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The Potential to Promote Resilience: Piloting a Minority Stress-Informed, GSA-Based, Mental Health Promotion Program for LGBTQ Youth

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Research indicates that lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth are at elevated risk for experiencing anxiety, depression, and psychiatric distress (Fergusson, Horwood, & Beautrais, 1999; Mustanski, Garofalo, & Emerson, 2010; Marshal et al., 2011). Meyer (1995, 2003) demonstrated that unique stress processes contribute to this elevated risk, and Hatzenbuehler (2009) identified important psychosocial mediators that underlie this stress-psychiatric distress relationship. Not only do these contributions advance our understanding for why LGBTQ populations evidence elevated risk for mental health disorders, but they also provide a framework for adapting existing and developing new intervention and prevention programs for LGBTQ populations.

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Recently, Craig (2013) described a new, 8- to 10-session, group counseling program created to promote resilience among ethnic minority, LGBTQ youth. The groups were "discussion based and focused on the exploration of shared experiences . . . in a safe, supportive environment that promoted collective problem solving and coping" (p. 377), and they covered the following topics: assertiveness, coming out, dating, family relationships, stereotypes and discrimination, stress management, and sexual health (Craig, 2013). Outcome data using an uncontrolled pre/post design suggests that the program enhances self-esteem and positive coping behaviors among LGBTQ youth (Craig, Austin, & McInroy, 2014).

There are numerous reasons to pursue the development of school-based programs, such as the one described by Craig (2013). First, they have the potential to address the unique stressors that place LGBTQ youth at risk within the same ecological system where these stressors are frequently encountered. For example, LGBTQ students are often the targets of verbal and physical harassment within the school environment, yet upward of two thirds of LGBTQ youth who experience such harassment never report it to teachers and staff, and just over one third of those who do report being harassed say that school staff fail to intervene (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). Second, previous research documents how negative parental reactions upon learning about an adolescent's LGBTQ status can increase risk for psychiatric distress (Ryan, Huebner, Diaz, & Sanchez, 2009). Thus, youth who are not 'out' to their parents may find school-based programming appealing because it could mitigate risks associated with adverse parental reactions. Such programming could also help adolescents improve their ability to assess how individuals may respond to their LGBTQ status and cope with negative responses when they are encountered. Finally, if such programming can be delivered in the school setting, the likelihood that mental health concerns will be addressed before they require a higher level of care (e.g., hospitalization) or result in tragedy may increase.

Thus, the program developed by Craig (2013) represents a positive step forward for the field and shows promise for promoting resilience among LGBTQ youth. At the same time, many evidence-based programs exist to address mental health concerns among youth in school settings, yet the research-to-practice divide remains

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incredibly problematic (Addis, 2002). However, unique vehicles, known as gay–straight alliances (GSA), which are school-based groups for LGBTQ youth and their allies, may offer a means for bridging the research-practice divide when delivering mental health promotion programming to LGBTQ youth. Fetner and Kush (2008) note that GSAs were "virtually nonexistent" (p. 115) before 1990; by 2003 the number of GSAs increased to 1,200 and by 2006 had climbed to more than 3,000. If effective mental health promotion programming can be seamlessly integrated into the GSA setting, then it may be possible to bridge the research-to-practice divide and disrupt the minority stress-psychiatric distress relationship on a large scale.

With these possibilities in mind, I introduce here a four-session, cognitive–behavioral, GSA-based, mental health promotion program for LGBTQ youth. The components of this program were selected based on the frequency with which they appear in existing evidence-based interventions and modified based on my experiences using cognitive–behavioral therapy (CBT) when working with LGBTQ youth in individual and group settings.

Selection of Program Components

Randomized controlled trials and meta-analytic reviews exist to support the efficacy of CBT for the treatment and prevention of adolescent depression (Clarke et al., 1995; Spirito, Esposito-Smythers, Wolff, & Uhl, 2011). Despite elevated rates of depression and suicidality among LGBTQ adolescents, randomized controlled trials of CBT for adolescent depression, and psychotherapy more generally, fail to assess and/or report participant sexual orientation in the published literature (Cochran, 2001; Treatment for Adolescents with Depression Study Team, 2005). That said, CBT for adolescent depression generally involves four core components: psychoeducation, cognitive coping, problem solving, and affective regulation (Spirito et al., 2011). The adaptation of these components to address minority stressors reflects a logical first step in providing affirmative mental health promotion programing for LGBTQ youth.

