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PRESIDENT'S COLUMN

Now That You Have Prescribed Exercise, How About Sleep?

Michael W. Otto, Ph.D.

Let me start this column by recalling a conversation from a number of years ago. The occasion was my first attendance at a sleep training conference. One of the speakers, a sleep expert, came up and warmly greeted me as an outsider to the conference, and then challenged me in a conversation that unfolded something like this:

Michael, you work in a graduate program that champions empirically-supported treatments for a wide range of disorders, and I know you frequently give talks on the benefits of these treatments. But let me ask you, in your program, do you routinely train your graduate-student and post-doctoral clinicians in cognitive-behavior therapy interventions for insomnia? After all, these treatments are brief, powerful, and complete well against pharmacologic alternatives, particularly for longer-term outcomes.

In response, I said, "uhm." And then I said, "uhm" again, and then I said, "good point, I will get right on it."

It is absolutely true that cognitive-behavior therapy interventions for insomnia (CBT-I) represent one of the important achievements of clinical psychology. These ultra-brief interventions can be delivered across only a few sessions, and are associated with strong and reliable benefits on overall insomnia severity, sleep efficiency, sleep quality, and maintained sleep after initial sleep onset (van Straten et al., 2017). Notably, these interventions are an especially efficacious alternative to sleep medications, as indicated by both head-to-head trials (e.g., Jacobs et al., 2004) and meta-analytic review (Brasure et al., 2016; van Straten et al., 2017). The evidence is strong enough that the American College of Physicians recently recommended, in their clinical practice guideline, that all adult patients receive CBT-I as the initial treatment for chronic insomnia (Qaseem et al., 2016). Training in these interventions is made easy by a number of very useful clinician guides (e.g., Edinger & Carney, 2015; Perlis, Jungquist, Smith, & Posner, 2008), as well as in-person training opportunities (e.g., http://www.med.upenn.edu/cbti/). In

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short, insomnia interventions represent one of those clinical tools that are useful for every clinician's tool belt. But why do I bring it up now?
Ongoing research has clarified that, not only is insomnia a risk factor for the development of some disorders (e.g., depression; Perlis et al., 2006), insomnia is linked with greater severity, poorer treatment outcome, and risk for relapse (Li, Lam, Chan, Yu, & Wing, 2012; Smith, Huang, Manber, 2005; Sunderajan et al., 2010). On the other hand, the good news is that sleep promotion interventions can enhance treatment outcome. Enhancing sleep has direct benefits to mood (Ballesio et al., 2017), and also appears to enhance extinction learning. For example, Zalta and associates (2013) found that the quality of sleep, assessed the night after each exposure-therapy session for social anxiety disorder, was predictive of greater benefit observed at the next session as well as by the endpoint of treatment. Researchers have also found that scheduled sleep after exposure sessions improved the retention and generalization of benefits (Kleim et al., 2014; Pace-Schott, Verga, Bennett, & Spencer, 2012), Why might this be the case?

Sleep has a number of cognition-enhancing effects, aiding the recall of information learned before sleep as well as aiding schema formation for this information (Landmann et al., 2014). Accordingly, sleep after a session can be considered one of a range of memory enhancement strategies for recall of therapeutic learning from sessions (Kredlow, Eichenbaum, & Otto, in press). Moreover, sleep has additional effects on emotionality. That is, while sleep has the effect of promoting recall, it appears to do so while dampening the emotional evocativeness of these memories (Walker & van der Helm, 2009). In short, sleep can help provide you with clear memories that are less emotionally loaded. Imagine the benefit of this to patients with generalized anxiety disorder or reactive depression, where these individuals often seem jangled by the previous day's negative emotional content. Sleep restoration has the potential to attenuate this jangling.

So, how do we get more efficacy out of the therapies we offer? One strategy is to stay vigilant to the sleep disruptions reported by our patients, evaluate the presence of other complicating factors (Becker et al., 2006), and to intervene with the efficacious CBT-I when appropriate. These interventions are also useful for helping patients discontinue their sleep medications and to maintain or extend their sleep gains (Bélanger, Belleville, & Morin, 2009). Also, following sessions where patient has demonstrated important therapeutic learning, clinicians may want to assign their patient a nap or an earlier time to bed to try to lock in these benefits by enhancing memory consolidation.

