Published in final edited form as:

Clin Psychol (New York). 2015 June ; 22(2): 151–171. doi:10.1111/cpsp.12098.

Toward Defining, Measuring, and Evaluating LGBT Cultural Competence for Psychologists

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Abstract

A central part of providing evidence-based practice is appropriate cultural competence to facilitate psychological assessment and intervention with diverse clients. At a minimum, cultural competence with lesbian, gay, bisexual, and transgender (LGBT) people involves adequate scientific and supervised practical training, with increasing depth and complexity across training levels. In order to further this goal, we offer 28 recommendations of minimum standards moving toward ideal training for LGBT-specific cultural competence. We review and synthesize the relevant literature to achieve and assess competence across the various levels of training (doctoral, internship, post-doctoral, and beyond) in order to guide the field towards best practices. These recommendations are aligned with educational and practice guidelines set forth by the field and informed by other allied professions in order to provide a roadmap for programs, faculty, and trainees in improving the training of psychologists to work with LGBT individuals.

Psychologists are likely to assess and treat sexual and gender minority clients given that sexual and gender minorities compose approximately 3% - 9% of the U.S. population (Chandra, Mosher, Copen, & Sionean, 2011; Savin-Williams, Rieger, & Rosenthal, 2013), and given the societal stressors affecting this population. In order to prepare graduates to provide affirmative and appropriate care in independent practice, or other clinical settings, psychology training programs should require standards for assessing and addressing cultural competence for trainees so that they are prepared to work with lesbian, gay, bisexual, and transgender clients. However, such standards do not currently exist. The present paper is an attempt to begin developing those standards and the recommendations offered should be considered in concert with the other papers in this special issue.

For the present paper, the following definitions are specified to characterize the diversity found within the lesbian, gay, bisexual, and transgender communities. *Lesbian, gay, and bisexual* individuals are individuals whose sexual identity, orientation, attractions, or behaviors differ from the majority of the surrounding culture or society (Ullerstam, 1966).

These groups, considered sexual minorities, are diverse in gender and sexuality in numerous ways. *Transgender* is an inclusive term describing the full spectrum of people with non-traditional gender identities (Carroll, Gilroy, & Ryan, 2002). *Sexual and gender minorities* are individuals who identify as lesbian, gay, bisexual, or transgender (LGBT), and, for the purposes of clinical training, this definition also includes individuals who are questioning their sexual orientation or gender identity. Sexual orientation and gender identity are not mutually exclusive constructs, and thus persons of any gender identity may have any sexual orientation, and vice versa.

Cultural competence involves having a requisite understanding of those cultural influences that affect the ability of healthcare professionals to provide appropriate care for patients from diverse cultural groups. In this paper, we: (1) define cultural competence in working with LGBT people and discuss why acquiring such training is needed, (2) describe some contextual social factors affecting these groups that underscore the importance of this type of training, (3) outline basic skills psychologists need to work competently with LGBT people, (4) review the foundations for specific LGBT competency training in order to move beyond basic skills toward burgeoning expertise across training levels, (5) outline and provide LGBT competency recommendations at the doctoral training level, (6) continue with training recommendations for internship, (7) describe advanced training elements for post-doctoral training and beyond, and (8) contextualize these recommendations for the profession and conclude with future directions in both science and practice in this important area of competence.

Cultural Competence: What is it and Why is it Important to Psychologists

By the late 1970's, health professionals were exploring the role of the environment (e.g., culture) in understanding illness and health, client satisfaction, and health disparities using methods developed and championed by the behavioral sciences (Kleinman, Eisenberg, & Good, 1978). Recognizing the changing demographics of the United States (U.S. Census, 2013), and a growing acknowledgement of the field's limitations in meeting the mental health needs of minorities (Kazarian & Evans, 1998), the field began to develop strategies to attract and retain gender and racial/ethnic minorities and made recommendations to address graduate training programs' curricular and practical training experiences (Ridley, 1985). The goals of this pioneering work were to integrate research findings that supported the need for adaptation toward the cultural background of clinical populations. By providing a framework for training programs to adapt newly modified curricula and engage in partnerships for diverse practical experiences, psychologists-in-training would then develop increased competence to treat individuals from diverse racial and ethnic backgrounds (e.g., DeVore & Schlesinger, 1981; Sue, 1998, 1999). Competencies evolved to include various other areas of difference such as socio-economic status, religious and spiritual beliefs, sexual orientation, and gender identity. Our focus in this paper is the latter of these cultural categories.

Although there are a number of definitions of cultural competence, the construct has generally been defined as having a necessary understanding of cultural influences to provide appropriate care for patients from a diverse cultural group, which may or may not differ

from the background of the clinician (see Hays, 2001; Sue, Zane, Nagayama Hall, & Berger, 2009). Cultural competence may involve an increased understanding of a specific minority group (e.g., African-Americans or Latinos) or a broader toolset that may be applied across diverse groups. Indeed, the literature on cultural competence with racial and ethnic minorities provides a useful framework for developing cultural competence with LGBT groups (Israel & Selvidge, 2003; Lyons et al., 2010). There also are a myriad of models and tools for conceptualizing areas of cultural competence. For the purposes of the current paper, the three-domain model of multicultural competence – one of the most commonly recognized frameworks – is used wherein cultural competence involves: (a) awareness of one's own beliefs, biases, and attitudes; (b) knowledge and understanding of the cultural group including expectations for the therapy relationship and how one's own cultural background comes into play; and (c) skills and tools to provide culturally-sensitive assessment and intervention (see Sue et al., 1982; Sue et al., 2009). Cultural competence also involves continuous learning and experience as cultural groups and contexts are continuously changing. Thus, as society changes, legal rights are expanded or contracted, and scientific understanding evolves, so too must the competencies of health professionals aiming to provide competent clinical services to diverse populations. Cultural competence with LGBT people therefore involves the sensitivity and understanding of individuals in the profession, from trainees to practicing clinicians, about the relevant issues that specifically and uniquely affect members of sexual and gender minority communities, and those psychological concerns that while more universally applicable, differentially influence those within these communities. Since competence can be taught and measured, trainees should be equipped with the necessary skills to work with this population, regardless of their individual personal previous experiences.

Studies note that health professionals report a lack of access to training that would help them meet the needs of LGBT clients and, even when training is available, it may not be mandatory (see Champaneria & Axtell, 2004; Lyons et al., 2010; Price et al., 2005). For example, one concern across some health professions (e.g., nursing or medicine) is that the evidence for the effectiveness of cultural competence training is lacking in methodological rigor in the design and evaluation of the trainings (Price et al., 2005). Similarly, although there has been a sharp increase in cultural competence curricula in medical schools from 1991 to 2000, difficulties remain with the assessment of the knowledge acquired during the cultural competence training of physicians (Champaneria & Axtell, 2004). In addition, the lack of a requirement that all students enroll in these prescribed trainings and cross-sectional evaluation designs add additional challenges. Limitations also have been reported in LGBT competence training for psychologists where assessment of competence post-training revealed that not all elements of the training remain effective over time (Grove, 2009; Rutter, Estrada, Ferguson, & Diggs, 2008). Psychologists in practice have also indicated conflicting perspectives about LGBT training, wherein one study based on 125 randomly selected practitioners from the American Psychological Association (APA) member database indicated interest in additional training for sexual minority populations yet paradoxically those studied did not think that their work with LGB people would be substantially improved as a result of additional training (Murphy et al., 2002). In addition,

the field still lacks an agreed-upon clear vision for guidelines to define cultural competence for working with sexual and gender minorities.

Although intervention guidelines have been developed and new research has endeavored to provide evidenced-based or -supported directions in this area (e.g., Martell, Safren, & Prince, 2003; Pachankis & Goldfried, 2013; Safren, Hollander, Hart, & Heimberg, 2001), what is needed is the development of minimal standards across the multiple training levels for psychologists that identify concrete formative steps within specific competencies that are necessary for psychologists to maximize their competence in working effectively with sexual and gender minority populations. Taken together, these issues establish a critical and timely need for cultural competence among psychologists, both those in training and those in practice. Two sources of literature used to develop cultural competence guidelines for working with the LGBT population include perspectives from both sides of the therapeutic relationship. This synergy facilitated a “bottom-up” and “top-down” approach that includes a review of the empirical literature on client perspectives and clinician recommendations on what is needed to achieve LGBT cultural competence. Next we provide contextual details of what LGBT people experience in society and begin to make recommendations about how psychologists can best serve the mental health needs of LGBT communities.

Political and Socio-Cultural Context Supporting a Need for Culturally Competent Training in Working with Sexual and Gender Minorities

In many ways, the past decade has witnessed dramatic changes in public awareness of overt institutionalized discrimination facing sexual and gender minority individuals. There also have been significant developments and controversy domestically and internationally in promoting equal rights for sexual and gender minorities. The downside of these advances is that each city, town, or state has a differing set of regulations that apply to LGBT people, in some cases safeguarding rights and freedoms, and in other cases denying equalities. Moreover, many academic and employing institutions will have their own sets of policies that further complicate the process of developing cultural competence.

