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The Impact Of A Group Counseling Intervention On Lesbian, Gay, Bisexual, Transgender, And Queer Older Adolescents' Levels Of Hope, Coping, And Suicidality

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THE IMPACT OF A GROUP COUNSELING INTERVENTION ON LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER OLDER ADOLESCENTS' LEVELS OF HOPE, COPING, AND SUICIDALITY

by

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ABSTRACT

This investigation examined the impact of an eight-week group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adolescents' (aged 18-20) levels of hopefulness, coping skills, and suicidality. An experimental, randomized-controlled-trial research design was employed to identify differences between the intervention group and waitlist control group participants' hopefulness, coping skills, and suicidality scores. In addition, the relationship between the LGBTQ+ participants' outcome variables (hopefulness, coping skills, and suicidality) scores was examined. Furthermore, the impact of group therapeutic factors experienced by the LGBTQ+ participants in intervention group for the variables of hopefulness, coping skills, and suicidality was examined.

Key findings included a significant interaction between time and group placement, indicating that the intervention group participants experienced significant improvements on measures of hopefulness, coping behaviors, and suicidality when compared to participants in the waitlist control group. In addition, hope was demonstrated to be a strong and significant predictor of suicidality. Furthermore, it was found that group therapeutic factors had a positive effect on intervention group participants' Adaptive Coping scores, but did not have an effect on Hopefulness, Maladaptive Coping, or Suicidality as hypothesized. Lastly, there was no significant differences between the demographic variables perceptions of parental/guardian support, perceptions of peer support, gender identity, or ethnicity on their hopefulness, coping behaviors, or suicidality. There was, however, a significant difference between bisexual's and lesbian's post-test scores on Suicidality, with bisexuals scoring significantly lower. No other significant differences were observed between sexual orientation and the other key constructs.

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Lastly, to Dan Savage, who saves lives with his message that "It Gets Better." Your advocacy on the behalf of queer people everywhere is an inspiration.

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CHAPTER ONE: INTRODUCTION

The challenges experienced by lesbian, gay, bisexual, transgender, and queer individuals, and those who otherwise identify as a minority in terms of sexual orientation and gender expression/identity (LGBTQ+) are well-documented. Researchers have found that LGBTQ+ adolescents are at higher risk for depression, suicidal ideation, self harm, and other negative coping behaviors such as drug use and sexual risk-taking than their heterosexual and cisgender peers (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Liu & Mustanski, 2012; Mathy, 2003; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Spirito & Esposito-Smythers, 2006). Furthermore, adolescents as a group are at-risk for suicide as suicide is the third leading cause of death among this age group (Centers for Disease Control and Prevention, 2010).

LGBTQ+ youth are two to seven times more likely to attempt suicide than non-LGBTQ+ youth, with risk factors including isolation, lack of hope, and negative coping skills contributing to increased ideation and attempts (Suicide Prevention Resource Center, 2008). A partial explanation for these elevated negative outcomes may be explained by the environment in which LGBTQ+ youth are exposed. Specifically, LGBTQ+ high school students experience frequent instances of homophobic remarks, verbal and physical harassment, and assault, which results in these students feeling unsafe, isolated, and depressed (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). In addition, individuals who identify as LGBTQ+ exhibit hopelessness and an inability to cope with these difficult circumstances (King et al., 2008; Rutter, 2006; Van Heeringen, & Vincke, 2000).

In response to the difficult systemic influences on LGBTQ+ adolescents and their high prevalence of risk factors (e.g., suicide), this study investigated the impact of an eight week

group counseling intervention on LGBTQ+ older adolescents' (ages 18-20) levels of hope (Herth, 1992), coping skills (Carver, 1997), and suicidality (Rohde, Lewinsohn, Seeley, & Langhinrichsen-Rohling, 1996) as compared to LGBTQ+ older adolescents who did *not* receive the intervention. In addition, for participants in the intervention group, the presence of group therapeutic factors (Joyce, MacNair-Semands, Tasca, & Ogrodniczuk, 2011) was measured to identify the impact of group therapeutic factors on group participants' hope, coping, and life attitudes scores. Furthermore, the relationship between LGBTQ+ older adolescents' hope, coping, life attitudes scores and their reported demographic data were examined. The findings from this study contribute to the knowledge base of effective group counseling interventions with LGBTQ+ youth.