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Minority Stressors and Mental Health Promotion for LGBTQ Youth

Meyer's (2003) minority stress model, coupled with the work of Hendricks and Testa (2012), specifies that a unique set of stressors, conceptualized along a distal-to-proximal continuum, can partially explain elevated rates of mental health disorders among LGBTQ populations. According to Meyer, distal stressors involve external events and experiences, whereas proximal stressors occur within the individual and involve specific psychological processes (e.g., cognitions). The first minority stressor involves *experiencing prejudice events*; for LGBTQ youth, experiencing bullying at school and being rejected by family and friends are common prejudice events that exacerbate mental health outcomes (Bontempo & D'Augelli, 2002; Rosario, Schrimshaw, & Hunter, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Ryan et al., 2009). Hatzenbuehler (2009) proposed a meditational framework and identified specific cognitive (e.g., hopelessness; negative self-schemas), affective (e.g., rumination; coping motives), and interpersonal (e.g., isolation) factors that link experiencing prejudice events with developing psychiatric distress. Mental health promotion programs should address this form of stress and target these mediating factors by assisting LGBTQ youth in identifying sources of social support, fostering cognitive coping and emotion regulation skills, and facilitating engagement in behaviors that will reduce the likelihood of experiencing future prejudice events.

A second minority stressor involves *expecting to experience prejudice events or rejection*. Many LGBTQ youth experience prejudice events and rejection (Bontempo & D'Augelli, 2002; Rosario et al., 2009; Russell et al., 2011; Ryan et al., 2009), and the expectation that these experiences will occur in the future produces hypervigilance that taxes executive functioning and compromises their mental health (Hetrick & Martin, 1987; Meyer, 2003). Hatzenbuehler and McLaughlin (2014) found that lesbian, gay, and bisexual adolescents who are exposed to stigmatizing environments display diminished hypothalamic-pituitary-adrenocortical axis reactivity. The authors liken growing up in a stigmatizing environment to experiencing traumatic stress, which can in turn produce hypervigilance. Thus, mental health promotion programs targeting LGBTQ youth should teach affective

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regulation, relaxation, and cognitive coping skills that address this form of stress.

A third minority stressor, *concealment*, involves engaging in strategies to conceal one's LGBTQ status. Concealment strategies are accompanied by constant self-monitoring to ensure that one's behavior conforms to heterosexual norms and gender role stereotypes. The decision to engage in concealment strategies may be protective when youth correctly appraise a person or environment as hostile; yet, if the appraisal is incorrect, such strategies are harmful in the sense that they increase the individual's level of stress (Lazarus & Folkman, 1984). Furthermore, having a concealable stigma, such as a minority sexual orientation, is associated with lower mood and self-esteem (Frable, Platt, & Hoey, 1998). The mechanism proposed to underlie this relationship is isolation from others who are stigmatized as a result of their minority group membership (Frable et al., 1998). To address this form of stress, mental health promotion programs should foster social connectedness and support among LGBTQ youth, while teaching a systematic method for making disclosure-related decisions.

The final minority stressor involves the *internalization* of negative societal views of LGBTQ people. This stressor can manifest as a desire to be heterosexual and gender conforming, and when confronted with stimuli that evoke awareness of oneself as being LGBTQ, the individual may engage in avoidant behaviors that occur internally (e.g., rumination) or externally (e.g., engaging in heteronormative activities; isolating oneself). This avoidance serves to temporarily manage negative affect and the awareness that the individual is part of a stigmatized group, but fails to address the issue more broadly (Skinta, Lazama, Wells, & Dilley, 2014). This stressor can be addressed with validation and affirmation of the individual's sexual orientation and/or gender identity, psychoeducation, and cognitive coping skills.

