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THE IMPACT OF A STRENGTHS-BASED GROUP COUNSELING INTERVENTION ON
LGBTQ+ YOUNG ADULTS'
COPING, SOCIAL SUPPORT, AND COMING OUT GROWTH

by

SHAINNA ALI

B.A. University of Central Florida, 2010

M.A. University of Central Florida, 2012

A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
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at the University of Central Florida
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Major Professor: Glenn W. Lambie

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ABSTRACT

Lesbian, gay, bisexual, transgender, and queer individuals, and those who otherwise identify as a minority in terms of affectional orientation and gender expression identity (LGBTQ+) have a higher rate of mental health concerns than their heterosexual and cisgender counterparts (Meyer, 2003). Young adulthood is a difficult time for individuals who identify as LGBTQ+ as internal identity development processes coincide with stressors from the outside world. The conflict between intrapersonal and interpersonal pressures may evoke a multitude of negative emotions such as anxiety, loneliness, isolation, fear, anger, resentment, shame, guilt, and fear. One difficult task that triggers these depreciating sentiments is the task of managing the process of coming out during LGBTQ+ young adulthood. The tumultuous, transformative coming out process prompts stressors that may cause the increase of mental health concerns for the LGBTQ+ population. Although counselors recognize the need and lack of counselor competency to assist LGBTQ+ individuals, there is limited (a) client-based outcome research and (b) intervention research to assert the efficacy of methods to assist LGBTQ+ young adults during the coming out process. Specifically, *no* studies were found that examined the efficacy of a group counseling intervention to assist LGBTQ+ young adults through the coming out process.

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. In an effort to contribute to the knowledgebase in the fields of counseling and counselor education, the researcher examined (a) if a strengths-based group counseling intervention influences LGBTQ+ young adults' levels of coping (as measured by the *Brief COPE* [Carver, 1997]), social support (as measured by the

Social Support Questionnaire-6 [Sarason, Sarason, Shearin, & Pierce, 1987]), and coming out growth (as measured by the *Coming Out Growth Scale* [Vaughan & Waehler, 2010]) over time; (b) the potential relationship between the outcome variables and group therapeutic factors (*Therapeutic Factors Inventory–Short Form* [TFI-S]; Joyce et al., 2011); and (c) the potential relationship between the outcome variables and the participants’ demographic data (e.g., age, affectional orientation, level of outness).

A one-group, pretest-posttest quasi-experimental design was utilized in this study. Participants received an eight-hour group counseling intervention divided in to four two-hour sessions. The counseling groups were offered at the University of Central Florida’s Community Counseling and Research Center (CCRC). There were three data collection points: (a) prior to the first session, (b) after the second session, and (c) at the end of the last session. The final sample size included 26 LGBTQ+ participants. The research questions were examined using: (a) Repeated Measures Multivariate Analysis of Variance (RM-MANOVA), (b) MANOVA, (c) Canonical correlation, (d) Analysis of Variance (ANOVA), (e) Pearson Product Moment Correlations, and (f) Cronbach’s alpha reliability analysis.

The RM-MANOVA results identified a multivariate within-subjects effect across time (Wilks’ $\lambda = .15$; $F(12, 14) = 6.77, p < .001$) and 84% of the variance was accounted for by this effect. Analysis of univariate tests indicated that *Social Support Number* ($F[1.63, 68.18] = 13.94, p < .01$; partial $\eta^2 = .25$), *Social Support Satisfaction* ($F[2, 50] = 10.35, p < .001$; partial $\eta^2 = .29$), *Individualistic Growth* ($F[2, 50] = 8.22, p < .01$; partial $\eta^2 = .25$), and *Collectivistic Growth* ($F[2, 50] = 9.85, p < .001$; partial $\eta^2 = .28$) exhibited change over time. Additionally, relationships were identified between the outcome variables of *Individualistic Growth*, *Adaptive*

Coping, and *Collectivistic Growth* and the group therapeutic factors of *Secure Emotional Expression*, *Awareness of Relational Impact*, and *Social Learning*. Furthermore, age of questioning was positively correlated with *Collectivistic Growth*.

In addition to a literature review, the research methods and statistical results are provided. Results of the investigation are reviewed and compared to previous research findings. Further, areas for future research, limitations of the study, and implications for the counseling and counselor education are presented. Implications of the study's findings include: (a) support for the use of a strengths-based group counseling intervention in order to increase social support and coming out growth in LGBTQ+ young adults, (b) empirical evidence of a counseling strategy promoting positive therapeutic outcomes with LGBTQ+ college age clients, and (c) verification of the importance of group therapeutic factors in effective group counseling interventions.

“I know that you’re with me and the way you will show, and you’re with me wherever I go...”

For dearest Neshanna, my everglow.

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LIST OF ACRONYMS (or) ABBREVIATIONS

ACA	American Counseling Association
ALGBTIC	Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling
APA	American Psychological Association
BIDR-IM	Balanced Inventory of Desirable Responding-Impression Management Scale
Brief COPE	Brief Cope Inventory
CIS-R	Clinical Interview Schedule-Revised
COGS	Coming Out Growth Scale
GLSEN	Gay, Lesbian, and Straight Education Network
HRC	Human Rights Campaign
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, or Other
MANOVA	Multivariate Analysis of Variance
MLR	Multiple Linear Regression
OI	Outness Inventory
PTSD	Post-Traumatic Stress Disorder
RM-MANOVA	Repeated Measures Multivariate Analysis of Variance
SSQ6	Social Support Questionnaire 6
SRG	Stress-Related Growth
SRGS-S	Stress-Related Growth Scale, Short Form
TFI-S	Therapeutic Factors Inventory, Short Form

CHAPTER ONE: INTRODUCTION

Lesbian, gay, bisexual, transgender, and queer individuals, and those who otherwise identify as a minority in terms of affectional orientation and gender expression identity (LGBTQ+) have a higher rate of mental health concerns than their heterosexual and cisgender counterparts (Meyer, 2003). One of the reasons for these increased mental health concerns may be that LGBTQ+ individuals are often stigmatized and marginalized by society (Human Rights Campaign [HRC], 2013b; Savin-Williams, 2001). Although times have changed, evidence of marginalization towards LGBTQ+ individuals still exists. Indication of marginalization of LGBTQ+ individuals at the macro level includes the lack of civil rights such as adoption, medical care, and workplace safety (Meyer, 2003; PEW Research Center, 2014). At a micro level, LGBTQ individuals often face prejudice, bias, and violence from peers (Kosciw, Greytak, Diaz, & Bartkiewicz, 2014; HRC, 2013b). Young adulthood is a difficult time for individuals who identify as LGBTQ+ as internal identity development processes coincide with stressors from the outside world. The clash between intrapersonal and interpersonal pressures may evoke a multitude of negative emotions such as anxiety, loneliness, isolation, fear, anger, resentment, shame, guilt, and fear (e.g., HRC, 2013a; Kosciw et al., 2014; Meyer, 2003; Savin-Williams, 2001; Vaughan & Waehler, 2010).

One difficult task that triggers these depreciating sentiments is the task of managing the process of coming out during LGBTQ+ young adulthood. The tumultuous, transformative coming out process prompts stressors that may cause the increase of mental health concerns for the LGBTQ+ population (Almeida, Johnson, R, Corliss, Molnar, & Azrael, 2009; Baams, Grossman, & Russell, 2015; Beals & Peplau, 2005; Budge, Rossman, & Howard, 2014;

Matthews & Salazar, 2012). When coming out, individuals require coping, social support, and intrapersonal strength in order to develop resilience, and subsequently persevere and progress onto a healthy adulthood (Meyer, 2003; Meyer, Schwartz, & Frost, 2008; Morrow, 2000; Murdoch & Bolch, 2005; Needham & Austin, 2010; Riggle, Whitman, Olson, Rostosky, & Strong, 2008). Although counselors recognize the lack of counselor competency to assist LGBTQ+ individuals and the subsequent need to increase said competency, there is limited (a) client-based outcome research and (b) intervention research to assert the efficacy of methods to assist LGBTQ+ young adults during the coming out process (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013; Bidell, 2005, 2012; Graham, Carney, & Kluck, 2012; Farmer et al., 2013; Israel, Ketz, Detrie, Burke, & Shulman, 2008). Specifically, *no* studies were found that examined the efficacy of a group counseling intervention to assist LGBTQ+ young adults through the coming out process. Group counseling was targeted because it offers the chance for professional help in a supportive environment which appears to be well suited for the coming out process and for the social needs of the target population (Goodrich & Luke, 2015; Griffith 2013)

Statement of the Problem

Coming out is a stressful, ongoing, and transformative process that encompasses the lifespan. During the coming out process, individuals are at-risk for a multitude of concerns such as anxiety, isolation, and depression (Baams et al., 2015; HRC, 2013a; Kosciw et al., 2014; Meyer, 2003; Savin-Williams, 2001; Vaughan & Waehler, 2010). Facilitative coping and social support are essential variables in reducing coming out concerns (Dunlap, 2014a; 2014b; Holder,

2015; HRC, 2013b; Meyer, Schwartz, & Frost, 2008). Although the need for counseling specific to LGBTQ+ coming out concerns is recognized, there is a lack of empirical evidence examining the efficacy of counseling interventions with this client population (Israel & Selvidge, 2003; Meyer, 2003; Vaughan & Waehler, 2010). Further, limited published research is available examining the effectiveness of strengths-based group counseling interventions with LGBTQ+ young adults through the coming out process (Vaughan & Rodriguez, 2014). Therefore, the primary purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. Secondary analyses that were explored included (a) the potential influence of group therapeutic factors and (b) the relationship between demographic variables and treatment group participants' coping, appraisal of social support, and coming out growth.

Significance of the Study

In a content analysis of 4,457 American Counseling Association (ACA) scholarly publications between 1998 and 2007, Ray and colleagues (2011) found that only six percent of published articles in counseling journals explored the effectiveness of counseling interventions. Hence, this study contributed to needed evidence-based practice research in the counseling field. In addition, *no* published research was identified investigating the efficacy of strengths-based group counseling interventions on LGBTQ+ young adults through the coming out process.

Organizations such as the HRC (2012; 2013a; 2013b) and the Trevor Project (2015) provide helpful resources to assist LGBTQ+ individuals through the coming out process. In

addition to these guidelines, counseling can be a helpful method to assist LGBTQ+ persons in handling stresses such as victimization, anxiety, and depression (ALGBTIC 2013; Budge, Rossman, & Howard, 2014; Chazin & Klugman, 2014; Cooper, 2008); however, there is paucity of evidenced-based outcome research on best practices to help LGBTQ+ clients.

Applicability of Group Counseling to the Coming out Process

Specific to the coming out process, LGBTQ+ young adults require adequate coping, social support, and intrapersonal strength to persevere and progress onto a healthy adulthood (ALGBTIC, 2013). Group counseling is an effective approach in providing social support (Yalom & Leszcz, 2005) and increasing coping strategies (Griffith, 2014; Meaney-Tavares & Hasking, 2013). Additionally, group counseling is an effective intervention strategy for individuals experiencing a range in their progress along the coming out continuum (Dunlap, 2014b). Furthermore, group therapy is suggested as a strengths-based intervention to contribute to well-being of LGBTQ+ individuals (Fisher et al., 2008; Craig, 2013; Goodrich & Luke, 2015; Griffith, 2014; Morrow, 1996; Riggle, Gonzalez, Rostosky, & Black 2014). Although group counseling is acknowledged as an applicable method in providing counseling to LGBTQ+ persons, the efficacy of coming out group counseling intervention has *not* been investigated LGBTQ+ young adults. Therefore, this study contributes to the literature by examining the influence of a strengths-based coming out group counseling intervention for LGBTQ+ young adults. Further, given the lack of investigated interventions to increase positive outcomes with LGBTQ+ young persons, the findings from the study may make a significant contribution to the young adult development, counseling, counselor education, and group intervention literature.

Theoretical Foundations

This research is based in the theory and research pertaining to four constructs of interest: (a) coping, (b) social support, (c) coming out growth, and (d) group therapeutic factors. The following section provides a brief overview to these four constructs of interest.

Coping

The following section reviews aspects of coping that are essential to address in the investigation. The primary parts of coping include: (a) the transactional model of stress and coping (Lazarus & Folkman, 1984), (b) the minority stress model (Meyer, 1995), (c) LGBTQ+ stress, (d) coming out stress, and (e) LGBTQ+ coping.

Transactional model of stress and coping.

The transactional model of stress and coping (Lazarus & Folkman, 1984) examines how individuals receive and perceive stress and the corresponding methods of reaction. Stress is conceptualized as the product of internal factors (e.g., personality) and external factors (e.g., environmental influences). Coping is noted as the active use of cognitive and behavioral mechanisms to respond to stress (Lazarus & Folkman, 1984). The transactional model of stress and coping provides a helpful conceptualization of stress and coping which assists in understanding how to use coping to reduce LGBTQ+ coming out stress.

Minority stress.

Meyer (1995) noted that minority stress is a socially-constructed, subjective experience which occurs at three levels: internal, external, and expectations (Meyer, 1995). *Internal stress* occurs from the individual level, *external stress* occurs from events (e.g., job loss, illness), and *expectations* occur from the recognition of minority status in society. The expectation domain of stress is due to the indirect pressure of marginalized identity. In the minority stress model, it is noted that environment and identity overlap, and stressors influence both aspects. Oftentimes, minority identity leads to actual identification with minority status and prompts stressors that are associated with that identity. Therefore, minorities do *not* need to directly experience prejudice or threats to perceive the impact of stress; recognizing stressors on individuals of the same community has the power to provoke stressful sentiments. Hence, an analysis of the experiences of individuals that fall within the minority classification may trigger stress in an individual as if he or she were the direct target (Meyer, 1995; 2003; 2010).

LGBTQ+ stress. Minority stress processes are applicable to LGB individuals (Meyer, 1995; Meyer & Dean, 1998). LGBTQ+ persons endure minority stress as norms and structures conflict those of the dominant culture (Meyer, 2003). Stressors may arise from direct or expectations of acute or chronic external events and conditions as well as from internalization of negative societal attitudes (Meyer, 2014). Research displays the widespread areas in which LGBTQ+ individuals endure stress which include (a) victimization (e.g., Berlan, Corliss, Field, Goodman, & Austin, 2010; D'Augelli, Pilkington, & Hershberger, 2002), (b) mental health (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Nadal et al., 2011), (c) physical health (e.g., Almeida et al., 2009; Bontempo & D'Augelli, 2002), (d) environmental considerations

(e.g., Downs, 2009; PEW Research Center), and (e) coming out stress (e.g., D’Augelli, 2005; Holder, 2015; Meyer, 2003).

LGBTQ+ coming out stress. The process of coming out is an continuous process which prompts stress throughout the lifetime (D’Augelli, 2005); including, but are *not* limited to, fears pertaining to acceptance, bullying, harassment, safety, and oppression (Coker, Austin, & Schuster, 2010; Kosciw et al., 2014). LGBTQ+ individuals may endure stress from anticipated negative reactions from peers, family, and friends (Meyer, 2003). Researchers have explored the experience of coming out and have noted that during the process individuals are susceptible to anxiety, depression (Baams, Grossman, & Russell, 2015; Dunlap, 2014a), low self-esteem (Fankhanel, 2010; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001), and poor self-acceptance (Holder, 2015). Common coming out stressors include isolation and alienation (Dunlap, 2014b; Flowers & Buston, 2001; HRC, 2013b). Often LGBTQ+ persons are at risk for being marginalized from their families, religious institutions, and overall communities.

LGBTQ+ coping. Societal change influencing the need and process of LGBTQ+ coping has been noted (Dunlap, 2014a; Kosciw et al., 2014). Common methods of adaptive coping in the literature include reading, playing video games, having supportive relationships, having a helpful community, LGBT clubs access to education, and access to therapy (Dunlap, 2014b; Holder, 2015; HRC, 2013b). Mastery and mobilization of social support have been noted as integral to buffering stress (Meyer, Schwartz, & Frost, 2008). Facilitative coping such as seeking help has been related to reduced anxiety, whereas avoidant coping has been correlated with increasing anxiety and depression (Budge, Rossman, & Howard, 2014). Contrastingly, maladaptive methods of coping such as substance use (Degges-White, Rice, & Myers, 2000;

D'Augelli, Grossman, Hershberger, & O'Connell; Holder, 2015) are associated with passive avoidance, ruminating, aggressive reactions, and resigning oneself to the situation (Newman, 2008). However, due to discrimination and societal dangers, perceivably maladaptive methods such as visibility management may be helpful for LGBTQ+ persons. Moreover, visibility management strategy which assists in protection from external stressors and coping with internal stressors, such as anxiety (Dewaele, Van Houtte, Cox, & Vincke, 2013). Within visibility management, individuals regulate the exposure of identity for safety measures. The complex process of managing identity is *not* to be minimized as denial or hiding; although it is often required to prevent harm, the method of visibility management may include stressors such as sadness and loneliness. Over time, an individual's disclosure process may be delayed due to chronic negative social stressors and the need for visibility management (Holder, 2015).

Appraisal of Social Support

Social support can be defined as the existence and provision of individuals and relationships that we value and can rely on for provision of resources (Cohen, 2004; House & Kahn, McLeod, & Williams, 1985; Lopez & Cooper, 2011; Sarason, Levine, Basham, & Sarason, 1983). Social support is conceptualized to influence stress, well-being, social functioning, self-esteem, self-efficacy, and problem solving behaviors (Cohen, 2004; Cohen & Willis, 1985; Lopez & Cooper, 2011). Social support is believed to be the facilitator of coping which in turn reduces negative effects of stress and overall well-being (Lopez & Cooper, 2011).

Although social support researchers agree that the construct is multidimensional, there is a lack of consensus on the conceptual aspects of social support (Lopez & Cooper, 2011; Sarason,

et al., 1983). Lopez and Cooper (2011) conceptualize social support in three categories: (a) connectedness or embeddedness, (b) actual or enacted, and (c) perceived. Considering the variability of the construct of social support, it is important to clarify and focus on one aspect. In considering the population and aims of this study as well as the existing research on social support, this researcher focused on perceived social support.

Perceived social support is comprised of two dimensions: (a) the number of availability of socially supportive persons, and (b) the level of satisfaction with the availability of socially supportive persons (Sarason et al., 1983). Researcher have examined the appraisal of social support (e.g., Sarason et al., 1983; Sarason & Sarason, 1986; Sarason et al., 1983; Sarason et al., 1987) and concluded that when there is an absence of actual support, an individual's appraisal of perceived support has been capable of reducing the impact of stress (e.g., Campos et al., 2008; Gjesfjeld, Greeno, Kim & Anderson, 2010).

In a meta-analysis of 246 studies pertaining to social support, Chu, Saucier, and Hafner (2010) found that perceived social support was more strongly related to well-being ($k = 604, r = .201$) than to other aspects of social support such as size of social network ($k = 53, r = .01$) and enacted support ($k = 147, r = .143$). Further, perception of social support has been noted as protective against the development of post-traumatic stress disorder (PTSD; Dinenberg, McCaslin, Bates, & Cohen, 2014). Beyond correlational data, Sarason and Sarason (1986) identified that it is possible to devise planned, supportive interventions to facilitate perception of social support. Considering the high stress and need for coping in the LGBTQ+ young adult population, perceived support is a necessary variable in enhancing social relationships and overall well-being (Cohen, 2004; Sarason & Sarason, 1986).

LGBTQ+ Social Support. The multifaceted construct of social support has been noted as essential with LGBTQ+ individuals. Social support may be an integral method of coping, and a variable to mitigate stress for LGBTQ+ individuals. Mirroring the general social support literature, social support has been identified to enhance the well-being of LGBTQ+ persons (Grossman, D'Augelli, & Frank, 2011; Hillier, Mitchell, & Ybarra, 2012; Murdock & Bolch, 2005; Riggle et al., 2008). LGBTQ+ individuals have several dimensions in which they may seek support, and the appraisal of support in these dimensions have been shown to influence well-being. Common dimensions of social support pertaining to LGBTQ+ individuals and the coming out process include (a) family, (b) friends, (c) community, and (d) online.

When receiving interpersonal acceptance and support for self-expression, levels of anxiety (Budge et al., 2014) and depression tend to decrease and levels of self-esteem (Beals & Peplau, 2005; Savin-Williams, 1990), well-being (Beals & Peplau, 2005; Legate, Ryan, & Weinstein, 2012), and life satisfaction (Beals & Peplau, 2005) tend to increase. In addition, higher levels of identity support are related to lower levels of emotional distress and buffer against stress (Doty, Willoughby, Lindahl, & Malik, 2010). Specific to young adults, LGBT persons assert that they have less surrounding support than their non-LGBT peers (HRC, 2013b).

The provision of social support may assist individuals through the coming out process. Individuals who have support for their identity are more likely to disclose (Legate, Ryan, & Weinstein, 2012). Further, establishing a social support system is one of the primary recommendations from individuals who experienced coming out (Glezer, 2009; Gragg, 2012; Holder, 2015). The provision of social support in the coming out process facilitates coping, well-being, and coming out growth.

Coming out Growth

Stress-related growth (SRG) refers to the belief that stressful occurrences provide prospects for growth (Park, Cohen, & Murch, 1996). Stress-related growth has been linked to traumatic events such as illnesses (Siegel & Schrimshaw, 200; Weiss, 2002) and bereavement (Parappully, Rosenbaum, van den Daele, & Nzewi, 2002). Following a stressful event, individuals may experience beneficial changes in (a) personal resources, (b) coping resources, and (c) social relationships (Carver, 1998; O'Leary, 1998).

Coming out is a stressful, ongoing, and transformative process that encompasses the lifespan. Coming out stressors may be triggered during the intrapersonal process of development or during the interpersonal process of disclosure. Considering the developmental processes within coming out paired with minority stressors, the coming out process may provide opportunities for growth (Vaughan & Rodriguez, 2014; Vaughan & Waehler, 2010). Coming out has been conceptualized to prompt a number of benefits such as improvements in stronger, more positive identities (e.g., HRC, 2012; McCarn & Fassinger, 1996), self-esteem (Legate et al., 2012), mental health (Floyd & Stein, 2002; Mohr & Fassinger, 2003; Oswald, 2000), social functioning (Savin-Williams, 2001; Stevens, 2004), and social networks (Riggle, Whitman, Olseon, Rostosky, & Strong, 2008).

Group Therapeutic Factors

A common theme in coming out studies of LGBTQ+ individuals is the suggestion of therapy (Alessi, 2014; Chazin & Klugman, 2014; Coolhart, 2006; Hartwell, Serovich, Graftsky, & Kerr, 2012). Dunlap's (2014a) qualitative study of 15 men and 15 women from 5 age cohorts (ages 18-74) of the LGB community noted that in addition to therapy, relationships, education, and community are helpful in navigating the process of coming out. Peer counseling programs, speaker panels, support groups, and Gay/Straight Alliances have been recognized for their utility in providing safe environments and support to individuals in the coming out process (Dunlap, 2014b; Fisher et al., 2008). Specifically, group counseling is a therapeutic modality in which all four of these recommendations can be considered (Fisher et al., 2008; Goodrich & Luke, 2015; Muller & Hartman, 1998; Roberts, 2007).

Yalom and Leszcz (2005) noted the 11 therapeutic factors of group psychotherapy: (a) instillation of hope; (b) cohesion; (c) universality; (d) altruism; (e) imparting information; (f) interpersonal learning; (g) development of socializing techniques; (h) imitative behavior; (i) catharsis; (j); corrective reenactment of the primary family group; and (k) existential factors. When considering the applicability of a group counseling intervention with LGBTQ+ clients, these therapeutic variables are *not* only facilitative, but essential. The 11 therapeutic factors have the potential to enhance LGBTQ+ young adults' coping, social support, and coming out growth. Specifically, Dunlap (2014a) suggests that instillation of hope and universality are key therapeutic factors in the coming out process. In general, counseling groups should help individuals to (a) discuss their experiences, feelings, and thoughts (Fisher et al., 2008); (b) develop effective coping strategies (Alessi, 2014; Chutter, 2007; Ford, 2003); and (c) promote positive behavioral changes (Fisher et al., 2008). Group counseling is helpful when LGBTQ+

young adult members range in their progress along the coming out continuum (Dunlap, 2014b). Furthermore, group therapy is suggested as a strengths-based intervention to contribute to well-being (e.g., Fisher et al., 2008; Craig, 2013; Goodrich & Luke, 2015; Griffith, 2014; Morrow, 1996; Riggle, Gonzalez, Rostosky, & Black 2014).

Operational Definition of Terms

In order to better understand the population of interest, LGBTQ+ young adults, operational definitions of terms are provided. The language chosen is an effort to be clear and consistent with terminology within the literature. The operational definition of each key term and construct is provided below in order to provide a context for the investigation that follows.

Affectional orientation

The term affectional orientation is used as an alternative to “sexual orientation.” Sexual orientation emphasizes sexuality; however, sexual attraction is only a single component of the dynamic attraction endured in relationships (American Psychological Association [APA], 2008). Affectional orientation more accurately encapsulates the multiple layers included in an individual’s “predisposed to bond with and share affection emotionally, physically, spiritually, and/or mentally” (AGLB TIC, 2013, p. 38).

Cisgender

This term cisgender applies to individuals whose self-identity conforms to the gender of their biological sex. As TIME (Steinmetz, 2014) explains, if a child is born and the doctor exclaims, “It’s a girl” and the infant grows up to identify as a woman as an adult, the person is

cisgender. The prefix “cis” means “on this side of,” whereas the prefix “trans” means “on the other side of.”

Coming out process

Coming out is often an ongoing, tumultuous, and transformative process. The overall process includes both internal and external variables. Internal variables pertain to an individual’s personal development in reference to LGBTQ+ identity, whereas external variables refer to the disclosure process of sharing LGBTQ+ identity with others. Due to contextual factors that vary per disclosure, each process is unique. Therefore, the coming out process can be conceptualized as a process that encompasses the lifespan (Ali & Barden, 2015).

Heterosexism

Heterosexism is defined as prejudice against individuals who are not heterosexual. Examples of heterosexism include, but are not limited to, assuming an individual identifies as heterosexual and using slurs such as “fag” (HRC, 2013a; 2013b).

Internalized Prejudice

Also known as internalized homophobia, biphobia, or transphobia, internalized prejudice occurs when messages, biases, and judgments from society transgress the boundary from external to internal. For example, an individual who is raised in a household with strong anti-gay values may be influenced by these hateful views, in turn; the individual may have identity confusion and lack self-acceptance (Frost & Meyer, 2013).

Gender identity and expression

Gender identity refers to a person's internal sense of being male, female, transgender, or another gender (e.g., hijra, two-spirit). Gender does *not* always align with a person's sex at birth. Gender expression is an individual's display (e.g., clothing, hairstyle) of one's gender identity (ALGBTIC, 2013).

Young adult

An individual who is in the process of transitioning from adolescence into the beginning of adulthood is in the stage of young adulthood. This developmental period is also known as "emerging adulthood" and "the frontier of adulthood" (Arnett, 2014; Simpson & Kettyle, 2008). Due to the changing landscape of western society since the mid-20th century, researchers have highlighted the distinct features of young adulthood from adolescence (Furstenberg, 2015; Settersten & Ray, 2010). During young adulthood, individuals evolve from parental dependence and take measures to achieve financial, residential, and emotional independence. Young adulthood is characterized by identity exploration, optimism, and widespread possibilities; however, it can also be a time of instability, extended responsibilities, and confusion due to unparalleled experiences in late adolescence (Arnett, 2014; Gottlieb, Still, & Neby-Clark, 2007; Jessor, Donovan, & Costa, 1991). For the purpose of this investigation, late adolescence pertains to individuals between the ages of 18-24.

LGBTQ+

The acronym LGBTQ+ is used as an inclusive umbrella term for individuals who qualify as

minorities in reference to their affectional orientation and/or gender identity, including individuals who identify as lesbian, gay, bisexual, transgender, queer, or another minority identity (e.g., questioning, asexual, intersex, and hijra third gender). For the purpose of this investigation, LGBTQ+ was used to refer to any person who does not identify as exclusively heterosexual and cisgender. It is important to recognize that although commonalities exist amongst the community of individuals who identify as LGBTQ+, significant variation and diversity exists due to the uniqueness of each individual.

Methodology

The following section presents the methodology of the investigation. The methods to follow include the: (a) research design, (b) research questions, (c) population and sampling, (d) group counseling intervention, (e) data collection procedures, (f) instrumentation, and (g) data analysis.

Research Design

Experimental research designs are highly regarded for their rigor (Shadish, Cook, & Campbell, 2002). A one-group pretest-posttest quasi-experimental design was used (Gall et al., 2007; Shadish et al., 2002). Participants received an eight-hour group counseling intervention to assist through the coming out process. The intervention was divided into four two-hour sessions. The participants met weekly for four consecutive weeks. There were three observation points, including (a) the first observation occurred prior to the first group, (b) the second occurred at the

midpoint of the intervention (i.e., after the second session), and (c) the final observation occurred after the intervention (i.e., after the fourth session).

Research Questions

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. The investigation tested if individuals would score higher on the three measures over time. In an effort to contribute to the knowledgebase in the fields of counseling and counselor education, the investigation sought to answer the following research questions:

Primary Research Question. Does a coming out group counseling intervention influence late LGBTQ+ young adults' levels of coping (as measured by the *Brief COPE* [Carver, 1997]), appraisal of social support (as measured by the *Social Support Questionnaire-6* [Sarason, Sarason, Shearin, & Pierce, 1987]), and coming out growth (as measured by the *Coming Out Growth Scale* [Vaughan & Waehler, 2010]) over time?

Exploratory Research Question 1. What is the relationship between LGBTQ+ young adults' group therapeutic factors (*Therapeutic Factors Inventory–Short Form* [TFI-S]; Joyce et al., 2011) scores and their levels of coping, appraisal of social support, and coming out growth?

Exploratory Research Question 2. What is the relationship between LGBTQ+ young adults' reported demographic variables (e.g., age, affectional orientation, time since out) and their levels of coping, appraisal of social support, and coming out growth?

Population and Sampling

The target population for the investigation was LGBTQ+ young adults (18-24) in the United States of America. Due to the hidden aspect of the LGBTQ+ young adult population, it is difficult to gain an accurate estimate of the overall population nationwide or worldwide (PEW, 2013). For example, although national statistics bureaus could be utilized to calculate the population size, due to the stressors associated with identification, individuals may *not* openly disclose their identity; thus, the reported estimate would be skewed. Since the recruitment and intervention occurred in Central Florida, the sample was narrowed to LGBTQ+ young adults who reside in the Greater Orlando area. Further, the sampling matched the recruitment strategies that are discussed later (i.e., setting).

It is suggested to examine power and effect sizes in addition to null-hypothesis significance testing (Shadish et al., 2002). The free statistical software, GPower, was utilized to calculate an a priori analysis on the sample required with moderate effect size (Faul et al., 2007). The calculation was conducted which considered three observation points, a power of 80%, and a moderate (.25) effect size. With zero correlation among repeated measures, a sample size of 55 cases would be needed. To account for attrition, the researcher aimed to recruit more than 55 participants.

Recruitment

Recruitment flyers were formulated using Dillman's (2014) *Tailored Design Method*. Promotional material was placed in local LGBTQ+ organizations such as Zebra Coalition, the Center, Pride Commons, and UCF's office of LGBTQ+ services. Additionally, websites and

social media outlets for these agencies may be utilized following approval. The researcher also visited these locations to recruit face-to-face and to increase trustworthiness in the researcher, the intervention, and the overall study.

Incentives. Incentives were utilized to improve participation (Dillman et al., 2014). The group counseling intervention was provided at-no-cost to individuals. Participants received \$10 for their involvement in the study; a \$5 gift card was provided at the beginning of the study (session one) and upon full completion of the study (session four). Further, food and water was provided at each group meeting.

Screening. A prescreening interview was scheduled to determine if the anticipated participant meets inclusion criteria (Gladding, 2012). Individuals qualified for this study if they identified as LGBTQ+ and were between the ages of 18-24. Additionally, eligible participants were required to have availability and transportation. Exclusion criterion included individuals who did *not* identify as LGBTQ+, were under the age of 18, or were over the age of 24. Considering the use of a group intervention, individuals were excluded from the study if they were *not* suitable to group treatment, such as individuals that may monopolize or who have severe mental health concerns that would distract from the group (i.e., psychosis, active illegal substance abuse, active domestic violence; Gladding, 2012). Individuals who did not qualify, but were interested in receiving group counseling were referred to local resources (i.e., Community Counseling Research Clinic, Counseling and Psychological Services, The Center, Zebra Coalition).

Group Counseling Intervention

Meyer (2003) asserted that in order to reduce the high rate of mental health concerns in the LGBTQ+ population, efforts must be made to reduce the minority stress endured. Further, Meyer noted that coping skills, social support, and intrapersonal characteristics are essential mediators of minority stress and mental health issues. Therefore, the intervention implemented counseling and psychoeducation techniques to foster positive coping skills and to increase the satisfaction of social support in an effort to improve coming out growth on both intrapersonal and interpersonal levels.

Group counseling is a helpful modality for increasing coping and social support (Gladding, 2012). Curative factors within group counseling including, but *not* limited to, cohesiveness, universality, socializing techniques, imitative behaviors, learning, existential factors, corrective experiences, and catharsis assist in facilitating coping, social support, and overall coming out growth (Yalom & Leszcz, 2002). From a social-constructivist perspective, coming out is contextual and unique to each individual and occurrence (Guittar, 2013; Rust, 1993). The process can often be lonely and isolating. Therefore, a group approach provides an opportunity to normalize the process and to experience cohesiveness and universality. Additionally, during young adulthood, individuals often lack role models to guide through the coming out process. Through a group approach, participants are *not* only learning from the facilitator and the provided materials, they are also experiencing vicarious learning (Bandura, 1995). For example, if an individual is in an early phase of identity development and is struggling with disclosing to his or her parent(s) and witnesses a peer successfully do so, he or she has the opportunity to grow from that indirect experience. From sharing experiences, the

process is *not* only normalized, but also provides a wider range of perspectives in which an individual has the ability to learn what is helpful and unhelpful during the process. The group modality permits for flexibility in gaining varying views and insight for individuals who have existential inquiries. Peers can learn from one another's processes whether positive or negative. Further, group provides an accepting, facilitative environment to release and heal from negative disclosures. Moreover, the group can provide an outlet for individuals to share their experiences, feelings, thoughts, and plans. An individual can experience catharsis for simply having a safe, comfortable environment to freely discuss and process identity, much less the overall ongoing process of coming out (Dentato, Craig, Messinger, Lloyd, & McInroy, 2014).

Data Collection Procedures

The data collection packet included three measures: (a) the *Brief COPE* (Carver, 1997), (b) *The Social Support Questionnaire 6* (Sarason et al., 1987), and (c) the *Coming Out Growth Scale* (Vaughan & Waehler, 2010). The data collection packets were administered at three data collection points throughout the study. The first data collection packet also included the demographics form and was collected at beginning of the first session to serve as baseline data (Gall et al., 2007). The second observation occurred at the midpoint of the study (i.e., after the second session). The final packet included the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) and was administered after the intervention (i.e., after the fourth session).

Instrumentation

Demographic Questionnaire. A brief demographic questionnaire was formulated to track the age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure

about LGBTQ+ status. Prior to being submitted to the IRB, the demographic questionnaire was reviewed by colleagues (i.e., dissertation committee, counselors) in order to provide support for face validity and readability. This questionnaire is displayed in Appendix H.

The Brief COPE. The *COPE* was developed by Carver (1989) to assess a broad range of coping responses. Carver developed the instrument on the foundation of theoretical models of coping such as the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984). Recognizing the utility of a shortened instrument in assessment, Carver (1997) created the 28-item *Brief COPE* (Carver, 1997) from the parent version. The *Brief COPE* can be used in this study and can be found in Appendix I.

The *Brief COPE* is to be analyzed in reference to positive and negative coping strategies rather than total scores (Jacobson, 2005; Moore, Biegel, & McMahon, 2011). Therefore, the *Brief COPE* instrument is examined in this study in reference to two categories: *Adaptive Coping* (subscales 1-10: active coping, planning, using instrumental support, using emotional support, venting, self-distraction, positive reframing, humor, acceptance, and religion) and *Maladaptive Coping* (subscales 11-14: behavioral disengagement, self-blame, denial, and substance use).

The Brief COPE was included in a large battery of assessments administered three times to a convenient sample of 168 individuals severely affected by Hurricane Andrew. The combined reliabilities from all three administrations met the minimum requirements for reliability (.50, Nunnally, 1978) and are as follows: active coping ($r = .68$), planning ($r = .73$), using instrumental support ($r = .64$), using emotional support ($r = .71$), venting ($r = .50$), self-distraction ($r = .71$), positive reframing ($r = .64$), humor ($r = .73$), acceptance ($r = .57$), religion

($r = .82$), behavioral disengagement ($r = .65$), self-blame ($r = .69$), denial ($r = .54$), and substance use ($r = .90$).

Mohanraj and colleagues (2015) tested the convergent validity of the *Brief COPE* and depression (*Clinical Interview Schedule-Revised* [CIS-R], Lewis et al., 1993) and identified found a significant correlation between maladaptive coping and depression (± 0.34 , $p < 0.001$). Moreover, Muller and Spitz (2003) found that active coping is linked to higher self-esteem, lower perceived stress, and lower psychological distress, whereas maladaptive coping strategies are widely linked to poor self-esteem, high perceived stress, and psychological distress.

Krägeloh (2011) noted that since its original publication, at least 463 scholarly publications have utilized the *Brief COPE* and of the sample, 399 studies have collected empirical data using the *Brief COPE*. The *Brief COPE* has been used to better understand coping for a variety of concerns such as HIV (Mohanraj et al., 2015; Vosvick et al., 2003), aging (Lagana & Zarakin, 2010), and depression (Cooper, Katona, Orrell, & Livingston, 2008). Specific to the population of interest for the study, the *Brief COPE* has been used with young adults (e.g., Miyazaki, Bodenhorn, & Zalaquett, 2008; Pais, Ribeiro & Rodrigues, 2004; Schnider, Elhai, & Gray, 2007; Steinhardt & Dolbier, 2008). Furthermore, the *Brief COPE* was used in an investigation of coping styles among gay men, providing support for its use with the LGBTQ+ community (David & Knight, 2008). Closely related to this research, Griffith (2014) used the *Brief COPE* to examine a group intervention for LGBTQ+ individuals ages 18-20. Griffith found that group counseling participants scored higher in coping behaviors, particularly in adaptive coping scores following the intervention.

The Social Support Questionnaire 6. The *Social Support Questionnaire 6* ([SSQ6], Sarason et al., 1987) is six-item measure that assesses perceived social support (SSQ-N), and the satisfaction with perceived social support (SSQ-S). This abbreviated measure can be found in Appendix J. The *SSQ6* has internal reliabilities ranging from .90-.93 on both subscales. A negative relationship was found between anxiety and social support. For the *Social Support Number* subscale the correlations with the *Multiple Adjective Affect Check List* (MAACL; Zuckerman & Lubin, 1965), the *Reactions to Social Situations Scale* (Sarason, 1986), and *State-Trait Anxiety Inventory* (Spielberger et al., 1979) were $-.26$ ($p < .001$), $-.31$ ($p < .001$), and $-.38$ ($p < .001$) respectively. For the *Social Support Satisfaction* subscale the correlations were $-.17$ ($p < .05$), $-.25$ ($p < .001$), and $-.55$ ($p < .001$), respectively, providing support for discriminant validity.

A negative relationship was found with the *SSQ6-N* and *SSQ6-S* scores and the *Beck Depression Inventory* (BDI; Beck et al., 1961, $r = -.19$, $p < .001$, $r = -.47$, $p < .001$), *UCLA loneliness scale* (Russell, Peplau, & Cutrona, 1980), and the *Social Reticence Scale* for shyness (Jones & Russell, 1982, $r = -.31$, $p < .001$, $r = -.20$, $p < .001$), providing support for discriminant validity. Positive associations were found between the *SSQ6-N* and *SSQ6-S* scores and the *Social Competence Questionnaire* (Sarason, Sarason, Hacker, & Basham, 1985, $r = .39$, $p < .001$, $r = -.20$, $p < .01$) and the *Family Environment Scale* (Moos & Moos, 1981, $r = .41$, $p < .001$, $r = .50$, $p < .01$). Multiple measures were used to establish concurrent validity regarding social support. Positive relationships were found between *SSQ6-N* and *SSQ6-S* scores and the *Inventory of Social Supportive Behaviors* (ISSB; Barrera et al., 1981, $r = .27$, $p < .001$, $r = .23$, $p < .001$), the *Interpersonal Support Evaluation List* (ISEL; Cohen & Wills, 1985, $r = .49$, $p < .001$, $r = .62$, p

< .001), the *Social Network List* (Stokes, 1983, $r = .39, p < .001, r = .15, p < .05$), and the *Perceived Social Support* (PSS; Procidano & Heller, 1983) from friends ($r = .44, p < .001; r = .52, p < .001$) and family ($r = .42, p < .001; r = .58, p < .001$); supporting the convergent validity of the *SSQ6-N* and *SSQ6-S*.

A limitation of the *SSQ6* is the correlation with social desirability. The *Marlowe-Crowne Social Desirability Scale* (Crowne & Marlow, 1964; Marlowe & Crowne, 1961) yielded positive correlations with both *SSQ6-N* ($r = .23, p < .001$) and *SSQ6-S* ($r = .21, p < .001$) scores. Additionally although, different samples were utilized, all samples utilized a convenient population of undergraduate psychology students. However, the *SSQ6* has been used for populations under stressful life events such as AIDS (Leserman et al., 2000). Additionally, the *SSQ6* has been previously used with young adults, thus supporting the application of the *SSQ6* in this study (Forbes & Roger, 1999; Price, Gray, & Thacker, 2015).

The Coming Out Growth Scale. The ability to grow from the stress endured during coming out has been acknowledged in the literature (e.g., Cox, Dewaele, Houtte, & Vincke, 2011; Meyer, 2014; Vaughan & Rodriguez, 2014). Vaughan and Waehler's *Coming Out Growth Scale* (COGS; 2010) measures the perceived gains from the process and outness. The 34-item version of the *COGS* will be utilized in order to allow for an examination of intrapersonal and interpersonal dimensions of growth. The *COGS* implemented in this study can be found in Appendix K.

The intrapersonal growth subscale of the *COGS* (Vaughan & Waehler, 2010) has 21 items and the collectivistic growth subscale has 13 items. The *Individualistic Growth* dimension includes perceived gains in authenticity/honesty, biopsychosocial well-being, and sexual

minority identity. The *Collectivistic Growth* dimension captures growth in LGBT-affirming views, a sense of belonging, and a collective LG identity.

The intrapersonal growth subscale of the COGS (Vaughan & Waehler, 2010) has a reliability of .96 and the collectivistic growth subscale has a reliability of .88. Non-significant relationships found between social desirability (impression management) scores (Balanced Inventory of Desirable Responding-Impression Management Scale [BIDR-IM]; Paulhus, 1994) and reports of individualistic growth; however, a significant negative relationship was found between BIDR-IM and COGS-G scores ($r = -.12, p < .05$). Positive, significant relationships were found between *Stress-Related Growth Scale-Short Version* (SRGS-S; Park et al., 1996) scores and *Individualistic Growth* ($r = .75, p < .001$) and *Collectivistic Growth* ($r = .58, p < .001$), providing support for concurrent validity. Overall COGS scores were moderately interrelated with SRGS-S scores ($r = .58-.75$); SRGS-S scores explained about 56.25% of the variance in COGS scores. The moderate relationship indicates that although related, the measures capture distinct experiences and thus, in order to fully measure coming out growth, the SRGS-S is insufficient.

