Carving Sexuality at Its Joints: Defining Sexual Orientation in Research and Clinical Practice

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In this article, we review basic research on sexual orientation for a clinical scientist–practitioner audience. We present contemporary and evolving approaches to defining and measuring sexual orientation, and we provide suggestions for how to translate psychological theory into best practices (i.e., how to select appropriate sexuality measures in both research and clinical settings). Our focus is on evaluating currently available measures of sexual orientation in terms of comprehensiveness and feasibility: How thoroughly are components of sexuality captured and how feasible it is to use such measures in research and clinical settings? Basic research in sexuality has progressed beyond our current clinical practices and should be used as a guide to more responsibly conceptualize participants and clients. While we determine that the current options are far from perfect, the critical clinician will find that contemporary measures of sexual orientation prove more useful than more simplistic predecessors. This review will elucidate best strategies for translating sexual orientation research and theory into clinical practice and provide clinicians and researchers alike with theoretically grounded support for tools of measurement and assessment.

Public Significance Statement
This review article translates basic sexual orientation research into best practices for research and clinical audiences. The numerous definitions and evolving, fluid components of sexual orientation demand careful thought when selecting measurement.

Keywords: sexual orientation, measurement, clinical, sexuality, LGBQ

The researcher’s difficulty in defining and measuring humans is exacerbated by people’s insistence on defining themselves. For as much as we scientifically attempt to reduce seemingly straightforward characteristics (e.g., race, gender, or sexuality) down to quantifiable checkboxes, it has become increasingly clear that the lived experiences of people exist outside of bounded categories. This is especially true in the study of sexual minorities, a diverse collection of people who continually eschew attempts to be neatly defined by the scientist attempting to carve nature at its joints. Early psychological methods in sexuality research used the dichotomy of heterosexual or homosexual, mirroring the similarly strict male–female sex and gender duality. However, today, we are faced with the task of taxonomizing Millennials who are far more likely than their parents to embrace identities outside of binary gender and sexuality options (GLAAD & Harris Poll, 2017). While a daunting task, working toward a near-optimal measurement of sexual orientation is necessary for the researcher who aims to answer questions about frequencies, similarities and differences, or life span development in terms of sexual orientation, as well as for the clinician who seeks to understand the full range of clients’ identities and experiences.

Clinical, social, and health researchers and practitioners similarly have strong motivations to understand how to best assess sexual minorities because of the heightened mental and physical health risks associated with stigmatization based on one’s sexual orientation (Meyer, 2003). Despite knowing that assessment of sexual orientation is critical for understanding experiences and risk factors, researchers’ and practitioners’ pursuit of sexual orientation information may be curtailed by (a) a lack of awareness about appropriate measures or assessments for sexual orientation, (b) the need for a simplified and quantified coding and classification system (e.g., homosexual or heterosexual; gay/lesbian, bisexual, or heterosexual), and (c) time constraints in measurement and assessment. For example, in clinical practice, an intake demographic form is often the first method of gathering information about a client. The purpose of this form should be to collect sufficient background data to create a picture of who clients are and what problems they face. Questions about gender, race/ethnicity, and sexual orientation are standard on these forms; however, demographic questions are often brief to save room for symptom-specific information. In clinical research, even less space may be
afforded to demographic questionnaires to minimize the burden on participants, or for ease of data coding. However, merely splitting clients into sexual minority and majority groups (e.g., homosexual and heterosexual) fails to address the diversity of experiences within both categories when, for example, a bisexual woman is more likely to experience physical and mental health problems than a lesbian woman (e.g., Fredriksen-Goldsen, Kim, Barkan, Balsam, & Minczer, 2010). Furthermore, a heterosexual-identified man who has had sexual experiences with other men may be overlooked on an intake questionnaire, while a woman with a partner who does identify in a binary gender system (i.e., woman/man) may struggle to respond to a one-item sexuality measure.

Many individuals defy typical nomenclature used in measurement, which results in the loss of rich data or an ignorance of potentially valuable clinical knowledge. Obtaining a fuller picture of sexual history, behaviors, desires, and identity can inform practitioners more specifically about the circumstances and risks their clients may face, as well as the diverse ways they may enjoy their sexualities. A good assessment can be a therapeutic process in itself, and the quality of research is limited by the quality of data. We argue that a careful and nuanced assessment of sexual orientation in clinical and research settings will yield more careful and nuanced insight into the lives of one’s clients and participants.

Overview

In this review, we critically analyze the current state of sexual orientation definition and measurement, with the goal of translating basic sexuality research for best practices in the clinical realm. While gender minorities are related and overlapping to this topic, they are not directly addressed by this review, apart from how gender diversity influences measurement of sexual orientation. Instead, we focus on how contemporary perspectives of sexual orientation can be best digested for clinical practice and research, situated within the context of historical approaches. Currently available measures of sexual orientation will be evaluated based on how thoroughly components of sexuality are captured, balanced with how realistic using a given scale may be across settings. While a 100-item measure may paint an incredibly clear picture of a person’s sexual orientation, it is unlikely to handily replace a single item in an already long battery of questionnaires. Emerging ideas about the classification of sexual minorities will be outlined and evaluated based on potential utility in the clinical realm. Basic research in sexuality has progressed beyond our current clinical practices and should be used as a guide to more responsibly conceptualize participants and clients. We hope this review serves as a critical menu of current options to guide best practices, and that the imperfections in current choices inspire both researchers and practitioners to continue listening to those they are measuring and to develop more sophisticated measures for the future.

The Complicated Landscape of Sexual Orientation

Human sexuality is complicated by the intersection of identity and behavior. The lived sexual and romantic experiences of people can consist of attractions, activities, fantasies, and partner choice across time (van Anders, 2015). These somewhat concrete variables are then self-bundled into an identity label that may or may not clearly forecast actual behaviors and desires, and are shaped by the surrounding culture and context. Neither identity nor behaviors are easily captured alone. The crossing of them into one construct—sexual orientation—becomes an issue that demands researchers to be critical in how we define and measure people and presents several challenges, including (a) overcoming blindness to “gray areas” developed in early sexuality research that lives on as artifacts in present research, (b) acknowledging that popular language used to describe sexuality evolves quickly, nonuniformly, and without consideration of scientists’ preferences for precise definitional criteria, and (c) recognizing that a single solution may never be reached because of the complexity of this construct, putting the onus on the researcher or clinician to put thought into what and in which way sexual orientation is measured.