Description of the Mental Health Promotion Program

Table 1 contains an overview of the four program sessions discussed herein. The first session introduced the concept of minority

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stress and identified coping skills that the participants used in response to stressors. This helped participants understand why some LGBTQ youth are at increased risk for having mental health-related challenges and recognize that their own mental health might benefit from having unique skills to cope with minority stressors. Examples of general and minority stresses were provided. The facilitator gave an example for each category of stressor and then participants were encouraged to provide examples from their own lives. Next, the participants were divided into two groups and given a stack of index cards. Each index card contained an example of a stressor and the participants had to match the example into one of five categories (i.e., general stress, experiencing prejudice, concealment etc.). The group decisions were then reviewed. The conversation then turned to coping, which was discussed in terms of active and avoidant coping; participants were encouraged to discuss the types of coping strategies they use and whether they felt those strategies were effective.

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Table 1
Program Session Objectives, Materials, and Examples of Discussion Prompts

Session 1	Psychoeducation
Objectives	• Identify four categories of minority stressors (i.e., prejudice events, expectations of prejudice, concealment, and internalized homophobia) • Distinguish minority stressors from general stressors • Recognize that the higher rates of anxiety, depression, suicide, and substance use that are reported among LGBTQ youth are the result of minority stressors • Develop motivation to learn new skills for coping with minority stressors
Materials	• Handout depicting a simplified version of Meyer's (2003) Minority Stress Model • Minority and general stressor identification activity
Examples of discussion prompts	"You know how sometimes you hear that LGBTQ youth are at higher risk for things like depression or suicide. Well I'm curious, why do you think that is?" "What are some examples of stressors that are unique to being a LGBTQ youth?" "If there are stressors that are unique to a person's sexual orientation or gender identity, then maybe there are some unique ways that LGBTQ youth cope with these stressors. What might be some unique ways that LGBTQ youth cope with minority stressors?"
Session 2	Affect regulation
Objectives	• Discuss common emotional reactions to general and minority stressors • Recognize that multiple emotions can be experienced simultaneously • Recognize that emotions can be experienced at different levels of intensity • Understand the connection between experiencing a stressor, emotional reactions, and behavioral responses • Learn and practice diaphragmatic breathing and progressive muscle relaxation
Materials	• Handout depicting a simplified version of Meyer's (2003) Minority Stress Model (for review) • Handout depicting common emotions and an emotion rating scale and questions to identify a specific emotional and behavioral response to a minority stressor • Progressive muscle relaxation CD (provided to each participant)
Examples of discussion prompts	"Think of a time when you experienced a minority stressor. Think about how this situation made you feel and how your feelings impacted your actions. Who would like to share their experience with the group?" "Those are some excellent examples; clearly some of us have a hard time keeping our emotions in check when we experience these kinds of events. Now imagine if you were able to decrease the intensity of your emotions in this situation. What do you think might happen"
Session 3	Cognitive coping skills
Objectives	• Identify goals for managing minority stress • Distinguish helpful, neutral, and unhelpful thoughts in relation to the experience of minority stress and goals • Become motivated to replace neutral and unhelpful thoughts with helpful thoughts that resulted in goal-directed feelings and behaviors
Materials	• Cognitive coping handout (six pages) that is designed to assist the participant in identifying goals for managing minority stress (i.e., seek support; reduce likelihood of future minority stress events etc.) and then thinking about the stress in ways that lead to feelings and behaviors that are consistent with the stated goals
Examples of discussion prompts	"Today's activity helps us to identify goals for managing minority stress. What are some goals that you might have when confronted with a minority stressor like homophobic teasing? In other words, what might be some realistic and positive outcomes that could occur after you experienced a minority stressor?" "We've spent a lot of time today talking about the thoughts we have after experiencing a minority stressor; who can explain to me the difference between helpful, neutral and unhelpful thoughts?" "What might happen if more of our thoughts resulted in emotions and behaviors that moved us toward our goals? How might this change us?"
Session 4	Disclosure-related decision making
Objectives	• Learn a systematic method for solving problems • Apply this method to the process of making disclosures about being LGBTQ
Materials	• Disclosure decision-making handout that is designed to teaching problem solving and to assist in systematically evaluating the potential positive and negative results that could come from the decision to disclose (or conceal) one's LGBTQ status
Examples of discussion prompts	"Who would like to share a 'coming out' experience they had; perhaps an experience in which initially you expected the person to react one way, say in a negative manner, and it turned out that the person's response was different than you expected?" "What are some of the clues or pieces of information that you use when evaluating how a person might respond to the fact that you identify as LGBTQ?"