Internationally, countries that have basic human rights laws inclusive of sexual and gender minority individuals stand in contrast to the recent spate of legal barriers to equality such as the threat of the death penalty for homosexuality in Uganda (Cowell, 2013), up to 10 years for “homosexual acts” in India (Harris, 2013), and criminalization of LGBT education in Russia (Herszenhorn, 2013). The changes in jurisprudence in these countries not only negatively impacts the relationship sexual and gender minorities have with their government, but also the institutionalized stigma extends into the culture with many news reports of violence directed towards LGBT individuals.

In the U.S., the past decade has witnessed dramatic changes in public awareness of overt institutionalized discrimination facing sexual and gender minority individuals. Examples include the legalization of gay marriage in many U.S. states and the lift on the ban on gays in the U.S. armed services, even though transgender people cannot serve openly in the military. At the time of this writing, 30 U.S. states and the District of Columbia have legalized same-sex marriage, though additional complications exist on the recognition of

gender transition for transgender people (CNN, 2014; Lambda Legal, 2014). These advancements may mitigate cultural and legal proscriptions that contribute to discrimination or limit equal civil rights for sexual and gender minorities. For example, the Arizona state legislature passed a law on February 20, 2014 allowing business owners to cite religious beliefs as a legal justification for denying service to same-sex couples (Paulson & Santos, 2014). The law was later vetoed by the governor after pressure from the business community and both U.S. Senators from Arizona, among other groups (Santos, 2014). The Kansas state house passed a similar bill that died in committee (Hanna, 2014; KS HB 2453). Two new bills in the Idaho legislature have passed out of committee unanimously, which, similar to the laws in Arizona and Kansas, allow for the legal refusal of services by businesses and other public entities, based on perceived sexual and gender minority status and a reversal of all local laws that were passed in the state which protect LGBT people from discrimination, including a right to receive healthcare services (Stern, 2014). Finally, in December 2014, the Michigan legislature passed a bill on to the state senate that will allow physicians and emergency medical technicians (i.e., EMTs) the legal right to refuse to provide lifesaving assistance to LGBT people for religious reasons (Gray, 2014).

These and other legal, cultural, and environmental factors place great stress and stigma on a population already at risk for experiencing prejudice and discrimination, in addition to increased health disparities relative to the general population (see Mayer et al., 2008; Meyer & Northridge, 2007; Wolitski, Stall, & Valdiserri, 2008). For example, the Employment Non-discrimination Act (ENDA; Civic Impulse, 2014), a bill to prohibit discrimination in hiring and employment on the basis of sexual orientation or gender identity, has been introduced 11 times to Congress since it was first proposed in 1994. Gender identity was included with sexual orientation first in the 2007 iteration and, though either the House of Representatives or the Senate have passed ENDA separately in different years, the legislation has failed to pass both chambers in a legislative session preventing it from becoming law. Although no federal protections in the workplace exist, 18 states and the District of Columbia have a non-discrimination law covering sexual orientation and gender identity, three states have such protections for sexual orientation, but not gender identity, and 29 states do not protect sexual orientation. In these states, and the three that only protect sexual orientation, a 2012 ruling protects transgender and gender non-conforming people under Title VII's prohibition on sex discrimination (U.S. Federal EEOC, 2012). Regulations have also offered housing protections to LGBT individuals and their families based on rule changes within the U.S. Department of Housing and Urban Development (HUD, 2012).

Studies support improved health among LGBT people in places where greater equality exists. One study that examined the impact of marriage equality on mental health outcomes among LGBT individuals in Massachusetts found that health care utilization costs significantly decreased in the year following the change in marriage laws allowing same sex marriage (Hatzenbuehler, O'Leirigh, Grasso, Mayer, Safren, & Bradford, 2012). Psychological distress has been documented among lesbian, gay, and bisexual adults residing in jurisdictions where constitutional amendments to limit marriage to heterosexual individuals appeared on election ballots (see Rostosky, Riggie, Horne, & Miller, 2009). An artifact of these laws being publicized is that they contribute to, or exacerbate, the experience of stigma by sexual and gender minorities. Important mental and physical health

outcomes are negatively influenced, in large part, by stressors induced by a hostile and homophobic culture, which often results in a lifetime of harassment, maltreatment, discrimination and victimization (Dentato, 2012; Marshall et al., 2008; Meyer, 2003). It is within this sociocultural landscape, where the promise of equality is counterbalanced with stigma and discrimination, that today's psychology trainees, and those already in the field practicing, find themselves.

Recommendation 1

1. To be best equipped to therapeutically address the unique and changing contextual conditions experienced by LGBT people, psychologists need to be aware of the historical context and remain informed about these sociocultural changes, both positive and negative. Training programs should therefore develop a plan for apprising trainees of environmental changes (e.g., legal, educational, societal) and their impact on the healthy functioning of LGBT individuals and communities.

Basic Skills Needed to Develop Competence in Working with LGBT

Populations

Studies have examined pathways toward competence provided from the perspective of those in the sexual and gender minority communities. Although some of the extant scholarship in this research area does not include transgender perspectives, for purposes of this paper, the findings and recommendations apply throughout the entirety of the LGBT community. For example, Israel, Gorcheva, Burns, and Walther (2008) surveyed 42 LGBT individuals to learn about what they considered to be helpful and unhelpful therapeutic experiences. Their content analysis of the data found that basic counseling skills, alliance, and confidentiality were among the most important aspects of the therapeutic experience for LGBT clients. These universal skills are thought to apply both transtheoretically and across a variety of practitioner training backgrounds. Therapist attitudes toward and knowledge about sexual and gender diversity was a desirable characteristic in a therapist (Burckell & Goldfried, 2006; Israel et al., 2008).

Godfrey, Haddock, Fisher, and Lund (2006) compiled data from a "panel of experts" in LGB mental health across disciplines (e.g., psychology, marital and family therapy) and summarized three categories to guide competence including clinician qualities, specific training experiences, and materials with which practitioners should be familiar. Open-mindedness about diversity and therapist self-awareness about comfort level, biases, and prejudice were qualities with the greatest convergence of professional opinion. The panelists agreed that practitioners should be familiar with the scientific literature on sexual orientation formation, the degree to which LGB issues were related to client goals, and the role of individual and institutional homophobia (and transphobia) in the lives of LGBT people (Eubanks-Carter, Burckell, & Goldfried, 2005). The latter of these, together with the internalization of homophobia, is thought to be significant across a number of the presenting issues among LGBT people (Eubanks-Carter, et al., 2005; Gonsiorek, 1996; Meyer, 1995; Meyer & Dean, 1998; Murphy, Rawlings, & Howe, 2002; Shidlo, 1994). Competence also

included assessing whether and to what degree a client had disclosed their sexual orientation to others (i.e., “out of the closet”).

Agreement on the importance of confidentiality aligned with similar research findings from clients themselves (Godfrey et al., 2006; Israel et al., 2008). The expert panel supported the idea that knowing LGB persons (e.g., colleagues, friends, or healthcare professionals) was an essential “out of the classroom” learning experience that supported competence. Didactic experiences that received support included inviting an LGB panel or guest speakers (including LGBT people across groups of intersecting diversity), face-to-face or the observation of therapy conducted with LGB people, or writing self-evaluation papers around the issues of sexual orientation. Although transgender professionals were not included among the expert panelists, a study with similar goals that used semi-structured interviews among LGBT therapists supported and extended these findings (see Israel et al., 2008). Regardless of whether issues surrounding sexual orientation or gender identity were the presenting concern, it was helpful when these identities were addressed at the time of assessment or early on in treatment. Referral to a specific therapist, with an expertise in LGBT mental health, was helpful relative to being assigned a therapist by triage. The practice environment was found to be influential with LGBT community health centers or university counseling centers being perceived as more supportive environments relative to hospital outpatient clinics. An additional important environmental feature included the geographic location where services were delivered. For example, services within U.S. states containing a culturally pervasive conservative religious orientation were generally viewed as unhelpful. Alliance and support were helpful as were a variety of theoretical approaches including cognitive-behavioral therapy (CBT), humanistic, feminist, and narrative approaches.

Across all training and practice levels, familiarity with the scholarly literature is also necessary to achieve cultural competence in working with the LGBT population. Theoretical paradigms have been advanced to explain the higher number of sexual and gender minorities, relative to their representative proportion of the population, that present with mental health concerns (Dean, Meyer, Robinson et al., 2000; Mayer, Bradford, Makadon, Stall, & Goldhammer, 2008; Wolitski, Stall, Valdiserri, 2008), substance use disorders (Green & Feinstein, 2012; Marshal et al., 2008; Woodford, Krentzman, & Gattis, 2012), nicotine dependence (Blosnich et al., 2013; Tang et al., 2007), and problematic levels of alcohol consumption (Lehavot & Simoni, 2011; McCabe et al., 2009). Increased rates of problems such as these are attributed to societal stress (i.e., prejudice, discrimination, and stigma), and also to the concurrent disparities in healthcare access and level of care. Whether sexual and gender minorities utilize services at a greater rate than the general population or at lesser rate due to perceived challenges with competence in LGBT health care, both hypotheses support the need for theoretically driven cultural competence training for psychologists.

