

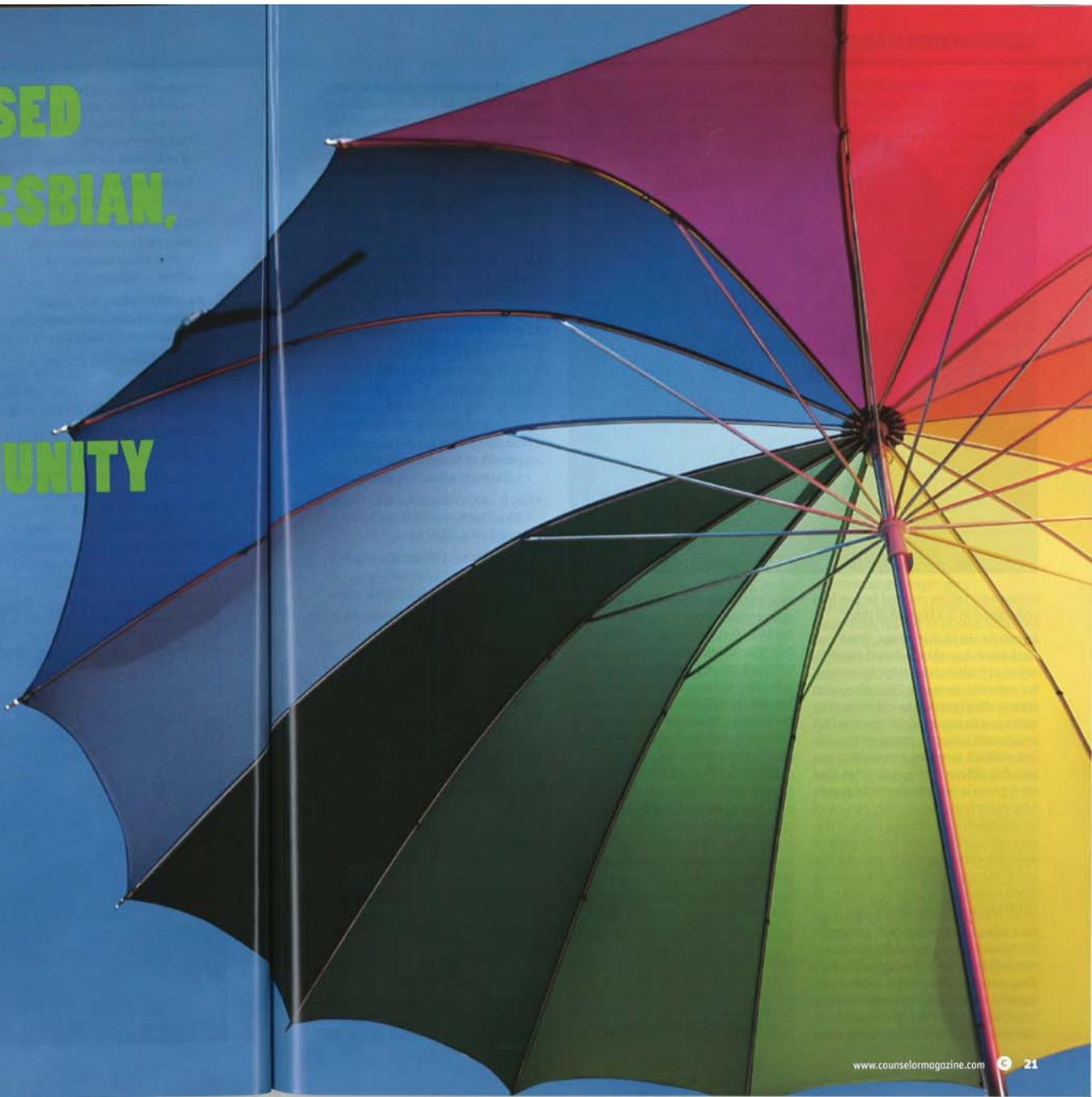
USING EVIDENCE-BASED PRACTICES IN THE LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUESTIONING COMMUNITY