Background of the Study

In 2010, author and advocate Dan Savage and his partner, Terry Miller, posted a YouTube video with the intention of providing an inspirational message to LGBTQ+ youth in a response to several gay teen suicides the garnered national media attention that year (Savage, 2010). The nine minute video, entitled "It Gets Better: Dan and Terry," describes their journey from being bullied and feeling isolated as teens to gaining acceptance from peers and family members in adulthood, finding love, and learning to value themselves for who they. The overall message shared is one of hope, helping young people to know that the hardships of adolescence are not permanent, and that yes, for many people it does indeed get better. Since that posting, the It Gets Better Project has become an international movement with over 50,000 user-generated videos offering personal stories and supportive messages. In addition to everyday individuals, videos were created by political figures (e.g., President Barack Obama, Hilary Clinton, and Nancy Pelosi), celebrities (e.g., Ellen DeGeneres, Adam Lambert, and Anne Hathaway), and

companies (e.g., Facebook, Google, and Pixar), all lending their support for LGBTQ+ youth (It Gets Better Project, 2010).

In addition to these personal narratives, research findings identify that bullying experiences for LGBTQ+ youth decrease at they get older. Specifically, in a seven year longitudinal study involving heterosexual and lesbian, gay, and bisexual (LGB) youth (N = 4,135; ages 13-20), researchers confirmed that LGB adolescents experience higher rates of name calling, threats of physical violence, and actual physical violence than their heterosexual peers, especially during the first year of the study (Robinson, Espelage, & Rivers, 2013). By year seven, however, there was a profound reduction in peer victimization for each group. For example, 57% of lesbian or bisexual girls and 52% of gay or bisexual boys had experienced bullying in the first year, but those rates had dropped to 6% and 9% respectively by year seven. For lesbian and bisexual females, these rates became non-significantly different after secondary school from their heterosexual female peers (Robinson, et al., 2013).

Robinson and colleagues' (2013) findings were congruent with findings from the National School Climate (NSCS) study conducted by the Gay, Lesbian, and Straight Education Network (GLSEN; n = 8,584). Although negative conditions are pervasive and occur at higher rates for LGBTQ+ adolescents, circumstances improve from middle school to high school, with high school LGBTQ+ students experiencing less regular physical harassment, dropping from 35.5% to 21.4% (Kosciw et al., 2012). The results of Kosciw and colleagues' (2012) investigation, which has been conducted since 1999, also marks the first time the findings show decreases in the overall number of homophobic remarks, verbal and physical harassment, and assault experienced by the participants. In addition, the number of Gay Straight Alliances (GSAs) on school campuses, curricular resources, supportive educators, and implementation of

anti-bullying and harassment policies had all increased from previous years (Kosciw et al., 2012). Therefore, LGBTQ+ students have good reason to have hope; as they get older, and as our society becomes more accepting, life appears to get better. It was hypothesized that a group counseling intervention that fosters hope as a coping skill would contribute to increased positive outcomes for LGBTQ+ adolescent participants.

Statement of the Problem

Despite ample evidence indicating the need for mental health interventions tailored for LGBTQ+ youth, there is a lack of empirical knowledge on the subject. In 2007, The American Foundation for Suicide Prevention in partnership with the Suicide Prevention Resource Center and Lesbian Medical Association assembled to address the need for increased understanding of the needs of LGBTQ+ clients (Haas et al., 2010). The conference participants, comprised of mental health researchers, clinicians, policy advocates, and educators, came to the conclusion that there is a significant gap between knowledge and practice, and that research is needed regarding interventions that reduce suicide risk for LGBTQ+ adolescents. In addition, after a review of the available literature on interventions with LGBTQ+ individuals of all ages in research databases (i.e., Academic Search Premiere, Education Full Text, ERIC, PsycArticles, and PsycInfo), few were identified (n = 5). Moreover, *no* studies were found that investigated group counseling interventions to increase hopefulness, foster positive coping skills, or reduce suicide proneness with LGBTQ+ youth. Essentially, a problem is identified; however, mental health and educational professionals are left with few evidence-based practices to support LGBTQ+ adolescents.

Given the negative experiences and subsequent suicide rates for the LGBTQ+ adolescents, helping professionals require sound interventions to support these youths'

functionality (Hass et al., 2010; Liu & Mustanski, 2012; Spirito Esposito-Smythers, 2006). Therefore, the purpose of the investigation was to examine the efficacy of a counseling group intervention to positively impact LGBTQ+ adolescents' levels of hope, coping, and suicidality.

Significance of the Study

Group counseling is an effective approach in: (a) increasing hopefulness for the future and general positive expectancy (McCay et al., 2007; Tollett & Thomas, 1995; Yalom & Leszcz, 2005); (b) teaching positive coping strategies (Meaney-Tavares & Hasking, 2013); and (c) reducing suicidal ideation and proneness (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012; Wood, Trainor, Rothwell, Moore, & Harrington, 2001). Nevertheless, the efficacy of group counseling interventions has *not* been investigated with the LGBTQ+ adolescent population, despite the identified need. As a result, the study provides knowledge as to the impact of an eight week group counseling intervention on LGBTQ+ older adolescents' levels of hope, coping skills, and suicidality as compared to LGBTQ+ older adolescents who do *not* receive the intervention. The study further examined the impact the presence of group therapeutic factors on these variables. Moreover, the results of the investigation provide insight into the relationship between participants' hope, coping, suicidality, therapeutic factors, and participants' demographic variables.

