

University of Louisville

ThinkIR: The University of Louisville's Institutional Repository

College of Arts & Sciences Senior Honors
Theses

College of Arts & Sciences

3-2018

A peer-support mental health response training for LGBTQIA+ adolescents.

Megan A Chernosky
University of Louisville

Follow this and additional works at: <https://ir.library.louisville.edu/honors>



Part of the [Social Work Commons](#)

Recommended Citation

Chernosky, Megan A, "A peer-support mental health response training for LGBTQIA+ adolescents." (2018).
College of Arts & Sciences Senior Honors Theses. Paper 152.

Retrieved from <https://ir.library.louisville.edu/honors/152>

This Senior Honors Thesis is brought to you for free and open access by the College of Arts & Sciences at ThinkIR: The University of Louisville's Institutional Repository. It has been accepted for inclusion in College of Arts & Sciences Senior Honors Theses by an authorized administrator of ThinkIR: The University of Louisville's Institutional Repository. This title appears here courtesy of the author, who has retained all other copyrights. For more information, please contact thinkir@louisville.edu.

A Peer-Support Mental Health Response Training for LGBTQIA+ Adolescents

Megan Chernosky

University of Louisville

Committee Members: Dr. Maurice Gattis, Dr. Sunshine Rote, Dr. Janet Woodruff-Borden

Abstract

This paper will discuss the correlation between participation in a mental health peer-support training and adolescents' self-reported feelings of preparedness to deal with mental health crises. The paper will focus on lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other non-heterosexual, non-cisgender youth (LGBTQIA+) between the ages of 13 and 21 years old. The study used a quantitative, written survey with eighteen questions before the intervention, and another with five questions after the intervention. The study originally involved eleven participants, but the number of participants decreased to seven due to attrition. The intervention was administered to every participant. The data were analyzed to find the averages and standard deviations for each category. The results found that the average preparedness increased after the intervention. Due to lack of a control group, the researcher was not able to determine causation, but they were able to determine correlation. The researcher concluded that there was a short-term increase in feelings of preparedness to deal with crises in correlation with receiving the mental health training.

A Peer-Support Mental Health Response Training for LGBTQIA+ Adolescents

Suicide is the second leading cause of death for people between the ages of 15 and 24 (Center for Behavioral, 2016). Mental health problems are also a significant problem for adolescents, to the point where almost one in two adolescents will struggle with some form of mental illness by the time they turn 18 (Center for Behavioral, 2016).

Teenagers are at a relatively high rate of committing suicide and suffering from mental illness. As teenagers, they have less independence than adults do. Teenagers do not have the ability to seek help from a professional the same way adults do, not without parental consent. As a result, teenagers tend to have less access to mental health care professionals. Teenagers also have more access to ways to communicate with each other than previous generations have, through cell phones and the internet. The first hypothesis that the researcher wanted to test was that adolescents are more likely to seek help from other adolescents than they are professionals or other adults in authority. The second, related hypothesis is that lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) youth are more likely to talk to people their own age if they have not disclosed their identity to their parents.

Assuming the above to be true, adolescents need to be trained on how to respond to mental health crises. Mental health professionals and teachers do receive some training on how to respond to mental health crises, but adolescents do not. The researcher analyzed other mental health trainings for laypeople in order to design a training that would work for adolescents. The training was intended to teach adolescents how to respond if a peer were to come to them during a mental health crisis. It was very clear that it was not intended to train the youth as a mental health counselor or therapist. The training was intended to teach them to deal with the emergency if there is one and then connect the individuals with resources that could help them.

The third and primary hypothesis of the researcher was that the described training would increase adolescents' self-reported feelings of preparedness to deal with mental health crises.

Rates of Prevalence

The following section will discuss rates of mental illness and suicide among adolescents as a whole and LGBTQIA+ adolescents in particular.

The Center for Behavioral Health Statistics and Quality performs an annual report to determine the lifetime prevalence of mental illnesses for adolescents under the age of 18. That term means the percentage of adolescents who have experienced a given mental illness before they turn eighteen. The 2016 report stated that 46.30% of adolescents will experience some form of mental illness before they turn 18 (Center for Behavioral, 2016). The most common type of mental illness is anxiety disorders with a total lifetime prevalence of 25.10%, meaning that one in four adolescents will have an anxiety disorder before they turn 18 (Center for Behavioral, 2016). The second most common type of disorder is mood disorders, with a total lifetime of 14.00% (Center for Behavioral, 2016). Major depressive disorder is the most common type of mood disorder, and the third most common disorder overall, with an individual lifetime prevalence of 11.20%, meaning that 11.20% of adolescents have experienced major depressive disorder by the time they are 18 (Center for Behavioral, 2016). As a part of that, the Center for Behavioral Health Statistics and Quality estimates that 12.5% of adolescents have experienced a major depressive episode in the last year (Center for Behavioral, 2016). The fourth most common disorder was attention deficit hyperactivity disorder, commonly abbreviated as ADHD, with a lifetime prevalence of 9.00% (Center for Behavioral, 2016). The fifth most common disorder is social phobia, with a lifetime prevalence of 5.50% (Center for Behavioral, 2016). The sixth most common disorder is Post-Traumatic Stress Disorder, with a lifetime prevalence of

4.00% (Center for Behavioral, 2016). The seventh most common type of disorder for adolescents is any type of eating disorder, with a lifetime prevalence of 2.70% (Center for Behavioral, 2016). The eighth most common disorder is agoraphobia, with a lifetime prevalence of 2.40%, followed closely by panic disorder, with a lifetime prevalence of 2.30% (Center for Behavioral, 2016).

One of the biggest risks for people with mental illness is suicide. Nine in ten people who complete suicide struggle with mental illness, and six out of ten people who complete suicide struggle with some form of depression (Dilillo, Mauri, Mantegazza, Fabiano, Marni, & Zuccotti, 2015). Suicide is the second leading cause of death for adolescents between the ages of 15 and 24 (Murphy, Xu, Kochanek, Curtin, & Arias, 2017). It is estimated that in 2015, the rate of suicide for adolescents was 12.5 out of every 100,000 (Murphy, et. al, 2017), but the rate increased to 13.7 out of every 100,000 in 2016, meaning that suicide rates are increasing (American Foundation, 2018). Suicide rates have been consistently increasing since 2008 (Dilillo, et. al, 2015; American Foundation, 2018). Additionally, while no agency collects data on the rate of adolescents who attempt suicide, the American Foundation for Suicide Prevention predicts that 25 people attempt suicide for every one person who complete, meaning that 342.5 adolescents out of every 100,000 attempt suicide each year (American Foundation, 2018). The United States Census Bureau estimates that there are 41,731,233 people between the ages of 10 and 19 in the United States in 2015, meaning that approximately 142,930 adolescents attempt suicide each year (U.S., 2016). Other estimates put that number far higher, at two million (Dilillo, et al., 2015).