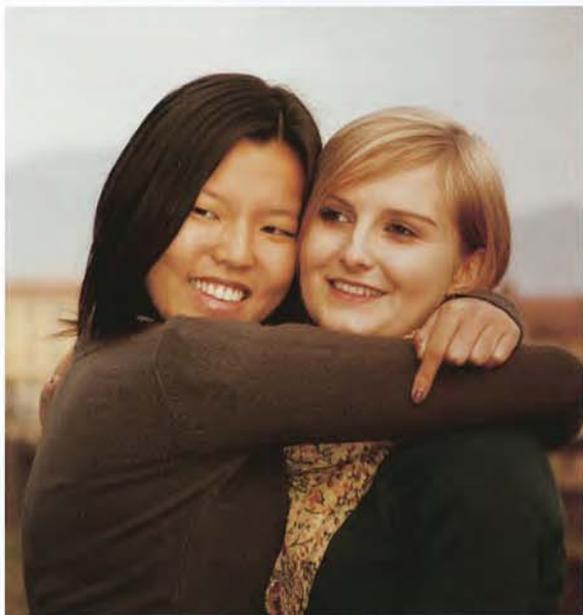
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In recent years, human-service practitioners and researchers have slowly witnessed the emergence of evidence-based practice (EBP) and evidence-based assessment (EBA). Despite the overall benefit of moving toward EBP, many human-service practitioners have voiced concern about its overarching applicability. Not all EBPs are created equally, and no EBP can provide a one-size-fits-all approach (Upshur, 2003). There is still a need to recognize and take into consideration the various factors that can affect a client, such as their cultural values, language, socioeconomic status, gender and treatment preference (Bernal, Jimenez-Chafey, & Rodriguez, 2009).

In January 2010, the Global Appraisal of Individual Needs Coordinating Center (GCN) invited experts, researchers, trainers and clinicians from around the United States to participate in the GAIN Cultural Sensitivity Summit in San Antonio, Texas. This event was sponsored in part

by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. The summit was dedicated to exploring issues relevant to various cultural groups (African American, Asian American, Hispanic and Latino, American Indian and Native Alaskan, rural and small community, LGBTQ, and religious and spiritual) and how we, as clinicians and researchers, can be more culturally sensitive to the clients we serve. Assessment is a major first step in most any therapeutic process. When assessing cross-cultural clients, it is important to capture relevant information about childhood, socialization, reasons for migration, acculturation experiences, and for first-generation immigrants, postmigration adaptation (Westermeyer, 1987). To avoid misdiagnosis and placement, it is essential to get an unbiased baseline measure of where the client is at the time they present for





evaluation. Taking cultural factors into consideration is a big part of that.

In article six of this series, Titus and Guthmann (2013) broadened the definition of “cultural diversity” by moving beyond ethnicity or race. Their discussion surrounding diversity based on hearing status and its impact on interpreting EBA results and adapting practices is easily generalized to other groups that are invisibly different from each other. One such group is the community of people who differ from the majority by way of sexual orientation. In part eight of this nine-part series we will briefly explore some key concepts, events and risk factors that may be important to consider when utilizing EBP to assess and treat LGBTQ adults and adolescents.

Like other cultural minority groups in the United States, the LGBTQ community has experienced marginalization, discrimination, unequal treatment and abuse. A variety of factors from ethnicity to biological sex affect that experience. As a result, the community may not share

uniform viewpoints, which can be the source of some sensitivity when discussing LGBTQ-related issues. The authors fully recognize that not all concepts, historical effects and common issues can be addressed within the limits of this article. Instead, this article is meant to provide a general overview of the trauma and other difficulties that the LGBTQ community may face and offer some thoughts about using evidence-based practice in the assessment and treatment of LGBTQ clients. While genuinely great strides have been made in the past couple of decades toward the society-wide acceptance of lesbian, gay, bisexual, transgendered and questioning people, the authors freely acknowledge that great obstacles remain.

What Does LGBTQ Mean?

Before discussing what LGBTQ means, we have to first understand the term *sexual orientation*. Sexual orientation is a combination of physical, emotional and romantic attractions to another person; it

is not defined by sexual behavior (APA, 2012; SAMHSA, 2001). Sexual orientation falls into one of three categories: 1) heterosexual (attractions to persons of the opposite sex), 2) homosexual (attractions to persons of the same sex) and 3) bisexual (attractions to both sexes).