Program Session Objectives, Materials, and Examples of Discussion Prompts

The second session began by reviewing examples of minority and general stressors; the remainder of the session involved teaching participants affect regulation skills. Introducing these skills was intended to help participants obtain the ability to regulate their emotions and physiology in the face of stress. Participants identified typical emotional and physiological responses to minority stressors and then discussed whether having greater emotional and physiological regulation might be beneficial in situations where they experienced or expected to experience minority stress. Participants also began to learn about the connections between minority stressors, emotional

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reactions, and subsequent actions. The remainder of the session was spent practicing diaphragmatic breathing and progressive muscle relaxation.

The third session involved teaching participants to use cognitive coping skills in the context of minority stress. Participants were introduced to this skill using the standard CBT framework (i.e., activating event, thoughts, feelings, and actions). Rather than focus on maladaptive or irrational cognitions, this session emphasized goal-directed thoughts, feelings, and actions. Participants were provided with an example where a prejudice event served as an activating event. The participants then identified a goal or goals (e.g., reduce the likelihood that the event will occur again the future; obtain social support etc.) they might have for themselves if they were to experience such an event. The example then continued by depicting a sequence of thoughts, feelings, and actions that would likely move most youth away from a desired goal (e.g., the sequence led to isolation and rumination). The example ended by depicting a sequence of thoughts, feelings, and actions that would likely move most youth toward a desired goal. Notably, in this example the desired goal was to obtain support from an individual who could help reduce the likelihood of future prejudice events. Overall, this session encouraged the participants to identify a goal that they would have for themselves, if they were to encounter a prejudice event, and then think, feel, and act in a way that is consistent with their goal(s).

The fourth session involved teaching participants to use a systematic method for making disclosure-related decisions. The participants were provided with a basic problem-solving framework (i.e., the STEPS method; Chorpita & Weisz, 2009) followed by a discussion about how deciding to disclose or conceal one's sexual or gender minority status may require a special kind of problem-solving skill. This led to a disclosure decision-making activity where participants identified a person that they had come out to (or anticipated coming out to) and discussed their expectations. They systematically evaluated the pros/cons of both disclosure and concealment. The participants then discussed how they appraised the situation and came to expect a given outcome. They were then instructed to identify alternate evidence—things that might suggest the person would respond in the opposite manner. This session was

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designed to help participants critically evaluate the disclosure process and evaluate the pros/cons of both disclosing and concealing their sexual minority statuses.

Evaluating Feasibility and Acceptability Among LGBTQ Youth

To assess whether mental health promotion programming can be integrated into the GSA setting I conducted a pilot study using the four-session program just described. I hypothesized that the program would be feasible to implement in the GSA setting, as indicated by successful recruitment and participation in the program. I also sought to determine whether such a program would be acceptable to LGBTQ youth and hypothesized that participants would view the program as educational, enjoyable, helpful, and relevant to their lives. Finally, I obtained feedback about the program from participants in order to make modifications for future use.

The program was delivered within a high school GSA in the northeastern United States. The participants were 10 GSA members, six of whom consistently attended GSA meetings, in a school of less than 500 students. To ensure anonymous participation, formal demographic information was not collected from the participants. Instead the GSA advisor working with the group reported aggregate information to the investigator based on her knowledge of the GSA members. Two participants were in 12th grade, four were in 11th grade, and four were in 10th grade. Eight of the participants were identified as sexual minorities (e.g., LGBTQ identification; history of same-sex or both-sex sexual behavior or attraction). At the beginning of each session participants identified their gender and/or preferred pronouns; three of the participants identified as male, four as female, and three identified as gender minorities (e.g., gender queer or gender neutral). Demographic data for the school district indicates that 90% of students were White and 21% were eligible for meal subsidies during the 2013–2014 school year.

Two weeks before the first study session, the GSA advisor read an announcement that described the study procedures; those who were interested in participating informed the GSA advisor. The

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program sessions were held during GSA meetings; students who were not interested in the program were free to complete homework in the library, which was adjacent to the room where the sessions were held. Notably, all students who arrived at the meetings when the program sessions were conducted took part in the program.