Adolescents are at a stage in their lives where they are less likely to trust in adults than they did when they were younger (Venta, Shmueli-Goetz, & Sharp, 2014). This is generally simply a natural part of development. It increases independence, which is a skill that helps an

individual in young adulthood (Venta, et. al., 2014). However, due to the lack of trust in adults, and the relative inexperience of adolescents as compared to adults, when an adolescent experiences a crisis, they often do not have the resources to deal with crises on their own (Roe, 2015). They will often turn to their peers for help instead of adults (Kalafat, & Elias, 1994). As a result, training adults to deal with adolescent mental health crises may not be as effective as training other adolescents (Kalafat & Elias, 1994).

LGBTQIA+ Adolescents and Mental Health

While the rates of prevalence for mental illness for adolescents are high, the statistics for LGBTQIA+ adolescents are even higher. People who identify as LGBTQIA+ are more likely to suffer from mental illness as compared to their heterosexual, cisgender peers (Lehavot & Simoni, 2011). Unfortunately, the researcher was not able to find comprehensive data on mental illness for LGBTQIA+ adolescents.

According to the Center for Disease Control, lesbian, gay, and bisexual adolescents are five times more likely to complete suicide as compared to their heterosexual counterparts (2016). The Williams Institute estimates that 45% of transgender individuals will attempt suicide by the time they turned 24 (Herman, Haas, & Rodgers, 2014). This risk increases significantly when an LGBTQIA+ adolescent is not accepted by their family (Haas, et. al., 2011). An adolescent with an unaccepting family is eight times more likely to attempt suicide as compared to their peers with accepting families (Dilillo, et al., 2015).

LGBTQIA+ adolescents are less likely to have accepting families as compared to cisgender heterosexual adolescents (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). They in particular are more likely to have stronger relationships with their peers, rather than their families (Mustanski, Newcomb, & Garofalo, 2011). It then follows that they are more likely to

seek support from their peers rather than their families. It is also shown that LGBTQIA+ adolescents are disproportionately more likely to seek support from other LGBTQIA+ adolescents (Wilkerson, Schick, Romijnders, Bauldry, & Butame, 2017). This is especially true in isolating situations. (Willging et. al, 2016)

Intervention Literature Review

The following section will analyze pieces of literature that discuss interventions that are similar to the intervention undertaken in this paper.

In a quantitative, non-experimental study performed by Mitchell, Kader, Darrow, Haggerty, and Keating (2013), researchers wanted to test if an intervention called Question, Persuade, Refer (QPR) would increase college students' knowledge of the warning signs of suicide, knowledge of how to ask someone about suicide, and knowledge of how to get help for someone who was experiencing thoughts of suicide. The original sample size was 1,644 college students, but only 274 completed all of the steps of the study. The college students' knowledge of the warning signs of suicide, knowledge of how to ask someone about suicide, and knowledge of how to get help for someone who was experiencing thoughts of suicide was measured through a survey of eleven questions. In ten of the questions, participants were asked to rate their level of knowledge and level of comfort, on a scale of one to three. One was a yes-or-no question, where participants were asked about their previous experiences with referring someone to help for suicidal ideation or actions. The researchers did mention in their study that the survey is not empirically validated, but it is a survey that comes with the QPR training. The subjects' knowledge was measured at three points in the process. The first was before the intervention, then again post intervention, and then again in a three month and a six month follow-up. The researchers found that "knowledge of the warning signs of suicide, how to ask someone about

suicide, persuading someone to get help, how to get help for someone, and local resources to help with suicide increased significantly in the short-term, and these gains were maintained over the long-term” (Mitchell, Kader, Darrow, Haggerty, Keating, 2013, n.p.). However, participants’ level of comfort in asking someone about whether or not they would commit suicide, which is an important part of the QPR intervention, increased initially, but returned to their baseline during the follow-up assessment (Mitchell, et. al., 2013). This study does appear to support QPR training, but without a control group or a process of randomization, there is no way to determine causation.

Jacobson, Osteen, Sharpe, and Pastoor performed a mixed method experiment in 2012. They sought to test if a QPR training would improve “knowledge of suicide warning signs and intervention behaviors, self-evaluation of suicide prevention knowledge, and knowledge of institutional resources” among University of Maryland Baltimore Campus Masters of Social Work (MSW) students (Jacobson, Osteen, Sharpe, & Pastoor, 2012, p. 273). One hundred nineteen students were randomly selected from the Masters of Social Work program, and 72 students completed the study. They randomly assigned the subjects into either the intervention group or the control group, which did not receive any intervention or training. The experiment resulted in the researchers concluding that people’s attitudes about suicide, specifically, asking people whether or not they were going to commit suicide, did not change as a result of the experiment, but the participants did tend to perceive that they were better prepared to handle those situations and had better knowledge of institutional resources as a result of the intervention.

Hadlaczky, Hokby, Mkrтчian, Carli, and Wassmerman constructed a meta-analysis of the literature surrounding Mental Health First Aid (2014). They summarized the results of fifteen

papers dedicated to reviewing Mental Health First Aid. It particularly focused on three areas of review. The first was the effect of the Mental Health First Aid training on the subjects' knowledge surrounding mental health issues. The second was the effect of the Mental Health First Aid training on the subjects' attitudes towards people with mental health issues. The third effect studied was effect of the Mental Health First Aid training on the subjects' behavior towards individuals with mental health problems. Each of the fifteen studies used a quantitative survey of the participants after the training in order to determine the change in knowledge, attitude, and behavior. The meta-analysis concluded that the Mental Health First Aid training increased overall knowledge of mental health problems, including symptomatology and treatment, decreased negative attitudes towards people with mental health issues, and increased supportive behavior towards individuals with mental illness.

A similar intervention to the QPR training and the Mental Health First Aid training is the Peer2Peer training. A Peer2Peer training was implemented at the Medical University of Graz in 2016. It was completed by Vajda. The Peer2Peer study is slightly more complicated than the QPR or Mental Health First Aid studies, because it tracked the number of contacts that were made by the people who were trained. It was intended to track specifically whether or not the training resulted in interventions. The initial study trained 119 subjects in responding to mental health crises. Training those 119 subjects resulted in a total of 94 interventions during the monitoring period. The researchers described the study as a success, due to the increase they observed in "practical skills in dealing with students in crises situations" (Vajda, 2016, n.p.).

Another of these types of trainings was tested at eight schools in the southern part of Vancouver Island in Canada (Stuart, Waalen PhD, & Haelstromm, 2003). It was called the Peer Gatekeeper Training, commonly abbreviated as PGT. The researchers sampled strategically, in

order to ensure representation from each of the districts, a secular private school, and a religious school. The sample measured 65 adolescents, with the average of 15.6 years of age, although it included individuals between the ages of 13 and 18. The training was designed to measure skills in intervening and attitudes towards mental illness. They determined that “significant differences in skills, attitudes toward suicide intervention, and knowledge occurred after training and were maintained in all areas over a 3-month period of time” (Stuart, Waalen, & Haelstromm, 2003, p. 330).