The word *gender* is often used to define maleness/masculinity or femaleness/femininity, whereas gender role is often determined by how a culture views behaviors that are deemed masculine or feminine (SAMSHA, 2001). It is important to understand that sexual orientation and gender identity are not one and the same or necessarily linked.

So what exactly is LGBTQ? LGBTQ describes a group of self-identified lesbian (L), gay (G), bisexual (B), transgender (T) and questioning (Q) people.

- Lesbian is a term used to describe a woman with enduring sexual or romantic attractions to other women.
- Gay is used to describe a man with enduring sexual or romantic attractions to other men.
- Bisexual is used to describe a male or female who is physically or romantically attracted to both sexes.
- Transgender is a somewhat broad term used to describe people whose gender identity or gender expression does not match the physical sex they were born with. Transgender people may have sexual or romantic attractions to males, females or both (SAMHSA, 2001).
- Questioning describes people who are not certain of their sexual orientation or gender identity. The Q in LGBTQ can also stand for “queer,” which can describe a range of sexual orientations with the exception of heterosexuality. Historically, queer was used as a slur, but it has since been adopted by members of the LGBTQ community as a way of not adhering to gender binaries or heterosexually defined labels (Heartland Alliance). This article will use “questioning” for the Q.

We should note that the term LGBTQ, although most frequently used to describe the sexual-minority

population, is not universally accepted, and clients should be allowed to self-identify whenever possible (SAMSHA, 2001). GAIN Cultural Sensitivity Summit participants felt that a key characteristic of a sound EBA like the GAIN was the ability to capture LGBTQ status. In addition, summit participants pointed out that some clients may self-identify outside the categorical groups provided on the GAIN or other EBAs, which an assessment should have the ability to note in an “other” category or in additional collateral information.

How Can EBP Be Used Effectively with LGBTQ Clients?

As described in the earlier articles in this series, the GAIN Cultural Sensitivity Summit participants identified five competencies for treatment professionals who want to use evidence-based practices with diverse populations:

- Recognize the importance of historical perspective
- Appreciate the impact of cultural explanations and stigmas
- Respect cultural variations, expectations and communication
- Create an atmosphere of cultural safety
- Show adaptability and flexibility

Using these five competencies as discussion points, we present some thoughts on using evidence-based practices with LGBTQ clients.

Recognize the Importance of Historical Perspective

It would require many volumes to cover the rich history of homosexuality, sexual orientation and identity, gay culture, the HIV/AIDS epidemic and the gay rights movement in the United States. However, for the purposes of this article, we will focus primarily on a few historical milestones that have helped to push LGBTQ issues to the forefront. An awareness of the culture’s history will help counselors understand the heritage that their LGBTQ clients are coming from.

In the first edition of the American Psychiatric Association’s (APA’s) *Diagnostic and Statistical Manual of*

Mental Disorders (DSM), released in 1952, homosexuality was categorized as a “psychopathic personality with pathological personality” (Robertson, 2004). In the early 1960s, approximately ten years after the initial release of DSM, a second edition of the DSM was released that reclassified homosexuality as a “sociopathic psychological disturbance” (Marmor, 1980). Labels such as these, endorsed by the American Psychological Association, inevitably contributed to the decision of many LGBTQ people to resist seeking mental health treatment for any reason.

In the 1960s homosexual activity was largely treated as “illegal” (Carter, 2004). As a result, police departments in cities throughout the United States did not reach out to members of the LGBTQ communities, instead treating them as social deviants and criminals (Gillespie, 2008). Gay establishments were closely monitored by police, and raids were not uncommon (Morrow, 2001). Men and women caught in gay bars or clubs would likely be subject to violence, humiliation, unwanted exposure, felony imprisonment or termination from employment, among other consequences (Katz, 1976). Throughout the mid to late twentieth century, police either failed to protect the LGBTQ community or persecuted it outright (Kohn, 2002). In general, not only was there a lack of protection for LGBTQ groups, but the constant threat of police harassment was of great concern. As a result, many learned to conceal their sexual identity as a means of survival (Grossman, 1995; Martin & Lyon, 1992; McLeod, 1997; Shenk & Fullmer, 1996).