At the beginning of each session, the investigator read an informed consent script and participants provided verbal assent/consent to participate. A waiver of parental permission was obtained from the Institutional Review Board (IRB) at Rhode Island Hospital for minor participants. Each program session lasted approximately 35 minutes. Participants then completed a 13-item feedback form (see Table 2). Ten of the items asked the participants to evaluate the session using a five-point scale (0- *strongly disagree*; 1- *disagree*; 2- *neither agree nor disagree*; 3- *agree*; 4- *strongly agree*). Three open-ended items asked participants to suggest changes for the session and to identify the most helpful and unhelpful aspects of the session. The study sessions took place on a weekly basis beginning in May, 2014.

Table 2
Items to Assess Each Session, Session Means, and Session Standard Deviations

Item	Session 1 Psychoeducation (n = 6)	Session 2 Affect (n = 5)	Session 3 Cognitive (n = 6)	Session 4 Decision making (n = 7)
	M (SD)	M (SD)	M (SD)	M (SD)
1. I enjoyed this session.	3.50 (0.55)	3.20 (0.44)	3.50 (0.55)	3.29 (0.49)
2. This session was relevant to my life.	3.00 (0.89)	3.40 (0.55)	3.33 (0.81)	3.00 (0.58)
3. I have a better understanding of stressors that are specific to LGBTQ people as a result of this session.	3.67 (0.52)	3.20 (0.45)	2.68 (0.52)	3.29 (0.49)
4. I am better able to cope with stress are a result of attending this session.	2.50 (0.84)	3.00 (0.00)	3.17 (0.75)	2.57 (0.53)
5. I think this session would be helpful for LGBTQ youth.	3.83 (0.41)	3.60 (0.55)	3.17 (0.75)	3.57 (0.53)
6. This session provided me with new information about coping with stress.	2.67 (0.82)	3.20 (0.45)	3.33 (0.52)	3.00 (0.58)
7. This session made me want to learn more about how I can be healthy.	2.67 (0.52)	3.20 (0.84)	2.33 (0.52)	2.43 (0.53)
8. I will use the knowledge I learned in this session.	3.17 (0.41)	3.00 (0.71)	3.33 (0.52)	3.14 (0.38)
9. This session was helpful.	3.33 (0.52)	3.40 (0.55)	3.50 (0.55)	3.14 (0.38)
10. I will use the skills I learned in this session.	3.50 (0.55)	3.00 (0.71)	3.33 (0.52)	3.43 (0.53)

Items to Assess Each Session, Session Means, and Session Standard Deviations

Feasibility and Acceptability of the Program

The first objective of this study was to evaluate the feasibility of integrating mental health promotion programming into the GSA setting. Ten GSA members participated in the study, and although each session was well attended, attendance was not consistent across all study sessions. Two participants attended four sessions, one attended three sessions, six attended two sessions, and one

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participant attended one session. The modal number of sessions attended was 2, with an average of 2.4 sessions attended per participant. Those identified by the GSA advisor as being consistent in their attendance at meetings attended an average of 2.8 sessions.

Notably, the number of participants who attended each session was similar to the typical attendance at GSA meetings. Also, this study took place at the end of the academic year, and it's possible that attendance would have been more consistent if the program had been delivered earlier in the semester or academic year. That said, no adverse events or issues of mandatory reporting emerged during the sessions, and overall, the results generally support the hypothesis that mental health promotion programming can be integrated into the GSA setting.

The second objective was to document the acceptability of the mental health promotion program. With respect to this objective, one interpretation of the attendance outcomes could be that the program was not acceptable; however, individual participant's patterns of attendance at the sessions were not indicative of attrition over time. Notably, the participant with 75% attendance missed the third session. Two of the participants with 50% attendance missed the first and second sessions and the participant with 25% attendance attended the final session. Only one participant attended the first two sessions and subsequently missed the remaining sessions. Furthermore, the descriptive statistics depicted in Table 2 suggest that the participants generally agreed that they acquired new knowledge, enjoyed the sessions, and felt the sessions were relevant to their lives. The results also indicate that the sessions were believed to be beneficial for the participants and other LGBTQ youth. With the exception of slightly lower ratings for items 4 and 7, the participants experienced and responded to the sessions in a similar manner, and the results generally support the hypothesis that the program would be acceptable.