The minority stress model (Meyer, 1995, 2003) suggests that societal stressors, over and above what is faced day-to-day by members of the general population, are additive and contribute to the negative health outcomes found among LGBT individuals (see Hatzenbuehler, 2009; Meyer, 1995, 2003). It has been suggested that minority stress for

sexual and gender minorities in particular, relative to other minority groups, is accounted for, in part, by the incongruent minority status relative to their families of origin (Garnets, 2002; Pachankis & Goldfried, 2004). LGBT populations are also more likely to report having experienced trauma over the course of their lifetime, including childhood sexual abuse (Corliss, Cochran, Mays, et al., 2009; Lenderking, Wold, Mayer, et al 1997; Mimiaga, Noonan, Donnell, et al. 2009) and problems of bullying, teasing, and other forms of victimization (Berlan, Corliss, Field, Goodman, & Austin, 2010; Bogart, Elliott, Klein, Tortolero, Mrug, Peskin et al., 2014; Copeland, Wolke, Angold, & Costello, 2013; Katz-Wise & Hyde, 2012; Shipherd, Maguen, Skidmore, & Abramovitz, 2011). We believe cultural competence training should include exposure to this and other theories, such as those related to intersectionality, as tools to familiarize and sensitize psychologists with the contextual sociocultural “realities” of living as an LGBT person in a wide variety of communities throughout the United States. An understanding of the socio-political context of LGBT populations and relevant theory will assist in guiding psychologists to a more complete clinical assessment, case formulation, and intervention planning that allows for effective clinical management that will aid LGBT clients in developing a more affirming sexual and gender identity.

In addition to the burgeoning peer-reviewed knowledge base, several handbooks and manuals written by experts provide significant guidance on clinical issues likely to be relevant in working with sexual and gender minorities. These not only provide background on presenting problems, but also provide support for case formulation and intervention techniques. Some recommended titles include: *Cognitive-Behavioral Therapies with Lesbian, Gay, and Bisexual Clients* (Martell, Safren, & Prince, 2003), the *Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients* (Bieschke, Perez, & DeBord, 2007), and the *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men* (Ritter & Tendrup, 2002). In addition, several key reports on LGBT health and webinars are reviewed elsewhere in this issue and provide important additional educational resources (see Matza, Sloan, & Kauth, 2015).

Across all training levels, some basic but often forgotten aspect of cultural sensitivity involves the language used across all aspects of communication. For example, the language used to conduct telephone intakes, clinical assessments, and therapeutic intervention should be modified and adapted to include less biased language just as the field has promoted for many years the adaptation of language about clinical problems based on a client's parlance. Forms that are used for assessment, practice, and general record keeping should be revised based on consideration of policies about how to address those who identify differently than the majority, such as individuals who use a name other than their legal name or that differs from their gender at birth. Although it is acknowledged that, for some institutions, modification of forms may present a challenges, this does not mean that psychologists cannot or should not model sensitivity, normalization, and acceptance of LGBT people.

In summary, the most current research on the need for competence suggests that LGBT clients emphasize the importance of confidentiality, therapeutic alliance, and the need for therapists who are knowledgeable about sexual and gender minority issues. Clinicians stressed open-mindedness about diversity and therapist self-awareness of bias, prejudice,

and knowledge of the role of individual and institutional homophobia (and transphobia) in the lives of LGBT people. A familiarity with the scientific literature on sexual orientation formation and a consideration of the degree to which LGBT issues were related to client goals were issues that also emerged. We have distilled the following recommendations based on the review and synthesis of this literature:

Recommendations 2 – 8

2. Cultural competence with sexual and gender minority groups involves: (a) awareness of one's own beliefs, biases, and attitudes regarding LGBT populations; (b) knowledge and understanding of LGBT populations, including expectations for the counseling relationship and how one's own sexual orientation and gender identity come into play; and (c) skills and tools to provide culturally-sensitive interventions for LGBT populations. Training programs should increase LGBT-specific knowledge both of theories of identity formation, minority stress, and the current state of the literature (which changes at rapid pace) about LGBT-specific concerns and health disparities.

4. At both training and independent practice levels, the awareness and application of LGBT-specific culturally sensitive language across all forms of communication, (e.g., call screening, forms used, assessment) should become standard practice.

5. Clinicians should expand the discussion of confidentiality and documentation issues during their initial contacts with LGBT clients as they may have greater concern about being permanently labeled as LGBT within medical records, and thus potentially “outed” to medical providers and to others.

6. Clinicians should be familiar with the societal context (e.g., legal, religious, regional sub-cultural differences) and explore family/personal context to inform case conceptualization (e.g., internal and/or external sexual prejudice) when working with LGBT clients.

7. Clinicians should attempt to understand if a presenting problem is LGBT-specific or if it is another individual difference factor in understanding a case and formulating a treatment plan, but not central to treatment.

8. Across training levels and throughout practice settings, psychologists should include appropriate assessment(s) of sexual orientation and gender identity that may better facilitate alliance and possibly improve response to treatment within their work with LGBT clients.

Related to this last recommendation (i.e., recommendation #8), sexual and gender minority men and women who disclose their sexual orientation have significantly fewer psychiatric symptoms than those who do not (Juster, Smith, Ouellet, Sindi, & Lupien, 2013; Schrimshaw, Siegel, Downing, & Parsons, 2013). In addition, negative reactions from others to the disclosure of sexual orientation have been linked to current and subsequent use of substances (e.g., alcohol, cigarettes, marijuana) and to other health risks (Cole, Kemeny, Taylor, & Visscher, 1996; Rosario, Schrimshaw, & Hunter, 2009). These findings underscore the importance of assessing “coming out” as an evolving and developmentally normative process examining the extent to which sexual and gender minority clients either

disclose or conceal their identities, and recognizing the possible implications for both mental and physical health. In addition, for many LGBT people, a psychologist may be the first person (professional or otherwise) with whom they share their sexual or gender identity. Thus, it is imperative to have sensitivity and a knowledge base that may facilitate a model of disclosure for the client that they may later apply with others.

Foundation for LGBT-Specific Guidelines in the Training of Psychologists

Minimum guidelines are set forth by the field related to the training of psychologists vis-à-vis the Guidelines and Principles of Accreditation (APA, 2013). These guidelines serve as a starting point for LGBT cultural competence under the broader heading of “diversity training.” The accreditation guidelines and principles enshrine, in detail, specific expectations to develop professional competence for work with a myriad of diverse and underserved groups including sexual and gender minorities. Two prefatory notes; first, another system for accrediting psychology graduate and internship programs has emerged, i.e., Psychological Clinical Science Accreditation System (PCSAS), developed and advanced by the Academy of Psychological Clinical Science (APCS). A careful examination of the PCSAS accreditation principles and model, review criteria, and the accreditation application itself reveal that standards for training in diversity in general, or LGBT competencies more specifically, have yet to be developed (PCSAS, 2014). Second, it is important to note that the APA guidelines and principles have evolved owing to empirical advances and these guidelines reflect the goals of the larger field, as that they were developed and approved by a Commission with broad representation across many areas (i.e., psychology training councils including APCS). For the purposes of this article, it is our intention to remain neutral on the topic of one accreditation system over another, and instead provide readers with information about the state of LGBT cultural competence training regardless of system(s) of accreditation.

Accreditation guidelines for the training of psychologists began more than 60 years ago after the U.S. Veteran's Administration asked the APA to identify university doctoral training programs that could provide adequate training to meet a significant need for psychological services for veterans of the armed forces (APA, 2013). These guidelines evolved into the *Guidelines and Principles for Accreditation of Programs in Professional Psychology*. A psychologist in this context is defined as clinical, counseling, or school psychologists with an earned doctoral degree and the LGBT cultural competence guidelines and recommendations that we offer here extend to each of these practice specialties. Accreditation is a mark of quality for the training of psychologists and the *Guidelines* specifically address the issue of cultural competence training. For example, in 2005, Domain A.5 of the guidelines was updated to be consistent with the definition of diversity as specified in the *APA Ethical Principles of Psychologists and Code of Conduct* (APA, 2002). Specifically, Principle E which speaks to respect for peoples' rights and dignity included sexual orientation, among other classifications, as a group for which “psychologists respect cultural, individual, and role differences” and that specific safeguards may be necessary to protect the rights and welfare of said groups (APA, 2002, p. 1063).

At the doctoral training level, Domain A.5 requires that in order for a program to be eligible for accreditation, the program must engage in actions that support respect and understanding of cultural and individual diversity (APA, 2012). This may be reflected in the program's policies for recruitment, retention, and development of faculty in issues of curriculum and practice. Other components of accreditation are associated with cultural competence and are specified in Domain D of the *Guidelines*, which speaks to cultural and individual differences and diversity in the training of psychologists (APA, 2012). There are two parts to this domain of accreditation guidelines. Part 1 addresses a program's systematic plans to attract and retain diverse trainees and faculty while part 2 addresses a program's plan to provide students with "relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of professional psychology" (APA, 2012., p.14).

Domain D.2 of these guidelines calls for programs to design and implement cultural competence training. Although sexual orientation and gender identity are listed as individual difference factors that should be included in psychologists' training, there are neither specifications nor guidance on how to carry out this type of training. This is, in part, by design so that training programs have flexibility in identifying the specifics about how the guidelines are to be implemented, evaluated, and achieved.