Current Challenges to Definition and Measurement

Early sexual orientation research began with an emphasis on stable heterosexual and homosexual groups. In doing so, early research mishandled the gray area in between heterosexuality and homosexuality by minimizing the existence of bisexuality and overemphasizing distinct types of sexuality (Sell, 1997). Later, quantitative analysis of the structure of sexuality provided support for the view that sexual orientation is a graded variable, rather than discrete categories (Haslam, 1997), and cannot be fully explained by only heterosexual and gay/lesbian designations (Gangestad, Bailey, & Martin, 2000). Furthermore, contemporary views hold that sexual orientation is not always a static category, but a potentially fluid identity that needs to be examined across the life span (Diamond, 2005; Hu, Xu, & Tornello, 2016; Savin-Williams, Joyner, & Rieger, 2012). With the growing acknowledgment that sexual orientation may be fluid and that sexual orientation categories may be indistinct, clinical researchers are tasked with balancing the scientific desire for standardization and the often-fuzzy nature of real-world sexuality. The language of labeling in current popular and sexual minority subcultures has indeed advanced beyond the heterosexual–bisexual–homosexual categorizations that usually appear on demographic forms (Whittington, 2012), and reveals methodological and conceptual gaps in the standard categories provided by researchers.

One solution proffered for allowing people the flexibility to identify with any label they choose is the “open box”—using a write-in category as either a substitute or supplement to the standard check-boxes. At face value, this may seem a simple alternative, but it falls apart particularly for the researcher who hopes to quantify their data or for clinicians who may not fully understand, for example, what a “polyamorous” or “queer” identity
entails (especially since identifiers may be imprecise). Practically speaking, measures cannot always include an open box for a myriad of self-identifiers and/or a long barrage of questions assessing how attractions have shifted across the lifetime, as this qualitative data collection approach may result in nearly as many sexual orientations as there are participants. For example, the common acronym LGBT (lesbian, gay, bisexual, and trans\textsuperscript{5}) can be expanded to QUILT/BAGPIPE (queer/questioning, undecided, intersex\textsuperscript{6}, lesbian, trans\textsuperscript{6}, bisexuale, asexual\textsuperscript{7}, gay, pansexual\textsuperscript{8}, indeterminate, polyamorous, and everyone else), and yet additional letters could still be added with the ever-expanding list of sexual (and gender) identity labels. These self-identifiers reflect current language used in sexual minority communities, and as such will vary across time and place—which makes translating these evolving terms into scientific or standardized variables difficult.

To complicate matters, gender minorities are often conflated or equated with sexual minorities for either convenience or community (as seen in “LGBT,” which includes trans’ individuals alongside sexual minorities), yet the two groups remain distinct despite overlap within some people (Galupo, Davis, Grynkiewicz, & Mitchell, 2014). Sexual minorities (e.g., bisexual or gay) refers to people whose attractions are not directed wholly toward people of different gender/sex, or do not identify as heterosexual. Gender minorities (e.g., transgender or genderqueer) are people whose gender identity either does not coincide with sex assignment at birth, and/or people whose gender identity does not fit within the gender binary of identifying as man or woman. While, for example, a transman may be only attracted to women and therefore identify as heterosexual, other transmen may identify as gay or queer. Although connected under the umbrella term “sexual and gender minorities,” these identities are separate. The challenges researchers and clinicians encounter in capturing gender identity are not perfectly parallel to those described in the current review.

Finally, and perhaps the most frustrating challenge is sexual orientation assessment, is the need for researchers and clinicians to accept that a single measure is unlikely to provide all information they seek to acquire. The ultimate lack of a single solution to this challenge reflects the multifaceted nature of this construct—sexuality is complicated, gender is complicated, and their intersection multiplies the ground a single-item measure is expected to cover. Instead, we are tasked to find a solution that best answers a given problem. An aim of this article is to outline the current options for defining and measuring sexual orientation, along with the strengths and limitations of each. Furthermore, we aim to convey that the best choice will be one made after careful consideration of the clients or participants involved.

Established Guidelines

Challenges of measuring sexual orientation are part of an ongoing discussion within psychology, and as such, there have already been organized efforts to compile guidelines for best practices for working with sexual minorities in psychology, such as that of the American Psychological Association (American Psychological Association, 2008). Another effort by the Sexual Minority Assessment Research Team [SMART], (2009) resulted in a report that outlines recommendations for measuring and analyzing sexual orientation. This can be a highly useful reference as it provides background on possible phrasings of sexual orientation questions across multiple situations, and takes into consideration some cultural issues. What advantage, then, is there in revisiting best practices for research and clinical practice?

The SMART guidelines (SMART, 2009), along with those of the American Psychological Association (2008), while still helpful, are already dated given that nearly a decade of advancement in establishing theoretically sound approaches to sexuality assessment has passed; the strides are documented in this article. However, even beyond the issue of updated research, previous guidelines (1) lack discussion of empirical findings to provide context to recommendations, (2) do not provide theoretical grounding for measurement choices, and (3) do provide basic tools for selecting items, but lack inclusion of sexual orientation diversity beyond gay/bisexual/heterosexual categorization or gender diversity beyond the man/woman binary. As discussed in this article, the current research would suggest that the lack of empirical and theoretical context, and absence of contemporary language, used for self-identification is insufficient for the modern researcher. Moreover, we attend to issues of sexual fluidity, trends across the life span (e.g., adolescents’ identification), and features of psychometric properties when available. This article provides theoretical and updated scaffolding to better understand options for measurement and how to best use other guidelines to choose measures for a given problem and context.

Sexual Minorities in Clinical Practice and Research

The exact percentage of non-heterosexual individuals in various populations is a moving target that changes across surveys, locations, and time. Estimates of non-heterosexuality vary widely from 3.5% of Americans (Gates, 2011) to 46% of British Millennials (indicating a Kinsey score of greater than 0; YouGov, 2015). Such discrepancy of findings reflects a dilemma in the measurement of sexual orientation: parsing apart groups into infinitely small subgroups is, of course, a legitimate concern for those not wanting to further complicate their demographic forms; yet, the varied responses to different surveys across time demand closer inspection. Clinicians particularly are tasked with a clear need to identify sexual minorities, due to sexual minorities’ overrepresentation in clinical settings, higher suicidality rate, and the differences in risk compared to heterosexual peers (Mustanski, Garofalo, & Emerson, 2010). Clinicians are also in the unique position of being a resource to clients struggling to self-define their sexuality, particularly when popular labels do not fit; being well-versed in multiple facets of sexuality is necessary for the clinician to facilitate this process flexibly.