The third objective was to obtain feedback to modify the program for future use. For each session, the responses were coded into one of four categories specified by the author and coded by a clinical psychology graduate student (the frequency of each code across the sessions is in parentheses): *no suggested changes/nothing*

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unhelpful (26); *suggested change* (11); *specific benefit noted* (20); and *specific criticism* (4). Statements such as, "I wouldn't change anything" and "Nothing was least helpful to me" were detected in many of the responses, which received the code of *no suggested changes/nothing unhelpful*. The *specific benefit noted* code also captured many of the responses, especially those in relation to the item about what was most helpful. For example, one participant wrote, "just putting the different stressors into the various categories really helped me to put things into perspective" and another indicated that, "this workshop helped me to realize that the ways I cope with stress are active and helpful." This feedback also suggests that some participants left the sessions with a desire to use what they learned, as evidenced by the following response, "The relaxation techniques definitely helped me out, and I will make my best effort to use them." Next, the participants offered a number of helpful suggestions, coded as *suggested change*, for how to improve the program and activities; they typically requested more opportunities for participant-directed discussion, increasing the involvement of and relevance to allies, developing more games/activities, and making the relaxation script more relevant to LGBTQ adolescents. Finally, four responses contained *specific criticisms* such as, "the information on general stressors was not that useful for me." Moving forward, this feedback will be used to refine the protocol in preparation for further evaluation. Overall, the hypotheses were generally supported; however, the present study did not evaluate the effectiveness of this mental health promotion program. Therefore, the next step for the present program is to conduct a small clinical trial to determine whether it has the potential to disrupt the minority stress–psychiatric distress relationship.

Important Considerations

If GSAs are a delivery vehicle for LGBTQ-specific programming, then GSA advisors are the drivers at the wheel. Thus, to ensure that future programs can be easily integrated into the GSA setting, such programs must be developed with input from GSA advisors. Therefore an essential question to be answered is what, if anything, do GSA advisors want in terms of mental health promotion programming? Furthermore, significant diversity exists among GSAs with respect to their advisors, activities, and members (Heck, Lindquist, Stewart,

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Brennan, & Cochran, 2013; Poteat et al., 2015). Some GSA advisors will have a mental health background, whereas others will not; some GSAs emphasize community engagement and advocacy efforts, whereas others focus on providing support to individual members. Given this heterogeneity, research must determine whether and how GSA-specific characteristics will impact the feasibility, acceptability, effectiveness, and dissemination of such programming. Finally, it is likely that the delivery of mental health promotion programming to LGBTQ youth may not be compatible with the activities and goals of all GSAs. In such instances other programs, like the one described by Craig (2013), may be more appropriate.

Furthermore, high schools that exist in communities with less affirming views of LGBTQ individuals may not have GSAs and even if they do, school administrators may not allow such a program to be delivered to LGBTQ students. Research suggests that GSAs are more likely to be established in communities where support for LGBTQ individuals already exists (Fetner & Kush, 2008), thus GSA- and school-based programming may not be viable in the communities with the greatest need. Yet, as evidence suggests that homophobia is on the decline (McCormack & Anderson, 2014), these environments may become more conducive to the development of GSAs in the future. In the meantime, youth in these settings would be ideal targets for Web-based programs, and the development and evaluation of programs within the GSA setting could provide a helpful blueprint for the programs of the future.

In closing, Meyer's (1995) minority stress model, and the numerous studies that followed, have truly advanced our understanding of LGBTQ health. However, 20 years have now passed, and little progress has been made to integrate what we know about minority stress with our knowledge of program development, evaluation, and dissemination. The results of this pilot study document the feasibility of delivering mental health promotion programming to LGBTQ youth within the GSA setting. The program, which specifically addresses minority stressors, appeared to be acceptable for the target population. Overall, these findings represent a preliminary step toward the integration that is needed to move our field forward and address mental health disparities among LGBTQ youth.

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