The weekend of June 27–29, 1969, marked the beginning of resistance toward police harassment and brutality. New York City police officers raided the Stonewall Inn under the premise that it was in violation of liquor laws and began arresting men who were socializing at the bar (Paquette, 1994). Many of the men began to defy the police, and others fought back. This event became known as the “Stonewall Riots.” (Gillespie, 2008). For many, the Stonewall Riots marked the beginning of what is now the gay liberation movement in the United States. (Gillespie, 2008; Carter, 2004; Brownworth, 1994; Kopkin, 1994)

because the LGBTQ community began to unify and tackle the discrimination they had faced (Robertson, 2004). Almost immediately following Stonewall, the gay activist movement gained significant momentum and quickly became more visible and political in nature, with groups like the Gay Liberation Front (GLF) leading the way. At the 1970 APA annual meeting, a group of gay rights activists confronted psychoanalyst Irving Beiber and publicly called for the removal of homosexuality from the DSM (Robertson, 2004; Bayer, 1987).

Despite a great deal of controversy, in 1973 the APA voted to remove homosexuality from the list of mental illnesses and created a new category called “ego-dystonic” disturbance (Robertson, 2004; Marmor, 1980). Then in 1975 the APA released the following statement:

Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities; further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations (Conger, 1975).

The APA’s decision to remove homosexuality from the list of mental illnesses was a major step toward demythologizing sexual orientation and behaviors and a major victory for LGBTQ groups (Robertson, 2004). However, the decision still left an uneasy feeling in the LGBTQ community because heterosexuality was still considered “normal” (Marmor, 1980). It wasn’t until 1986 that the “ego-dystonic” disturbance would be removed from the DSM altogether.

Despite the progress that has been made in the psychiatric community in the past 30-plus years, there are still divisive debates surrounding the “normalcy” of homosexuality (Robertson, 2004). In 2009, the APA adopted a resolution urging mental health professionals to avoid telling clients that they can change their sexual orientation through therapy or other treatments (APA, 2009). Despite a lack of empirical evidence to support reparative and conversion therapies and the APA’s stance against it, these therapies still exist (APA, 2009; Haldeman,

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2001). Summit participants emphasized that when selecting an EBA or EBP, clinicians should steer away from those that don't affirm LGBTQ identity or imply that it is "abnormal."

Appreciate the Impact of Cultural Explanations and Stigmas

What does it mean to "come out"? Coming out is a personal process by which a person comes to accept his or her sexual orientation, becomes involved in LGBTQ activities, recognizes attitudes toward homosexuality and gains a degree of comfort with their sexual orientation and the self-disclosure of their sexual identity to others (APA, 2012; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001; Center for Substance Abuse Treatment, 2001). There is no correct way or single process to come out, and there are some who will ultimately never come out on their own accord (Cass, 1979). People who do not come out and who continue to use extreme caution surrounding the privacy of their sexual orientation are referred to as "closeted" (APA, 2012). With increased visibility and acceptance, LGBTQ youth are coming out at earlier ages (Savin-Williams, 2005).

Coming out is a major milestone for many in the LGBTQ community because it marks a significant period of discovery and self-affirmation. It is a bit of a cultural phenomenon in that there are many stories to be told surrounding the coming-out experience. Out individuals are usually willing to share their stories and struggles with others as a way of providing hope that things will get better. The coming-out experience is not uniformly pleasant for many LGBTQ people and can be a major source of fear, stress and maladaptive coping behaviors.

Why should researchers and counselors know about coming out? Coming to terms with sexual orientation and gender identity can prove to be challenging for adolescents and adults because disclosing sexual orientation to family and peers may place them at risk for alienation and rejection (D'Augelli, Hersberger, & Pilkington, 1998). The stress of dealing with not "fitting in" can prove to be too much for both adults and adolescents,

and many turn to alcohol and drugs as a means of coping or escape. For many adolescents who lack the tools to accept the societal scrutiny that comes with being labeled a "sexual minority," substance abuse and dependence can add additional challenges (Orenstein, 2001; Morrow, 2004). Research conducted by Rosario, Crimshaw, and Hunter (2009), based on a sample of 156 lesbian, gay and bisexual youths aged 14 to 21, suggested that negative reactions to a person's disclosure of sexual identity are associated with greater levels of substance use or abuse.

Summit participants felt that it was critical to select EBAs that establish and recognize sources of social support for LGBTQ adolescents in various stages of the coming-out process because positive sources may be limited. Finding positive activities and social supports can be equally challenging for adults coming out. Like many minority populations, the LGBTQ community has been targeted by tobacco and alcohol companies, and, historically, there has been a heavy emphasis on bar culture.

