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Extending Training in Multicultural Competencies to Include Individuals Identifying as Lesbian, Gay, and Bisexual: Key Choice Points for Clinical Psychology Training Programs

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Abstract

Traditional models of multicultural training for professional psychology have focused primarily on racial and ethnic minorities and have not included competencies focused on individuals identifying as lesbian, gay, and bisexual (LGB), despite documented evidence of health disparities for sexual minorities. Ways to adapt models based on Sue's (1992) 3 × 3 competencies (attitudes and beliefs, knowledge, and skills across the dimensions of awareness of one's own cultural influences and biases, understanding the client perspective, and appropriate interventions for an individual client) for LGB health are described. This includes the addition of an action/advocacy dimension. Six key choice points for clinical psychology training programs adding LGB competency to a multicultural competency training component are outlined. Potential challenges and solutions for expanding multicultural training are discussed.

Keywords: lesbian health, gay health, bisexual health, minority health disparities, multicultural competency, training models

Multiculturalism has become increasingly important in the field of clinical psychology as the changing social makeup of the United States has brought multicultural issues to the forefront. Such issues include employment and housing discrimination, minority health disparities, and general social inequality for minority group members. Psychological research in this area has primarily focused on identifying cultural factors that impact mental health and examining the effectiveness of mainstream psychological treatments for various ethnic groups (e.g., Lee & Ahn, 2012; Nadimpalli & Hutchinson, 2012). Building on the knowledge from this literature, some researchers have proposed models for incorporating multicultural training into graduate psychology programs (Newell et al., 2010; Sue, 1997). For the most part, however, multiculturalism remained a marginalized topic within psychological research until the early 2000s, when the American Psychological Association issued its "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2003). This document presented a professional and ethical standard for competence in working with different ethnic groups across all domains of psychology. It represented an institutional change wherein multicultural competence was no longer considered optional or specialized but rather an expectation for all psychologists. While there is certainly still room for improvement, it is fair to say that substantial progress has been made due to changes at the institutional and individual levels, and in both practice and research (Bluestone, Stoke, & Kuba, 1996; Jones, Sander, & Booker, 2013).

Recently, sexual minority research has begun to proliferate following the lead of the changing social climate, which has brought the issue of inequality for sexual minorities to the forefront. As discussed elsewhere in this issue, the Institute of Medicine Report (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, & Transgender Health Issues and Research Gaps and Opportunities, 2011) and Report from the Joint Commission (The Joint Commission, 2011) both identified health disparities for sexual minorities and made recommendations for reducing the disparities. These recommendations include the need for increased competency among health professionals in meeting the needs individuals who identify as lesbian, gay, and bisexual. In 2012, APA released "Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients." As the title suggests, the guidelines established standards for clinical practice involving sexual minorities, including a brief section emphasizing the need for improved graduate training in this area. Unfortunately, little investigation has been done to determine what constitutes sufficient training. Some contributions have been made on this topic (e.g., Biaggio, Orchard, Larson, Petrino, & Mihara, 2003; Newell et al., 2010), but there is no standard training model at this time. The goal of the present article is to incorporate the available sexual minority literature into the broader diversity literature to identify key choice points so that graduate programs can incorporate competency with sexual minorities into multicultural training.

Definitions and Identification of Sexual Minorities

Multicultural competence is defined as "going beyond the mere possession of multicultural sensitivity to also attain an acceptable level of knowledge, a sufficient shift in attitude, and the production of a repertoire of behaviors consistent with successfully interacting with

diverse populations in multicultural settings" (Wallace, 2000, p. 1101). This definition distinguishes between passive tolerance of a client's minority status and an active effort to meet the needs of a client based on individual differences. It is an important first step in achieving multicultural competence to be able to speak openly and comfortably about relevant topics. This includes using the currently accepted terminology, which can be difficult because the connotations of words change over time, and previously acceptable terms can become disrespectful. Generally, the key to keeping up with this "euphemism treadmill" is to maintain a channel of communication that allows for agreement and adjustment of terminology.

For the purposes of this article, the term *sexual minorities* will be used to refer to individuals who identify themselves as gay, lesbian, or bisexual. Thus, it will be used interchangeably with *LGB individuals*. *Sexual minorities* often includes individuals who identify as transgender or gender dysphoric, but the term is narrowed here for two interrelated reasons. First, the bulk of the extant literature on sexual minority treatment and clinical training deals only with lesbian, gay, and bisexual (LGB) individuals and may not be applicable for those who identify outside of a binary definition of gender. Second, any attempt to address the experiences of individuals who identify as transgender should take into consideration the unique concerns related to gender diversity, and the scope of this article does not allow for such an endeavor. It should also be noted that while sexual minorities are grouped under the umbrella term "LGB," it cannot be assumed that gay men, lesbians, and bisexual individuals share the same experiences (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, & Transgender Health Issues & Research Gaps & Opportunities, 2011). Even within one subgroup (i.e., gay men), there is a vast array of experiences that intersect with other aspects of each individual's identity. Thus, all statements made about sexual minorities pertain to trends in the group as a whole but may not apply to all members of a sexual minority group.