Furthermore, the intervention curriculum can be disseminated to provide mental health and educational professionals with the tools needed to address concerns and/or implement preventative measures among LGBTQ+ youth clients in school and clinical environments. Given the lack of empirically investigated interventions to increase positive outcomes with LGBTQ+ adolescents, the findings from the study made a significant contribution to the adolescent development, counseling, counselor education, and group intervention literature. Moreover, a

content analysis of articles within American Counseling Association (ACA) division-affiliated journals (N = 4,457) from 1998 to 2007 revealed that only 6% of counseling research articles explored effectiveness of counseling interventions (Ray et al., 2011). Therefore, this study contributes to needed evidence-based practice research in the counseling field.

Theoretical Foundations

Hope

Stotland (1969) provided the first integrated conceptual models for hope, identifying hope as the expectation to attain a specific goal. In Stotland's model, hope is action-oriented—a cognitive motivational force. Hope is also described as an affective experience that informs behavior and cognitive processes. Averill, Catlin, and Chon (1990) describe hope as being an emotional experience; therefore, it can be episodic in nature. They posited that "hope is a relatively short-term response tendency, usually initiated and terminated by specific environmental conditions" (p. 93). Snyder is perhaps the most well-known—and certainly most prolific—researcher of hope. In Snyder's model (2002), hope is conceptualized as a cognition containing goal-directed thinking. Specifically, hope is defined as a cognitive set that is based on a reciprocally derived sense of successful (a) agency, which refers to goal-directed determination; and (b) pathways, the act of planning on ways to meet goals (Snyder et al., 1991). In other words, where there is a will there is a way. However, in a meta-analysis on hope in the helping professions, a comparison of Snyder's *Hope Scale* (1991) to other instruments to measure hope illustrated that the sole focus on goals represented the most narrow view of the concept (Schrank, Bird, Rudnick, & Slade, 2012). What Snyder's theory fails to account for is hope in the absence of distinct goals or a sense of assuredness that one's hopes will come to fruition. The concept of "it gets better," a current driving force in the LGBTQ+ community, is

focused on the hope—and not necessarily the certainty—that one's situation will eventually become less difficult to endure. The conceptualization of hope in this context is much larger and enduring, and could be absent any specific future goals.

Other theories conceptualize hope as a much more complex and nuanced construct than an emotion or a goal. According to Frankl (1963), hope can also be a non-time-oriented coping mechanism that helps one transcend suffering, and can exist regardless of the possibility of goal achievement (Farran, Herth, & Popovich, 1995). Dufault and Martocchio (1985) define hope as a "multidimensional dynamic life force characterized by a confident *yet uncertain* expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant" (p. 380). Hope in this sense is a complex act of interweaving thoughts, emotions, and actions that develop over time; it is a process, rather than a trait. Within this definition, Dufault and Martocchio distinguish between two related but distinct spheres: generalized and particularized hope. *Generalized hope* refers to a desire for an indeterminate positive future development (e.g., "it gets better"), and serves to: (a) provide motivation to keep going in difficult times; and (b) function as a coping mechanism that protects against despair. Conversely, *particularized hope* involves a specific and valued future outcome. Hope in this state also aids in constructive coping in that it motivates one to overcome obstacles in order to reach the object of hope. The *Herth Hope Scale* (HHS) and *Herth Hope Index* (HHI; a brief version of the HHS) are modeled after Dufault and Martocchio's multidimensional theory of hope (Herth, 1991; Herth, 1992). The HHS and HHI are designed to capture "a more global sense of hope," "hope despite diminished or absent interpersonal relations," "hope as a sense of 'being' available and engaging in relationships" rather than "'doing' for oneself and others", and "potential hope for controlling behavioral and emotional responses" not necessarily events and experiences (Herth 1992, p.

1252). Unlike other theories, this description of hope leaves room for defining and measuring hopes that extend outside of personal wants, such as altruistic hope directed toward an entire community. Hope in this sense is also identified hopefulness as a coping mechanism.

Coping

Lazarus and Folkman (1984) provide the most well-known theory of coping, and define the construct as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Coping is a process that involves three components: (a) primary *appraisal*, the process of perceiving a threat to oneself; (b) *secondary appraisal*, the process of generating a potential response to the threat; and (c) *coping*, the active process of putting a response into practice (Lazarus and Folkman). However, coping is not always a linear or complete process. For example, simply realizing that an acceptable coping response is readily available should the potential threat occur may result in finding the initial event to be less ominous or discouraging. Conversely, finding that one coping strategy is less effective than anticipated may result in an amplification of how the initial threat is perceived, thereby resulting in a reappraisal of one's coping response. The process may cycle in what is known as a stressful transaction (Lazarus and Folkman).

