Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice 26 (2019) 300-306

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

The Social Context of Clinical Practice With Sexual Minority Clients: Commentary on the Special Issue

Christopher R. Martell, *University of Massachusetts*
Mark E. Williams, *Fitchburg State University*

Clinical research with sexual minority clients has evolved and has contributed to recognition and affirmation of sexual minorities. This commentary traces a history of research that was at one time based on heteronormative biases, what we refer to as a "first wave" to a movement through a "second wave" of research comparing sexual minorities to heterosexual counterparts in order to adapt existing clinical practices and advocate for them in the context of political challenges and social opposition. We look at the articles in this special issue as exemplary of what may be considered the "third wave" of this research that begins with the assumption that sexual minority populations are unique and valued subcultures and proposes best practices with these populations.

All research is conducted in particular contexts and researchers work from a particular perspective. For example, with regard to working with traditionally oppressed groups, feminist, postmodern, participatory action researchers introduced the concept of power and positionality. While these researchers tend to conduct qualitative rather than quantitative research, the concepts of positionality and accounting for insider/outsider status (Merriam et al., 2001) are relevant as well to quantitative research and to the four articles in this special series. Awareness of one's positionality allows us to recognize that the assumptions we make regarding research, therapy, the participants and clients we work with are relative, and that we are never objective observers. We do not argue that it is always necessary for researchers and clinicians to disclose their positionality, and we recognize that there are compelling arguments in favor of disclosing as well as equally compelling reasons that people do not disclose how their perspectives are shaped by their socio-cultural identities. The point is that research and treatment occur within particular contexts, and researchers and clinicians are vital parts of that context as much as the communities with whom we work.

Keywords: sexual minorities; social context; positionality; clinical research

Insiders and Outsiders in Work With Sexual Minorities

It has been suggested, to a certain extent, that "gay" is equated with being White (Han, 2007). Thus, researchers that are White and identify as gay men are limited "insiders" into the larger community of individuals that, through identity or behavior, are members of a sexual minority. They are "outsiders" to sexual minority communities of color, women, and to those that do not identify as cis-gender. Being an outsider does not imply bigotry or opposition to any particular group. It simply points to one's positionality when entering the conversation.

As Merriam et al. (2001) pointed out, however, being an insider or an outsider is complicated. Being White, male, cis-gender, educated, and gay is only part of the story. Socio-economic class is a position from which we experience the world, and for many people who have benefited from the opportunities of higher education, that position has changed during their lifetimes as first-generation college students may have moved from poverty or working class backgrounds to middle or upper-middle class social standing. Living in an urban or rural setting provides further complexity to the multiple contexts we inhabit. Religious identities, which are never as simple as defining oneself as "Jewish," "Christian," "Muslim," "Hindu," and so on, since there is great diversity within those groups, further define experiences of being insiders or outsiders in the context of community. Sexual minority individuals may encounter great diversity of acceptance or rejection in relation to their faith communities, as well as in their own personally held traditional or progressive belief systems.

This brings us to the four articles in this series. They represent research on historically oppressed communities and provide data to support best practices within these communities. Variations in positionality, or insider/outsider status, can be seen in the various populations studied. Positionality does not imply that scholars conducting this research need to identify in any particular way, but only that they must be aware of the context from which they conduct the research. Considerations of insider/outsider status must be taken into consideration when recruiting participants, analyzing data, and reporting results, recognizing that research with oppressed communities becomes part of the social context and social understanding of these communities that can promote well-being or exacerbate oppression. Common among these four articles is the perspective of the minority stress model regarding sexual orientation (Meyer, 1995). The significance of researchers using the lens of minority stress cannot be understated. In order to demonstrate the important contribution that this model has made to research on sexual minorities, we take a broad look over the historical context of this research.

