persons’ Beliefs About Wellness

Dear: (Name)

I am writing to let you know about an opportunity to participate in a research study about affectionally fluid persons’ beliefs about wellness. This study is being conducted by Marty Jencius, PhD., Pete Finnerty, M.S., Steve Rainey, PhD., and Steven Brown, PhD.

The study includes a Q sort of wellness statements (ranking statements from strongly agree to strongly disagree) followed by completion of questions related to the Q sort and some background information questions. It should take you about 20-25 minutes to complete the Q sort, fill out the corresponding grid and answer questions.

If you are at least 18 years old and identify as along the continuum of affectional/sexual orientation (including identifications of bisexual, queer, omnisexual, pansexual, etc.) or do NOT identify as exclusively heterosexual or gay/lesbian you may participate in this study.

To participate please email Pete Finnerty at pfinnert@kent.edu to set up a time to meet in person or have a packet sent to your address.

If you would like additional information about this study, please contact Marty Jencius, PhD.

Thank you for your consideration, and once again, please do not hesitate to contact me if you are interested in learning more about our project.

Marty Jencius, PhD
Associate Professor
Principal Investigator
Pete Finnerty, M.S., PCC-S
Doctoral Candidate
Kent State University
APPENDIX D

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Appendix D

Informed Consent to Participate in a Research Study

Study Title: Affectionally Fluid Persons’ Beliefs About Wellness

Principal Investigator: Marty Jencius, PhD

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose: I am completing research on affectionally fluid (AF) persons’ beliefs about wellness due to interest in this topic and how the research potentially can assist counselors to better serve the population.

Inclusion Criteria: If you are at least 18 years old and identify as along the continuum of affectional/sexual orientation (including identifications of bisexual, queer, omnisexual, pansexual, etc.) or do NOT identify as exclusively heterosexual or gay/lesbian you may participate in this study.

Procedures: If you agree to participate, you will be asked to sort 32 statements about wellness, complete a background questionnaire, and fill out a short set of questions. The set of statements are about wellness and will be sorted by you from “most agree” to “most disagree.” The sort and all accompanying forms will take approximately 20-25 minutes to complete. Please read and follow all directions.

Benefits: This research will not benefit you directly. However, your participation in this study will help us to better understand beliefs about wellness for the AF community.

Risks & Discomforts: There are no anticipated risks beyond those encountered in everyday life.

Privacy & Confidentiality: No identifying information will be collected. Your signed consent form will be kept separate from your study data, and responses will not be linked to you. Your study related information will be kept confidential within the limits of the
law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

**Voluntary Participation:** Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact Information:** If you have any questions or concerns about this research, please contact Martin Jencius, PhD. at (330) 672-2662. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

**Consent Statement and Signature:** I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

_________________________  _____________________
Participant Signature     Date
APPENDIX E

SCRIPT/DIRECTIONS FOR PARTICIPANT
Appendix E

Script/Directions for Participant

Thanks again for agreeing to participate in this research study about AF persons’ beliefs about wellness. It should take 20-25 minutes of your time.

Consent:
The Institutional Review Board of Kent State University has approved this project. The consent outlines what is asked of you in this study, how you can stop at any time, and whom you contact if you have concerns. Please take a moment to read the consent and sign at the bottom if you agree to participate. This is the first item in the packet after this page.

Packet:
The research study packet includes the following in order: this instruction sheet for sorting, an informed consent (you must give consent through signing and dating the consent to participate), the Q sample materials and a response grid (a table of 32 boxes to record your sort) with some space for additional comments if you need more space for commentary after completing the following Q sort questions, and a background questionnaire/Q sort questions to be completed after the sort.

Q Technique:
First you will lay out the grid on which you will later record your sort. Then you will lay out each of the wellness statements (posted on cards) and then take time reading through all of the cards, creating 3 piles: one on the right you are certain match with your beliefs regarding wellness, one on the left which you are certain do not match with your beliefs regarding wellness, and one in the middle that either you have no feelings toward or don’t know where to place.

After you have created three piles, please pick up the pile on the right and choose the two statements that most agree to your beliefs regarding wellness in the +4 column. It does not matter which goes on top. (Due to the response grid being smaller than the actual cards please place under the grid in order to follow the rubric of the grid)

Next, please shift over to the pile on the left, or those statements you most disagree with your beliefs regarding wellness. Choose the two statements you most disagree with and place them in the -4 ranking column.

Continue filling in rankings, going back and forth from the positive and negative columns of the grid until you empty each pile.
Once you have exhausted all the cards you are welcome to reexamine the sort and switch statements as desired.