There were no significant differences in COGS scores between lesbian biological women and gay biological men ($t = 1.28, df = 313; t = 1.84, df = 312$). Additionally, unlike the findings from Bonet et al.'s (2007) study, no growth differences were noted across education levels or between racial/ethnic minorities. Both *Individualistic* and *Collectivistic Growth* subscales had significant relationships with dispositional optimism ($r = .25, p < .001; r = .16, p < .01$), identity integration/synthesis ($r = .43-.46, p < .001; r = .35-.40, p < .001$), amount of involvement in the LGBT community ($r = .36, p < .01, COGS-CG: r = .46, p < .01$), age at first consensual same-

gender experience ($r = -.15, p < .01$; $r = -.19, p < .01$), and overall level of outness ($r = .30, p < .001$; $r = .26, p < .001$). Time elapsed since the beginning of the coming out process was significantly related to individual growth ($r = .13, p < .05$), but not to collectivistic growth. Hence, although demographic variables such as biological sex, ethnicity, or education may not influence *COGS* scores, experience with coming out and involvement in the LGB community may be influential factors in facilitating coming out growth.

Although instruments have been established to measure outness (e.g., *Outness Inventory* [OI]; Mohr & Fassinger, 2000) and instruments have been established to measure stress-related growth (e.g., *SRGS-S*; Park et al., 1996), the *COGS* (Vaughan & Waehler, 2010) is the first of its kind which examines stress-related growth gained from the coming out process. Since the *COGS* is a new measure, the only publication that has measured coming out growth with the *COGS* is related to the study of its creation (Vaughan & Waehler, 2010). One limitation is that the *COGS* was validated on a sample of lesbian and gay identified individuals. This investigation is the first study to use the *COGS* to measure the stress-related growth gained from the coming out process with additional sexual and gender minorities (e.g., asexual, bisexual, transgender). Further, this research contributes to the literature on coming out growth and determining if coming out growth can be increased from a group counseling intervention.

Therapeutic Factors Inventory Short Form. The *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) was designed to measure the effectiveness of group counseling (e.g., curative factors and dynamics). This instrument was administered once, at the conclusion of the group. The *TFI-S* is a shortened version of the 99-item *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). The version utilized in this study can be seen in

Appendix L. The *TFI-19* is based off of Yalom's 11 therapeutic factors and higher scores demonstrate participants' positive experiences within group. In this study, the TFI-S was analyzed by the use of subscale scores. The four TFI subscales include: (a) *Instillation of Hope*, (b) *Secure Emotional Expression*, (c) *Awareness of Relational Impact*, and (d) *Social Learning*. Items are formatted on a seven-point Likert-type scale ranging from strongly disagree to strongly agree. Example prompts on the instrument include, "I feel a sense of belonging in group," "this group empowers me to make a difference in my own life," and "things seem more hopeful since joining group."

Each *TFI* factor demonstrates good internal consistency (*Instillation of Hope* [$r = .90$], *Secure Emotional Expression* [$r = .85$], *Awareness of Interpersonal Impact* [$r = .79$], and *Social Learning* [$r = .66$]). Additionally, a quasi-experimental study of counselors-in-training participating in multicultural growth groups provided further support for the internal consistency of the subscales: instillation of hope (.65), secure emotional expression (.52), awareness of relational impact (.88), and social learning (.88; Johnson & Lambie, 2013). A quasi-experiential study exploring the influence of group counseling on LGBTQ young adults found that the Cronbach's alpha for the total TFI-S was acceptable ($\alpha = .78$; Pallant, 2010). Additionally, Cronbach's alpha for the TFI-S subscales was acceptable (*Instillation of Hope* $\alpha = .84$, *Secure Emotional Expression* $\alpha = .78$, *Awareness of Relational Impact* $\alpha = .85$, and *Social Learning* $\alpha = .86$; Griffith, 2014).

Data Analysis

The Statistical Package for Social Science (SPSS) software package for Windows version

21.0 (IBM Corp., 2012) was utilized to analyze the data in this study. The dataset for the investigation included one independent variable (time) and multiple continuous dependent variables: (a) *Brief COPE* scores (Carver, 1997); (b) *SSQ-6* scores (Sarason et al., 1987), (c) *COGS* scores (Vaughan & Waehler, 2010); and (d) *TFI-S* scores (Joyce et al., 2011). Additional variables from the brief demographic questionnaire included participants' age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+ data was examined prior to ensure that necessary statistical assumptions have been met prior to analysis.

Primary Research Question. A repeated-measures multivariate analysis of variance (RM-MANOVA) was utilized to determine if there was a significant difference in participants' coping, social support appraisal, and coming out growth scores over time (Pallant, 2010; Tabachnick & Fidell, 2013). The independent variable was time and the dependent variables were the outcome scores (i.e., coping, coping, social support, and coming out growth). A MANOVA was utilized because there are multiple dependent variables that are theorized to be interrelated. A repeated-measures analysis was utilized to strengthen the statistic with multiple points rather than to use only one pretest and one posttest.

Exploratory Research Question 1.

A canonical correlation was utilized to analyze the relationship group therapeutic factors and outcome variables (Tabachnick & Fidell, 2013). Additionally, Pearson Product Moment Correlations (two-tailed) were used to calculate whether there was a significant relationship between the individual group therapeutic factors and participants' and *Adaptive Coping*, *Maladaptive Coping*, *Social Support Number*, *Social Support Satisfaction*, *Collectivistic Growth*,

and *Individualistic Growth*.

Exploratory Research Question 2. Depending on the structure of the data, statistics were selected to calculate whether there was a relationship between participants' demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+ status) and coping, appraisal of social support, and coming out growth. For continuous variables (i.e., age, coming out stress, outness) a Pearson Product Moment Correlation was utilized. When two or more groups were being examined, a MANOVA was utilized to explore the demographic variable.

Ethical Considerations

Methods were implemented to ensure that the investigation was conducted in an ethical manner, including: (a) obtaining approval from the IRB, (b) informing participants of their rights, (c) expressing limits to confidentiality, and (d) removing identifying information on instrument packets. Since this study pertains to a marginalized group, there are ethical considerations specific to this population. In the coming out process, individuals who are disclosing their affectional orientation or gender may be cautious due to safety concerns. The counseling group was intended to assist individuals in the lifelong coming out process. Individuals who are towards the beginning of their journey may be particularly hesitant about disclosure. Since treatment is provided in a group counseling format the limit to confidentiality extends beyond participant-practitioner. Participation was voluntary, and participants were informed of their right to withdraw from the study at any time.

Potential Limitations of the Study

Limitations are noted in areas such as sampling, research design, instrumentation, and treatment. The entire project occurred in Central Florida. Although Central Florida can be representative of the United States, it is unknown whether the results can be transferred to other areas (i.e., rural). Due to the hidden nature of the LGBTQ+ population, it is difficult to estimate generalizability (Gall et al., 2007; PEW, 2013). Marginalized status may have caused difficulty in acquiring a suitable sample; specifically, considering a sample size of 75 participants (Faul et al., 2007). Moreover, these participants would need to be consistent with treatment in order to avoid concerns of subject and measurement attrition. A similar age range was chosen to increase cohesiveness and because young adulthood is noted as a pivotal time in development (Dunlap, 2014b; Guittar; 2013; HRC, 2013b). We assert that coming out encompasses the lifespan (Dunlap, 2014a; Guittar, 2013; HRC, 2013a); however, we cannot be certain if the results apply to individuals beyond the range of 18-24.

The detection change in constructs targeted relies heavily on the instruments of choice. Particular attention was given to brief, clear, psychometrically-sound instruments; however, all instruments have their limitations. Although self-report measures have a weakness, they were needed for this study as experiences from coming out are personal and unique. Specifically for the *COGS* (Vaughan & Waehler, 2010), due to its recent establishment, reliability and validity evidence to date only exists from the primary creators. Further, this was the first quasi-experimental study to utilize the *COGS* to measure the ability of group treatment to influence coming out growth.

The lack of a control group in the quasi-experimental design makes it difficult to draw conclusions from the differences in scores over time. Since the treatment curriculum was developed for this study, individuals may be biased by the appeal. Moreover, since the treatment was intended to assist through the coming out process and the measures are self-report, beliefs of change may influence the reported scores. Although consistency was provided through the use of one facilitator and adherence to a treatment manual, researcher bias and the influence of one facilitator is difficult to account for in scores.

Chapter One Summary

This chapter introduced the pertinent constructs in this research study (i.e. coping, social support, coming out growth, and group therapeutic factors). Additionally, the researcher introduced the rationale for the study, explained the potential significance of the study, and provided operational definitions of terms used throughout the study. The researcher also conveyed key aspects of the methodology including the (a) design, (b) research questions, (c) population, (d) sample, (e) recruitment procedures, (f) intervention, (g) instrumentation, and (h) data analysis. Finally, limitations and ethical considerations were provided.

CHAPTER TWO: REVIEW OF THE LITERATURE

The primary purpose of this study was to investigate the effects of a strengths-based coming out group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. Secondary analyses explored: (a) the potential influence of group therapeutic factors and (b) the relationship between demographic variables and treatment group participants' coping, social support, and coming out growth. Considering the purpose of the investigation, the researcher examined the literature on the theoretical background and empirical support pertaining to the identified constructs: (a) coping; (b) appraisal of social support; (c) coming out growth; and (d) group therapeutic factors. The following section provides a brief overview of these constructs. Emphasis was placed on literature pertaining to the population of interest: individuals in young adulthood who identify as LGBTQ+.

Coping

Theories and Definitions of Coping

Transactional model of stress and coping. The transactional model of stress and coping (Lazarus & Folkman, 1984) is used to examine how individuals receive and perceive stress, and the corresponding methods of reaction. Stress is conceptualized as the product of internal factors, such as personality, and external factors, such as environmental influences. Coping is noted as the active use of cognitive and behavioral mechanisms to respond to stress (Lazarus & Folkman, 1984). In an effort to subdue stress, individuals may cope in a multitude of ways including meditation, prayer, exercise, and substance use. There are three components of the transactional

model of stress and coping: (a) primary appraisal, (b) secondary appraisal, and (c) coping.

Primary appraisal involves the perception of a threat, *secondary appraisal* is the generation of a potential response to the given threat, and *coping* is the active utilization of the stress mediating response (Folkman & Lazarus, 1984). When a stimulus occurs, individuals draw on internal and external analysis to determine if the event is potentially harmful. An individual's perception of a stressful event can also be perceived as a challenge or opportunity for growth (Folkman & Lazarus, 1980).

According to Lazarus and Folkman (1984), there are two forms of coping: (a) emotion-focused, and (b) problem-focused. *Emotion-focused coping* involves methods to reduce or prevent negative emotional responses such as anxiety or depression. Examples of emotion-focused coping are substance use, meditation, relaxation, minimizing, being open to learning new skills, mediating, and/or journaling. In contrast, *problem-focused coping* incorporates methods which attempt to directly address the stressor. Examples of problem-focused coping include seeking therapy, problem solving, planning, and negotiation. When individuals evaluate the utility of their coping strategies, they determine if their methods were effective in resolving the concern. Sometimes, individuals find that their methods were ineffective, and are faced with extended distress and the need to determine new, more effective methods of coping.

Minority stress. Meyer (1995) noted that minority stress is chronic as it is influenced by social and cultural structures. The surrounding world has the potential to influence an individual's stress. Stress is a socially-constructed, subjective experience. Societal norms, expectations, and pressures may influence individuals differently. In an act of domestic terrorism in June of 2015, a mass shooting occurred at historically black church in Charleston, South

Carolina killing nine innocent victims. The shooter, Dylann Roof, was motivated by his hateful views towards African Americans. The horrific shooting prompted fear and anxiety in minorities across America. However, since stress is unique, the event may have been interpreted differently and the influence of the event may have varied among minorities (Meyer, 2003).

Minority stress occurs at three levels: (a) internal, (b) external, and (c) expectations. Internal stress occurs from the individual level, external stress occurs from events (e.g., job loss, illness), and expectations occur from the recognition of minority status in society. The third domain of stress is due to the indirect pressure of marginalized identity. General stressors are *not* unique to minorities; however, distal stressors occur from witnessing prejudice events related to minority identity and proximal stressors arise from expectations of experiencing further prejudice events. In the minority stress model, it is noted that environment and identity overlap, and stressors influence both aspects. Oftentimes, minority identity leads to actual identification with minority status and prompts stressors that are associated with that identity. Therefore, minorities do *not* need to directly experience prejudice or threats to perceive the effect of stress; recognizing stressors on individuals of the same community has the power to provoke stressful sentiments. In February of 2012, 17-year-old Trayvon Martin was fatally shot in an altercation with neighborhood watchman George Zimmerman. Following the event, individuals in the community rallied for justice for Trayvon, including Zimmerman's arrest. The case highlighted the concept of racial profiling in Florida, and the nation at large. Racial profiling is an example of a distal stressor, but also a proximal stressor as individuals may become vigilant. Hence, an analysis of society or experiences of individuals that fall within the minority classification may trigger stress in an individual as if he or she were the direct target.

Identity prominence or salience, valence, and level of integration are influential factors on minority stress (Meyer, 2003). Prominence, or salience, refers to an individual's identification and commitment to the minority identity (Thoits, 1999). Thus, although stress is pervasive in the overall LGBTQ+ population, minority stress may have a stronger influence on individuals who prominently adopt LGBTQ+ identity (Meyer, 2003). The identification with a minority identity is not stable, rather it fluctuates. An individual who openly identifies as lesbian and engages regularly in LGBTQ+ community activities and services may have more identity prominence than an individual who is uncertain of his or her gender identity or affectional orientation and has not disclosed to others. However, even a self-identified LGBTQ+ activist is impressionable to societal influence. For example, if an open individual were to be placed in a rural, unaccepting community, it is possible that his or her identity salience may be influenced by surrounding prejudice, bias, and danger. An individual's personal evaluation of identity is also known as valence. Internalized prejudice is a common valence concern for LGBTQ+ persons. Also known as internalized homophobia, biphobia, or transphobia, internalized prejudice occurs when messages, biases, and judgements from society transgress the boundary from external to internal. For example, an individual who is raised in a household with strong anti-gay values may be influenced by these hateful views, in turn; the individual may have identity confusion and lack self-acceptance. Finally, the concept of integration considers that each individual is comprised of multiple, intersecting identities (Crenshaw, 1989; Hays, 2001; Meyer, 1995). Hence, integration refers to the degree in which minority identity melds with an individual's other identities. Aligned with the example of the individual who may have internalized prejudice, lack of acceptance and subsequent integration can be due to conflicting identities or roles. For example,

a transgender who wishes to, but has *not* transitioned may be living a life that is not aligned with the gender of choice. When an individual is unable to integrate or express the identity he or she wishes to, stressful conflict arises. Further, individuals with multiple minority identities may be at-risk for increased stress (Meyer, 2010). Considering the influence of identity prominence, valence, and integration, minority stress is pervasive and chronic for LGBTQ+ individuals (Meyer, 1995; Meyer & Dean, 1998).

LGBTQ+ stress. LGBTQ+ persons endure minority stress as norms and structures conflict those of the dominant culture (Meyer, 2003). Stressors may arise from direct or expectations of acute or chronic external events and conditions as well as from internalization of negative societal attitudes (Meyer, 2014). Over the years, social progress has been decreasing potential triggers for minority stress (Dunlap, 2014; PEW, 2014). Evidence of societal progress can be seen from the American Psychiatric Association's removal of Homosexuality from the *Diagnostic and Statistical Manual* (1973), the repeal of Don't Ask Don't Tell, and the recent Supreme Court jurisdiction asserting same-sex marriage as a constitutional right. Although the progress in society is evident, marginalization of LGBTQ+ individuals remains. For one, such advances are often associated with the United States and other Western countries. The documentary *Dangerous Living* (Baus, Hunt, & Scagliotti, 2003) provides a contemporary example of the violent risks LGBTQ+ individuals' face across the globe such as incrimination and physical violence including death. Grazing the surface on the status of LGBTQ+ issues in Honduras, Namibia, the Philippines, Pakistan and Vietnam, the documentary conveys the severity of LGBTQ+ stress worldwide. Regardless of the incremental progress, LGBTQ+ individuals continue to live dangerous lives in America as well. Research findings identified the

widespread areas in which LGBTQ+ individuals endure stress which include (a) victimization (e.g., Berlan, Corliss, Field, Goodman, & Austin, 2010; D’Augelli, Pilkington, & Hershberger, 2002), (b) mental health (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Nadal et al., 2011), (c) physical health (e.g., Almeida et al., 2009; Bontempo & D’Augelli, 2002), (d) environmental considerations (e.g., Downs, 2009; PEW, 2013), and (e) coming out stress (e.g., D’Augelli, 2005; Holder, 2015; Meyer, 2003).

Victimization. LGBTQ+ young adults are more likely to experience victimization than their heterosexual peers (Berlan, Corliss, Field, Goodman, & Austin, 2010; HRC, 2013b). D’Augelli, Pilkington, and Hershberger (2002) examined LGB victimization in a sample of young adults under the age of 21 ($N = 350$) and identified that more than half of the youth reported being victims of verbal abuse due to their orientation and 11% were physically assaulted. The various types of victimization the youth recalled witnessing included being shunned (27%); verbal insults (34%); threats of violence (21%); objects thrown (12%); being punched, kicked, or beaten (10%); and sexual assault (4%).

Similarly, the Gay, Lesbian, and Straight Educational Network (GLSEN) conducted a study to examine the experiences of LGBT students ($N = 7,898$) between the ages of 13 and 21 in a nation-wide sample from 2,770 school districts. About three-quarters of the students reported verbal harassment in the last year due to their sexual orientation and 52.5% because of their gender expression. Of the sample, 64.5% of students reported frequently hearing homophobic remarks such as “dyke” or “faggot” and 56.4% reported frequently hearing judgmental gender expression remarks such as “not acting feminine/masculine [enough]” (Kosciw, Greytak, Diaz, & Bartkiewicz, 2014, p. xvi). About one third of these remarks were in

reference to transgender persons and included labels such as “tranny” or “he/she.” The harassment at school was *not* solely subject to peers; over half of the sample reported hearing negative remarks about sexual orientation and gender expression from teachers and/or staff. Therefore, beyond peer harassment, LGBTQ+ students may experience victimization from adults who are responsible for their safety and protection. Students who experienced higher levels of victimization were more likely to have lower grade point averages, twice as likely to report they have no plans for post-secondary education, and three times more likely to have missed school within the past month (Kosciw et al., 2014).

Verbal victimization is *not* confined to school walls; 90% of LGBT youth report hearing negative messages about being LGBT (HRC, 2013b), and verbal harassment extends to the online realm (Weiderhold, 2014). In addition to peer harassment, the origins of victimization are often peers and family. In a study of 44 transgender youth aged 15-21, more than two-thirds of the participants reported verbal abuse related to their gender identity from peers or parents (Grossman, D'Augelli, & Frank, 2011). Verbal attacks may take the form of direct explicit statements, but may also take the form of microaggressions.

Microaggressions are brief, common verbal and behavioral slights that can be derogatory, condescending, or hostile insults towards a minority group (Nadal et al., 2011; Sue, 2010). Microaggressions can be microinsults, which are often unconscious conveyances of rudeness, but may include microassaults, which are purposeful use of explicit language or nonverbal behavior with intention to harm a minority (Nadal et al; Sue, Capodilupo, et al., 2007). Nadal and colleagues examined the lived experience of 26 LGB individuals with the average age of 25.7. Participants noted eight types of microaggressions they have experienced which have

negatively influenced their identity development and led to detrimental relationships such as those with friends, family, coworkers. The types of microaggressions noted included: (a) use of heterosexist terminology, (b) endorsement of heteronormative behaviors/culture, (c) exoticization, (d) assumptions of a universal LGB experience, (e) assumption of abnormality/pathology, (f) discomfort or disapproval, (g) denial of the reality of heterosexism, and (h) threats. Although Nadal and colleagues' study provides a foundation to conceptualize microaggressions, unfortunately the experience of queer or transgender individuals is not included. Shelton (2013) also examined microaggressions and included individuals that identified as queer in addition to LGB. The microaggressive experiences of 16 self-identified LGBQ psychotherapy clients were explored to provide information on how therapists may unknowingly cause harm to their clients. The seven themes included: (a) assumption that sexual orientation is the root cause of presenting issues, (b) avoidance or minimization of sexual orientation, (c) attempts to over identify with LGBQ clients, (d) making stereotypical assumptions about LGBQ clients, (e) expressions of heteronormative bias, (f) assumption that LGBQ individuals need psychotherapy due to identity, and (g) warning and dangers of identifying as LGBQ. Although the study's findings identified ways in which therapists may use verbally abusive slights, inferences can only be made to LGBQ individuals. Additionally, about three-quarters of the sample identified as White; thus, the results may *not* encompass microaggressive experiences of LGBTQ+ ethnic minorities.

LGBTQ+ victimization extends beyond verbal abuse and includes physical violence as well. A PEW (2013) study provides testimony to the multitude of stressors endured by LGBT individuals. Of the nationally-representative sample of 1,197 LGBT adults, 30% stated they have

been physically threatened or attacked. LGBT youth are twice as likely to report being kicked, shoved, or physically assaulted at school (HRC, 2013b). In a study by GLSEN, 36.2% of students reported being physically attacked due to their orientation and 16.5% due to their gender identity (Kosciw et al., 2014). Approximately one-fifth to one-third of transgender youth report physical abuse from their peers or parents (Grossman et al., 2011). LGBTQ+ youth are disproportionately faced with victimization as compared to their heterosexual peers; further, victimization has long-lasting effects on mental health. LGBTQ+ victimization is a dangerous concern which warrants attention in counseling. LGBTQ+ victimization as it relates to the coming out process is included in the treatment intervention.

Mental health. LGBT young adults who experience victimization have higher levels of depression, self-harm, and suicidal ideation, and have lower levels self-esteem and happiness (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; HRC, 2013b; Kosciw et al., 2014). Individuals who report more identity stress also report more dysphoria (Lewis, 2008), and may report symptoms associated with Post-Traumatic Stress Disorder (PTSD; D'Augelli, Pilkington, & Hershberger, 2002; Nadal et al., 2011). In a survey of public high school students, Almeida and colleagues (2009) found that LGBTQ youth were more likely to report self-harm (21% vs. 6%, $p < 0.0001$) and suicidal ideation (30% vs. 6%, $p < 0.0001$). Needham and Austin (2010) examined the persistence of mental health concerns in lesbian and gay individuals over time within a sample of over 11,000 adolescents enrolled in grades 7 through 12 and follow-up measures were conducted five years later. The researchers found that lesbian and bisexual youth had higher depressive symptomology and suicidal thoughts than heterosexual youth and gay youth had higher odds of suicidal thoughts than heterosexual youth.

Rosario, Rotherarn-Borus, and Reid (1996) investigated gay and bisexual individuals aged 14-21 in New York City ($N = 136$). More than three-quarters of the participants reported identity-related stress. Identity-related stressful events have been found to be moderately associated with emotional distress. Specifically, although the effect size was small, identity-related stress was related to increased fighting ($r = .16, p < .06$) and depression ($r = .17, p < .06$). A strength of Rosario and colleagues' study is that a majority of the participants were Hispanic or Black, thus giving the perspective of double-minority status on mental health. Based in New York, Project STRIDE is concerned the intersection of minority identities related to sexual orientation, gender, and race/ethnicity. In a more diverse sample of 396 White, African-American, and Latino participants aged 18-59, Kertzner, Meyer, Frost, and Stirratt (2009) found that the youngest cohort, ages 18-28 had the lowest social well-being. The results of these studies provided partial support for the Minority Stress Model (Meyer, 1995) as Latino respondents report more depressive symptoms and less psychological well-being than White respondents. Additionally, Meyer, Schwartz, and Frost (2008) found that black and Latino LGB individuals were more likely than white LGB individuals to experience stressful events related to identity racial/ethnic prejudice. Meyer (2010) suggests that due to the double-jeopardy hypothesis, "double-minorities," individuals who belong to multiple minority groups, may endure more mental health concerns than individuals who do not classify within minority group or belong to one minority group. Craig and McNroy's (2013) study of a community-based sample of 137 multiethnic sexual minority youth provided support for Meyer's (2010) double-minority hypothesis as participants with cumulative risks of physical or mental health ($OR = 3.8; 95\% CI = 1.8, 4.6$ and physical or sexual abuse ($OR=3.8; 95\% CI=2.2, 5.4$) were four times more likely

to report suicide risk. Research on mental health concerns of LGBTQ+ individuals extends beyond the United States (D'Augelli, Pilkington, & Hershberger, 2002; Klein, Holtby, Cook, & Travers; Lewis, 2012; Naidoo & Mabaso, 2014; Rickards & Wuest, 2006). Kuyper and Fokkema's (2011) examined the relationship between mental health and minority stress and found that the regression model was significant $F(3, 388) = 7.83, p < .001, R^2 = .06$; therefore, LGB individuals face negativity and mental health repercussions.

Physical health. Researchers have asserted that due to minority stress, LGB persons are more at risk for physical health problems (Fredriksen-Goldsen, Kim, & Barkan, 2012; Frost, Lehavot, & Meyer, 2011; Lick, Durso, & Johnson, 2013; Meyer, 2003). Psychological stress responses are noted in addition to health behaviors, sociocultural factors, and health status. Disparities noted include, but are *not* limited to, eating and dieting concerns (Lock & Steiner, 1999), chronic fatigue (Cochran & Mays, 2007), diabetes (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010), breast cancer (Brandenburg, Matthews, Johnson, & Hughes, 2007; Dibble, Roberts, & Nussey, 2004), and heart disease (Cochran & Mays, 2007; Diamant & Wold, 2003). The severity of health disparities noted signify the dangerousness of LGBTQ+ stress.

Lick, Durso, and Johnson (2013) provide a conceptual model illustrating the proposed mechanisms that underlie the aforementioned physical health disparities. The researchers provide a detailed review of studies documenting physical health disparities since the 1990s. Moreover, the authors assert that the increase in physical health concerns in the LGB population is due to minority stress at all three levels of interpersonal, institutional, and broader structural stressors.

In order to cope with interpersonal stressors, LGBTQ+ individuals may turn to harmful methods of coping which influence their physical health. Data from the 1995 Youth Risk Behavior Survey identified that the combined effect of LGB status and victimization were association with high levels of health risk behaviors such as suicidality, substance use, and risky sexual behaviors (Bontempo & D'Augelli, 2002). Studies have shown that LGBT individuals have high rates of drug and alcohol use (Almeida et al., 2009; HRC, 2013b; Park & Hughes, 2007). Additionally, some individuals may be more susceptible to physical health concerns due to the impact of minority stress. Frost, Lehavot, and Meyer (2015) used external raters to examine the relationship of minority stress and the physical health of LGB participants. A logistic regression analysis showed that the odds of experiencing a physical health problem were three times higher for minorities who experienced a prejudice event.

Environmental Considerations. The conditions of the surrounding environment have the potential to influence LGBTQ+ stress levels. Warm and accepting or hostile and isolating environments may influence an individual's stress. Within the environment, the social structure and systems are important to consider as they provide a strong influence on environmental considerations. A thorough examination of the potential influences will be explored in the social support construct; however, two common environments that may engender LGBTQ+ stress include: (a) school (Kosciw et al., 2014) and (b) work (Prati & Pietrantonio, 2014; Rostosky, 2002)

The Gay, Lesbian, and Straight Educational Network (GLSEN, 1999) examined LGBT students' experiences in school. In responding to the nationwide need, the National School Climate survey is conducted biennially to better-understand the experiences of LGBT youth and

methods of intervention to improve their school experiences. The most recent study (Kosciw et al., 2011) noted that 55.5% of LGBT students felt unsafe at school because of their sexual orientation and 37.8% because of their gender expression. Due to the lack of safety, almost one-third of these students missed school once in the past month and over one-tenth missed more than four days during that time. LGBT youth may feel helpless in dealing with safety issues at school. Over 56% of the students who were victimized did *not* report the incident due to fear the intervention would be ineffective or exacerbate the situation. Of the students who reported incidents, over 61% said that staff did *not* respond. In addition, more than half of the students reported enduring discriminatory policies which reduced their sense of safety; these acts of discrimination included being disciplined for public displays of affection (28.2%), being prevented from attending a school function with someone of the same gender (18.1%), being restricted from forming a gay-straight alliance (GSA; 17.8%), being prohibited from discussion LGBT topics in assignments (17.5%), and being prohibited from wearing items that support LGBT issues (15.5%)

Beyond the school environment, hostile work environments also prompt LGBTQ+ stress (Di Marco, Arenas, Munduate, & Hoel, 2015; Downs, 2009; Rostosky, 2002; Tindall & Waters, 2012). Data from a nationally-representative survey of 1,196 LGBT adults indicated that over one-fifth of the sample have been treated unfairly by an employer (PEW, 2013). Similarly, a study of 1,460 LGB workers in Italy identified that heterosexist climate mediate relationships between open disclosure at work and job satisfaction and anticipated discrimination moderate the relationships between disclosure and job satisfaction (Prati & Pietrantoni, 2014).

LGBTQ+ coming out stress. The coming out process provides unique stressors to LGBTQ+ individuals. A groundbreaking HRC study (2013a) of more than 10,000 LGBT-identified youth ages 13-17 provides a snapshot of their experiences compared to their heterosexual peers. When asked to describe one thing they would like to change in their lives the top three answers of LGBT participants included understanding tolerance/hate (18%), their parent or family situation (15%), and where or who they live with (9%) whereas non-LGBT participants were more concerned with money (20%), appearance, (9%), and improving mental health. When asked to describe the most important current problem in their lives the most common answers of LGBT youth included unaccepting families (26%), school situation or bullying (21%), and fear of being out or open (18%); whereas, non-LGBT youth were concerned with classes, grades, and exams (25%), college or future career (14%), or financial pressures. Therefore, based on the divergent concerns of LGBT youth as compared to non-LGBT youth, it is apparent that coming out stressors play an influential role on LGBTQ+ youth.

Coming out is a continuous process which prompts stress throughout the lifetime (D'Augelli, 2005); including, but are *not* limited to, fears pertaining to acceptance, bullying, harassment, safety, and oppression (Coker, Austin, & Schuster, 2010; Kosciw et al., 2014). LGBTQ+ individuals may endure stress from anticipated negative reactions from peers, family and friends (Meyer, 2003). Burn, Kadlec, and Rexer (2005) found that college students ($N = 175$) perceived offensiveness was associated with decreased likelihood of coming out ($p < .001$). Legate, Ryan, and Weinstein (2012) learned that in their sample of 161 LGB respondents outness was a main effect. Outness was found to be related to higher self-esteem, $B = .16$, $t(143) = 3.78$, $p < .001$; $r = .30$, lower depression, and less anger. Several studies explored the experience of

coming out and have noted that during coming out individuals are susceptible to anxiety, depression (Baams, Grossman, & Russell, 2015; Dunlap, 2010), low self-esteem (Fankhanel, 2010; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001), and poor self-acceptance (Holder, 2015). Common coming out stressors include isolation and alienation (Dunlap, 2010; Flowers & Buston, 2001; HRC, 2013b). Specifically, LGBTQ+ persons are at risk for being marginalized from their families, religious institutions, and overall communities.

Parental rejection during disclosure is an influential occurrence that may cause severe stress on an LGBT+ individual (Baiocco et al., 2015). Individuals may experience conflict between their identity and the beliefs of their family or overarching culture (Bates, 2010; Fisher et al., 2008). Sometimes LGBTQ+ individuals are faced with coming out to parents multiple times for reasons such as reinforcing their orientation, clarifying aspects of identity, or sharing more information about their lives (Denes & Afifi, 2014). When faced with multiple disclosures, especially to the same person, individuals are faced with incremental stress. Additional disclosures that may prompt stress, such as to peers, children, and siblings, are explored further in the social support section (Crawford, Allison, Zamboni, & Soto 2002; Legate, Ryan, & Weinstein, 2011; Morris et al., 2001).

Additionally, it can be difficult for LGBTQ+ persons to integrate their religious or spiritual identity (Gold & Stewart, 2011). About 29% of LGBT adults say they have been made to feel unwelcome in their chosen place of worship. Additionally, about six in ten LGBT youth say that places of worship are *not* accepting, and 35% say their own place of worship is unaccepting. Having awareness of the lack of acceptance in places of worship, religion can be a

stressor which prevents individuals from being open about their identity, thus further perpetuating stress (Bates, 2010; Fisher, 2008).

Qualitative studies have explored the fear of disclosing identity due to the surrounding environment (Degges-White & Myers, 2000; Dunlap, 2014; Guittar, 2013). LGBTQ+ youth may feel that they live in a community which is not accepting; moreover, these individuals may also believe their local and/or state governments are not accepting (HRC, 2013b). When asked to describe general experiences in LGBT individuals' communities, participants reported community intolerance (27%), difficulty in not being closeted (20%), feeling out of place or lonely (18%), and receiving verbal abuse (15%; HRC, 2013b). LGBT individuals' isolating sentiments have the potential to evolve into suicidality (Baams, Grossman, & Russell, 2015; Bernal & Coolhart, 2005; Bontempo & D'Augelli, 2002; D'Augelli, Grossman, & Starks, 2006). D'Augelli, Hershberger, and Pilkington (2001) found that in a sample of LGB youths aged 14-21 ($n = 350$), nearly half had at least thought of suicide and about one third reported at least one suicidal attempt because of their sexual orientation. Although LGBTQ+ individuals are at risk for multiple stressors pertaining to disclosure of identity, active coping has been noted as signs of strength and resiliency.

LGBTQ+ coping. In handling minority stressors, LGBTQ+ individuals cope in a number of ways. To begin with, the general strengths and resilience of the population have been noted. Societal change influencing the need and process of coping has been recognized in recent generations (Dunlap, 2010; Kosciw et al., 2014) and three-quarters (77%) of LGBT youth are confident that things will continue to get better (HRC, 2013b). For 55 transgender youth, resilience accounted for 40%–55% of the variance in relation to depression, trauma symptoms,

mental health symptoms, and internalizing and externalizing problems (Grossman, D'Augelli, & Frank, 2011).

Common methods of adaptive coping include reading, playing video games, having supportive relationships, having a helpful community, LGBT clubs access to education, and access to therapy (Dunlap, 2014; Holder, 2015; HRC, 2013b). Mastery and mobilization of social support are integral to buffering stress and are discussed in the social support section of this chapter (Meyer, Schwartz, & Frost, 2008). Facilitative coping such as seeking help has been related to reduced anxiety, whereas avoidant coping has been correlated with increasing anxiety and depression (Budge, Rossman, & Howard, 2014). Contrastingly, maladaptive methods of coping such as substance use (Degges-White, Rice, & Myers, 2000; D'Augelli, Grossman, Hershberger, & O'Connell; Holder, 2015) are associated with passive avoidance, ruminating, aggressive reactions, and resigning oneself to the situation (Newman, 2008). However, due to discrimination and societal dangers, perceivably maladaptive methods such as visibility management may be helpful for LGBTQ+ persons. Moreover, visibility management may serve as strategy which assists in protection from external stressors and coping with internal stressors, such as anxiety (Dewaele, Van Houtte, Cox, & Vincke, 2013). Within visibility management, individuals regulate the exposure of identity for safety measures. The complexity of visibility management is *not* to be minimized as denial or hiding; although it is often required to prevent harm, management may include stressors such as sadness and loneliness. Over time, an individual's disclosure process may be delayed due to chronic negative social stressors and the need for visibility management (Holder, 2015).

Appraisal of Social Support

Theories and Definitions of Social Support

Social support has been defined as the existence and provision of individuals and relationships that we value and can rely on for provision of resources (e.g., instrumental, informational, and emotional; Cohen, 2004; House & Kahn, 1985; Lopez & Cooper, 2011; Sarason, Levine, Basham, & Sarason, 1983). *Instrumental support* incorporates the provision of material aid, such as task or financial assistance. *Informational support* involves the provision of relevant information intended to help the individual cope and is commonly provided in the form of guidance or advice. *Emotional support* refers to the expression of empathy, caring, reassurance, and trust and also involves opportunities for expression and venting (House & Kahn, 1985).

The construct of social support is in the developmental and social psychological literature (Sarason, Sarason, & Lindner, 1983) and early research was heavily influenced by John Bowlby's attachment theory (1969, 1980). Social support is one of three aspects of social relationships (i.e., social support, social integration, and negative interaction; Cohen, 2004). Social support is conceptualized to influence stress, well-being, social functioning, self-esteem, self-efficacy, and problem solving behaviors (Cohen, 2004; Cohen & Willis, 1985; Lopez & Cooper, 2011). Many theoretical perspectives have been utilized in reference to social support such as the (a) the stress and coping perspective, (b) the social constructionist perspective, and (c) the relationship perspective (Lakey & Cohen, 2000). Each of these views acknowledges the potential for social support to enhance well-being. Heavy emphasis is placed on the stress and coping perspective (Cassel, 1976, Cobb, 1976); social support is believed to be the facilitator of

coping which in turn reduces negative effects of stress and overall well-being (Lopez & Cooper, 2011).

Although social support researchers agree that social support is multidimensional, there is a lack of consensus on the conceptual aspects of the construct (Lopez & Cooper, 2011; Sarason, Levine, Basham, & Sarason, 1983). Lopez and Cooper (2011) conceptualized social support in three categories: (a) connectedness or embeddedness, (b) actual or enacted, and (c) perceived. Social connectedness refers to the quantity and quality of the ties of informal and formal relationships. Informal relationships encompass persons such as friends, family, and neighbors whereas formal relationships include teachers, counselors, or other professionals. Actual support incorporates the report of support received. Perceived social support refers to the cognitive appraisal of support to promote coping and reduce stress and additional negative effects. Perceived support pertains to both availability and adequacy of the surrounding system and speaks to the concept of invisible support and the power of appraisal. Invisible support is an ineffective form of support that may occur when a support act occurs beyond the recipient's awareness or when a recipient does *not* classify the act as supportive (Bolger, Zuckerman, & Kessler, 2000). Therefore, the perception of social support is an essential element contributing to the magnitude of social support in an individual's life.

There are a number of instruments that measure the differing aspects of social support such as the *Social Network List* (Stokes, 1983), the *Inventory of Socially Supportive Behaviors* (Barrera, Sandler, Ramsey, 1981), and the *Interpersonal Support Evaluation List* (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). When exploring the interrelations of these measures of social support, Sarason, Shearin, Pierce, and Sarason (1987) found that measures of

support networks and received support were not strongly related to most of the perceived available support measures. Considering the variability of the construct of social support, it is essential to clarify and focus on one aspect. In considering the population and aims of the present study as well as the existing research on social support, the researcher has decided to focus on perceived social support.

Empirical Research on Perceived Social Support

Perceived social support is comprised of two dimensions: (a) the number of available socially supportive persons, and (b) the level of satisfaction with the availability of socially supportive persons (Sarason, Sarason, & Lindner, 1983). Considerable research has examined the appraisal of social support (e.g., Sarason et al., 1983; Sarason & Sarason, 1986; Sarason, Sarason & Lindner, 1983; Sarason, Sarason, Shearin, & Pierce, 1987). Research findings identified that in the absence of actual support, an individual's appraisal of perceived support has been capable of reducing the effects of stress (Bovier, Chamot, & Perneger, 2004; Campos, Schetter & Abdou, 2008; Castle, Slade, Barranco-Wadlow & Rogers, 2008; Dunst, Jenkins, & Trivette, 1984; Gee & Rhodes, 2008; Gjesfjeld, Greeno, Kim & Anderson, 2010; Honey, Hastings, & Mcconachie, 2005; Lin, Thompson & Kaslow, 2009; Rodriguez, Mira, Myers, Morris & Cardoza, 2003). Chu, Saucier, and Hafner (2010) aimed to better understand the association between social support and well-being. After reviewing 1,400 abstracts, the authors determined 246 were suitable for their meta-analysis. Only a small association was found between social support and well-being; however, perceived social support in particular was strongly related with well-being. Further, perception of social support has been noted as

protective against development of PTSD (Dinenberg, McCaslin, Bates, & Cohen, 2014). Beyond correlations, Sarason and Sarason (1986) found that it is possible to devise planned, supportive interventions to facilitate perception of social support. Considering the high stress and need for coping in the LGBTQ+ young adult population, perceived support is a necessary variable in enhancing social relationships and overall well-being (Cohen, 2004; Sarason & Sarason, 1986).

Empirical Research on LGBTQ+ Social Support. The multifaceted construct of social support has been noted as essential with LGBTQ+ individuals. As a method of coping, social support may assist in improving stressful LGBTQ+ situations. Unfortunately, compared to other types of stress, identity-related stress seems to be less available as individuals tend to convey less support (Doty, Willoughby, Lindahl, & Malik, 2010). Specific to young persons, LGBT individuals assert that they have less surrounding support than their non-LGBT peers (HRC, 2013b).

Mirroring the general social support literature, social support has been known to enhance the well-being of LGBTQ+ persons. When receiving interpersonal acceptance and support for self-expression levels of anxiety (Budge, Rossman, & Howard, 2014) and depression tend to decrease and levels of self-esteem (Beals & Peplau, 2005; Savin-Williams, 1990), well-being (Beals & Peplau, 2005; Legate, Ryan, & Weinstein, 2012), and life satisfaction (Beals & Peplau, 2005) tend to increase. In addition, higher levels of identity support are related to lower emotional distress and buffer against stress (Doty, Willoughby, Lindahl, & Malik, 2010).

Goodenow and colleagues (2006) found that the presence of social support for LGB students was related to increased safety. Sexual minority students who did not have access to a social support group, such as a gay-straight alliance, were twice as likely to report dating

violence (OR .48), skipping school due to fear (OR .43), or being threatened or injured at school (OR .47). LGB youth who did not have access to social support groups were three times more likely to report multiple suicide attempts within the past year (OR .29) whereas, LGB students who believed there was at least one support member they could talk to about a problem were one third as likely to report multiple suicide attempts within the last year (OR.34).

The provision of social support may assist individuals through the coming out process. Individuals who have support for their identity are more likely to disclose (Legate, Ryan, & Weinstein, 2012). Further, establishing a social support system is one of the primary recommendations from individuals who experienced coming out (Glezer, 2009; Gragg, 2012; Holder, 2015).

In considering an individual's social network, LGBTQ+ individuals have several dimensions in which they may want or seek support. Common dimensions of social support pertaining to LGBTQ+ individuals and the coming out process include (a) family (e.g., Pew, 2013), (b) friends (e.g., Doty, Willoughby, Lindahl, & Malik, 2010), (c) community (e.g., HRC, 2013b), and (d) online (e.g., Craig & McInroy, 2014).

Family. About four in ten LGBT adults say that they were rejected by their family at one point in their lives (Pew, 2013). According to the HRC (2013b), about 60% of LGBT youth say their family is accepting and more than half of LGBT youth say they are out to their family, and 25% of LGBT youth report being out to their extended family. It is important to consider the sampling concern for this research however, as individuals who may be isolated and alienated may be less likely to respond to the survey and therefore the experience of individuals who are facing LGBTQ+ stress and lack effective support may not be captured in this study. Hence, the

estimate for LGBT youth who remain closeted due to lack of support may be more than the one-third denomination suggested.

Support from immediate family members is helpful in combatting stressors of the LGBTQ+ experience. Jordan and Deluty (1998) found that being out was the most important variable in predicting familial social support (Beta = .27, $p < .0001$). Additionally, Craig and Smith (2014) found that for LGBT Hispanic, Black, and White youth, familial support moderates perceived discrimination and school performance whereas peer and social support did not compare. Furthermore, family support has been shown as a strong predictor of self-acceptance of identity and mental health. Familial reactions are unique and vast, ranging from positive to negative (D'Augelli, 2002). Parents may display positive support through acceptance, affection, and/or activism (Broad, 2011; Carnelley, Hepper, Hicks, & Turner, 2011). Similarly, siblings may respond with a range of reactions including concerns for the protection of the sibling (Hilton & Szymanski, 2011). Siblings can often provide essential support when support from parents may be lacking. Aranda and colleagues (2015) found that disclosing to a sibling was a significant predictor for less depression (OR .33, $p < .05$).