The most recent US Census indicated that at least 9 million Americans identify as lesbian, gay, or bisexual (US Census Bureau, 2000), but this figure does not encompass a subgroup of individuals who may identify themselves as nonheterosexual using other labels or in specific contexts. Other population estimates indicate about 3–5% of the US population identifies as gay, lesbian, or bisexual with as many as 11% (over 25 million people) reporting at least some same-sex attraction (Gates, 2011). As with other minority groups, LGB individuals are overrepresented in the population of people diagnosed with a psychiatric disorder. According to the National Epidemiological Study of Alcohol and Related Conditions (Grant et al., 2005), the 12-month prevalence of a psychiatric disorder in the LGB population is 56.3% compared with 34.6% among heterosexuals. One study also suggested that gay men are four times as likely to attempt suicide as their heterosexual counterparts, while lesbian women are twice as likely as heterosexual women (King et al., 2008). This may be due to *minority stress*, or the idea that stigma, discrimination, and prejudice create a stressful environment for minority group members, increasing the likelihood that they will experience mental health problems (Meyer, 2003).

Lesbian, gay, and bisexual individuals are also more likely to seek mental health services compared with heterosexual individuals (Cochran, Sullivan, & Mays, 2003), and mental health providers frequently report having LGB clients (e.g., Murphy, Rawlings, &

Howe, 2002). However, it appears that satisfaction with these services is lower among sexual minorities, reportedly due to homophobia, heterosexist bias, and lack of understanding about sexual minorities' experiences (Palma & Stanley, 2002). Although treatment satisfaction does increase when LGB clients perceive their therapists as more competent and sensitive to LGB concerns (Burckell & Goldfried, 2006), many LGB individuals have found their mental health providers to be lacking in multicultural competence.

Treatment providers appear to agree with that assessment of their abilities. There have been a number of studies highlighting clinicians' doubts about their own competency with sexual minority clients. For example, Eliason and Hughes (2004) found that counselors working in hospitals in both rural and urban areas report deficits in their training and competency regarding sexual minority issues. Between 35% and 50% of participants (depending on location and educational background) lacked knowledge of topics such as internalized homophobia and the coming out process. Between 10% and 20% agreed that their sexual minority clients were less likely to benefit from treatment compared with their heterosexual counterparts. A similar study involving VA psychologists found extensive deficits in training, with over half of participants reporting that they had received less than one class period of training about sexual orientation issues (Johnson & Federman, 2014). This study also found that older VA psychologists rated themselves as less competent compared with younger psychologists in working with sexual minority clients. However, a study involving counseling psychology graduate students found that even current and recent students perceive themselves to be in the low to moderate range for competence in working with LGB clients (Graham, Carney, & Kluck, 2012). This begs the question of how well graduate programs are currently training aspiring psychologists on these issues. According to a study conducted by Sherry, Whilde, and Patton (2005), which evaluated 104 counseling and clinical psychology doctoral programs, the answer is not encouraging. Less than a quarter of these programs reported that they incorporate LGB issues into courses other than those dedicated specifically to diversity or sexuality, or into general competency evaluations throughout training. Biaggio et al. (2003) pointed out that only 27% of clinical psychology graduate programs include LGB faculty while 53% include LGB graduate students. This indicates that approximately half of LGB graduate students do not have LGB faculty members to look to as role models. These figures may have changed somewhat over the last decade, but more recent statistics were not available. However, the extremely limited literature on training on multicultural competencies with sexual minorities suggests that insufficient training continues to be a serious shortcoming in clinical psychology.

Grounding LGB Health Competencies in a Traditional Multicultural Model

The development of training models for competencies related to racial and ethnic diversity gained momentum at least 20 years prior to similar developments for LGB training. Thus, before we review LGB-specific training models, it may be helpful to look to the broader diversity training literature as a starting point.