EBPs could also be used to help LGBTQ clients equip themselves with tools and resources to deal with the potential challenges they face when coming out. Summit participants viewed the selection of strength-based EBAs and EBPs as essential, since many LGBTQ adolescents and adults seeking treatment may already feel somewhat defeated. Factors that increase resilience, like peer or familial social support, do not eliminate the effects of victimization that these youths might have already experienced (Mustanski, Newcomb, & Garafalo, 2011). Selecting EBPs that are trauma-informed would also be ideal for the LGBTQ population. Trauma is not limited to that associated with rejection; for many, it is marked by acts of physical violence, abuse, and school- and cyberbullying.

Respect Cultural Variations, Expectations and Communications

Does the LGBTQ community have a culture? In short, yes. The word *culture* refers to an "integrated pattern of human behavior that includes thoughts,

communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group" (NASW, 2000). There is prominent LGBTQ cultural symbolism, such as the pink triangles derived from the symbol used by the Nazis at concentration camps to mark LGBTQ prisoners and the rainbow flag, which represents cultural diversity and pride in the LGBTQ community; LGBTQ-centered events like PRIDE promote diversity, recognition and awareness of LGBTQ people; and geographic concentrations such as Boystown in Chicago and Greenwich Village in New York City. At the heart of the LGBTQ culture and community is a shared belief in the legitimacy of their identity and status as human beings. GAIN Cultural Sensitivity Participants recognized that the LGBTQ culture is sometimes harder to identify because it is not limited to the common defining traits of race, ethnicity, common geographic area or physical characteristics.

What is so intriguing about the LGBTQ community is the diversity within the community. It spans a wide array of religious, gender identity, ethnic, social, economic and racial backgrounds. Trying to define all subcultures and ethnicities within the community is somewhat analogous to a never-ending game of Scrabble: The combinations are endless, and, in many ways, LGBTQ people epitomize what it means to be cross-cultural.

It is important to emphasize the heterogeneous nature of the LGBTQ community experience and how it is affected by a variety of factors. The concept of "intersectionality" would best explain how race, ethnicity, culture, gender, age, sexual orientation, socioeconomic class and disability can create diversity within groups like the LGBTQ community (Cole, 2009). Sometimes this interplay of cultures can create conflict for LGBTQ people. Take for example the stigma faced by lesbians: It may not be equivalent to the stigmas that gay men or bisexuals face because of additional factors like sexism (APA, 2007). Sexism is primarily based upon gender and is an added challenge for not just lesbians but many females of various cultural groups. Or consider the 2001 documentary by

Sandi Simcha Dubowski, *Trembling Before G-D*, which is focused on gay and lesbian Orthodox Jews. The people profiled in this film explore how their religious beliefs are just as central to their being as their sexual orientation or identity.

To properly assess and treat LGBTQ clients, there is a need to understand where they fit within their culture. Does the client identify primarily with the LGBTQ culture? Does the client identify primarily with their racial or ethnic culture? Does the client consider themselves in limbo, trying to balance multiple cultures? GAIN Cultural Sensitivity Summit participants felt that this was a key consideration when it comes to working with



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the LGBTQ population: Not only should clinicians and researchers be aware of the overall LGBTQ culture, they should also be familiar with the variances within the culture and other cultural interplay. Summit participants felt this could prove to be an additional challenge for clinicians utilizing EBPs with LGBTQ clients because it requires a much broader cultural knowledge base. The question then becomes how you adapt the EBP to account for the "multiple" cultural interactions. This is something that will likely greatly vary from client to client, but it is important for clinicians to allow clients to explain their cultural context and how they fit in as it can have great impact on the client's recovery (SAMSHA, 2001).

Being able to recognize and affirm others' cultures and beliefs requires a conscious effort and is one of the first steps to being more culturally sensitive. When working with a marginalized group like LGBTQ, cultural sensitivity is increasingly important as a matter of building rapport. Cultural sensitivity is a conscious knowledge that, while there are differences between cultures, one should not assign judgments or values to the differences between cultures, like "better" or "worse," but instead respond to other cultures with dignity and respect (Wintz & Cooper, 2003).