The high incidence rate of sexual minorities with mental health problems (e.g., suicidality, a history of victimization, and drug...
alcohol abuse; Mays & Cochran, 2001; Mustanski et al., 2010; Valentine et al., 2015) highlights the need for health providers to screen early and thoroughly for sexuality across the life span, as the risk level fluctuates across subgroups and age (e.g., Fredriksen-Goldsen et al., 2010). Early in the therapeutic relationship, self-disclosure may be less forthcoming in person, compared to survey-based responses (Youn et al., 2015; Youn, Kraus, & Castonguay, 2012). This is a concerning problem, as nondisclosure of sexual minority status to family, friends, or health professionals has been consistently linked to poorer psychological well-being (Durso & Meyer, 2013). Research suggests that nondisclosure is more likely to occur in bisexual men (39.3%) and bisexual women (32.6%) than in gay men (10%) or lesbians (12.9%; Durso & Meyer, 2013), which, paired with the higher psychological risks faced by bisexual individuals, indicates a cause for clinical concern. Self-disclosure of sexual orientation can be fundamental to therapy, particularly in people who are less willing to divulge that information, as concealment of sexual orientation is linked to greater mental distress (e.g., Schrimshaw, Siegel, Downing, & Parsons, 2013).

Definitions of sexual orientation and identity are necessary to consider before stepping into the assessment of those constructs, as descriptions will outline the aspects of sexuality that are of most interest to the researcher or clinician when selecting a measure out of a myriad of options. Researchers more interested in questions of difference (e.g., how are sexual minorities different from heterosexual individuals?) may choose looser definitions that lead to less detailed measures; in particular, they may limit sexual orientation as a 2- or 3-level variable for analytic purposes. Specialized researchers that hone in on a smaller selection of the population may be more concerned with a wider diversity of sexuality, and therefore choose more specific measures to determine who truly “counts” as a member of the sample of interest. By contrast, because clinicians seek to understand the unique contributions of identity and experience, particularly with vulnerable populations such as sexual minorities, they may operate under definitions that allow the individual greater flexibility in describing their identity, and thus prefer to use measures that balance time cost with richness of data needed to begin the therapeutic relationship. Both groups will also need to approach this problem with consideration of the stigma attached to many labels for given populations, such as with the pathologizing history of the term “homosexual.” The present review serves as a resource for researchers and practitioners to evaluate extant measurement options and to identify parameters in how they choose to examine sexual orientation.

Traditional, Contemporary, and Evolving Definitions and Measures of Sexual Orientation

Sexual orientation has been overwhelmingly described by a set of three labels: heterosexual (straight), homosexual (gay, lesbian), and bisexual (Sell, 1997). These categories have been defined by the individual’s orientation toward attractions of same-sex partners, other-sex partners, or both. Historically and up to the present, there has been difficulty across researchers in settling on a single definition, but sexual orientation often is described as consisting of some combination of attractions, behaviors, and self-identification of sex- and/or gender-related sexual preference. It is problematic that definitions of sexual orientation are numerous and lack consensus, which lends itself to the difficulty in its measurement; however, it also reflects that this construct is not wholly grounded in natural boundaries, but is also laden in culture-specific material, as evidenced by the shifts in popular language used to (self-)identify sexual minorities. Historical and modern, scientific and lay-person approaches will be compared and contrasted to pin-point where movements have occurred across time and people, and diverged between people and researcher. We briefly review historical approaches; while some of the features of classic measurement are still relevant currently, more in-depth reviews can be found elsewhere (e.g., Sell, 1997). Strengths, weaknesses, and best practices for measuring sexual identity for clinical research and practice will be outlined after each section, although any attempt at a concrete answer will be belied by the difficulty of balancing utility and theoretical demands.

Traditional Approaches

Four early scales were considered the primary options of the time: basic dichotomous scales (homosexual or heterosexual), the Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953), the Klein Sexual Orientation Grid (KSOG; Klein, Sepekoff, & Wolf, 1985), and the Shively and DeCecco Scale (Shively & de Cecco, 1977). The well-known Kinsey Scale consists of a bipolar scale ranging from 0 (exclusively heterosexual) to 6 (exclusively homosexual) that provided a graduated departure from previous categorization methods that only considered heterosexual, (sometimes) bisexual, and homosexual classifications (Sell, 1997). The KSOG (Klein et al., 1985) was created to address the lack of distinctions between “psychological reactions” and “overt experiences” by the Kinsey scale, and used separate dimensions to measure sexual behavior and sexual thoughts. The KSOG retained Kinsey’s scaled approach—1 (heterosexual) to 7 (homosexual). Later, concerns about the independence of masculinity and femininity (Bem, 1981) as separate constructs rather than polar opposites were mirrored in concerns about the independence of heterosexuality and homosexuality; Shively and de Cecco (1977) posited that attractions to men and women should be measured separately. The Shively and DeCecco Scale assessed both heterosexual and homosexual attractions separately on scales of 1 (not at all heterosexual/homosexual) to 5 (very heterosexual/homosexual), in both physical and affective realms.

From these early scientific efforts emerge several issues central to contemporary definition and measurement of sexual orientation. First, one should consider the degree to which people prefer same- or other-sex people separately, so as not to conflate them as two competing ends of the same scale. By separating same/other preference into two scales (e.g., “how attracted are you to women?” and “how attracted are you to men?”), we can identify a host of combinations that characterize clients’ sexualities. If attraction to men and women are presented on one scale, it would be impossible to interpret the meaning of the scale’s midpoint (e.g., is the midpoint a lack of attraction to women and men or equal attraction to women and men?). Furthermore, by simply altering the wording of the scales to specify “romantic” and “sexual” attraction, researchers and clinicians can identify people who may report high same-sex preference for romantic attraction and middling other-sex preference for sexual attraction.

From the Klein Grid, the element of time becomes prominent as a way of assessing lifetime orientation, as is the distinction between actual behaviors/attractions and ideal behaviors/attractions.
Assessment of present, past, and ideal identity may facilitate identifying clients who may experience distress with their present sexual orientation; for example, clinicians would be better able to identify sexual minorities who experience internalized homophobia (i.e., internalizing negative societal beliefs about same-sex attraction and behaviors) if their actual orientation is gay but ideal orientation is heterosexual. Finally, the Klein Grid provides a long list of sexuality facets that are often overlooked but may prove to be important (e.g., fantasies) if included in further research, and may be useful clinical information.

Another issue these early measurements raise is the use of self-report versus observer ratings. While the Klein Grid and Shively and DeCocco Scale are self-report measurements, the original Kinsey Scale was used by interviewers to interpret the experiences reported by participants. These different approaches can be contrasted through use of the Johari Window model, in which quadrants of behavior and motivation are defined by the crossing of that which is known or not known to the self with that which is known or not known to others (Laft & Ingham, 1961). For example, aspects about a person that are known by others but not by the self are considered a “blind spot,” whereas what is known about the self but not by others is a “hidden area.” Relying only on self-reported information to describe sexuality might miss components that are unknown or suppressed by an individual, such as physiological reactions. However, use of physiological or observer ratings could impose power dynamics between researcher/subject or clinician/client by implying the individual’s self-defined identity is insufficient.