Friends. Friendship can be a helpful component in the support system of LGBTQ+ persons (Doty et al., 2010; Klein, Holtby, Cook, & Travers, 2015; Legate, Ryan, & Weinstein, 2012). Positive relationships have been noted between support from LGBT and non-LGBT friends' support and individual comfort with disclosure (Jordan & Deluty, 1998; Shilo & Savaya, 2011). Although familial support may be more influential than support from friends, support through friendship is essential when familial support may be lacking or absent. In times in which

adults may be intimidating, LGBTQ+ youth may find solace in disclosing to supportive friends (Dentato et al., 2014; Legate, Ryan, & Weinstein, 2012).

Community. The HRC (2013b) provides helpful information in conceptualizing LGBT youths' experiences with community-level support. Nearly half of LGBT youth do *not* feel in their community and about 42% say their community is unaccepting of their identity. Furthermore, only one-fifth of the respondents say there is a place in their community to go to be accepted. Negative experiences about the community include intolerance, feeling lonely, and verbal abuse. About one-third report that their local government is *not* accepting of their identity and more than four in ten youth report that their state government is unaccepting.

Kiedman (2002) investigated self-identified LGB young adults ($N = 225$) and found that there were significant relationships with LGB protective factors and school involvement. Individuals who reported more emotional support and understand from school sources had higher levels of involvement, self-acceptance, and self-esteem. These themes are echoed in GLSEN's national climate survey in which participants who felt supported at school were more likely to have higher GPAs, miss less school, and feel more connected to the community (Kosciw et al. 2014).

Peer comfort is an important aspect of outness in LGBTQ college students, and college students are more likely to disclose to peers than to faculty (Dentato et al., 2014). Students may refrain from approaching staff or faculty in fear that they will *not* be supported (HRC, 2013b); however, supportive educators do exist within the school community. A vast majority (96.1%) of participants in GLSEN's most recent school survey noted that they could identify at least one supportive staff member. Additionally, there are ways that youth receive messages of a safe

environment beyond individuals. Over a quarter of respondents noted that they had seen a safe space symbol within their school (Kosciw et al. 2014)

Online. When social support is *not* available in the real world, LGBTQ+ individuals may escape to cyberspace in order to seek support. Online media may provide individuals access to resources, a realm to explore identity, and come out. When in an unsafe community, LGBTQ+ youth may seek real stories of individuals who they can comfortably connect to and relate to online (Craig & McInroy, 2014). In a qualitative study of LGB and non-LGB young persons' ages 13-19, Hillier, Mitchell, and Ybarra (2012) found that LGB participants were more likely to be adventurous and diverse in their internet use than their non-LGB peers. Aspects of online communication, such as making friends and making plans to meet someone from online, were seen as dangerous to non-LGB participants and were more likely to be common practice among LGB respondents. Hillier and colleagues' (2012) study shows that LGBTQ+ youth may utilize the internet to find like-minded individuals and to find social support that may be lacking in the real world. The need and desire for connection and social support may be potentially dangerous for LGBTQ+ youth as safety precautions are often not evaluated. The internet may provide a helpful source of support for LGBTQ+ youth who are unable to find support in their family, friends, or community.

Coming out Growth

Theories and Definitions of Coming out Growth

Stress-related growth. In order to conceptualize coming out growth (COG), we must first consider the foundational construct of stress-related growth (SRG). *Stress-related growth* refers

to the belief that stressful occurrences provide prospects for growth (Park, Cohen, & Murch, 1996). The concept of SRG can be traced back to Viktor Frankl (1955/1986; 1959/1985; 1961) and Abraham Maslow's (1954; 1964; 1968) theories in which traumatic stress was seen as catalysts for newfound meaning and purpose. The phenomenon of stress-related growth is commonly reported in the stress and coping literature as it melds well with Lazarus and Folkman's (1984) transactional model which was described earlier. Within the stress and coping literature challenging events are perceived as opportunities for growth SRG (Carver, 1998; O'Leary, 1998; Park, 1998).

The dimensions of SRG have been explored and conceptualized in different ways (e.g., Collins et al., 1990; Park et al., 1996; Schaefer & Moos, 1992; Tedeschi & Calhoun, 1996). From their research with trauma and SRG, Schaefer and Moos (1992) noted three aspects of SRG. Following a stressful event, individuals may have experience beneficial changes in (a) personal resources, (b) social relationships, and (c) coping resources. Changes in personal resources may include enhanced self-efficacy, capacity for empathy, and self-understanding. Additionally, individuals may become more mature, develop new cognitive skills, and make healthy improvements in their values and priorities. Related to the concept of social support, individuals may experience new or improved social relationships. Finally, enduring a stressful occurrence may improve problem-solving, emotional regulation, and overall coping skills. Combined with personal clinical experiences related to SRG, Schaefer and Moss' (1992) dimensions provided the foundation for Park and colleagues' (1996) stress-related growth scale.

Stress-related growth is a multidimensional concept which has several related constructs. In a review of SRG studies, Tennen and colleagues (1992) recognized that nearly three-quarters

of the studies displayed a direct link between SRG and psychological health which persists over time (e.g., Frazier, Conlon, & Glaser, 2001; McMillen et al., 1997; McMillen & Fischer, 1998; Park et al., 1996). In the following years, the finding linking SRG and psychological health was echoed in studies that found that higher levels of SRG is related to higher levels of overall psychological health (Aldwin, Levenson, & Spiro, 1994; Curbow, Somerfield, & Baker, 1993; Frazier & Kaler, 2005; Mendola et al., 1990; Silver et al., 1983; Taylor & Wood, 1984; Thompson, 1991). Additionally, the power of perception is noteworthy as higher rates of perceived threat have also been correlated with higher SRG (Armeli, Gunthert, & Cohen, 2001; McMillen et al., 1997; Park et al., 1996; Tedeschi & Calhoun, 1995; 1996; 2004). Stress-related growth has received criticism for its manufactured nature (Collins, Taylor, & Skokan, 1990; Fiske & Taylor, 1991; Taylor, 1983, 1989; Taylor & Brown, 1988; Taylor, Wood, & Lichtman, 1983). There have been claims that SRG is conflated with positive reappraisal; however, several scholars assert that although the constructs are related, they are separate (Calhoun et al., 2000; Collins et al.; Koenig et al., 1998; Tennen et al., 1992). Furthermore, SRG has been shown to be unrelated to social desirability (e.g., $r = .00$: Park et al., 1996; $r = -.15$: Tedeschi & Calhoun, 1996).

Stress-related growth has been linked to traumatic events such as breast cancer, natural disasters (Siegel & Schrimshaw, 2000; Weiss, 2002), and bereavement (Lehman et al., 1993; Malinak, Hoyt, & Patterson, 1979; Miles & Crandall, 1983; Parappully, Rosenbaum, van den Daele, & Nzewi, 2002). Stress-related growth from typical stresses is less captured in the literature; however, researchers have found that developmental stressors may be related to SRG (e.g., Carver; Greer, 1980; Lazarus & Folkman, 1984; O'Leary, 1998; Parappully et al., 2002).

Therefore, considering the developmental processes within coming out paired with minority stressors, the coming out process may provide opportunities for growth (Blankenship, 1998; Vaughan & Rodriguez, 2014; Vaughan & Waeher, 2009).

Traditional conceptualization of coming out. Since the 1970s, researchers have acknowledged the importance of the coming out process and have created models to describe the process (e.g., Cass 1979, 1984; Cooper, 2008; Degges-White & Myers, 2005; McCarn & Fassinger, 1996; Troiden, 1989). A common model utilized pertaining to coming out is *Homosexual Identity Formation Model* (Cass, 1979), which asserts that individual's progress through stages of confusion, comparison, tolerance, acceptance, pride, and synthesis. Through exploration, individuals gain acceptance for identity which is often followed by pride and integration of identity into life. Since the *Homosexual Identity Formation Model* was based on clinical experience with white adult males, efforts have been made to examine the application with diverse individuals. Kahn's (1991) discriminant analysis found support for the order of the six stages among 81 lesbian participants. Although Kahn's work provides partial support for the model, similar to Cass' work, a majority of the participants were Caucasian and thus the findings may not be extended to diverse individuals. Degges-White and Myers (2000) also examined the applicability of Cass' model with lesbians' coming out and found that the model did *not* fit the participants' experiences. Although all 12 individuals experienced the initial stage of confusion and fourth stage of acceptance, the remaining four stages were not experienced by all participants. Further, the stage of identity pride, which is associated with visible demonstration of identity in the community, was only experienced by five women. The lack of alignment between participants' experiences and Cass' (1979) original model may be explained by the

model being based on the experiences of adult white males. Although Cass asserts that the process is influenced by society, an individual may regress through stages, and an individual may skip stages, the linear, developmental approach is still prominent.

Developmental models such as *Developmental Stages of the Coming out Process* (Coleman, 1982) denotes potential ranges in which coming out should occur; however, findings contradict the limited scope and critique the rigidity of such models (Degges-White & Myers, 2000; Dunlap, 2014; Floyd & Stein, 2002; Guittar, 2013). Floyd and Stein (2002) examined milestone events of sexual minority youth ages 16 to 27 and found that some individuals experienced coming out “early” ($n = 29$) while others experienced coming out beyond age 18 ($n = 43$). Contrary to the age implications suggested in early developmental models, coming out occurs well into adulthood as studies have explored the coming out process for adults disclosing throughout the lifespan (Fruhauf, Orel, & Jenkins, 2009; Treyger, et al., 2008).

Models of coming out emphasize the internal process of identity awareness (e.g., Cass, 1979; Chapman & Brannock, 1987; Coleman, 1982). Although the internal process does require attention, emphasis causes the external process of disclosure to lose attention. Researchers utilize a constructivist perspective to acknowledge the social factors at play in the coming out process (Cox & Gallois, 1996; Fassinger & Miller, 1996); however, the process in which an individual evaluates disclosure for multiple interpersonal encounters and relationships is *not* thoroughly addressed in a manner which may assist counselors in helping sexual minority clients.

Rust (1993) asserted that a social-constructivist perspective on coming out is essential. McCarn and Fassinger (1996) heeded the suggestion of recognizing social context and proposed

a model that emphasizes coming out in phases, thus increasing flexibility. Their four-phase model of awareness, exploration, commitment, and synthesis incorporates a personal and interpersonal process. Although McCarn and Fassinger's model looks at an interpersonal process, the interpersonal aspect within the model pertains to group identity in the LGBTQ+ community rather than the stressful task of disclosing identity throughout the lifespan.

Although considerable research has been targeted towards understanding the COP, models vary and encompass factors such as awareness, disclosure, community membership, and intimate experiences. Researchers place coming out within the overarching process of sexual minority identity development (e.g., Cass, 1979; Coleman, 1982). Additionally, coming out is noted as a singular event that occurs as a stage within sexual minority identity development (Cass, 1979; Chapman & Brannock, 1987; Coleman, 1982; Degges-White & Myers, 2005; Minton & McDonald, 1984; Troiden, 1989). Common stage approaches assert a stepwise method to coming out (Cass, 1979; Fassinger & Miller, 1996; Minton & McDonald, 1984; Troiden, 1989); failing to demonstrate the complexity of coming out.

Contemporary conceptualization of coming out. Traditional models of LGBTQ+ identity development have been critiqued for being narrow and simplistic (Floyd & Stein, 2002; Klein, Holtby, Cook, & Travers, 2015). Primary criticism stems from the prescriptive element implied in linear models (Hunter & Hickerson, 2003). The stepwise approach implies that there is an end to the process; however, due to societal bias and heteronormativity, coming out is understood to be a lifelong process (HRC, 2013a; Lewis, 2012). Even primary theorists (e.g., Cass; 1979; Coleman, 1981/1982; Lee, 1977; McCarn & Fassinger, 1996; Minton & McDonald, 1984; Troiden, 1979, 1989) have noted that the linear models they present should be viewed as more of

a guideline than a rule, as many individuals skip stages or experience stages in a slightly different developmental sequence (Cass, 1984; Floyd & Stein, 2002; Kitzinger & Wilkinson, 1995; Lee; McDonald, 1982; Morris et al., 1995; Sophie, 1985/1986; Troiden; Troiden & Goode, 1980). Moreover, these models (e.g., Cass, 1979; Lee, 1977) predominantly had a Eurocentric male, bias and is therefore missing variability in participants, thus limiting generalizability.

Traditional trajectory does *not* have essential flexibility to account for diverse experiences. Coming out is difficult to define without trivializing the vast variation experiences with forming and maintaining an LGBQ identity (Fassinger, 1991; Friend, 1990; Guittar, 2014; Stevens, 2004). Social constructs and context are often minimized or not considered, although in actuality, such variables have the potential to bear heavy influence on the coming out process. Unlike other minorities, visibility may be a choice for LGBTQ+ persons; therefore, individuals are constantly faced with a decision-making process of disclosure (Halwani et al., 2008). The process varies per context, especially when considering safety, and is not a simplistic, dichotomous, or one-time process of being open.

Coming out is a stressful, ongoing, and transformative process that encompasses the lifespan. Eliason and Schope (2007) reviewed prominent stage models, highlighting key aspects of coming out that are accepted in the contemporary conceptualization of coming out. Their review acknowledges that in the overall aspiration for integration, individuals experience an internal process of development and an external process of sharing. Therefore, coming out is two-fold in which an individual experiences an intrapersonal process of identity development and an interpersonal process. The intrapersonal process involves an individual's process of development in which he/she recognizes differences, may experience confusion, and seeks self-

understanding and self-acceptance (Eliason & Schope, 2007; Lewis, 2012; Klein, Holtby, Cook, & Travers, 2015).

Coming out stressors may be triggered during the intrapersonal process of development or during the interpersonal process of disclosure. Internal discord may prompt feelings of loneliness, disconnection, confusion, grief, shame, anger, fear, vulnerability, and depression that lead to potential suicidal ideations (HRC, 2013; Lewis, Derlega, Berndt, Morris, & Rose, 2001). Due to heterosexist bias LGBTQ+ individuals are faced with the dilemma of disclosing identity (Dermer, Smith, & Barto, 2010). Due to societal bias, LGBTQ+ individuals are often faced with the task of disclosing identity to others such as friends, family, coworkers, and neighbors. The identity disclosure process occurs throughout the lifetime and requires confidence and social support (Klein et al., 2015). Moreover, coming out is a complicated process in which factors such as fear and danger may affect disclosure (Rickards & Wuest, 2006). Furthermore, scholars have asserted that due to social and cultural influences, coming out is a subjective experience; the general experience has evolved within the last 50 years, and continues to be influenced by history and society (Ali & Barden, 2015; Cass, 2005; Dunlap, 2014; HRC, 2013).

Opportunities for coming out growth. The coming out process prompts stressors that may provide opportunities for growth. The potential for these strengths have been overlooked in LGBTQ+ literature (Lytle, Vaughan, Rodriguez, & Shmerler, 2014). Since the rise coming out models, theorists have suggested that coming out growth is possible. Plummer (1975) asserted that the benefits of coming out may outweigh the costs. Although stressors exist, the decision to disclose one's sexual minority identity may be enticing and empowering. From enduring the process, individuals may experience coming out growth (Vaughan & Waehler, 2010). Coming

out has been conceptualized to prompt a number of benefits such as the development of stronger, more positive identities (Cass, 1979, 1984, 1996; Coleman, 1981/1982; HRC, 2012; McCarn & Fassinger, 1996; Sophie, 1985/1986), ability to cope with stress (Cass; Coleman; Lee; Troiden), ability to form and strengthen relationships, (Cass, 1979, 1984, 1996; Coleman, 1981/1982; HRC, 2013). Beyond theory, research findings have also provided support that individuals may grow from experiences during the coming out process.

Coming out has been associated with increased self-esteem (Cohen & Savin-Williams, 1996; Gartrell, 1984; Savin-Williams, 2001; Vargo, 1998). For example, in a study by Legate, Ryan, and Weinstein (2012), LGB respondents' outness was found to be significantly related to higher self-esteem, ($B = .16, t [143] = 3.78, p < .001, r = .30$). Furthermore, identity disclosure has also been associated with positive, strengthened identity, which often improves resilience and overall mental health (Floyd & Stein, 2002; Mohr & Fassinger, 2003; Oswald, 2000). Crews and Crawford (2015) found that LGBTQ individuals who are out have higher levels of self-compassion ($M = 3.4, SD = .766$) than individuals who are not ($M = 3.13, SD = .729, t [213] = -2.461, p < .015$). Participants in qualitative studies express hope that coming out will allow them to feel more genuine (Cramer & Roach, 1988; Evans & Broido, 1999; Glezer, 2009; LaSala, 2000; Maguen et al., 2002; Monroe, 2001; Rhoads, 1995; Stevens, 2004). Feeling more open, authentic, and honest with others may enhance social skills and functioning (Savin-Williams, 2001; Stevens, 2004).

Coming out may strengthen one's social support and overall networks (Gonsiorek, 1995; Jordan & Deluty, 1989; Riggle et al., 2008; Savin-Williams, 1990). Lesbian and gay participants in Monroe's (2000) study reported that disclosure lead to feeling accepted, welcomed, loved, and

embraced. Disclosing identity may help to establish new relationships or to deepen current bonds (Berger, 1990, 2000; Monroe, 2001; Oswald, 2000; Savin-Williams, 2001). In disclosing to others, individuals met with acceptance may also experience greater self-acceptance of one's minority identity (Rhoads, 1995; Savin-Williams 2001; Stevens, 2004). Specifically, individuals may seek approval from their close family members; acceptance from these individuals thus perpetuates self-acceptance. Murphy (1989) found that lesbian women who were out to their parents felt that they no longer need to compartmentalize and/or hide, thus they were able to better develop and integrated identity. A similar finding was echoed by Oswald (2000) who found that coming out to family allowed participants to feel validated. Families are also faced with a disclosure process and the parallel experience may influence empathy and relationship growth (Baptist & Allen, 2008).

Coming out growth has been associated with gains in mental health functioning (e.g., Berger 1990, 1992; Frable et al., 1997; Franke & Leary, 1991; Morris et al., 2001; Jordan & Deluty, 1998; Savin-Williams). Rosario and colleagues (2001) learned that positive attitudes towards identity were related to lower anxiety and depression among sexual minority youth. Similarly, Legate, Ryan, and Weinstein (2012) learned LGB respondents outness was related to lower depression $B = -.16, t(143) = -3.23, p < .01, r = .26$, and less anger. $B = -.14, t(144) = -2.85, p < .01, r = .23$. When exploring the relationship between disclosure and depression among African American (26.5%), Latina (19.7%), and White (53.8%) adult self-identified lesbians ($N = 351$), Aranda and colleagues (2012) found that disclosure to a sibling was a significant predictor of less depression ($p < .05$). Support for reduced distress is also validated by the

association with coming out and the reduction of alcohol and drugs as a coping mechanism (Vaughan & Waehler, 2010).

Solomon and colleagues (2015) explored 102 undergraduate LGB students' ability to experience growth from coming out. The researchers found that growth was significantly associated with both positive social reactions, $r(100) = .27, p < .01$ and negative social reactions, $r(100) = .21, p < .05$. Thus, regardless of reaction, individuals who disclose are presented with an opportunity to experience growth. Therefore, perhaps the greatest signifier of the potential for coming out growth can be seen in attitudes of LGBT youth. More than three-quarters of LGBT youth surveyed by the HRC (2013b) expressed confidence that things will get better. Coming out provides potential for growth; however, the opportunity must be brought to light, fostered, and strengthened in order to assist LGBTQ+ individuals through the coming out process.

Limitations of coming out growth research.

Although the influence of coming out has been noted in the literature for decades, the strengths-based perspective is quite new (Vaughan & Waehler, 2010; Vaughan & Rodriguez, 2014). Exploration into outness has increased; however, there is variability in assessment. Many measures assess outness through single-item or Likert methods (e.g., D'Augelli & Herschberger, 1993; Franke & Leary, 1991; Waldner & Maguder, 1999) which inhibit the ability to better understand the reliability of those studies. Researchers such as Berger (1992), Frable, Wortman, and Joseph (1997), Jordan and Deluty (1998), and Savin-Williams (2001) have made efforts to develop measures for outness. Although the creation of assessments is helpful, the variability of these measures makes it difficult to examine validity. The *Outness Inventory* (OI; Mohr &

Fassinger, 2000) has adequate psychometric properties (e.g., internal consistency, $r = .72$) and can be used to formulate better studies in the future.

In addition to measurement limitations, the majority of the coming out growth research is correlational in nature. In order to better understand coming out growth, experimental studies are needed. Furthermore, a majority of the studies that examine benefits of coming out consider lesbian and gay participants. Although some studies examine the influence of bisexual or transgender individuals, no study was identified examining coming out in LGBTQ+ young adults. Therefore, intervention studies are needed in order to identify effective strategies to support LGBTQ+ young adults.

Group Therapeutic Factors

Theories and Definitions of Group Therapeutic Factors

Yalom and Leszcz (2005) highlighted the therapeutic factors of group psychotherapy, including: (a) instillation of hope; (b) cohesion; (c) universality; (d) altruism; (e) imparting information; (f) interpersonal learning; (g) development of socializing techniques; (h) imitative behavior; (i) catharsis; (j) corrective reenactment of the primary family group; and (k) existential factors. When considering the applicability of a group counseling intervention with LGBTQ+ clients, these therapeutic variables are *not* only facilitative, but essential.

Minority stressors, such as lack of acceptance, may cause LGBTQ+ young adults to lack hope and may trigger mental health concerns such as isolation, anxiety, and/or depression (Dunlap, 2011; D'Augelli, 2002; Grossman, D'Augelli, & Frank, 2011; Kertzner, Meyer, Frost, & Stirratt, 2009; Kuyper & Fokkema, 2011). The facilitator, topics, and peers all have the potential to

contribute to a client's hopefulness. Benefits of LGBTQ+ young adults' increased levels of hope include increased self-esteem and self-efficacy (Schrank et al., 2012).

LGBTQ+ persons are often marginalized by society (Dermer et al, 2010). Repercussions of marginalization may cause feelings of alienation, isolation, and may prompt mental health concerns. Exposure to individuals who have also endured marginalization, in addition to additional stressors, may provide LGBTQ+ individuals with a place of community in which they not only belong, but are able to process with others who are able to relate to their concerns. Furthermore, individuals may experience the benefit of universality in which they recognize that others are enduring similar concerns (Fisher et al., 2008; Hillier et al., 2012; Joos & Broad, 2007). Therefore, group therapy provides individuals with a sense of cohesion with similar individuals. Cohesion is a helpful component in enhancing coping, social support, and well-being.

A consistent reported concern for LGBTQ+ youth is the lack of role models (Chutter, 2007; Mears, 2004; Riggle, Whitman, Olseon, Rostosky, & Strong, 2008). Further, many individuals do *not* feel they have a person or place to seek aid for LGBTQ+ concerns in their community (HRC, 2013b). In a group, members have the opportunity to provide and receive warmth, openness, acceptance, feedback, and guidance to and from peers in a genuine, altruistic manner. Helpful information such as developmental concepts or guidance for disclosure may *not* be readily accessible for LGBTQ+ youth. Group can be a helpful place to impart helpful information. A wide-range of information can be shared with LGBTQ+ youth in a group setting to assist their well-being such as concrete information on danger and discrimination, resources for assistance, accepting communities, and methods of coping. Additionally, informal

information may be shared amongst peers in which participants can learn from one another's experiences.

Peer learning is a helpful component for LGBTQ+ young adults when considering coming out concerns (Roberts, 2007). Individuals who are earlier in their development and/or disclosure process may be able to learn from their experienced peers (Dunlap, 2014).

Interpersonal learning is a valuable aspect of group in which participants are able to gain knowledge from interactions with other members. In observing peers, in the microcosmic atmosphere of group members are able to recognize socializing techniques of themselves and others, and are able test and learn what methods are most productive, comfortable, and aligned with their personality (Goodrich & Luke, 2015).

Individuals who have faced the coming out process are able to share their positive and negative experiences; peers are able to draw insight from these experiences and learn vicariously. Further, feedback may cause an individual to realize what was particularly helpful for one person and may wish to imitate such behavior in life within and beyond group (Gladding, 2012; Goodrich & Luke, 2015; Yalom & Leszcz, 2005).

The comfort and support of the group may provide participants with a safe zone to practice empowering coming out disclosures. Feedback is available from peers and the facilitator which may create a learning experience for not only the individual, but for the group overall. Individuals may experience catharsis in discussing, processing, or role-playing an aspect of coming out. Although helpful for practicing upcoming disclosures, group may provide a safe space to bring closure to negative experiences from the past. Individuals may receive feedback on their past process(es) that may assist in the future. Beyond feedback, members may be able to

be comforted and heal from these negative experiences. When these negative events from the past are processed, the support and encouragement from the group may provide a corrective and healing shield for the wound (Goodrich & Luke, 2015; Yalom & Leszcz, 2005).

Finally, group provides individuals with a comfortable, facilitative environment to field existential factors. For example, individuals who suffer from isolation may learn to balance being themselves within group while having a source of social support as well. Additionally, deep inquiries into identity and life may be safely explored within group as well (Goodrich & Luke, 2015; Yalom & Leszcz, 2005).

The 11 therapeutic factors have the potential to enhance LGBTQ+ young adults' coping, social support, and coming out growth. Additionally, research findings identify specific aspects of therapy that may assist LGBTQ+ individuals in therapy. Furthermore, group therapy is suggested for a strengths-based intervention to contribute to well-being (Craig, 2013; Fisher et al., 2008; Goodrich & Luke, 2015; Griffith, 2014; Morrow, 1996; Riggle et al., 2014).

Therapy with LGBTQ+ Young Adults

A common theme in the literature is the suggestion for affirmative practice with LGBTQ+ persons (e.g., Goodrich & Luke, 2015; Hill, 2009; Hunter & Hickerson, 2003; Mayer et al., 2014; Panchankis & Goldfried, 2004; Vaughan & Rodriguez, 2014). Affirmative practice can be conceptualized as an adaptation of leading models of counseling with special consideration of LGBTQ+ issues (Roberts, 2007). Further, researchers recommend that rather than focusing on pathology, clinicians should focus on strengths (Bernal & Coolhart, 2005; Craig, 2013; Rosario et al., 2001; Savin-Williams, 1990, 2001). However, Lytle, Vaughan,

Rodriguez, and Shmerler (2014) highlight that a strengths-based perspective has been overlooked in training and practice with the LGBTQ+ population. Moreover, the current disconnect between LGBTQ+ and strengths-based literatures results in a disservice to the LGBTQ+ client population.

A variety of interventions are recommended for LGBTQ+ clients including cognitive behavioral therapy (CBT), emotion-focused therapy (EFT), interpersonal therapy, motivational interviewing (MI), and acceptance and commitment therapy (ACT) (Alessi, 2014; Hill, 2009; Lytle et al., 2014). Specific to CBT interventions such as modifying core beliefs, increasing coping skills, offering support and encouragement, and adopting a nonjudgmental stance may be of value for LGBTQ+ counseling (Alessi, 2014). Helpful ACT interventions include observing thoughts and feelings, mindfulness, understanding the self as context, goal-setting, skills training, and commitment to action are (Stitt, 2014). Brief treatment models are also suggested for weekly or bi-weekly sessions for four to six weeks (Ford, 2003).

Regardless of method, the essentiality of focusing on LGBTQ+ stress is asserted (Budge, 2014; Estrada & Rutter, 2006; Kuyper & Fokkema, 2011). Alessi (2014) notes that is important to assess for the influence of LGBTQ+ stressors, such as to prejudice events, stigma, internalized homophobia, and sexual orientation concealment, in counseling. Dewaele and colleagues (2013) emphasizes the importance of understanding visibility management as a safety precaution for clients; further, clinicians should make attempts to assist clients in building supportive social networks. Hill (2009) and Alessi highlight that clinicians working with LGBTQ+ clients should evaluate coping strategies and encourage development of adaptive behaviors which assist in

handling stress. Specifically, LGBTQ+ individuals need to be honored for the variation in processes and routes that take with counseling and in life (Lytle et al., 2014)

The HRC (2013, 2013) provides helpful guides for LGBTQ+ clients who are coming out as well as individuals such as friends, family, and clinicians who wish to support LGBTQ+ persons through their process. Helpful tips in preparing to disclose include considering (a) preparation time (b) assessing social signals, (c) using resources, (d) what is important to say, (e) individuals who can be supportive, and (f) appropriate timing (HRC, 2013). For helpers, it is suggested to ask respectful questions in order to show interest. Additional tips include honesty and providing reassurance (HRC, 2012).

Recognizing the deficit in counseling guidelines for assisting LGB youth through the coming out processes, Matthews and Salazar (2012) formulated the *Integrative Empowerment Model*. The *Integrative Empowerment Model* focuses on highlighting factors that contribute to the process to prepare counselors to be able to comprehend the variability in coming out, including the positives, negatives, precautions, and benefits. The *Integrative Empowerment Model* is organized into three domains: (a) client inputs, (b) counselor strategies and interventions, and (c) outputs.

Client inputs are divided into internal and external factors (Matters & Salazar, 2012). Internal variables include stage of development, internalized feelings of homophobia, self-esteem, self-acceptance, and mental health behaviors. External factors include race, ethnicity, religion, family, peer environment, access to support, and previous experiences in counseling. The inputs section acknowledges that each client is unique in his/her combination of internal and external variables. Further, although client internal variables may be the root of the client's

process, external variables have the potential to facilitate or hinder coming out status (Dentato et al., 2014; Riggle et al., 2014; Rostosky, 2002).

A number of strategies are recommended in the *Integrative Empowerment Model* which include: (a) getting trained in LGB issues, (b) addressing personal beliefs, (c) being open and supportive, (d) working with parents as needed, (e) addressing environmental issues, (f) addressing cultural concerns, (g) discussing previous counseling, and (h) providing resources (Matthews & Salazar, 2012). These suggestions provide a helpful start for counseling; however, these strategies pertain to ongoing assessment and processing. Counselors should build on the model by adding to the few specific techniques are noted (i.e., role playing, reframing). Additionally, strategies and interventions should be chosen with care, and should be determined based on the client's inputs (Goodrich & Luke, 2015; Hill, 2009)

The final aspect of the *Integrative Empowerment Model* (Matthews & Salazar, 2012) includes potential outputs, which can amount from the process. The coming out process has the potential to provide implications on self-esteem, self-acceptance, mental health behaviors, and identity acceptance and/or integration. Further, the process may influence systems such as family, peer, and institutional sources of support. Moreover, it is essential that throughout the process continued support is assessed and provided to the need of the client.

The *Integrative Empowerment Model* (Matthews & Salazar, 2012) is an effective framework for counselor education and enhancing practice to encourage and support LGB youth through the coming out process, however, it has limitations. The authors created the *Integrative Empowerment Model* for working with lesbian, gay, and bisexual clients; however, it is unclear for the extension of the theory to other genders and sexual minorities. As noted prior, several

facilitative suggestions are provided; however, tangible interventions are lacking. Additionally, although Matthews (C. Matthews personal communication, June 16, 2015) expresses the need for research support for the model, no empirical evidence exists for the model. The *Integrative Empowerment Model* was utilized in the present study in an attempt to utilize a framework and to provide empirical evidence for future practice and research.

Group therapy with LGBTQ+ Young Adults. A common theme in studies of LGBTQ+ individuals, when considering coming out, is the suggestion of therapy (Alessi, 2014; Chazin & Klugman, 2014; Coolhart, 2006; Hartwell, Serovich, Graftsky, & Kerr, 2012). Dunlap's qualitative study of 15 men and 15 women from 5 age cohorts (ages 18-74) of the LGB community noted that in addition to therapy, relationships, education, and community are helpful in navigating the process of coming out. Peer counseling programs, speaker panels, support groups, and Gay/Straight Alliances have been recognized for their utility in providing safe environments and support to individuals in the coming out process (Dunlap, 2014; Fisher et al., 2008). Specifically, group counseling is a therapeutic modality in which all of four of these recommendations can be considered (Fisher et al., 2008; Goodrich & Luke, 2015; Muller & Hartman, 1998; Roberts, 2007).

Group counseling is suggested as a useful modality when members may be at-risk (Fisher et al., 2008). Group counseling is helpful when members range in their progress along the coming out continuum (Dunlap, 2014). In general, counseling groups should help students discuss their experiences, feelings, and thoughts, help develop coping strategies, and assist with positive behavior change (Fisher et al., 2008).

Muller and Hartman (1998) offered an example for group counseling for LG adolescents which would allow participants to discuss and better understand their feelings related to their identity. In the 25-session group plan family relationships, interpersonal issues, and resources would be discussed. Although coming out was an aspect addressed within the group format, it was not the primary topic. Moreover, although the population could have included young adults, no specific information is provided for the participants' ages. Further, no outcome research was conducted on the group framework.

Craig (2013) developed an affirmative school based group counseling intervention in effort to promote resiliency of multiethnic sexual minority youth. The format included 8-10 45 minute weekly sessions of 8 to 10 participants between the ages of 14 and 19. The group was discussion-based and focused on sharing experiences in a safe and supportive environment. Shared experiences, collective problem solving, and coping were main components. From the experience, Craig (2013) provides critical considerations such as highlighting strengths in every session, attending to intersecting to identities, using cognitive-behavioral strategies, and integrating affirmative consent. Although suggestions and session details are useful, unfortunately no research was provided on the effectiveness of the group.

A helpful resource for clinicians leading an LGBTQ+ group is Goodrich and Luke's (2015) book on group counseling with LGBTQI persons. First and foremost, the resource discusses foundational necessities such as counselor competence. Within the book, suggestions for a counseling group include a recruiting between 6-12 member and focusing on developmental issues, personal problems, behavioral changes, and/or prevention. Disclosure/coming out groups are emphasized. Similar to other scholars (e.g., Dunlap, 2014), the

authors note the importance of underlining privacy and confidentiality within a coming out group. Similarly, safety checks are accentuated; thoughtful, intentional methods in facilitating coming out are provided. Aligned with general therapy suggestions discussed prior (e.g., Matthews &, Salazar, 2012), the authors also highlight role-play as an intervention in processing and preparing for disclosures. Although these guidelines were formulated on research and clinical experience, *no* empirical evidence is provided for the disclosure/coming out group framework provided.

Empirical Research on Group Therapy with LGBTQ+ Young Adults

Although the need for counseling specific to LGBTQ+ concerns is recognized in the literature, there is a severe lack of empirical evidence on these methods. Further, less data exists on strengths-based group work with LGBTQ+ young adults through the coming out process. Mears' (2004) dissertation was intended to examine the influence of a visualization and goal-setting group intervention on lesbian and bisexual young women's self-esteem. However, the author's process changed to a focus group study exploring the participants' experiences in coming out. The sample of 19 women ranged along the spectrum of disclosure; half defined themselves as "completely out" and the remaining participants varied in telling friends and family. Participants shared their difficulties in coming out such as concern for negative reactions, the role of religion and the media, feelings of isolation, and the lack of role models. Similarly, participants noted that acceptance from family, positive media, resources, social support, and identity assurance were helpful. In reflecting on the intervention, participants shared enjoyment for hearing about others' experiences with coming out and perceived an increase in appreciation

for coming out experiences. Combining the literature and qualitative data ascertained Mears created a group plan to assist clients. Although Mears' research is helpful in understanding what may be helpful in coming out interventions as research was involved in creating the framework; unfortunately, *no* empirical evidence exists for the efficacy of the provided framework.

Similar to Mears, Martinez' (2012) dissertation focused on forming a group intervention to reduce high-risk behaviors in victimized gay youth. Helpful guidelines are provided such as the use of CBT, exploration of stigma and shame, positive affirmations for self-esteem, and use of technology; however, *no* empirical evidence is provided for the efficacy of the framework. Both authors provided helpful contributions to LGBTQ+ group counseling literature and highlight the need for future empirical studies for counseling research with LGBTQ+ clients.

Griffith (2014) contributed to the literature by exploring the influence of a group counseling intervention on young adult (18-20) LGBBQTQ+ individuals' hopefulness, coping, and sociality. A repeated measures MANOVA found a multivariate effect for between-subjects (of the combined hope, coping, and suicidality scores) across group type (regardless of time point): Wilks' $\lambda = .702$, $F(4, 28) = 2.97$, $p < .05$. Further, treatment group participants' scores improved when compared to the control group in terms of: (a) hopefulness ($F[2, 62] = 10.19$, $p < .05$), partial $\eta^2 = .247$; (a) adaptive coping ($F[2, 62] = 6.44$, $p < .05$), partial $\eta^2 = .172$; (a) maladaptive coping ($F[2, 62] = 4.66$, $p < .05$), partial $\eta^2 = .131$; (a) suicidality ($F[2, 62] = 8.04$, $p < .05$), partial $\eta^2 = .206$). Power levels (.76 to .98) were noted as adequate for these analyses. Griffith's study is *not* only useful in contributing to the literature on coping and LGBTQ+ young adults; moreover, it is unique as it is the first to explore the relationship between group therapeutic factors and hopefulness, and group therapeutic factors and suicidality.

A Pearson Product Correlation was utilized to determine the potential relationship between group therapeutic factors and constructs of interest. Of the analyses, a moderate positive correlation was found between total TFI-S total scores and adaptive coping ($r = .51, p < .05$, 26.0% of the variance explained). However, no significant relationships were found amongst the additional constructs (i.e., maladaptive coping, suicidality, hopefulness). Although social support was *not* a primary construct of interest, demographic questions related to social support were used for secondary analyses. No significant relationships were found between participants' perceived familial support and the constructs or perceived peer support and the constructs. One reason for the lack of significance between support and constructs could be because the analyses used support scores from the pretest; the intervention could have contributed to the perception in social support; however, the effect would not be captured in the analysis. Additionally, since social support was *not* a primary construct, a psychometrically sound social support instrument was not utilized and thus, the analyses lack reliability and validity. Although Griffith's research provides support for group therapy in assisting LGBTQ+ individuals between the ages of 18-20, the results may have differed if individuals 20-24 were included. Furthermore, since there was *not* a direct focus on outness, we cannot generalize the data.

Morrow (1995) conducted quasi-experimental research on a coming out issues group for adult lesbians between the ages of 24 and 48. The experimental group met for two hours weekly for ten weeks. The topics included identity development, homophobia and heterosexism, assertiveness, sexism, racism, career, and family. There were *no* significant differences found between groups for lesbian identify development; however, significant differences were found in empowerment scores between groups ($t = 3.16, p = .002$) and over time ($t = 5.52, p = .0001$) as

well as in disclosure scores between groups ($t = 1.43, p = .08$) and over time ($t = 2.90, p = .01$). Overall, the data yields some support for the group counseling intervention. Limitations of Morrow's study are important to consider such as (a) the biased sample of all white women, (b) the uncertainty of application to other sexual or gender minorities, (c) the small sample size, and (d) the reliance on 2 observation points (i.e., pretest and posttest). Additionally, the research arose from social work literature and although insights may be transferred, there may be variability in conveying these results in counseling literature.

Riggle and colleagues (2014) analyzed the efficacy of a brief counseling intervention in increasing positive identity, self-esteem, and collective self-esteem. The results displayed a significant increase from pretest to posttest; however, the results decreased to baseline levels by the one-month follow up. In addition to partial support for the efficacy of the intervention, a strong quality of the group is that it was designed for LGBTQA persons. Limitations include attrition, the small, convenient sample, and the brief intervention. The study examines the effect from a one-time, brief intervention, which may be the root cause of the diminished benefits at the follow-up observation. The authors suggest future researchers should explore ways to enhance the long-term effects of positive identity interventions.

Chapter Summary

This chapter provided an overview of the primary constructs of interest: (a) coping; (b) appraisal of social support; (c) coming out growth; and (d) group therapeutic factors. Background conceptualization and empirical research were provided for each variable.

First, the researcher examined the interrelation between stress and coping. Stress and coping were explored in reference to LGBTQ+ persons and the coming out process in particular. Next, the researcher examined the multidimensional construct of social support and makes a case for the utilization of perceived social support in this study. The necessity of social support for LGBTQ+, specifically within the process of coming out, was explained. Then, the researcher examined the concept of stress-related growth and the ability for individuals to grow from enduring coming out related stress. Finally, the utility of group therapeutic factors was explored and a case is made for the application of group counseling to facilitate LGBTQ+ young adults' growth through the coming out process. In conclusion, although theory and research findings identify the utility of facilitating coping, social support, and coming out growth for LGBTQ+ young adults, there remains a need for outcome-based research to test the usefulness of these constructs in assisting clients through concerns pertaining to the coming out process.

CHAPTER THREE: METHODOLOGY

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young adults' (ages 18-24) levels of coping (as measured by the *Brief COPE* [Carver, 1997]), appraisal of social support (as measured by the *Social Support Questionnaire-6* [SSQ-6; Sarason, Sarason, Shearin, & Pierce, 1987]), and coming out growth (as measured by the *Coming Out Growth Scale* [COGS; Vaughan & Waehler, 2010]). Specifically, this investigation tested if individuals scored higher over time in terms of coping, social support, and coming out growth. Additionally, this study examined the relationships between coping, social support, and coming out growth with (a) group therapeutic factors (as measured by the *Therapeutic Factors Inventory-Short Form* [TFI-S; Joyce, MacNair-Semands, Tasca, & Ogrodniczuk, & John, 2011]) and (b) participants' reported demographic data.

The research methodology provides a thorough description of the design (i.e., one-group pretest-posttest quasi-experimental design) and method for this study. Threats to validity (i.e., statistical conclusion, construct, internal, and external) are discussed in addition to mechanisms that were implemented in effort to mitigate these threats. Data collection, including population, sample, recruitment, incentives, and screening are described. Further, instrumentation for the study, including a rationale for selection of instruments and a discussion of their corresponding psychometric properties is reviewed. The primary characteristics of the group counseling intervention (treatment) are introduced. Additionally, research hypotheses and questions are presented along with their data analysis procedures. Finally, ethical considerations and potential limitations of the study are provided.

Research Design

Experimental research designs are highly regarded for their rigor (Shadish, Cook, & Campbell, 2002). A one-group pretest-posttest quasi-experimental design was used (Gall et al., 2007; Shadish et al., 2002). Participants received an eight-hour group counseling intervention to assist through the coming out process. The intervention was fractioned into four two-hour sessions. The participants met once weekly for four consecutive weeks. There were three observation points within the study, including (a) the first observation occurred prior to the intervention, (b) the second occurred at the midpoint of the intervention (i.e., after the second session), and (c) the final observation occurred, after the intervention (i.e., after the fourth session).

Mitigating Threats to Validity

Validity refers to the approximate truth of a knowledge claim (Shadish et al., 2002). In stating that a method is valid, we make a judgment on its proposed accuracy or truth. Threats to validity are perilous reasons in which our claims may be false. Awareness of validity threats in research is essential as they assist in designing a sound study, understanding the potential limitations of a study, and anticipating criticisms of the study. The following section presents four aspects of validity (i.e., statistical conclusion, construct, internal, and external) in addition to mechanisms to strengthen these aspects within this study.

Statistical Conclusion Validity

Statistical conclusion validity refers to the covariation of the cause-and-effect and how the strength in which the cause-and-effect covary. Statistical conclusion threats that may apply to this study include: (a) low statistical power, (b) inaccurate effect size calculation, (c) violated assumptions, (d) fishing, (e) unreliability of measures, (f) restriction of range, (g) unreliability of treatment implementation, (h) heterogeneity of respondents, and (i) extraneous variance in the experimental setting (Gall et al. 2007).