In recent years, additional guidelines, outside of those adopted for accreditation, have been published by the APA to clarify the organization's stance on care provided to sexual minorities, as well as aspirations for the education and training of psychologists in this regard (APA 2009, 2012). A task force report on gender identity and gender variance was published by APA in 2009, though similar guidelines in support of diverse gender identities are currently under review (APA, 2009). Nevertheless, limitations remain in bridging these guidelines and the minimal or ideal training requirements for competence in working with LGBT individuals. That is to say that the accreditation guidelines do not fully align with the policy statements for LGBT people and thus should be considered *minimum requirements* in order to receive or maintain accreditation. One such concern arises out of idiosyncratic differences between the gender, racial/ethnic, social class, religious, disability, and sexual orientation groups. Cultural competence can be specific, and sometimes unique, to various cultural groups, however, individuals that present for psychological services often have more than one minority status, sometimes referred to as intersectionality. Though it is not possible to offer a more thorough review of the concept in this article, the general idea of intersectionality applies to LGBT people when there are additional minority or culturally subordinate statuses that intersect with sexual and/or gender minority status (e.g., Anderson & McCormack, 2010; Bowleg, 2013; Bowleg, 2008; Rahman, 2010). Our recommendations that follow are designed to move the field toward an ideal training model for cultural competence with LGBT people rather than simply rearticulating the minimum standards. Additional recommendations are provided elsewhere in this issue (see Hope & Chappell, 2015).

For cultural competence training in this domain to improve from its current state, the field should not wait for the federal government to mandate the inclusion of sexual and gender minorities among those groups already designated as a protected class. This type of

expectation may further facilitate outreach to and protect an underrepresented group, like LGBT people, in academia in general and in psychology training more specifically. Programs should develop systematic plans to attract and retain diverse trainees. Issues relevant to sexual and gender minorities should be a focus of these efforts similar to those of other underrepresented groups. When considering implementation of these recommendations, intersectionality must also be addressed so that one faculty or student is not unduly called upon to represent all aspects of diversity in a program. Thus, programs should codify and continuously review and revised plans to provide trainees with knowledge (i.e., curriculum) and experience (e.g., practica) that emphasize the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of the profession.

Recommendations 9 –10

9. Sexual orientation and gender identity should be included as an element of diversity equal to current “protected classes” in the United States in all hiring, retention, and promotion decisions in order to recruit, retain, and develop LGBT faculty, or faculty with LGBT research agendas.

10. LGBT competence standards will improve when trainees have at the minimum one LGBT-focused academic class and clinical practicum experience. Therefore, in addition to some curricular enhancements that we identify in the next section based on training level, our recommendation is that trainees at all levels should have relevant and sufficient clinical experiences in working with sexual and gender minority individuals, couples, and/or families.

Doctoral Training Programs: Foundations for More Advanced Cultural Competence with Sexual and Gender Minorities

Training psychologists with an awareness, knowledge base, and skill set to work with LGBT individuals involves competencies that include both breadth and depth. The range of exposure may begin during initial graduate-level coursework and after formalized training is completed, extend to continuing education. However, the graduate training period provides a critical opportunity to acquire training not only to provide competent care for LGBT populations, but also to support more advanced expertise in this area at higher training levels.

At the doctoral level, programs generally have three to five years of training activities through which opportunities to impart and evaluate cultural competence are possible. Although some programs choose to develop a single diversity course where graduate students are trained on issues of cultural competence among many underserved constituencies, other programs prefer to infuse elements of diversity training into multiple courses. For example, in the latter case this may involve including readings about sexual and gender minorities in a breadth course such as social psychology, or in a clinical or counseling intervention course. These and other styles can be successful in providing a starting point toward competency. However, we believe a single graduate-level course intending to cover competency across all areas of diversity, or broadly infusing elements of

diversity across each unique population distributed within different courses, is insufficient to prepare graduate students for LGBT cultural competence as they transition to internship and licensure. In addition, trainees who are interested in specializing their clinical work with LGBT populations will not have adequate preparation for the next levels of training without an increased doctoral-level intensity of preparation.

Practice guidelines were developed by APA (American Psychological Association, 2012) with two specific guidelines that pertain directly to education and training (i.e., guidelines 19 & 20). Guideline 19 states that psychologists [should] strive to include lesbian, gay, and bisexual issues in professional education and training, while guideline 20 states that psychologists are encouraged to “increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.” (APA, 2012, p. 26). It is worth clarifying that guidelines on gender identities are forthcoming from APA. These guidelines, though developed for psychologists post-graduation, provide an excellent framework with which to design, construct, and evaluate training programs.

Enhancements in instruction may serve as a gateway to other recommended training activities that will improve LGBT competence. For example, curricular changes that include LGBT diversity that is specified through the objectives and activities for each course, opportunities to translate science into practice with sexual and gender minorities, and providing practicum experiences that incorporate cultural competence in working with LGBT clients are ideal standards to improve competence. To the extent possible, trainees should have opportunities within their graduate practicum experiences to provide evidence-based interventions with LGBT clients and receive appropriate supervision.

When implemented, these interactive curricular and practical experiences move competency from basic to applied science. A sound model of applied learning with research support about the therapeutic needs of the LGBT community should involve doctoral trainees reading the scholarly work published in this area. This will guide clinical engagement with all clients at the initial assessment around their sexual and gender identity followed by an ability to practice this skill while receiving clinical supervision (Burckell & Goldfried, 2006; Goldberg & Lindenberg, 2006; Israel et al., 2008). In addition to coursework and clinical practica, evaluations of competence with LGBT populations should be conducted to assess the effectiveness of the training. In keeping with this stance, our recommendations are designed to expand and improve upon the “single course” or “infused” models of diversity training across many different minority categories. We advocate a model that develops all curricula at the doctoral training level to include specified relevant and applicable LGBT learning objectives and activities to go beyond minimal competence and support pathways for trainees to develop expertise.

An example of how this may be achieved is by use of the required “diversity essay” that is a standard part of the APPIC (APPIC Application for Psychology Internships) clinical internship application. Programs could devise rubrics to score these essays that would serve at least two functions: (1) an evaluation of learning and competence, and (2) areas for improvement in LGBT competence. An unintended positive consequence of this suggestion

may be a significant increase in the cultural competence knowledge based of prospective interns in the context of additional faculty oversight.

For example, the Caban (2011) study of 221 professional psychology graduate students, (i.e., clinical, counseling, or school) had the goal of developing an instrument to measure graduate student learning in the area of cultural competence. Using a *stages of change* model (see Prochaska & DiClemente, 1983) the author constructed the measure and conducted an exploratory factor analysis. The five factors that were extracted aligned with the stages of change model. Trainees that participated in a greater number of diversity trainings, who currently participated in diversity research, or who themselves were members of underrepresented groups were more likely to be in the latter stages of change regarding cultural competence. Further psychometric validation of this scale and the inclusion of transgender people may enable doctoral programs to adopt this type of instrument for evaluation of LGBT-specific cultural competence training.

With regard to the inclusion of LGBT issues in training as articulated under Guideline 19 (APA Practice Guidelines, 2012), doctoral training programs must remain innovative in incorporating novel and evidence-based approaches to working with LGBT individuals. These may include colloquia by experts in the area. Trainees, together with the guidance of one or more faculty, may be encouraged to present to their peers on topics related to working with sexual and gender minorities. A caveat is that implementation of these recommendations should not always be expected of faculty, staff, or students that identify as a sexual or gender minority. Being a member of a specific group does not mean that one has the innate interest or cultural competence to provide clinical services to that population. This also may provide an undue burden on faculty, staff, or students, the latter of whom are in training themselves and possibly still formulating their own sexual and gender identities given the traditional matriculation age within graduate programs.

We agree that doctoral programs should have the freedom to design curricular changes that best align with their goals, objectives, theoretical orientation, and other pertinent factors; however, diversity in general, and sexual and gender minority diversity in particular should be included in the curriculum in a way that can be evaluated to assess competence. In order for doctoral trainees to be prepared for the rigors of their internship training, they must receive adequate training in their doctoral programs on cultural competence with sexual and gender minorities. Although neither the accreditation guidelines nor the literature point to a specified number of clinical hours or practice-based activities in order to achieve competence in working with lesbian, gay, bisexual, or transgender clients, we recommend that graduate programs require direct clinical experiences in working with the LGBT population. Thus, the expectation is that doctoral students will have this type of training experience before embarking on the clinical internship year. Although this recommendation is better categorized as basic rather than ideal for LGBT-specific competence, there are limitations. Even with this suggestion, for example, a trainee may only gain experience with a lesbian, a bisexual man, or a transgender individual which will not be sufficient for developing expertise. For a more thorough depiction of the issues and choice points associated with developing LGBT cultural competence in graduate training, we refer readers to Hope and Chappell (2015).

Recommendations 11 – 15

11. Graduate coursework shall include at least one section within most core courses on LGBT diversity issues. This could be in the form of a three-hour seminar within each course (i.e., 3 hours over the length of the semester or quarter), and include directed readings, examination questions, and/or presentations on topics relevant to LGBT populations. For example, research methods courses may address recruitment, data collection, and confidentiality concerns for studies about sexual and gender minority populations or that include significant samples where sexual and gender minority individuals were studied in addition to heterosexuals. Assessment and intervention courses might discuss and model evidence-based intervention approaches and their application with LGBT populations (e.g., Martell, Safren, & Prince, 2003; Safren & Rogers, 2001).