The History of Psychotherapy Research With Sexual Minority Clients

When we go back far enough in time, the literature on sexual minority individuals is rife with the project of pathologizing minority sexual orientations. A great deal of early research focused on treating "abnormal" inclinations and on discovering the etiology of "homosexuality" seen as a disorder (e.g., Rado, 1940). Of course, considering positionality, we can consider the position of those early researchers. The researchers were predominantly White, apparently cis-gender, self-proclaimed heterosexual men. This gave the literature a particular focus on "homosexual men" as the group frequently under study. While lesbians were not considered any less pathological by mainstream mental health groups at the time, most of the research concentrated on men. We can, in hindsight, suggest that this is due to the threat to dominant masculinity that gay men supposedly posed—and still pose. In defense of heteronormative standards, the early research looked for explanations about etiology of illness and "cures." Rather than center attention on the impact of social context on the mental health of sexual minority individuals, this early psychological research was focused on the "inside-out," conceptualizing sexual minority identities as an abnormal and disordered internal state leading to intrapsychic distress and conflict with heteronormative assumptions. To use language familiar to the CBT community, this was the *first wave*, so to speak. Affirmative research and therapy, including considerations of the impact of minority stress were decades away.

During what we might call the *second wave*, researchers looked to understand sexual minorities in terms of degrees of variability from the heterosexual norm, rather than as fundamentally disordered. While this was a great improvement on earlier pathologizing research, much of this laudable research still, out of necessity, compared sexual minority populations to heterosexual populations. The referent group throughout this research was that of cis-gender heterosexuals. Thus, literature demonstrated that same-sex couples were *as committed and happy as* heterosexual couples (e.g., Kurdek, 1998; Kurdek and Schmit, 1986), or that children raised by same-sex couples faired *as well, and in some cases better, than* children raised by heterosexual couples (Patterson, 1992). Explicitly countering stereotypes, older gay men were found to be *as happy and successful* in transitioning to older adulthood as heterosexual men (Wahler and Gabbay, 1997). While there was also much research on the experiences of being a member of a sexual minority in a hetero-dominant world, this second wave of sexual minority research in many ways served the purpose of apologetic.[1] The researchers, some of whom themselves identified as members of a sexual minority, had the burden of demonstrating that lesbian, gay, and bisexual people were well within the normal curve on matters of aging development, sustaining relationships, and childrearing. The research made groundbreaking contributions to the field, and the researchers conducted this controversial line of inquiry often at the risk of jeopardizing academic and professional careers. This research has been instrumental in supporting legislation that allows greater rights for same-sex couples to adopt children, have two-parent adoptions, and to legally marry one another.

Continued advances in this second wave of sexual minority treatment literature affirmed sexual minorities as valued members of society who experienced problems in living "like everybody else," a position that could be justified from the many studies in the earlier years of what we are calling the *second wave*. This line of research, particularly in light of empirically based practice or empirically supported treatments, sought to answer the questions of how various treatments studied predominantly with heterosexual subjects generalized to sexual minority populations. Still, the heteronormative comparisons continued, in that nearly all of the treatment development or treatment outcome literature had been conducted with samples of heterosexual clients. When study participants included people that engaged in same-sex sexual behaviors, or identified as members of a sexual or gender minority, the numbers were usually so small

[1] The term *apologetic* may be unfamiliar to *C&BP* readers. It is a term usually used in theological or religious studies referring to rational arguments that defend a particular doctrinal position.

that it was impossible to conduct any analyses that would compare the sample based on sexual orientation. Interventions that were mostly studied with heterosexual clients were used with lesbian, gay, and bisexual women and men, sometimes adapted in an affirmative manner (Martell, Safren, and Prince, 2004), although the original RCTs either did not gather information about sexual orientation in their samples, or had too small a number of self-identified sexual minority individuals to reach definitive conclusions about treating sexual minorities. Even studies designed to test interventions with sexual minority individuals broadly have not looked specifically at interventions with bisexual individuals.