Methodology

This study was approved by the human subjects board at University of Louisville on January 25, 2018. The human subjects board approved an assent for the participants under eighteen, because the risk of informing parents that their child was to participate in a study on LGBTQIA+ adolescents was believed to be riskier than the study itself. The study was conducted through a local agency in Louisville, Kentucky, which shall remain unnamed in order to protect the confidentiality of the participants in the study. The agency has access to numerous adolescents who identify as LGBTQIA+ and their allies. The researcher volunteers at the agency and coordinated with the leaders of the agency in order to conduct the study at the agency. The study was conducted January 26, 2018. Approximately thirty adolescents came to the agency on that night, and were told the nature of the survey and asked to participate. There were no consequences to not participating in the study. Adolescents who chose to participate were asked to sit in a room for the study, and adolescents who chose not to participate were shown to another room. The presentation given in the room was a slide presentation, given on a projector. The presentation was given by the researcher, and it involved both visual and auditory aspects, in

order to maximize the ability to learn, regardless of the learning style. There was also a brochure, which was left in the agency for individuals to take as needed.

Survey Measures

Data for the intervention were collected through two quantitative surveys. The first was given immediately prior to the intervention. This survey included a demographic assessment, covering age, race, gender, and sexual orientation. Age was asked in four categories. The first was 13 to 15, and then 16-17, and then 18-21, and then over 21. Because the study was focused on adolescents, anyone over the age of 21 would not be considered. Race was asked in seven categories: White/Caucasian, Black/African-American, Hispanic/Latinx, Asian, Native American, Pacific Islander, Mixed, and other, with a space to fill in the blank. They were allowed to check as many boxes as were applicable. Gender was asked through two questions. The first asked how the individual identified, man, woman, bigender, agender, non-binary, genderfluid, or other, with a space to fill in a blank. In this, bigender refers to someone who identifies as two genders (Trans, 2018). Agender refers to someone who does not identify with any gender (Beemyn, 2018). Non-binary refers to someone who identifies as a gender other than man or woman (Trans, 2018). Genderfluid refers to someone whose gender changes over time (Trans, 2018). These definitions were not provided on the test. These definitions, and the definitions on the two questions following this one, were not given because of the culture surrounding participants. Participants at the agency knew what each of these words mean, and defining them would have proven redundant. This option also allowed subjects to choose more than one, as applicable. The second question about gender asked if the subject identifies as cisgender. Cisgender means identifying as the sex that was assigned at birth (University, 2015; Beemyn, 2018). It asked yes or no. The final question was sexual orientation. It asked subjects to

choose between lesbian, gay, bisexual, queer, pansexual, asexual, and other, with a space to fill in the blank. Lesbian means someone who identifies as women who is attracted to other people who identify as women (University, 2015). Gay refers to someone who is attracted to the same gender as them (University, 2015). Bisexual refers to someone who is attracted to two or more genders (University, 2015). Pansexual refers to someone who is attracted to individuals regardless of their gender (University, 2015). Asexual refers to someone who does not experience sexual attraction (University, 2015). Queer refers to someone who is not heterosexual, but does not want to use other labels. It can also be an umbrella term (University, 2015). In this section, definitions were also not provided for the same reason discussed above. Subjects were allowed to choose more than one answer.

The study also asked whether or not a subject had disclosed their sexual orientation and gender identity to their parents and whether or not they had disclosed their sexual orientation and gender identity to people at school. Then it asked if they had ever had any friends experience mental health crises, and if those friends had ever come to them while experiencing a mental health crisis. It also asked five questions about what resources they had in terms of a support network, between adults and peers. Then it asked if they were to have a mental health crisis, who they would go to to talk about it. The final question asked them to rate their level of preparedness to deal with mental health crises, on a five-point scale, with five being very prepared and one being not prepared at all. It asked that for five types of crises, including panic attacks, anxiety attacks, depression and hopelessness, suicidal thoughts, and suicidal actions. The first assessment had 18 questions.

The second survey was given immediately after the investigation. It was considerably shorter, only five questions, specifically the last five questions, with the five point scale on how prepared they feel to deal with specific types of mental health crises.

Both surveys were administered on physical paper. No information was obtained to determine an individual's identity or to assess which survey given after the intervention was associated with which survey given before the intervention, so there is no way to track individual changes.

Intervention

The intervention began with the consent documents, and then each participant took an initial assessment. The first topic brought up in the slide presentation was a trigger warning in order to minimize traumatization. It alerted participants of the topics that would be covered and let subjects know that, if they felt uncomfortable at any point during the presentation, they were allowed to leave with no consequences. There was also an alternative program provided, for anyone who did not feel comfortable participating in the intervention. After that, it discusses the CLOG acronym, which stands for Check for risk of harm, Listen non-judgmentally, Offer encouragement, and Give resources for professional support. Then it discussed how the acronym could be used for each type of mental health crisis, starting with suicide, and proceeding on to discuss depression, self-injury, and panic attacks. It concludes by discussing self-care, using the metaphor of oxygen masks. On airplanes, flight attendants always remind patrons to put on their own masks before they help someone else put on theirs. The same principle applies to mental health in that one can not help a peer if one is also experiencing a crisis. The final activity was discussing ways to self care, where each participant discussed how they self-care.

The brochure was designed to summarize the points of the presentation. The brochure is a tri-fold, with six panels. It was designed online, in a way that was both aesthetically pleasing and calming, using primarily green colors and a natural palette. The inside panel of the brochure, the one that is the first to be seen upon opening the brochure, includes the acronym CLOG, along with what each letter stands for and some tips for orchestrating each of the steps. Once the brochure is open, the two panels on either side feature tips for dealing with suicide, panic attacks, depression, and self harm. It also gives layperson definitions. The center panel also features an easy-to-follow risk assessment diagram. The first question, at the top, tells the subject to ask the person if they are considering suicide. One arrow, on the right, says no. The other, on the left, says yes. The left arrow leads to another question. The right arrow leads to a box saying “Listen, Offer encouragement, Give resources”. The back of the brochure discussed several resources that they could use, including several hotlines and resources in the area. The brochures are available at the agency for anyone to take if they need it.

Development of Intervention

While researching the mental health training intervention, the researcher attended two mental health trainings similar to the one designed. This was partially to find more information for the training, and partially to research strategies for effective learning.