The developmental progression of racial/ethnic diversity training models began with broad recommendations and calls to the profession (e.g., Sue, Arredondo, & McDavis, 1992). Theory and research then began to refine these ideas by attempting to determine the

best interventions for diverse populations and, subsequently, the best strategies for training. Several different approaches were proposed and advocated. Among these was the *culturally encapsulated* philosophy, which argued that knowledge based on Western research is applicable regardless of cultural or ethnic background and that modifying treatment or training on this basis is unnecessary and may even encourage stereotyping (Patterson, Cameron, & Lalonde, 1996). This approach is problematic because a great deal of valuable information is lost if an individual's unique experiences and personal history are discounted. Despite this obvious drawback, the culturally encapsulated philosophy is the current *de facto* approach given the limited availability of treatments supported by experimental studies involving diverse samples.

Somewhat similar to this perspective is the *etic approach*, which involves identifying universal human experiences and focusing on them in treatment (Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994; Speight, Myers, Cox, & Highlen, 1991). This approach recognizes that cultural differences exist and that they impact psychological functioning, but it attempts to work around this by focusing on common factors across all people. Unfortunately, these universal factors are often so broad that they are not useful and nearly impossible to measure. A third and very different model, the *emic approach*, involves incorporating culture-specific goals based on values and worldviews that are distinct from Western ones (Lee & Bailey, 1997; Sadowsky & Taffe, 1991). This means that a unique approach to treatment (and clinical training) is needed for every ethnic group. Some studies have supported the adaptation of evidence-based treatments for other cultures (e.g., McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Murray et al., 2013). However, there are no data supporting the notion that culture-specific treatments are always better. Even if there were, the amount of research required to support every type of treatment for every cultural group renders this approach impractical.

Although this debate continues at some level, the current consensus is that cultural characteristics should be taken into consideration as part of an integrated case conceptualization. This position was officially adopted by the APA in its Multicultural Guidelines (APA, 2003). It is also consistent with the 2006 APA Presidential Task Force report on evidence-based practice in psychology, which encouraged clinical psychology training programs to incorporate individual and cultural characteristics with the best available research and clinical expertise (APA Presidential Task Force on Evidence-Based Practice, 2006).

In addition to conceptual approaches to treatment and training for diverse populations, pedagogical considerations have also been widely debated. Sue (1997) was among the first to definitively assert that diversity training must be integrated throughout graduate programs. The authors argue that relying on a single diversity course not only provides insufficient training, but it also reinforces the general attitude that there is a "regular" and an "other" type of clinical work. The integrated approach has since become standard at least in theory, though with variable success. The guidelines for the accreditation of doctoral programs in professional psychology (APA, 2013) require only that training in individual and cultural diversity be covered across the substantive areas addressed in the curriculum. Functionally, many programs meet this requirement, in part, with a single course in multicultural psychology.

Sue et al. (1992) outlined the content and structure for their multicultural training model. First, areas of competency are broken down into *beliefs/attitudes, knowledge, and skills*. Beliefs and attitudes refer to a clinician's awareness of cultural differences and of the impact of their own culture on the way they view others. Knowledge refers to an understanding of norms, practices, and values of specific cultural and ethnic groups. Skills refer to an active effort by clinicians to enrich their multicultural attitudes and knowledge through education and consultation, as well as an ability to interact comfortably and effectively with members of other cultural and ethnic groups. Sue et al. (1992) further stated that these three competency areas each apply to the following clinician characteristics: (a) awareness of one's own cultural influences and biases, (b) understanding the perspective of clients from various cultural backgrounds, and (c) developing appropriate intervention strategies for an individual client based on the three competency areas.

In the context of school psychology, Newell et al. (2010) built on the previous model by proposing a detailed, sequential model for diversity training throughout a graduate program. Competencies are described in terms of specific attitudes, knowledge, and skills, as well as underlying conceptual meanings. Competencies are also broken down by student, faculty, and institution-level interventions. For example, Newell et al. (2010) would describe a student's personal cultural bias as an example of an attitude at the student level and a university health center's professional relationship with a local minority group as an institution-level skill. The benefit of such a delineated training model is that it is possible to identify areas of strength and weakness and to target them accordingly. To its further credit, the model proposed by Newell et al. (2010) adheres to an evidence-based approach, citing support from the literature for each training component. Unfortunately, the dearth of research in this area provides only scant evidence for each topic. More research with diverse populations is needed in order to strengthen the foundation for a multicultural competency training model. Further, this model mainly refers to training with regard to racial and ethnic diversity. An evidence-based model for LGB competency training would require an even greater research effort given the current paucity of sexual minority literature.

Still, much can be learned from the progress made in racial/ethnic diversity training models when considering the task at hand. In many ways, sexual minority competency training should overlap with the multicultural training, which has already been established. Issues such as prejudice, discrimination, sociopolitical developments, and the marginalization and rejection of minorities by mainstream society bind the groups together. Alderson (2004) drew on the model proposed by Sue et al. (1992) to show that such a model would be appropriate for sexual minority competency training. Alderson proposed a single-course curriculum, which attempts to cover all nine competencies from Sue et al. (1992) and to incorporate LGB-specific issues, such as coming out and advocacy. This is a good example of how the most prominent model of diversity training can be combined with an understanding of LGB issues to produce an effective sexual minority training model.