In conclusion, adequate sleep mirrors some of the benefits of regular exercise on promoting both mood and cognition, and sleep and exercise also share the additional benefit of promoting health and longevity (Bellesi et al., 2017; Cappuccio, D'Elia, Strazzullo, & Miller, 2010). So let me close this column similarly to the way I opened the last issue of The Clinical Psychologist (Otto, 2017): "did you prescribe sleep this week?" Ψ

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BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

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Society of Clinical Psychology/ Division 12 Election Results

We are very pleased to announce the results of the Society of Clinical Psychology/Division 12 Elections. We had an impressive slate of candidates this year, including many well established leaders of the field.

President-Elect

Jonathan S. Comer, Ph.D.

Treasurer

Jonathan Weinand, Ph.D.

Council Representatives

Kenneth J. Sher , Ph.D.

Mark B. Sobell, Ph.D., ABPP

Congratulations to each of the elected candidates, and a sincere thank you to all who ran. It is only with strong candidates that we are able to ensure strong leadership and a prosperous future for the organization. We hope a number of others will consider running for leadership positions of the Society in the future.

Dear members,

We hope this letter finds you safe and well. The leaders of APA Division 12, the Society of Clinical Psychology, and the Division 12 Diversity Committee would like to actively reach out to its members and the larger community to follow-up regarding the violence enacted by white supremacists and affiliated hate groups in Charlottesville, Virginia during the weekend of August 11-13, 2017. We would like to acknowledge this horrific event and share our deep sorrow and concern for the Charlottesville and University of Virginia community. Our thoughts also extend to all who may be negatively impacted, injured, or disturbed by hatred and bigotry and violence in the United States and world around them.

The Society of Clinical Psychology and its members wish to reiterate our commitment and determination to promote and celebrate diversity, inclusiveness, and mutual respect. We reject and denounce those activities, which impede the promotion of diversity and inclusiveness, including acts of hatred, intolerance, bigotry and violence.

The mission of APA is to advance psychology to benefit society and improve people's lives. The Society of Clinical Psychology supports and promotes values and actions that further this mission. We realize that each of you is committed to this mission and encourage you to continue to engage the community, your clients, students, and each other in ways that reflect our core values.

Many thanks.

Respectfully,

J. Kim Penberthy, Ph.D., ABPP, APA Division 12 Diversity Committee Chair

Michael Otto, Ph.D., President, APA Division 12

Jonathan S. Comer, Ph.D. - Editor

Sensitivity to Sounds: A New Clinical Forefront[1]

Dean McKay, Ph.D.
Fordham University

Snoring. Loud sniffling due to a runny nose. Chewing with an open mouth. These are just a few sounds that most people recognize immediately as causing mild to moderate adverse reactions. The widespread recognition that some sounds cause distress have led to sayings such as "The noise was so unpleasant it was nails on a chalkboard."[2] In some instances, the progenitor of the offending noises has been met with aggressive responses. For example, in 2015 a Nebraska woman attacked her boyfriend with a crowbar for snoring loudly (Moye, 2015). In another case, a man was murdered at a movie theater for eating popcorn too loudly (Hartman, 2011).

The examples of aggressive responses to unpleasant noises are extreme. There is, however, a growing recognition that some individuals struggle to a great extent with certain sounds. This problem has a special name, misophonia, coined by Jastreboff and Jastreboff (2001). It is also known as Selective Sound Sensitivity, and has generated attention in the popular media (i.e., Scotti, 2017). Misophonia has also been the subject of research scrutiny. Before discussing the broad features of misophonia, based on the limited available research, there are several audiological problems that should be ruled out first should someone come into the office complaining of selective sound sensitivity.