12. Practicum experiences should include not only direct recruitment and welcoming of sexual and gender minority populations via advertising and other methods in order to provide a richer clinical experience at the doctoral level, but also to provide supervision experiences that reflect and model “real-life” adaptation of skills with individuals from LGBT backgrounds.

13. Doctoral trainees should have at the minimum one supervised client who identifies as LGBT and at least 12 sessions with that client (or have additional LGBT clients if that therapeutic relationship ends earlier). These client cases shall be supervised by a qualified supervisor.

14. Doctoral clinical psychology training programs should strive to develop a process to evaluate LGBT cultural competence among trainees before advancing to internship. For example, a program may choose to use the qualifying examination as a mechanism to evaluate LGBT cultural competence before trainees move into doctoral candidacy and thus be eligible to apply for internship. Evaluation of competencies might also be accomplished through direct assessment.

15. Efforts should be made within the clinical faculty to include literature that reflects psychological phenomena within LGBT minority populations that are considered as legitimate standards, rather than being presented as an “other” category. To clarify, this means that readings assigned should not assume the “default client” is a Euro American heterosexual.

Internship Training and Cultural Competence

At the internship training level, programs provide one year of training activities and experiences that are primarily designed to provide an intensive clinical training experience. It is expected that the training experiences at this level are “characterized by greater depth, breadth, duration, frequency, and intensity” than practicum training that prepared students for the transition from graduate student to doctoral intern (APA, 2012, p. 18). Thus our recommendations for internship align with the focus toward applying knowledge and skills clinically.

The size of the internship cohort may influence the amount of time needed; we suggest a two-hour didactic that includes an expert to work with interns on clinical issues relevant to LGBT cultural competence. With this in mind, this type of didactic experience should be scheduled early in the training year so that interns benefit and apply the readings, role-plays, and expert instruction with their clinical cases.

Another opportunity for improving cultural competence at the internship level of training comes from substantial clinical supervision. Our suggestion involves harnessing the intensive clinical year with opportunities for growth in trainee comfort in working with LGBT people and in their skills and abilities to deliver competent psychological services to this population. Given that the regulations require a minimum of 4-hours per week of clinical supervision, internship programs have the opportunity to train clinical supervisors to work with trainees on skills to be used in sessions with sexual and gender minority clients. In many geographic locations, there is a great likelihood that trainees will encounter an LGBT person seeking clinical services during their training year. This likelihood is enhanced for those programs located in a major metropolitan area with a substantial LGBT community, but also could be enhanced through recruitment activities on the part of the training program to improve the diversity of the populations they serve and thus indirectly improve upon their cultural competence training.

If this is not possible, we would expect the internship to provide an equivalent experience such as watching a video and then conducting a role play, either with other interns guided by a supervisor, or directly with a clinical supervisor. Additionally, although it is acknowledged that relative geography may render this recommendation complex for some programs, the expansion of Telehealth, and the empirical support for psychological interventions to address some presentations using that platform, and community advertising strategies should support this important training experience.

For programs that simply cannot routinely provide such experiences, there are still significant learning opportunities that may be achieved via assessment of trainees and faculty. In addition to integrating LGBT sensitive language into forms (e.g., recommendation #4), an internship learning experience could include the use of psychological instrumentation to evaluate gender and sexual identity formation (e.g., Bradford & Mayer, 2007; Mosher, Chandra, & Jones, 2005). For example, Cass' (1979, 1984) six-stage model forms the basis for many interventions with sexual minority populations (Dunkle, 1996; Mobley & Slaney, 1996). Additional research will be needed to either incorporate gender minorities into this model, or develop an independent model for transgender people. A more thorough revisiting of the model may be needed given additional contributions to the scholarly literature. In their study of lesbians, Degges-White, Rice, and Myers (2000) found evidence for the Cass model of identity formation among a sample of lesbians, however they also reported some discrepancies. A resource, inclusive of all LGBT people, for up-to-date evaluation instruments comes from a National Institute of Child Health and Human Development funded population research center focused on LGBT health (see Mayer et al., 2008). An exercise that may identify biases and normalize anxiety that trainees and supervisors may have about working with LGBT people might involve an anonymous survey of interns and faculty using an index of homophobia (see Bouton et al.,

1987; Hudson & Ricketts, 1980). This assessment as a learning experience has been constructive, when conducted with other health professionals to identify and guide training strengths and challenges (Erlen, Riley, & Sereika, 1999).

Recommendations 16 – 20

16. To evaluate LGBT-specific competence, Internship programs may choose to utilize the Association of Psychology Postdoctoral and Internship Center (APPIC) APPIC Application for Psychology Internships (AAPI) diversity essay to evaluate prospective interns on their previous experiences with LGBT competency, and

17. During internship, required didactic trainings should include direct instruction, of at least 2-hours, by an expert that improves cultural competence in working with LGBT clients, as well as in the development of gender identity and the treatment concerns of transgender individuals.

18. To have cultural competence in working with LGBT clients, we recommend that at minimum, an intern have at least one experience working with a member of the LGBT population together with supervision by a qualified supervisor.

19. Internship trainees should be provided with guidance on how to acquire additional specialty training to increase competency toward the level of an expert in working with LGBT clients. Programmatic efforts should be improved to provide guidance to interns on the transition to post-doctoral fellowships, e.g., VA fellowships specializing in LGBT healthcare or other additional training opportunities related to health disparities.

20. Faculty at internship programs should be provided with training and resources in order to provide appropriate supervision of LGBT cases.

Post-doctoral Training and Beyond: Emerging LGBT-Specific Expertise

Whether psychologists choose to seek additional training via a post-doctoral fellowship or move directly into the field, expectations and competencies are thought to be more advanced and complex at these levels. Our first 10 recommendations were the minimum training activities for psychologists to achieve competency in working with LGBT people across all training levels including those in the profession. The next set of recommendations, i.e., #11 to 15, were geared toward doctoral training programs, and #16 to 20 were guidance for internship programs.

Given the specialization that occurs during post-doctoral training and the variability in clinical versus research focus of that training, we recognize that experiences related to LGBT-specific competence during these training year(s) need to be commensurate with the emphasis of the particular post doc. For example, with sexual and gender minority competence on the agenda, post-doctoral residents, together with their mentors, can generate specific training activities and readings to further clinical and research expertise. Again, readers are referred to Matza, Sloan, and Kauth (2015) for consideration of essential readings and webinars. The evaluation of expertise at this level might be through demonstration(s) of advanced competency, which could be accomplished using a variety of modalities from a publication, lecture in a professional or community setting, training

provided to practicum or interns, courses taught in higher education settings, or by other means.

Integrating Sue's model for cultural competence (1998) that supports self-awareness, knowledge, and skills will improve psychologists' competency in working with lesbian, gay, bisexual, and transgendered clients. Additional areas that should be considered for integration for those interested in specialization in LGBT health at the fellowship level include: (a) human sexuality, gender identity, and multidimensional models of sexual orientation and gender identity development over the lifespan; (b) mental health issues and disparities affecting lesbian, gay, bisexual, and transgender individuals; (c) lesbian, gay, bisexual, and transgender identity development in a heteronormative society, including ethnic and cultural factors affecting identity; (d) the effects of stigmatization upon lesbian, gay, bisexual and transgender individuals, couples, and families; (e) intersectionality of multiple identities; (f) unique career development and workplace issues experienced by LGBT individuals; (g) nontraditional relationship forms, e.g., family systems outside of a dyad; (h) issues of religion and spirituality for lesbian, gay, bisexual, and transgender people; and (i) health and wellness issues (Israel, Ketz, Detrie, Burke, & Shulman, 2003). These areas of competence and guidelines support lifelong learning as new research points to updated evidence-based approaches in working with LGBT clients. They also provide a framework for those psychologists who wish to specialize in working with this population. In addition, dissemination activities would be appropriate evaluative criteria for fellows seeking expertise in this area. As experts, manuscript preparation and publication, book chapters, conference presentations, training of other health professionals, invited talks, grant writing, and clinical case demonstrations are some initial ways advanced competency might be evaluated. It is also reasonable to expect postdoctoral fellows to be a part of professional organizations that are associated with LGBT health broadly defined.

After an extensive review of the most current science, the APA published new practice guidelines for working with lesbian, gay, and bisexual clients (American Psychological Association, 2012). Twenty-one guidelines were developed ranging from attitudes toward homosexuality and bisexuality (1-6), relationships and families (7-10), issues of diversity (11-16), economic and workplace issues (17-18), education and training (19 & 20), and research (21). Each of the guidelines contains a rationale, application, and a review of the most current literature. Similar guidelines for transgender individuals are forthcoming from APA. Continuing education might require the presentation of new information around changes in therapeutic guidelines during any year that they occur.

Other professions have outlined practice guidelines for working with LGBT individuals that are inclusive of gender minorities suggesting progress across some health professions. For example, the American Academy of Child and Adolescent Psychiatry published a practice parameter for LGBT children and adolescents (see Adelson and the American Academy of Child and Adolescent Psychiatry, 2012). This particular practice parameter was developed in accordance with American Medical Association policy (Adelson et al., 2012) suggesting that the competencies extend beyond psychiatry into other medical specialties. At the postdoctoral level of training or at the "early career psychologist" stage of the profession, psychologists will benefit in their continuously evolving LGBT-specific competence from a

review of the most recent practice guidelines developed by allied health professions. It is appropriate at this stage for those in the profession to seek additional training or stay current with the literature through a more self-generated plan for professional growth.