Choice Points in Incorporating LGB Health into Multicultural Training

Some excellent multicultural training models that build on Sue's original work can be found in the literature for professional psychology including school psychology (e.g., Newell et al.,

2010) and counseling psychology (e.g., Alderson, 2004; Rutter, Estrada, Ferguson, & Diggs, 2008). Given that APA accreditation guidelines require each program to develop their own approach to multicultural training within the context of the program's training model (APA, 2013), each program will have to engage in self-assessment of the current and aspired multicultural competence. Drawing on these models as well as Sue's original work, we will highlight some key choice points in multicultural training for clinical psychologists that are particularly relevant for competencies when working with sexual minorities.

Choice Point #1: Identifying Core Competencies

The traditional three competencies identified by Sue (1991) are *beliefs and attitudes*, *knowledge*, and *skills*. To this list, Jones et al. (2013), among others, have argued that *advocacy and action* should be added as a fourth core competency. Application of each of these core competencies for working with sexual minorities will be described, including the importance of advocacy and action for this population.

Addressing beliefs and attitudes includes a self-reflective process to identify explicit and implicit attitudes about individuals who are perceived to be different from trainees that may impact culturally competent services. Such self-awareness includes understanding one's own values and beliefs as well as becoming aware of cultural and institutional norms that confer privilege to some groups and oppress others. An opportunity to engage in this self-reflective process is important for working with sexual minorities for all students, including those who identify as gay, lesbian, or bisexual themselves. The pervasiveness of negative messages about LGB individuals in American culture is well established (Herek, 2009b), and these messages are internalized even by sexual minorities (Herek, Gillis, & Cogan, 2009). Studies utilizing implicit assessment of attitudes (e.g., Banse, Seise, & Zerbes, 2001) make it clear that even individuals who espouse egalitarian models often have been influenced by the heterocentric culture that considers heterosexuality the norm.

Identifying and changing attitudes and beliefs may be outside the experience of many faculty and students in clinical psychology training programs. The self-reflection and affect-laden discussions of risky topics such as cultural norms, gender, religion, and sexual orientation may sometimes occur in practicum classes or clinical supervision but are rarely the norm in a typical course on assessment or behavioral interventions. Such discussions require both the instructor and students to trust each other and be open to hearing information that makes them uncomfortable and challenges long-held beliefs. One key element is the instructor's skill in creating a classroom climate that facilitates these exchanges. The instructor will need to be nondefensive and nonjudgmental, modeling an openness to the various viewpoints and experiences of others. Rather than the typical role of being the expert, the successful instructor will take a collaborative approach to sharing his or her own expertise and knowledge. Jones et al. (2013) identified a number of strategies to facilitate teaching about attitudes and beliefs including self-assessment questionnaires, literature and films, journaling, implicit association tests, and some interactive activities. Formal and informal interactions with the local LGB community can be invaluable as well. Having a class that includes individuals from various cultural groups and LGB students allows them to bring in their "lived experience," which can facilitate this process—as long as the students feel safe and are not expected to speak as the representative of a particular group.

Students may have a variety of reactions in a multicultural course that focuses on attitudes and beliefs about sexual minorities. Heterosexual students may be distressed as they become aware of the extent to which they have benefited from heterosexual privilege that comes from laws, cultural norms, and some religions that privilege heterosexuality. LGB students may be gratified to have their experiences validated but also may be angry or distressed as sexual prejudice is expressed by their peers or as their internalized homonegativity becomes more apparent. Students with certain religious backgrounds may struggle to reconcile those beliefs with their preparation for working with sexual minorities in a professional capacity.

The second core competency, knowledge, refers to having an accurate understanding of important aspects of other cultural groups including history, sociopolitical context, and the relevant empirical and clinical literature in psychology. For individuals who identify as lesbian, gay, or bisexual, this includes a history of discrimination and devaluation that is rarely taught in public school history classes and a rapidly changing cultural and legal context across the globe. The local context is important as LGB individuals may have vastly different experiences depending on local laws and the extent of a local LGB community. Strong connections between the program and the local LGB community can facilitate knowledge about current concerns and events. Regularly following news sources such as the *Huffington Post* (huffingtonpost.com) can provide up to date information about the global climate for sexual minorities that may not appear in traditional news sources. Teaching the knowledge component should also recognize the heterogeneity of the LGB community as well. Gay men, lesbians, bisexual men, and bisexual women have different experiences and differences stressors, even within the context of shared experiences. For example, gay men are most likely to be the victims of hate crimes (Herek, 2009a). Bisexuals tend to be less accepted by and involved with the lesbian and gay community (Herek, Norton, Allen, & Sims, 2010). LGB identity also intersects with other identities such as race/ethnicity or socioeconomic status (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, & Transgender Health Issues & Research Gaps & Opportunities, 2011).