Taken together, traditional measures provide insight for using two-scale formats with flexible wording, measures that account for a temporal understanding of sexuality across the life span (past, present, ideal), and assessment of not only self-identification, but also attraction, fantasy, and behavior. These scales set the stage for contemporary researchers and provided new language for every aspect of community. Self-identification does not occur within a vacuum, and this piece of the definition is a good reminder to consider the participant or client as they exist in their environment. This includes the political climate, as well as the nature of social and community support available to the individual, which may either encourage or discourage identifying in a particular manner.

For example, “queer” as a reclaimed identity is a politically charged, divisive term, and frequently used as a method to renounce both sexual and gender identity categories (Gamson, 1995). An antilabel of sorts, queer represents a rejection of binaries and norms, and may be adopted by both sexual or gender minorities. Part of the appeal of “queer” is its ambiguity, which may be appreciated by those who disdain traditional labels, whose sexuality is fluid, or those who are not interested in rigid self-definitions. Queer is also sometimes used as an umbrella term for sexual or gender minorities, although it should be noted that its use is controversial; thus, clinicians and researchers should avoid collapsing all “non-traditional” identities as “queer.” While a reclaimation of the term from its stigma-laden history is ongoing, there are still many people who find it defamatory, perhaps particularly for those of older generations who experienced that term as an insult.

Similarly, “homosexual” is a term with historical baggage; it carries with it the medicalization and pathologizing of same-sex attraction that for many years served as justification for prejudice (Ward, 2015). Now, the term is most often seen as a dog-whistle by those opposed to the equal treatment of sexual minorities, in place of less-loaded terms such as gay or lesbian. While there is evidence to suggest that the word “homosexual” elicits negative reactions about sexual minorities from heterosexual people, there is a lack of research demonstrating how sexual minorities respond to this word as a self-identification label (Rios, 2013). The GLAAD Media Reference Guide and American Psychological Association’s Committee on Lesbian and Gay Concerns classify “homosexual” as an offensive term, and many style guides of news outlets and publications also avoid the term (Committee on Lesbian & Gay Concerns, 1991; GLAAD, 2016). However, given that the authors still come across “homosexual” as an option on demographic forms, it should be noted that clinicians and researchers would best serve their clients and participants if they replaced this with the more appropriate “gay/lesbian.” “Bisexual” and “heterosexual” do not carry the same historical weight, and are therefore not treated similarly to “homosexual” despite linguistic similarities.

Although the APA definition accounts for social context (i.e., community), it fails to address the role of gender diversity as it relates to sexual orientation. As addressed later via the Sexual–Romantic Scale and Gender-Inclusive Scale (Galupo, Lomash, & Mitchell, 2017), positioning responses toward only men, women, or both will exclude those whose partners or attractions lie outside of a binary gender system (e.g., gender nonconforming individuals). While this may only affect a small percentage of respondents, careful thought should be put into deciding how to frame questions so as to not alienate participants and clients, while also remaining
accessible to others. Efforts of inclusivity through the following measures may, in fact, enhance trust in participant–researcher and client–practitioner relationships.

**Contemporary measurements.** In contrast to the evolution in how sexual orientation is discussed in mainstream news and media, there seems to be a stagnation in updating the measures being used in research. Traditional measures (e.g., limited option forced choice scales, the Kinsey Scale, and Klein Sexual Orientation Grid) remain a staple of today’s studies. In the following section, we outline contemporary scales of sexual orientation published since Sell’s review, and we discuss their strengths and weaknesses in relation to the issues outlined above. When available, psychometric properties of scales will be detailed. An overview of the format of these measures is provided in Table 1.

**Self-reported sexual identity labels.** While self-reports of sexual identity labels are clearly an important assessment of sexual orientation, they can also be among the most difficult to use in quantitative research, because of the vast and growing list of self-identifiers used for sexuality. Many studies have limited responses for participants to choose from (e.g., “gay,” “lesbian,” “heterosexual,” or “bisexual”; Chung & Katayama, 1996), which is certainly a straightforward method, but several problems emerge from this approach. First, it clearly limits the ways in which people can convey their sexual identity to researchers (what if one identifies as queer, or asexual?). Second, the number of people who self-identify as heterosexual or straight is significantly greater than people who report only heterosexual behaviors and attractions (Savin-Williams, 2001); only offering “heterosexual” or “bisexual” as choices obscures those who may identify as one but act as another.

While creating and updating an exhaustive laundry list of labels would be a task near Sisyphean levels, there is merit in looking for the themes emerging out of the vast sea of identifiers. While various facets of sexual orientation have been identified and used in definitions (e.g., Klein Grid), the relative importance attached to each aspect is not fully understood at individual or group levels. It is useful to turn to both quantitative and qualitative methodologies to answer these questions. For example, Friedman and colleagues (2014) found that responses to two questions of sexual orientation (“During your life, with whom have you had sexual contact?” and “Which of the following [heterosexual, gay or lesbian, bisexual, or not sure] best describes you?”) differently predicted rates of smoking, suicide, risk, and methamphetamine use. In particular, sexual behavior and sexual identity separately predicted health risk behaviors, as did various combinations of grouping responses to the sexuality questions (e.g., same vs. opposite sex attraction, creating unique categories for bisexual identity and those who were “not sure”). Ultimately, this study provided evidence of the importance of thinking critically about measurement and, importantly, revealed the loss of important data when non-heterosexuals were lumped into a single group, or when sexual contact and identity were viewed as a monolith.

**Standard self-report measurements.** In much of scientific research and demographic surveys, sexual orientation is being captured through a single question: Do you identify as heterosexual/straight, gay/lesbian, or bisexual? Other questionnaires include a scale for participants to mark to what degree they are attracted to men only, women only, both men and women, or no one and (3) Are you only attracted to females, equally attracted to females and males, mostly attracted to males, only attracted to males, or not sure? While these three questions are an improvement upon a single item, as they address self-identification, sexual behavior, and sexual attraction, the bands of options for participants to select from is narrow. The guidelines note that the response options should evolve with time, based on pilot testing with new populations—something that seems necessary given that there is no option for people who do not identify in those ways. The following measures offer different approaches to tackling this problem, and their strengths and weaknesses are discussed below.