Power refers to the ability of a test to detect relationships in the analysis (Shadish et al., 2002). In order to control for low power and adequate effect size measurements, the free statistical software, GPower, was utilized to calculate an a priori analysis on the sample required with moderate effect size (Faul, Erdfelder, Lang, & Buchner, 2007). The calculation was conducted which considered three observation points, a power of 80%, and a moderate (.25) effect size. With zero correlation among repeated measures 55 participants would be needed. The researcher utilized this estimation to motivate and guide the recruitment process. Further, in order to account for attrition, the researcher aimed to recruit more than the required 55 participants identified from the power analysis (Gall et al., 2007).

A detriment to statistical conclusion validity would be violating assumptions. The researcher utilized an assumptions checklist for a repeated measures multiple analysis of variance (MANOVA) to guide her process. A MANOVA is utilized since there is one independent variable and the multiple dependent variables are interrelated, ratio or interval data and there are *not* too many. Once the data was collected the researcher checked for missing data,

outliers, homogeneity of variance, and normal distribution of the dependent variables (Mayers, 2013; Tabachnick & Fidell, 2013).

Fishing or error rate, violations occur when the significance values are *not* adjusted accordingly and may surmount in Type I error. In analyzing data, the researcher implemented necessary adjustments (e.g., sphericity not assumed) to mitigate concerns with statistical conclusion validity (Shadish et al., 2002). Unreliability of measures also inhibits statistical conclusions; therefore, the researcher intentionally selected reliable measures of each construct to account for this issue. Moreover the reliability tested and reported for each measure (Shadish et al., 2002).

Restriction of range is a concern in which the observations are too similar to detect change (Shadish et al., 2002). For example, if the scores were high at two distinct points, it would be difficult to note the change. Due to this potential ceiling effort, the researcher analyzed distributions to check for trends between observations one and two, two and three, and one and three.

The reliability of the treatment implementation has the ability to influence statistical inferences as well. A treatment manual and consistency of facilitation of the intervention across groups helped to reduce this concern. Heterogeneity of units refers to the variability of participants influencing statistical conclusions. For example, demographic variables may interact with results. In order to understand what characteristics of an individual are attributed to statistically significant changes, the researcher ran follow-up measures to better understand sample heterogeneity (Shadish et al., 2002).

There are a number of extraneous variables that may influence the experimental setting such as lighting, temperature, and noise (Shadish et al., 2002). Generally speaking, what prompts a comfortable environment to participants varies. However, the researcher made attempts to ameliorate potential distractions. Since this study aimed to examine the efficacy of a group counseling intervention, the researcher made efforts to emulate a counseling environment with medium to low lighting, comfortable seating, and minimal outside noises.

Construct Validity

Construct validity refers to the extent to which a measure operationalizes the concepts that are being studied (Gall et al., 2007). Threats to construct validity that may apply to this study include: (a) inadequate explication, (b) mono-operation bias, and (c) experimenter expectancies.

In order to explore a construct, the construct of interest should be clearly and accurately defined. Instruments should be selected with reliability to measure the construct of interest. Inadequate explication may occur when constructs are broad or confounding (Shadish et al., 2002). For example, social support is noted as a multidimensional construct (Lopez & Cooper, 2011; Sarason, Levine, Basham, & Sarason, 1983); therefore, particular care was taken to consider which aspect of social support would be (a) helpful for LGBTQ+ young adults coming out, (b) targeted in the intervention, and (c) measured by the a social support instrument. Since perceived social support is more influential than actual support (Chu, Saucier, & Hafner, 2010; Dinenberg, McCaslin, Bates, & Cohen, 2014), perceived social support was chosen as a topic within group counseling, and a reliable measure of perception of social support was available this aspect of social support was chosen to enhance construct validity, and to improve the overall

quality of the study. In an effort to maintain construct validity, the researcher was intentional about instrument selection.

Mono-operation bias is a threat to the validity of this study. For each construct, only one measure was chosen, additionally, the selected measures were consistent across multiple observation points. Therefore, it is difficult to discern whether results have implications for the overall construct or whether these implications are specific to the specific instruments chosen. Although using one measure for each construct may be a potential threat, efforts such as examining psychometric qualities of the instruments with diverse samples of data were considered to reduce the influence of mono-operation bias (Gall et al., 2007; Shadish et al.; 2002).

As an experimenter, the research intent for the study may have been leaked to the participants and may have influenced their behaviors and responses (Gall et al., 2007). Group members may be under the influence of experimenter bias. Also known, as the Pygmalion effect, the researcher's aspirations for the group to assist clients may cause participants to perform differently than they would have without the researcher's influence (Shadish et al., 2002). Since the researcher was the facilitator for *all* groups, this is a particular concern, on the other hand, having one facilitator, specifically the researcher, enhances treatment fidelity.

Internal Validity

Internal validity refers to aspects of the study that may inhibit correct inferences from the data (Creswell, 2014). Internal threats include reasons in which we may *not* believe in a causal relationship within the study (Shadish et al., 2002). In quasi-experimental studies, threats to

internal validity refers to the extent in which extraneous variables can be controlled in order for observed effects to be attributed to the treatment condition (Gall et al., 2007). Threats to internal validity that may apply to this study include: (a) instrumentation, (b) testing, (c) history, (d) maturation, (e) regression artifacts, and (f) treatment mortality.

Instrumentation and Testing. A change in measurement may lead to false conclusions of treatment effect (Shadish et al., 2002). In order to account for threats to instrumentation validity, measures were *not* altered during the study; the same measurements were utilized at each observation point. Moreover, the packets for all observations will be printed and collated at one time point prior to the intervention. However, testing issues remain a concern as participants were exposed to the same measures multiple times and may become “test-wise” (Gall et al., 2007, p. 385). Although the multiple observation points increase the strength of the statistic, the participants’ familiarity with the instruments may have influenced scores.

History and maturation. Studies that extend over time may be at the risk for external events related to time influencing the treatment observation. The intervention groups for this study were held during the fall of 2015; since the intervention was *not* be conducted for an extended range history-related threats are minimized. However, since the intervention was held over four weeks, maturation, or changes in the participants, may hinder validity. Participation fatigue may be an issue as multiple exposures to the same measures and time spent during the study may have caused individuals to lose interest and may report inaccurate scores on their assessments. Recognizing the maturation threat to validity, the researcher was intentional in choosing data collection instruments that not only dealt with the specific constructs, but were also condensed. Both the *Brief COPE* (Carver, 1997) and *Social Support Questionnaire 6*

(Sarason et al., 1987) are shortened versions of the original measures; although these instruments may have reduced reliability than the original tests (i.e., internal consistency and test-retest), these shortened versions were intentionally chosen to reduce instrumentation fatigue (Gall et al., 2007). Even removing the concept of fatigue, all participants are at risk for desensitization. Simply seeing the measures multiple times poses a bias and potentially causes observation desensitization (Shadish et al., 2002).

Regression artifacts. Individuals who are dealing with coming out concerns face a multitude of risks in which they may be seeking treatment to alleviate. Persons who are in need of the study may select the treatment and over time, their scores may regress towards the mean. All individuals who pass the screening will be offered the treatment at some time. Although it may seem as though all individuals who wish to receive treatment would be enrolled in the intervention, the researcher recognizes that additional concerns such as time and scheduling may have also influenced assignment. Concerns such as time, availability, and resources may have inhibited an individual who is interested in treatment from attending. Additionally, in order to account for statistical regression bias, three observation points were utilized (Shadish et al., 2002).

Treatment mortality. Also known as attrition, treatment mortality occurs when participants fail to complete study measures (Shadish et al., 2002). Individuals may fail to complete observations for a variety of reasons including illness and time commitment (Gall et al., 2007). One way to account for attrition is to try to recruit more than the minimum required (Creswell, 2014). Incentives were also used to reduce attrition (Dillman et al., 2014; Gall et al.,

2007). Participants were provided a \$5.00 gift card at the start of the study and another at the culmination of the group. Further, food and water was provided at each group meeting.

External Validity

Since external validity allows us to draw appropriate inferences from the sample's results to other settings, situations, or persons. Hence, concerns with external validity may arise due to characteristics of the sample, timing, or setting (Creswell, 2014). Threats to external validity that apply to the present study include: (a) population, (b) ecological, or (c) representative design.

Population validity. Population validity refers to the applicability of inferences from the study's sample to the overall target population (Gall et al., 2007). It is estimated that there are about 2,320,195 individuals currently reside in Central Florida. The population in the Greater Orlando area has increased almost 40% since 2000 and is projected to continue (Florida Office of Economic and Demographic Research, 2015; Bureau of Economic and Business Research, 2014; Bureau of Economic and Business Research, 2015). However, demographic data in the state of Florida and within the United States Census does not include gender or sexual orientation, and thus it is difficult to estimate the comparison of the Central Floridian sample to the country.

Due to the invisible minority status of LGBTQ+ individuals, understanding the overall population is difficult for this study. Embedded in the overall rationale for the study, individuals may choose to keep their identities private due to concerns with comfort and safety, thus hindering accurate estimations of the overall population size and corresponding characteristics. Additionally, due to geographic factors such as state laws, individuals across the nation may vary

in their likelihood to respond to statistics organizations with their accurate gender or orientation. The author recognizes that Central Florida may have differences from other United States locations; however, the location is representative of the country at large. Nevertheless, due to gaps in state and country reporting and societal implications, the accuracy of this extension is noted as a limitation.

Ecological validity. Ecological validity pertains to the applicability of inferences from the study's sample to other treatment conditions (Gall et al., 2007). In ecological validity, the testing environment is analyzed for its potential influence on behavior. To account for the concern for ecological validity, the researcher provides thorough description of the treatment methods to promote clarity for outside readers. Although a detailed description will assist the audience, the researcher must also take measures to reduce threats to ecological validity as they influence the participants.

All participants are subject to the Hawthorne effect. No deception was used and thus participants were fully aware that they were participating in research; the mere knowledge of the effect may have caused participation to be skewed (Shadish et al., 2002). Moreover, as the treatment is a new intervention, participants are at risk for the novelty effect. Even if they have received treatment prior, the ingenuity of the group intervention approach for coming out may cause participants to be skewed due to enthusiasm or excitement. Generally, novelty effects erode and thus the influence may be seen if scores are high towards the beginning and taper off with subsequent observations. Participants may have also been influenced by facilitator. In this study, the researcher doubles as the facilitator. Scores may have been influenced by individuals' perception of facilitator and it may be difficult to differentiate whether these effects could apply

to other persons (Gall et al., 2007). A treatment manual was formed and utilized in an attempt to mitigate this concern during study administration and for replication studies.

Representative design validity. Representative design validity pertains to the degree in which the research environment relates to the natural environment in which the counseling intervention could occur (Gall et al., 2007). A research environment may trigger artificial learning behaviors that may *not* be apparent in the naturalistic setting. One way representative design validity is accounted for in this study is that the groups were administered in an actual community mental health clinic. Moreover, the rooms were designed to accommodate group counseling; therefore, emulate a natural group therapy environment.

Procedures

In order to begin this study, the researcher sought approval from the University of Central Florida's IRB prior to recruitment or data collection. The IRB application included essential information for the study including the (a) rationale, (b) population of interest, (c) data collection procedures, (d) data analysis, (e) settings, (f) potential risks for participants, and (f) data storage. All supplemental materials such as recruitment flyers, data collection instruments, and the intervention manual were included as well.

Population and Sample

The overall population is LGBTQ+ young adults (18-24) in the United States. Due to the hidden aspect of the LGBTQ+ population, it is difficult to gain an accurate estimate of the population worldwide or nationwide (PEW, 2013). For example, although national statistics

bureaus could be utilized to calculate the population size, gender and sexual orientation data is absent. Further, due to the stressors associated with identification, individuals may *not* openly disclose their identity; thus, the estimate would be skewed. Since the recruitment and intervention occurred in Central Florida, the sample included LGBTQ+ young adults who resided in the Greater Orlando area. Further, the population coverage aptly matches the recruitment strategies which will be discussed later.

Shadish and colleagues (2002) suggest examining statistical power and effect sizes in addition to null-hypothesis significance testing prior to beginning an investigation. The free statistical software, GPower, was utilized to calculate an *a priori* analysis on the sample required with moderate effect size (Faul et al., 2007). The calculation was conducted which considered three observation points, a power of 80%, and a moderate (.25) effect size. In order to understand the minimum amount of cases needed, zero correlation among repeated measures was utilized. The analysis suggested a minimum of 55 cases for appropriate power. To account for attrition, the researcher aimed to recruit more than 55 participants.

Recruitment. Flyers were formulated for recruitment purposes. These flyers were created using Dillman's (2014) *Tailored Design Method*. Promotional material was placed in local LGBTQ+ organizations such as Zebra Coalition, the Center, Pride Commons, and UCF's office of LGBTQ+ services. Additionally, websites and social media outlets for these agencies were utilized. The researcher will also visit these locations to recruit face-to-face and to increase trustworthiness in the researcher, the intervention, and the overall study.

Incentives. As noted, treatment morality can pose a major threat to validity and overall research quality (Shadish et al., 2002). Missed observations may result in measurement attrition,

or participants may choose to remove themselves from the study, resulting in participant attrition (Gall et al., 2007). Recognizing these concerns, incentives were utilized to improve participation (Dillman et al., 2014). A difference in perspectives on incentives is presented in the literature. Henrikus and colleagues (2002) found that incentives are helpful for increasing registration rates; however, incentives may *not* increase retention. Contrastingly, Van Horn and colleagues (2011) learned that voucher incentives, even when delayed in reinforcement, have a strong influence on continuing care. Similarly, Chen and colleagues (2015) also found that cash incentives are helpful in increasing participation. Field and Behrman (2005) assert that a limitation of incentivized participation is that decision-making may become distorted. Nevertheless, scholars (e.g., Guyll, Spoth, & Redmond, 2003; Storms & Loosveldt, 2004) highlight that monetary incentives are important as they can reduce sampling bias. A five dollar gift card was provided at the beginning of the study and at the end of the study, thus providing the opportunity to earn \$10 in participation incentives. Further, food and water was provided at each group meeting.

Screening. A prescreening interview was scheduled to determine if the anticipated participant met inclusion criteria (Gladding, 2012). This study sought participants aged 18-24 who identify as LGBTQ+. Additionally, eligible participants had availability and transportation. Exclusion criteria included individuals who do *not* identify as LGBTQ+ or are under the age of 18 or over the age of 24. Considering the use of a group intervention, individuals were excluded from the study if they are *not* suitable to group treatment, such as monopolizers or individuals with severe mental health concerns that would distract from the group (i.e., psychosis, active

illegal substance abuse, active domestic violence; Gladding, 2012). Contact information was provided for the primary researcher on the recruitment material.

Coming out Group Counseling Intervention

Meyer (2003) asserted that in order to reduce the high rate of mental health concerns in the LGBTQ+ population, efforts must be made to reduce the minority stress endured. Further, Meyer noted that coping skills, social support, and intrapersonal characteristics are essential mediators of minority stress and mental health issues. Therefore, this strengths-based group counseling intervention utilized counseling and psychoeducation techniques to foster positive coping skills and to increase the satisfaction of social support in an effort to improve coming out growth on both intrapersonal and interpersonal levels (Goodrich & Luke, 2015; Hill, 2009; Lytle, Vaughan, Rodriguez, & Shmerler, 2014).

Group counseling is a helpful modality for increasing coping and social support (Gladding, 2012). Curative factors including, but not limited to, cohesiveness, universality, socializing techniques, imitative behaviors, learning, existential factors, corrective experiences, and catharsis will assist in facilitating coping, social support, and growth (Yalom & Leszcz, 2005). From a social-constructivist perspective, coming out is contextual and unique to each individual and occurrence (Guittar, 2013; Rust, 1993). The coming out process can often be lonely and isolating. Therefore, a group approach provides an opportunity to normalize the process and to experience cohesiveness and universality. Additionally, during young adulthood, individuals often lack role models to guide through the coming out process. Through a group approach participants are not only learning from the facilitator and the provided materials, they

are also experiencing vicarious learning (Bandura, 1995). For example, if an individual is in an early phase of identity development and is struggling with disclosing to his or her parent and witnesses a peer successfully do so, he or she has the opportunity to grow from that indirect experience. From sharing experiences, the process is not only normalized, but also provides a wider range of learning in which an individual has the ability to learn what is helpful and unhelpful during the process. The group modality permits flexibility in gaining perspectives and insight for individuals who have existential inquiries. Peers can learn from one another's processes whether positive or negative. Further, group provides an accepting, facilitative environment to release and heal from negative disclosures. Moreover, the group can provide an outlet for individuals to share their experiences, feelings, thoughts, and plans. An individual can experience catharsis for simply having a safe, comfortable environment to freely discuss and process identity, much less the overall ongoing process of coming out.

Finally, scholars suggest employing affirmative practices with LGBTQ+ persons (e.g., Goodrich & Luke, 2015; Hill, 2009; Hunter & Hickerson, 2003; Mayer, 2014; Panchankis & Goldfried, 2004; Vaughan & Rodriguez, 2014). Affirmative practice can be conceptualized as an adaptation of leading models of counseling with special consideration of LGBTQ+ issues (Roberts, 2007). Further, researchers recommended that rather than focusing on pathology, clinicians should focus on strengths (Bernal & Coolhart, 2005; Rosario et al., 2001; Savin-Williams, 1990, 2001). However, Lytle and colleagues (2014) noted that a strengths-based perspective has been overlooked in training and practice with the LGBTQ+ population. Moreover, the current disconnect between LGBTQ+ and strengths-based literatures results in a

disservice to the LGBTQ+ client population.

The Intervention Manual

A manual was utilized in order to standardize the intervention and to enhance treatment fidelity (Gall et al., 2007). The manual consists of facilitator guidelines, an outline of the group curriculum, required handouts, and recommended resources. The complete intervention manual can be seen in Appendix F.

The introduction to the manual informs the reader of the ongoing process of coming out that included intrapersonal and interpersonal components. The purposes of (a) recognizing and normalizing the potential to experience difficulty from the multiple processes of disclosing identity throughout one's life, (b) assisting with adequate preparation for the trials and tribulations that disclosure may entail, and (c) providing a community environment for members who may need a sense of universality and support to combat societal marginalization, stigmatization, and isolation are delineated. The facilitator guidelines introduce the facilitator to the affirmative approach embodied in the curriculum. Additionally, the competency areas of awareness, knowledge, and skills are highlighted in reference to the LGBTQ+ population.

The group curriculum includes interactive and psychoeducational sessions with the aim of encouraging constructive behaviors and healthy ways of coping and utilizing a positive support system. The general schedule for each session includes a check-in, the topic of the day, an activity, and assigned homework. The session topics vary to cover the both the skills and cycle of coming out in an intentional, developmental order.

The first session introduces the members to the group goals, rules, and purposes. Members are encouraged to introduce themselves and begin to engage with their peers. The primary session begins to lay the foundation for the remaining of the group sessions as the cyclical concept of coming out is introduced. The second session focuses on coping and the awareness phase of coming out. The third session targets social support and assessing the decision to disclose identity. The final session includes practice of coping and social support skills as well as coming out plans.

Setting

The groups were offered at the University of Central Florida's Community Counseling and Research Center (CCRC). The CCRC is the only location of its kind in Central Florida as it provides free outpatient (e.g., individual, couple, family, and group) counseling for members of the community. The CCRC location was intentionally chosen for its proximity to the recruitment locations (e.g., Pride Commons). Additionally, being located on a university campus, the CCRC was inferred that a campus location was suitable for the population age range. However, population was not limited to students and thus student status was not required for this study. Therefore, free parking was provided to participants who were not students, but were within the age range of 18-24. In an effort to promote safety and confidentiality, participants utilized a private entrance that is not accessible to outside members. Additionally, a consistent room was used that was designed specifically for group use.

Instrumentation

The data collection packet included three measures (a) the *Brief COPE* (Carver, 1997), (b) *The Social Support Questionnaire 6* (Sarason et al., 1987), and (c) the *Coming Out Growth Scale* (Vaughan & Waehler, 2010). These packets were administered at three data collection points throughout the study. Demographics, contact information, and the first data collection packet were collected at the beginning of the first session to serve as baseline data (Gall et al., 2007). The second packet was administered at the end of the second session. The fourth packet included the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) and was distributed at the end of the final group.

Demographic Questionnaire

A brief demographic questionnaire was created to track the age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about LGBTQ+ status. The demographics questionnaire can be seen in Appendix H. All participants completed the form within the first packet of instruments prior to the start of the intervention. In order to provide support for face validity and readability, the demographic questionnaire was reviewed by colleagues (i.e., dissertation committee, counselors) prior to being submitted to the IRB.

The Brief COPE

The *COPE* (Carver, 1989) was developed to assess a broad range of coping responses. The *COPE* was developed on the foundation of theoretical models of coping such as the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984). Recognizing the utility

of a shortened instrument in assessment, Carver (1997) created the 28-item *Brief COPE* (Carver, 1997) from the parent version. The condensed version utilized in this study can be found in Appendix I. The *COPE* subscales measure essential aspects of coping which include: (a) active coping, (b) planning, (c) using instrumental support, (d) using emotional support, (e) venting, (f) self-distraction, (g) positive reframing, (h) humor, (i) acceptance, (j) religion, (k) behavioral disengagement, (l) self-blame, (m) denial, and (n) substance use. All of the 14 subscales have two 4-point Likert-type scale items each and scores range from 0-112. Examples of items include: “I have been taking action to try to make the situation better,” and, “I’ve been looking for something good in what is happening.” Response options include (a) “I don’t usually do this at all,” (b) “I usually do this a little bit,” (c) “I usually do this a medium amount,” and (d) “I usually do this a lot.”

The *Brief COPE* was *not* intended to be in a measure of total scores, instead, it is suggested to use the instrument in reference to positive and negative coping strategies (Hampel & Petermann, 2005; Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006). Therefore, the *Brief COPE* is examined in reference to two categories: *Adaptive Coping* (subscales 1-10: active coping, planning, using instrumental support, using emotional support, venting, self-distraction, positive reframing, humor, acceptance, and religion) and *Maladaptive Coping* (subscales 11-14: behavioral disengagement, self-blame, denial, and substance use).

Psychometric features of the Brief COPE. The *Brief COPE* was included in a large battery of assessments administered to a convenient sample of 168 individuals severely affected by Hurricane Andrew. Participants were mostly female (66%); a majority of the participants

identified as non-Hispanic White (40%), then African American (34%), Hispanic (17%), and Asian (5%). Follow-up observations occurred six months later (124) participants, and 1 year later (126 participants). The third assessment took place one year later with 126 participants. The combined internal consistency reliabilities from all three administrations the reliabilities met the minimum (.50, Nunnally, 1978) and are as follows: active coping ($r = .68$), planning ($r = .73$), using instrumental support ($r = .64$), using emotional support ($r = .71$), venting ($r = .50$), self-distraction ($r = .71$), positive reframing ($r = .64$), humor ($r = .73$), acceptance ($r = .57$), religion ($r = .82$), behavioral disengagement ($r = .65$), self-blame ($r = .69$), denial ($r = .54$), and substance use ($r = .90$). Mohanraj and colleagues (2015) examined the reliability and validity of the *Brief COPE* with a sample of 299 persons living with HIV in India. Fifty-four individuals completed the test-retest portion of the study; reliability on the subscales ranged from .44 (behavioral disengagement) to .89 (substance use). Convergent validity was also analyzed between depression (*Clinical Interview Schedule-Revised* [CIS-R], Lewis et al., 1993) and the researchers found a significant correlation between maladaptive coping and depression ($\pm 0.34, p < 0.001$). Moreover, Muller and Spitz (2003) found that active coping is linked to higher self-esteem, lower perceived stress, and lower psychological distress, whereas maladaptive coping strategies are linked to poor self-esteem, high perceived stress, and psychological distress.

Krägeloh (2011) noted that since its original publication, at least 463 scholarly publications have noted the *Brief COPE* and of the sample, 399 studies have collected empirical data using the *Brief COPE*. The *Brief COPE* has been used to better understand coping for a variety of concerns such as HIV (Mohanraj et al., 2015; Vosvick et al., 2003), heart failure (Bean, Gibson, Flattery, Duncan, & Hess, 2009; Paukert, LeMaire & Cully, 2009), aging

(Lagana & Zarakin, 2010), depression (Cooper, Katona, Orrell, & Livingston, 2008), breast cancer (Culver, Arena, Antoni & Carver, 2002), and brain injury (Wood & Rutterford, 2006). Specific to the population of interest for the present study, the *Brief COPE* has been used with young adults (e.g., Gould, Watson, Price, & Valliant, 2013; Love & Sabiston, 2011; Mahmoud, Staten, Lennie, & Hall, 2015; Miyazaki, Bodenhorn, & Zalaquett, 2008; Perczek, Carver, Price, & Pozo-Kaderman, 2000; Ebert, Tucker, & Roth, 2002; Schnider, Elhai, & Gray, 2007). Furthermore, the *Brief COPE* was used in an investigation of coping styles among gay men, providing support for its use with the LGBTQ+ community (David & Knight, 2008). Closely related to the present research, Griffith (2014) used the *Brief COPE* to examine a group intervention for LGBTQ+ individuals ages 18-20.

The Social Support Questionnaire 6

Social support is a multifaceted construct. Social support encompasses actual support (e.g., instrumental, informative, emotional) and sources of support (e.g., family, friends). Cohen and Wills (1985) proposed that social support is related to well-being as it offers positive emotions, a sense of self-worth, and predictability in life; additionally, functions as a stress buffer by reinforcing self-esteem, self-efficacy, and problem solving behaviors. Sarason and colleagues (1987) asserted that appraisal of social support may be more important than actual support. In a meta-analysis of 246 studies of social support, Chu, Saucier, and Hafner (2010) found small associations between social support and well-being; however, perceived social support was more strongly related to well-being. Even in situations in which actual support is *not* provided, an individual's appraisals of the perceived availability of social support has been

shown to be capable of reducing the negative impact of stress on their well-being (Bovier, Chamot, & Perneger, 2004; Campos, Schetter & Abdou, 2008; Castle, Slade, Barranco-Wadlow & Rogers, 2008; Dunst, Jenkins, & Trivette, 1984; Gee & Rhodes, 2008; Gjesfjeld, Greeno, Kim & Anderson, 2010; Honey, Hastings, & Mcconachie, 2005; Lin, Thompson & Kaslow, 2009; Rodriguez, Mira, Myers, Morris & Cardoza, 2003). The group approach implemented in the present study does not seek to take on the task of changing actual social support during the short intervention span; however, the intervention seeks to assist clients in navigating, utilizing, and appreciating their current support. Therefore, since the intervention aims to influence appraisal of social support the *Social Support Questionnaire 6* ([SSQ6], Sarason et al., 1987). The SSQ6 utilized in this research can be found in Appendix J.

There are two components to SSQ6 (Sarason et al., 1987): (a) the perceived social support (SSQ-N) and (b) the satisfaction with perceived social support (SSQ-S). In the first portion, the test-taker lists the individuals who are available for support for each prompt, such as “Whom could you count on if you lost your job or were expelled from school?” In the second section, the test-taker rates his or her satisfaction with the number listed in portion one on a Likert-type scale. The scale ranges from 1 (very unsatisfied) to 6 (very satisfied).

Psychometric features of the Social Support Questionnaire 6. The *SSQ6* is an abbreviated version of the original 27-item *SSQ* (Sarason et al., 1983). The original *SSQ* had internal reliabilities ranging from .97-.98 on the number subscale and .96-.97 on the satisfaction subscale whereas the *SSQ6* ranges from .90-.93 on both subscales. The *SSQ6* was originally tested on three independent samples: (a) 182 psychology students, (b) 81 male and 136 undergraduate students in an introductory psychology course, and (c) 59 men and 87 women in an introductory

psychology course. Each sample completed a battery of assessments including scales of anxiety, depression, and other measures of social support. For anxiety measures, sample one was given the *Multiple Adjective Affect Checklist* (MAACL; Zuckerman & Lubin, 1965), sample two was given the *Reactions to Social Situations Scale* (Sarason, 1986), and sample three was given the *State-Trait Anxiety Inventory* (Spielberger et al., 1979). A negative relationship was found between anxiety and social support. For the number subscale the correlations with the *Multiple Adjective Affect Check List* (MAACL; Zuckerman & Lubin, 1965), the *Reactions to Social Situations Scale* (Sarason, 1986), and *State-Trait Anxiety Inventory* (Spielberger et al., 1979) were $-.26$ ($p < .001$), $-.31$ ($p < .001$), and $-.38$ ($p < .001$) respectively. Samples one and three were administered the *Beck Depression Inventory* (BDI; Beck et al., 1961) and a negative relationship was found with *SSQ6-N* ($r = -.19$, $p < .001$; $r = -.19$, $p < .001$) and *SSQ* scores ($r = -.29$, $p < .001$, $r = -.47$, $p < .001$). Similarly, a negative relationship was found between the *UCLA loneliness scale* (Russel et al., 1980) and the number subscale ($r = -.49$, $p < .001$) and the satisfaction subscale ($r = -.59$, $p < .001$) in sample one and sample 2 ($r = -.52$, $p < .001$; $r = -.60$, $p < .001$). Moreover, a negative relationship was found between the *Social Reticence Scale for Shyness* (Jones & Russell, 2982) and *SSQ6-N* ($r = -.31$, $p < .001$) and *SSQ6-S* ($r = -.20$, $p < .001$). The findings show that stronger perceived social support (number and satisfaction) may be related to reduced anxiety, depression, loneliness, and shyness.

Positive associations were found between both *SSQ6* subscales and social aspects such as skill and support, providing support for convergent validity. The *Social Competence Questionnaire* (Sarason et al., 1985), a measure of social skill, was positively correlated with *SSQ6-N* ($r = .39$, $p < .001$) and *SSQ6-S* scores ($r = -.20$, $p < .01$). Additionally, the *Family*

Environment Scale (Moos & Moos, 1981) was associated with *SSQ6-N* ($r = .41, p < .001$) and *SSQ6-S* scores ($r = .50, p < .01$). The Parental Bonding Instrument (Parker et al., 1979) was utilized in samples two and three to understand the potential relationships with parental care and overprotection with available and perceived satisfaction with social support. A positive relationship was found between maternal care and *SSQ6-N* ($r = .34, p < .001$; $r = .43, p < .001$) and *SSQ6-S* ($r = .15, p < .05$; $r = .63, p < .001$.) scores for both samples. Similarly, a positive relationship was found between paternal care and *SSQ6-N* ($r = .37, p < .001$; $r = .40, p < .001$) and *SSQ6-S* ($r = .32, p < .001$; $r = .48, p < .001$.) scores for both samples. Contrastingly, a negative relationship was found between maternal overprotection and *SSQ6-N* ($r = -.20, p < .01$; $r = -.21, p < .01$) and *SSQ6-S* ($r = -.17, p < .01$; $r = -.31, p < .001$.) scores for both samples. Relatedly, a negative relationship was found between paternal overprotection and *SSQ6-N* ($r = -.14, p < .05$; $r = -.17, p < .05$) and *SSQ6-S* ($r = -.12, p < .01$; $r = -.22, p < .01$.) scores for both samples. Perceived social support may be related to social skills and relationship quality with family members. Specifically, parental care is associated with perceived support; however, too much care, or overprotection, may have a detrimental influence on support and relationships.

Multiple measures were used to establish concurrent validity regarding social support. Positive relationships were found between the *Inventory of Social Supportive Behaviors* (ISSB; Barrera et al., 1981) and the *SSQ6-N* ($r = .27, p < .001$) as well as the *SSQ6-S* ($r = .23, p < .001$). Positive relationships were also found between the *Interpersonal Support Evaluation List* (ISEL; Cohen et al., 1985) and the *SSQ6-N* ($r = .49, p < .001$) as well as the *SSQ6-S* ($r = .62, p < .001$). The size subscale of the *Social Network List* (Stokes, 1983) had positive correlations with *SSQ6-N* ($r = .39, p < .001$) scores and *SSQ6-S* ($r = .15, p < .05$) scores. Further, the percentage of

confidants subscale was positively related with *SSQ6-N* scores ($r = .34, p < .001$) and *SSQ6-S* scores ($r = .32, p < .001$). The *Perceived Social Support* (PSS; Procidano & Heller, 1983) instrument was used to better understand the relations between perception of support from friends and family to available support and satisfaction with available support. Positive relationships were found between *SSQ6-N* scores and perceived support from friends ($r = .44, p < .001$; $r = .52, p < .001$) as well as perceived support from family ($r = .42, p < .001$; $r = .58, p < .001$). Thus, the link between level of perceived social support and relationship quality applies beyond family members and extends to friends and the greater social network.

A limitation of the *SSQ6* is the correlation with social desirability. The *Marlowe-Crowne Social Desirability Scale* (Crown & Marlow, 1964; Marlowe & Crowne, 1961) yielded positive correlations with both *SSQ6-N* ($r = .23, p < .001$) and *SSQ6-S* ($r = .21, p < .001$) scores. Additionally although, different samples were utilized, all samples utilized a convenient population of undergraduate psychology students. However, the *SSQ6* has been used for populations under stressful life events such as AIDS (Leserman et al., 2000). Additionally, the *SSQ6* has been previously used with young adults (Forbes & Roger, 1999; Price, Gray, & Thacker, 2015). Although the social desirability and limited sampling may be a concern of the *SSQ6*, the instrument has been used with young adults and for individuals under stress, therefore the *SSQ6* is an appropriate measure for examining perceived social support for LGBTQ+ young adults enduring the stressors of the coming out process.

The Coming Out Growth Scale

The ability to grow from the stress endured during coming out has been acknowledged in the literature (Cox, Dewaele, Houtte, & Vincke, 2011; Meyer, 2014; Vaughan & Rodriguez, 2014). Vaughan and Waehler's (2009) *Coming Out Growth Scale* (COGS) measures the perceived gains from outness. There are two useable versions of COGS: (a) a 36-item version which examines overall coming out growth, and (b) a 34-item version which allows for examination of overall coming out growth in addition to the two factors of intrapersonal and collectivistic growth. The 34-item COGS will be utilized in order to allow for an examination of intrapersonal and interpersonal dimensions of growth. Items are arranged on a Likert-type scale from one (not at all) to five (a lot). The COGS used in this study can be seen in Appendix K.

The intrapersonal growth COGS subscale has 21 items and the collectivistic growth subscale has 13 items. The individualistic growth dimension includes perceived gains in authenticity/honesty, biopsychosocial well-being, and sexual minority identity. Examples of intrapersonal growth subscale items include, "I stand up for myself more within relationships," and "I am more free to be myself." The collectivistic growth dimension captures growth in LGBT-affirming views, a sense of belonging, and a collective LG identity. Examples of collectivistic growth subscale items include, "I have challenged by own stereotypes about lesbian/gay people" and "I am more aware of negative treatment of lesbian/gay people in society."

Psychometric features of the Coming Out Growth Scale. The COGS was created with a sample of 959 lesbian women and gay men. The dataset was split and data for 418 persons was used for the exploratory factor analysis and the rest were saved for future analyses. Of the sample, 196 (46.9%) were lesbians who were biologically female, 219 (52.4%) were biologically

male gay men, and three lesbian (.7%) were transgender (male-to-female). Participants ranged in age from 17-95 with an average age of 35.5 ($SD = 13.23$). The sample ranged in education levels from less than high school to doctorate or professional degree. Additionally, the sample represented all four major regions of the United States. In order to better understand the psychometric properties of the *COGS*, participants were given a battery of instruments including the *OI* (Mohr & Fassinger 2000), *The Life Orientation Test-Revised* (LOT-R, Scheier et al. 1994), *The Gay Identity Questionnaire-Revised* (Fassinger 2001a) and the *Lesbian Identity Questionnaire-Revised* (Fassinger 2001b), *Stress-Related Growth Scale-Short Version* (SRGS-S: Park et al. 1996), and the *Balanced Inventory of Desirable Responding-Impression Management Scale* (BIDR-IM; Paulhus, 1994).

The intrapersonal growth subscale has an internal consistency reliability of .96 and the collectivistic growth subscale has a reliability of .88. Non-significant relationships found between social desirability (impression management) scores (BIDR-IM; Paulhus, 1994) and reports of individualistic growth; however, a significant negative relationship was found between BIDR-IM and COGS-G scores ($r = -.12, p < .05$). Since socially desirable responding does *not* influence both subscales of the COGS and were utilized in this study.

Positive relationships were found between *SRGS-S* scores and individualistic *COG* ($r = .75, p < .001$) and collectivistic *COG* ($r = .58, p < .001$). Overall *COGS* scores were moderately interrelated with *SRGS-S* (Park et al., 1996) scores ($r = .58-.75$); *SRGS-S* scores explained about 56.25% of the variance in *COGS* scores. The moderate relationship indicates that although related, the measures capture distinct experiences and thus, in order to fully measure coming out growth, the *SRGS-S* is insufficient. Stress-related growth is notably similar to coming out

growth; however, since coming out is an aspect of stress-related growth, the *SRGS-S* would *not* adequately cover the construct of coming out growth and cannot be used in place of the *COGS*.

There were no significant differences between lesbian biological women and gay biological men ($t = 1.28, df = 313$; $t = 1.84, df = 312$). Additionally, unlike the findings from Bonet et al.'s (2007) study, no growth differences were noted across education levels or between racial/ethnic minorities. Both individualistic and collectivistic growth subscales had significant relationships with dispositional optimism ($r = .25, p < .001$; $r = .16, p < .01$), identify integration/synthesis ($r = .43-.46, p < .001$; $r = .35-.40, p < .001$), amount of involvement in the LGBT community ($r = .36, p < .01$, *COGS-CG*: $r = .46, p < .01$), age at first consensual same-gender experience ($r = -.15, p < .01$; $r = -.19, p < .01$), and overall level of outness ($r = .30, p < .001$; $r = .26, p < .001$). Time elapsed since the beginning of the coming out process was significantly related to individual growth ($r = .13, p < .05$), but *not* to collectivistic growth. No differences between sex or education groups may allude to the relatedness of the coming out experience across diverse individuals. However, bright perspective and self-acceptance may perpetuate growth in addition to time and depth of outness. Therefore, the group intervention aimed to target perspectives and engage individuals in the community.

Although measures have been established to measure outness (e.g., *Outness Inventory* [OI]; Mohr & Fassinger, 2000) and measures have been established to measure stress-related growth (e.g., *SRGS-S*; Park et al., 1996), the *COGS* is the first of its kind which examines stress-related growth gained from the coming out process. Since the *COGS* is a relatively new measure, the only scholarly publication that measures coming out growth with the *COGS* instrument is the creation study (Vaughan & Waehler, 2010). A limitation of the *COGS* is that the instrument was

validated on a sample of lesbian and gay identified individuals rather than a sample including BTQ+. Therefore, this is the first study to measure stress-related growth gained from the coming out process with the *COGS* with additional sexual and gender minorities. This study contributes to the literature on coming out growth and determining if coming out growth can be increased from a group counseling intervention.

Therapeutic Factors Inventory Short Form

The TFI-19 (Joyce et al., 2011) is utilized in this study to measure the effectiveness of group counseling (e.g., curative factors and dynamics). The TFI-19 used in this study can be seen in Appendix L. *TFI-19* is a shortened version of the 99-item *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). The TFI-19 is based off of Yalom's 11 therapeutic factors and higher scores demonstrate participants' positive experiences in group. The TFI-19 is analyzed by the use of total scores as well as subscale scores. The TFI-19 subscales include: (a) instillation of hope, (b) secure emotional expression, (c) awareness of relational impact, and (d) social learning. TFI-19 items are formatted on a seven-point Likert-type scale ranging from strongly disagree to strongly agree. The lowest possible score is 19 and the maximum is 133. Example prompts on the TFI-19 include, "I feel a sense of belonging in group," "this group empowers me to make a difference in my own life," and "things seem more hopeful since joining group."

Psychometric features of the Therapeutic Factors Inventory Short Form. A sample of 380 adults participating in 52 distinct group therapy groups at 8 different clinical locations within the United States and Canada was utilized to explore the factor structure of the *TFI-S*. The model was consistent with the hypothesized four factors with instillation of hope yielding six items, secure emotional expression yielding seven items, awareness of relational impact yielding six

items, and social learning yielding four items. However, confirmatory factor analysis was conducted and items demonstrating multiple non-modeled covariances, cross-factor item loadings, and/or content redundancy were considered for deletion. The removal of four items (5, 6, 12, and 14) resulted in a 19-item instrument. The TFI-19 has four items on the instillation of hope subscale, seven items on the secure emotional expression subscale, five items on the awareness of interpersonal impact subscale and three items on the social learning subscale. Each factor demonstrates good internal consistency (instillation of hope [$r = .90$], secure emotional expression [$r = .85$], awareness of interpersonal impact [$r = .79$], and social learning [$r = .66$]). Additionally, a quasi-experimental study of counselors-in-training participating in multicultural growth groups provided further support for the internal consistency of the subscales: instillation of hope (.65), secure emotional expression (.52), awareness of relational impact (.88), and social learning (.88; Johnson & Lambie, 2013). A quasi-experiential study exploring the influence of group counseling on LGBTQ young adults found that the Cronbach's alpha for the total *TFI-S* was acceptable ($\alpha = .78$; Pallant, 2010). Additionally, Cronbach's alpha for the *TFI-S* subscales was acceptable (Instillation of Hope $\alpha = .84$, Secure Emotional Expression $\alpha = .78$, Awareness of Relational Impact $\alpha = .85$, and Social Learning $\alpha = .86$; Griffith, 2014).

The *Group Climate Questionnaire* (GCQ-S; MacKenzie, 1983), a measure designed to assess individual members' perceptions of a group's therapeutic environment, was used to examine convergent validity. Statistically significant relationships were found between the subscales ($p < .001$) with medium to large effect sizes for the engaged subscale and small effect sizes for the remaining subscales. Hence, there is support that the *TFI-S* measures the intended construct and adequately addresses group climate.

The *Brief Symptom Inventory* (Derogatis, 2000), an 18-item instrument that measures psychological distress, and the *Inventory of Interpersonal Problems* (IIP; Pilkonis, Kim, Proietti, & Barkham, 1996), a 28-item measure of interpersonal functioning were utilized to examine predictive validity. The *TFI-19* factors were found to be significantly predictive of post-treatment levels of anxiety, depression, general symptomatic distress, and general interpersonal distress. Three of the four *TFI-19* subscales, instillation of hope, secure emotional expression, and awareness of relational impact, accounted for significant variation in the *BSI-18* Anxiety scale at post-treatment. Instillation of hope at week four accounted for a small proportion of the variation (1.0%) in post-treatment Depression scale scores. All of the *TFI-19* subscales displayed significant relationships with the post-treatment scores for the *BSI-18* Global Severity index. Although no significant predictive relationships were identified for the interpersonal sensitivity, interpersonal ambivalence, or aggression subscales, the instillation of hope factor at week four was significantly associated with the *IIP* (total score) at post-treatment, and it accounted for 7.0% of the variation. Therefore, the group intervention targeted *Instillation of Hope* in an effort to enhance overall interpersonal functioning at group completion.

The desirability scale of the *Personality Research Form* (Jackson, 1984) was used to measure social desirable responding with the *TFI-19*. A limitation of the *TFI-19* is the social desirable responding. Three of the four *TFI-19* subscales at week four: *Secure Emotional Expression*, $r(248) = .26, p < .001$; *Awareness of Relational Impact*, $r(247) = .17, p < .007$; and *Social Learning*, $r(247) = .16, p < .01$ were found to be related to the *PRF*. Considering the potential for socially desirable responding, the researcher considered this limitation in analyzing scores and implications upon study completion.