Recommendations 21 – 25

21. As expertise is developed for fellows or early career psychologists, dissemination activities not limited to the following are expected for LGBT-specific competence: manuscript preparation and publication, book chapters, conference presentations, training of other health professionals, invited talks, grant writing activities, and clinical case demonstrations.

22. Advanced competency should require either reviewing papers related to LGBT health, and/or reading journals to stay abreast of the most current scholarly work. Many journals are appropriate for this learning activity including, but not limited to the *Psychology of Sexual Orientation and Gender Diversity* and *LGBT Health*.

23. Items should be vetted, tested, and added to the Examination for Professional Practice in Psychology (EPPP; Association of State and Provincial Psychology Boards, 2011). Additional items on the EPPP will be a measure of competency overall, and to practice with LGBT people.

24. In order to maintain licensure, jurisdictions should require continuing education units (i.e., CEUs) with the goal of ensuring professionals stay current with the scholarly literature to maintain LGBT-specific competencies.

25. At least one CEU should be dedicated to issues of cultural competence with sexual and gender minorities.

Lastly, we broaden the discussion with a few additional recommendations and conclusions in order to provide a professional context of sexual and gender minority competence.

The Professional Context

It has been over 40 years since the American Psychological Association declassified homosexuality as a mental disorder and instead recognized that variation in human sexuality is normal (American Psychological Association, 1975). Great progress has been made in the profession in our understanding of sexual and gender minorities. Some problems continue to be challenges for the field to improve equality for LGBT people and by extension harmonize cultural competence training.

In January of 2002, the APA Monitor reported that the then Committee on Accreditation, now Commission on Accreditation (CoA), voted unanimously NOT to remove Footnote 4 from the Guidelines and Principles for Accreditation, meaning that religious institutions with doctoral, internship, or post-doctoral residency training programs could still claim exemption from diversity requirements, set forth by science and endorsed by the field, thus allowing those programs to give preferences to students and faculty from the same religious affiliation. Additionally they are able to continue to refrain from complete compliance with

the diversity elements of the guidelines and principles for accreditation (source: <http://www.apa.org/monitor/jan02/exemption.aspx>).

In essence, footnote 4 allows applicant training programs, as well as those that are undergoing re-accreditation, to exempt themselves from complete adherence to those policies specifically designed to increase diversity, in particular as most often applied toward LGBT people, when hiring faculty, staff, or accepting students into training programs. Although only a few programs invoke the footnote, this policy provides an explicit justification for psychology training programs to use religious belief rather than scientific knowledge or clinical proficiency in the selection of trainees and faculty.

Transgender individuals have these and additional challenges even as some civil rights have improved for sexual minorities. For example, gender minorities have fewer workplace discrimination protections relative to sexual minorities, and continue a dialogue, as a community, with the mental health professions over the classification of “gender dysphoria” in DSM-5; though progress has been made from the previous diagnosis of “gender identity disorder” in DSM-IV-TR (American Psychiatric Association, 2013). A promising development, for those countries and health systems that use the soon to be revised International Statistical Classification of Diseases and Related Health Problems (ICD-10: World Health Organization, 1992), is that the working group charged with revisions to the new ICD-11 are “to abandon a psychopathological model of transgender people” and move toward an evidence-based model for those affected by the categories under sexual and gender identity (Drescher, Cohen-Kettenis, & Winter, 2012, p. 568).

It is no longer acceptable for 21st century psychologists to consider classifying minority sexual orientation (i.e., LGB) as a “stand-alone” clinical disorder,” though this certainly may have been the case in the early 1970's before the declassification of homosexuality. Mindful of clinical practice guided by science, we should ensure that past prejudices do not negatively impact our clients as the literature transitions from a model of pathology to a model of contextualizing sexual orientation and gender diversity as normative. Psychologists should be familiar with the current research on issues affecting LGBT populations and of provisions, such as policy statements from the American Psychological Association (Anton, 2009, 2010), that support the use of affirmative interventions – rather than potentially ineffective, if not harmful, interventions (e.g., conversion therapy) – to promote mental health and well-being among LGBT individuals, their relationships, and their families.

Recommendations 26 – 28

26. The Commission on Accreditation (CoA) should vote to remove the “Footnote 4” for its guidelines and principles of accreditation. This will align with the APA stance on sexual orientation and gender identity (SOGI), but more importantly, use scientific evidence to guide training for all programs.

27. Training programs and psychologists already in the field should be cautious about pathologizing transgender individuals in the interim. Working collaboratively with transgender clients will allow for the use of a diagnostic category, if required, with the

caveat that psychologists should help to support a reduction in stigmatization that comes with this group of psychiatric diagnoses.

28. Additional accreditation systems that emerge should strive to incorporate these and other evidence-based LGBT competencies into their accreditation guidelines for the promotion of mental health among LGBT individuals, their relationships and families.

Conclusions

Using resources and guidelines published by experts and professional organizations in the field, we endeavored to add to the scholarly literature by clarifying and recommending options to improve cultural competence at multiple stages of career development for professional psychologists. The direction provided is cumulative and supports lifelong learning as socio-political, legal, and cultural beliefs and attitudes evolve. These changes are in addition to the rapid pace of change within this field as it is informed and guided by science. Our intention was to stimulate further discussion about these issues so that professional psychologists are prepared to work with minority populations who may be different from their own identities.

The field may find developing, measuring, and implementing these suggestions to be a herculean task. Indeed, there is much to be learned about the effects of culture on the clients we work with in clinical and research settings. Yet acquiring cultural competence to work with and be effective for sexual and gender minority individuals is not a single process that must be added to perhaps an already bloated curriculum. As demonstrated through this review, cultural competency with LGBT individuals is a process, and one that should be ongoing over the course of one's career. The process should be rigorously researched, driven by science, supported by the profession, include measures and data to support outcomes to demonstrate competencies, and be inclusive of the multiple stakeholders in this area including trainees, faculties, independent practitioners, and the sexual and gender minority communities.

Our recommendations were generated with the primary goal of improving cultural competence among professional psychologists through training, evaluation, practical experiences, and continuing education. It is our sincere hope that the field improves in this area in support of the pioneering work conducted by psychologists that has served many scientists across a variety of disciplines in the area of sexual and gender minorities.

Acknowledgments

Some of the author time (CO) was supported by grant R01 MH095624. Some of the author time (SAS) was supported by grant K24 MH094214.

References

- Adelson SL. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2012; 51(9):957–974.10.1016/j.jaac.2012.07.004 [PubMed: 22917211]

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th. Washington, DC: 2013.
- American Psychological Association. Policy statement on discrimination against homosexuals. *American Psychologist*. 1975; 30:633.
- American Psychological Association. Ethical principles of psychologists and code of conduct. *The American Psychologist*. 2002; 57(12):1060–1073. [PubMed: 12613157]
- American Psychological Association. Accreditation Operating Procedures of the Commission on Accreditation. 2009. Retrieved from <http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf>
- American Psychological Association. Guidelines for psychological practice with lesbian, gay, and bisexual clients. *The American Psychologist*. 2012; 67(1):10–42.10.1037/a0024659 [PubMed: 21875169]
- American Psychological Association. Guidelines and Principles for Accreditation of Programs in Professional Psychology. 2013. Retrieved from <http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf>
- Anderson E, McCormack M. Intersectionality, critical race theory, and American sporting oppression: Examining black and gay male athletes. *Journal of Homosexuality*. 2010; 57(8):949–967.10.1080/00918369.2010.503502 [PubMed: 20818524]
- Anton BS. Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives. *American Psychologist*. 2009; 64:372–453.10.1037/a0015932
- Anton BS. Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist*. 2010; 65:385–475.10.1037/a0019553
- Association of State and Provincial Psychology Boards. Examination for professional practice in psychology. Tyrone, GA: 2011.
- Berlan ED, Corliss HL, Field AE, Goodman E, Austin SB. Sexual orientation and bullying among adolescents in the growing up today study. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*. 2010; 46(4):366–371.10.1016/j.jadohealth.2009.10.015 [PubMed: 20307826]
- Bieschke, KJ.; Perez, RM.; DeBord, KA., editors. Handbook of counseling psychotherapy with gay, lesbian, bisexual, and transgender clients. 2nd. Washington, DC: American Psychological Association; 2007.
- Blosnich J, Lee JGL, Horn K. A systematic review of the aetiology of tobacco disparities for sexual minorities. *Tobacco Control*. 2013; 22(2):66–73.10.1136/tobaccocontrol-2011-050181 [PubMed: 22170335]
- Bogart LM, Elliott MN, Klein DJ, Tortolero SR, Mrug S, Peskin MF, et al. Schuster MA. Peer victimization in fifth grade and health in tenth grade. *Pediatrics*. 2014; 133(3):440–447.10.1542/peds.2013-3510 [PubMed: 24534401]
- Bouton RA, Gallaher PE, Garlinghouse PA, Leal T, Rosenstein LD, Young RK. Scales for measuring fear of AIDS and homophobia. *Journal of Personality Assessment*. 1987; 51(4):606–614.10.1207/s15327752jpa5104_13 [PubMed: 3681646]
- Bowleg L. When black + lesbian + woman = black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*. 2008; 59(5-6):312–325.10.1007/s11199-008-9400-z
- Bowleg L. Once you've blended the cake, you can't take the parts back to the main ingredients": Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles*. 2013; 68(11-12):754–767.10.1007/s11199-012-0152-4
- Bradford, J.; Mayer, K. The Fenway Guide to Lesbian, Gay, Bisexual, and TransgenderHealth. Philadelphia, PA: American College of Physicians; 2007. Demography and the LGBT population: What we know, don't know, and how the information helps to inform clinical practice.
- Burckell, LA.; Goldfried, MR. Psychotherapy. Vol. 43. Chicago, Ill: 2006. Therapist qualities preferred by sexual-minority individuals; p. 32-49.