The first was a Mental Health First Aid training, designed by the National Council on Behavioral Health, and performed through the Family and Children’s Place in Louisville, Kentucky. The training lasted eight hours and covered depression, suicide, anxiety attacks, panic attacks, psychosis, and substance abuse. It involved a slide presentation covering each topic and several other activities. It also involved a take-home book filled with information on how to respond to mental health crises. The main idea of the Mental Health First Aid training was an

acronym, ALGEE. The first letter, A, stood for Assess for Risk of Suicide or Harm. The second letter, L, stood for Listen Non-Judgmentally. The third letter, G, stood for Give Reassurance and Information. The fourth letter, E, stood for Encourage Appropriate Professional Help. The fifth letter, also E, stood for Encourage Self-Help and Other Support Strategies. The training applied the acronym to each crisis. For example, the training examined how to Assess for Risk of Suicide or Harm with someone who was experiencing psychosis. The training also featured several role-playing activities, where participants interacted with one another pretending to be struggling with depression or thoughts of suicide, for example.

The second training was a QPR training, as discussed above, designed by the QPR Institute, performed through the University of Louisville Campus Housing department, for their employees. The training lasted approximately two hours. It solely covered dealing with someone who expresses thoughts of suicide or suicidal actions. Like the other training, it also used an acronym. This one was QPR. The first letter, Q, stood for Question, meaning to ask someone directly whether or not they are planning to commit suicide. The second letter, P, stood for Persuade, meaning to persuade someone not to do it, or at least to delay it. The third letter, R, stood for Refer, meaning to give resources for professional help. The training also featured a role-playing session, where one participant pretended to be suicidal and another had to talk them out of it using QPR. However, in this instance, one of the participants appeared to be visibly distressed by pretending to be mentally ill, as she disclosed that she had struggled with being suicidal before and now felt triggered by being forced to act that way again. There was also a take-home pamphlet. It included the acronym and the suicide hotline.

Development of An Acronym

Since both trainings used an acronym, the researcher decided to incorporate an acronym into this training as well. Concrete acronyms are more effective mnemonics than abstract mnemonics (Campos, Camino, & Pérez-Fabello, 2011). Nonsense acronyms or initialisms, like QPR or ALGEE, are less likely to be memorable than initialisms that are based in words, like AIDS, for example (Campos, Camino, & Pérez-Fabello, 2011). The researcher attempted to find an acronym that would also be a real word in order to increase recall.

The acronym that was created was CLOG. The first letter, C, stands for Check for risk of harm. The second letter, L, stands for Listen non-judgmentally. The third letter, O, stands for Offer encouragement. The fourth letter, G, stands for Give resources for professional support.

Suicide Training

The first thing the researcher wanted subjects to know about suicide intervention was the warning signs, so that they would know when to intervene. The National Suicide Prevention Lifeline lists the warning signs of suicide as

“talking about wanting to die or to kill themselves, looking for a way to kill themselves, like searching online or buying a gun, talking about feeling hopeless or having no reason to live, talking about feeling trapped or in unbearable pain, talking about being a burden to others, increasing the use of alcohol or drugs, acting anxious or agitated; behaving recklessly, sleeping too little or too much, withdrawing or isolating themselves, showing rage or talking about seeking revenge, extreme mood swings” (National, 2018, n.p.)

While these are more or less agreed upon, others also mention low self-esteem, and previous experience with mental illness (Dilillo, et. al., 2015). McSwain, Lester, and Gunn III also mentioned a mnemonic for remembering suicide warning signs (2012). The mnemonic is

IS PATH WARM. In order, the letters stand for “ideation, substance abuse, purposelessness, anxiety, trapped, hopelessness, withdrawal, anger, recklessness, and mood change” (McSwain, Lester, & Gunn III, 2012).

Subjects were told to perform a risk assessment looking for desire to complete suicide, opportunity to complete suicide, a plan of how to complete suicide, a plan of when to complete suicide, and actions taken to complete suicide. Risk assessments such as the above have been shown to be relatively effective for untrained individuals to use in order to assess the likelihood to attempt suicide (Runeson, Odeberg, Pettersson, Edbom, Jildevik Adamsson, & Waern, 2017).

Depression Training

The subjects were informed that this training does not certify them as mental health counselors or therapists, and as such, they are not licensed to perform therapy or diagnose anyone with a mental illness. So, while it was clear that they had no ability to diagnose, the study did look at the diagnostic criteria for depression from the fifth edition of the Diagnostic and Statistical Manual of Mental Health, commonly abbreviated as the DSM V. The criteria were used to teach subjects about some of the symptomatology that would merit the CLOG intervention. The fifth edition of the Diagnostic and Statistical Manual of Mental Health lists the diagnostic criteria of major depressive disorder and depressive episodes as

“Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks. Mood represents a change from the person's baseline. Impaired function: social, occupational, educational ... Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)... Decreased interest or pleasure in most activities, most of each day ... Significant weight change (5%) or change in appetite ... Change in sleep:

Insomnia or hypersomnia... Change in activity: Psychomotor agitation or retardation... Fatigue or loss of energy... Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt... Concentration: diminished ability to think or concentrate, or more indecisiveness... Suicidality: Thoughts of death or suicide, or has suicide plan”

(American Psychiatric, 2013, n.p.).

The researcher summarized the symptoms slightly in order to present an amount of information that would be palatable and easy to remember. The slide presentation listed the symptoms as “Feeling sad or hopeless, Change in eating or sleeping, Irritability, Lack of interest in activities” in order to make it memorable.

Non-Suicidal Self-Injury

The next section in the presentation discussed self-injury without intent to die. This topic was a difficult topic to cover due to the different interpretations of the behavior. People who engage in non-suicidal self-injury are statistically, more likely to attempt suicide at least once in their life (Selby, Bender, Gordon, Nock, & Joiner Jr, 2012). It is also clear that self-injury can be dangerous, if due to nothing else than the fact that it results in numerous wounds without medical supervision or, often, medical attention. Untrained or inexperienced adolescents may accidentally injure themselves in a way that they do not intend, with serious medical consequences.

However, for individuals who engage in non-suicidal self injury, it can serve as a coping mechanism (Hasking, et. al., 2010). There are many reasons why someone would engage in non-suicidal self-injury, including an increased amount of stress and compulsion to self-injure (Selby, et. al., 2012). Other reasons also include to feel pleasure, to avoid negative feelings, to feel or avoid feeling numb, to get attention, or to avoid suicidal thoughts, with the most common feeling

expressed being to avoid negative thoughts (Claes, Klonsky, Muehlenkamp, Kuppens, & Vandereycken, 2010). Taking away a coping skill from someone without introducing an alternative can be ineffective or even harmful. The researcher wanted to avoid having a subject shame their friend into ceasing non-suicidal self-injury only to have the friend complete suicide due to a lack of coping skills. Additionally, it is recommended that someone experiencing non-suicidal self-injury receive treatment from a mental health professional with training in order to receive therapy, as opposed to an untrained peer (Brausch, & Girresch, 2012).