Research Questions

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. The investigation tested if individuals scored higher in the three measures over time. In an effort to contribute to the knowledgebase in the fields of counseling and counselor education, this investigation sought to answer the following research questions:

Primary Research Question

Does a coming out group counseling intervention effect late LGBTQ+ adolescents' levels of coping (as measured by the *Brief COPE* [Carver, 1997]), appraisal of social support (as measured by the *Social Support Questionnaire-6* [Sarason et al., 1987]), and coming out growth (as measured by the *Coming Out Growth Scale* [Vaughan & Waehler, 2010]) over time?

Exploratory Research Question 1

What is the relationship between LGBTQ+ young adults' group therapeutic factors (*Therapeutic Factors Inventory–Short Form* [TFI-S]; Joyce et al., 2011) scores and their levels of coping, appraisal of social support, and coming out growth?

Exploratory Research Question 2

Is there a statistically significant relationship between LGBTQ+ young adults' reported demographic variables (e.g., age, affectional orientation, outness) and their levels of coping, appraisal of social support, and coming out growth?

Data Analysis

The Statistical Package for Social Science (SPSS) software package for Windows version 21.0 (IBM Corp., 2012) was utilized to analyze the data. The dataset for the investigation included one independent variable (i.e., time) and multiple continuous dependent variables: participants' (a) coping skills (as measured by the *Brief COPE*; Carver, 1997); (b) appraisal of social support (as measured by the *SSQ-6*; Sarason et al., 1987), (c) coming out growth (as measured by the *COGS*; Vaughan & Waehler, 2010); and (d) experience of group therapeutic factors (as measured by the *TFI- S*; Joyce et al., 2011). Additional variables from the brief demographic questionnaire included participants' age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+. Data was examined prior to ensure that necessary statistical assumptions have been met prior to analysis.

Primary Research Question

A repeated-measures MANOVA was utilized to determine if there was a significant difference in participants' coping, social support appraisal, and coming out growth scores over time (Pallant, 2010; Tabachnick & Fidell, 2013). The independent variable was time and the dependent variables were the scores (i.e., coping, coping, social support, and coming out growth). A MANOVA is a "generalization of ANOVA in which there are several dependent variables" (Tabachnick & Fidell, 2013, p.245). A repeated-measures analysis was utilized to strengthen the statistic with multiple points rather than to use only one pretest and one posttest. Additionally, a MANOVA was used since the dependent variables are related (Pallant, 2010). A MANOVA was used in contrast to an ANOVA as this statistic adjusts to avoid inflated Type I

error and can display interacting effects (Pallant, 2010). Utilizing an ANOVA may have made it more difficult to discern statistically significant results. Further, a MANOVA may display differences not shown in ANOVAs (Tabachnick & Fidell, 2013).

Exploratory Research Question 1

A canonical correlation was utilized to analyze the relationship group therapeutic factors and outcome variables (Tabachnick & Fidell, 2013). Additionally, Pearson Product Moment Correlations (two-tailed) were used to calculate whether there was a significant relationship between the individual group therapeutic factors and participants' and *Adaptive Coping*, *Maladaptive Coping*, *Social Support Number*, *Social Support Satisfaction*, *Collectivistic Growth*, and *Individualistic Growth*.

Exploratory Research Question 2

Depending on the structure of the data, statistics were selected to calculate whether there was a relationship between participants' demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+ status) and coping, appraisal of social support, and coming out growth. For continuous variables (i.e., age, coming out stress, outness) a Pearson Product Moment Correlation was utilized. When two groups were being examined, Hotelling's Trace was utilized. Finally, when more than two groups were being examined, a MANOVA was utilized to explore the demographic variable.

Ethical Considerations

Steps were taken to ensure that the investigation is conducted in an ethical manner, including: (a) obtaining approval from the IRB, (b) informing participants of their rights, (c) clearly expressing limits to confidentiality, and (d) removal of identifying information on instrument packets. Since this study pertains to a marginalized group, there are ethical considerations specific to this group. In the coming out process, individuals who are disclosing their affectional orientation or gender may be cautious due to safety concerns. The group was intended to assist individuals in the lifelong coming out process. Individuals who are towards the beginning of their journey may be particularly hesitant about disclosure. Since treatment was provided in a group counseling format the limit to confidentiality extends beyond participant-practitioner. Considering the potential time-sensitive nature of coming out concerns for interested participants, a comparison group was not utilized. Instead, individuals who were adequately screened and could attend were considered for the treatment. Finally, this study was voluntary and individuals were permitted to withdraw from the study at any time.

Potential Limitations of the Study

A number of the limitations of this study are delineated in the threats to validity section above. Limitations are noted in areas such as population, research design, instrumentation, and treatment.

Research Design

The quasi-experimental design utilized may pose limitations. The lack of a comparison group causes makes it difficult to attribute difference in scores to the independent variables.

Additionally, since the research occurred in Central Florida, it is unknown whether the results can be transferred to other areas (i.e., rural).

Sampling

Due to the hidden nature of the LGBTQ+ population, it is difficult to estimate generalizability (Gall et al., 2007). Additionally, marginalized status may cause difficulty in acquiring a suitable sample. Specifically, an adequate same size with moderate effect would require 75 participants (Faul et al. 2007). Moreover, these participants needed to be consistent with treatment in order to avoid concerns of subject and measurement attrition.

Another limitation is the age range. A similar age range was chosen to increase cohesiveness and because young adulthood is noted as a pivotal time in development (Dunlap, 2014; Guittar; 2013; HRC, 2013b). However, due to this age range, we cannot be certain whether implications can be drawn for individuals who are not between the ages of 18 and 24. Due to the difficulty in gaining approval for research with minors through the IRB, we are uncertain if the results may apply for individuals under the age of 18. Similarly, we assert that coming out encompasses the lifespan (Ali & Barden, 2015; Dunlap, 2013; Guittar, 2013; HRC, 2013; Rust, 1993); however, the results may *not* apply to individuals beyond the age of 24.

Instrumentation

The detection change in constructs targeted relies heavily on the instruments of choice. Particular attention was given to brief, clear, psychometrically-sound instruments; however, all

instruments have their limitations. Although self-report measures have a weakness, they were needed for the present study as experiences from coming out are personal and unique. Specifically for the *COGS* (Vaughan & Waehler, 2010), due to its recent establishment, reliability and validity evidence to date only exists from the primary creator. Further, this is the first quasi-experimental study to utilize the *COGS* to measure the ability of group treatment to influence coming out growth.

Treatment

Since the treatment is new, individuals may be biased by the appeal; further, since the treatment is intended to assist individuals through the coming out process and self-report measures are used, beliefs of change may influence the reported scores. Although consistency is provided through the use of one facilitator and adherence to a treatment manual, researcher bias and the influence of one facilitator is difficult to account for in scores.

Ray and colleagues' (2011) content analysis of American Counseling Association (ACA) division-affiliated journals ($n = 4,457$) articles from 1998 to 2007 revealed that only 6% of counseling research articles explored effectiveness of counseling interventions. No prior research has been conducted which examines the effects of a coming out counseling group. Therefore, regardless of limitations noted, the present study contributes to needed evidence-based practice research in the counseling field.

Chapter Summary

This chapter reviewed the research methods that used for this investigation examining the impact of an strengths-based group counseling intervention for LGBTQ+ older adolescents on: coping (as measured by the *Brief COPE* [Carver, 1997]), appraisal of social support (as measured by the *Social Support Questionnaire-6* [Sarason et al., 1987]), coming out growth (as measured by the *Coming Out Growth Scale* [Vaughan & Waehler, 2010]), and (d) presence of group therapeutic factors (as measured by the Therapeutic Factors Inventory Short Form [TFI-S; Joyce, et al., 2011]). This chapter provided a detailed description of the design (i.e., comparison group, pretest-posttest quasi-experimental approach with nonrandom assignment) and method of the present study. Threats to validity (i.e., statistical conclusion, construct, internal, and external) are discussed in addition to mechanisms that will be implemented in effort to mitigate these threats. Data collection, including population, sample, recruitment, incentives, and screening, are described. Further, instrumentation for the study, including a rationale for selection of instruments and a discussion of their corresponding psychometric properties, is explained. The primary characteristics of the intervention were introduced. Additionally, research hypotheses and questions were shared along with their data analysis procedures. Finally, ethical considerations and potential limitations of the study were provided.

CHAPTER FOUR: RESULTS

Chapter four presents the results of the current investigation that examined the impact of a strengths-based group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young adults' coping, appraisal of social support, and coming out growth. The research hypothesis guiding the study tested the premise that the participants' scores on the three data collection instruments would increase over time. A one-group pretest-posttest quasi-experimental design was utilized to measure the change in scores over time. Additionally, the influence of group therapeutic factors on participants' coping, social support, and coming out growth scores were analyzed. Finally, the relationship between participants' demographic variables and coping, social support, and coming out growth were examined.

This chapter provides a review of the study's (a) research design; (b) sampling and data collection methods; (c) participants' descriptive data; (d) preliminary data analysis procedures and assumption testing; and (e) data analyses, and (f) results for the primary and exploratory research hypotheses. The chapter concludes with a summary of the meaningful findings of the investigation.

Research Design

This study utilized a one group pretest-posttest quasi-experimental design. Experimental research designs are the most rigorous approach in determining the relationship between independent and dependent variables (Gall et al., 2007). Due to ethical concerns of withholding treatment and the difficulty in attaining an adequate sample from a hidden population, a one-group design was utilized (Shadish et al., 2002). Although some quasi-experimental studies may

have limited internal validity due to the absence of a control group or random assignment, including pretest observations in a one group design provides a comparison condition with less error variance than a two group design, while still avoiding many plausible threats to internal validity when using a non-equivalent control group design. Three data collection points (pretest, midpoint, and posttest) were utilized to provide better insight into change over time (Pallant, 2010). Further, midpoint test, and posttest measures helped to analyze extraneous influence on participants' scores (Dugard & Todman, 1995).

Potential participants were recruited through flyers placed in locations (e.g., classrooms, hallways, Pride Commons, LGBTQ+ Services, Orlando LGBT Center, and Zebra Coalition) and online (websites, social media, and list serves) where members of the LGBTQ+ community would likely see them. Additionally, the researcher made announcements in-person throughout the Central Florida area. Each participant completed a formal prescreening interview with the investigator to ensure that they met the inclusion criteria (see Appendix E for the screening form) and were available for four sessions during the provided time slot. Characteristics for exclusion to participate in the investigation included: (a) being under the age of 18 or over the age of 24; (b) having suicidal or homicidal ideation and (c) active drug use or domestic violence. Individuals who did not meet these criteria were provided appropriate mental health referrals. The intervention was offered at a community counseling and research center (CCRC) in Central Florida.

Data Collection

Institutional review Board (IRB) approval was granted in August of 2015. Data collection took place between September and November of 2015. Data was collected from participants at three points: (a) before the intervention, (b) at the middle of the study (i.e., after the second session), and at the end of the intervention (i.e., after the fourth session). Assessments took approximately 10-15 minutes to complete. During intake, participants were randomly assigned participant identification numbers (e.g., 11). At the first assessment point, participants were made aware of their codes and were instructed to avoid including identifying information on their forms (e.g., name). At each observation point, assessments were provided with manila envelopes labeled with their corresponding number to promote confidentiality and reduce bias (Gall et al., 2007). Physical data was stored in the researcher's locked office. Digital data was stored on the researcher's password-protected computer in a password-protected file.

Sampling Procedures

Sampling

The target population included LGBTQ+ individuals between the ages of 18 and 24. Since it is difficult to estimate the size of the LGBTQ+ population, the researcher opted to recruit from an accessible population in the Central Florida area. Locations in which LGBTQ+ individuals would seek counseling assistance were targeted. College locations were noted as a prime area to attain participants of this age range. The researcher contacted counseling centers at the University of Central Florida (UCF) and Rollins College. Additionally, promotional materials were shared through campus organizations such as UCF LGBTQ+ Services,

department mailing lists, and social media platforms such as Pride Commons. Further, the researcher engaged with the UCF Pride Faculty Association, and was able to reach faculty and staff members who shared with university students. Moreover, the researcher posted recruitment flyers on campus bulletin boards. Since the target population was not limited to students, recruitment extended beyond the campus realm as well. Local LGBTQ+ organizations such as the Zebra Coalition, Aspire Healthcare, and The LGBT Center of Central Florida were instrumental in sharing promotional materials and informing local qualifying youth on the group counseling opportunity.

Response Rates

A total of 45 individuals inquired about participating in the investigation. Following the screening process, 32 individuals were eligible for participation. The seven individuals who were deemed unacceptable for this study were either under the age of 18, over the age of 24, or had active suicidal ideation. All individuals who did not qualify were provided referrals for additional support. Since the intervention follows a group format, individuals needed to have availability that matches other participants in order to be assigned. Of the 32 eligible individuals, 28 had suitable availability and were assigned to one of three groups. All 28 participants completed the initial packet; however, 27 participants completed the second packet (96.43% response rate) and 26 participants completed the third packet (92.86% response rate). Two participants began jobs during the study that conflicted with attendance and needed to drop out of the group. Pallant (2010) asserts that the sample size should be at least more than the number of dependent variables; therefore, the sample utilized is adequate. Additionally, Lipsey (1990)

asserts that at an alpha level of .05, the present sample size meets the criterion to achieve adequate effect sizes (.25) and power (.80) for experimental designs. Finally, the analyses displayed that regardless of sample size, statistically significant results were found with adequate effect sizes and power.

Descriptive Statistics

Although 28 participants began the study, 26 LGBTQ+ individuals provided complete data for this study. The 26 participants whose data is used in this study were university students between the ages of 18 and 24 ($M = 19.96$, $SD = 1.78$, $Mdn = 20$, $Mode = 20$). Seven reported being freshman (26.9%), eight were sophomores (30.8%), six were juniors (23.1%), four were seniors (15.4%), and one student was in graduate school (3.8%). In reference to ethnicity, the majority of participants identified as Caucasian/White ($n = 12$, 46.2%), followed by Hispanic/Latino ($n = 6$, 23.1%), and Multiracial ($n = 4$, 15.3%). One participant identified as Black/African-American (3.8%), one as Asian (3.8%), one as West-Indian (3.8%), and one as Persian (3.8%).

Regarding gender, seven participants identified as male (26.9%), seventeen participants identified as female (65.4%), one participant identified as genderqueer (3.8%), and one participant identified as genderfluid (3.8%). Only one participant identified as transgender. No participants identified as intersex. In terms of affectional orientation, a majority of the participants identified as lesbian ($n = 8$, 30.8%), there was an equal percentage ($n = 7$, 26.9%) of individuals who identified as gay and bisexual. Two participants identified as asexual (7.7%), one participant identified as queer (3.8%), and one participant identified as polysexual/pansexual

(3.8%). A majority of participants were single ($n = 22$, 84.6%) whereas four individuals were in a relationship (15.4%).

Within the topic of coming out concerns, a majority of participants stated that they were actively considering coming out to someone ($n = 16$, 61.5%). Of these individuals, most were planning to come out to immediate family members ($n = 10$, 38.5%), then others to friends ($n = 2$, 7.7%), extended family ($n = 2$, 7.7%), both friends and family (7.7%). Immediate family members included the option of parents and siblings, whereas family included relatives beyond parents and siblings.

Participants were asked to rate how stressful coming out was on a scale of 1-10, most participants rated their coming out stress at 8 ($n = 8$, 34.6%), then 10 ($n = 4$, 15.4%), nine ($n = 4$, 15.4%), seven ($n = 4$, 15.4%), six ($n = 3$, 7.7%), five ($n = 3$, 7.7%), and only one participant rated coming out stress at two (3.8%). Additionally, participants were asked to rate their level of openness with their LGBTQ+ identity on a scale of 1-10, where most participants identified as 8 in outness (30.8%) then 7 (19.2%), 5 (19.2%), 9 (15.4%), 3 (7.7%), 4 (3.8%), and 6 (3.8%).

Instrument Data

Coping

The 28-item *Brief COPE* (Carver, 1997) was developed on the foundation of theoretical models of coping, such as the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984). The *Brief COPE* (Carver, 1997) can be found in Appendix I. The COPE subscales measure essential aspects of coping which include: (a) active coping, (b) planning, (c) using instrumental support, (d) using emotional support, (e) venting, (f) self-distraction, (g) positive

reframing, (h) humor, (i) acceptance, (j) religion, (k) behavioral disengagement, (l) self-blame, (m) denial, and (n) substance use. Items are assessed on a four-point Likert scale. Examples of items include: “I have been taking action to try to make the situation better,” and, “I’ve been looking for something good in what is happening.” Response options include (a) “I don’t usually do this at all,” (b) “I usually do this a little bit,” (c) “I usually do this a medium amount,” and (d) “I usually do this a lot.” The *Brief COPE* was *not* intended to be in a measure of total scores; instead, it is suggested to use the instrument in reference to positive and negative coping strategies (Hampel & Petermann, 2005; Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006). Therefore, the *Brief COPE* is examined in reference to two categories: *Adaptive Coping* (subscales 1-10: active coping, planning, using instrumental support, using emotional support, venting, self-distraction, positive reframing, humor, acceptance, and religion) and *Maladaptive Coping* (subscales 11-14: behavioral disengagement, self-blame, denial, and substance use).

When examining Cronbach’s alpha, values below .7 are considered to demonstrate low reliability, values above .7 are considered to be acceptable, and values above .8 are high (Pallant, 2010). In Griffith’s (2014) quasi-experimental study examining the influence of group counseling on LGB young adults adequate or high reliability was noted for both *Adaptive Coping* ($\alpha = .81, .83, .85$) and *Maladaptive Coping* ($\alpha = .88, .84, .84$) at pretest, midpoint, and posttest points. In the present study, *Adaptive Coping* displayed high internal consistency at all observation points: pretest ($\alpha = .85$), midpoint ($\alpha = .80$), and posttest ($\alpha = .84$). *Maladaptive Coping* scores displayed adequate internal consistency for pretest ($\alpha = .72$), midpoint ($\alpha = .70$) and posttest ($\alpha = .71$) scores. Descriptive statistics for the *Brief Cope* are presented in Table 1.

Social Support

The *Social Support Questionnaire 6* (SSQ6; Sarason et al., 1987) is 6-item measure that assesses perceived social support (SSQ-N), and the satisfaction with perceived social support (SSQ-S). This abbreviated measure can be found in Appendix J. The SSQ6 has internal reliabilities ranging from .90-.93 on both subscales. In the present study SSQ-N, pretest ($\alpha = .93$), midpoint ($\alpha = .98$), and posttest ($\alpha = .94$) scores all displayed high internal consistency. The SSQ-S internal consistency scores were adequate for pretest ($\alpha = .88$), midpoint ($\alpha = .88$), and posttest ($\alpha = .87$) assessment points. Descriptive statistics for the *Social Support Questionnaire 6* are presented in Table 1.

Coming out Growth

Vaughan and Waehler's *Coming Out Growth Scale* (COGS; 2010) measures the perceived gains an individual achieves from coming out. The COGS can be utilized in terms of overall scores or subscale scores. The 34-item version COGS is utilized in order to allow for an examination of intrapersonal and interpersonal dimensions of growth. The *individualistic growth* subscale of the COGS (Vaughan & Waehler, 2010) has 21 items and the *collectivistic growth* subscale has 13 items. The intrapersonal growth dimension includes perceived gains in authenticity/honesty, biopsychosocial well-being, and sexual minority identity. The interpersonal growth dimension captures growth in LGBT-affirming views, a sense of belonging, and a collective LG identity. The COGS implemented in this study can be found in Appendix J.

The *individualistic growth* subscale of the COGS (Vaughan & Waehler, 2010) has a reliability of .96 and the *collectivistic growth* subscale has a reliability of .88. In the present

study, internal consistency for the subscale of *individualistic growth* was high for pretest ($\alpha = .96$) and midpoint scores ($\alpha = .83$), and posttest ($\alpha = .96$) scores. Similarly, internal consistency for the *collectivistic growth* subscale was high for pretest ($\alpha = .91$) and midpoint ($\alpha = .96$), and posttest scores ($\alpha = .91$). Descriptive statistics for the *Coming Out Growth Scale* are presented in Table 1.

Group Therapeutic Factors

The *Therapeutic Factors Inventory 19* (TFI-19; Joyce et al., 2011) was designed to measure the effectiveness of group counseling (e.g., curative factors and dynamics). The *TFI-19* is a shortened version of the 99-item *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). The version utilized in this study can be seen in Appendix L. The *TFI-19* is based off of Yalom's 11 therapeutic factors and higher scores demonstrate participants' positive experiences within group. In this study, the *TFI-19* is analyzed by subscale scores. The four TFI subscales include: (a) *Instillation of Hope*, (b) *Secure Emotional Expression*, (c) *Awareness of Relational Impact*, and (d) *Social Learning*. Items are formatted on a seven-point Likert-type scale ranging from strongly disagree to strongly agree.

Table 1:

Instrument statistics for the Brief COPE, SSS-6, and COGS

Descriptive Statistics	<i>M</i>	<i>Mdn</i>	Mode	<i>SD</i>	Range	Min.	Max.
<i>Brief COPE – Adaptive</i>							
Pretest	56.04	58.00	58.00	9.29	34.00	38.00	72.00
Midpoint	54.65	55.50	42.00	7.57	24.00	42.00	66.00
Posttest	57.88	60.00	65.00	9.09	34.00	39.00	73.00
<i>Brief COPE – Maladaptive</i>							
Pretest	13.19	12.50	18.00	.48	14.00	8.00	22.00
Midpoint	12.31	12.00	9.00	.42	12.00	8.00	20.00
Posttest	11.92	11.00	8.00	.45	13.00	8.00	21.00
<i>Social Support Questionnaire 6-Number</i>							
Pretest	4.51	4.08	4.17	2.04	8.00	1.00	9.00
Midpoint	4.76	4.50	4.50	2.56	8.33	.67	9.00
Posttest	5.76	5.83	9.00	2.53	8.00	1.00	9.00
<i>Social Support Questionnaire 6-Satisfaction</i>							
Pretest	5.04	5.33	5.00	.84	3.00	3.00	6.00
Midpoint	4.99	5.42	5.50	1.03	4.00	2.00	6.00
Posttest	5.51	5.67	6.00	.65	3.17	4.00	7.17
<i>Coming Out Growth Scale-Individualistic Growth</i>							
Pretest	80.73	82.50	80.00	18.26	74.00	32.00	106.00
Midpoint	84.23	86.50	84.00	19.09	87.00	27.00	114.00
Posttest	92.77	98.50	106.00	15.99	67.00	43.00	110.00
<i>Coming Out Growth Scale-Collectivistic Growth</i>							
Pretest	43.61	45.00	45.00	9.37	40.00	17.00	57.00
Midpoint	44.77	46.00	51.00	10.10	43.00	16.00	59.00
Posttest	48.58	49.50	56.00	9.71	41.00	19.00	60.00

According to Joyce and colleagues (2011), the subscales display good internal consistency (*Instillation of Hope* [$\alpha = .90$], *Secure Emotional Expression* [$\alpha = .85$], *Awareness of Interpersonal Impact* [$\alpha = .79$], and *Social Learning* [$\alpha = .66$]). Additionally, a quasi-experimental study of counselors-in-training participating in multicultural growth groups provided further support for the internal consistency of the subscales: *Instillation of Hope* ($\alpha = .65$), *Secure Emotional Expression* ($\alpha = .52$), *Awareness of Relational Impact* ($\alpha = .88$), and *Social Learning* ($\alpha = .88$; Johnson & Lambie, 2013). Furthermore, a quasi-experiential study exploring the influence of group counseling on LGBTQ young adults found that the Cronbach's alpha for the *TFI-19* subscales were acceptable (*Instillation of Hope*, $\alpha = .84$; *Secure Emotional Expression*, $\alpha = .78$; *Awareness of Relational Impact*, $\alpha = .85$; and *Social Learning*, $\alpha = .86$; Griffith, 2014). In the current study, internal consistency for all *TFI-19* subscales were questionable (*Instillation of Hope* [$\alpha = .62$], *Secure Emotional Expression* [$\alpha = .67$], *Awareness of Interpersonal Impact* [$\alpha = .60$], and *Social Learning* [$\alpha = .54$]). Descriptive statistics for the *Therapeutic Factors Inventory* are presented in Table 2.

Table 2

Instrument statistics for the *TFI-19*

Descriptive Statistics	<i>M</i>	<i>Mdn</i>	Mode	<i>SD</i>	Range	Min.	Max.
<i>Instillation of Hope</i>	6.40	6.63	7.00	.60	1.75	5.25	7.00
<i>Secure Emotional Expression</i>	6.28	6.28	6.29	.39	1.43	5.57	7.00
<i>Awareness of Relational Impact</i>	6.18	6.30	7.00	.73	2.20	4.80	7.00
<i>Social Learning</i>	5.83	5.83	7.00	.92	3.00	4.00	7.00

Data Analysis

The purpose of this study was to understand whether LGBTQ+ young adults who participated in an affirmative group counseling intervention would experience an: (a) increase in adaptive coping; (b) decrease in maladaptive coping; (c) increase in the size of their social support system; (d) increase in satisfaction with their social support system; (e) increase in individualistic coming out growth; and (f) increase in their collectivistic coming out growth. In addition to the effect of the overall intervention, this investigation examined the relationship between group therapeutic factors and coping, social support, and coming out growth scores. Furthermore, the correlation between the participants' demographic data and their coping, social support, coming out growth scores were examined.

Primary Research Question

A repeated measures multivariate analysis of variance (RM-MANOVA) was utilized in order to determine whether the intervention had an impact on participants' coping, social support, and coming out growth scores over time. Statistical assumptions were addressed prior to analyzing the data for the research questions. Essential assumptions for a RM-MANOVA include: (a) sample size, (b) multivariate normality, (c) linearity among dependent variables, (d) homogeneity of variance, and (e) sphericity among dependent variables. Pallant (2010) asserts that at minimum the dataset should include more cases than dependent variables, which is satisfied by the current study. High power was displayed for the overall model and the subscales of *Social Support Number*, *Social Support Satisfaction*, *Collectivistic Growth*, and *Individualistic Growth* (Pallant, 2010). The effect size for the overall model was large (.85) as well as for *Social*

Support Number (.25), *Social Support Satisfaction* (.29), *Collectivistic Growth* (.28), and *Individualistic Growth* (.25).

Visual inspection of the Q-Q plots resulted in apparent normality for all subscales. Linearity was further clarified by test of within-subjects contrasts which indicated the coping subscales were not linearly related to one another ($p > .05$); however, *Social Support Number* ($p < .01$), *Social Support Satisfaction* ($p < .01$), *Collectivistic Growth* ($p < .001$), and *Individual Growth* ($p < .001$) subscales were linear. Mauchly's Test of Sphericity indicated that sphericity was assumed for *Adaptive Coping* ($p = .75$), *Maladaptive Coping* ($p = .65$), *Social Support Satisfaction* ($p = .47$), *Collectivistic Growth* ($p = .98$), and *Individualistic Growth* ($p = .42$). However, the assumption was violated for *Social Support Number* ($p = .04$); therefore, in order to correct for this violation Greenhouse-Geisser was utilized when examining *Social Support Number*. When checking multivariate normality, a test of Mahalanobis distance (23.54) exceeded the critical value (22.46), indicating multivariate nonnormality. However, MANOVA is robust against lack of multivariate normality (Stevens, 2007)

Inferential Results. A RM-MANOVA confirmed that there was a multivariate within-subjects effect across time, Wilks' $\lambda = .147$, $F(12, 14) = 6.77$, $p < .001$, and 84% of the variance was accounted for by the intervention (time). Analysis of univariate tests indicated that *Maladaptive Coping* ($F[2, 50] = 1.45$, $p = .24$, partial $\eta^2 = .06$) did *not* exhibit change over time. Additionally, *Adaptive Coping* ($F[2, 50] = 3.15$, $p = .05$, partial $\eta^2 = .11$) was not statistically significant due to the lack of support from pairwise comparisons. However, *Social Support Number* ($F[1.63, 68.18] = 13.94$, $p < .01$, partial $\eta^2 = .25$), *Social Support Satisfaction* ($F[2, 50] = 10.35$, $p < .01$, partial $\eta^2 = .29$), *Individualistic Growth* ($F[2, 50] = 8.22$, $p < .01$, partial $\eta^2 =$

.25), and *Collectivistic Growth* ($F [2, 50] = 9.85, p < .001, \text{partial } \eta^2 = .28$) exhibited significant change. Power to detect changes was high for *Social Support Number* (.95), *Social Support Satisfaction* (.98), *Individualistic Growth* (.94), and *Collectivistic Growth* (.98).

An examination of pairwise comparisons provided more detail into the changes over time. None of the subscales indicated significant changes over time between the pretest and midpoint observation points; however, significant change was noted from pretest to posttest for *Social Support Number*, *Social Support Satisfaction*, *Individualistic Growth*, and *Collectivistic Growth* and from midpoint to posttest. *Social Support Number*, *Individualistic Growth*, and *Collectivistic Growth* scores displayed a general increase over time between points. The mean scores are presented in Figures 1-6.

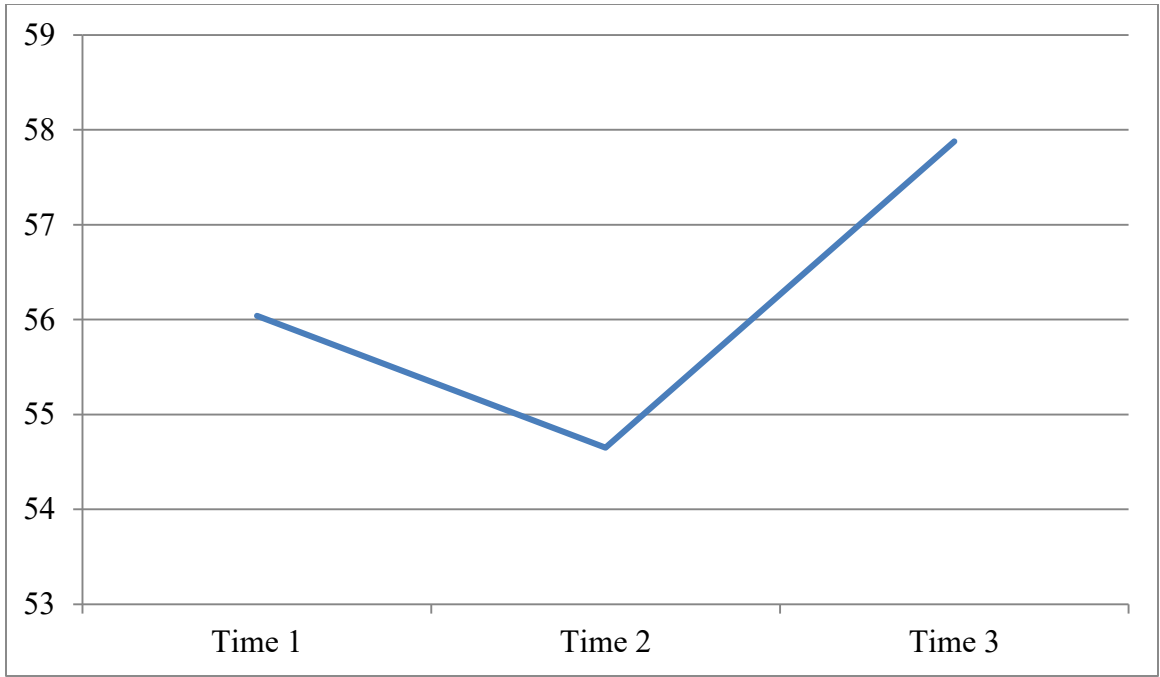


Figure 1: Mean scores for Adaptive Coping

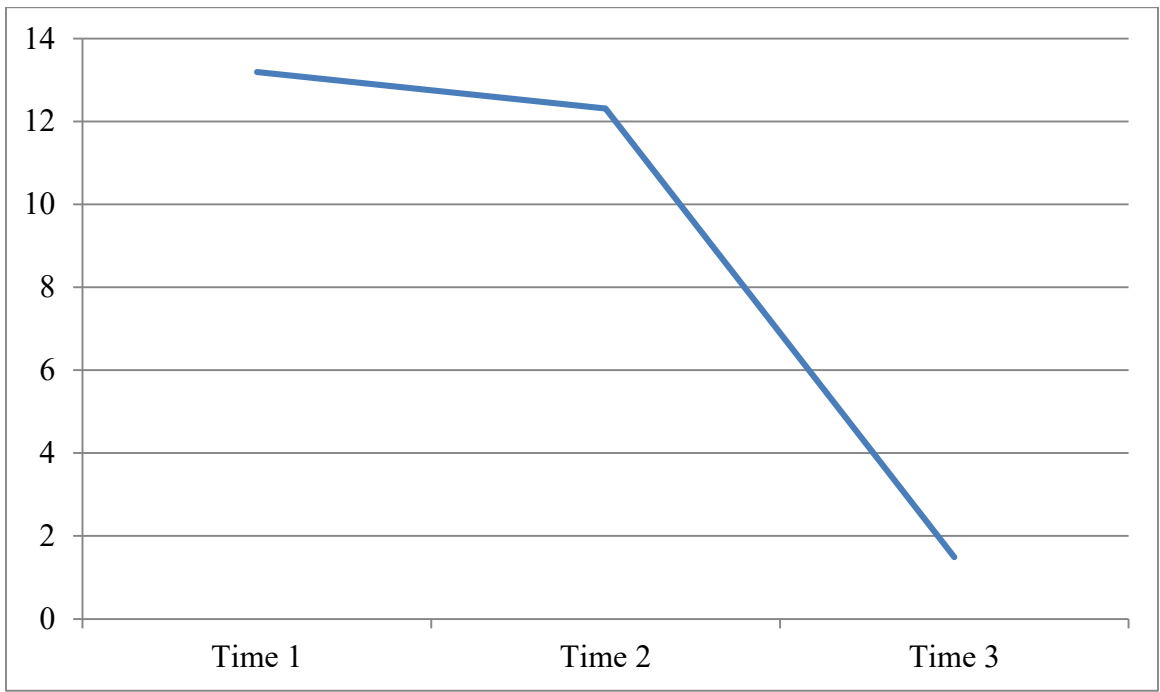


Figure 2: Mean scores for Maladaptive Coping

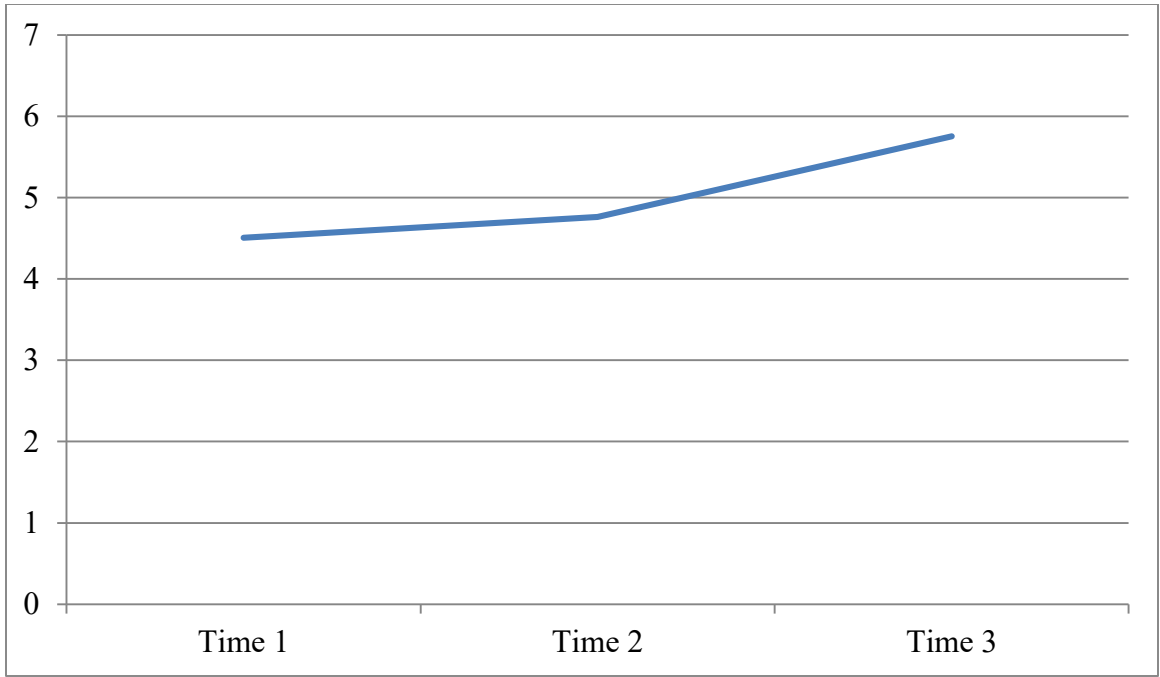


Figure 3: Mean scores for Social Support Number

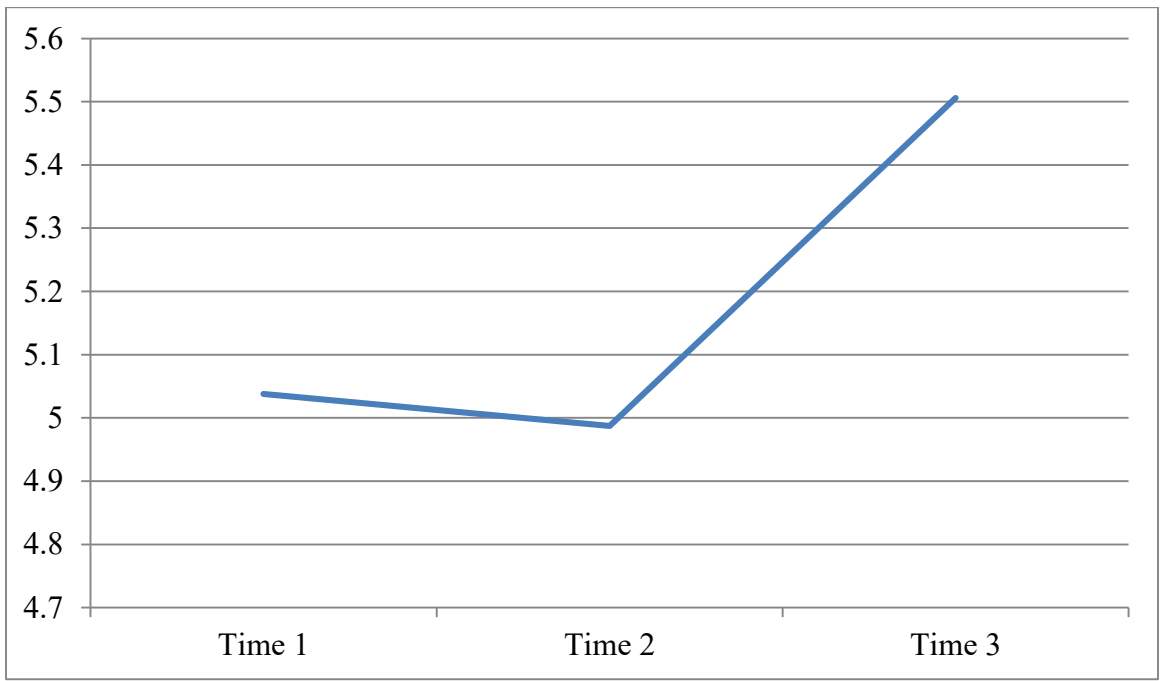


Figure 4: Mean scores for Social Support Satisfaction

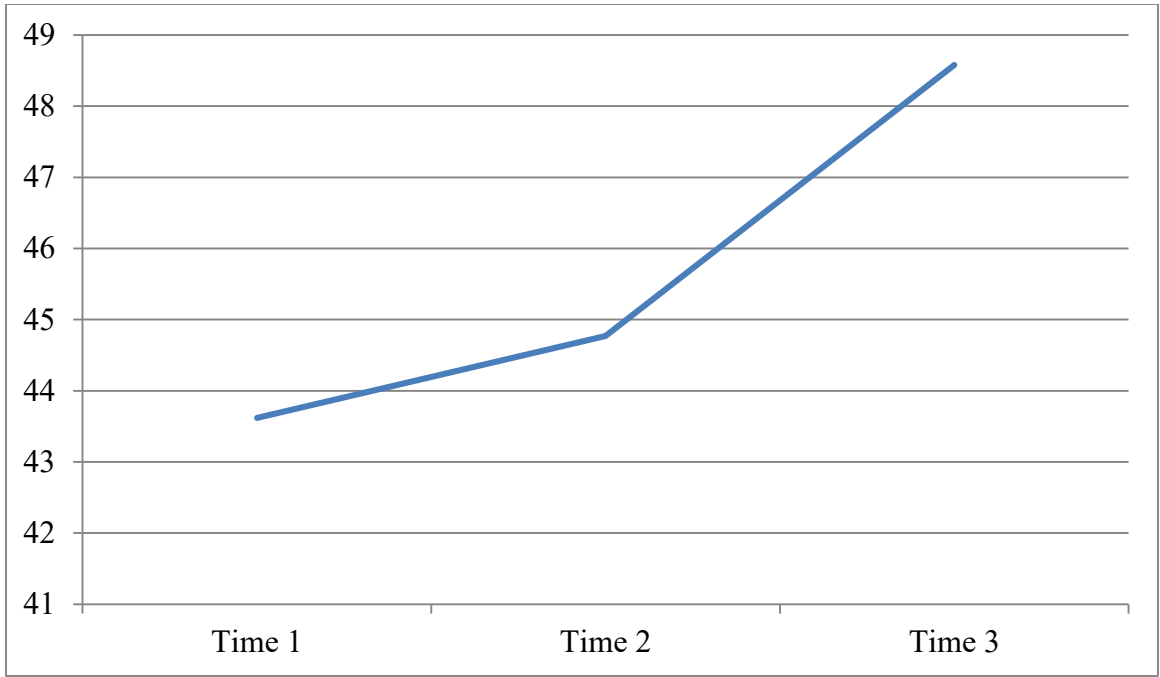


Figure 5: Mean scores for Collectivistic Growth

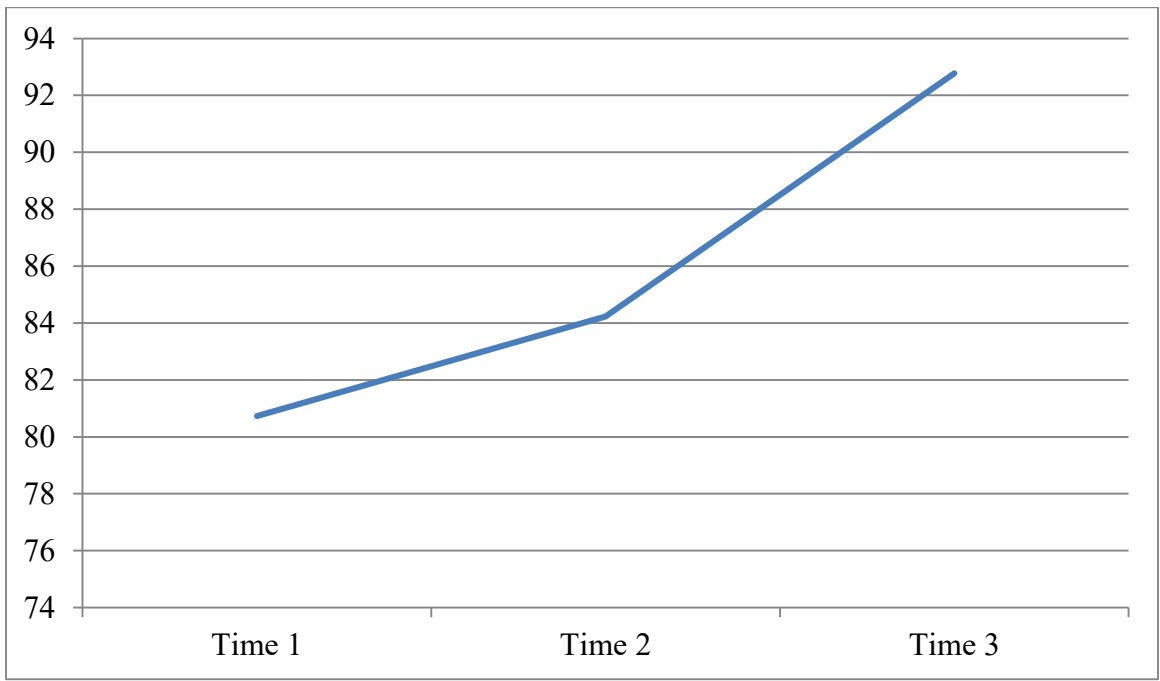


Figure 6: Mean scores for Individualistic Growth

The results indicate that the influence of the group counseling intervention promoted change over time. Specifically, the data analyses identified that improvement in scores occurs within all of the subscales for social support and coming out growth. Furthermore, *Social Support Number* ($\eta^2 = .25$, $1 - \beta = .92$), *Social Support Satisfaction* ($\eta^2 = .29$, $1 - \beta = .98$), *Individualistic Growth* ($\eta^2 = .25$, $1 - \beta = .95$), and *Collectivistic Growth* ($\eta^2 = .28$, $1 - \beta = .98$) demonstrated large effect sizes and high power (Cohen, 1988; Pallant, 2010). Therefore, the results of the analysis with these data promoted strong evidence to support the utility of the group counseling intervention with this sample of participants.