Saewyc and colleagues (2004) examined response rates and demographic differences in sexual orientations questions in
<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of items</th>
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<tr>
<td>Multidimensional Measure of Sexual Orientation (Lhomond et al., 2014)</td>
<td>3</td>
<td>Based on self-report via survey questions; strategy for organizing information about sexual attraction, experience, and identity</td>
<td>Categorization into one of five groups: (1) no same-sex experience, (2) no same-sex attraction, (3) same-sex experience, heterosexual-identified, (4) same-sex experience, bisexual-identified, (5) same-sex experience, gay/lesbian-identified</td>
<td>N = 9,872 men and women, aged 18–69, based on secondary analysis of the survey Context of Sexuality in France (2006), which randomly sampled French households</td>
<td>Group membership was found to predict alcohol and cannabis consumption, depression (conceptualized as markers of coping/distress)</td>
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<td>Relative Frequency of Same-Sex Attractions (Diamond, 2000)</td>
<td>1</td>
<td>Pie chart with 16 equal regions; participants fill in percentage of current sexual attractions that are towards the same sex on a day-to-day basis</td>
<td>Single percentage that indicates degree of attraction to same-sex versus other-sex</td>
<td>N = 80 lesbian, bisexual, and unlabeled women, aged 18–25, from a community sample</td>
<td>Method was chosen based on previous research demonstrating this variable to be primary in self-evaluation of identity. Reliability assessed by correlating 2-week test–retest data; r = .99</td>
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<tr>
<td>Sexual-Romantic Scale (Galupo et al., 2017)</td>
<td>4</td>
<td>Self-report scale using range of 1 (almost never true) to 7 (almost always true)</td>
<td>Four numbers that can be used to see variation/similarities across domains</td>
<td>N = 179 non-heterosexual individuals from a convenience sample, aged 18–65, who were asked to compare this scale to the Kinsey Scale and the Klein Sexual Orientation Grid</td>
<td>Items created based on previous theory about dimensionality of sexuality and feminist intersectional theory. Face validity assessed by participants; thematic analysis of responses guided edits</td>
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<td>Gender-Inclusive Scale (Galupo et al., 2017)</td>
<td>6</td>
<td>Self-report scale using range of 1 (almost never true) to 7 (almost always true)</td>
<td>Six numbers that can be used to see variation/similarities across domains</td>
<td>N = 179 non-heterosexual individuals from a convenience sample, aged 18–65, who were asked to compare this scale to the Kinsey Scale and the Klein Sexual Orientation Grid</td>
<td>Items created based on previous theory about dimensionality of sexuality and feminist intersectional theory. Face validity assessed by participants; thematic analysis of responses guided edits</td>
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<tr>
<td>Attraction/Intimacy Assessment Inventory (Starks et al., 2009)</td>
<td>83</td>
<td>Self-report scale using range of 1 (does not describe me at all) to 5 (describes me very well)</td>
<td>Four factor scores: (1) Attraction to Females, (2) Intimacy with Females, (3) Attraction to Males, and (4) Intimacy with Males</td>
<td>N = 284 undergraduate participants (M_age = 19.8 years, SD = 1.95)</td>
<td>Items generated based on gendered sexuality and both attraction and intimacy. PCA-guided factor analysis; Cronbach's alpha &gt; .77 for each sub-scale</td>
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<tr>
<td>Multiple Continua Model of Sexual and Relational Orientations (Moe et al., 2011)</td>
<td>5</td>
<td>5 continua that can be adapted for either interview settings or self-report survey</td>
<td>Relative placement along five continua: (1) Desire for male or female genitalia/secondary sex characteristics, (2) Desire for masculine to feminine gender expression, (3) Low to high desire for sexual and relational behaviors, (4) Desire for relational behaviors with same to other genders, and (5) High to low identification with LGBTQ communities</td>
<td>N/A</td>
<td>Theoretical conceptualization of the variety of sexual and relational desires people have over their lifespan</td>
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</table>
eight adolescent health surveys. Five of the eight surveys included more than one question, and only three assessed more than one dimension of sexual orientation. Question topics over the eight questionnaires covered the dimensions of self-identity, attraction, sexual fantasy, sexual behavior, and sexual intentions; however, it was rare for more than one dimension to be assessed by the same survey. The nonresponse rates comparatively across surveys indicated that for adolescents, complex questions with numerous possible responses, items about sexual activity, and items presented on the first couple of pages of a set of questionnaires (i.e., where responses may be visible to others) decreased the likelihood of the question being answered. Saewyc and colleagues (2004) recommended that when measuring sexual orientation in youth, questions should be written in concrete terms and with simple, concise language. It was also recommended that scales cover attraction, gender of sexual partners, self-labeling, and fantasies to create a holistic picture of sexual orientation.

**Attraction/Intimacy Assessment Inventory (AIAI).** The AIAI is an 83-item instrument that was created to investigate the relationship between self-identification of sexual orientation and attraction and intimacy (Starks, Gilbert, Fischer, Weston, & DiLalla, 2009). The authors’ conceptualization of sexual orientation, called gendered sexuality, is grounded in the bidimensional model of orientation Shively and De Cecco (1977) used in their scale where same- and other-sex attraction is assessed separately. While they acknowledge the problematic assumption of dichotomous gender in their scale, Starks et al. (2009) argue that individuals responding to their scale are likely to have societally influenced beliefs about gender, and therefore separate men and women as distinct and comprehensive categories. There are four broad factors measured by the AIAI, each with three subdomains (Physical, Emotional, and Relationship Attraction): Attraction to Females, Attraction to Males, Intimacy With Females, and Intimacy With Males. Each of the 12 subdomains had satisfactory reliability ($\alpha = .77$ to $0.99$), and items within each factor had loadings of below 0.40 on any other factor.

Total sum scores for each factor were demonstrated to be useful to investigate the influence of discrepant Intimacy and Attraction scores on satisfaction in relationships, suggesting that measuring intimacy and attraction separately provides useful information for both clinicians and researchers. Uniquely, this scale does not reference sexual identity (e.g., no references to heterosexuality or homosexuality), and instead only includes statements about discrete attractions or behaviors individuals may have experienced (e.g., “Females appear in my sexual fantasies” and “I am in a romantic relationship with a male, and I feel he is very committed”). When separate responses to sexual-identity questions were compared to responses on the scale from participants who had completed both, the majority of people identified as heterosexual, yet variability appeared in AIAI responses that indicated heterogeneity in heterosexuals (Starks et al., 2009). However, despite the strengths of this scale, a primary drawback is the length; an 83-item measure is unlikely to be attractive to researchers not specifically interested in sexuality, or to clinicians with an already lengthy list of questionnaires during the intake process. Future research should consider scale development for a short form of this measure.

**Multiple Continua Model of Sexual and Relational Orientations.** One of the few scales to represent multiple ways that sexual orientation may be conceptualized by the individual, the Multiple Continua Model of Sexual and Relational Orientations is also a measure specifically designed for clinical populations (MCM; Moe, Reicherzer, & Dupuy, 2011). Five continua are assessed: desire of sex characteristics (ranging from strong preference for male genitalia to female genitalia, and male secondary sex characteristics to female secondary sex characteristics), desire of gender expression (masculine to feminine), sexual and relational interest (low interest to high interest), relational orientation (same gender to other gender preference), and community identification (low identification with LGBT community to high identification). This provides a detailed profile of intake clients whose sexual orientation and related features may be highly heterogeneous—for example, the degree to which a gay client identifies with the LGBT community varies widely and may help clinicians from making assumptions about their involvement or their networks of social support. This scale is also particularly helpful in its disentanglement of sex and gender preferences. However, this measure has not been empirically validated, and may benefit from splitting its bipolar continuum into separate responses (e.g., changing masculinity–femininity to degree of masculinity and degree of femininity), as seen in scales such as the Shively and DeCecco Scale.