Response Grid:
Using the response grid in your packet please write the number of each statement in the corresponding box. You will notice the number in the corner of each card.

Background Questionnaire and Q Sort Questionnaire:
When you complete writing the numbers on the response grid, please complete the Background Questionnaire and Q Sort Questionnaire. Please complete each to the best of your ability. You will notice there is a section for additional comments on the Response Grid sheet. You can add comments there if you need more room.

Returning Grid Materials:
Please utilize the stamped envelope to return the following:
Informed Consent
Response Grid with numbers written in the squares
Background Information/Q Sort Questions sheet

You may keep, dispose of, or send back the actual Q sort materials (statements and numbers).

THANK YOU!
APPENDIX F

BACKGROUND AND Q SORT QUESTIONNAIRE
Appendix F

Background and Q Sort Questionnaire

The following are several questions regarding your background and demographics associated with your identity. Please answer each question to the best of your ability. Below these demographic questions are Q sort questions to be answered after completing the sort. If you have any questions about any of the material presented on this form please do not hesitate to ask. Thank you for your participation.

Please describe by filling in the blanks:

1. Age (in years): __________
2. Ethnicity: ______________________________________________________
3. Identified Racial Group: __________________________________________
4. Affectional Orientation identification: ______________________________
5. Gender Identity (Man/Woman/Androgynous):
   ________________________________________________________________
6. Assigned/Biological Sex (Female/Male/Intersex): _________________
7. Highest level of education (if student, current degree sought):
   ______________________________
8. Current Relationship Status:
   _______________________________________________________________
9. Employment Status:
   __________________________________________________________________
10. Spiritual/Religious affiliation or beliefs:
    __________________________________________________________________

Q-sort Questions

11. Describe how the statement you ranked at +4 (Most agree with your beliefs about wellness) is essential to your beliefs.
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________

193
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Describe how the statement you ranked at -4 (Most disagree with your beliefs about wellness) is most inessential to your beliefs.</td>
</tr>
<tr>
<td>13.</td>
<td>Describe other statements you believe assist in defining your beliefs (either positive, negative, or neutral rankings).</td>
</tr>
<tr>
<td>14.</td>
<td>What statements were difficult to place? Please note the difficulty in placing.</td>
</tr>
<tr>
<td>15.</td>
<td>Are there any other beliefs or concepts about wellness that materialized during the sort?</td>
</tr>
</tbody>
</table>
APPENDIX G

MATRIX OF FACTOR LOADINGS AND DEMOGRAPHICS
## Appendix G

### Matrix of Factor Loadings and Demographics

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<tr>
<th>Sort</th>
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<th>Race</th>
<th>Rel/Sp</th>
<th>GenID</th>
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</thead>
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<td>NR</td>
<td>WHT</td>
<td>AGN</td>
<td>TNB</td>
</tr>
<tr>
<td>2</td>
<td>-09 40  -10 26</td>
<td>YA</td>
<td>PS</td>
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*aLoadings in bold significant (p<.05), decimals omitted. Loadings in italics used in estimating factor scores.

*Abbreviations refer to following:
- **Age**: YA (young age), MA (middle age), and OA (older age).
- **Orientation Identification (OrID)**: AP (asexual panromantic), BI (bisexual), FL (fluid), HB (heteromorphic bisexual), HM (heterosexual mostly), NR (no response), PR (panromantic), PS (pansexual), QP (queer/pansexual), QR (queer), and SP (sapiosexual).
- **Race**: ASN (Asian), BLK (black), HIS (Hispanic), WHT (white), and WNA (white/native).
- **Religion/Spirituality (RelSP)**: AGN (agnostic), AGS (Agnostic but spiritual), ATH (atheist), BEF (Belai Faith), BUD (Buddhist), CAT (Catholic), CHL (Christian-Lutheran), CHR (Christian), HND (Hindu), HJU (Humanistic Judaism), NM (Not a materialist), NPM (non-practicing Methodist), NR (Nonreligious/nontheist), PAG (pagan), PRO (Protestant), SH (Spiritual, holistic, other beliefs), SHA (Shamanism), TAO (Taoist), and WCH (witch).
- **Gender Identity (GenID)**: 2SP (two-spirit), GF (genderfluid), GQ (genderqueer), GQ/NB (genderqueer/non-binary), MN (man), TNB (transmasculine non-binary), and WM (woman).
REFERENCES
REFERENCES


Exploring the relations of autonomy support, outness, and wellness for lesbian, gay, and bisexual individuals. *Social Psychological And Personality Science, 3*(2), 145-152. doi: 10.1177/1948550611411929


access to services among young men who have sex with men in New York City.


doi:10/1080/19359705.2012.763080


June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