Exploratory Research Question 1

The first exploratory research question sought to understand whether there was a relationship between LGBTQ+ young adults' group therapeutic factors (*Therapeutic Factors Inventory-Short Form* [TFI-S]; Joyce et al., 2011) scores and their levels of coping, appraisal of social support, and coming out growth. Therefore, a canonical correlation was utilized to determine whether there was a relationship between the TFI-S subscales (i.e., *Instillation of Hope*, *Awareness of Relational Impact*, *Social Learning*, and *Secure Emotional Attachment*) and the subscales from each measure of coping, social support, and coming out growth.

Multicollinearity was assessed by examining Pearson correlations, tolerance and variance inflation factors (VIF). The correlations in Table 3 show potential concerns with multicollinearity ($r < .7$). However, tolerance and VIF were suitable, as no tolerance value was less than .1 and no VIF exceeded 10. Inspection of the scatterplots and normal probability plots did not indicate obvious evidence of non-linearity. The residual statistics from a series of

multiple, linear regressions were normally distributed. All skewness nor kurtosis values were between -3 through +3, and no univariate or multivariate outliers were indicated by Mahalanobis tests, or Cook's Distances.

The canonical correlation analysis tested four possible canonical roots. Together, the four roots found a statistically significant relationship between group therapeutic factors and the psychological outcome variables, $F(24, 57.03) = 2.15, p < .01$. However, of these four roots, only one was statistically significant. The canonical correlation from the first root was .88 (with 77% overlapping variance), the second canonical correlation was .60 (36% overlapping variance), the third canonical correlation was .49 (24% overlapping variance), and the fourth was effectively zero. Although the canonical correlations suggest that, even after accounting for shared correlation between the sub-factors for each measure, there was a relationship between the group therapeutic factors and the outcome variables; this does not tell us which specific variables relate to each other, and it was possible that multicollinearity affected the result, since only one canonical correlations was significant. Therefore the Pearson correlations reported in Table 3 were used to interpret these relationships.

Significant, positive relationships were found between *Adaptive Coping*, *Individualistic Growth*, *Collectivistic Growth* and each of the four group therapeutic factors, but *Maladaptive Coping*, *Social Support Number*, and *Social Support Satisfaction* were not related to any of the therapeutic factors. *Installation of Hope* was strongly correlated with *Adaptive Coping* ($r = .68, p < .001$), *Individualistic Growth* ($r = .71, p < .001$), and *Collectivistic Growth* ($r = .52, p < .01$). *Secure Emotional Expression* was moderately correlated with *Adaptive Coping* ($r = .47, p < .05$) and *Individualistic Growth* ($r = .47, p < .05$); however, a strong relationship was detected with

Collectivistic Growth ($r = .52, p < .05$). The *Awareness of Interpersonal Impact* subscale displayed a strong correlation with *Adaptive Coping* ($r = .52, p < .01$), and moderate relationships with *Individualistic Growth* ($r = .47, p < .05$) and *Collectivistic Growth* ($r = .47, p < .05$). Finally, *Social Learning* was strongly correlated with *Adaptive Coping* ($r = .72, p < .001$), *Collectivistic Growth* ($r = .69, p < .001$), and *Individualistic Growth* ($r = .71, p < .001$).

Table 3

Correlations between Group Therapeutic Factors and Coping, Social Support, and Coming out Growth

	<i>Instillation of Hope</i>		<i>Secure Emotional Expression</i>		<i>Awareness of Relational Impact</i>		<i>Social Learning</i>	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
<i>Adaptive Coping</i>	.68	<.01	.47	.01	.52	<.01	.72	<.01
<i>Maladaptive Coping</i>	-.21	.15	-.06	.39	-.05	.40	.06	.37
<i>Social Support Number</i>	.15	.23	.06	.39	.03	.44	.29	.07
<i>Social Support Satisfaction</i>	.19	.18	-.02	.47	.24	.12	.26	.10
<i>Collectivistic Growth</i>	.52	<.01	.52	<.01	.46	.04	.69	<.01
<i>Individualistic Growth</i>	.71	<.01	.47	.01	.56	<.01	.71	<.01

Exploratory Research Question 2

The final research inquiry sought to determine if a relationship exists between LGBTQ+ young adults' reported demographic variables (i.e., *age, age of questioning, age of disclosure, gender, planning to disclose, ethnicity, affectional orientation, and education*) and their levels of coping, appraisal of social support, and coming out growth. For continuous variables (i.e., *age, coming out stress, outness*), a Pearson Product Moment Correlation was utilized. When two or more groups were being examined a MANOVA was utilized to explore the demographic variable.

A Pearson Product Moment Correlation (two-tailed) was used to calculate whether there was a significant relationship between participants' demographic traits, which included *age, the age in which participants' began to question their identity, and the age in which participants first told someone about their LGBTQ+ identity, coming out stress, and level of outness* and each of the dependent variables in the primary research question. Examination of scatterplots generally suggested low to no correlation, did not display curvilinear relationships, and extreme outliers were not noted. The only significant relationship between the pairs of variables was between *age of questioning* and *Collectivistic Growth*, which had a negative relationship ($r = -.46, p = .02$).

In reference to gender in the sample, seven individuals identified as male and 17 individuals identified as female. Only two participants identified beyond the gender binary: one identified as transgender and one identified as genderfluid. Therefore, due to the small representation of gender variance, only cisgender men and cisgender women were compared. Hotelling's Trace, a multivariate t-test, was used to compare males and females' posttest scores for coping, social support, and coming out growth. Statistical assumptions were tested prior to

the analysis. Mahalanobis' maximum distance (14.23) did not exceed the critical value (22.46), Box's M test showed that homogeneity of variance was not violated ($p = .04$), and Levene's test of equality of variance indicated that homogeneity of variance between groups was not violated for any dependent variable. The omnibus multivariate test indicated that there was no significant difference in coping, social support, or coming out growth scores between males and females, $T^2 = .35$, $F(6, 17) = 1.00$, $p = .45$.

In reference to disclosure plans, 16 participants shared that were actively planning to disclose whereas 10 were not. Assumptions were tested prior to the analysis. Mahalanobis' maximum distance (15.16) did not exceed the critical value (22.46), Box's M test showed that homogeneity of variance was not violated ($p = .66$), and Levene's test of equality of variance indicated that homogeneity of variance between groups was not violated. The results indicated that there was no significant difference in coping, social support, or coming out growth scores between individuals who were actively planning to disclose and individuals who were not actively planning to disclose, $T^2 = .16$, $F(6, 19) = .56$, $p = .76$.

In reference to ethnicity, a majority of the sample ($n = 12$) identified as White, and then followed by Hispanic/Latino ($n = 8$). Three participants identified as multiracial (2 or more races), one participant identified as multiracial (3 or more races), one participant identified as Asian, one participant identified as Black, one participant identified as West Indian, and one participant identified as Persian. Due to the small representation of diversity, the *ethnicity* variable was transformed to White (12) and non-White (16). Assumptions were tested prior to the analysis. Mahalanobis' maximum distance (15.16) did not exceed the critical value (22.46), Levene's test showed that homogeneity of variance was assumed in all of the subscales, and

Box's M test showed that homogeneity of variance was not violated ($p = .01$). The results indicated that there was no significant difference in coping, social support, or coming out growth scores between individuals who were White or non-White, $T^2 = .31$, $F(6, 19) = .99$, $p = .46$.

A MANOVA was used to explore how *affectional orientation* was related to the coping, social support, and coming out growth subscales. Seven individuals identified as gay, eight individuals identified as lesbian, and six individuals identified as bisexual. Two participants identified as asexual, one participant identified as polysexual and one participant identified as queer. Due to the small representation of polysexual, queer, and asexual individuals, only lesbian, gay, and bisexual participants were compared. Assumptions were tested prior to the analysis. Mahalanobis' maximum distance (14.13) did not exceed the critical value (22.46). Levene's test displayed that homogeneity of variance was assumed. Additionally, Box's M test showed that homogeneity of variance was not violated ($p = .07$). A MANOVA indicated that there were no statistically significant differences between the three groups for coping, social support, or coming out growth scores, (Wilks' $\lambda = .44$, $F(12, 28) = 1.20$, $p = .33$).

In reference to *education*, seven participants were freshmen, eight participants were sophomores, eight participants were juniors, four participants were seniors, and one participant was a graduate student. Since the one graduate student was not significantly different in age, the senior and graduate student categories were collapsed for the analysis. A MANOVA was used to calculate whether there was a relationship between participants' level of education (i.e., freshman, sophomore, junior, and senior/grad) and coping, appraisal of social support, and coming out growth scores. Assumptions were tested prior to the analysis. Mahalanobis' maximum distance (15.16) did not exceed the critical value (22.46). However, Box's M test

showed that homogeneity of variance was violated ($p < .001$). Levene's test displayed that homogeneity of variance was assumed. A MANOVA indicated that there were no statistically significant differences between the three groups for coping, social support, or coming out growth scores, (Wilks' $\lambda = .40$, $F(18, 48.57) = 1.02$, $p = .46$).

Summary

This chapter presented the detailed results for the statistical analyses run in the investigation. Major findings included a significant change in scores in time throughout the intervention, especially in reference to the constructs of social support and coming out growth. Additionally, relationships were noted between the outcome variables of *Individualistic Growth*, *Adaptive Coping*, and *Collectivistic Growth* and all of the group therapeutic factors of *Secure Emotional Expression*, *Awareness of Relational Impact*, and *Social Learning*. Furthermore, age of questioning was positively correlated with *Collectivistic Growth*. A discussion of the results provided in this chapter are found in the following chapter in addition to implications for counseling and counselor education, limitations of the present study, and directions for future research.

CHAPTER FIVE: DISCUSSION

The purpose of Chapter Five is to provide an overview of the study and discussion of the results. Chapter Five expands on the analyses presented in Chapter Four, and compares the results to findings discussed in Chapter Two. Moreover, this chapter integrates the results of the present investigation with the context of the literature and provides implications for counseling and counselor education. Furthermore, limitations of the study and recommendations of future research are provided.

Overview

Lesbian, gay, bisexual, transgender, and queer individuals, and those who otherwise identify as a minority in terms of affectional orientation and gender expression identity (LGBTQ+) have a higher rate of mental health concerns than their heterosexual and cisgender counterparts (Meyer, 2003). One of the reasons for these increased mental health concerns may be that LGBTQ+ individuals are often stigmatized and marginalized by society (Human Rights Campaign [HRC], 2013b; Savin-Williams, 2001). Although times have changed, evidence of marginalization towards LGBTQ+ individuals remains. Indication of marginalization of LGBTQ+ individuals at the macro level includes the lack of civil rights such as adoption, medical care, and workplace safety (Meyer, 2003; PEW Research Center, 2014). At a micro level, LGBTQ individuals often face prejudice, bias, and violence from peers (Kosciw, Greytak, Diaz, & Bartkiewicz, 2014; HRC, 2013b). Young adulthood is a difficult time for individuals who identify as LGBTQ+ as internal identity development processes coincide with stressors from the outside world. The conflict between intrapersonal and interpersonal pressures may

evoke a multitude of negative emotions such as anxiety, loneliness, isolation, fear, anger, resentment, shame, guilt, and fear (e.g., Kosciw et al., 2014; Vaughan & Waehler, 2010).

One difficult task that triggers these depreciating sentiments is managing the process of coming out during LGBTQ+ young adulthood. The tumultuous, transformative coming out process prompts stressors that may cause the increase of mental health concerns for the LGBTQ+ population (Baams, Grossman, & Russell, 2015; Budge, Rossman, & Howard, 2014; Matthews & Salazar, 2012). When coming out, individuals require coping, social support, and intrapersonal strength to persevere and progress onto a healthy adulthood (Meyer, 2003; Meyer, Schwartz, & Frost, 2008; Murdoch & Bolch, 2005; Needham & Austin, 2010). Although counselors recognize the need and lack of counselor competency to assist LGBTQ+ individuals, there is limited (a) client-based outcome research and (b) intervention research to assert the efficacy of methods to assist LGBTQ+ young adults during the coming out process (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2013; Bidell, 2005, 2012; Graham, Carney, & Kluck, 2012; Farmer et al., 2013; Israel, Ketz, Detrie, Burke, & Shulman, 2008). Specifically, *no* studies were found that examined the efficacy of a group counseling intervention to assist LGBTQ+ young adults through the coming out process. Moreover, group counseling was selected because it offers the chance for professional help in a supportive environment which appears to be well suited for the coming out process and for the social needs of the target population (Goodrich & Luke, 2015; Griffith 2013).

Summary of the Study

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. Specifically, the researcher sought to understand whether LGBTQ+ young adults who participated in an affirmative group counseling intervention would experience an: (a) increase in adaptive coping; (b) decrease in maladaptive coping; (c) increase in the size of their social support system; (d) increase in satisfaction with their social support system; (e) increase in individualistic coming out growth; and (f) increase in their collectivistic coming out growth. In addition to the effect of the overall intervention, this investigation examined the relationship between group therapeutic factors and coping, social support, and coming out growth scores. Furthermore, the relationships between the participants' demographic data and their coping, social support, coming out growth scores were examined.

Theoretical Constructs

This research is based in the theory and research pertaining to four constructs of interest: (a) coping, (b) social support, (c) coming out growth, and (d) group therapeutic factors. The following section provides a brief overview to these four constructs including theoretical foundation and instruments selected for the study.

Coping. In Lazarus and Folkman's (1984) transactional model of stress and coping stress is conceptualized as the product of internal factors (e.g., personality) and external factors (e.g., environmental influences). Coping is noted as the active use of cognitive and behavioral mechanisms to respond to stress. Thus, coping mechanisms are not only the armor, but also the

artillery in combatting life's widespread stressors. Beyond internal and external factors, Ilan Meyer (1995) highlights that in the lives of minority individuals, expectations also prompt stress. Minorities do *not* need to directly experience prejudice or threats to perceive the impact of stress; recognizing stressors on individuals of the same community has the power to provoke stressful sentiments (Meyer, 2003; 2010). For example, LGBTQ+ persons endure minority stress as norms and structures conflict those of the dominant culture (Meyer, 2003). Minority stress is not limited to experience of external events; stressors may arise from direct or expectations of acute or chronic external events and conditions as well as from internalization of negative societal attitudes (Meyer, 2014). Research displays the widespread areas in which LGBTQ+ individuals endure stress which include (a) victimization (e.g., Berlan, Corliss, Field, Goodman, & Austin, 2010), (b) mental health (e.g., Nadal et al., 2011), (c) physical health (e.g., Almeida et al., 2009), (d) environmental considerations (e.g., Downs, 2009; PEW Research Center), and (e) coming out stress (e.g., D'Augelli, 2005; Holder, 2015).

The process of coming out is an ongoing process which prompts stress throughout the lifetime (Ali & Barden, 2015; D'Augelli, 2005); including, but are *not* limited to, fears pertaining to acceptance, bullying, harassment, safety, and oppression (Coker, Austin, & Schuster, 2010; Kosciw et al., 2014). LGBTQ+ individuals may endure stress from anticipated negative reactions from peers, family, and friends (Meyer, 2003). Researchers have explored the experience of coming out and have noted that during the process individuals are susceptible to anxiety, depression (Baams, Grossman, & Russell, 2015; Dunlap, 2014a), low self-esteem (Fankhanel, 2010), and poor self-acceptance (Holder, 2015). Common coming out stressors include isolation and alienation (Dunlap, 2014b; Flowers & Buston, 2001; HRC, 2013b). Often LGBTQ+ persons

are at risk for being marginalized from their families, religious institutions, and overall communities.

In recognizing the variety of stressors LGBTQ+ persons endure, especially during coming out, the importance of coping is recognized (Dunlap, 2014a; Kosciw et al., 2014). Facilitative coping such as seeking help has been related to reduced anxiety, whereas avoidant coping has been correlated with increasing anxiety and depression (Budge, Rossman, & Howard, 2014). Contrastingly, maladaptive methods of coping such as substance use (D'Augelli, Grossman, Hershberger, & O'Connell; Holder, 2015) are associated with passive avoidance, ruminating, aggressive reactions, and resigning oneself to the situation (Newman, 2008). Common methods of adaptive coping in the literature include having supportive relationships, having a helpful community, involvement in LGBT clubs, access to education, and access to therapy (Dunlap, 2014b; Holder, 2015; HRC, 2013b).

Social Support. Social support can be defined as the existence of individuals and relationships that we value and can rely on and the provision of resources received from those individuals (Cohen, 2004; Lopez & Cooper, 2011). Social support is conceptualized to influence stress, well-being, social functioning, self-esteem, self-efficacy, and problem solving behaviors (Cohen, 2004; Lopez & Cooper, 2011). Social support is believed to be the facilitator of coping which in turn reduces negative effects of stress and overall well-being (Lopez & Cooper, 2011).

Although social support scholars concur that the construct is multidimensional, there is a lack of consensus on the conceptual aspects of social support (Lopez & Cooper, 2011). Lopez and Cooper (2011) conceptualize social support in three categories: (a) connectedness or embeddedness, (b) actual or enacted, and (c) perceived. Researchers have examined the appraisal

of social support (e.g., Sarason & Sarason, 1986; Sarason et al., 1987) and concluded that when there is an absence of actual support, an individual's appraisal of perceived support has been capable of reducing the impact of stress (e.g., Gjesfjeld, Greeno, Kim & Anderson, 2010). Due to the inability to directly manipulate a participant's social structure, particularly within the time range of the intervention, perceived social support was targeted in this study. Furthermore, considering the high stress and need for coping in the LGBTQ+ young adult population, perceived support is a necessary variable in enhancing social relationships and overall well-being (Cohen, 2004; Sarason & Sarason, 1986).

Coming out Growth. Stress-related growth (SRG) refers to the concept that stressful occurrences provide prospects for growth (Park, Cohen, & Murch, 1996). Stress-related growth has been linked to traumatic events such as illnesses (Siegel & Schrimshaw, 200; Weiss, 2002) and bereavement (Parappully, Rosenbaum, van den Daele, & Nzewi, 2002). Following a stressful event, individuals may have experience beneficial changes in (a) personal resources, (b) social relationships, and (c) coping resources (Carver, 1998; O'Leary, 1998).

Coming out is a stressful, ongoing, and transformative process that encompasses the lifespan. Coming out stressors may be triggered during the intrapersonal process of development or during the interpersonal process of disclosure. Considering the stressors of coming out, paired with overall minority identity stress, the coming out process may provide opportunities for growth (Vaughan & Rodriguez, 2014; Vaughan & Waecher, 2009). Coming out has been conceptualized to prompt a number of benefits such as improvements in stronger, more positive identities (e.g., HRC, 2012; McCarn & Fassinger, 1996), self-esteem (Legate et al., 2012),

mental health (Floyd & Stein, 2002; Mohr & Fassinger, 2003), social functioning (Savin-Williams, 2001; Stevens, 2004), and social networks (Riggle et al., 2008).

Group Therapeutic Factors. A common theme in studies of LGBTQ+ individuals, when considering coming out, is the suggestion of therapy (Alessi, 2014; Chazin & Klugman, 2014; Coolhart, 2006). Peer counseling programs, speaker panels, support groups, and Gay/Straight Alliances have been recognized for their utility in providing safe environments and support to individuals in the coming out process (Dunlap, 2014b; Fisher et al., 2008). Specifically, group counseling is a therapeutic modality in which all of four of these recommendations can be considered (Fisher et al., 2008; Goodrich & Luke, 2015).

Yalom and Leszcz (2005) noted the 11 therapeutic factors of group psychotherapy (a) instillation of hope; (b) cohesion; (c) universality; (d) altruism; (e) imparting information; (f) interpersonal learning; (g) development of socializing techniques; (h) imitative behavior; (i) catharsis; (j); corrective reenactment of the primary family group; and (k) existential factors. When considering the applicability of a group counseling intervention with LGBTQ+ clients, these therapeutic variables are *not* only facilitative, but essential. The 11 therapeutic factors have the potential to enhance LGBTQ+ late young adults' coping, social support, and coming out growth. In general, counseling groups should help individuals to (a) discuss their experiences, feelings, and thoughts; (b) develop effective coping strategies; and (c) promote positive behavioral changes (Fisher et al., 2008). Group counseling is helpful when LGBTQ+ young adult members range in their progress along the coming out continuum (Dunlap, 2014b). Furthermore, group therapy is suggested as a strengths-based intervention to contribute to well-being (e.g., Goodrich & Luke, 2015; Griffith, 2014; Riggle, Gonzalez, Rostosky, & Black 2014).

Participants

The target population included LGBTQ+ individuals between the ages of 18 and 24. A total of 45 individuals inquired about participating in the investigation. Following the screening process, 32 individuals were eligible for participation. The seven individuals who were deemed unacceptable for this study were either under the age of 18, over the age of 24, or had active suicidal ideation. All individuals who did not qualify were provided referrals for additional support. Since the intervention follows a group format, individuals needed to have availability that matches other participants in order to be assigned. Of the 32 eligible individuals, 28 had suitable availability and were assigned to one of three counseling groups of eight to 10 members each. All 28 participants completed the initial packet; however, 27 participants completed the second packet (96.43% response rate) and 26 participants completed the third packet (92.86% response rate). Further information on participants' demographics is provided in Descriptive Statistics.

Data Collection

Prior to the beginning to the study, approval was received by the University of Central Florida's Institutional Review Board (IRB). Subsequently, data collection took place between September and November of 2015. Data was collected from participants at three points: (a) before the intervention, (b) at the middle of the study (i.e., after the second session), and (c) at the end of the intervention (i.e., after the fourth session). Assessments took approximately 10-15 minutes to complete. During intake, participants were randomly assigned participant identification numbers (e.g., 11). At the first assessment point, participants were made aware of

their codes and were instructed to avoid including identifying information (e.g., name). At each observation point, assessments were provided with manila envelopes labeled with their corresponding number to promote confidentiality and reduce bias (Gall et al., 2007). Physical data was stored in the researcher's locked office. Digital data was stored on the researcher's password-protected computer in a password-protected file.

Discussion

Demographic Data

A total of 26 LGBTQ+ individuals between the ages of 18 and 24 ($M = 19.96$, $SD = 1.78$, $Mdn = 20$, $Mode = 20$), participated complete data for this study. All participants were university students, seven reported being freshman (26.9%), eight were sophomores (30.8%), six were juniors (23.1%), four were seniors (15.4%), and one student was in graduate school (3.8%). In reference to ethnicity, the majority of participants identified as Caucasian/White ($n = 12$, 46.2%), followed by Hispanic/Latino ($n = 6$, 23.1%), and Multiracial ($n = 4$, 15.3%). One participant identified as Black/African-American (3.8%), one as Asian (3.8%), one as West-Indian (3.8%), and one as Persian (3.8%). Therefore, a majority of the sample identified as an ethnic minority (53.8%). The ethnic demographics in this study are similar to Florida and United States demographics in reference to the majority and largest minority group and include representation from a variety of ethnic groups (United States Census Bureau, 2014).

More participants identified as female (65.4%) than male (26.9%); furthermore, one participant identified as genderqueer (3.8%), and one participant identified as genderfluid (3.8%). In terms of affectional orientation, a majority of the participants identified as lesbian ($n =$

8, 30.8%), there was an equal percentage ($n = 7$, 26.9%) of individuals who identified as gay and bisexual. Two participants identified as asexual (7.7%), one participant identified as queer (3.8%), and one participant identified as polysexual/pansexual (3.8%). A majority of participants were single ($n = 22$, 84.6%) whereas four individuals were in a relationship (15.4%).

Due to the variability in sampling, it is difficult to compare related LGBTQ+ studies. Additionally, the process comparing the participants' demographic data to other similar samples is further complicated by the nature of the hidden LGBTQ+ population and constraints in sampling (i.e., safety, readiness; PEW, 2013). The Gay Lesbian and Straight Education Network's nationwide sample almost half of the participants identified as female (49.6%) and as in the present study a majority identified as White/Caucasian (67.9%). In this nationwide sample, Kosciw and colleagues (2014) categorizes gay and lesbian together (61.3%) which comprised of the majority group, followed by bisexual (27.2%), and questioning or unsure (3.7%). Although the categorical distinctions were not synonymous with the current study, the ratio of affectional orientation is the same in the present study. However, a higher percentage of participants identified as transgender (8.3%) or "other" gender (e.g., genderqueer, androgynous; 7.0%). Furthermore, the participants' age in Kosciw and colleagues' (2014) study ranged from 13-20; thus, although some of the ages overlap with the age in the present study, it is not the same age requirement utilized in the present study (i.e., 18-24). Thus, the sample utilized in the present study was similar to the samples utilized in previous, related studies.

In a study exploring stress-related growth in the coming out process, Cox, Dewaele, Van Houtte, and Vincke (2011) also measured affectional orientation differently as they utilizes the Kinsey scale ranging sexual identity from zero (i.e., exclusively heterosexual) to six (i.e.,

exclusively homosexual). The researchers then lumped individuals who scored a five or six into the category of lesbian or gay (60.5%), and individuals who selected three, four, or five were categorized as bisexual (39.5%). Cox and colleagues' study utilized a different method of identifying affectional orientation; however, the ratio was still similar to our study. No ethnicity information was provided for comparison. Although the participants ages included the age range in the present study (i.e., 18-24), the age of participants in Cox and colleagues' study included participants as young as 14 and as old as 30.

In another study exploring stress-related growth in the coming out process, Solomon, McAbee, Asberg, and McGee (2015) had a sample in which a majority identified as female (51%), 43.1% identified as male, and 5.9% identified as transgender. Similar to the GLSEN study and Cox and colleagues' (2011) study, a majority of the participants fell into the category of gay or lesbian (76.5%); and the remaining participants identified as bisexual. As in the present study and in the GLSEN (2014) study, a majority identified as Caucasian (84%). Unlike the present study, the remaining ethnicity categories were African American (3.9%), Asian American (2.9%), Hispanic American (2.9%), and Native American (2%). Participants' ages included the required range in the present study; however, the range extended through age of 67 ($M = 29.9, SD = 13.18$).

Similar to the present study design, Griffith (2013) and Riggle and colleagues' (2014) studies examined LGBTQ+ growth over time due to a counseling intervention. Griffith's study was unique from the studies aforementioned as most participants identified as gay (38.2%), closely followed by bisexual, pansexual, or fluid (35.3%), then lesbian (14.7%), and questioning (5.9%). Similar to the present study, Griffith's intervention accounted for asexuality (2.9%).

Additionally, a majority of the participants identified as Caucasian (58.8%), followed by Multiracial (17.6%), followed by Hispanic or Latino (14.7%), followed by African-American (5.9%), and lastly Pacific Islander (2.9%). Griffith's study included the individuals within the age range required in the present study; however, participants were only between the ages of 18 and 20 and were not between the ages of 21 and 24. Finally, Riggle and colleagues' (2014) sample also identified as majority female (48.1%), followed by male (32.7%), followed by genderqueer (13.4%), and transgender (5.8%). Unique from the samples above, the majority group in Riggle and colleagues' study identified as lesbian (28.9%), followed by gay (19.2%), followed by queer (19.2%), followed by bisexual (17.3%), followed by heterosexual (11.5%), and pansexual (3.9%). Ages for included the range of the present study (18-24), yet extended through the age of 32.

Although the studies abovementioned vary in size, purpose, and design, there are similarities that help to support the sample in the present study. All of the studies had a majority of Caucasian and female participants. Most of the studies had African-American as the largest minority group with the exception of Griffith's (2014) study and the present study. Both studies took place in the state of Florida in which the ethnicity distinctions in the samples parallel that of the statewide ethnic breakdown. Many of the studies included participants within the 18 through 24 age range. Studies varied in the method of reporting affectional orientation and gender identity; however, in an effort to be inclusive, the present study allowed participants to self-describe (i.e., fill in) their identity rather than select.

Within the topic of coming out concerns, a majority of participants stated that they were actively considering coming out to someone ($n = 18, 64.3\%$). Of these individuals, most were

planning to come out to immediate family members ($n = 10, 35.7\%$), then others to friends ($n = 3, 10.7\%$), family ($n = 3, 10.7\%$), and two to both friends and family (7.2%). Immediate family members included the option of parents and siblings, whereas family included relatives beyond parents and siblings. Griffith (2013) was the first to inquire about outness rates in a group counseling intervention study. Unlike the present study, 79.4% previously disclosed to their parents, 64.7% to siblings, 52.9% to extended family, 82.4% to peers and acquaintances and all disclosed to their friends. Moreover, due to the high rates of disclosure, Griffith (2013) acknowledged that higher rates of need exist. Therefore, the present study examines the impact of a group counseling intervention for a sample with greater need regarding coming out.

Participants were asked to rate how stressful coming out was on a scale of 1-10, most participants rated their coming out stress at 8 ($n = 9, 32.1\%$), then 10, ($n = 5, 17.9\%$), 7 ($n = 5$), (17.9%), 9 ($n = 4, 14.3\%$), six ($n = 2, 7.1\%$), five ($n = 2, 7.1\%$), and only one participant rated coming out stress at 2 (3.6%). Additionally, participants were asked to rate their level of openness with their LGBTQ+ identity on a scale of 1-10, where most participants identified as 8 in outness (28.6%) then 7 (21.4%), 5 (17.9%), 4 (14.3%), 3 (10.7%), 4 (3.6%), and 6 (3.6%).

Instrument Descriptive Statistics

Coping. The 28-item *Brief COPE* (Carver, 1997) was developed on the foundation of theoretical models of coping, such as the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984). The *Brief COPE* (Carver, 1997) can be found in Appendix I. The COPE subscales measure essential aspects of coping which include: (a) active coping, (b) planning, (c) using instrumental support, (d) using emotional support, (e) venting, (f) self-distraction, (g)

positive reframing, (h) humor, (i) acceptance, (j) religion, (k) behavioral disengagement, (l) self-blame, (m) denial, and (n) substance use. Items are assessed on a four-point Likert scale.

Examples of items include: “I have been taking action to try to make the situation better,” and, “I’ve been looking for something good in what is happening.” Response options include (a) “I don’t usually do this at all,” (b) “I usually do this a little bit,” (c) “I usually do this a medium amount,” and (d) “I usually do this a lot.” The *Brief Cope* was *not* intended to be in a measure of total scores; instead, it is suggested to use the instrument in reference to positive and negative coping strategies (Hampel & Petermann, 2005; Jacobson, 2005; Moore, Biegel, & McMahon, 2011). Therefore, the *Brief Cope* is examined in reference to two categories: *Adaptive Coping* (subscales 1-10: active coping, planning, using instrumental support, using emotional support, venting, self-distraction, positive reframing, humor, acceptance, and religion) and *Maladaptive Coping* (subscales 11-14: behavioral disengagement, self-blame, denial, and substance use).

When examining Cronbach’s alpha, values below .7 are considered to demonstrate low reliability, values above .7 are considered to be acceptable, and values above .8 are high (Pallant, 2010). In the present study, *Adaptive Coping* displayed high internal consistency at all observation points: pretest ($\alpha = .85$), midpoint ($\alpha = .80$), and posttest ($\alpha = .84$). *Maladaptive Coping* scores displayed adequate internal consistency for pretest ($\alpha = .72$), midpoint ($\alpha = .70$) and posttest ($\alpha = .71$) scores. Participants’ scores for *Adaptive Coping* were: (a) pretest ($M = 56.04, SD = 9.29$); (b) midpoint ($M = 54.65, SD = 7.57$); and (c) posttest ($M = 57.88, SD = 9.09$). Moreover, *Maladaptive Coping* scores were: (a) pretest ($M = 13.19, SD = .48$); (b) midpoint ($M = 12.31, SD = .42$); and (c) posttest ($M = 11.92, SD = 3.62$). Descriptive statistics for the *Brief Cope* are presented in Table 1.

Due to the lack of a suggested subscale factoring from the developer, it is difficult to compare *Brief Cope* scores across multiple studies. Some studies have used 14 subscales (e.g. Platter & Kelly, 2012); four subscales (e.g. Fatima & Tahir, 2013; Steinhardt & Dolbier, 2008, and three subscales (e.g., Jacobson, 2006; Schnider, Elhai, & Gray, 2007). In a study examining patient anxiety and depression the brief cope was used in two subscales, however, self-distraction and venting were included in maladaptive (Kasi et al., 2012); however, Griffith (2014) includes such items in the adaptive coping category. Since Griffith's (2014) research employed the same subscale distinctions and included LGBTQ+ individuals between the age of 18 and 20, comparisons can be made. Regarding internal consistency, high reliability was noted for all *Adaptive Coping* observation points for both studies; however, *Maladaptive Coping* was adequate for the present study, yet high at pretest ($\alpha = .88$), midpoint ($\alpha = .84$), and posttest ($\alpha = .84$) points.

In regards to *Adaptive Coping*, participants' scores in the present study were: higher ($M = 56.04$, $SD = 9.29$) than Griffith's (2014) study at pretest ($M = 50.62$, $SD = 9.20$), yet less ($M = 54.65$, $SD = 7.57$) at midpoint ($M = 56.43$, $SD = 8.88$) as well as posttest ($M = 57.88$, $SD = 9.09$; $M = 58.00$, $SD = 7.24$) administrations. Moreover, *Maladaptive Coping* scores were: (a) pretest ($M = 13.19$, $SD = 3.82$); (b) midpoint ($M = 12.31$, $SD = 3.51$); and (c) posttest ($M = 11.92$, $SD = 3.62$). All observations displayed *Maladaptive Coping* scores that were less than in Griffith's (2014) study: (a) pretest ($M = 15.52$, $SD = 6.24$); (b) midpoint ($M = 14.10$, $SD = 5.05$); and (c) posttest ($M = 12.05$, $SD = 3.66$).

In the present study, *Adaptive Coping* scores decreased from pretest to midpoint and increased from midpoint to posttest. The reduction and subsequent increase in *Adaptive Coping*

scores may have been due self-report bias (Gall et al., 2007). At pretest observation, participants may have perceived themselves at a high level of coping; however, learning about coping may have caused their self-appraisal to decrease. The increase by the third observation may be attributed to skills learned in the counseling intervention (Shadish et al., 2002). The lack of statistically significant change in *Maladaptive Coping* may be due to insufficient coverage of negative coping skills in the group intervention. Compared to Griffith's study (2014), in which coping changed over time, the lack of significant change over time may have been due to the difference in sessions. Although both studies were eight hours in total, Griffith's study utilized eight sessions whereas the current study utilized four.

Social Support. The SSQ6 (Sarason et al., 1987) is 6-item measure that assesses perceived social support (*SSQ-N*), and the satisfaction with perceived social support (*SSQ-S*); the abbreviated measure can be found in Appendix J. Sarason and Sarason's (1986) study showed that experimentally provided social support is facilitative for both college students with low support and high support; yet, this study did provide demographic information on gender or affectional orientation. Additionally, this study utilized the SSQ rather than the abbreviated instrument implemented in the present study. In a study examining social support on college athletes, Yang and colleagues (2010) found that social support structure may change due to an injury, further, post injury, athletes report greater satisfaction with social support. Although demographic information was not provided for gender and affectional orientation, the results show the influence of a traumatic moment prompting stress-related growth (Park, Cohen, & Murch, 1996).

Although the concept of social support has been explored with the LGBTQ+ population, instrumentation has varied (e.g., Doty, Willoughby, Lindahl, & Malik, 2010). The SSQ has been utilized with the LGBTQ+ population (e.g., Otis & Skinner, 1996); however, only one other study was found utilizing the abbreviated version employed in the present study (King et al. 2003). A main finding that was that individuals who identified as gay or lesbian had similar levels of social support as their heterosexual peers, yet higher levels of psychological distress. Nevertheless, King and colleagues' (2003) study did not include individuals beyond heterosexual or homosexual and did not provide instrument reliability statistics.

The *SSQ6* has internal reliabilities ranging from .90-.93 on both subscales. In the present study *SSQ-N*, pretest ($\alpha = .93$), midpoint ($\alpha = .98$), and posttest ($\alpha = .94$) scores all displayed high internal consistency. The *SSQ-S* internal consistency scores were sound for pretest ($\alpha = .88$), midpoint ($\alpha = .88$), and posttest ($\alpha = .87$) assessment points. Participants' scores for *SSQ-N*, were: (a) pretest ($M = 4.51, SD = 2.04$); (b) midpoint ($M = 4.76, SD = 2.56$); and (c) posttest ($M = 5.76, SD = 2.53$). Furthermore, *SSQ-S* scores were: (a) pretest ($M = 5.04, SD = .84$); (b) midpoint ($M = 4.99, SD = 1.03$); and (c) posttest ($M = 5.51, SD = .65$). Due to the lack of outcome research in reference to the social support of LGBTQ+ persons, there are no studies to compare to the mean scores of *Social Support Number* and *Social Support Appraisal*. Although Friedman and Leaper (2010) utilized the SSQ with their sample of sexual minority college women, composite scores were utilized rather than subscale scores for *Number* and *Satisfaction*. However, the SSQ scores were higher in the present study than in Kafetsios and Sideridis' (2006) study of individuals between the ages of 18 and 34 (*SSN* : $M = 3.11, SD = 6.00$; *SSS*: $M = 4.83, SD = 1.17$), than in Kafetsios and Nezelek's (2012) study of university students in Greece and

Britain (*SSN*: $M = 3.85$, $SD = 1.07$; *SSS*: $M = 3.88$, $SD = .79$), and higher than Johnson and Johnson's (2013) study of female undergraduate students in the Midwestern United States (*SSN*: $M = 3.92$, $SD = 2.28$; *SSS*: $M = 4.88$, $SD = .51$). Descriptive statistics for the *Social Support Questionnaire 6* are presented in Table 1.

Coming out Growth. Vaughan and Waehler's (2010) COGS measures the perceived gains an individual achieves from coming out. The *COGS* can be utilized in terms of overall scores or subscale scores. The 34-item version *COGS* is utilized in order to allow for an examination of intrapersonal and interpersonal dimensions of growth. The *individualistic growth* subscale of the *COGS* (Vaughan & Waehler, 2010) has 21 items and the *collectivistic growth* subscale has 13 items. The intrapersonal growth dimension includes perceived gains in authenticity/honesty, biopsychosocial well-being, and sexual minority identity. The interpersonal growth dimension captures growth in LGBT-affirming views, a sense of belonging, and a collective LG identity. The *COGS* implemented in this study can be found in Appendix K. Although studies have explored the themes indicated in coming out growth (e.g., Craig & McInroy, 2015; Mohr & Fassinger, 2003) and the concept of stress-related growth from coming out (Cox et al., 2011; Solomon, et al., 2015), the present study is the first study to utilize the *COGS* to measure if coming out growth can be increased over time. Therefore, instrument statistics in the present research may only be compared to the original study.

The *Individualistic growth* subscale of the *COGS* (Vaughan & Waehler, 2010) has a reliability of .96 and the *Collectivistic growth* subscale has a reliability of .88. In the present study, internal consistency for the subscale of *Individualistic growth* was high for pretest ($\alpha = .96$) and midpoint scores ($\alpha = .83$), and posttest ($\alpha = .96$) scores. Similarly, internal consistency

for the *Collectivistic growth* subscale was high for pretest ($\alpha = .91$) and midpoint ($\alpha = .96$), and posttest scores ($\alpha = .91$). Participants' scores for *Individualistic growth* were: (a) pretest ($M = 80.73, SD = 18.26$); (b) midpoint ($M = 84.23, SD = 19.09$); and (c) posttest ($M = 92.77, SD = 15.99$). Furthermore, *Collectivistic subscale* scores were: (a) pretest ($M = 43.62, SD = 9.37$); (b) midpoint ($M = 44.77, SD = 10.10$); and (c) posttest ($M = 48.58, SD = 9.71$). Beyond the creation of the scale, no other studies have utilized the COGS to date. However, the scores displayed in the current study are consistent with the primary research study since the mean score for *Individualistic Growth* was 82.81 ($SD = 19.59$) and the mean score for *Collectivistic Growth* was 42.99 ($SD = 10.55$; Vaughan & Waehler, 2010). Descriptive statistics for the COGS are presented in Table 1.

Group Therapeutic Factors. The TFI-19 (Joyce et al., 2011) was designed to measure the effectiveness of group counseling (e.g., curative factors and dynamics). The TFI-19 is a shortened version of the 99-item *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). The version utilized in this study can be seen in Appendix L. The TFI-19 is based off of Yalom's 11 therapeutic factors and higher scores demonstrate participants' positive experiences within group. In this study, the TFI-19 is analyzed by subscale scores. The four TFI subscales include: (a) *Instillation of Hope*, (b) *Secure Emotional Expression*, (c) *Awareness of Relational Impact*, and (d) *Social Learning*. Items are formatted on a seven-point Likert-type scale ranging from strongly disagree to strongly agree.

According to Joyce and colleagues (2011), the subscales display good internal consistency (*Instillation of Hope* [$\alpha = .90$], *Secure Emotional Expression* [$\alpha = .85$], *Awareness of Interpersonal Impact* [$\alpha = .79$], and *Social Learning* [$\alpha = .66$]). Additionally, a quasi-

experimental study of counselors-in-training participating in multicultural growth groups provided further support for the internal consistency of the subscales: *Instillation of Hope* ($\alpha = .65$), *Secure Emotional Expression* ($\alpha = .52$), *Awareness of Relational Impact* ($\alpha = .88$), and *Social Learning* ($\alpha = .88$; Johnson & Lambie, 2013). Furthermore, a quasi-experiential study exploring the influence of group counseling on LGBTQ young adults found that the Cronbach's alpha for the *TFI-19* subscales were acceptable (*Instillation of Hope*, $\alpha = .84$; *Secure Emotional Expression*, $\alpha = .78$; *Awareness of Relational Impact*, $\alpha = .85$; and *Social Learning*, $\alpha = .86$; Griffith, 2014). In the current study, internal consistency for all TFI-19 subscales were low (*Instillation of Hope* [$\alpha = .62$], *Secure Emotional Expression* [$\alpha = .67$], *Awareness of Interpersonal Impact* [$\alpha = .60$], and *Social Learning* [$\alpha = .54$]). The subscale scores were: (a) *Instillation of Hope* ($M = 6.40$, $SD = .60$); (b) *Secure Emotional Expression* ($M = 6.28$, $SD = .39$); (c) *Awareness of Interpersonal Impact* ($M = 6.18$, $SD = .73$); and (d) *Social Learning* ($M = 5.83$, $SD = .92$). Descriptive statistics for the *Therapeutic Factors Inventory* are presented in Table 2. In comparison to Johnson's (2013) study of counseling students, the present study displayed higher mean scores on all of the subscales: (a) *Instillation of Hope* ($M = 3.61$, $SD = .75$), (b) *Secure Emotional Expression* ($M = 3.06$, $SD = .62$), (c) *Awareness of Relational Impact* ($M = 2.77$, $SD = .53$), and (d) *Social Learning* ($M = 3.22$, $SD = .57$). The present study also displayed higher group therapeutic factor mean scores than Griffith's (2014) study with LGBTQ+ individuals ages 18 through 20: (a) *Instillation of Hope* ($M = 5.78$, $SD = 1.03$), (b) *Secure Emotional Expression* ($M = 5.77$, $SD = 1.11$), (c) *Awareness of Relational Impact* ($M = 5.15$, $SD = 1.31$), and (d) *Social Learning* ($M = 4.98$, $SD = 1.31$). The higher group therapeutic factor mean scores in the present study may provide support for the connectedness of the group

processes and may promote the curriculum.