Tinnitus: Unlike misophonia, tinnitus sufferers report persistent buzzing sounds that are not externally generated. At present there are no cures for tinnitus.[3] However, treatment programs have developed employing psychosocial interventions with large reductions in distress associated with tinnitus (Hesser et al., 2011).

Hyperacousis: Unlike misophonia, hyperacousis is an intolerance to sound volume generally. However, in similar fashion to misophonia, hyperacousis sufferers experience physical pain, anxiety, and annoyance due to sounds at a volume that is readily tolerated by most of the general population. The etiology is as yet unknown, and there are no known treatments (Pienkowski et al., 2014).

Dean McKay

Phonophobia: This condition is marked by extreme fear of specific loud noises. It is often present in children (i.e., fear of balloons) and is a criteria for migraine, where the headache is exacerbated by the noise (Goadsby, Lipton, & Ferrari, 2002). In the case of phonophobia due to sudden loud noises such as children's fears of balloons, treatment generally involves exposure-based approaches (Yule, Sacks, & Hersov, 1974). Phonophobia (and photophobia, or fear of bright lights) is alleviated with reduction of headache symptoms when it is present in migraine.

Palinacousis: This is a neurological condition characterized by hallucinations of external sounds echoing. It has been found to be associated with some seizure disorders. The condition is relatively rare, with few reported cases in published research. However, cases reported have been considered due to temporal-parietal seizure (Mohamed, Ahuja, & Shah, 2012; Terao & Matsungaga, 1999) and schizophrenia (Wustmann, Roettig, & Mameros, 2010).

Assessment Domains in Misophonia

Psychological research into misophonia began from a clinical observation that suggested the condition was associated with obsessive-compulsive disorder (OCD). For example, based on self-report Schroeder et al. (2013) found that individuals with misophonia found the symptoms were similar in experience to obsessive-compulsive symptoms. In a larger undergraduate sample, misophonia symptoms were commonly reported, and severity of symptoms was associated with obsessive-compulsive symptoms, as well as general anxiety and depression (Wu et al., 2014).

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[2]This saying may be obsolete soon, as chalkboards increasingly are replaced by white-boards and erasable markers.

[3]Full disclosure – the author has suffered occasional tinnitus, and upon consulting a medical doctor was informed there was no cure and that it was something that people have to 'just learn to live with.'

As misophonia sufferers report anxiety, depression and obsessive-compulsive symptoms, these are all areas for assessment. However, many misophonia sufferers also report problems with anger control (Taylor, 2017) as well as other sensory intolerance (Taylor et al., 2014; Wu et al., 2014). However, it is as yet unclear just how significant any one symptom domain may be in contributing to misophonia. For example, in a large community sample (N=628), obsessive-compulsive symptoms were not a distinguishing feature in misophonia, and instead the condition was marked by higher levels of sensitivity to interoceptive experiences (McKay et al., in press). As a result, any evaluation of misophonia calls for evaluation of several major dimensions of psychopathology.

Treating Misophonia

Given the aforementioned clinical observation, but with mixed controlled support, that misophonia is associated with OCD, case treatment research has implemented cognitive-behavioral approaches employing exposure-based methods as part of a program of therapy. Audiological treatment conceptualizations also emphasized desensitization in a manner similar to exposure (Jastreboff & Jastreboff, 2014). One published case that showed successful alleviation of misophonia was similar in format to available protocols for anxiety disorders, including development of a hierarchy, identification of cognitions associated with target aversive sounds, self-monitoring, and between session exposure to facilitate generalization following within-session exposure (Bernstein, Angell, & Dehl, 2013).

My lab is presently conducting a randomized trial for misophonia. The components of treatment are exposure and stress management. Participants receive either exposure first, or stress management first. After seven sessions, participants receive the treatment they did not receive first for an additional seven sessions. All treatment is conducted via web camera. While we do not yet have findings to report, there are some clinical insights worth sharing here.

Buy-in on Exposure

Our recruitment strategy focused in part on direct communication with the misophonia community. There is a Misophonia Association, and that organization maintains a Facebook page. There is also a community subreddit for misophonia. The challenge is that many misophonia sufferers regard exposure as harmful, a point that is well taken given the challenges in crafting a solid hierarchy for developing a treatment program.