Meyer (1995) posits that in addition to coping with personal adverse events, minorities such as the LGBTQ+ population must face additional societal stressors. The combination of discrimination, prejudice, and stigma experienced by these individuals results in hostile social environments that increase the likelihood of experiencing stress on their coping system. Minority stress is characterized by three conditions, in that it is: (a) *unique*, an additive to day-to-day stressors and is distinctive among stigmatized populations; (b) *chronic*, in that it is stable over

time as an underlying cultural structure; and (c) *socially-based*, stemming from social processes, institutions, and structures beyond individual influence (Meyer, 2003). Minority coping is conceptualized in that it involves managing stressors that stem from their stigmatized status in society. While coping strategies at an individual level varies, minority coping involves developing a sense of unity among fellow members of their community, thereby reducing stigmatization and providing personal validation; this strategy is known as "group-level" coping (Meyer, p. 677). An LGBTQ+ identity may then become a source of strength and resilience when it is associated with opportunities for social support and coping; these factors have the potential to reduce the impact of stress (Branscombe, Schmitt, & Harvey, 1999; Crocker & Major, 1989; Meyer, 2003; Miller & Major, 2000). Therefore, counseling in a group environment may address the presence of additional minority stress among LGBTQ+ adolescents.

Suicidality

Suicidality refers to a range of behaviors, including: (a) *completed suicide*, as in taking one's life; (b*) suicidal ideation*, one's thoughts about suicide ranging from fleeting thinking to detailed planning; and (c) *suicide proneness*, the engagement in overtly suicidal behavior as well as risk-taking and potentially injury-producing behaviors, coupled with a lack of engagement in health and safety behaviors, or self-enhancement behaviors (Lewinsohn et al., 1995). Rohde, Seeley, Langhinrichsen-Rohling, and Rohling (2003) refer to suicide proneness as "life attitudes," which are comprised of the spectrum of life-enhancing and life-endangering behaviors. Traditionally, suicidality is assessed by considering past suicide attempts (e.g., has the individual tried to kill themselves in the past), past suicidal ideation (e.g., has the individual had past thoughts about killing themselves), and present suicidal ideation (e.g., is the individual

currently considering committing suicide). Only in the past two decades of research has suicide proneness as a risk-factor become more prominent in scholarly literature (Graber & Brooks-Gun, 1995; Lewinsohn et al., 1995; Rohde et al., 2003). Behaviors within the construct of suicidality are comprised of thoughts, feeling, and actions which include not taking care of one's body, fixating on the concept of death, feeling that life is not worth living and engaging in high levels of risky behavior (Rohde et al., 1996). A primary advantage of being able to measure life attitudes is that it allows for earlier prediction of possible suicide (Rohde et al., 2003).

Group Therapeutic Factors

Therapeutic factors that are unique to the group experience have been an area of inquiry for decades. Corsini and Rosenberg (1955) offered the first comprehensive analysis of group processes and dynamics in a meta-analysis of 300 conceptual scholarly works on the topic. They identified nine major therapeutic factors, which were categorized into three groups: (a) intellectual; (b) emotional; and (c) actional. Yalom (2005), however, was the first to identify group therapeutic factors based on empirical research, and classified 11 curative factors: (a) instillation of hope; (b) altruism; (c) universality; (d) imparting information; (e) development of socializing techniques; (f) corrective reenactment of the primary family group; (g) imitative behavior; (h) interpersonal learning; (i) cohesiveness; (j) catharsis; and (k) existential factors. A detailed description of each of these factors follows:

Instillation of hope. Hope in this sense describes the members' expectation that the intervention will be effective, and is considered critical in therapeutic environments (Yalom & Leszcz, 2005). The higher the expectation that the group will be beneficial, the greater the benefit, and the more positive the influence for each individual and the group as a whole. Group

leaders can help foster the instillation of hope by describing the expected benefits of group at the outset, and highlighting members' progress and successes throughout sessions.

Universality. The construct of universality describes the therapeutic value in hearing that others share similar thoughts, emotions, and struggles of your own (Yalom & Leszcz, 2005). As each member self-discloses information based on their lived experiences, feelings of isolation are lifted and empathy is increased. In groups composed of individuals for whom secrecy is a prevalent and isolating factor (as is often the case among LGBTQ+ adolescents), the presence of universality can be particularly therapeutic (Yalom & Leszcz).

Altruism. The giving of oneself to be of benefit to others in a group environment is a key therapeutic factor, especially for those who may consider themselves to be burdens (Yalom & Leszcz, 2005). The experience of finding that they have something unique and important to others (in terms of sharing experiences and providing support) can provide a boost to one's self-esteem.