Research Questions

Primary Research Question. The purpose of this study was to understand whether LGBTQ+ young adults who participated in an affirmative group counseling intervention would experience an: (a) increase in adaptive coping; (b) decrease in maladaptive coping; (c) increase in the size of their social support system; (d) increase in satisfaction with their social support system; (e) increase in individualistic coming out growth; and (f) increase in their collectivistic coming out growth.

The primary research question sought to understand whether a coming out group counseling intervention influences late LGBTQ+ young adults' levels of coping (as measured by the *Brief COPE* [Carver, 1997]), appraisal of social support (as measured by the *Social Support Questionnaire-6* [Sarason, Sarason, Shearin, & Pierce, 1987]), and coming out growth (as measured by the *Coming Out Growth Scale* [Vaughan & Waehler, 2010]) over time. A RM-MANOVA confirmed that there was a multivariate within-subjects interaction effect across time (Wilks' $\lambda = .163$; $F [12, 14] = 5.97, p < .001$) and 84% of the variance was accounted for by this effect. Analysis of univariate tests indicated that *Adaptive Coping* ($F [1.80, 44.98] = 1.01, p = .37$; partial $\eta^2 = .04$) and *Maladaptive Coping* ($F [1.93, 48.31] = .145, p = .24$; partial $\eta^2 = .06$) did not exhibit significant change over time. However, *Social Support Number* ($F [2, 50] = 10.35, p < .01$; partial $\eta^2 = .25$), *Social Support Satisfaction* ($F [1.88, 47.10] = 10.35, p = .001$; partial $\eta^2 = .29$), *Individualistic Growth* ($F [1.87, 46.72] = 8.22, p < .01$; partial $\eta^2 = .25$), and *Collectivistic Growth* ($F [2, 49.92] = 9.85, p < .001$; partial $\eta^2 = .28$) exhibited significant change. Power to detect changes was high for all of the subscales: *Adaptive Coping* (.21),

Maladaptive Coping (.29), *Social Support Number* (.95), *Social Support Satisfaction* (.98), *Individualistic Growth* (.94), and *Collectivistic Growth* (.98).

An examination of pairwise comparisons provided more detail into the changes over time. None of the subscales indicated significant changes over time between the pretest and midpoint observation points ($p > .05$); however, significant change was noted from pretest to posttest ($p < .05$) for *Social Support Number*, *Social Support Satisfaction*, *Individualistic Growth*, and *Collectivistic Growth* and from midpoint to posttest. *Social Support Number*, *Individualistic Growth*, and *Collectivistic Growth* scores displayed a general increase over time between points. As anticipated, *Maladaptive Coping* scores showed a general decrease over time. *Adaptive Coping* scores reduced from pretest to midpoint and then increased from midpoint to posttest. *Social Support Number* scores decreased from pretest to midpoint and then increased from midpoint to posttest. The changes in marginal means for subscale scores are presented in Figures 1 - 6.

The intervention was designed to assist LGBTQ+ young adults experiencing coming out-related concerns. Specifically, the group curriculum focused on coping skills, improving social support, and promoting resilience through coming out growth. The results indicate that the influence of the group counseling intervention promoted change over time. Moreover, the data analyses identified that improvement in scores occurs within all of the subscales for social support and coming out growth. Furthermore, *Social Support Number* ($\eta^2 = .25$, $1 - \beta = .95$), *Social Support Satisfaction* ($\eta^2 = .29$, $1 - \beta = .98$), *Individualistic Growth* ($\eta^2 = .25$, $1 - \beta = .94$), and *Collectivistic Growth* ($\eta^2 = .28$, $1 - \beta = .98$) demonstrated large effect sizes and high power (Cohen, 1988; Pallant, 2010). Therefore, the results of the analysis with these data promoted

strong evidence to support the utility of the group counseling intervention with this sample of participants.

The present study contrasts previous findings, suggesting that an intervention may change coping scores over time (e.g., Griffith, 2014; Sikkema et al., 2013). A main difference between the previous studies that have shown change in coping over time may be the number of sessions. The Coping Course (Rohde et al., 2004) developed for juvenile offenders exhibiting life-threatening behaviors included 16 sessions and the Living in the Fact of Trauma (LIFT) group intervention included 15 sessions. Although Griffith's study included eight sessions, the overall time commitment was equivalent to the current study (4, 2-hour sessions). Nevertheless, due to the change in both *Adaptive Coping* ($F [2, 62] = 6.44, p < .05$; partial $\eta^2 = .172$) and *Maladaptive Coping* ($F [2, 62] = 4.66, p < .05$; partial $\eta^2 = .131$) scores, the fewer sessions utilized in the present study may have contributed to the lack of change in coping over time.

The change in social support scores were consistent with Sarason and Sarason's (1986) findings that experimentally provided social support may an individual's appraisal of social support. Scholars have noted the need for social support in the LGBTQ+ population (e.g., Fisher et al., 2008, Kosciw et al, 2014); specifically, in relation to coming out (e.g., Cooper, 2008; Cowie & Rivers, 2000, Dunlap, 2014). Several correlational studies have highlighted the link between social support and LGBTQ+ well-being (e.g., Budge, Rossman, & Howard, 2014; Vincke & Bolton, 1994) and some studies have emphasized the relationship with identity support (e.g., Beals & Peplau, 2005; Grossman, D'Augelli, & Frank, 2011). Researchers have asserted the need for social support as a method of LGBTQ+ coping (e.g., Budge et al., 2014; Doty et al., 2011). Moreover, several scholars have provided group counseling intervention descriptions as a

means of both providing and learning about methods to increase social support (e.g., Budge et al., 2014, Craig, 2014); however, no data on effectiveness was provided. Two prior studies were identified that examined the influence of a strengths based group counseling intervention on social support over time. Thus, the findings provide the first direct evidence for the efficacy of a group counseling intervention in increasing social support over time. Specifically, the results of this study provide evidence that being a participant in a group counseling intervention may help LGBTQ+ young adults to both increase the number of individuals in their social support system and enhance their satisfaction with their social support system. Therefore, the group curriculum may be utilized for LGBTQ+ young adults in general, yet may be particularly helpful for increasing the size and quality of social support needed for enduring coming out concerns.

Stress from LGBTQ+ identity is discussed in the literature. Researchers note the potential for individuals to experience stress-related growth from the coming out process. This present study is the first of its kind in reference to examining the potential facilitative effect of a group counseling intervention on coming out growth. Thus, the findings are pivotal in providing the assertion that group counseling may be able to contribute to an increase in coming out growth. Moreover, a strengths-based group counseling intervention may be useful in increasing both individualistic and collectivistic aspects of coming out growth. Hence, the group curriculum provides a helpful resource in fostering resilience and growth from the coming out process.

Exploratory Research Questions.

Exploratory Research Question 1. The first exploratory research question sought to understand whether there was a relationship between LGBTQ+ young adults' group therapeutic

factors (TFI-S; Joyce et al., 2011) scores and their levels of coping, appraisal of social support, and coming out growth. A canonical correlation was utilized to determine whether there was a relationship between the TFI-S subscales (i.e., *Instillation of Hope*, *Awareness of Relational Impact*, *Social Learning*, and *Secure Emotional Attachment*) and coping, social support, and coming out growth.

The first canonical correlation was .88 (77% overlapping variance), the second canonical correlation was .60 (36% overlapping variance), the third canonical correlation was .49 (24% overlapping variance), and the fourth was effectively zero. When considering the four canonical correlations, the result was statistically significant, $F(24, 57.03) = 2.15, p < .01$. The Pearson's Product Moment Correlations displayed significant relationships between *Adaptive Coping*, *Individualistic Growth*, *Collectivistic Growth* and the group therapeutic factors.

Installation of Hope was strongly correlated with *Adaptive Coping* ($r = .68, p < .001$), *Individualistic Growth* ($r = .71, p < .001$), and *Collectivistic Growth* ($r = .52, n = 26, p < .01$). These relationships show that there may be a relationship between individual's optimism about group counseling and their abilities to cope and grow. Additionally, individuals may gather positive feedback and learn from the experiences of their peers, thus prompting an increase in hopefulness. Gaining hope in group may contribute to an individual's ability to grow personally and in relationships as well.

Secure Emotional Expression was moderately correlated with *Adaptive Coping* ($r = .47, n = 26, p < .05$) and *Individualistic Growth* ($r = .47, p < .05$); however, a strong relationship was detected with *Collectivistic Growth* ($r = .52, n = 26, p < .05$). *Secure Emotional Attachment* includes items of belongingness and safety in the group (Joyce et al., 2011). The correlations

show that *Secure Emotional Attachment* may be related to intrapersonal aspects of coping and growth, however, the strong relationship with *Collectivistic Growth* may convey that a sense of security in group is essential to promote interpersonal coming out growth. LGBTQ+ individuals often do not feel safe in disclosing their identity to due potential repercussions pertaining to stigma, harassment, or violence. Therefore, the ability to connect to others regarding identity is often a missed opportunity. However, since group may provide an opportunity for individuals to openly speak about identity and to feel connected in safe in doing so, individuals may be able to learn methods to cope effectively and to experience coming out growth.

The *Awareness of Interpersonal Impact* subscale displayed a strong correlation with *Adaptive Coping* ($r = .52, n = 26, p < .01$), and moderate relationships with *Individualistic Growth* ($r = .47, n = 26, p < .05$) and *Collectivistic Growth* ($r = .47, n = 26, p < .05$). The group therapeutic factor of *Awareness of Interpersonal Impact* pertains to a member's ability to see her or her influence on others. Influence on others can be reflected on individuals within the group, but beyond group as well. The relationship between *Adaptive Coping* and *Awareness of Interpersonal Impact* may be attributed individuals reflecting on their impact on others and subsequently becoming motivated for learning positive coping mechanisms to assist themselves and others. Additionally, since strengths'-based cognitive behavioral methods were utilized to reframe and better understand thought processes of themselves and others, the specific coping skills taught may have prompted individuals to consider their influence on others, thus prompting intrapersonal and interpersonal coming out growth.

Finally, *Social Learning* was strongly correlated with *Adaptive Coping* ($r = .72, p < .001$), *Collectivistic Growth* ($r = .69, p < .001$), and *Individualistic Growth* ($r = .71, p < .001$).

In contrast to *Awareness of Interpersonal Impact*, *Social Learning* considers the influence that other individuals within group have on the individual. When considering the concept of vicarious learning within social learning theory (Bandura, 1995), group counseling provides members with the opportunity to learn positive methods from the facilitator as well as from their peers. Learning from others' mechanisms and experiences subsequently connects to intrapersonal and interpersonal growth.

Compared to other intervention studies, group therapeutic factor scores were higher than previous studies. The subscale scores were almost double that of Johnson's (2013) study of counseling students. Although Griffith's (2014) study utilized a sample from a similar population, scores in the present study were higher across all of the group therapeutic factors. However, Griffith's study provides helpful data as it is the only other study that examined group therapeutic factors with LGBTQ+ clients. Specifically, Griffith's study also examined the relationship between group therapeutic factors and coping. For both studies, *Maladaptive Coping* was *not* related to group therapeutic factors. Thus, there is no evidence that either intervention is able to decrease unhealthy coping strategies such as denial and self-blame. *Adaptive Coping* was related to all of the group therapeutic factors in the present study whereas in Griffith's study, a moderate relationship was only noted between *Adaptive Coping* ($r = .51, p < .05$) and *Secure Emotional Attachment* ($r = .52, p < .05$). Therefore, the present study may have had a strong presence of group therapeutic factors. The difference in group therapeutic factors could be attributed to the difference in (a) group curricula, particularly the emphasis psychoeducation and coming out in the present study; (b) facilitators; (c) sample; and (d) group members.

Exploratory Research Question 2. The final research inquiry sought to determine if a relationship exists between LGBTQ+ young adults' reported demographic variables (e.g., *age*, *age of questioning*, *age of disclosure*, *gender*, *ethnicity*, *affectional orientation*, and *education*) and their levels of coping, appraisal of social support, and coming out growth. Furthermore, the correlation between the participants' demographic data and their coping, social support, coming out growth scores were examined.

There was no statistically significant relationship detected between *age* and coping, social support, or coming out growth, which is consistent with research examining LGB stress and coming out growth (e.g., Rosario et al., 1996; Solomon et al., 2015; Vaughan & Waehler, 2010). The lack of a relationship between *age* and the outcome variables could possibly imply that individuals between the ages of 18 and 24 may benefit equally from a group counseling intervention. However, similar to the original study by Vaughan and Waehler (2010), *Age of Questioning* displayed a negative relationship with *Collectivistic Growth* ($r = -.46, p < .05$). Hence, age of questioning may be more telling than actual age. Individuals who begin questioning earlier may have had more time to reflect and on his or her process and thus may be more able to develop in the area of *Collectivistic Growth*. The results of the original exploration of the COGS (Vaughan & Waehler, 2010) suggested that outness was related to growth; however, no relationships were identified between coping, social support, and coming out growth with coming out stress or level of outness. Therefore, regardless of the level of stress or outness, individuals may be able to gain from the group counseling intervention.

The literature provides conflicting data on the differences between LGBTQ+ individuals of varying ethnic groups. In a study by Rosario and colleagues (1996), ethnicity was not related

to stress. This finding was consistent with the lack of differences in coming-out growth scores between ethnic groups in Vaughan and Waehler's (2010) work. However, another study by Rosario and colleagues' (2002) found that African-American LGB youth have more discomfort with their identity than other ethnicities. Furthermore, Meyer and colleagues (2008) highlighted that Black and Latino individuals were exposed to more stress and had less available coping resources than White LGB participants. Similar in design to the present study, Griffith's (2014) counseling intervention identified no differences in outcome variables in reference to ethnicity. When examining significant differences between groups for coping, social support, or coming out growth scores, a Hotelling's Trace statistic showed no significant difference between White and non-White participants ($p > .05$). Regardless of the ethnicity demographic ratio, majority and minority individuals were able to benefit equally from the group. However, due to the sampling distribution, it is unknown whether a minority group may score better than another minority group within the intervention.

In reference to gender, a study by Doty and colleagues (2010) suggested that males have more stressors than females. However, Griffith's (2014) group counseling intervention study showed no difference in score between males and females. A Hotelling's Trace statistic showed no difference in stress between gender identities with these data. Therefore, regardless of gender identity, male and female participants may benefit from the group. Nevertheless, the present study included two gender non-binary participants who were not included in the analysis. Therefore, the present finding regarding the lack of difference between genders goes not account for difference in scores for individuals who do not identify as male or female.

When examining significant differences between groups for coping, social support, or coming out growth scores, a Hotelling's Trace statistic showed no difference between individuals planning to disclose or not planning or not planning to disclose ($p > .05$). Since coming out it is acknowledged that coming out is a continuum that spans across the lifetime, the group may assist individuals in reflecting on past disclosures and may also help individuals prepare for future disclosures. Thus, the results of the study may have implications for individuals who are and are not actively in the process of coming out. Specifically, the group may be beneficial to individuals regardless of whether or not they have disclosed to others. There were members in the group who had disclosed to a few close individuals in their lives and were able to process future plans for disclosure. Group may allow individuals to process past experiences and prompt growth for individuals who are openly a part of the community as well. For example, there were members in the group who identified as "fully out"; however, the group provided them with the opportunity to discuss instances in which they experiences pain and loss from coming out. Finally, group may provide a safe space of individuals to share their lack of plans for disclosure to certain individuals and to experience catharsis and growth from the process. For example, many individuals discussed their decisions to not disclose their identity to certain individuals due to conflicting values and lack of safety. Group counseling provided them with the validation of their concerns, did not minimize their choices, and affirmed their identities.

In reference to orientation, Legate and colleagues' (2012) study suggested that lesbian individuals have more support than individuals who identity as bisexual or gay. However, Kertzner and colleagues (2009) assert that bisexual participants report lower social well-being. A

MANOVA identified no statistically significant difference ($p < .001$) between lesbian, gay, or bisexual participants ($p = .07$). This finding is consistent with Griffith's (2014) group counseling intervention study which determined no differences between lesbian, gay, or bisexual participants' outcome variables.

Furthermore, when examining significant differences between groups for coping, social support, or coming out growth scores, a MANOVA identified no statistically significant difference ($p < .001$) between level of education (i.e., freshman, sophomore, junior, senior/grad) or between lesbian, gay, or bisexual participants ($p = .07$). Similarly Vaughan and Waehler (2010) found that individuals did not score differently based on education level. However, Vaughan and Waehler highlight that the lack of education variability may have influenced the result. Nevertheless, the finding may imply that regardless of education level, LGBTQ+ participants may be able to benefit from the group.

Limitations of the Study

As with any research, this study has limitations which are important to explore in order to inform future studies. This section explains limitations in the areas of (a) research design, (b) sampling, (c) instrumentation, and (d) treatment.

Research Design

The quasi-experimental research design utilized in this study may have posed threats to both internal and external validity. Since participants expected to gain from the group counseling intervention, it is possible that a novelty effect was at play. The lack of a control group creates

concern in concluding that change over time occurred as a direct effect of the intervention. Moreover, the present study could not control for participant maturation. Due to the ethical concern of providing treatment to clients in need (ACA, 2014), individuals who were suitable and available were included in this study. Nevertheless, the lack of nonrandom assignment may threaten statistical conclusion validity.

The use of a consistent facilitator and standardized group curriculum were precautions for treatment fidelity. However, each group has unique dynamics that may have influenced participants' scores. Additionally, since the researcher doubled as the facilitator, it is possible that researcher bias may have influenced participants. Moreover, since multiple counselors were not used, it is difficult to differentiate between the influences of the facilitator versus the group treatment intervention (Shadish et al., 2002).

The small sample size ($N = 26$) may indicate limited generalizability (Gall et al., 2007). Small sample size may limit the ability to detect significant relationships, however, power was high in the primary research question. Additionally, subject attrition occurred as 26 of the 28 participants who began the study completed all instruments. The design included incentives (i.e., food, water, and a total of \$10.00 gift cards) in an effort to prevent subject attrition; however, the influence of the incentives is not explored and may have caused reactive self-report changes (Shadish et al., 2002).

Sampling

Due to the hidden nature of the LGBTQ+ population, it is difficult to estimate generalizability (Gall et al., 2007). Marginalized status may have caused difficulty in acquiring a

suitable sample, and may cause concern for future researchers as well. Although recruitment occurred throughout the Central Florida area on college campuses and at LGBTQ+ related organizations, an individual who is early in the phase of questioning identity may be less likely to respond to the call for participants. Contrastingly, individuals who openly identify and are faced with repercussions of openly identifying (e.g., homelessness, joblessness) may not have been able to adhere to the attendance requirement.

A purposive sample was utilized in this study. The purposive sample criterion for inclusion required participants who identify as LGBTQ+ and were between the ages of 18 and 24, thus, the sample may be biased. Another limitation is the age range. A similar age range was chosen to increase cohesiveness and because young adulthood is noted as a pivotal time in development (Dunlap, 2014; Guittar, 2013; HRC, 2013b). However, due to this age range, we cannot be certain whether implications can be drawn for individuals who are beyond the ages of 18 and 24. Due to the difficulty in gaining approval for research with minors through the IRB, we are uncertain if the results may apply for individuals under the age of 18. Similarly, although coming out concerns encompass the lifespan (Ali & Barden, 2015; Dunlap, 2013; Guittar, 2013; HRC, 2013; Rust, 1993), the results may *not* apply to individuals beyond the age of 24. Since a majority of the participants identified as lesbian, gay, or bisexual, it is possible that the majority group may have influenced generalizability. Although individuals beyond LGB were included, the small sample may not adequately account for changes in other groups. Beyond participant characteristics, it may be difficult to generalize results of this study to other treatment settings (e.g., private practice, agency) and other modalities (e.g., individual counseling).

The entire project occurred in Central Florida. Although Central Florida can be representative of the United States, it is unknown whether the results can be transferred to other areas (i.e., rural). Additionally, although efforts were made in order to recruit participants who were not enrolled in college, all participants were current university students. All but one participant belonged to the same university. Furthermore, although effort was made to host counseling groups at locations beyond the University of Central Florida (i.e., The LGBT Center of Orlando, Zebra Coalition), lack of interested and available participants from other locations caused all of the groups to be administered on the University of Central Florida's main campus.

Instrumentation

The detection of change in constructs targeted relies heavily on the instruments of choice. Particular attention was given to select brief, clear, psychometrically-sound instruments; however, all instruments have their limitations. Although self-report measures have a weakness, they were needed for the present study as experiences from coming out are personal and unique. Specifically for the COGS (Vaughan & Waehler, 2010), due to its recent establishment, published reliability and validity evidence to date only exists from the primary creator. Further, this is the first quasi-experimental study to utilize the COGS to measure the ability of group treatment to influence coming out growth.

It is possible that the *Brief COPE* (Carver, 1997) and *Social Support Questionnaire* (Sarason et al., 1987) may have had concerns with construct validity. In reference to the coping, it is possible the broad categories of adaptive and maladaptive may not have been appropriate for coping in reference to LGBTQ+ coming out concerns. Overall, coping and social support may be

different for the LGBTQ+ population. Thus, if instruments were created specifically for LGBTQ+ persons' coping and social support and tested with LGBTQ+ individuals, the results may have varied.

Although particular attention was given to selecting brief measures, since instruments were administered at three points within four weeks it is possible that participants may have experienced instrumentation fatigue. Furthermore, repeated encounters with the same measures may have caused desensitization (Shadish et al., 2002). Thus, answers may have been skewed, particularly in reference to the second and third administrations. For example, individuals may have become accustomed to the measure and may have answered with less attention and detail than the primary observation. Nevertheless, all instruments have some degree of measurement error.

Treatment

Since the treatment is new, individuals may be biased by the appeal; further, since the treatment is intended to assist individuals through the coming out process and self-report measures are used, beliefs and hopes of change may have influenced the reported scores. Although consistency is provided through the use of one facilitator and adherence to a treatment manual, researcher bias and the influence of one facilitator is difficult to account for in scores. Similarly, due to the Hawthorne effect, the participants may have been influenced by the presence of the researcher.

Ray and colleagues' (2011) content analysis of ACA division-affiliated journals ($n = 4,457$) articles from 1998 to 2007 revealed that only 6% of counseling research articles explored

effectiveness of counseling interventions. No prior research has been conducted which examines the effects of a coming out counseling group. Therefore, the curriculum was created for the present study and was not previously tested. Regardless, the study contributes to needed evidence-based practice research in the counseling field by providing a new curriculum with evidence to support its efficacy regarding the ability to facilitate coping, social support, and coming out growth in LGBTQ+ young adults.

Implications and Recommendations for Future Research

Implications

Regardless of the abovementioned limitations, the results from the present study provide implications for the LGBTQ+ community, counselors, and counselor educators. Prior to the investigation, no studies were identified that explored a strengths-based group counseling intervention to increase LGBTQ+ young adults' social support and coming out growth. Furthermore, no studies were identified which aimed to test the ability of a strength's based group counseling intervention to influence coping in LGBTQ+ young adults between the ages of 18 and 24. The present study provides support for the use of a strengths-based group counseling intervention in order to increase social support and coming out growth in LGBTQ+ young adults. Thus, the results contribute to filling the gap of outcome-based, counseling, and group interventions. Furthermore, the ability to utilize a group counseling intervention to foster strengths is a promising find for the LGBTQ+ community. Due to minority stressors, LGBTQ+ persons may often lack a strengths-based perspective, nevertheless, the results from this study demonstrate that the group counseling methods utilized may be able to build and activate underutilized strengths. Regardless of minority identity, the results of this study provide support for group therapeutic factors in influencing positive client outcomes such as social support and growth. Moreover, the results contribute to evidence-based methods for assisting LGBTQ+ clients in counseling. The results provide insight into counseling method with LGBTQ+ clients both in general and with specific emphasis on the coming out process. Counselors can implement the brief, strengths-based group curriculum in order to provide helpful methods to assist their young adult LGBTQ+ clients. The curriculum can be beneficial in a variety of environments

such as schools, campus counseling centers, community mental health clinics, and private practices.

It is recognized in the counseling literature that clinicians lack the appropriate knowledge and skills for adequate counseling competence with LGBTQ+ individuals (e.g., Bidell, 2013; Graham, Carney, & Kluck, 2012). In accordance with the ALGBTIC's competencies (2013), the present research study stemmed from acknowledging the gaps in the literature. Furthermore, the curriculum developed for this study affirms identity, recognizes that coming out encompasses the lifespan, and utilizes the power of group work to affirm and support LGBTQ+ individuals. Thus, counselors who recognize the boundaries of their competence, the need for continuing education and the importance of maintaining practice standards that are current and effective may benefit from this outcome-based research (ACA, 2014; ALGBTIC, 2013). Specifically, counselors should learn to conduct this intervention and in order to provide a useful strengths-based curriculum for LGBTQ+ young adult clients.

The findings from the present study identify that counselors working with LGBTQ+ individuals between the ages of 18 through 24 may benefit from using a strengths based group counseling approach. Additionally, group counseling may be a helpful modality to consider in promoting social support and growth. Specifically, the group curriculum may be a facilitative tool for coming out concerns. Counselors may be able to adapt activities from the group curriculum to meet the needs of the LGBTQ+ clients in individual counseling. Furthermore, the curriculum may have beneficial components for family counseling with an LGBTQ+ client.

The results of the present study can be also used to inform ethical and effective counselor education (ACA, 2014; ALGBTIC, 2013; CACREP, 2016). Counselor educators are

responsible for infusing LGBTQ+ material into courses in order to foster the development of counselor trainees (ACA, 2014). Moreover, curricula should include ethical and culturally relevant methods for designing and facilitating groups (CACREP, 2016). Culturally sensitive approaches, such as the strengths-based mechanisms employed in this study, should also be included in supervision (CACREP, 2016). Counselor educators are obliged to promote the utilization of methods which are empirically supported, thus, the results from this present study can be used to inform counselor education in the realms of (a) ethical practice, (b) LGBTQ+ counseling, (c) group counseling, and (d) research.

Recommendations for Future Research

This research is part of an essential wave of outcome-based LGBTQ+ group counseling research; however, recognizing the novelty, future research is recommended to strength the group counseling curriculum and to enhance the counseling literature at large. First, methods should be taken to replicate the present study to examine if the intervention is effective for other populations. For example, although the hidden nature of the population is recognized and the Central Florida location chosen for this study may be representative of the United States, it would be helpful to duplicate the study in another location such as a particularly rural area or location beyond the United States.

Generalizability could also be enhanced by implementing the intervention with samples of varying diversity in reference to age, ethnicity, education, affectional orientation, and gender. It is recognized that identity development concerns occurs prior to young adulthood; thus, it would be beneficial to examine the effectiveness of this group counseling intervention with

younger, school-aged populations (Kosciw et al., 2013; HRC, 2013). Contrastingly, scholars acknowledge that coming out concerns encompass the lifespan and thus this study should be replicated with individuals beyond young adulthood (Ali & Barden, 2015; Breshears & Braithwaite, 2014; Dunlap, 2014; Fruhauf, Orel, & Jenkins, 2009). This sampling aim of this study was to utilize a diverse sample of young adults, however, a majority of the participants identified as Caucasian in reference to ethnicity and as lesbian, gay, or bisexual in terms of affectional orientation. It would be beneficial to replicate the counseling intervention with a different sample including different ethnic minority individuals.

Future research should examine if the group counseling intervention could be improved by tailoring particular components. Since the group facilitator may have influence on participants, future studies may examine the use of multiple facilitators or the presence of co-facilitators. Additionally, in the current study, coping did *not* change over time; thus, it may be beneficial to add a more structured coping component to the curriculum. For example, an open-ended approach was utilized to exploring strengths, however, direct psychoeducation on identification of strengths could have better targeted coping (Lytle et al., 2014). Nevertheless, it is possible that the lack of significant change was due to the four-session format. Therefore, future studies should examine the usefulness of extending the group format beyond eight hours. Contrastingly, due to the repeated design and requirement for consistent attendance, individuals who belonged to the population yet were unable to commit to multiple sessions were unable to partake in the intervention. Thus, it may be beneficial to explore if the intervention can be provided in a time format that is more conducive to individuals in dire need (i.e., two four-hour sessions).

Although the group curriculum was developed in an effort to be inclusive, it may be helpful to tailor the group format and content to specific populations. For example, the group setting may be beneficial for collectivistic cultures; however, the content matter does not specifically address cultural concerns of responsibility in collectivistic cultures (Glezer, 2009; Li & Orleans, 2001). Additionally, coming out is a unique process for any LGBTQ+ individual, although the community approach was utilized in the present study, it may be beneficial to add identity-specific components. For example, the medical process of transitioning could be a worthwhile addition to the intervention in exploring the efficacy with transgender persons.

Beyond group counseling, future studies should examine the usefulness of the strengths-based intervention with other counseling modalities. Researchers should explore if the curriculum can be refined for individual counseling administration. Since it is recognized that coming out concerns affect individuals beyond the identified client, future studies should examine if the intervention is effective in family counseling. Using a systemic perspective, researchers can also explore the influence of the intervention on parents (Troutman & Evans, 2014), siblings (Hilton & Szymanski, 2011), children (Joos & Brand, 2000), partners and spouses (Treyger, Ehlers, Zajicek, & Trepper, 2008), and step-family members (Lunch & Murray, 2000).

Due the marginalized nature of the LGBTQ+ population, the internet may be a safe space for individuals to receive support and counseling (Hillier, Mitchell, & Ybarra, 2012). Future studies should examine if online administration is efficacious in aiding LGBTQ+ persons. Future studies should also examine the group counseling intervention with amendments in research design. To improve generalizability, studies should utilize a comparison group and non-

random assignment. Further, researchers should aim to acquire larger sample sizes. Future studies should utilize multiple facilitators and examine the influence of the group counselor. It is possible that the lack of significant changes in coping over time may have been attributed to construct validity. It may be beneficial to explore the use of a psychometrically-sound instrument specific to LGBTQ+ stress and coping. Future research should utilize qualitative methods to explore the experiences of clients in the group. It would be helpful to gain participants' perspective on what was useful or unhelpful in order to inform future practice. Finally, future research should examine effective methods of teaching the strengths-based group counseling intervention in counselor education and supervision.

Conclusion

The purpose of this study was to investigate the impact of a strengths-based coming out group counseling intervention on LGBTQ+ young adults' (ages 18-24) levels of coping, appraisal of social support, and coming out growth. A one group pretest-posttest quasi-experimental design was selected to explore the change in coping skills, social support, and coming out growth over time. Additionally, the impact of group therapeutic factors was examined in relation to outcome variables (coping, social support, and coming out growth). The relationship between demographic variables and outcome variables were explored as well.

Key findings included a significant change in the participants' appraisal of their social support and coming out growth scores over time; however, no change was detected for coping. Further, relationships were detected between all of the group therapeutic factors (i.e., *Instillation of Hope*, *Social Learning*, *Awareness of Relational Impact*, and *Secure Emotional Attachment*)

and adaptive coming and coming out growth. Finally, scores for coping, social support, and coming out growth were not related to participants' *age, gender, ethnicity, education, affectional orientation, coming out stress, level of outness* or current status of planning to disclose identity to others. Contrastingly, age of questioning was negatively related to collectivistic growth.

The results of this study provide support for the utilization of a strengths-based group counseling intervention to assist LGBTQ+ young adults experiencing coming out concerns. The promising results shows that LGBTQ+ individuals may be able to combat minority stressors with the curative factors of group when paired with the curriculum utilized. This study is an important contribution to the counseling literature as it shows that it is possible to facilitate essential strengths over time. Finally, the findings provided empirical support for a strengths based group curriculum that should be used for counselor education and professional development in order to effectively assist LGBTQ+ clients.

APPENDIX A
UCF INSTITUTIONAL REVIEW BOARD APPROVAL



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138
To: **Shainna Ali and Co-PI: Glenn William Lambie**
Date: **August 19, 2015**

Dear Researcher:

On 08/19/2015, the IRB approved the following human participant research until 08/18/2016 inclusive:

Type of Review: UCF Initial Review Submission Form
Project Title: The Impact of a Strengths-Based Group on LGBTQ+ Late Adolescents' Coping, Social Support, and Coming out Growth
Investigator: Shainna Ali
IRB Number: SBE-15-11493

The scientific merit of the research was considered during the IRB review. The Continuing Review Application must be submitted 30 days prior to the expiration date for studies that were previously expedited, and 60 days prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form cannot be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>. If continuing review approval is not granted before the expiration date of 08/18/2016, approval of this research expires on that date. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

All data, including signed consent forms if applicable, must be retained and secured per protocol for a minimum of five years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained and secured per protocol. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual. On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

A handwritten signature in black ink that reads "Joanne Muratori".

Signature applied by Joanne Muratori on 08/19/2015 04:13:54 PM EDT IRB manager

APPENDIX B
INFORMED CONSENT



The Impact of a Strengths-Based Group on LGBTQ+ Late Adolescents' Coping, Appraisal of Social Support, and Coming out Growth

Informed Consent

Principal Investigator: Shainna Ali, M.A.

Sub-Investigator & Faculty Supervisor: Glenn Lambie, Ph.D

Investigational Site(s): *University of Central Florida Community Counseling & Research Center and The Zebra Coalition*

Researchers at the University of Central Florida (UCF) study many topics. To do this we need the help of people who agree to take part research studies. You are being invited to take part in a research study which will include up to 200 individuals who live in Central Florida. You have been asked to take part in this research study because you are between the ages of 18-24 at the start of the investigation, and identify as lesbian, gay, bisexual, transgender, queer or otherwise as a minority in terms of affectional orientation, gender identity, or gender expression (LGBTQ+).

The person conducting this research is Shainna Ali, a third year doctoral student candidate at UCF in the Counselor Education Department. Because the researcher is a graduate student, she is being guided by Dr. Glenn Lambie, a UCF faculty supervisor in the Department of Child, Family, & Community Sciences.

What you should know about a research study:

- Someone will explain this research study to you.
- A research study is something you volunteer for.
- Whether or not you take part is up to you.
- You should take part in this study only because you want to.
- You can choose not to take part in the research study.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want before you decide.

Purpose of the research study: The purpose of this study is to investigate the effects of a group intervention for LGBTQ+ individuals (ages 18-24) who live in Central Florida. The study will

seek to examine the effects of the intervention on participants' levels of coping, social support, and coming out growth.

What you will be asked to do in the study: After obtaining consent, participants will partake in a brief screening interview (10-15) in person or via telephone. You will be asked for contact information (an email address and/or phone number, based on what you are comfortable providing) which will be used by the principal investigator to inform you whether or not you have been selected to participate and to discuss scheduling. A separate document will contain your contact information. This document will not contain any details of the study, only the contact information of participants.

If you are selected to be included in this study you will participate in a group designed to increase coping, social support, and coming out growth. Groups will begin in September of 2015, however, start date will depend on the time admitted to the study. Therefore, the specific group may begin in October, November, or December of 2015. The groups will last approximately two hours and will consist of 4 weekly sessions. Additionally, the groups will contain 8-15 additional individuals who identify as LGBTQ+. These groups will be facilitated by the principle investigator, Shainna Ali. A standardized curriculum will be used. Because the group intervention is a strengths-building -type group, you will be asked to share personal experiences with group members and the group facilitator. Whether you choose to share personal experiences, however, is entirely up to you. You will be asked to complete an assessment packet at three points during the study: (1) during screening; (2) after the second session; and (3) at the end of the last scheduled group session. Furthermore, you will be asked to complete a demographic form prior to being assigned to a group. The assessments should take approximately 15-20 minutes to complete. You do not have to answer every question or complete every task. You will not lose any benefits if you skip any questions.

Recording: No audio or video recording will be used in this study.

Compensation: All participants will be provided a \$5 gift card (e.g., Walmart, Publix, Target, Amazon) as a token of appreciation for their participation at the first group session. Upon completion of the study, participants will be provided an additional \$5 gift card at the end of the 4th session. Additionally, water and food will be provided at group meetings.

Location: Please also note that you are responsible for securing transportation to and from your home and the intervention location (Community Counseling Clinic at UCF/ Zebra Coalition) for each session.

Confidentiality: During the intervention, you are expected to respect the confidentiality of your peers, and thus, what is said in group is expected to remain within group. Efforts will be made to remove identifying information in data analyses. Your name will be replaced with an alpha-numeric code. However, we cannot promise complete secrecy.

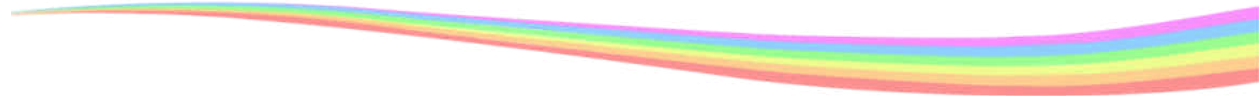
Risks: Although the potential for risk is minimal, participants may experience distress from group the topics covered in the group intervention. If this occurs, please consult your group facilitator to provide appropriate resources. Additionally, you may seek assistance at the UCF Community Counseling and Research Center (407-823-2052).

Withdrawing from the study: You may choose to withdraw from this study at any time. If you decide to leave the study, contact the investigator so you can be removed from the schedule.

Study contact for questions about the study or to report a problem: If you have any questions, concerns, or complaints, please contact Shainna Ali (ShainnaAli@knights.ucf.edu), Doctoral Candidate of Counselor Education Program in the College of Education & Human Performance or Glenn Lambie, Ph.D., (Glenn.Lambie@ucf.edu) faculty supervisor, professor, and chair of the Department of Child, Family, & Community Sciences in the College of Education & Human Performance at the University of Central Florida.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823- 2901.

APPENDIX C: RECRUITMENT FLYER



Research Study Call for Participants

LGBTQ+ Strengths-Based Group

Attention! We're looking for individuals ages 18-24 who are interested in participating in a study examining the effects of a strengths-based group designed specifically for individuals who identify as lesbian, gay, bisexual, transgender, queer or otherwise as a minority in terms of sexual orientation, gender expression, and/or gender identity (LGBTQ+). Group counseling will be provided at no cost to participants. We are seeking a maximum of 200 participants and groups will include 8-15 members.

Groups will take place at The University of Central Florida's Community Counseling and Research Center during the fall of 2015. There will be four two-hour group sessions (total time commitment will be approximately 8 hours). Groups will take place at the same time and place for four consecutive weeks. Food and water will be provided at each group session. Participants will receive a \$10 gift card.

Please note, individuals will only be able to participate if they:

- Self-identify as LGBTQ+
- Are between the ages of 18 and 24 at the start of the study (September 2015)
- Can commit to attending the 4 scheduled sessions.

If interested or if you have any additional questions please feel free to contact the principal investigator, Shainna Ali (ShainnaAli@knights.ucf.edu or 631-220-9182) or the faculty mentor Dr. Glenn Lambie (Glenn.Lambie@ucf.edu).

APPENDIX D: RECRUITMENT LETTER

Subject: Strengths-Based LGBTQ+ Coming out Group (at no cost to participants)

Good morning/afternoon,

My name is Shainna Ali and I am a doctoral candidate in Counselor Education at the University of Central Florida. I am contacting you today because I am looking for individuals ages 18-24 who are interested in participating in a study examining the effects of a strengths-based group counseling intervention designed specifically for youth who identify as lesbian, gay, bisexual, transgender, queer or otherwise as a minority in terms of sexual orientation, gender expression, and/or gender identity (LGBTQ+). This group will be provided at no cost to participants.

The purpose of the study is to determine the influence of an LGBTQ+ strengths-based group on coping, social support, and experiencing growth from the coming out process. Because your organization is involved in improving the lives of LGBTQ+ persons within our community, I believe you may have contacts for individuals who would be interested in this group. After a pre-screening interview to determine eligibility, participants will be added a group that may begin in September, October, November, or December of 2015. The total time commitment expected for this study is approximately 8 hours. We are seeking a maximum of 200 participants and groups will include 8-15 members.

Groups will take place at one of the following locations:

- (1) Community Counseling Clinic at UCF:
4000 Central Florida Boulevard Orlando, FL 32816-1250
- (2) Zebra Coalition:
911 N Mills Ave, Orlando, FL 32803

There is no cost for attending this group. The project is about helping young LGBTQ+ individuals. In my experience as a friend, counselor, and researcher I have noticed that although groups that assist individuals in coping and fostering social support throughout the coming out process would be helpful, I also noticed the lack of availability of this type of group. With your help, I hope to have an intervention worth disseminating at a national level that can be beneficial for educators, counselors, and clients.

Please note, individuals will only be able to participate if they: (a) self-identify as LGBTQ+; (b) are 18-24 years old at the start of the study; and (c) are able to commit to attending the scheduled group sessions.

Although I cannot promise any benefits from taking part in this research, potential benefits include an increase in participants' level of coping, ability to enhance social support, and personal growth. An increase in these factors has been linked to reduced substances abuse, anxiety, depression, and suicidality and improvements in happiness, well-being, and mental health. Furthermore, the information derived from this group may help inform future interventions to help improve the lives of other LGBTQ+ persons.

If you're interested in helping to recruit for this study, I have attached a flyer with information that can be posted or distributed directly. If you have any additional questions please feel free to contact me at (631)220-9182 or at ShainnaAli@knights.ucf.edu. Also, please let me know if you have contact information for anyone else you think might be interested. If you have any concerns, please contact my faculty mentor, Dr. Glenn Lambie at Glenn.Lambie@ucf.edu. Thank you so much for your time and consideration, and I look forward to hearing from you!

Take care,

Shainna Ali

Doctoral Candidate, Counselor Education

APPENDIX E: SCREENING FORM

Group Participant Screening Form

NOTE: Pre-screening cannot be completed until the potential participant has received an informed consent form

Age as of September 1, 2015: _____

Identifies as LGBTQ+? Yes No

Lives in Central Florida? Yes No

“I’m going to read you a list of conditions that may make you ineligible for the study. At the end, you can tell me if any of these are true for you, but you don’t have to tell me specifically unless you would like to. I may be able to provide some additional resources for you.”

- Cannot commit to attending four group sessions
- Unable to or not willing to maintain a confidential environment
- Does not work well in groups
- Active illegal substance use
- Active illegal domestic violence
- Active suicidal ideation/plan
- Psychosis (e.g., delusions, hallucinations)

How comfortable are you participating in activities and sharing your feelings in a group of your peers and the group facilitator?

Ever been in counseling? Yes No

Why do you want to join the group?

Where did you hear about the group?

Seems interested in and committed to the study? Yes No

Possesses an appropriate disposition for groups? Yes No

Recommended for the study? Yes No

Notes: _____

Please note your general availability to attend a group:

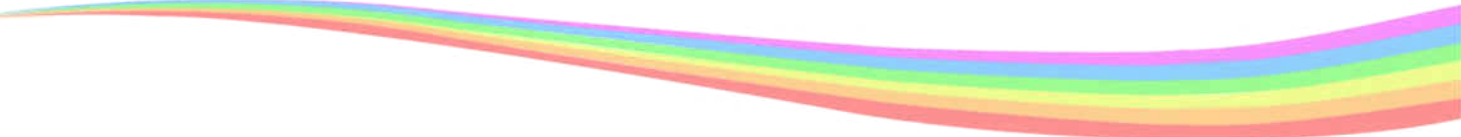
What day and time of the week could you attend for four weeks in a row?