Like other problems that prompt avoidance, the prospect of exposure causes some hesitation since it is often viewed as counter-intuitive. In the case of anxiety-related conditions, the explanations that might be applied to encourage participation in treatment may be developed around the fact that the sufferer already largely experiences the feared stimuli, just in uncontrolled ways. Therefore, treatment is an opportunity to develop mastery in encountering these situations through guided practice.

In the case of misophonia, many clinicians may have a sound clinical understanding of exposure yet fail to craft a plan that can address the problem of aversive noises. One reason involves the challenge in knowing whether the stimuli chosen is too difficult. Another challenge is predicting whether the aversive reaction will in fact diminish with continued exposure. And finally, thinking of sounds in gradients of intensity is unfamiliar territory for most clinicians.

Hierarchy Development for Misophonia – It's not like other hierarchies

Consider for a moment the typical hierarchy for use in exposure therapy: some situation is described that provokes fear, and the increments of that situation are ones that involve visualizations, contact with the skin, or an interpersonal exchange. In few instances are sounds the specific source of avoidance. Accordingly, constructing hierarchies based largely on sound is unfamiliar territory for therapists.

In our therapy trial, we have focused a good deal of attention on the basic mechanics of constructing a hierarchy, paying particular attention to gradients of sounds. It also requires taking a more granular approach to how different sounds are produced. For example, a common problematic sound for people with misophonia is chewing noises. At first blush, it may not be obvious how to construct a hierarchy around this particular problem, since chewing can be either loud (i.e., mouth open) or softer (mouth closed). However, careful inquiry reveals that some foods produce different reactions than others. Table 1 provides an illustrative hierarchy for chewing and associated eating sounds.

This process can be developed for any class of sounds, but it requires careful consideration for the full range of how different noises are produced. In our experience with over 30 treated individuals thus far, while there are some typical sounds that provoke aversive reaction in misophonia, the structure of the hierarchies have varied widely.

Doing Exposure – Source Material

So now you have your hierarchy constructed, its time to get started on exposure. You immediately face a problem – are you going to be the one producing the sounds? Do you recruit a confederate? And will a recording of the session be sufficient for the between-session exercises necessary to produce good outcome?

It seems impractical for the clinician to also be the source of noises. There are too many ways this could go awry, and it also requires bringing in all kinds of stimuli to produce the sounds. For example, if it were chewing sounds as described above, this would mean having a range of foods available in the office, some of which would not be addressed in a session, and then having it all available again the following session until some kind of in-session mastery is achieved. Recruiting a confederate can be problematic. If it is a family member, you exert little control over the manner of the sounds, and the potential interpersonal factor (i.e., past adverse experiences) can easily color this exercise to be about something other than the target noises. And if it is a recording, it is difficult to know if the sound quality will be high enough for repeated practice after the session ends.

Fortunately we live in the era where seemingly everyone has recorded almost anything a clinician could imagine. Want a video of a monkey vomiting, with associated noises? Search for it on Youtube. Need to get a video of a cat hang gliding? Again, Youtube will provide you with more than one clip.[4] So, it should come as no surprise that a wide range of sounds, with accompanying video imagery, is available online. Sticking with the aversive chewing sounds example, there is a trove of videos of individuals eating all variety of foods to suit the needs of the most granular hierarchy. Given how frequently chewing sounds have been a source of distress in our treatment sample, we stumbled upon a community of Youtube subscribers who find different types of eating noises to be relaxing. The experience of comfort from chewing sounds has been called Autonomous Meridian Sensory Response (AMSR) and has been studied to a limited extent (although fMRI research on the default mode network in this group has been described, Smith, Fredborg, & Kornelson, 2017).

Additional Considerations

In misophonia, sufferers have cued responses based on visual situations that signal the onset of target aversive noises. Sticking with the chewing example, seeing a dinner plate could serve as a visual cue for the aversive response. This means that exposure must necessarily focus on the sounds, but also the visual situations associated with the noises. We have found that developing a hierarchy that incorporates these visual cues are helpful in developing interventions.