Imparting information. The construct of imparting information includes direct instruction from the facilitator and the giving of advice by fellow members (Yalom & Leszcz, 2005). Group members often feel anxiety due to a lack of certainty about what they can do to improve their situation; the imparting of information, therefore, can be a curative feature of group work.

Development of socializing techniques. Although the directness of skills taught varies from group to group, social learning serves to highlight discrepancies between members' intent of a behavior and their actual impact on themselves and others (Yalom & Leszcz, 2005). The primary benefit of the socializing techniques factor is that feedback from others often provides the needed impetus for positive change.

Corrective reenactment of the primary family group. Group members can often represent a family environment, allowing members to have the opportunity to live out family of origin roles, thus providing insight into maladaptive behavior patterns and issues (Yalom & Leszcz, 2005).

Imitative behavior. The imitative behavior factor describes the tendency of group members to imitate the behaviors of the facilitator or fellow members (Yalom & Leszcz, 2005). Learning and growth can be fostered when positive examples are set (e.g., listening empathetically, providing support, self-disclosure, etc.).

Interpersonal learning. The interpersonal learning factor represents the ability of group members to learn from others by having one's assumptions challenged in a safe and therapeutic setting (Yalom & Leszcz, 2005).

Cohesiveness. The feelings of emotional closeness among group members are described as cohesion (Yalom & Leszcz, 2005). It is the feeling of "we-ness" that keeps members engaged in the group experience and provides a sense of belonging. Group cohesion is a key factor in individual therapeutic outcomes, and is signified by support, acceptance, and the inclination to form meaningful relationships (Yalom & Leszcz).

Catharsis. Described as a "purging of emotion," catharsis is the intense outward emotional expression of feeling that can take place during group sessions (Yalom & Leszcz, 2005).

Existential factors. Perhaps the most complex group factor, existential issues in the group environment are conceptualized as having five parts: (a) recognition that life can be unfair; (b) recognition that life contains pain and death; (c) recognition that one has to face life; (d)

facing issues of life and death; and (e) recognition that individual responsibility is necessary for actions in life (Yalom & Leszcz, 2005).

These 11 therapeutic group factors, particularly the instillation of hope and universality, have the potential to foster growth among LGBTQ+ adolescents in a way that individual counseling is unlikely to accomplish. The identification of these group therapeutic factors and subsequent supporting research led to a group modality being selected for this investigation (Butler & Fuhriman, 1980, 1983; Colijn, Hoencamp, Snijders, & Van der Spek, 1991; Wheeler, O'Malley, Waldo, Murphey, & Blank, 1992). Group counseling interventions have the potential to increase hopefulness and increase peer connectedness among members. It was anticipated that increased levels of individual therapeutic factors and the experience of therapeutic factors as a whole would have a positive impact on participants' hope, coping, and suicidality.

Operational Definition of Terms

The operational definition of each key term and construct is provided below in order to provide a context for the investigation that follows. These definitions are divided into two groups: (a) terms regarding the study's population; and (b) terms regarding the key constructs of the study.

Population Terms

Affectional orientation. The term affectional orientation is used as an alternative to "sexual orientation," which refers to an enduring pattern of emotional, romantic, and/or sexual attractions (or lack thereof) to men, women, or both sexes. Affectional orientation also refers to a person's sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions (American Psychological Association [APA], 2008). The decision to substitute "affectional" for "sexual" is based on: (a) the view that one's

orientation is defined by romantic feelings and who one is predisposed to fall in love with; (b) sexual attraction is only a single component of this larger, more complex dynamic; and (c) use of the term "sexual orientation" reduces a complex system of emotions and connections to sex.

Gender identity and expression. Gender identity refers to a person's internal sense of being male, female, transgender, or another gender (e.g., a third gender as in the hijras of Indian culture, or no gender at all), while gender expression refers to the way an individual communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics (American Psychological Association Task Force on Gender Identity, Gender Variance, and Intersex Conditions, 2011). Transgender, for example, is an umbrella term for persons whose gender identity and/or gender expression, does not conform to that typically associated with the biological sex to which they were assigned at birth.

Cisgender. The term cisgender replaces the term "nontransgender" in referring to individuals who "have a match between the gender they were assigned at birth, their bodies, and their personal identity" (Schilt & Westbrook 2009, p. 461).

LGBTQ+. Use of the acronym LGBTQ+ delineates an umbrella term for the communities of individuals who identify as lesbian, gay, bisexual, transgender, queer, or otherwise as a minority in terms of affectional orientation or gender identity and expression (e.g., questioning, asexual, intersex, hijra third gender, etc). Essentially, LGBTQ+ is used to refer to any person who does *not* identify as exclusively heterosexual and cisgender. Despite commonalities within this group, there is significant diversity among the various subgroups represented by this definition in terms of identity, culture, and issues faced.