The researcher presented both opinions to the subjects. It was explained that the eventual goal would be to get someone to use better coping mechanisms than self-injury, but that, at least until the person could get to a place where they could receive professional health, it would be advantageous to engage in harm reduction strategies. The researcher explained this using the metaphor of a stoplight. It would be ineffective to try to “go to red”, because they were not trained to intervene. It would be more effective and feasible to try to “go to yellow”, to get the person to slow down. Because non-suicidal self injury is a physical process, during the check for harm stage, subjects were instructed to make sure that the person was not experiencing physical distress, such as passing out or getting dizzy, and if they were, to seek medical attention. Then they were instructed to minimize risk of infection by making sure that all instruments of self-injury and all wounds were clean and bandaged. When it came to Offering encouragement, they were instructed to suggest alternatives, if the person was interested in doing so. The researcher was unable to find empirical, peer-reviewed data on alternatives to self-injury that could be given by non-mental health professionals, so they used alternatives from their past experience and invited the subjects to brainstorm as well.

Panic Attacks

The final type of mental health crisis addressed was panic attacks. Once again, the subjects were told that they were not able to diagnose anyone, but they were given a list of symptoms of a panic attack, as listed in the fifth edition of the Diagnostic and Statistical Manual of Mental Illness. The diagnostic criteria for panic attacks are

“palpitations, pounding heart, tachycardia, sweating, muscle trembling, shaking, shortness of breath, sensations of smothering, choking sensations, chest pain or discomfort, nausea, abdominal distress, dizzy, lightheaded, instability, feeling faint, derealization, depersonalization, fears of losing control or going crazy, fear of dying, numbness, tingling sensations, chills, hot flushes.” (American Psychiatric, 2013, n.p.).

The subjects were instructed to keep a calm voice, and speak firmly but clearly to the person experiencing a panic attack. They also were given a brief breathing intervention training. Breathing interventions have been proven to be effective when dealing with panic attacks (Meuret, Rosenfield, Seidel, Bhaskara, & Hofmann, 2010). They were instructed on square breathing, which is breathing in for a count of four, holding for a count of four, breathing out of the count of four, and then holding for the count of four.

Role-Playing

While both mental health trainings in which the researcher participated involved role-playing, the researcher chose not to use role playing activities for two reasons. The first was to avoid retraumatization for anyone who had experience with mental illness. Retraumatization can have severe consequences and, as there was no trained mental health counselors working during the intervention, the researcher felt the risks outweighed the benefits (Vickerman, & Margolin, 2007). The second reason was due to time constraints placed upon the research by the agency.

Data Analysis

The data from the intervention were transferred from each individual survey to a spreadsheet in a private program with data backed up online. There is virtually no access to the data from any outside source, and there was no confidential data placed on the internet, meaning that there is extremely low risk of a breach in confidentiality.

From the original survey, which had eighteen questions, no analysis was done on any questions where the responses were not numerical but categorical, so each of the answers were counted in order to find the percentages of the total. The final five responses were numerical, and so the data was analyzed to calculate the average for each category. That was calculated by using the formula $\frac{x_1 + \dots + x_n}{n}$, where x_1 represents the first number in the series, and x_n refers to the last number in the series, and n refers to the total number of numbers in the series. The standard deviations were also calculated for each question. The standard deviations were calculated with the formula $\sqrt{\frac{\sum_i^N 1(x_i - \bar{x})^2}{N-1}}$, where i refers to any given number for which there is a value, x_i refers to the i^{th} number in the series, \bar{x} refers to the average of all numbers, and N refers to the total number of items in the series. These formulas were also used for the data with the ages.

Each of the five questions in the second survey was also analyzed for average and for standard deviation, using the same formulas.

Results

The next section will review the results of both surveys, and the data collected. It will also provide numerical and mathematical analysis of the data. The meaning of the data will be discussed in the discussion section.

Demographic Assessment

The total number (N) of people who took the initial survey was eleven. Four individuals left before it was time for the second survey.

Age. Six individuals self-identified as 13-15, two self-identified as 16-17, and three self-identified as 18-21. None self-identified as over 21. The average age of participants is 15.95, with a standard deviation of 2.47 years.

Race. Ten of the participants identified as white/caucasian. One identified as Native American and mixed.

Gender. Five participants identified as women, three identified as solely non-binary, one identified as a man, one identified as genderqueer, and one identified as both agender and non-binary. Genderqueer means someone who does not identify with any of the other gender labels (Trans, 2018). For the purposes of simplicity in data analysis, the categories will be reduced to women, men, and individuals who do not identify as men or women. As for the second question, seven identified as transgender, and four identified as cisgender. Of that group, one individual identified as a trans man, and one identified as a trans woman. The individuals who do not identify as men or women also are part of the group identified as transgender.

Sexual Orientation. One person identified as solely gay, one as solely bisexual, two as solely queer, and three identified as solely pansexual. One person identified as bisexual and pansexual. One person identified as gay and queer. One person identified as asexual and bisexual and polyamorous. Polyamorous refers to a person who is involved romantically or sexually with multiple consenting people at the same time. One person identified as solely polysexual, which refers to someone who is attracted to more than two genders, but not all genders.

Coming Out to Parents. The next set of questions asked about the idea of being out. Coming out means disclosing an identity as part of the LGBTQIA+ community. Seven of the participants said that they had come out to their parents. Three said that they had not come out to their parents. One person checked both yes and no. Six of the participants said that they were out at school. Three said that they were not. Two checked both yes and no. The researcher speculates that the people who checked both yes and no either are out to some of their family or friends, but not others, or they have disclosed only part of their identify, not all of it.

Mental Health of Friends of the Subjects

Every participant said that they have a friend who has a problem with mental health. Eight of them said that they have been contacted by a friend who was experiencing a mental health crisis. Two of them said that they had not, although one of them did answer the next question, which was “If yes, please check any and all crises that you have had a friend come to you with.” One of them left the question blank, but also answered the next question. Of those ten that answered the question, seven said that they had talked to someone experiencing a panic attack, eight said that they had talked to someone experiencing an anxiety attack, eight said they had talked to someone experiencing a depressive episode, and ten said they had talked to someone experiencing suicide ideation. One said they had talked to someone experiencing relationship problems, one said they had talked to someone experiencing self harm, and one said they had talked to someone who had attempted or was attempting suicide.

Support Network of the Subjects

The objective of this section was to determine whether or not subjects had an effective support network, and to where they would go if they had a mental health crisis. Ten of the subjects said they had an adult in their life that they could talk to that was not a professional. One

of them said they did not. Seven of the subjects said that they had an adult to talk to who was a mental health professional. Four of them said they did not. Seven of the subjects said that they were able to reach that adult if they needed them. Three of the subjects said that they were not able to reach the trusted adult. One said they did not have a trusted adult to whom they could talk. Ten subjects said that they had someone their age who they could talk to about mental health problems. One subject said they did not. Of the ten who said they did have someone to whom they could talk, all ten of them said they could reach the person their own age if they needed to reach them.

The final question before the preparedness questions was to whom they would talk if they needed to talk to someone. Three said that they would speak to a trained medical professional. Five said they would talk to another adult. Six said they would talk to someone their age. One said they would talk to an anonymous hotline.