While the emotional reactions to noises are often anger or anxiety, disgust is another aversive reaction to target noises. Again, consider the dimensional nature of misophonia: most people can identify sounds that provoke disgust, such as the noise your shoe makes when one steps down into dog feces (or the sound it makes when the foot is lifted). That specific 'squish' noise can provoke disgust reaction without any other associated stimuli. The emotional reaction from noises has implications for other judgments (i.e., moral judgments; Angelika & Prinz, 2013), and therefore warrants careful consideration.

Conclusions

Misophonia is a problem that is attracting recent research attention. While it is in the early stages, sufferers are nonetheless seeking help from psychologists. There is little in the way of meaningful guidance for how to address the specific treatment needs of this group. While case studies suggest exposure based interventions alleviate distress, controlled research is under way to provide clearer answers on how to provide relief. It is expected that the growing body of research will provide crucial insights into how to address this problem. Ψ

Table 1. Illustrative hierarchy for chewing/mouth sounds associated with misophonia

Sound	SUDS (0-100)
Chewing potato chips/tortilla chips	95
Chewing saltines	90
Chewing gum, mouth open	80
Chewing crunchy vegetables (carrots, celery)	70
Slurping soup	65
Chewing soft vegetables (beans, sautéed vegetables)	50
Chewing gum, mouth closed	45
Eating mashed potatoes	35
Drinking soup, quietly	30
Eating cooked spaghetti, other soft foods	25

Note: SUDS = Subjective Units of Distress

[4]Your intrepid author did the necessary searches to find clips for these examples. You're welcome.

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Congratulations to the distinguished group of Division 12 members who were recognized at our 2017 Awards Ceremony!

Dr. Thomas Ollendick, Award for Distinguished Scientific Contributions to Clinical Psychology

Dr. William Pelham, Jr., Award for Distinguished Scientific Contributions to Clinical Psychology

Dr. Denise Sloan, Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology

Dr. James Boswell, David Shakow Early Career Award for Contributions to Clinical Psychology

Hogrefe Publishing Corp. Booth

Jennifer Martinez, M.A., Student Diversity Award

Also honored at the Awards Ceremony, but not pictured, were:

Dr. Donna Kiyo Nagata (Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology), Dr. Adam Leventhal (American Psychological Foundation Theodore Millon Award), Dr. Paul Perrin (Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology), Jessica Leigh Humility and Christopher R. DeCou (Distinguished Student Research in Clinical Psychology Award), Jonah N. Cohen (Distinguished Student Practice in Clinical Psychology Award), and Alex Thibeault (Distinguished Student Service in Clinical Psychology Award)

Are We (Not) Asking the Right Questions? Ethical and Clinical Considerations for Work with Sexual Minority Clients

Adam Fried, Ph.D.
Midwestern University

Lesbian, gay and bisexual (LGB) adolescents and adult face numerous health disparities, including limited access to care (Institute of Medicine, 2011), increased mental health issues, such as depression (Coker, Austin & Schuster, 2010) and high incidence of victimization (Williams & Chapman, 2011). Yet, research suggests that health care providers do not regularly discuss sexual orientations or attractions with clients/patients (Macapagal, Bhatia, & Green, 2016; Kitts, 2010) and may assume that all are heterosexual (Arbeit, Fisher, Macapagal, & Mustanski, 2016). A recent study by Maragh-Bass et al (2017) found that 80% of physicians surveyed believed that asking about sexual orientation would be offensive to patients, while only 10% of patients reported they would be offended. More than half of the patients surveyed believed that knowledge of sexual orientation would be associated with improved and targeted care. Another recent study by Haider et al. (2017) suggested that more than three-quarters of the physicians surveyed believed that the patients would refuse to provide information about sexual orientation, while only 10% of patients said that they would refuse.