Cultural sensitivity allows us to heighten our awareness of how our own cultural values could in turn affect the assessment and treatment of our clients (Paniagua, 2005). Understanding the potential for bias will help us better assess and treat clients in a way that is relevant and appropriate for them. GAIN Cultural Sensitivity Summit participants thought this to be a critical piece when working with members of LGBTQ groups because many LGBTQ clients share an overarching concern of being judged negatively. You don't have to be LGBTQ to understand and work with LGBTQ clients. You simply need to be able to affirm their sexual orientation, be able to recognize their challenges and reserve your personal judgments to avoid a biased assessment and treatment experience.

When working with any cultural group, not just LGBTQ, it is not enough to simply recognize and be aware of the differences between cultures. You must put your knowledge into actions. Cultural competence is a process by which individuals and systems respond respectfully and effectively to people of all cultural backgrounds in a way that affirms their individual worth and dignity (NASW, 2001). By taking an active role in gaining cultural competence, you can do your part to deliver effective assessment and treatment (Paniagua, 2005).

Create an Atmosphere of Cultural Safety and Acceptance

Currently in the United States, there is a special interest in equal rights for LGBTQ people, with heavy emphasis on issues

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such as gay marriage, nondiscrimination legislation, and antibullying and antihate crime bills, all of which have sparked heated debate among our nation's politicians, educators, religious leaders and media. A recent Princeton, New Jersey, Gallup Special Report Poll (February 2013) revealed that approximately 3.5% of U.S. adults identify as lesbian, gay, bisexual or transgender. Statistics on LGBTQ youth in the United States are not as easily accessible, and sample sizes greatly vary because it is often considered "controversial" to ask young people questions related to sexual orientation. For example, the federal Protection of Pupil Rights Amendment (PPRA) allows parents the express right to limit their child's participation in surveys or questionnaires that may contain controversial or sexual subject matter, and schools must notify parents annually of their rights.

As a group, LGBTQ have been targets of antigay violence (Herek & Berrill, 1992). The Federal Bureau of Investigations' Hate Crimes 2011 statistics report stated that approximately 20.8% of hate crimes in the US were motivated or resulted from sexual-orientation bias. In short, members of LGBTQ groups are not universally revered or accepted. This may pose a barrier to assessment and treatment because of clients' fear of not being accepted or of having violence inflicted upon them. Summit participants felt that it was important for LGBTQ clients to be aware of agency nondiscrimination policies and other policies protecting physical safety and prohibiting harassment of clients.

Violence and victimization are common among marginalized minority populations, and the LGBTQ community is no exception. Sexual minority youth are more likely to be victims of bullying, peer sexual harassment, dating and partner physical abuse than heterosexual youth (Williams, Connolly, & Pepler, 2003; Waldo, Hesson-McGinnis, & Agullini, 1998).

In 2012 a report issued by the Human Rights Campaign, which surveyed over 10,000 youth predominately between 13 and 17 years of age, revealed the following statistics (the report used the abbreviation "LGBT"):

- 4 in 10 youth (approximately 42% of the sample) said that the community in which they live is not accepting of LGBT people, while only 16% of non-LGBT youth feel that way.
- Approximately half of LGBT youth (47%) said that they do not fit in their community, while only 16% of non-LGBT youth felt that way.
- 67% of straight youth described themselves as happy, but only 37% of LGBT youth described themselves as happy.
- 83% of LGBT youth believed they will be happy eventually, but only 49% believed they can be happy if they stay in the same city or town.
- 6 in 10 LGBT youth said that their family is accepting of LGBT people, while a third said that their family is not.
- 92% said that they heard negative messages about being LGBT, and 60% said that those messages come from elected leaders (Human Rights Campaign).

In addition, a study conducted by the Williams Institute found that approximately 40% of homeless youth are LGBTQ, with one of the top five reasons being that they were forced out by parents because of their sexual orientation or gender identity (Durso & Gates, 2012). Lesbian, gay and bisexual youth are two to three times more likely to commit suicide (Garafalo, 1999). Bullying is one of the most common forms of victimization experienced in both schools and communities and also contributes to increased levels of depression (GLSEN, 2011).

GAIN Cultural Sensitivity Summit participants agreed that, although suicide, violence, victimization, substance use and homelessness are prevalent in the LGBTQ population, it is important to note that they are not the norm. Although clinicians and researchers should be aware of these issues, they should not assume that all LGBTQ youth have experienced them.