The third core competency, skills, refers to the ability to practice assessment, treatment, consultation, and supervision in a culturally sensitive manner. It is the application of the beliefs/attitudes and knowledge competencies into professional practice. For clinicians working with sexual minorities, this could range from basic skills such as creating a therapeutic environment where a client can disclose their sexual orientation to incorporating a client's level of disclosure about their sexual orientation into the case formulation and treatment plan. Numerous resources are available that outline the skills needed for working with LGB clients (e.g., Balsam, Martell, & Safren, 2006; Martell, Safren, & Prince, 2003). Training programs may find that the Joint Commission "Field Guide" (The Joint Commission, 2011) provides useful practical information as well.

Although not originally included by Sue (1991), the fourth core competency of advocacy and action is especially important for cultural competency with individuals who identify as LGB. Advocacy and action starts with recognizing that one's efforts to practice in a multiculturally competent manner may be embedded within a system and context that is less than supportive of those goals (e.g., Jones et al., 2013). Full multicultural competence means that sometimes one has to advocate on behalf of clients or take action to change a

system that is biased against them. Certainly such advocacy and action may be needed for all cultural groups, and the more recent emergence of the LGB community as needing culturally sensitive services, the lack of such training (e.g., Alderson, 2004), and the changing sociopolitical climate means that new trainees may be at the forefront of multicultural competence in many of the settings in which they find themselves. Advocacy and action need not refer to political activity, although it may include that. Jones et al. (2013) argued that advocacy is the action that follows from putting one's awareness, knowledge, and skills into practice. In the context of LGB multicultural competency, advocacy means speaking up or taking action to counter heterocentrism. At an institutional level, it might involve asking that an agency change their intake paperwork to recognize all possible relationship statuses or developing and sharing a listing of community resources that are friendly to sexual minorities. At an individual level, advocacy might mean sharing empirical knowledge about the coming out process with a treatment team during a treatment planning meeting for a gay youth.

Choice Point #2: Choosing Integration versus Separate Course Model of Multicultural Training

Newell et al. (2010) argue that both a separate course and integration of multicultural training across the curriculum are essential to meet students' needs for multicultural training. A separate course is most useful for addressing the first two components of multicultural competency—beliefs and attitudes and knowledge. The challenges described above for changing beliefs and attitudes are best done within a carefully designed course with an atmosphere of trust to allow students to develop self-awareness (Jones et al., 2013). Knowledge about LGB psychology, history, and sociopolitical context can also be transmitted within a course focused on multiculturalism. This knowledge, like any other body of knowledge being taught in a clinical psychology training program, can be delivered in a traditional format. A well-designed course will include strategies to continue lifelong learning, as is needed on many other topics in clinical psychology training program. One difference for LGB multicultural competency, however, is the content for the knowledge competency is evolving daily. Changing laws and social policies mean that course content will need to be constantly updated. These changes also mean that research literatures on psychology of sexual orientation can become quickly outdated as the levels of discrimination and stigma, and available support change. Studies of the coming out process for adolescents that are as recent as 5 years old may be an inaccurate reflection of the experience of today's sexual minority youth. Also, many issues related to the climate for LGB individuals are local, meaning that course content must reflect the relevant laws, policies, and social culture of the local LGB community. For example, a culturally competent clinician must know what, if any, legal protections are in place to prevent discrimination on the basis of sexual orientation in employment or housing before providing services for someone who is in the process of coming out as lesbian, gay, or bisexual. The quality of the broadest knowledge content will more likely be up to date if a smaller number of faculty members are required to keep it current. Also, if the content is confined to a single course, it is easier to keep track of what has been taught rather than fracturing it across multiple courses.

In contrast to the first two dimensions of competency, skills and advocacy/action may be best taught when integrated across the curriculum. Once students have the self-awareness and knowledge, then they can be prepared to apply it across the range of professional activities including assessment, intervention, and consultation. A strong multicultural curriculum means that any skill being taught is done so with an awareness of the cultural context, including the context for LGB individuals. The nature of the multicultural skill will be dependent on the context. Assessment training should include an awareness of which measures may be heterocentric and what adaptations, if any, are appropriate (e.g., Weiss, Hope, & Capozzoli, 2013). Courses on psychopathology should incorporate models specific to LGB health (e.g., Pachankis & Bernstein, 2012). Teaching clinical skills should include guidance on discussing sexual orientation and sexual minority issues with clients so that LGB clients are not required to serve as teachers to their therapists (Martell et al., 2003). Practice for clinical skills, such as role plays or observation of sessions, should reflect the multicultural context as well. For example, when using role plays to practice skills in a behavior therapy fundamentals course, the first author requires students to enact half of the roles reflecting a cultural minority group (including sexual minorities) based on material presented earlier in the class.