Our current wave, exemplified by the articles in this special series, has moved us further forward in developing well-informed affirmative treatment. Contemporary research more frequently starts by presuming that what accounts for differences in sexual minority mental health and outcomes is the stigmatizing and inhospitable social context. This is in contrast to seeking an understanding of how different or similar sexual minority populations are to heterosexist norms. This also furthers the agenda beyond attempts to fit models of treatment found effective with dominant populations to the experiences of sexual minority clients. As such, new models of treatment must be innovated and examined to address this unique aspect of nonheteronormative identities. Rather than emphasize how similar these populations are to dominant identities, building from the minority stress model (Meyer, 1995), researchers are embracing the uniqueness of challenges facing sexual minority individuals. The development of new treatments is justified by the unique aspects of invalidation and socially proscribed stresses of living as a sexual minority in a heteronormative social context. Understanding the experience of minority stress on sexual minority populations allows researchers to gain a greater understanding of the impact of these stressors on mental health. Understanding the impact of minority stress allows examination of treatments that have been developed to address these needs that are specific to sexual minority communities. Identifying health and mental health disparities between groups necessitates comparisons among people identifying with various sexual orientations. Current research focuses on identifying best practices with sexual minorities, presuming the unique challenges of coping with the stresses of not conforming to heteronormative assumptions, and serves less of the function of apologetics. As the articles in this series all elucidate, these communities continue to face discrimination, oppression, and sometimes open violence from mainstream culture, and these stresses are compounded for individuals with multiple minority statuses from within the sexual and gender minority communities themselves. Even when rights are granted, attempts are made to take other rights away. A major civil rights victory in allowing same-sex couples the right to marry throughout the United States (Obergefell v Hodges, 584 U.S. 135 S. CT 2584) was decided in 2015. Three years later, however, when a baker refused to bake a wedding cake for a same-sex couple because it was against his religion, the Supreme Court ruled that the Colorado Civil Rights Commission had not initially acted in a neutral manner in their ruling against him. The court determined they had violated the baker's right of free speech and exercise of religion (Masterpiece Cakeshop, Ltd. et al., petitioners V. Colorado Civil Rights Commission, et al., 584 U.S 138 S. Ct. 1719). While this decision has been presented as complex and concerned more with the Colorado Civil Rights Commission not acting appropriately, the result is that the door has been left open for discrimination against same-sex couples based on personal religious beliefs, despite the law of the land affirming the right of same-sex couples to marry. Research that directly addresses such unique stressors and coping strategies necessitated by them navigates complicated territory. Uniqueness is recognized as a key lens for understanding sexual minority experiences and needs on their own terms, and highlighting unique experiences potentially feeds the arguments of sexual diversity as pathology that continues to characterize a great deal of public and legislative debate today. Concepts of relative sameness or uniqueness, regardless of their theoretical intent, continue to fuel culture wars and legislative and judicial battles with concrete, often detrimental impact on the lives of sexual minority individuals and their families.

Implications of Social Context on Research and Practice

Of note, current research, as has been true from the earliest affirming research, can be misconstrued when viewed through a heteronormative lens. Despite the intentions of researchers, their findings can be misused to support unfounded assumptions about communities of people that have developed different cultural and behavioral norms than the dominant culture, or that have demonstrated the integrity to be public about behaviors and attitudes that many in the dominant culture may hide. For example, literature that acknowledges the reality and function of nonmonogamy contracts (Macapagal, Feinstein, Puckett, and Newcomb, this issue; Scott, Whitton, and Buzella, this issue) may be used to support notions that gay men in particular cannot make emotional commitments. Exploring unique issues of nonmonogamy has been misconstrued in public debate to reinforce the notion of inherent pathology, rather than to recognize that many in this community follow a different norm, shaped by a history of explicit exclusion from heternormative institutions, social supports, and

mores. It should come as no surprise that many individuals forced to forge intimate relationships and families in intentional contradiction to the hegemony of the heteronormative standard, have constructed their own norms that many sexual minority partners find meaningful, sustainable, and culturally consistent within their communities. Couples having the capacity to speak openly about decisions regarding nonmonogamy demonstrates capacities for emotional intimacy that are not apparently present in many heterosexual couples when similar behaviors occur, but are shrouded in silence and stigma and more commonly become grounds for dissolution of heterosexual relationships and families. Minority stress and the resilient adaptations of same-sex relationships have shaped different strengths and challenges facing sexual minority individuals. The articles in this volume investigate many of those unique strengths and challenges, not in order to conform them to heteronormative ideals, but to competently engage in promoting health and well-being with treatments informed by the historical and present impact of minority stress.

These studies indicate the importance of context. The history of clinical research concerning sexual minority populations has increasingly brought into focus the ways in which social context is not only a factor in shaping the well-being of sexual minority clients, but in many cases is the crucial lens to understand the unique risks and protective factors for these individuals. All of the articles in this issue cite the minority stress model (Meyer, 1995, 2003), indicative of the growing awareness of the mechanisms by which an oppressive social context accounts for maladaptive coping and mental health outcomes for many sexual minority individuals. Heterosexist, homophobic, and bi-negative social contexts at the macro level construct stressful environments in which sexual minority individuals navigate threats and enacted discrimination in their daily lives.