Of the individuals who said that they had not come out to their parents, one in three said that they not have an adult who was not a medical professional that they felt they could trust. Of the people who said they had come out to their parents, none said that they did not have an adult they could trust who was not a mental health professional. Two of the three individuals who said that they had not come out to their parents said that they did not have a mental health professional they could trust, while two out of seven individuals who said that they had come out to their parents said that they did not have a mental health professional who they could trust. Two out of the three people who said they had not come out to their parents said that they could not reach a trusted adult if they had a crisis, while one out of seven individuals who said that they had come out to their parents said that they could not reach a trusted adult if they had a crisis. Two out of the three individuals that said they had not come out to their parents said that they

would go to a peer if they had a mental health crisis as opposed to a trusted adult. Two out of seven individuals who had come out their parents said that they would go to a peer if they had a mental health crisis as opposed to a trusted adult.

Of the group of three individuals who said that they had not come out at school, all of them identified a peer who they would trust, and all but one who said they had come out at school said that they had a peer who they would trust. One of three who said that they had not come out at their school said that they would go to their peer in case of a mental health crisis, as opposed to three of six who said that they had come out at school.

Preparedness to Deal with Crises

The next series of questions on the assessment given before the intervention asked about how prepared the subject felt to deal with a mental health crisis if a peer came to them about it. The survey given after the intervention asked the same questions, in the same way. It asked them to rate how prepared they felt on a scale of one to five, with five being very prepared and one being not prepared at all. Every subject answered every question.

The average level of preparedness for dealing with all mental health crises before the intervention was approximately 3.29, with a standard deviation of 0.24. The average standard deviation for the data collected before the intervention was approximately 1.00, with a standard deviation of approximately 0.2. The average level of preparedness for dealing with all mental health crises after the intervention after the intervention was approximately 4.11, with a standard deviation of approximately 0.42.

Panic attacks. The first question addressed how prepared the subject felt to deal with someone having a panic attack. The average that was determined for the assessment before the intervention was approximately 3.09. The standard deviation of the data before the intervention

was approximately 0.83. The average determined for the assessment given after the intervention was approximately 4.29. The standard deviation of the data given after the intervention was approximately 0.76. This was an increase in average preparedness of approximately 1.2, and a decrease in standard deviation of approximately 0.07.

Anxiety attacks. The second question asked how prepared the subject felt to deal with someone having an anxiety attack. The average determined for the assessment before the intervention was approximately 3.18, with a standard deviation of 0.75. The average determined for after the intervention was approximately 4.43, with a standard deviation of 0.79. This resulted in an increase in average preparedness of approximately approximately 1.25, with an increase in standard deviation of approximately 0.04.

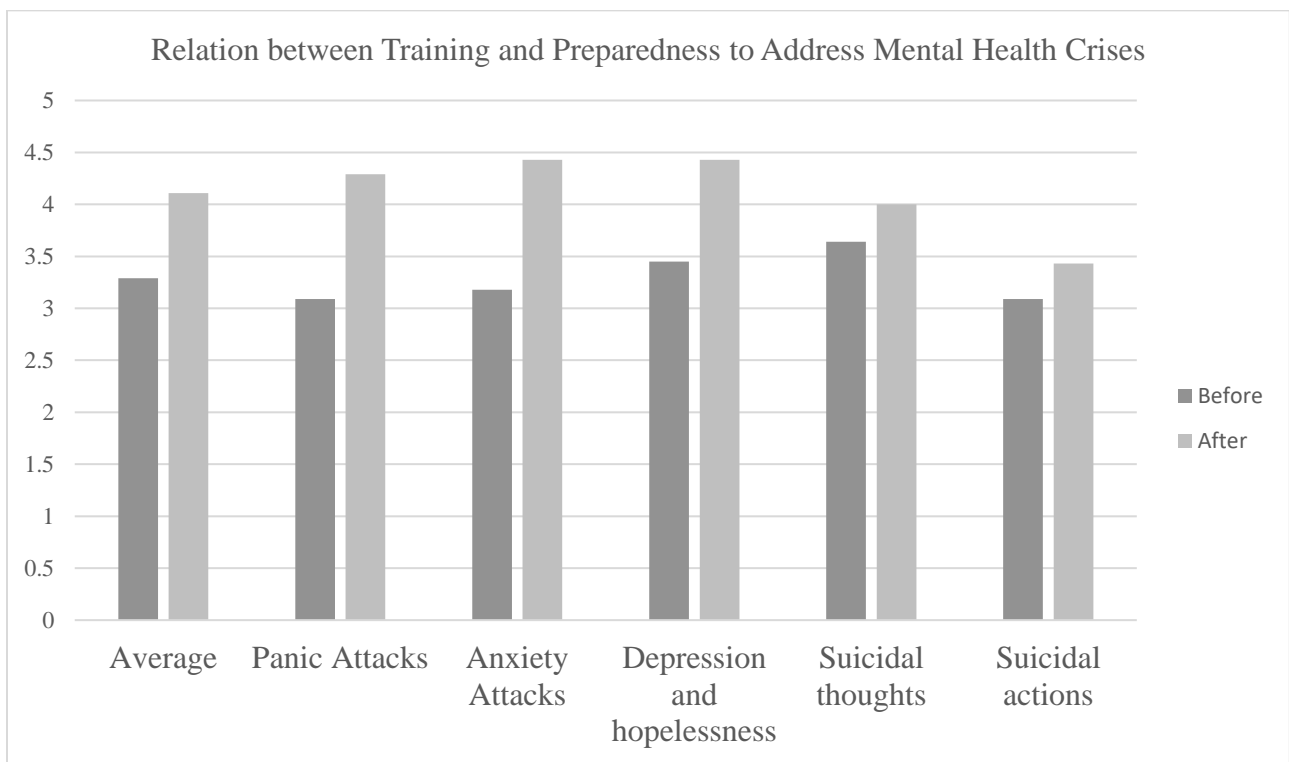
Depression and hopelessness. The third question asked how prepared the subject felt to help someone experiencing depression and hopelessness. The average calculated for the assessment before the intervention was approximately 3.45. The standard deviation for that data was approximately 1.13. The average calculated for the assessment after the intervention was approximately 4.43. The standard deviation calculated for that data was approximately 0.53. This resulted in an increase in average preparedness of approximately 0.98, with a decrease in standard deviation of approximately 0.6.

Suicidal thoughts. The fourth question addressed how prepared the subject felt to deal with someone experiencing suicidal thoughts. The average determined for the assessment given before the intervention was approximately 3.64, with a standard deviation of approximately 1.03. The average determined for the assessment given after the intervention was approximately 4.00, with a standard deviation of approximately 0.82. This means that there was an increase in the average preparedness of approximately 0.36, with an increase of approximately 0.21.