While most of the research is focused on medical care, I often wonder how many psychologists regularly ask clients about sexual attractions or identity. How many refrain from exploring specific aspects of our patient/client's sexual identity due to fears of a negative reaction? For example, some psychologists and trainees may fear that asking questions about whether the patient/client has disclosed their sexual identity ("being out") to others will be perceived as offensive. What values and assumptions are we communicating to clients/patients by not asking these questions? Sexual minority clients/patients may be surrounded by family members, friends, and individuals at school, work, and in the community who may be hostile or react negatively to individuals who identify as LGB. For some, the therapy room may be one of the only places where a sexual minority client/patient feels comfortable communicating their attractions, experiences and identity. In this column, I plan to briefly review some ethical considerations related to the assessment of sexual attractions and identities (applicable to both LGB and non-LGB clients/patients) and therapeutic considerations, including those that arise when engaging and working with adolescent sexual minorities.

Missed Opportunities

The medical literature describes "missed opportunities" in terms of clinical encounters in which there were lost chances to engage patients in important discussions that may impact their health. For example, asking patients about sexual behaviors may lead to more personalized care, such as education about safe sexual practices and HIV/STI testing and prevention. How many of these "missed opportunities" occur in mental health care?

A survey of mental health providers in the Veterans Affairs health care system revealed that half do not assess sexual orientation with patients and a similar proportion indicated that this information would not alter their treatment plan or approach (Sherman et al., 2014). What does it communicate to our clients/patients when we don't ask about sexual attractions or identity? What critical clinical information might we be missing by not asking? For example, an adolescent may present as extremely withdrawn and anxious, but may not feel comfortable relaying to the therapist that the source of this negative affect stems from the fear that her father will disapprove of her same sex relationship and force her out of the house.

Competence and Exploring Assumptions and Beliefs

Through its principles and standards, the APA Ethics Code (APA, 2017) emphasizes the importance of self-knowledge and self-evaluation. For example, with each new referral or professional request, psychologists must examine their training, education, and knowledge to provide competent professional services (Standard 2.01 Boundaries of Competence, Standard 2.03 Maintaining Competence). Competence in working with LGB clients requires understanding key theoretical concepts and scholarly and scientific literature related to LGB identity and development as well as the impact of discrimination, marginalization, rejection, and victimization on LGB individual's daily experiences and their role in the higher mental health and substance use problems among LGB populations (APA, 2012; Boroughs, Bedoya, O'Cleirigh, & Safren,

2015; Godfrey, Haddock, Fisher & Lund, 2006).

Providing competent and informed care also requires that psychologists engage in self-reflection about their own beliefs, values and assumptions (APA, 2017; Prilleltensky, 1997). When providing services to sexual minority individuals, both LGB and non-LGB therapists should examine their own attitudes and beliefs on a variety of topics, including:

- Do I presume that clients are heterosexual?
- Do I believe that sexual orientation is an important component of an individual's identity?
- When I learn a client is a sexual minority, is their orientation presumed to be the cause of one's problems?
- Have I critically examined any heteronormative, heterosexist and/or homophobic beliefs or attitudes about sexuality that I may hold?
- Are any of my beliefs about LGB individuals actually stereotypes and how might these be unintentionally conveyed through professional services? For example, questions meant to assess frequency and nature of sexual activity may unintentionally reflect an unexamined stereotype about promiscuity among gay men.
- How might the experience of being a sexual minority impact a client/patient's experience in school, home, work, peer relationships, or views about themselves?
- Am I providing a safe, affirming environment where sexual minority individuals (especially youth) feel comfortable disclosing and discussing attractions and identity.
- Do I believe that sexual orientation is something that can be changed?[1]
- Do I understand the effects of stigma, prejudice and discrimination on the daily lives and experiences of LGB individuals?