More than just an explanatory model of the etiology of mental and behavioral health disparities, the articles in this volume illuminate how minority stress shapes the experiences of various sexual minority clients differently. Both articles addressing clinical work with couples, Scott and colleagues (this issue) and Macapagal and colleagues (this issue) highlight the clinical implications of minority stress and the particular ways it impacts relationship satisfaction and behavioral health choices of same-sex couples. These authors report that there are challenges to providing relationship services that are culturally appropriate for same-sex couples. Existing interventions were developed for monogamously partnered, different-sex couples. They include heteronormative assumptions. They do not address unique challenges faced by same-sex couples, and many clinicians feel unprepared to work with same-sex couples. They suggest three requirements of providers working with same-sex couples: to be knowledgeable about same-sex relationships, use interventions free from heterosexist bias, and accept same-sex relationships. Scott et al. (this issue) insightfully acknowledge that there has been bias regarding same-sex couple dynamics. While it has been observed that there may be more frequent relationship dissolution, for example, such outcomes may have had more to do with obstacles posed by the larger culture such as historically prohibited access to marriage. We must point out, however, that even the idea of life-long relationships that last "until death do they part" maintains a cultural bias that may not be the cultural ideal for many sexual minority clients.

Areas that need addressing with same-sex couples are communication styles and abilities. This is common among all couples therapies, and all couples have conflict and arguments. A difference between same-sex couples and different-sex couples may be that some of the content of couple arguments differ (Scott et al., this issue). Interestingly, the research that suggests that male couples argue about sex outside of marriage more than different-sex couples makes complete sense, given that cultural norms mostly dictate that this behavior is unacceptable in different-sex couples and therefore is not typically discussed prior to there being a betrayal of this prohibition. Scott and colleagues also suggest that there are differences in relationship roles, frequency of sex inside and outside the relationship, parenting, and social support. There is evidence that same-sex couples demonstrate resilience in the face of lack of societal support, and clinicians must be capable of acknowledging and addressing these unique strengths and challenges such couples face.

Macapagal et al. (this issue) specifically highlight the importance of providing young male couples sexual education in HIV and other sexually transmitted infection prevention. These authors further explore the issue of nonmonogamy in presenting a case of a couple dealing with jealousy in an open relationship and how the therapist helped them to discuss an agreement about their sexual behavior outside of the relationship. Building upon this consideration, future research may also need to include the impact of envy on same-sex couples that may actually find themselves in competitive roles for other partners to whom they are both attracted, but who may show preference to one of them over the other. Envy and jealousy are not unique to same-sex relationships, but the social context and history of minority stress must inform how clinicians work with these couples.

Feinstein, Dyar, and Pachankis (this issue) foreground the particular manifestation of minority stress that emerges from multiple social contexts for bisexual individuals. Varying forms of invalidation from dominant (heterosexual) culture as well as from within sexual

minority-identified social contexts create multiple layers of risks faced by bisexual individuals, which appears to be born out in the prevalence rates of psychopathology and substance use. Burton, Wang, and Pachankis (this issue) emphasize the importance of social context and minority stress, and the need for clinicians to assess the unique influences of minority stress in the lives of each sexual minority client. Practitioners must recognize that the pathways and impacts of minority stress are varied across the broad diversity of sexual minority individuals seeking clinical care. Social context not only explains the unique risks faced by sexual and gender minority clients, but it demands the best contextual assessment and considerations of cognitive and behavioral clinicians.

Just as all of the articles in this issue highlight the importance of social context in conceptualizing and clinically intervening directly with sexual minority clients, they also uniformly call for clinical attention to intervening in structures and systems that constitute the persistent invalidations, obstacles, and sometimes instrumental threats to the well-being of these clients. It is professionally unsatisfying and ultimately inefficient to recognize the pervasive contextual factors that impose minority stress on sexual minority individuals, and yet restrict the scope of our interventions solely on armoring them to weather an inhospitable environment. All of the articles in this volume indict the systems of which clinicians are a part as requiring intentional intervention at the mezzo level, calling for changes in the environment of care in order to increase access and to deliver care more competently to clients. When working with couples, both Scott and colleagues (this issue) and Macapagal et al. (this issue) specifically highlight the need for promotional and instructional materials to reflect other than heteronormative depictions of relationships. Interventions must address how gender roles may be enacted differently in same-sex couples, in contrast to assumptions about relationship dynamics that presume different-sex couples. Clinical intake forms can be a subtle signal of insensitivity at best, and instrumental obstacles to access care, at worst. It is insufficient to invest in culturally competent clinical care when intervening with sexual minority clients directly, while the offices, organizations, and delivery of ancillary services perpetuate the marginalization and rendering invisible of these individuals as further mechanisms for exacerbating minority stress.