**Multidimensional Measure of Sexual Orientation.** Lhomond, Saurel-Cubizolles, Michaels, and the CSF Group (2014) used a sample of 9,872 sexually active French participants to construct a multidimensional measurement of sexual orientation with three dimensions: attraction, sexual behavior, and self-definition. A single variable was created from three measurements: report of ever having at least one same-sex sexual partner, report of degree of attraction to same- and/or other-sex partners, and self-identification as either heterosexual, homosexual, gay or lesbian, or bisexual. Groups were defined by first dividing the sample into those who had or had not ever had a same-sex sexual partner. Those without a same-sex sexual experience were then divided into two subgroups based on presence of any reported same-sex attraction. Participants with a same-sex sexual experience were grouped based on response to the self-identification question. Greater same-sex attraction predicted a greater likelihood of having only same-sex partners, and one percent of participants who reported no same-sex attraction reported having a same-sex partner in the past. Of note, correlations between the three questions were higher for men than women.

This approach to measuring sexual orientation is helpful in its ability to define more specific groupings of attraction, behavior, and identification, while also providing a simple outcome variable for use in measurement. History of sexual partners allows the researcher to begin to account for fluidity, although only in the domain of sexual behavior (which itself is defined in a limited and general manner). However, the responses to self-identification are forced to a small number of options for simplicity, and does not account for asexuality or distinguish between sex and gender.

**Sexual–Romantic Scale and Gender-Inclusive Scale.** Two recent scales were created with the intention of addressing the issues of unidimensional responses and of attraction to nonbinary gender facets (SRSGIS; Galupo et al., 2017). The Sexual–Romantic Scale measures same-sex and other-sex attraction on
separate dimensions for both sexual and romantic factors, a method for which they found quantitative and qualitative support. However, plurisexual (bisexual, pansexual, or fluid) and transgender identifying people provided feedback that the binary approach to gender did not capture their lived experiences accurately. The Gender-Inclusive Scale was created to address this concern, and includes dimensions for attraction toward masculine, feminine, androgyous, and gender nonconforming people, as well as toward men and women. Reports from participants indicate that this was well-received across identities and appears to address several concerns raised by this article.

**Strengths and limitations.** Contemporary scales of sexual orientation have improved upon previous measures in their attempt to capture a broader picture of sexuality facets (i.e., including questions about sexual history, attraction, and identity). Some scales go further by parsing apart physical, emotional, and relational attraction (AIAI), strength of identification with LGBT communities (MCM), or including nonbinary gendered targets of attraction (SRSGIS). The richness of data that can be collected using these methods is positive for both the researcher and practitioner, but also possibly for the individuals completing these surveys—having a client think about their sexuality from multiple perspectives (e.g., emotional intimacy vs. physical attraction to a given gender) may prompt more introspection or dialogue if not previously explored. However, one cost that comes from the improvements in breadth is that these scales may take significantly longer to administer than more simplistic scales or single-item measures of self-identification.

**Translational implications.** Although self-reported identity labels are convenient for researchers and clinicians, self-reported options may fail to address important information (e.g., behaviors that may predict health behaviors), exclude new and widespread identity categories (e.g., queer and nonbinary attractions), and wrongfully conflate people who identify as “mostly heterosexual” with heterosexuals. In Table 2, we outline currently available options for self-report measurements of sexual orientation, how each may best fit for different research approaches or clinical situations, and the limitations of each. In Table 1, we review the format and existing data of each scale (e.g., a survey that provides a category designation) and how each scale’s construction was evaluated by their authors.

A primary, if possibly unsatisfactory, takeaway from a review of these scales is that Sell’s goal of finding a standard measure to be used across all situations is likely misguided in the current era of ever-evolving terms and identities. Sexual orientation is a complex construct that should be evaluated at different levels of complexity appropriate for the situation, and it is the task of the clinician and researcher to think critically about their selection of a measure. Just as there is not a single depression inventory appropriate for every context, the justification for selection of sexual orientation measures will depend on variables such as the available time, the research question, or the clinical relevance. For example, clinicians who work with adolescents may find it helpful to include more self-labeling options (e.g., “questioning” and “queer”), given the range of labels clients may use at that age (Russell et al., 2009). We encourage researchers and clinicians to brainstorm with their staff how to best word questions related to sexual orientation, as they would discuss for any measure to be used for research and clinical purposes. Similar to the implications of traditional measures, we encourage researchers and clinicians to broaden their assessment of sexual orientation to include at least some other options (e.g., behavior, attraction, gender of partners) in addition to self-identification.

Although we have a sufficient APA definition on which to draw and contemporary measures of sexual orientation that account for psychological, social, and sexual complexity, this does not imply that the work is done, and that the current options are satisfactory. As discussed below, as our understanding of sexuality and gender becomes more nuanced, measurements should continue to be created and refined in response.

**Problems With Categorical Parsing**

An emergent issue from the complexities of measuring a fluid, multifaceted, and heterogeneous variable such as sexual orientation is that of categorical parsing. As mentioned above, there is an impossible balance to be struck between using every possible self-identifier across multiple dimensions, and succinctly collapsing this information into a single datum. Both the researcher, who hopes to plug this variable neatly into a line of code, and the clinician, who would prefer to minimize the real estate taken up by a question on an intake form, (hopefully) struggle with the question of how much information is necessary? We are not alone in this—researchers concerned with promoting intersectionality, for example, are steeped in this problem of how to assess people’s identities quantifiably when identities contain multitudes (e.g., Bowleg, 2008).

In intersectional theory, the possible variables and their interrelations are innumerable and the statistics available have not yet reached a state where all variables can be considered. Rather than remaining static, however, intersectionality provides a lens from which all researchers can critically consider which participants are being sampled and why. Similarly, sexuality researchers can inform wider audiences on best practices when measuring sexual identity, attraction, behaviors, and fluidity. No perfect solution exists, but incremental steps toward a more comprehensive and theory-informed measurement of sexual orientation can improve research and practice at large—just as every person lies at intersections of different identities, every person has a complex and faceted sexuality, rich with information waiting to be gathered.