Working with Adolescent Sexual Minorities

Building a trusting, safe therapeutic relationship with clients is a critical prerequisite (and, in some cases, vehicle) for improvement and lasting change. As therapists who work with younger populations know all too well, engaging adolescents can be a difficult task at times. Barriers to engagement may include disagreements about the presenting problem (including the nature, severity or even the presence of a problem), concerns that the therapist will relay information disclosed by the adolescent in session to a parent, lack of a connection between the adolescent and therapist, or fears that the adolescent will be negatively evaluated or judged. Such concerns may be particularly salient in work with adolescent sexual minorities. Research suggests that minority youth may postpone or avoid seeking health care due to concerns that the provider may not maintain confidentiality (including telling parents who the adolescent believes will react negatively) or disapprove of the adolescent's sexual identity or their engagement in same sex sexual activity (Arbeit, Fisher, Macapagal, & Mustanksi, 2016; Williams & Chapman, 2012). Confidentiality dilemmas (such as whether to disclose potentially dangerous sexual behaviors, such as unprotected sex under the influence of alcohol or drugs) may be most acute when working minors, such as adolescents, but also may arise in working with individuals who have appointed guardians, such as individuals with intellectual and/or developmental disabilities. During informed consent, clinicians are also advised to discuss implications of being identified as "LGB" within medical records that can be seen by others, including the possibility that other providers may learn of the patient/client's sexual identity without the client realizing it (Boroughs, Bedoya, O'Cleirigh & Safren, 2015).

Training Implications

A critical training goal for students is to develop competencies in individual and cultural diversity. Multicultural competence requires an appreciation of individual cultural, political, economic, and other important identities of the client that may impact the professional work (Fisher, 2014) and is critical to implementing affirmative counseling techniques. Despite the increased emphasis on LGBT cultural competence in recent years, training programs still do not include substantial content in these areas (Matza, Sloan, Kauth & DeBakey, 2015; Pachankis & Goldfried, 2013). In the aforementioned study by Sherman et al. (2014), less than half of the VA providers had received training on LGBT issues, either in graduate school or in post-graduate training/education. These findings raise important questions as a field. For example, how should we define and evaluate LGBT cultural competence? What are the implications of the lack of training on LGB health issues for the next generation of the psychologists? What does the lack of training in LGB health in psychology programs communicate to our students?

[1]There is not sufficient space to discuss the clinical, empirical and ethical issues related to sexual orientation conversion efforts (SOCE). For a detailed discussion, please see http://www.apa.org/pi/lgbt/resources/sexual-orientation.aspx and https://store.samhsa.gov/product/SMA15-4928

Concluding Comments

Recent research examining professional attitudes and health care practices with LGB patients/clients highlights significant gaps in our education and training, resulting in "missed opportunities" to provide competent, respectful and individualized clinical care. Optimal care with LGB individuals requires specific clinical, cultural and ethical competencies gained through education and training, careful self-evaluation of assumptions and beliefs, and discernment to recognize and respond to ethical issues that may be particularly relevant in assessment and treatment with LGB clients.

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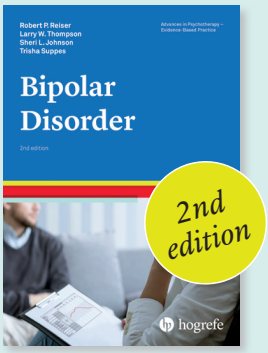

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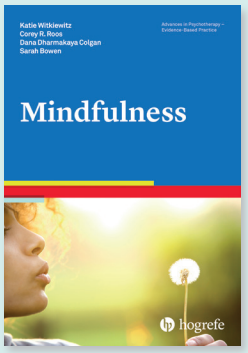

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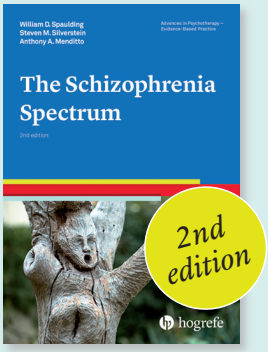

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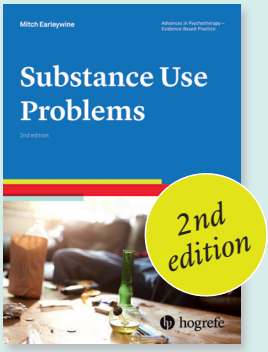

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