EBAs like the GAIN often explore sensitive issues surrounding common co-occurring issues related to substance abuse and mental health treatment such

as suicide, violence and victimization. Clinicians using EBAs should recognize the importance of those items but that they may be uncomfortable for clients to answer or may trigger potentially traumatic memories. It is important to allow clients to take breaks, remind them that they have the right to refuse to answer any questions asked of them and have LGBTQ-sensitive trauma-informed resources available. Summit participants also emphasized the importance of setting the stage. Creating a space that reflects safety and acceptance can be as simple as prominently displaying common LGBTQ symbols such as rainbow flags, pink triangles, safe-zone stickers and posters emphasizing diversity. Such symbols convey openness and have a great impact on rapport with LGBTQ clients.

Assessment and treatment can potentially expose clients to a variety of issues surrounding the confidentiality of their disclosures. It is important to explain early in the process, prior to assessment or treatment, the rules and limitations pertaining to client confidentiality and patient rights. For example, the GAIN provides an introduction to the assessment and explains how the information will and won't be used. A cultural adaptation for LGBTQ clients would be to ensure that issues surrounding their sexual orientation and identity will not be shared without proper disclosures in place. In addition, clinicians should know how and when to recognize significant others and family when appropriate. Just because a client has come out to themselves, or self-identifies as LGBTQ, does not mean that they are out to their parents, friends or communities. There is a cultural expectation between LGBTQ clients and their clinicians that you will respect their privacy and not inadvertently out them to others.

Show Adaptability and Flexibility

Selecting EBPs that are both adaptable and flexible is important because they generally cannot account for all cultural nuances. A major benefit of using an EBA like the GAIN is that it is modular in nature (sections can be added or excluded without effecting the validity

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and reliability of the instruments); it is considered a "semistructured" assessment, meaning administrators have the flexibility to explain items and provide culturally appropriate examples as needed; and it can be administered in multiple sessions to allow for breaks as needed.

In 2005, the GCC started receiving comments from concerned GAIN users that the instrument was not adequately capturing LGBTQ status. In an effort to explore and address these concerns, an LGBTQ workgroup was formed. It was determined that the items were not adequately capturing LGBTQ status because of the limited choices on the GAIN (focused mostly on sexual behavior), the placement of the relevant items (in the risk behaviors section) and the reference to sexual orientation as a preference (implying choice), with no mention of sexual, emotional or romantic attractions. As a result, in later versions of the GAIN the items on LGBTQ status were placed in the environment section as opposed to the risk behaviors section, and new items were developed to better reflect self-identification of LGBTQ status based upon romantic, emotional and enduring sexual attractions. Summit participants emphasized the importance of

cultural adaptations like these and how they can increase the likelihood of disclosure. When using EBAs, it is important to assess from a clinical standpoint whether the items regarding LGBTQ status appropriately capture the information without implying judgment. EBAs should also be flexible and have the capacity for additional adaptations as cultural groups continue to evolve.

Conclusion

LGBTQ, culturally speaking, is a complex group because of the diversity within its subgroups. The LGBTQ experience, although linked by some commonalities and affected by certain risk factors, is not always generalizable. It is important not to use your cultural knowledge as a way to stereotype clients who identify as LGBTQ. Clinicians and researchers must continue to recognize the uniqueness of the LGBTQ experience. Becoming a culturally sensitive clinician or researcher is not something that happens on its own.

The first step is taking the time to educate yourself about key topics and historical events that may have shaped the LGBTQ identity and perspective. As clinicians and researchers, it is important to acknowledge your own worldview limitations and learn to tolerate the

potential uneasiness that comes with topics related to cultural groups outside your own (Cardemil & Battle, 2003). The second step is applying your knowledge from a clinical-interpretation standpoint, making adaptations when appropriate without compromising the integrity and fidelity of the EBA or EBP you are using. Adaptations don't have to be complicated; they can be as simple as displaying relevant symbols of diversity, fostering acceptance and creating an environment that allows for comfortable disclosure. Third, it is always important to use your sound clinical judgment in conjunction with your cultural knowledge when interpreting EBA findings and implementing EBPs with LGBTQ populations.

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