Suicidal actions. The fifth question asked how prepared the subject felt to deal with someone who has taken action to attempt suicide. The average calculated for the data taken before the intervention was approximately 3.09. The standard deviation for the data before the intervention was approximately 1.22. The average calculated for the data taken after the intervention was approximately 3.43 and the standard deviation for the taken after the intervention was approximately 0.77. This means that there was an increase in average preparedness of 0.34, and a decrease in standard deviation of approximately 0.45.

Graph

The information above is summarized below, in a graph.



Discussion

It is not possible to draw conclusions about causation, nor is it generalizable to the population as a whole. Having said that, the researcher was able to conclude that, in the population of LGBTQIA+ adolescents who attended the study, there was a correlation between

the mental health intervention training and an increase in self-reported feelings of preparedness to deal with mental health crises. This supports the third and primary hypothesis of the researcher.

Every category of mental health crisis that was assessed demonstrated an increase in self-reported preparedness. The self-reported feelings of preparedness increased the most for dealing with anxiety attacks, and increased the least for preparedness to deal with suicidal actions. Before the intervention, individuals felt the most prepared to deal with suicidal thoughts, and least prepared to deal with suicidal actions and panic attacks. After the intervention, individuals felt most prepared to deal with depression and hopelessness and anxiety attacks, and least prepared to deal with suicidal actions. It is strange that anxiety attacks increased as much as they did, since the intervention did not address anxiety attacks. The researcher also believes that it makes sense for the lowest level of comfort to be in suicidal actions, because that is the mental health crisis with the most clear and present danger.

The first hypothesis of the researcher that adolescents were more likely to turn to a peer for help during a crisis as compared to an adult, was partially supported, although it was not as strongly supported as the researcher believed that it would be. The researcher found that six people said that they would go to a peer for support, as opposed to five people that said that they would go to a trusted adult that was not a mental health professional, and three said they would talk to a mental health professional. More people said they would go to a peer as opposed to any other category, but more people said they would go to some type of adult than a peer.

However, when looking at specifically adolescents who had not disclosed their LGBTQIA+ identity to their parents, adolescents who had not disclosed to their parents were less likely to have an adult that they could trust in their life, meaning that they were less likely to turn

to a trusted adult, as compared to their peers. This research supported the second hypothesis of the researcher, that LGBTQIA+ youth are more likely to talk to people their own age if they have not disclosed their identity to their parents.

Limitations of the Research

This research study was conducted with only seven participants who completed the intervention. This rendered randomization unfeasible. Instead, the researcher simply performed the intervention on any willing participants. The randomization would have made it possible to discuss causation, but without it, researcher can only discuss correlation. Had the researcher had more access to more participants, they would have randomly assigned the participants into groups and given the presentation to one group and a different presentation to another group in order to have them serve as a control group. Changes in feelings of preparedness would then be attributable to the presentation as opposed to other, interfering factors.

Additionally, because the data set is so small, it is difficult to reliably determine outlying pieces of data. Outlying pieces of data can be caused by individual differences between people, and may not be representative. With larger data samples, it becomes easier to determine what data pieces are due to human differences and what the true average experience is.

The sample obtained was not obtained in a way that represents a larger population. Having one agency host the study and allowing participants to choose to participate means that the sample that was involved in the study most likely does not have the same characteristics as the population of LGBTQIA+ adolescents as a whole. All respondents live in the Kentucky area, particularly within driving distance of Louisville. All respondents were aware of the LGBTQIA+ agency and had sought to attendance. All respondents were present at the agency on January 26th, 2018 at 8:30 pm. None of these characteristics are common to the population as a whole. Many

LGBTQIA+ adolescents live outside of the Louisville area. Many adolescents, especially older adolescents, have employment that require them to work on a Friday night. These two factors mean that conclusions drawn in this study can only be attributed to the individuals in the study, not to the population as a whole.

Recommendations for Future Research

The researcher believes that this is a topic that could be useful. Based on research and personal experience, many adolescents find it challenging to obtain mental health care through a trained professional, especially during a time of crisis. It may be helpful to redo this training with a larger sample size and with the ability to randomize the treatment groups in order to determine if the conclusions from this study are accurate and are generalizable to a larger population. Having more resources may also allow testing for the long-term recall effects, as some of the studies mentioned in this paper were able to do. It may be advantageous to control for the location, by doing similar studies in other cities, particularly cities in other cultures. Louisville tends to share a lot of cultural aspects with other American southern urban cities. It may be advantageous to see if similar results will occur in urban areas in the American northeast, Midwest, or northwest. It may also be advantageous to test rural areas. In these areas, research should be conducted in a way that finds samples representative of the larger population as a whole, including LGBTQIA+ adolescents who are of varying socioeconomic statuses and varying races, as the sample in this study did not include a variety of racial backgrounds. If such a study is conducted, it may be advantageous to define the sexual orientations and gender identities listed in the survey. While the group of participants above knew what all of the terms meant, it is possible that a group that was not as homogenous as the participants may not.

It may be wise to test this with other populations that are difficult to reach for mental health care, like the impoverished population or a population of people dealing with substance abuse. This strategy should theoretically make it easier for any isolated population to learn to deal with mental health crises.

Additionally, the researcher is also interested in determining if the other results of this experiment is true, that adolescents, especially LGBTQIA+ adolescents, are more likely to confide in their peers as compared to adults. This research could be done through a survey of adolescents, particularly LGBTQIA+ adolescents. The idea of doing a nationwide survey of LGBTQIA+ adolescents is not unfeasible. Every other year, the Gay-Lesbian-Straight Education Network completes a survey of LGBTQIA+ adolescents in schools to determine their educational experience (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016).

Recommendations for Future Practice

Based solely on the findings of this study, which is not generalizable to the population as a whole, it may be more advantageous for practitioners to find a single member of a marginalized or unduly isolated population and train them to respond to mental health crises. This training may help other individuals, if the trained individual is able to help them. While this is not a permanent solution to the problem of the high rates of mental illness and suicide, as it does not provide a trained professional using research-informed interventions, it does at least provide a temporary solution that may keep someone alive for long enough to be able to seek that mental health care that they need.