As students move into new roles conducting assessment, intervention, or consultation, the next step of advocacy/action would follow. This last step may most naturally occur in the context of practicum training, especially if practica are conducted at external agencies that are not controlled by the training program. However, it could also occur within non-clinical roles in a training program such as teaching and research. Examples would include a teaching assistant or instructor who advocated to add the experiences of LGB individuals into a curriculum from which they were absent or consulting with a colleague about reducing heterosexism in a questionnaire being used in research.

Students' ability to take on the advocacy role likely requires a foundation that started in the classroom—especially in a core multicultural class that addresses the first two components (attitudes and beliefs and knowledge), and when the multicultural skills are taught. As students become aware of their own attitudes and beliefs and those of others, the impact of those attitudes and beliefs on others can easily be part of the conversation. As students come to understand how policies and practices disadvantage sexual minorities, potential remedial actions can be identified as well. For example, an advanced student who advocated for a gay youth being bullied at an inpatient unit that served as a practicum site could come to the class and describe that experience. As students gain knowledge about sexual minorities, they could also practice sharing that knowledge with others. For example, individuals or small groups could prepare classroom presentations on specific topics such as research on the “coming out” experience for adolescents or which local schools have gay-straight alliance clubs that can be a referral resource. Training programs that chose advocacy as one of the components of competency can lay the foundation for students by explicitly identifying it as a goal, communicating the goal to all instructors and supervisors across settings, and making a point to highlight examples when it occurs. As faculty members engage in advocacy themselves, they can serve as role models, demonstrating that it is a valued and expected competency.

Choice Point #3: Taking Action to Recruit and Retain Sexual Minority Faculty and Students

As across all types of diversity, inclusion of faculty and students who identify as lesbian, gay, or bisexual is a key component of a program that has strong multicultural training (e.g., Biaggio et al., 2003; Newell et al., 2010). The greater the diversity among the faculty, the more likely students from underrepresented groups will be attracted to a program. No data are available on whether gay, lesbian, and bisexual individuals are underrepresented among psychology faculty or graduate students. However, the success of sexual minority students and faculty may depend, in part, on the recognition by the institution and program that they may experience minority stress (Meyer, 2003) on top of the usual professional stressors, making a welcoming and affirming climate essential to their ability to thrive in the face of that stress. Concealment of one's identity has psychological costs (e.g., Meidlinger & Hope, 2013; Pachankis & Goldfried, 2013; Tetreault, Fette, Meidlinger, & Hope, 2013) and programs where being "out" is clearly safe should help with retention, productivity, and success of sexual minorities. Programs can communicate their support of LGB students and faculty on publicity materials by mentioning sexual minorities explicitly in formal and informal nondiscrimination statements, highlighting LGB-related research or training opportunities, identifying LGB competency as a core multicultural competency in program descriptions and being watchful that all printed and online materials avoid heterocentricity. The multicultural competency of advocacy/action may come into play at a program level as program leaders work to mitigate the impact of or to eliminate systemic heterocentrism such as noninclusive benefits policies and lack of legal recognition for all families.

Choice Point #4: Selecting or Creating Practicum Sites That Include Sexual Minorities

Practicum training in clinical psychology often occurs at in-house training clinics, research clinics, and at community hospitals and agencies. Although a variety of factors influence faculty decisions about which sites are appropriate for training, the availability of diverse, underserved, or unique populations often figures into the decision. Programs wishing to meet multicultural competency training goals that include LGB individuals should select sites that are likely to be used by them (or at least avoiding choosing only sites seen as not LGB-friendly such as some services sponsored by religious organizations). Practica experiences can be cultivated at community clinics with a specific mission to serve the LGB community, if these are available. Because in-house training clinics are typically controlled by the programs they serve, creation of LGB-oriented services may be a good option. This may involve simply advertising the training clinic as LGB-friendly to the community or identifying a specialty service that can be publicized. At the University of Nebraska-Lincoln, we have added a "Rainbow Clinic" specialty service within our training clinic that primarily involves routing calls for the Rainbow Clinic to a specially trained graduate student who, under supervision, identifies an appropriate trainee/supervisor pair to provide the requested services.