Older Adolescent. Broadly defined, an older adolescent is an individual who is in the process of developing from adolescence into an adulthood; there is no one scientific definition

for the term older adolescent. For the purpose of this investigation, an older adolescent is operationally defined as any individual between the ages of 18-20.

Construct Terms

Hope. Dufault and Martocchio (1985) define hope as a "multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant" (p. 380). Within this definition of hope are two related but distinct spheres: generalized and particularized hope. Generalized hope refers to a desire for an indeterminate positive future development (e.g., "it gets better"), and serves to: (a) provide motivation to keep going in difficult times; and (b) function as a coping mechanism that protects against despair. Conversely, particularized hope involves a specific and valued future outcome.

Coping. Lazarus and Folkman (1984) define coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Other phrases that refer to and are used interchangeably to describe this construct include "coping skills," "coping behaviors," and "coping strategies."

Suicidality. Rhode and colleagues (1996) describe suicidality in terms of "life attitudes," which referring to an individual's overall thoughts, feelings, and actions regarding: (a) death (e.g., suicidal ideation, suicidal proneness, longevity; (b) health (e.g., illness, self-care, and wellness; (c) injury (e.g., risk-taking and safety); and (d) self (e.g., self-worth and self-image). A measure of life attitudes in this instance is synonymous with suicide proneness.

Therapeutic factors. Yalom (1995) describes therapeutic factors as the positive manifestations of counseling group experiences that engage group members in the group process and facilitate intrapersonal and interpersonal development.

Research Hypothesis & Exploratory Questions

The purpose of this research investigation was to compare mean differences in LGBTQ+ older adolescents' hopelessness, coping skills, and suicidality scores who participate in an eight-week group counseling intervention as compared to LGBTQ+ older adolescents who did *not* participate in the group intervention. Specifically, the following research questions and hypotheses guided the investigation:

Primary Research Question and Hypothesis

What is the impact of an eight-week group counseling intervention on LGBTQ+ older adolescents' (ages 18-20) levels of hopefulness (as measured by the *Herth Hope Index* [HHI; Herth, 1992), positive coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the *Life Attitudes Schedule Short Form* [LAS-SF; Rohde, et al., 1996]) as compared to LGBTQ+ older adolescents who do *not* receive the intervention?

It was hypothesized that for the intervention group, there would be increases in scores related to hopefulness and positive coping behaviors, and a decrease in negative coping behaviors and suicidality when compared to pre-test scores, and when compared to the control group. No significant differences in scores were expected for the control group.

Exploratory Research Questions and Hypotheses

Exploratory research question 1. Are LGBTQ+ older adolescents' (ages 18-20) self-reported levels of hopefulness (as measured by the HHI [Herth, 1992]) and positive coping skills

(as measured by the *Brief COPE* [Carver, 1997]), predictive of decreased suicidality (as measured by the LAS-SF [Rohde, et al., 1996])? It was hypothesized that higher scores in hopefulness and positive coping skills would correlate with lower scores in suicidality.

Exploratory research question 2. What is the relationship between the presence of group therapeutic factors total and subscale scores (as measured by the *Therapeutic Factors Inventory Short Form* [TFI-S; Joyce et al., 2011]) and levels of hopefulness (as measured by the HHI [Herth, 1992]), coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the LAS-SF [Rohde, et al., 1996]) in a sample of LGBTQ+ adolescents (ages 13-19)? It was hypothesized that there would be a positive relationship between group therapeutic factors and hopefulness, coping skills, and suicidality.

Exploratory research question 3. What is the relationship between LGBTQ+ older adolescents' (ages 18-20) demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, perception of peer support and perception of parental support) and their levels of hopefulness (as measured by the HHI [Herth, 1992]), coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the LAS-SF [Rohde, et al., 1996])?

Methodology

Research Design

An experimental, repeated measures design was employed to examine the noted research hypotheses. Experimental research designs are the most rigorous design in determining the cause and effect relationship between independent and dependent variables (Gall, Gall, & Borg, 2007). Moreover, experiments that incorporate randomized control provide evidence that the observed effects are due to the intervention rather than other variables (Gall et al., 2007). Therefore, the

investigation employed random assignment into intervention or control groups. The online tool offered at www.randomizer.org was used to identify intervention versus control group participants (Urbaniak & Plous, 2012). Moreover, the use of pre-test, mid-test, and post-test measures aided in assessing the level of extraneous influence on participants' outcomes, and to increase the power of the statistical analysis (Dugard & Todman, 1995; Pallant, 2010). The study also utilized waitlist control groups rather than no-treatment control groups as the waitlist control group design allows for all of the participants to experience the benefits of receiving the intervention (West & Spring, 2007).