A Call to Intervene at a Macro Level

All of the articles in this volume draw attention still further beyond the mezzo level to call for clinicians and researchers to actively intervene in the social norms, accepted social practices, and legal obstacles placed in the way of the full and equal participation of sexual minority individuals in civil society. The uniform recommendation of all of the articles in this volume is that clinicians must advocate for social change. If the health and well-being of sexual minority clients is the goal, bringing the best of clinical expertise at the macro level is necessary to be part of changing the grossly inhospitable social environment that a growing consensus recognizes as the malignant source of damaging minority stress for sexual minority individuals.

Embedded within these articles is also a recognition that the communities within which sexual minority clients live and seek social support are complicated variables in leveraging mezzo- and macro-level change in the service of direct "in the room" clinical care. Feinstein et al. (this issue) most directly implicate how the sexual minority community itself can become a risk factor to the well-being of bisexual individuals. At the same time, intimate relationships and social networks ("families of choice") within sexual-minority-identified communities constitute crucial sources of support that can buffer the invalidation of heterosexism, homophobia, and bi-negativity. The articles in this volume highlight the crucial impact of community for sexual minorities, both as a potential buffer and social support in the midst of minority stress, and, at least at times, as a source of minority stress.

In addition to the concrete and specific strategies described in the articles in this issue for intervening at the organizational and societal level to address minority stress, additional attention needs to grapple with community-level variables that form another layer of social context for sexual minority clients. Conceptualizing psychological intervention at the level of sexual minority communities is rare, but the implications of the articles in this issue suggest that this may be an important direction in the ongoing evolution of this line of research. Public health researchers have charted strategies for investigating and intervening in community level variables impacting the health and well-being of minority populations. Community Based Participatory Research (CBPR) has become an important model for forging partnerships between researchers and oppressed communities, in order to conceptualize and test interventions as well as to understand the social context that shapes the realities within these communities in unique ways (Mohammed et al., 2012; Wallerstein & Duran, 2010). The explicit approach of partnering with oppressed communities in this way conceptualizes community members and researchers as co-learners in the conduct of research. Partnering with communities may be another important level of innovation necessary in order to understand and intervene effectively, and culturally competently, in order to influence macro-level policy changes in support of sexual minority communities grappling with the impact of minority stress. Characterizing sexual minority communities as valorous sources of resilience and coping, or,

conversely, indicting them as vectors for further marginalization, stigma, and chronic stress, should be a humbling project for any researcher. Tackling intersecting identities within these communities to examine how they may exacerbate the impact of minority stress for racial minority, gender nonbinary, and bisexual community members, for example, is almost certainly necessary to account for the impact of social context on mental health outcomes. Honestly accounting for the impact that such research endeavors may have on the immediate well-being of sexual minorities requires that those of us invested in the production of knowledge consider the intended and unintended consequences of our efforts. Even researchers who position themselves as members of these communities must conscientiously examine the historical context of their research questions, and the uses to which their findings may promote or impair the well-being of their research subjects. Utilizing CBPR or similar approaches may be what is required to responsibly and accurately examine the role of sexual minority communities as part of the social context buffering and exacerbating the minority stress increasingly seen as foundational for understanding how to innovate therapeutic research for sexual minorities. It can be assumed that any research conclusions that highlight uniqueness within these communities may be deployed to undermine the ability of sexual minorities to participate fully in civil society. To be different has been consistently used as shorthand to be considered pathological. Similarly, promoting the academic inquiry of how oppressed communities may further enact oppression could ultimately serve to delegitimize and destabilize powerful ways in which they have buffered invalidating and unsafe macro-level influences historically and presently. These are crucial questions implied by the body of research in this issue, and researchers must conscientiously learn from our history, and learn from the marginalized communities we study and seek to intervene with, to approach these questions responsibly and ethically.