Choice Point #5: Including Sexual Minorities in Multicultural Research Competency

Multicultural competence in the research domain was less represented in earlier models of multicultural competency (e.g., Sue et al., 1992). However, a science-practitioner or clinical

science model of training highlights the integration of research and practice. Similarly, the evidence-based practice model requires consideration of the empirical literature in the design and delivery of service. Even if one is only a consumer of the scientific literature, a modest level of multicultural research competence is needed to evaluate potential biases and limitations in the literature. Multicultural research, as defined by the American Psychological Association (2003), is research in which cultural variables are a core aspect of the study, from conceptualization to finished product. Some students will undertake multicultural research as a primary focus. However, all students should routinely consider their research questions in a multicultural framework. This includes, but is not limited to, recruitment of samples, selection of measures, and research questions that reflect a multicultural perspective and do not automatically advantage or disadvantage a cultural group, inclusion of appropriate cultural variables, and interpretation of findings with an awareness of potential cultural influences and implications. For example, in a dissertation on family communication, the student and dissertation committee would grapple with refining research questions that are explicit on the variables of interest without assumptions of heterosexuality. Selection of the measures and recruitment of the sample would consciously consider the appropriateness of all types of families. Interpretation of the data would extend to all types of families or recognize limitations in generalization.

Newell et al. (2010) and Rogers (2006) argued that the best model programs in school psychology include faculty and students who conduct multicultural research. This could easily extend to clinical psychology training programs. Recruitment and retention of faculty and students who conduct research on LGB-related topics would certainly add expertise to facilitate meeting a multicultural research competency. At the same time, many programs of research in clinical psychology could fruitfully include a focus on LGB issues given that many common clinical problems such as anxiety and mood disorders and substance abuse are overrepresented in sexual minorities (e.g., Cochran & Mays, 2009; Sandfort, de Graaf, Biful, & Schnabel, 2001) and sexual minorities are more likely to seek psychological services than are heterosexual individuals (Grella, Greenwell, Mays, & Cochran, 2009). In this case, the choice point for the program is to value research on LGB-related issues and to assume that such research is appropriate and of interest to all students and faculty, not just those who identify as LGB.

Choice Point #6: Choosing Strategies to Evaluate Multicultural Competence That Include Competency with LGB Individuals

Accreditation requirements increasingly require an evaluation of how competencies are being met by students (American Psychological Association, 2013). A full discussion of evaluation of multicultural competency is beyond the scope of this article. However, a program that wishes to include LGB-related competency in their training model must also include an evaluation component.

Evaluating multicultural competency is challenging because the various components are difficult to operationalize. For example, how does a program balance valuing beliefs and attitudes that facilitate culturally sensitive research and services with students' rights for free thought and religious expression? However, some method for assessment is necessary in order to identify areas which need improvement as well as recognizing success.

Newell et al. (2010) proposed having a detailed list of competencies to be demonstrated by students, broken down into four levels of competency: Emerging, Basic, Proficient, and Advanced. This allows for observable progression by each student, according to that student's supervisor or advisor. However, this method leaves much room for interpretation and subjectivity, making it challenging to compare between students and across programs or pinpointing specific areas for need improvement. In an attempt to overcome this problem, a number of scales have been developed to evaluate multicultural competency (D'Andrea, Daniels, & Heck, 1991; Gamst et al., 2004), but they almost invariably focus on racial/ethnic issues. One rare exception to this rule is the Sexual Orientation Competency Scale (SOCCS; Bidell, 2005).

The SOCCS is a self-report measure that assesses clinicians' self-perceived competency in working with sexual minority clients. The SOCCS is divided into the Awareness, Knowledge, and Skills subscales. The Awareness subscale assesses the respondent's attitudes toward sexual minority clients, while the Knowledge subscale measures the respondent's understanding of topics related to sexual minority experiences in society and in treatment. The Skills subscale assesses respondents' perceptions regarding their own competency in providing adequate psychological services to LGB clients. Subscale and total scores are calculated by averaging the responses across items, with higher scores indicating higher levels of competency. Bidell (2005) demonstrated that the psychometric properties of the SOCCS are promising, and the measure has subsequently been used by a number of studies related to the topic of competency working with sexual minority clients. One disadvantage of the SOCCS is that it fails to include advocacy/action component of competency. Furthermore, as a self-report measure, it is limited by the respondent's self-awareness and thus may serve better as a tool to promote discussion and increase self-awareness rather than as an outcome measure for evaluating competency.