Procedures

Recruitment. Prior to the recruitment of participants, the researcher received approval from an Institutional Review Board (IRB) to conduct the study (Appendix A). Study participants were recruited via flyers (Appendix D) and in-person announcements at LGBTQ+ related events and organization meetings throughout the greater Orlando, Florida area. In addition, study details were announced via email distribution lists and announcements were posted on LGBTQ+ related social media websites (Appendix C). Participants were also referred on an individual basis to participate in the investigation.

Each participant completed a formal pre-screening interview conducted by the investigator in order to assess overall readiness and motivation to be a part of a group environment, as well as the applicability of potential participants' concerns to the elements of the intervention (Appendix E). Characteristics for exclusion to participate in the investigation included: (a) being under the age of 18; (b) a suicide attempt within the last 12 months; or (c) active drug abuse in order to minimalize facilitator liability and to trigger referrals for individual counseling or more appropriate groups to match the intensity of the individuals' need. Informed

consent was also reviewed with potential participants during the screening, and hard copies were provided to participants for their records (Appendix B). The researcher emphasized that participation in the study was voluntary, participants could withdraw at any time without penalty, and that all collected data was confidential (i.e., assigned alpha numeric codes known only to the researcher were used to connect participants to assessment data in place of names), and stored in a locked cabinet in a locked office. Participants were also made aware that they would be randomly selected to participate in either the intervention group or the waitlist control group. Furthermore, participants were made aware of minimal risks associated with the study, such as experiencing triggering events and intense emotions, as well as the potential for breach of confidentiality by fellow group members (though members were repeatedly reminded of the importance of confidentiality throughout the course of the intervention). Other than the intervention itself, participants did *not* receive any additional incentives for participation. The intervention was offered through two mental health centers located in the greater Orlando Metropolitan area.

Data collection. Data collection for the investigation occurred between September 2013 and December 2013. Approval to conduct the study was received by the Institutional Review Board prior to the collection of any data. Data were collected from participants at three points during the investigation: (a) a pre-assessment, completed during the first week of the study; (b) a mid-assessment, completed after the fourth week of the study; and (c) a post-assessment, completed on the eighth week of the study. The data collection instruments were provided to the participants (intervention and control group) in a manila envelope, and the participants were instructed to *not* include identifying information on either the envelope or the assessments themselves in order to ensure confidentiality. Each participant was assigned a unique code

identifier known only to the researcher, which also facilitated the ability to connect each of the participants' three data collection interval scores by assigning a letter noting group placement, a unique participant number, and an number noting whether the assessment was a pre, mid, or post test (e.g., participant A37-1, A37-2, A37-3). Assessment packets took approximately 10-15 minutes to complete. Data were stored in a locked desk in the researcher's office.

Intervention group participants completed each of the assessments immediately following the first, fourth, and eighth group sessions. Waitlist control group participants had three options for completing the data collection packets during the first, fourth, and eighth week of the investigation: (a) they could have the assessment packet mailed to them along with a self-addressed stamped envelope for returning the completed instruments; or (b) they could pick-up and drop-off the assessment packet at a designated location, or (c) they could make an appointment with the researcher to complete the assessment packet in a neutral location. The mailed envelopes included only the individual participant's code identifier in lieu of their name.

Sampling Procedures and Population Sample

Sampling procedures. The target population for the investigation were older adolescents, defined for the purposes of this study as being between the ages of 18-20, who also identify as lesbian, gay, bisexual, transgender, queer, or otherwise as minority in regards to affectional orientation or gender identity/expression (LGBTQ+). Due to the difficulty in estimating the total population of LGBTQ+ late adolescents living in the United States, or even in a particular community, the researcher recruited participants from an accessible population of individuals who could realistically be included in the sample, by identifying potential participants from specific universities, community centers, and organizations located within the greater metropolitan Orlando, Florida area. The sample was recruited during May through

August, 2013 through via flyers, emails, posting on social networking sites, face-to-face announcements, and individual referral.

Population sample. Any older adolescent who identifies as lesbian, gay, bisexual, transgender, queer, or otherwise as a minority in terms of affectional orientation or gender identity was eligible for this study. An "older adolescent" was defined as an individual between the ages of 18 and 20. Individuals who were 17 years of age or younger were excluded from this study but were considered for future research.

The desired sample size for this study was determined by the determination of significance at the .05 alpha level and adequate power at .80. An *a priori* power analysis was conducted for this study, taking into account the effect size, the sample size, the number of groups, and the number of measurements in the study. Per the recommendation of Balkin and Sheperis (2011), the free statistical program G*power was used to conduct the analysis (Faul, Erdfelder, Lang, & Buchner, 2007). Given that the parameters of the study include two groups (i.e., assignment to either the intervention or the control group), three measures (i.e., pre-test, mid-test, and post-test), and within-between interaction multivariate analysis of variance (MANOVA) in data analysis with significance at the .05 alpha level, desired power at .8, and an anticipated medium to large effect size, the study required a minimum sample size of 32 participants. Therefore, the minimal sample size for adequate power was met ($n = 34$), thereby decreasing the likelihood of Type II error, and increase the ability to generalize results (Balkin & Sheperis, 2011).