Conclusion

During what we have chosen to call a "third wave" of research on sexual minorities, researchers begin from a strongly affirmative stance going deeper into the unique experiences of populations shaped by an oppressive social context. Research has evolved from serving as apologetics that advocate for acceptance and integration of sexual minority communities, to promoting the position that sexual minorities represent unique cultural variations that must be addressed in clinical practice. While there are many different "positionalities" within these communities, researchers and clinicians alike must take into account the unique needs, challenges, and contributions of the communities with whom they work. The work itself, however, must happen at and beyond the individual level to shift the larger societal context from oppression to affirmation. Published psychological research becomes part of the social context, shaping avenues for healing and resilience, as well as potentially exacerbating stress for sexual minority clients. Through better understanding effective interventions with sexual minority clients, this research contributes to the macro-level social endeavor of recognizing such clients as both uniquely stressed as well as fully human. We thank the authors who have contributed to this special issue, and whose research continues to move us forward in developing best practices with sexual minority populations.

References

Burton, C. L, Wang, K., & Pachankis, J. E. (this issue). Psychotherapy for the spectrum of sexual minority stress: Application and technique of the ESTEEM treatment model. *Cognitive and Behavioral Practice,* this issue.

Feinstein, B. A., Dyar, C. & Pachankis, J. E. (this issue). A multilevel approach for reducing mental health and substance use disparities affecting bisexual individuals. *Cognitive and Behavioral Practice,* this issue.

Han, C. (2007). They don't want to cruise your type: Gay men of color and the racial politics of exclusion. *Social Identities*, *13*, 51–67, https://doi.org/10.1080/13504630601163379.

Kurdek, L. A. (1998). Relationship outcomes and their predictors: Longitudinal evidence from heterosexual married, gay cohabiting, and lesbian cohabiting couples. *Journal of Marriage and the Family*, *60*, 553–568.

Kurdek, L. A., & Schmit, J. P. (1986). Relationship quality of partners in heterosexual married, heterosexual cohabiting, and gay and lesbian relationships. *Journal of Personality and Social Psychology*, *51*(4), 711–720.

Macapagal, K., Feinstein, B. A., Puckett, J. A., & Newcomb, M. E. (this issue). Improving young male couples' sexual and relationship health in the 2TOGETHER program: Intervention techniques, environments of care, and societal considerations. *Cognitive and Behavioral Practice,* this issue.

Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York: Guilford.

Merriam, S. B., Johnson-Bailey, J., Lee, M. -Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, *20*, 405–416, https://doi.org/10.1080/02601370110059537.

Mohammed, S. A., Walters, K. L., LaMarr, J., Evans-Campbell, & Fryberg, S. (2012). Finding middle ground: negotiating university and tribal community Interests in community-based participatory research. *Nursing Inquiry*, *19*(2), 116–127, https://doi.org/10.111/j.1440-1800.2011.00557.x.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, *36*, 38–56 Retrieved from https://www.jstor.org./stable/2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697, https://doi.org/10.1037/0033-2909.129.5.674.

Patterson, C. J. (1992). Children of lesbian and gay parents. *Child Development*, *63*, 1025–1042 Retrieved from https://www.jstor.org/stable/1131517.

Rado, S. (1940). A critical examination of the concept of bisexuality. *Psychosomatic Medicine*, *2*, 459–467.

Scott, S., Whitton, S. W., & Buzella (this issue). Relationship interventions to same-sex couples: Clinical considerations,

program adaptations, and continuing education. *Cognitive and Behavioral Practice*, this issue.

Wahler, J., & Gabbay, S. G. (1997). Gay male aging. Journal of Gay and Lesbian Social Services, *6*(3), 1–20, https://doi.org/10.1300/J041v06n03_01.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research Contributions to intervention research: The intersection of science and Practice to improve health equity. *American Journal of Public Health*, *100*(S1), S40–S46, https://doi.org/10.2105/AJPH.2009.184036.

The authors declare that there are no conflicts of interest.

Address correspondence to Christopher R. Martell, Ph.D., University of Massachusetts, Psychological and Brain Sciences, 135 Hicks Way, Tobin 137, Amherst, MA 01003; e-mail: christophermartellphd@gmail.com

Received: October 5, 2018
Accepted: December 4, 2018
Available online 12 December 2018