- Caban, A. Development and initial validation of the Multicultural Competence Change Scale for psychology trainees (Doctoral dissertation). 2011. Retrieved from ProQuest Dissertations & Theses Global. (816348942)
- Carroll L, Gilroy PJ, Ryan J. Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development*. 2002; 80(2):131–139.10.1002/j.1556-6678.2002.tb00175.x
- Cass VC. Homosexual identity formation: A theoretical model. *Journal of Homosexuality*. 1979; 4(3): 219–235.10.1300/J082v04n03_01 [PubMed: 264126]
- Cass VC. Homosexual identity formation: Testing a theoretical model. *Journal of Sex Research*. 1984; 20(2):143–167.10.1080/00224498409551214
- Champaneria MC, Axtell S. Cultural competence training in us medical schools. *JAMA*. 2004; 291(17):2142–2142.10.1001/jama.291.17.2142 [PubMed: 15126447]
- Chandra, A.; Mosher, WD.; Copen, C.; Sionean, C. Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2008 National Survey of Family Growth. Hyattsville, MD: National Center for Health Statistics; 2011.
- Civic Impulse. S. 815 — 113th Congress: Employment Non-Discrimination Act of 2013. 2014. Retrieved from <https://www.govtrack.us/congress/bills/113/s815>
- CNN. Same-sex marriage in the United State. 2014 Oct. Retrieved from <http://www.cnn.com/interactive/us/map-same-sex-marriage/>
- Cole SW, Kemeny ME, Taylor SE, Visscher BR. Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*. 1996; 15(4):243–251.
- Copeland WE, Wolke D, Angold A, Costello EJ. Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry*. 2013; 70(4):419–426.10.1001/jamapsychiatry.2013.504 [PubMed: 23426798]
- Corliss HL, Cochran SD, Mays VM, Greenland S, Seeman TE. Age of minority sexual orientation development and risk of childhood maltreatment and suicide attempts in women. *The American Journal of Orthopsychiatry*. 2009; 79(4):511–521.10.1037/a0017163 [PubMed: 20099942]
- Cowell, A. Ugandan lawmakers pass measure imposing harsh penalties on gays. *The New York Times*. 2013 Dec 20. Retrieved from <http://www.nytimes.com/2013/12/21/world/africa/ugandan-parliament-approves-antigay-law.html>
- Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al. Xavier J. Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association*. 2000; 4(3):102–151.10.1023/A:1009573800168
- Degges-White S, Rice B, Myers JE. Revisiting Cass' theory of sexual identity formation: A study of lesbian development. *Journal of Mental Health Counseling*. 2000; 22:318–333.
- Dentato, M. The minority stress perspective. School of Social Work: Faculty Publications & Other Works. 2012. Retrieved from http://ecommons.luc.edu/socialwork_facpubs/2
- DeVore, W.; Schlesinger, EG. Ethnic-sensitive social work practice. 2nd. United States: Merrill Pub. Co; 1981.
- Drescher, J.; Cohen-Kettenis, P.; Winter, S. *International Review of Psychiatry*. Vol. 24. Abingdon, England: 2012. Minding the body: Situating gender identity diagnoses in the ICD-11; p. 568–577.
- Dunkle JH. Toward an integration of gay and lesbian identity development and Super's life-span approach. *Journal of Vocational Behavior*. 1996; 48(2):149–159.10.1006/jvbe.1996.0015
- Erlen JA, Riley TA, Sereika SM. Psychometric properties of the Index of Homophobia Scale in registered nurses. *Journal of Nursing Measurement*. 1999; 7(2):117–133. [PubMed: 10710857]
- Eubanks-Carter C, Burckell LA, Goldfried MR. Enhancing therapeutic effectiveness with lesbian, gay, and bisexual clients. *Clinical Psychology: Science and Practice*. 2005; 12(1):1–18.10.1093/clipsy.bpi001
- Garnets LD. Sexual orientations in perspective. *Cultural Diversity and Ethnic Minority Psychology*. 2002; 8(2):115–129.10.1037/1099-9809.8.2.115 [PubMed: 11987589]
- Godfrey K, Haddock SA, Fisher A, Lund L. Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy*. 2006; 32(4):491–504. [PubMed: 17120521]

- Goldberg, JM.; Lindenberg, D. Moving beyond trans sensitivity: Developing clinical competence in transgender care (The Trans Care Project): Project summary and analysis. 2006. Retrieved from: <http://transhealth.vch.ca/resources/library/tcpdocs/projectanalysis.pdf>
- Gonsiorek, J. Mental health and sexual orientation. In: Savin-Williams, R.; Cohen, editors. *Lives of lesbians, gays, and bisexuals: Children to adults*. Ft. Worth: Harcourt Brace College Publishers; 1996. p. 462-478.
- Gray, K. Religious freedom bill passes out of Michigan House. Detroit Free Press. 2014 Dec. retrieved 12/12/14: <http://www.freep.com/story/news/local/michigan/2014/12/04/michigan-religious-freedom-bill-moves-house/19889979/>
- Green KE, Feinstein BA. Substance use in lesbian, gay, and bisexual populations: An update on empirical research and implications for treatment. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors*. 2012; 26(2):265–278.10.1037/a0025424 [PubMed: 22061339]
- Grove J. How competent are trainee and newly qualified counsellors to work with Lesbian, Gay, and Bisexual clients and what do they perceive as their most effective learning experiences? *Counselling and Psychotherapy Research*. 2009; 9(2):78–85.10.1080/14733140802490622
- Hanna, J. Kansas senate judiciary chairman says anti-gay bill is dead in legislature - KansasCity.com. The Kansas City Star. 2014. Retrieved from <http://www.kansascity.com/2014/02/18/4833004/kansas-senate-judiciary-chairman.html>
- Harris, G. India's supreme court restores an 1861 law banning gay sex. The New York Times. 2013 Dec 11. Retrieved from <http://www.nytimes.com/2013/12/12/world/asia/court-restores-indias-ban-on-gay-sex.html>
- Hatzenbuehler ML. How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin*. 2009; 135(5):707–730.10.1037/a0016441 [PubMed: 19702379]
- Hatzenbuehler ML, O'Cleirigh C, Grasso C, Mayer K, Safren S, Bradford J. Effect of same-sex marriage laws on health care use and expenditures in sexual minority men: A quasi-natural experiment. *American Journal of Public Health*. 2012; 102(2):285–291.10.2105/AJPH.2011.300382 [PubMed: 22390442]
- Hays, PA. Addressing cultural complexities in practice: A framework for clinicians and counselors. Vol. vii. Washington, DC, US: American Psychological Association; 2001.
- Herszenhorn, D. The New York Times. 2013 Aug. Gays in Russia find no haven, despite support from the West; p. A1
- HUD. Equal access to housing in HUD programs regardless of sexual orientation or gender identity. 2012. Retrieved from <http://portal.hud.gov/hudportal/documents/huddoc?id=12lgbtfinalrule.pdf>
- Hudson WW, Ricketts WA. A strategy for the measurement of homophobia. *Journal of Homosexuality*. 1980; 5(4):357–372.10.1300/J082v05n04_02 [PubMed: 7204951]
- Israel T, Gorcheva R, Burnes TR, Walther WA. Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*. 2008; 18(3): 294–305.10.1080/10503300701506920 [PubMed: 18815981]
- Israel T, Ketz K, Detrie PM, Burke MC, Shulman JL. Identifying counselor competencies for working with lesbian, gay, and bisexual clients. *Journal of Gay & Lesbian Psychotherapy*. 2003; 7(4):3–21.10.1300/J236v07n04_02
- Israel T, Selvidge MMD. Contributions of multicultural counseling to counselor competence with lesbian, gay, and bisexual clients. *Journal of Multicultural Counseling and Development*. 2003; 31(2):84–98.10.1002/j.2161-1912.2003.tb00535.x
- Juster RP, Smith NG, Ouellet É, Sindi S, Lupien SJ. Sexual orientation and disclosure in relation to psychiatric symptoms, diurnal cortisol, and allostatic load. *Psychosomatic Medicine*. 2013; 75(2): 103–116.10.1097/PSY.0b013e3182826881 [PubMed: 23362500]
- Kansas State Protecting Religious Freedom Regarding Marriage Act. Vol. 2453. KS Assemb. B: 2014.
- Katz-Wise SL, Hyde JS. Victimization experiences of lesbian, gay, and bisexual individuals: A meta-analysis. *Journal of Sex Research*. 2012; 49(2-3):142–167.10.1080/00224499.2011.637247 [PubMed: 22380586]