References

- American Foundation for Suicide Prevention. (2018). Suicide Statistics. Retrieved from:
<https://afsp.org/about-suicide/suicide-statistics/>.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Beemyn, G. (2018). Transgender terminology. Amherst: The Stonewall Center. Retrieved from:
<https://hr.cornell.edu/sites/default/files/trans%20terms.pdf>
- Brausch, A. M., & Girresch, S. K. (2012). A review of empirical treatment studies for adolescent nonsuicidal self-injury. *Journal of Cognitive Psychotherapy*, 26(1), 3-18. doi:
10.1891/0889-8391.26.1.3
- Campos, A., Camino, E., & Pérez-Fabello, M. J. (2011). Using the keyword mnemonics method among adult learners. *Educational Gerontology*, 37(4), 327-335. doi:
10.1080/03601271003608886
- Center for Disease Control. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance. Atlanta, GA: U.S. Department of Health and Human Services.
- Claes, L., Klonsky, E. D., Muehlenkamp, J., Kuppens, P., & Vandereycken, W. (2010). The affect-regulation function of nonsuicidal self-injury in eating-disordered patients: which affect states are regulated?. *Comprehensive Psychiatry*, 51(4), 386-392.
- Gonzales, A. H., & Bergstrom, L. (2013). Adolescent non-suicidal self-injury (NSSI) interventions. *Journal of Child and Adolescent Psychiatric Nursing*, 26(2), 124-130. doi:
10.1111/jcap.12035

- Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., & ...
Brown, G. K. (2011). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and
Transgender Populations: Review and Recommendations. *Journal Of Homosexuality*,
58(1), 10-51. doi:10.1080/00918369.2011.534038
- Hadlaczky, G., Hokby, S., Mkrtchian, A., Carli, V., Wasserman, D. (2014). Mental Health
First Aid is an effective public health intervention for improving knowledge, attitudes,
and behaviour: A meta-analysis. *International Review of Psychiatry*, 2014; 4; 467-475.
doi: 10.3109/09540261.2014.924910.
- Hasking, P. A., Coric, S. J., Swannell, S., Martin, G., Thompson, H. K., & Frost, A. D. (2010).
Brief report: Emotion regulation and coping as moderators in the relationship between
personality and self-injury. *Journal of adolescence*, 33(5), 767-773.
doi:10.1016/j.adolescence.2009.12.006
- Herman, J., Haas, A., & Rodgers, P. (2014). *Suicide attempts among transgender and gender
nonconforming adults*. Los Angeles: The Williams Institute, UCLA.
- Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention.
Suicide and Life-Threatening Behavior, 24(3), 224-233. doi: 10.1111/j.1943-
278X.1994.tb00747.x
- Jacobson, J. M., Osteen, P. J., Sharpe, T. L., & Pastoor, J. B. (2012). Randomized Trial of
Suicide Gatekeeper Training for Social Work Students. *Research On Social Work
Practice*, 22(3), 270-281. doi:10.1177/1049731511436015
- Kosciw, J., Greytak, E., Giga, N., Villenas, C. & Danischewski, D. (2016). *The 2015 National
School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer
youth in our nation's schools*. New York: GLSEN

- Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of consulting and clinical psychology, 79*(2), 159.
- McSwain, S., Lester, D., & Gunn III, J. F. (2012). Warning Signs For Suicide In Internet Forums. *Psychological Reports, 111*(1), 186-188. doi:10.2466/12.13.PR0.111.4.186-188
- Meuret, A. E., Rosenfield, D., Seidel, A., Bhaskara, L., & Hofmann, S. G. (2010). Respiratory and cognitive mediators of treatment change in panic disorder: Evidence for intervention specificity. *Journal Of Consulting And Clinical Psychology, 78*(5), 691-704.
doi:10.1037/a0019552
- Mitchell, S. L., Kader M., Darrow, S. A., Haggerty, M. Z., & Keating, N. L. (2013). Evaluating Question, Persuade, Refer (QPR) Suicide Prevention Training in a College Setting. *Journal Of College Student Psychotherapy, 27*(2), 138-148.
doi:10.1080/87568225.2013.766109
- Mitchell, S. L., Kader M., Darrow, S. A., Haggerty, M. Z., & Keating, N. L. (2013). Evaluating Question, Persuade, Refer (QPR) Suicide Prevention Training in a College Setting. *Journal Of College Student Psychotherapy, 27*(2), 138-148.
doi:10.1080/87568225.2013.766109
- Murphy, S.L., Xu, J.Q., Kochanek, K.D., Curtin, S.C., & Arias, E. (2017). Deaths: Final data for 2015. *National Vital Statistics Reports; vol 66 no 6*. Hyattsville, MD: National Center for Health Statistics.
- Mustanski, B., Newcomb, M. E., & Garofalo, R. (2011). Mental Health of Lesbian, Gay, and Bisexual Youths: A Developmental Resiliency Perspective. *Journal Of Gay & Lesbian Social Services, 23*(2), 204-225. doi:10.1080/10538720.2011.561474

- National Suicide Prevention Hotline (2018). We can all prevent suicide. Retrieved from <https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/>
- Roe, S. L. (2015). Examining the Role of Peer Relationships in the Lives of Gay and Bisexual Adolescents. *Children & Schools*, 37(2), 117-124. doi:10.1093/cs/cdv001
- Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Jildevik Adamsson, I., & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *Plos ONE*, 12(7), 1-13. doi:10.1371/journal.pone.0180292
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205-213.
- Selby, E. A., Bender, T. W., Gordon, K. H., Nock, M. K., & Joiner Jr, T. E. (2012). Non-suicidal self-injury (NSSI) disorder: A preliminary study. *Personality Disorders: Theory, Research, and Treatment*, 3(2), 167. doi: 10.1037/a0024405
- Stuart, C., Waalen PhD, J. K., & Haelstromm, E. (2003). Many helping hearts: An evaluation of peer gatekeeper training in suicide risk assessment. *Death Studies*, 27(4), 321. doi: 10.1080/0748118039099082
- Trans Student Educational Resources. (2018). LGBTQ+ Definitions. Retrieved from <http://www.transstudent.org/definitions>.
- University of Western Australia. (2015). Sexuality and gender terms. Retrieved from <http://www.student.uwa.edu.au/experience/health/fit/share/sexuality/definitions>.
- U.S. Census Bureau. (2016, June). Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015.

- Vajda, C. (2016). "Peer2Peer" – A university program for knowledge transfer and consultation in dealing with psychosocial crises in med-school and medical career. *GMS Journal For Medical Education*, 33(4), 1-11. doi:10.3205/zma001051
- Venta, A., Shmueli-Goetz, Y., & Sharp, C. (2014). Assessing attachment in adolescence: A psychometric study of the Child Attachment Interview. *Psychological Assessment*, 26(1), 238. doi: 10.1037/a0034712
- Vickerman, K. A., & Margolin, G. (2007). Posttraumatic stress in children and adolescents exposed to family violence: II. Treatment. *Professional Psychology: Research and Practice*, 38(6), 620. doi: 10.1037/0735-7028.38.6.620
- Wilkerson, J. M., Schick, V. R., Romijnders, K. A., Bauldry, J., & Butame, S. A. (2017). Social Support, Depression, Self-Esteem, and Coping Among LGBTQ Adolescents Participating in Hatch Youth. *Health Promotion Practice*, 18(3), 358-365. doi:10.1177/1524839916654461
- Willging, C. E., Israel, T., Ley, D., Trott, E. M., DeMaria, C., Joplin, A., & Smiley, V. (2016). Coaching mental health peer advocates for rural LGBTQ people. *Journal Of Gay & Lesbian Mental Health*, 20(3), 214-236. doi:10.1080/19359705.2016.1166469