A similar dilemma has been ongoing in other realms of identity research that may help clarify the direction sexual orientation research should take. Race, like sexual orientation, is not a construct with a definitional consensus; it also can consist of an unwieldy list of labels (the 2000 U.S. Census included 126 racial and ethnic categories; Winker, 2004). Yet despite ongoing scientific and theoretical discussions on the exact nature of these constructs, both nonetheless have immense real-world influence on people’s lives through their place in the social construction of privilege and power. Race identity theories, however, recognize the importance of both recognizing the utility of racial categories and moving toward identifying the underlying explanatory variables that give real-world saliency to these boxes (Helms, Jernigan, & Mascher, 2005). For example, Helms and colleagues (2005) argue that race is used as shorthand for other constructs (e.g., ethnic identity, discrimination experiences) that characterize people’s daily experiences, which is somewhat similar to how
broad sexual orientation group labels are used as umbrella terms for attractions, behaviors, and identities.

Helms and colleagues (2005) suggest two primary ways that this methodological problem can start to be addressed with race, and their suggestions are relevant here, too. First, they encourage consistent reporting of how race is measured, because this highlights how, like with other scales, the tool used provides only an approximation of the construct. Indeed, we recommend researchers and clinicians specify and provide justification about their measurement selection (e.g., in a write-up of a method or clinical documentation). Second, Helms et al. (2005) advise using hierarchical regression analyses to replace single identity categories with multiple theory-relevant constructs. For example, a researcher can input both physical and sexual attraction separately to observe their individual (yet likely overlapping) contributions to an outcome.

It can feel overwhelming to think we need to strike the perfect balance in measurement, but this is a misguided goal. Ultimately,
some level of generalization is necessary for functional purposes across members of a group. The task becomes determining when, for a specific problem, more or less detail is necessary. This is a common issue in clinical research when selecting a specific population to target for a new treatment—“everyone” could be too broad, but “cooccurring narcissistic personality disorder and trichotillomania in biracial early adolescents” is likely too specific to be helpful. Kazdin (2008) addresses this issue through an illustration of a matrix, in which the axes of clinical problems, ethnicity/culture, and treatment techniques are crossed, creating a near-infinite number of cells that a treatment could target. This is an unrealistic approach to the problem of parsing, and Kazdin suggests instead that our goal should be to identify underlying and impactful patterns across this multitude.

In the realm of sexual orientation assessment and measurement, this means doing research on what components (or combination thereof) are most important for a given situation. When predicting risky drinking behaviors, for example, is it worthwhile for the researcher to know an individual’s unique self-identity label, or is it more meaningful to ask about the client’s or participant’s experience of homophobia and their partner history to test what may be contributing to a proposed relationship of drinking behaviors and sexual orientation? Answering these questions and engaging in careful deliberation about what the clinician or researcher needs to know is at the heart of the problem of parsing, and this cannot be accomplished if researchers continue to rely on simplistic survey methods with little thought applied to their selection.

**Evolving Approaches to Definition and Measurement**

**Gender or sex?** Current research has questioned the very notion of sexual orientation as a description of attraction to specific sexes (van Anders, 2015). A fundamental question to ask when first defining “sexual orientation” or “sexual identity” is the object of desire—is the variable of interest sex or gender, and are there other concerns that should be included? It is unclear from the bulk of research whether “heterosexual,” for example, refers to a specific sex (e.g., male, female) or a specific sexes (van Anders, 2015). A fundamental question to ask when first defining “sexual orientation” or “sexual identity” is the object of desire—is the variable of interest sex or gender, and are there other concerns that should be included? It is unclear from the bulk of research whether “heterosexual,” for example, refers to a specific sex (e.g., male, female) or a specific sexes (van Anders, 2015). Delineates sexual identity, orientation, and status as three separate components of sexuality, which provides an important foundation for having clear and specific discussion on these topics. Sexual identity is defined as a person’s self-chosen labels, politics, and communities that may comprise preferences for gender/sex (e.g., male, female), partner number (e.g., monogamous, polyamorous, asexual), or others (e.g., kink-identified). In contrast, sexual orientation subsumes interest, attraction, and fantasies (e.g., heterosexual, monosexual, bisexual, and polyamorous). Sexual status encompasses the behaviors and activities involved in sexuality (e.g., abstaining).

Sexual Configurations Theory (SCT) is a recently proposed theoretical framework that addresses these concerns and focuses on two parameters of sexuality: gender/sex and partner number (van Anders, 2015). Fundamental to this theory are concerns that previous work on sexuality does not adequately define sexual orientation, oversimplifies a complex phenomenon in favor of tidy categories, does not account for fluidity, and blurs gender and sex while maintaining a binary system of gender in understanding sexuality and gender expression (e.g., femme/butch women, transmen). SCT divides sexuality into two separate yet interrelated dimensions: eroticism (bodily pleasure) and nurturance (love and closeness). This theory holds that every person has a unique sexual configuration and exists within the space of sexual diversity, which allows for the study of both sexual minority and majority members, and their positioning with each other. While SCT focuses on gender/sex and partner number, it also reminds researchers to consider other aspects of sexuality when relevant, such as age, kink-identification, or intelligence.

Sexual identities are conceptualized as a person’s label for their own sexual configuration of gender/sex, partner number, eroticism/nurturance, and orientations, statuses, and identities. While this theory’s many facets sound as though they may lead to overcomplicated measurements, SCT encourages the researcher to be selective and consider what aspect or level of sexuality is to be studied—for example, is the research question about all sexual minorities, or specifically polyamorous transwomen? In practice, this theory has demonstrated utility in both generating insight in individuals and guiding qualitative research by scaffolding detailed conceptualizations of sexuality (Schudson, Dibble, & van Anders, 2017). Using interviews and instructing participants to use diagrams for mapping their sexualities, Schudson et al. (2017) found that the structure of SCT provided participants the opportunity to express a range of diverse and nuanced sexual experiences and identities. Indeed, SCT is argued to be empirically testable; however, further studies are needed to demonstrate its use in quantitative research (van Anders, 2015). In summary, sexual orientation has and is used as a catch-all for orientation, identity, and status, but being more specific can be beneficial as research attempts to move forward in the conceptualization of orientation.

**Measurements across time.** Measurements of sexuality that occur over more than one time point are an important method for capturing the fluidity of self-identification and behaviors. Often, questions about self-identity are framed as a static attribute or only ask about current identification. Other questions, usually about behavior, will ask for numbers of past partners, which are more likely to capture the variability of aspects of sexual orientation across time.