In need of additional mental health services? Yes No

If yes, referral(s) provided: _____

APPENDIX F: GROUP CURRICULUM

Outward and Onward



Group Curriculum Packet

Shainna Ali

The following curriculum has been designed as a part of a dissertation study entitled: *The Impact of a Strengths-Based Group Counseling Intervention on LGBTQ+ Late Adolescents' Coping, Social Support, and Coming out Growth*. The four-session counseling intervention consists of interactive and psychoeducational sessions with the aim of encouraging constructive behaviors and healthy ways of coping and utilizing a positive support system. Content has been selected based on empirical support for the efficacy of the activities. This packet contains: (1) facilitator guidelines, (2) an outline of the group curriculum, and (3) required handouts.

The group intervention will take place over 4 consecutive weeks, one session per week, with each session lasting approximately 2 hours. The ideal size would be 8-10 group members.

Each session is briefly described in this document. If you have any questions, comments, or concerns, please feel free to contact the author Shainna Ali at (631) 220-9182 or via email at ShainnaAli@knights.ucf.edu.

Dear Facilitator,

Coming out is an ongoing process that encompasses the lifespan. Due to societal bias and assumption of heteronormative identity individuals are tasked with the decision to disclose in multiple context throughout their lives such as to their family members, friends, colleagues, and neighbors. Although similarities may exist, each disclosure process is unique due to the distinctive qualities of the individual (“discloser”), the person (“disclosee”), and the surrounding context. As an individual develops comfort, strength and resiliency within identity, the process may become easier; however, each exceptional decision has the power to provide anxiety and stress regardless of the individual’s position in life or development.

This group was created first and foremost to recognize and normalize the potential to experience difficulty from the multiple processes of disclosing identity throughout one’s life. Secondly, the purpose of this group is to assist individuals in being adequately prepared for the trials and tribulations that disclosure may entail. Finally, the group may provide a community environment for members who may need a sense of universality and support to combat societal marginalization, stigmatization, and isolation.

Thank you for your willingness to assist in this group to affirm and empower LGBTQ+ individuals through their lifelong coming out processes. On the following page you will find helpful guidelines to assist you as a facilitator, counselor, and a person.

With gratitude,
Shainna Ali

Facilitator Guidelines

Following guidelines asserted by the American Counseling Association and American Psychological Association, this group utilizes an affirmative rather than reparative approach. Sexual orientation change efforts have been recognized for their deleterious influence on clients whereas affirmative methods have gained acceptance in the literature as best practice methods for working with LGBTQ+ clients.

Counselors must develop competence in order to effectively aid LGBTQ+ clients. The primary areas of competence include awareness, knowledge, and skills.

Awareness

It may be helpful to utilize your own reflective practice to ensure that your personal attitudes and beliefs are not influencing group members or inhibiting their autonomy. It is essential that you are open-minded. Respect clients as independent beings. Although it is helpful to recognize their status in their development and disclosure processes, it is not helpful to assume, judge, or sway a client's positionality.

Knowledge

It is recommended to have background knowledge in identity development, coming out process, and LGBTQ+ counseling literature overall. Essential topic areas include (a) language, (b) history, (c) models of development, and (d) counselor competence. Recommended resources for facilitators are found in this packet.

Language is continually evolving. Additionally, terms may vary over time, cultures, and regions. Aim to use language that is common, current, and inclusive. Refrain from terminology such as "preference" or "lifestyle." In this group you are encouraged to empower clients to use language of their choice and to use their own language. Please note that in session one members will note their preferred pronouns on their nametags to be used throughout the group. Demographic information will collect affectional orientation, gender identity, and gender expression; however, this is not the focus of the group. Individuals are not to focus on these labels unless they choose to do so independently.

Skills

Your primary role as a facilitator is to affirm, empower, and validate group members. Use positive, encouraging language and affirm client successes. Incorporate and amplify strengths when problems are noted. Instill hope and motivate clients throughout the course of the group.

This group is intended to provide a safe space for LGBTQ+ late adolescents to gain helpful skills and discuss the coming out process. Please be sure to facilitate a comfortable,

accepting, nonjudgmental environment. Additionally, it is beneficial to have safe space signs and other environmental symbols of acceptance, safety, and community.

Group Structure

- *Purpose of the group:* Psychoeducation and support
- *Target clientele:* LGBTQ+ individuals enduring the process of coming out
- *Number and length of sessions:* Four two-hour sessions
- *Number of participants:* 8-15
- *Number of facilitators:* can be led by one clinician or 2 co-leaders

Session Themes

1	Introduction to Group	Introduction to the Cycle of Coming out
2	Coping	Awareness
3	Social Support	Assessment
4	Practice	Decision

General Breakdown of Each Session

Check-in	This may be a brief discussion or icebreaker that introduces the topic for the day. In sessions 2-4 this discussion or activity will link to the previous session and transition for to the new topic.
Topic	Discussion of the day’s topics as they relate to skills (i.e., adaptive coping, activating social support, or practice) and the cycle of coming out (i.e., awareness, assessment, and decision).
Activity	The activity will be related to the topics and will allow exploration and/or practice.
Homework	Participants are given an exercise or topic to reflect upon related to the session’s topic that will be utilized in a subsequent session.

Session 1: Welcome

Purpose: To introduce the group members to the facilitator, peers, and to discuss group procedures (e.g. length of the group, duration, etc.). Members will complete an ice-breaker activity. After orienting members to the group, discussion will include the importance of and establishment of group goals. Finally, the facilitator will lead the group in a discussion about the ongoing-process of coming out.

Objectives:

1. Group procedures, confidentiality, and rules will be discussed.
2. Members will be able to take part in an icebreaker.
3. Members and the facilitator will introduce themselves.
4. Members will begin discussion of the coming out process.
5. Facilitator will assign HW on affirmations.

Supplies: Paper, pens, and name tags.

Procedure:

Topic	Time	Tasks
Welcome	15-20 min	<ul style="list-style-type: none"> • Welcome participants to the group • Discuss procedures, confidentiality, and rules • Provide participants with name tags and allow them to put their name and preferred pronouns. • Briefly explain the outline of the session (see objectives).
Icebreaker: Pieces of Me	10 min	<ul style="list-style-type: none"> • Provide paper and instruct group members to think of the different aspects of their identity. <ul style="list-style-type: none"> ○ Aspects of identity can include hobbies, culture, and/or groups they may belong. If necessary, the facilitator may provide examples (e.g. female, Hispanic, volleyball). • Have group members write these pieces of their identity sporadically across the paper. • After writing the pieces, members should divide of the fractions of their overall identity.
	10 min	<ul style="list-style-type: none"> • Discuss the concept of intersectionality and how individuals are comprised of multiple identities which are unique from person to person.

		<ul style="list-style-type: none"> • Share that there is a positive benefit or strength to each piece of identity. • In each piece, encourage members to place corresponding positives, strengths, or benefits. <ul style="list-style-type: none"> ○ For example, in the Volleyball section a member may put “determined,” “cooperative,” or “athletic.”
	10 min	<ul style="list-style-type: none"> • Pair group members and give them the opportunity to share about their pieces. Encourage group members to help one another if they have difficulty in thinking of a positive for a piece.
	15-20 min	<ul style="list-style-type: none"> • Have the partners take turns introducing their partner to the group and share a strength learned about the other person. • Facilitator introduction
Discussion: Challenges of being LGBTQ+	10-15 min	<ul style="list-style-type: none"> • When all members have introduced themselves, allow members to share if they had difficulty finding a corresponding strength for a piece and allow the group to assist. • Use the discussion of strengths to discuss diversity and challenges with particular emphasis on prejudice, stigma, and internalized prejudice. Discuss how these factors contribute to the ongoing, potentially stressful aspects, of coming out throughout the lifespan.
Introduction to the Cycle of Coming out	10-15 min	<ul style="list-style-type: none"> • Introduce members to the cycle of coming out (awareness, assessment, and decision) that will be used throughout the group. • Affirm that each member has strengths that can be activated through this process. Further, note that the group is a safe space in which members can discuss their process and seek assistance without judgment.
Building Strengths	10 min	<ul style="list-style-type: none"> • To conclude, have members write 3-5 of the strengths from their pieces of me activity on the opposite side of their name tag, the side that faces their body. Emphasize that their strengths will always be there throughout the group and in life.

Homework	10 min	<ul style="list-style-type: none"> • Introduce the group the concept of an affirmation and encourage members to reflect on their strengths to develop an affirmation for the next session. <ul style="list-style-type: none"> ○ Affirmations are meaningful statements of encouragement and optimism. ○ Follow the 4 P's: Present, positive, powerful, and precise. ○ e.g. "I am optimistic about my future."
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Cisgender Female	Texas	Volleyball	Lesbian
Hispanic	Student		



Session 2: The Awareness Phase

Purpose: The purpose of this session is to empower clients through the first phase of coming out disclosures, awareness. During this time individuals become aware that they may need to make the decision to disclose. Cognitive processes such as internal dialogue, negative thoughts, and common thinking errors will be discussed in reference to this phase. Additionally, methods of coping such as reframing and using affirmations will be explored.

Objectives:

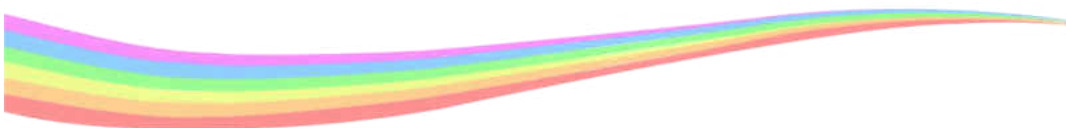
1. Members will be able to discuss the awareness phase.
2. Members will be able to share experiences pertaining to the awareness phase.
3. Emotions and thoughts during the awareness phase will be normalized.
4. Facilitator will discuss negative thoughts and participants will be able to share negative thoughts from the past.
5. Facilitator will provide the “Common thinking errors” sheet to normalize common cognitive distortions.
6. Members will be able to share thinking errors they experience/have experienced during awareness.
7. Members will learn to flip perspectives through reframing.
8. Members will learn how to use affirmations to cope with the awareness phase.

Supplies: Name tags, paper, pens, worksheets (thinking errors/flip side, affirmations)

Procedure:

Topic	Time	Tasks
Welcome	5 min	<ul style="list-style-type: none">• Welcome members to the group and briefly outline the session (see objectives).
Introduce the Awareness Phase	15-20 min	<ul style="list-style-type: none">• Explain the phase of awareness• Allow members to share when they have been in this phase• Review common emotions and feelings in the awareness phase. Allow members to share first and then fill in with common thoughts and feelings that may validate or provide a broader perspective. Be sure to affirm positive emotions and thoughts and link to strengths in the process overall.
Coping with negative thoughts	5-10 min	<ul style="list-style-type: none">• Provide members with the “Flip side” worksheet.• Have members write negative thoughts that have

		gone through their minds in this phase or relation to coming out at large in the left column.
	20-25 min	<ul style="list-style-type: none"> • Allow members to flip the page to see the “Common thinking errors” sheet. • Have members work in pairs to see if any of their thinking patterns fall within those categories. • Using the thinking errors sheet as a guide, have members collaborate to come up with the “flip side” to their negative thinking. • When applicable, tie in strengths discussed from session one. • When applicable, tie in affirmation from session one. • Facilitator should monitor the pairs and assist as needed.
	10-15 min	<ul style="list-style-type: none"> • As a group, members can share their “flip sides”. • Process the use of flip sides. <ul style="list-style-type: none"> ○ When possible, highlight strengths in the participants’ ability to convey a reframe.
Using affirmations to cope	20-25min	<ul style="list-style-type: none"> • Provide members with the affirmations worksheet. • Allow members to share their affirmation from HW and other applicable affirmations. • Have members choose their favorite affirmation to write on the back of their name tag.
HW	5-10 min	<ul style="list-style-type: none"> • Conclude by affirming the members’ strengths and prompt them to consider an individual who supports them for HW.



Session 3: The Assessment Phase

Purpose: The purpose of this session is to empower clients through the second phase of coming out disclosures, assessment. After becoming aware that they may need to make the decision to disclose, individuals are faced with the process in which a thorough assessment of pros and cons should be considered. Personal choice and readiness and the role of social support will be discussed. Additionally, methods of coping such as reframing and using affirmations will be explored.

Objectives:

1. Members will be able to discuss the assessment phase.
2. Members will be able to share experiences pertaining to the assessment phase.
3. Members will learn to assess the pros and cons of potential disclosures.
4. Members will learn of the importance of social support in the coming out process.
5. Members will learn of the different types of social support
6. Members will examine their social support system.
7. Members will learn how to utilize their support system in the coming out process.

Supplies: Paper, pens, handout (My Support), and whiteboard

Procedure:

Topic	Time	Tasks
Welcome	5 min	<ul style="list-style-type: none"> • Welcome members to the group and briefly outline the session (see objectives).
Circles of support	10-15 min	<ul style="list-style-type: none"> • Provide members with the My Support handout and a writing utensil for the circles of support activity. • Instruct members to place their name in the middle of the sheet. • Encourage members to think of all of the supportive people in their lives and place their names around their own name. <ul style="list-style-type: none"> ○ The closer the person’s name is to the member’s name shows closeness in real life.
	10-15 min	<ul style="list-style-type: none"> • Refer to the “Types of Support” section on the handout. • For each type of support have members reflect who in their system fits that type of support.
	10-15 min	<ul style="list-style-type: none"> • Refer to the “Seeking Support” section on the handout. • Have members share how to seek support from their support system.

	5 min	<ul style="list-style-type: none"> • Provide members with the Resources sheet to provide additional opportunities for support.
The Assessment Phase	5-10 min	<ul style="list-style-type: none"> • Transition to the pros and cons of assessment by discussing the importance of social support in the coming out process.
	10-15 min	<ul style="list-style-type: none"> • Introduce members to the assessment phase. • Allow members to share their experiences with the assessment phase.
	20-25 min	<ul style="list-style-type: none"> • Use a whiteboard to list pros and cons <ul style="list-style-type: none"> ○ Have members collaborate on a list for each • Emphasize that each situation is unique and depends on your own reason/readiness, the person you are disclosing to, and the surrounding environment. • Remind members to look at their name tag for their strengths and affirmation • Highlight that the support system is another layer of strength • Remind the group that there is only one more week •
HW	5 min	<ul style="list-style-type: none"> • Prompt members to consider a role model (LGBTQ+ may be helpful, but not required) that has strengths that they admire for HW.

Session 4: Termination/Decision Phase

Purpose: The purpose of this session is to conclude with educating members of the final phase of the coming out cycle (decision) and to terminate the group. Members will have the opportunity to create a coming out plan and to roleplay effective methods of disclosing. The group will end with a review of the coming out cycle and essential topics covered within the group such as coping, utilizing social support, and making a coming out plan.

Objectives:

1. Members will be able to discuss the decision phase.
2. Members will be able to create a coming out plan.
3. Members will be able to practice effective methods of disclosure.
4. Members will be able to share what they learned from group.
5. Members will collaborate in closing the group.

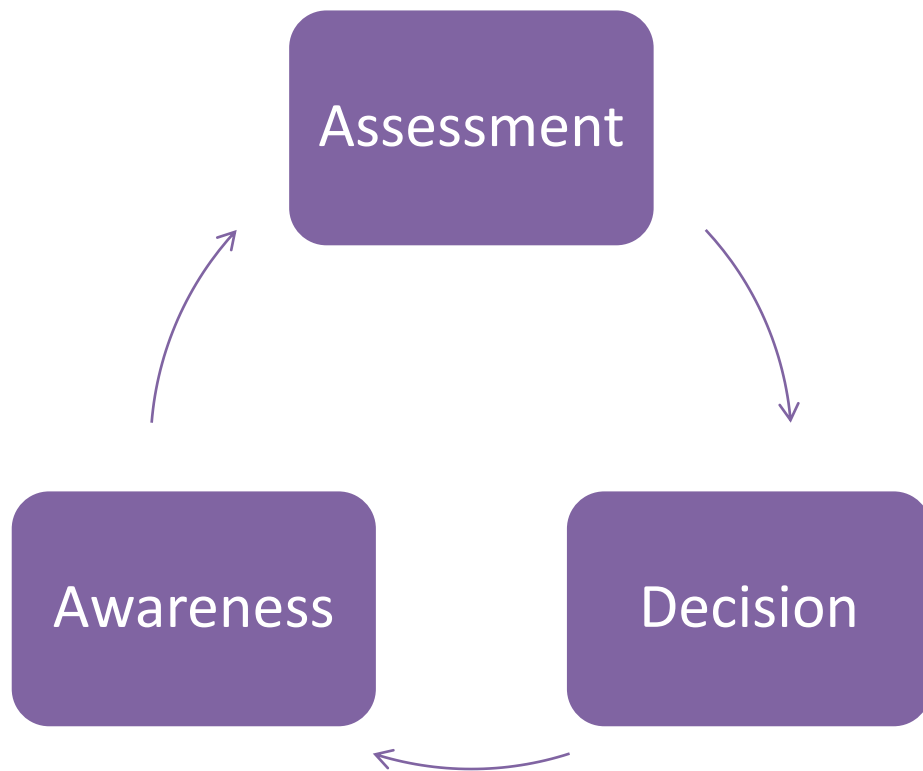
Supplies: Index cards, writing utensils, name tags, and worksheet (coming out plan)

Procedure:

Topic	Time	Tasks
Welcome	5 min	<ul style="list-style-type: none"> • Welcome members to the group and briefly outline the session (see objectives).
Role models	10-15 min	<ul style="list-style-type: none"> • Process the role model HW <ul style="list-style-type: none"> ○ Allow members to share who their role models are and why ○ Allow peers to provide feedback such as what the individual's coming out experiences were like (if applicable) and how the member has similar strengths.
Coming out Plan	10 min	<ul style="list-style-type: none"> • Introduce coming out plan (worksheet) • Highlight that although the cycle remains the same (i.e., awareness, assessment, decision), the plan may change dependent on <ul style="list-style-type: none"> ○ The self-readiness/reason ○ The person-beliefs/attitudes/relationship ○ The environment-safety ○ Revisit the pros and cons list from session 3 ○ Emphasize the use of social support ○ Consider how to share
	10 min	<ul style="list-style-type: none"> • Prompt members to consider either a past or future disclosure and practice with the sheet (therefore, this can

		be a corrective or planning measure)
	10-15 min	<ul style="list-style-type: none"> • After filling out the sheet, pair members to share their experiences and provide feedback • Remind members that disclosure is not always the decision
	10-15 min	<ul style="list-style-type: none"> • Hand out index cards and allow members to think of difficult time to disclose (this can be an actual event from the past or an anticipated event) • Have them briefly describe the scenario and write on the index card • Have members fold the cards in half and submit into a bowl or bag
	20-25 min	<ul style="list-style-type: none"> • Pair members and allow them to pick a scenario • Partners will choose one of the scenarios and practice with disclosure • Group members will provide feedback to their peers' demonstrations.
	10-15 min	<ul style="list-style-type: none"> • Process members' relatability to the scenario • Process what it was like to "correct" an experience from the past or practice for the future • Highlight that although similarities will exist with disclosures, each is unique and they all require attention in order to honor yourself and your decisions.
Revisiting strengths and coping	5 min	<ul style="list-style-type: none"> • Have members take off their name tags and review their strengths and affirmations.
Review	10-15 min	<ul style="list-style-type: none"> • Take a moment to review the overall group content (cycle and topics) and to validate the contribution and strength of the group members.
Termination: Affirmation activity	15-20 min	<ul style="list-style-type: none"> • Hand out index cards for termination activity • Prompt members to write an affirmation that relates to growth from coming out • Similar to earlier, fold and submit into a bowl or bag. • Allow members to randomly pick a card. • As members pick a card they can share what they learned from the group and their affirmation. • Remind members of the use of their handouts and resource information

The Cycle of Coming out



The cycle of coming out pertains to an individual's interpersonal process of disclosure. An individual enters the first phase, *awareness*, when they recognize a situation in which they are faced with the decision-making task of disclosure. Next, an individual is prompted into assessment in which multiple variables are considered regarding disclosure such as motivation, benefits, consequences, and relationship quality. Finally, an individual makes a decision regarding the choice to share or withhold identity. There is no right or wrong decision, however, a thorough analysis of the overarching context and internal variables may facilitate an informed, healthy, and safe choice.

The Flip Side

My old thoughts

My new thoughts

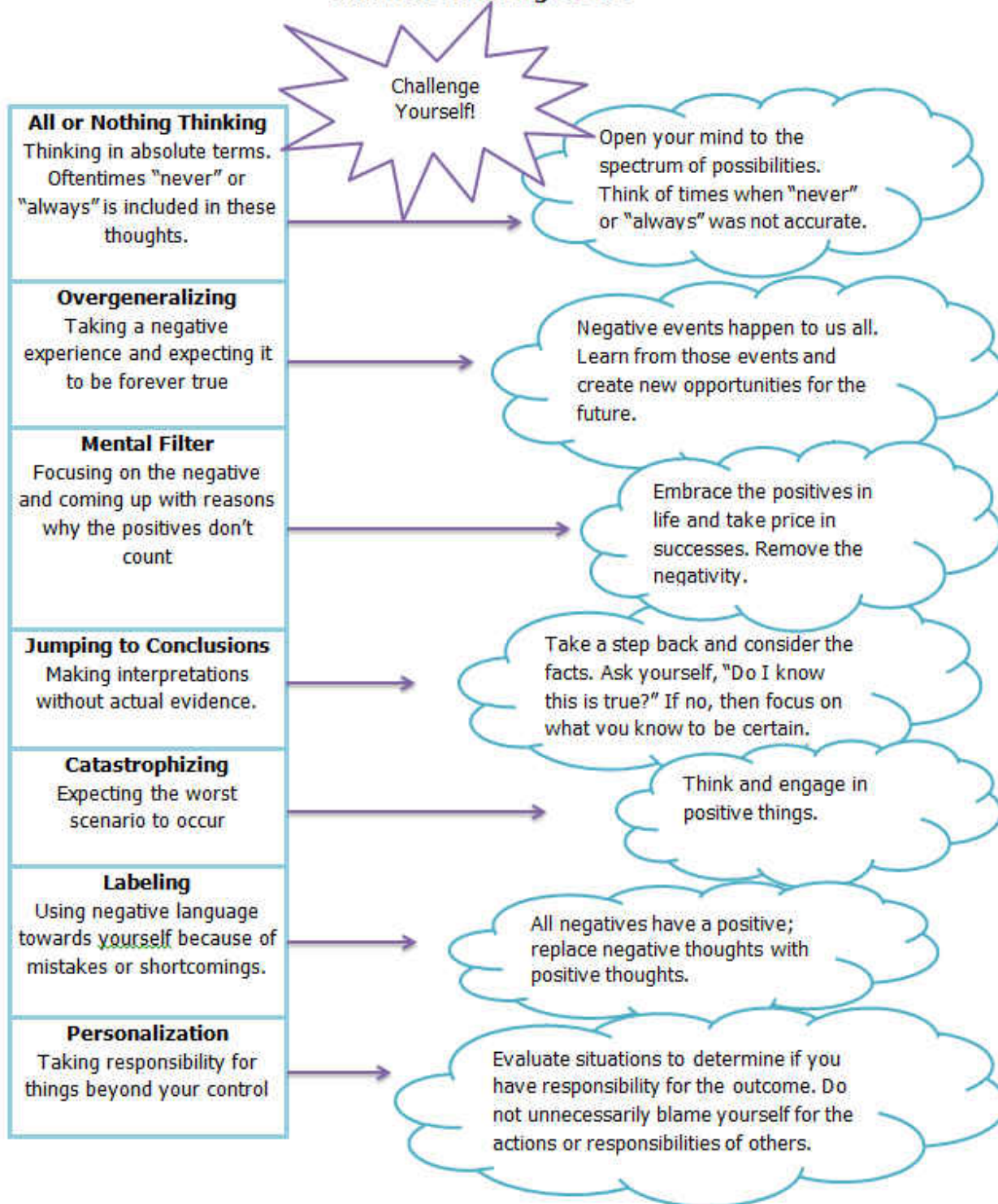
Blank space for writing old thoughts.

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Common Thinking Errors



Positive Affirmations

- I am strong
- I have strength
- I am determined
- I am unique and special
- I am a loving person
- I make wise decisions
- I am always changing
- I wish the best for everyone
- I have many strengths
- I am in control of my choices
- I can overcome obstacles in my life
- I am calm and confident
- I love and accept my body
- I can find a balance in my life
- I am optimistic about the future
- I can see the bigger picture
- Every failure can be a learning experience
- Live in the present moment
- This too shall pass

Make your own!

- Personalize your statement
- Use the present tense
- Use powerful words
- Be positive
- Be precise

My Support System

Types of Support	Examples
Instrumental -Providing material aid support involves the provision of material aid, for example, financial assistance or help with daily tasks.	
Informational -Providing helpful information to help guide or cope.	
Emotional -Providing empathy, reassurance, and trust for emotional expression and healing.	

Ways I can improve my social support system

Resources

Local

- UCF Community Counseling and Research Center
 - <http://education.ucf.edu/ccf/>
 - (407)823-2052
- The Zebra Coalition
 - <http://zebrayouth.org/>
 - (407)228-1446
 - (877)909-3272 (Hotline)
- The Center
 - <http://glbcc.org/>
 - (407)228-8272
- PFLAG Orlando
 - <http://www.pflagorlando.org/>
 - (407)236-9177
- UCF Pride Commons
 - <http://sja.sdes.ucf.edu/>
 - (407)823-3082

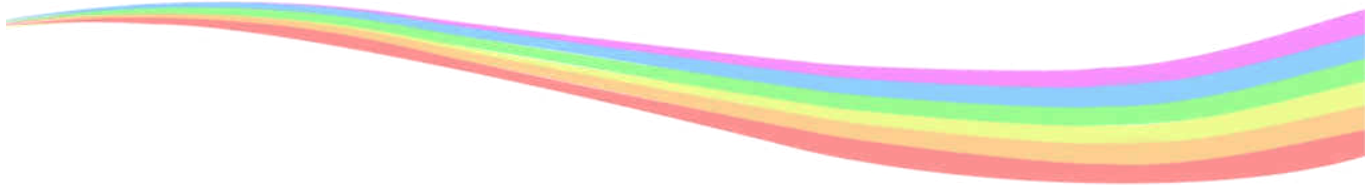
Websites

- It Gets Better
 - http://www.hrc.org/campaigns/coming_out-center
- Human Rights Campaign: Coming out Center
 - http://www.hrc.org/campaigns/coming_out-center
- The Trevor Project: Coming out as you
 - <http://www.thetrevorproject.org/section/YOU>
- OUT sports
 - <http://www.outsports.com/comingout>
- RUCO: Are you coming out
 - <http://www.rucomingout.com/>
- When I came out
 - <http://whenicameout.com/>
- GLAAD
 - <http://www.glaad.org/>
- Avert
 - http://www.avert.org/coming_out.htm
- Stonewall

- http://www.stonewall.org.uk/at_home/coming_out/
- The Advocate
 - <http://www.advocate.com/>

Books

- It gets better
- When I knew
- The other side of the closet: The coming out crisis for straight spouses and families
- The key to unlocking the closet door: A coming out guide on a journey toward unconditional self-love
- Coming out to play
- Is it a choice? Answers to the most frequently asked questions about gay & lesbian people
- Flying free



My Coming out Plan

Me	You
<p>Common motivations for disclosing:</p> <ul style="list-style-type: none"> • Relationship building-Sharing a part of identity will improve the relationship. • Problem solving- Sharing to end the person’s questions. • Therapeutic-Sharing in an effort to feel better. • Preventative-Sharing in order to avoid future difficulties. • Political/ideological-Sharing in order to change perspectives of LGBTQ+ persons. 	
<p>My motivation for disclosing:</p>	
Potential Benefits	Potential Consequences
<p>Affirmation:</p>	
<p>My strengths:</p>	
<p>How I can cope:</p>	
<p>Who I can contact:</p>	
<p>My decision:</p>	

Recommended Resources for Facilitators

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- Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2013). *Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling competencies with lesbian, gay, bisexual, queer, questioning, interview, and ally individuals*. Alexandria, VA: Author.
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- Dunlap, A. (2014b). Supporting youth in the coming out process: Theory-based programming. *Smith College Studies in Social Work*, 84(1), 107-129.
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APPENDIX G: INFORMED CONSENT



The Impact of a Strengths-Based Group on LGBTQ+ Late Adolescents' Coping, Appraisal of Social Support, and Coming out Growth

Informed Consent

Principal Investigator: Shainna Ali, M.A.

Sub-Investigator & Faculty Supervisor: Glenn Lambie, Ph.D

Investigational Site(s): *University of Central Florida Community Counseling & Research Center and The Zebra Coalition*

Researchers at the University of Central Florida (UCF) study many topics. To do this we need the help of people who agree to take part research studies. You are being invited to take part in a research study which will include up to 200 individuals who live in Central Florida. You have been asked to take part in this research study because you are between the ages of 18-24 at the start of the investigation, and identify as lesbian, gay, bisexual, transgender, queer or otherwise as a minority in terms of affectional orientation, gender identity, or gender expression (LGBTQ+).

The person conducting this research is Shainna Ali, a third year doctoral student candidate at UCF in the Counselor Education Department. Because the researcher is a graduate student, she is being guided by Dr. Glenn Lambie, a UCF faculty supervisor in the Department of Child, Family, & Community Sciences.

What you should know about a research study:

- Someone will explain this research study to you.
- A research study is something you volunteer for.
- Whether or not you take part is up to you.
- You should take part in this study only because you want to.
- You can choose not to take part in the research study.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want before you decide.

Purpose of the research study: The purpose of this study is to investigate the effects of a group intervention for LGBTQ+ individuals (ages 18-24) who live in Central Florida. The study will

seek to examine the effects of the intervention on participants' levels of coping, social support, and coming out growth.

What you will be asked to do in the study: After obtaining consent, participants will partake in a brief screening interview (10-15) in person or via telephone. You will be asked for contact information (an email address and/or phone number, based on what you are comfortable providing) which will be used by the principal investigator to inform you whether or not you have been selected to participate and to discuss scheduling. A separate document will contain your contact information. This document will not contain any details of the study, only the contact information of participants.

If you are selected to be included in this study you will participate in a group designed to increase coping, social support, and coming out growth. Groups will begin in September of 2015, however, start date will depend on the time admitted to the study. Therefore, the specific group may begin in October, November, or December of 2015. The groups will last approximately two hours and will consist of 4 weekly sessions. Additionally, the groups will contain 8-15 additional individuals who identify as LGBTQ+. These groups will be facilitated by the principle investigator, Shainna Ali. A standardized curriculum will be used. Because the group intervention is a strengths-building -type group, you will be asked to share personal experiences with group members and the group facilitator. Whether you choose to share personal experiences, however, is entirely up to you. You will be asked to complete an assessment packet at three points during the study: (1) during screening; (2) after the second session; and (3) at the end of the last scheduled group session. Furthermore, you will be asked to complete a demographic form prior to being assigned to a group. The assessments should take approximately 15-20 minutes to complete. You do not have to answer every question or complete every task. You will not lose any benefits if you skip any questions.

Recording: No audio or video recording will be used in this study.

Compensation: All participants will be provided a \$5 gift card (e.g., Walmart, Publix, Target, Amazon) as a token of appreciation for their participation at the first group session. Upon completion of the study, participants will be provided an additional \$5 gift card at the end of the 4th session. Additionally, water and food will be provided at group meetings.

Location: Please also note that you are responsible for securing transportation to and from your home and the intervention location (Community Counseling Clinic at UCF/ Zebra Coalition) for each session.

Confidentiality: During the intervention, you are expected to respect the confidentiality of your peers, and thus, what is said in group is expected to remain within group. Efforts will be made to remove identifying information in data analyses. Your name will be replaced with an alpha-numeric code. However, we cannot promise complete secrecy.

Risks: Although the potential for risk is minimal, participants may experience distress from group the topics covered in the group intervention. If this occurs, please consult your group facilitator to provide appropriate resources. Additionally, you may seek assistance at the UCF Community Counseling and Research Center (407-823-2052).

Withdrawing from the study: You may choose to withdraw from this study at any time. If you decide to leave the study, contact the investigator so you can be removed from the schedule.

Study contact for questions about the study or to report a problem:

If you have any questions, concerns, or complaints, please contact Shainna Ali (ShainnaAli@knights.ucf.edu), Doctoral Candidate of Counselor Education Program in the College of Education & Human Performance or Glenn Lambie, Ph.D., (Glenn.Lambie@ucf.edu) faculty supervisor, professor, and chair of the Department of Child, Family, & Community Sciences in the College of Education & Human Performance at the University of Central Florida.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823- 2901.

APPENDIX H: DEMOGRAPHICS FORM

Demographics Form

1. Age: _____
2. Gender Identity: Male Female Other: _____ (*please specify*)
3. Do you consider yourself transgender (does what is on your original birth certificate differ from how you describe your gender)? Yes No
4. Are you intersex? Yes No
5. Affectional/Sexual Orientation: _____
(*please specify*)
6. Ethnicity: _____
(*please specify*)
7. Level of education: _____
(*please specify*)
8. Relationship status: _____
(*please specify*)
9. At what age did you first question your LGBTQ+ identity? _____
10. At what age did you first disclose your LGBTQ+ identity? _____
11. To whom did you first disclose your LGBTQ+ identity? _____
12. Do you currently have individuals who you are actively planning to disclose your LGBTQ+ identity to? Yes No
13. If yes, please describe your relationship to these individuals (e.g., brother, coworker): _____
14. When you are preparing to come out to someone what is helpful?

15. When you are preparing to come out to someone what makes it difficult?

16. Reflecting on the entire process of disclosing your identity to others (coming out), on a scale of 1-10 how stressful was this process was for you?

Not at all stressful Extremely stressful

1 2 3 4 5 6 7 8 9 10

17. Considering your history of disclosures thus far, on a scale of 1-10 how open would you say you are with 1 being no disclosures and 10 being disclosed to everyone?

1 2 3 4 5 6 7 8 9 10

APPENDIX I: BRIEF COPE

The Brief COPE (Carver, 1997)

Instructions: These items deal with ways you've been coping with the stress in your life. There are many ways to try to deal with problems. These items ask what you've been doing to cope with your issues lately. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it.

Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

I haven't been doing this at all
I've been doing this a little bit
I've been doing this a medium amount
I've been doing this a lot

START HERE:

1. I've been turning to work or other activities to take my mind off things.	1	2	3	4
2. I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3. I've been saying to myself "this isn't real."	1	2	3	4
4. I've been using alcohol or other drugs to make myself feel better.	1	2	3	4
5. I've been getting emotional support from others.	1	2	3	4
6. I've been giving up trying to deal with it.	1	2	3	4

7. I've been taking action to try to make the situation better.	1	2	3	4
8. I've been refusing to believe that it has happened.	1	2	3	4
9. I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10. I've been getting help and advice from other people.	1	2	3	4
11. I've been using alcohol or other drugs to help me get through it.	1	2	3	4
12. I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
13. I've been criticizing myself.	1	2	3	4
14. I've been trying to come up with a strategy about what to do.	1	2	3	4
15. I've been getting comfort and understanding from someone.	1	2	3	4
16. I've been giving up the attempt to cope.	1	2	3	4
17. I've been looking for something good in what is happening.	1	2	3	4
18. I've been making jokes about it.	1	2	3	4
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
20. I've been accepting the reality of the fact that it has happened.	1	2	3	4
21. I've been expressing my negative feelings.	1	2	3	4
22. I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23. I've been trying to get advice or help from other people about what to do.	1	2	3	4
24. I've been learning to live with it.	1	2	3	4
25. I've been thinking hard about what steps to take.	1	2	3	4

26. I've been blaming myself for things that happened.	1	2	3	4
27. I've been praying or meditating.	1	2	3	4
28. I've been making fun of the situation.	1	2	3	4

Thank you for your time in completing this questionnaire!

APPENDIX J: SOCIAL SUPPORT QUESTIONNAIRE

The Social Support Questionnaire-6 (Sarason, Sarason, Shearin, & Pierce, 1987)

Instructions: The following questions are about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the persons' initials and their relationship to you (see example). Do not list more than one person next to each of the numbers beneath the question.

For the second part, circle of satisfied you are with the overall support you have.

If you have had no support for a question, circle the words "No one," but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer the questions as best you can. All of your responses will be kept confidential.

EXAMPLE:

Who do you know whom you can trust with information that could get you in trouble?

No one

1. T.N. (brother)
2. L.M. (friend)
3. R.S. (friend)
4. G. N. (father)
5. L. J. (employer)
- 6.
- 7.

How satisfied?

Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
-----------------------	-------------------------	---------------------------	------------------------------	----------------------------	--------------------------

8.	6	5	4	3	2	1
9.						
Please begin on the next page →						

START HERE:

Question 1	How satisfied?					
Whom can you really count on to be dependable when you need help?						
No one						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
	6	5	4	3	2	1
Question 2	How satisfied?					

Whom can you really count on to help you feel more relaxed when you are under pressure or feeling tense? No one 1. 2. 3. 4. 5. 6. 7. 8. 9.						
	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
	6	5	4	3	2	1
	Please continue on the next page →					

Question 3	How satisfied?					
Whom accepts you totally, including both your worst and your best points? No one 1. 2. 3. 4. 5. 6. 7. 8. 9.						
	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
	6	5	4	3	2	1

Question 4	How satisfied?					
Whom can you really count on to care about you, regardless of what is happening to you? No one 1. 2. 3. 4. 5. 6. 7. 8. 9.	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
Please continue on the next page →						

Question 5	How satisfied?					
Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps? No one 1. 2. 3. 4. 5. 6. 7. 8. 9.	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
Question 6	6	5	4	3	2	1
How satisfied?						

<p>Whom can you count on to console you when you are very upset?</p> <p>No one</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p> <p>8.</p> <p>9.</p>	Very satisfied	Fairly satisfied	A little satisfied	A little dissatisfied	Fairly dissatisfied	Very dissatisfied
<i>Thank you for your time in completing this questionnaire!</i>						

APPENDIX K: COMING OUT GROWTH SCALE

The Coming Out Growth Scale (Vaughan & Waehler, 2010)

Directions:

Based on your own experiences of sharing your LGBTQ+ identity (“coming out”) to others in your life, please indicate how this experience has directly impacted your life by choosing the response that best describes your experience, as a result of coming out to others.

Not at all / Not
A little bit
Moderately
Quite a bit
A lot

START HERE:

1. I am more satisfied with the amount of social support I have in my life.	1	2	3	4	5
2. I have come to see other LGBTQ+ people in a more positive light.	1	2	3	4	5
3. I have greater access to potential romantic partner(s).	1	2	3	4	5
4. I feel less pressure to be dishonest about who I am attracted to/dating.	1	2	3	4	5
5. I feel like I “fit in” better with other LGBTQ+ people.	1	2	3	4	5
6. I am more aware of the contributions of LGBTQ+ people have made to society.	1	2	3	4	5
7. I stand up for myself more within my relationships.	1	2	3	4	5
8. I am more comfortable with being LGBTQ+.	1	2	3	4	5
9. I believe I make better choices about behaviors that affect my physical health.	1	2	3	4	5
10. I have greater access to potential sexual partner(s).	1	2	3	4	5

11. I feel less pressure to dress or act according to gender stereotypes.	1	2	3	4	5
12. I have challenged others' stereotypes about LGBTQ+ people.	1	2	3	4	5
13. I have experienced positive changes in my relationship(s) with my partner(s).	1	2	3	4	5
14. I became more interested in social/political issues affecting LGBTQ+ people.	1	2	3	4	5
15. I am more aware of negative treatment of LGBTQ+ people in society.	1	2	3	4	5
16. I have more happiness and/or joy in my life.	1	2	3	4	5
17. My LGBTQ+ identity feels like a more important part of who I am.	1	2	3	4	5
18. I have experienced positive changes in my relationships with straight people.	1	2	3	4	5
19. I feel more complete or whole as a person.	1	2	3	4	5
20. I began to question "traditional" heterosexual values and norms.	1	2	3	4	5
21. I feel more comfortable interacting with other people.	1	2	3	4	5
22. I believe I cope better with stress related to my LGBTQ+ identity.	1	2	3	4	5
23. My self-confidence has increased.	1	2	3	4	5
24. Overall, my life feels less stressful.	1	2	3	4	5
25. I have become more involved in activities or organizations focused on LGBTQ+ people.	1	2	3	4	5
26. I have become a stronger/more courageous person.	1	2	3	4	5
27. I feel less pressure to be dishonest about my LGBTQ+ identity with others.	1	2	3	4	5
28. My LGBTQ+ identity feels more real/valid to me.	1	2	3	4	5

29. I respect myself more.	1	2	3	4	5
30. I have become more honest with important people in my life.	1	2	3	4	5
31. I feel more free to be myself.	1	2	3	4	5
32. I have challenged my own stereotypes about LGBTQ+ people.	1	2	3	4	5
33. I feel more genuine or authentic as a person.	1	2	3	4	5
34. I am more comfortable discussing my LGBTQ+ identity with others.					

Thank you for your time in completing this questionnaire!

APPENDIX L: THERAPEUTIC FACTORS INVENTORY-SHORT FORM

Therapeutic Factors Inventory-Short Form (TFI-19)

(Joyce, McNair-Semands, Tascda, & Ogrodniczuk, 2011)

Directions:

Please rate the following statements as they apply to your experience in your group by circling the corresponding number, using the following scale:

1= Strongly Disagree to 7= Strongly Agree

START HERE:

- | | |
|---|---------------|
| 1. Because I've got a lot in common with other group members, I'm starting to think that I may have something in common with people outside group too. | 1 2 3 4 5 6 7 |
| 2. Things seem more hopeful since joining group. | 1 2 3 4 5 6 7 |
| 3. I feel a sense of belonging in this group. | 1 2 3 4 5 6 7 |
| 4. I find myself thinking about my family a surprising amount in group. | 1 2 3 4 5 6 7 |
| 5. It's okay for me to be angry in group. | 1 2 3 4 5 6 7 |
| 6. In group I've really seen the social impact my family has had on my life. | 1 2 3 4 5 6 7 |
| 7. My group is kind of like a little piece of the larger world I live in: I see the same patterns, and working them out in group helps me work them out in my outside life. | 1 2 3 4 5 6 7 |
| 8. Group helps me feel more positive about my future. | 1 2 3 4 5 6 7 |
| 9. It touches me that people in group are caring toward each other. | 1 2 3 4 5 |
| 10. In group sometimes I learn by watching and later imitating what happens. | 1 2 3 4 5 6 7 |
| 11. In group, the members are more alike than different from each other. | 1 2 3 4 5 6 7 |

12. It's surprising, but despite needing support from my group, I've also learned to be more self-sufficient.	1	2	3	4	5	6	7
13. This group inspires me about the future.	1	2	3	4	5	6	7
14. Even though we have differences, our group feels secure to me.	1	2	3	4	5	6	7
15. By getting honest feedback from members and facilitators, I've learned a lot about my impact on other people.	1	2	3	4	5	6	7
16. This group helps empower me to make a difference in my own life.	1	2	3	4	5	6	7
17. I get to vent my feelings in group.	1	2	3	4	5	6	7
18. Group has shown me the importance of other people in my life.	1	2	3	4	5	6	7
19. I can "let it all out" in my group.	1	2	3	4	5	6	7

Thank you for your time in completing this questionnaire!

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