While the SOCCS may provide information about individuals, no known measure exists for evaluating the adequacy of training. This is problematic, as improvements at the graduate level of training will be needed in order to implement the desired change in individual clinicians. Ponterotto, Alexander, and Grieger (1995) introduced a Multicultural Competency Checklist (MCC) for evaluating the institutional climate and training standards of graduate programs in terms of their inclusion of racial/ethnic minority issues that could perhaps be extended to sexual minorities. The checklist is meant to be completed by training directors or by faculty as a group as a way to monitor progress in incorporating cultural diversity into their graduate programs. Although little information is known about the viability of this checklist, an effort to objectively evaluate graduate programs may help to guide the process of improving multicultural training as a whole.

Caveats and Conclusions

Traditional models of multicultural competency can be adapted to changing cultural contexts, including the need for culturally sensitive services for sexual minorities. The focus of this discussion has been on individuals who identify as lesbian, gay, or bisexual but of course such identities do not occur in a vacuum. LGB individuals may also be people of color, economically challenged, differently abled, a linguistic or religious minority and/or

an older adult. In such cases, integrative approaches to multicultural competency may provide the most flexibility as trainees identify their own and their clients' intersecting identities. This discussion has also focused on doctoral training programs in clinical psychology, but many of the points could extend to masters programs or other behavioral health training programs.

As faculty members begin to implement a training model for competency with sexual minorities, some predictable challenges may arise. First, across classroom and clinical settings, students and faculty will need to consider the extent to which their own sexual orientation should be disclosed or discussed. Does the bisexual faculty member who has been passing for heterosexual in their current marriage need to disclose? Does the graduate student who is currently coming to understand himself as gay man need to share that process in the multicultural class? How does a therapist handle a client's inquiries about the therapist's sexual orientation? Secondly, individuals who identify with a particular minority group may see themselves as experts, or be perceived by others in that way. As noted above, even students who identify as LGB may have incorporated negative cultural messages. However, it may require even more sensitivity on the part of a heterosexual instructor or clinical supervisor to help a novice student see that his or her experience as a sexual minority is not the universal experience. Finally, several of the recommendations noted above encourage involvement with the local LGB community. This involvement may raise clinical and ethical concerns as students and faculty members find themselves at community activities with current and former clients, especially in smaller cities. Involvement with the community may give a program more credibility, but a proactive discussion of how to handle these situations may need to be part of every initial clinical encounter. Training in both didactic and supervisory capacities should cultivate these skills appropriate to students' level of training (Bruss, Brack, Brack, Glickaug-Hughes, & O'Leary, 1997).

Strong multicultural training requires allocation of resources including classroom time, practicum sites, recruitment and retention of diverse faculty and students, and investment in assessment of competencies. These are all scarce resources with many competing demands. However, training programs must prepare psychologists for the professional demands of the coming decades when the typical client, student, or supervisee may well be a person of color, or someone in a same-sex marriage, or a youth who always knew he was gay because sexual minority role models are readily available. Research will need to grapple with the multicultural context to stay relevant.

A key motivation for developing multicultural competency with sexual minorities is to help address the health disparities identified in the Institute of Medicine report (Institute of Medicine [US] Committee on Lesbian, Gay, Bisexual, & Transgender Health Issues & Research Gaps & Opportunities, 2011). Clinical psychology has much to offer in understanding and remediating minority stress, changing public attitudes and policies, and improving assessment, prevention, and intervention strategies for sexual minorities. Being competitive for public and private research funds that are becoming available to address LGB health disparities requires a sophisticated multicultural understanding. Training programs that thoughtfully consider their training model will produce professionals who are most competitive for these funds. In fact, these funding opportunities may be an opening for discussion of change for programs that have historically lacked LGB-related training.

Development of a training model with a strong multicultural competency component requires substantial self-reflection and intentional decision-making on the part of the faculty. Within the ideographic context of a given program, the choice points discussed above can help guide those decisions:

1. Identifying Core Competencies
2. Choosing Integration versus Separate Course Model of Multicultural Training
3. Taking Action to Recruit and Retain Sexual Minority Faculty and Students
4. Selecting or Creating Practicum Sites That Include Sexual Minorities
5. Including Sexual Minorities in Multicultural Research Competency
6. Choosing Strategies to Evaluate Multicultural Competence That Include Competency with LGB Individuals

Undoubtedly, it would be helpful to have a larger research literature guiding these decisions and perhaps greater multicultural competency in new professionals will spur them to develop such a literature. In the meantime, each program can apply the principles of the scientist-practitioner model (Barlow, Hayes, & Nelson-Gray, 1984) to itself—identifying program goals, developing nomothetic and idiographic methods of assessment of competencies and outcomes, and monitoring progress toward the identified goals in a single-subject design. Of course, this means keeping in mind that the goals and assessment strategies are fair and sensitive to the needs of all students, with their varied and complex identities.

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