- Kazarian, S.; Evans, D. Cultural clinical psychology: Theory, research and practice. New York: Oxford University Press; 1998.
- Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*. 1978; 88(2):251–258. [PubMed: 626456]
- Lamda Legal. Transgender people and marriage laws. 2014. Retrieved from http://www.lamdalegal.org/sites/default/files/publications/downloads/trt_transgender_marriage-laws.pdf
- Lehavot K, Simoni JM. The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology*. 2011; 79(2):159–170.10.1037/a0022839 [PubMed: 21341888]
- Lenderking WR, Wold C, Mayer KH, Goldstein R, Losina E, Seage GR 3rd. Childhood sexual abuse among homosexual men. Prevalence and association with unsafe sex. *Journal of General Internal Medicine*. 1997; 12(4):250–253. [PubMed: 9127231]
- Lyons HZ, Bieschke KJ, Dendy AK, Worthington RL, Georgemiller R. Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research and Practice*. 2010; 41(5):424–434.10.1037/a0021121
- Marshal MP, Friedman MS, Stall R, King KM, Miles J, Gold MA, et al. Morse JQ. Sexual orientation and adolescent substance use: A meta-analysis and methodological review*. *Addiction*. 2008; 103(4):546–556.10.1111/j.1360-0443.2008.02149.x [PubMed: 18339100]
- Martell, CR.; Safren, SA.; Prince, SE. Cognitive-behavioral therapies with lesbian, gay, and bisexual clients. Guilford Press; 2004.
- Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health*. 2008; 98(6):989–995.10.2105/AJPH.2007.127811 [PubMed: 18445789]
- McCabe, SE.; Hughes, TL.; Bostwick, WB.; West, BT.; Boyd, CJ. *Addiction*. Vol. 104. Abingdon, England: 2009. Sexual orientation, substance use behaviors and substance dependence in the United States; p. 1333-1345.
- Meyer, I.; Dean, L. Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek, G., editor. *Psychological perspectives on lesbian and gay issues*. Thousand Oaks, CA: Sage; 1998. p. 160-186.
- Meyer IH. Minority stress and mental health in gay men. *Journal of Health and Social Behavior*. 1995; 36(1):38–56. [PubMed: 7738327]
- Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*. 2003; 129(5):674–697.10.1037/0033-2909.129.5.674 [PubMed: 12956539]
- Meyer, I.; Northridge. *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*. New York: Springer; 2007.
- Mimiaga MJ, Noonan E, Donnell D, Safren SA, Koenen KC, Gortmaker S, et al. Mayer KH. Childhood sexual abuse is highly associated with HIV risk-taking behavior and infection among MSM in the EXPLORE Study. *Journal of Acquired Immune Deficiency Syndromes* (1999). 2009; 51(3):340–348.10.1097/QAI.0b013e3181a24b38 [PubMed: 19367173]
- Mobley M, Slaney RB. Holland's theory: Its relevance for lesbian women and gay men. *Journal of Vocational Behavior*. 1996; 48(2):125–135.10.1006/jvbe.1996.0013
- Mosher, W.; Chandra, A.; Jones, J. *Advance Data from Vital and Health Statistics*. Hyattsville, MD: National Center for Health Statistics; 2004. Sexual behavior and selected health measures: Men and women 15–44 years of age.
- Murphy JA, Rawlings EI, Howe SR. A survey of clinical psychologists on treating lesbian, gay, and bisexual clients. *Professional Psychology: Research and Practice*. 2002; 33(2):183–189.10.1037/0735-7028.33.2.183
- Pachankis JE, Goldfried MR. Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity*. 2013; 1(S):45–58.10.1037/2329-0382.1.S.45
- Pachankis J, Goldfried M. Clinical issues in working with lesbian, gay, and bisexual clients. *Psychotherapy: Theory, Research, Practice, Training*. 2004; 41:227–246.

- Paulson, M.; Santos, F. The New York Times. 2014 Feb. Religious right cheers a bill allowing refusal to serve gays; p. A1
- Psychological Clinical Science Accreditation System. 2014 Dec 11. Retrieved from <http://www.pcsas.org/>
- Price EG, Beach MC, Gary TL, Robinson KA, Gozu A, Palacio A, et al. Cooper LA. A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine: Journal of the Association of American Medical Colleges*. 2005; 80(6):578–586. [PubMed: 15917363]
- Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*. 1983; 51(3):390–395. [PubMed: 6863699]
- Rahman M. Queer as intersectionality: Theorizing gay Muslim identities. *Sociology*. 2010; 44(5):944–961.10.1177/0038038510375733
- Ridley CR. Imperatives for ethnic and cultural relevance in psychology training programs. *Professional Psychology: Research and Practice*. 1985; 16(5):611–622.10.1037/0735-7028.16.5.611
- Ritter, K.; Terndrup, AI. *Handbook of affirmative psychotherapy with lesbians and gay men*. Guilford Press; 2002.
- Rosario M, Schrimshaw EW, Hunter J. Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors*. 2009; 23(1):175–184.10.1037/a0014284 [PubMed: 19290704]
- Rostosky SS, Riggle EDB, Horne SG, Miller AD. Marriage amendments and psychological distress in lesbian, gay, and bisexual (LGB) adults. *Journal of Counseling Psychology*. 2009; 56:56–66.10.1111/j.1939-0025.2010.01033.x
- Rutter PA, Estrada D, Ferguson LK, Diggs GA. Sexual orientation and counselor competency: The impact of training on enhancing awareness, knowledge and skills. *Journal of LGBT Issues in Counseling*. 2008; 2(2):109–125.10.1080/15538600802125472
- Safren SA, Hollander G, Hart TA, Heimberg RG. Cognitive-behavioral therapy with lesbian, gay, and bisexual youth. *Cognitive and Behavioral Practice*. 2001; 8(3):215–223.10.1016/S1077-7229(01)80056-0
- Safren SA, Rogers T. Cognitive-behavioral therapy with gay, lesbian, and bisexual clients. *Journal of Clinical Psychology*. 2001; 57(5):629–643. [PubMed: 11304703]
- Santos F. Arizona vetoes right to refuse service to gays. The New York Times. 2014:A1.
- Savin-Williams RC, Rieger G, Rosenthal AM. Physiological evidence for a mostly heterosexual orientation among men. *Archives of Sexual Behavior*. 2013; 42(5):697–699.10.1007/s10508-013-0093-1 [PubMed: 23479358]
- Shipherd JC, Maguen S, Skidmore WC, Abramovitz SM. Potentially traumatic events in a transgender sample: Frequency and associated symptoms. *Traumatology*. 2011; 17:56–67.
- Schrimshaw EW, Siegel K, Downing MJ, Parsons JT. Disclosure and concealment of sexual orientation and the mental health of non-gay-identified, behaviorally bisexual men. *Journal of Consulting and Clinical Psychology*. 2013; 81(1):141–153.10.1037/a0031272 [PubMed: 23276123]
- Shidlo, A. Internalized homophobia: Conceptual and empirical issues in measurement. In: Green, B.; Herek, G., editors. *Psychological perspectives on lesbian and gay issues*. Thousand Oaks, CA: Sage; 1994. p. 176-205.
- Stern, M. Idaho's new anti-gay bill: Doctors and teachers can turn away gays. *Slate Magazine*. 2014 Feb. Retrieved from http://www.slate.com/blogs/outward/2014/02/19/idaho_anti_gay_segregation_discrimination_against_gays_will_be_legal.html
- Sue DW, E J, Durran A, Feinberg L, Pedersen P, J E, Vasquez-Nuttall E. Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*. 1982; 10(2):45–52.10.1177/0011000082102008
- Sue S. In search of cultural competence in psychotherapy and counseling. *The American Psychologist*. 1998; 53(4):440–448. [PubMed: 9572007]

- Sue S. Science, ethnicity, and bias: Where have we gone wrong? *The American Psychologist*. 1999; 54(12):1070–1077. [PubMed: 15332528]
- Sue S, Zane N, Nagayama Hall GC, Berger LK. The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*. 2009; 60:525–548.10.1146/annurev.psych.60.110707.163651
- Tang A, Yu Z, Gui Y, Zhu H, Long Y, Cai Z. Identification of a novel testis-specific gene in mice and its potential roles in spermatogenesis. *Croatian Medical Journal*. 2007; 48(1):43–50. [PubMed: 17309138]
- Ullerstam, L. *The erotic minorities: A Swedish view*. New York, NY: Grove Press; 1966.
- United States Equal Employment Opportunity Commission. *Annual Report on the Federal Work Force Part 1*. 2012
- U.S. Census Bureau. *State & county Quickfacts*. 2013. Retrieved from <http://quickfacts.census.gov/qfd/index.html>
- Wolitski, RJ.; Stall, R.; Valdiserri, RO. *Unequal opportunity: Health disparities affecting gay and bisexual men in the United States*. Oxford University Press; 2008.
- Woodford MR, Krentzman AR, Gattis MN. Alcohol and drug use among sexual minority college students and their heterosexual counterparts: The effects of experiencing and witnessing incivility and hostility on campus. *Substance Abuse and Rehabilitation*. 2012; 3:11–23.10.2147/SAR.S26347 [PubMed: 24474863]
- World Health Organization. *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization; 1992.