Does sexual orientation change across the life span? Drawing on research with national probability samples, adolescents, and sexual minority women, we can confidently infer that one’s previous report of sexual orientation may not correspond with present or future identification. For example, using data from the National Survey of Midlife Development in the United States (MIDUS I and II), Mock and Eibach (2012) examined patterns of stability and variability of self-identified sexual orientation across genders. Overall, 2% of participants reported different sexual orientations at the second time point compared to their first report 10 years ago. In women, self-identification was significantly more stable for those who originally identified as heterosexual than either bisexual or homosexual. In men, bisexual identification was significantly more fluid than either heterosexual or homosexual identification. Similarly, Ott, Corliss, Wypij, Rosario, and Austin (2011) examined the fluidity of self-reported sexual orientation in 13,840 youths across four waves of data (1999, 2001, 2003, and 2005). Across the four time points, 10% of men and 20% of women identified as a sexual minority, and an additional 2% of men and women reported being “unsure” about their orientation. The assessment of fluidity across the six years revealed that women were more likely to report a change in sexual orientation, and likelihood...
of reporting a sexual minority identity increased with age. Furthermore, Diamond (2000) worked with 80 sexual minority women over a period of two years, to understand the fluctuations of identity. While only women who did not identify as heterosexual were invited to participate, a measurement of relative frequency of attraction to women was used to track same-sex attraction across the two time points. Participants filled in a selection of a pie chart to represent the “percentage of your current sexual attractions that are directed toward the same sex on a day-to-day basis.” This measure was selected due to previous research indicating that relative frequency of same-sex attraction is a major indicator used by individuals to assess their own sexual orientation (Rust, 1992; Sell, 1997). Of note, half of these women reported that their sexual orientation changed over this period, primarily in women who began the study identifying as either bisexual or unlabeled. This study also highlighted the importance of measuring both identity, attraction, and behavior, as 25% of lesbian-identified women reported having sexual contact with men during the two years of the study; however, lesbian women’s reported attraction to women remained fairly constant.

Translational implications. Critiques of the way sexual orientation is defined and situated within a broader sexuality context through the recently proposed SCT framework pushes us to think more deeply and dimensionally about orientation, but there are still questions to work through about how this theory translates to practice. SCT identifies a complex net of variables that make up sexuality, leading to a dizzying selection of possible questions to ask in a potential SCT-informed measure. Thankfully, this theory does not direct us to use comprehensive questionnaires; rather, it implores us to be more critical in the selection of our variables of interest. We should have prior justification for measuring sexuality at a specific level (e.g., group level vs. intrapersonal; identity vs. behavior; orientation vs. status) or angle (physical vs. relational attraction), based on what we need to know about our respondents. This mindset can already be applied when selecting from the current options available.

One theme that has recently emerged is that the focus on sexual minorities may come at the expense of understanding sexual diversity. A parallel can be made between this and the evolution of gender studies—while the initial focus, as reflected in many university department names, was on women, our research is expanding as we move beyond the gender dichotomy and fracture the monolith of masculinity. While the rationale for placing importance on sexual minorities is clear—they represent a vulnerable population still at risk across the world—it may also be time to expand our critical gaze of understanding sexual orientation to include the majority (i.e., heterosexual people). Studies have demonstrated that heterosexuality starts to fracture the more it is focused on, as evidenced by the “mostly heterosexual” group that emerges when given the explicit option to identify as such among both women and men (Savin-Williams & Vrangalova, 2013; Ward, 2015). Thus, not only do we implore researchers and clinicians to think critically about the aspects of sexual orientation of interest to them, but to consider how the sexual complexity of both majority and minority sexual groups may be captured by the assessment.

For practical purposes of incorporating these measures and given the time it may take to administer comprehensive measures of sexual orientation, clinicians should consider how to electronically disseminate measures (e.g., through online survey software) either in person or as part of a homework exercise for clients with the resources to complete surveys from home. This strategy would allow clients to complete measures at their own pace and with privacy that may not be easily afforded by a waiting room. Moreover, digital questionnaires can be embedded with skip logic that could present in-depth questions only for those whose responses require follow-up. Electronic tools of in-depth measurement could ideally provide a snapshot of clients’ past and present sexual lives without impeding on preexisting intake forms and the time needed for appointment. It is in our best interest as researchers and clinicians to update our practices to reflect evolving theories and expressions of sexuality, which will require us to think strategically about what is included in assessment, as well as how and when to collect this information.

Discussion

The myriad ways in which individuals self-identify their sexual orientation may be more limited in usefulness for researchers than for clinicians; however, self-identification labels can coexist in measurements along with more standardized operationalizations of behavior and identity. As scientists, it is easy to bemoan the messiness of data and difficult to abandon simple categories for complex constellations of attributes. However, this is a problem that will likely become easier to tackle as survey methods become more sophisticated and allow us to more easily ask questions beyond simple categories. Asking for frequency or strengths of desires/behaviors complements the open-response approach to asking about sexual orientation, as both pieces of information are important to capture. When information retrieved from single time points are codified as permanent characteristics, rather than as slices of a possibly fluid process, researchers miss out on a wealth of information. Ultimately, we remind researchers that the costs of collecting too little information more often outweigh those of collecting too much, because collapsing across groups (e.g., coding all non-heterosexual participants as sexual minorities) is far easier than expanding upon information not available (not knowing how people decided to select the “heterosexual” group out of only two options). The dangers for clinicians will likely lie more in the effect of wording and options on their clients—has a clinician alienated a client by not allowing them to self-identify, or overlooked a salient part of their sexuality that then fails to be unearthed?

This article cannot provide an easy answer for clinicians or clinical researchers wondering how best to measure sexual diversity. Instead, this review is intended to provide a menu of options for immediate use—with the caveat that no approach is perfect—as well as material to identify problems and provoke questions for future research. Currently, the state of the literature demands that researchers and clinicians purposefully consider what aspects of sexuality they truly need to capture in their measurements. Is the goal of the study to examine how self-identification influences health, or is it to understand how the discrepancy between attraction and behavior may limit relationship satisfaction? As a clinician, is the priority to collect a detailed history of romantic and sexual experiences, or to flag significant predictors of mental health? How can assessment of sexuality be used to promote self-awareness in clients? Theoretically, it is also important to define each construct that is collected—when sexual orientation is a variable
of interest, what is actually meant by “attraction to women?” By “women,” is sex or gender being referred to, and what facets of attraction are of concern? Sexual Configurations Theory (van Anders, 2015) provides a broad theoretical net from which to start, but ultimately the options need to be refined to suit the research question or clinical concern.

In the included tables, we provide current scale offerings based on for whom the scales may be most useful, with respect to a researcher’s and clinician’s goals. While not exhaustive, this menu can be used as a tool to begin thinking about needs when seeking out a measurement for research or practice. No option is perfect, but some measures are more suited to specific goals than others. Across goals, however, it is nearly always easier to collapse information when group sizes are too small, than to expand on data that was not collected; asking for more detail or including open-ended responses will result in a richer dataset and will allow researchers and clinicians to stay informed about contemporary identity labels, as language used to describe one’s sexuality is an evolving process. We hope this review sparks dialogue among researchers and clinicians, but it will strengthen the faith participants and clients have in our abilities to understand their lives.

References


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