Group Counseling Intervention

The primary goal of the group counseling intervention curriculum was to increase hope, coping skills, and reduce suicidality in LGBTQ+ older adolescent participants. Strategies and

interventions to increase hope are *not* prevalent in the available research, and are described in qualitative studies (Shrank & Bird, 2011). No studies were found that described experimental research that implemented interventions to increase hope in LGBTQ+ adolescents, lending additional credence to the importance of this study. That said, the most promising interventions identified in the available literature include: (a) fostering relationships; (b) peer support; (c) goal-setting; and (d) developing protective factors like self-esteem, self-efficacy, and general well-being (Shrank & Bird). Therefore, activities that foster these factors were incorporated in a supportive group format. For coping, Stone and Neale (1984) highlighted the primary components that assist in positive coping behaviors: (a) acceptance; (b) social support; (c) catharsis; (d) direct action; (e) relaxation; and (f) situation redefinition (e.g. reframing). Some of these conditions are met by virtue of the group environment (Yalom & Leszcz, 2005), while others were increased through a variety of activities. Finally, suicidal ideation is mitigated by the presence of protective factors like (a) positive expectancy (i.e., hope); (b) positive coping strategies; and (c) peer-based support. A copy of the intervention curriculum is provided in Appendix K.

LGBTQ+ older adolescent participants that were randomly selected to participate in the intervention in group counseling did so over eight consecutive weeks, one session per week, with each session lasting approximately 60 minutes. Group sizes were restricted to five to six participants, as with larger groups the opportunity for member interaction and relationship development decreases, and becomes leader rather than member centered (Gladding, 2012). An interactive, experiential format was selected for the group intervention based on empirical support identifying that such delivery methods promote higher client satisfaction, increased response to the intervention, and greater retention of learning (Emer, McLarney, Goodwin, &

Keller, 2002; Greene & Cole, 1991). Furthermore, the use of psychoeducation was used to foster positive participant outcomes. Psychoeducation in group interventions involves the conveying of information to the group participants and fostering of their skill development for the purpose of promoting interpersonal growth and preventing future difficulties among those who may be at risk for developing future problems (Association for Specialists in Group Work, 2000; Brown, 1997; Gladding, 2012). Specifically, psychoeducational group work with adolescents decreases psychological symptoms (e.g., anxiety, interpersonal sensitivity; Wang, 1997), alleviates depression (Gaynor & Lawrence, 2002), increases self-esteem (Wells, Miller, Tobacyk, & Clanton, 2002), and improves coping strategies and resources (Hayes & Morgan, 2005). In addition, a strength-based approach (e.g., identifying group participants' existing strengths and developing resiliency) was employed as this therapeutic method is beneficial in improving adolescents' life satisfaction, overall well-being, and group cohesion (e.g., Harris, Brazeau, Clarkson, Brownlee, & Rawana, 2012; Proctor et al., 2011).

The first session of the group curriculum was focused on introductions and an icebreaker, explaining the goals of the group; discussion regarding what brought members to the group, and general rapport building. In addition, the informed consent and limits/exceptions to confidentiality was reviewed. Furthermore, the participants completed four data collection instruments: (a) a participant demographic questionnaire (Griffith, 2013); (b) the *Herth Hope Index* (HHI; Herth, 1992); (c) the *Brief COPE* (Carver, 1997); and (d) *Life Attitudes Schedule – Short Form* (LAS-SF; Rhode et al., 1996). Emergency resources for the participants were also discussed and disseminated at the first group meeting, including a national suicide hotline and additional local community resources. Group intervention sessions two through four focused on participants identifying current coping skills and improving their positive coping skills (e.g.,

creating a wellness wheel, diaphragmatic breathing, and positive reframing). Immediately following the fourth group intervention session, participants completed mid-point assessments for the HHI, *Brief COPE*, and LAS-SF. Group intervention sessions five through seven focused on the participants building hope (e.g., hopes for the future art assignments, a letter to themselves from the future, and goal-setting). The eighth group intervention session (the termination meeting) focused on: (a) reviewing the participants' progress since the beginning of group; (b) discussing how they planned to continue their progress now that group intervention was concluding; and (c) facilitating a metaphorical "gift exchange" activity in which participants express "gifts" they would like to give or felt they received from other group members and/or the group facilitator. At the conclusion of the eighth group intervention session, the participants completed the HHI, *Brief COPE*, and LAS-SF for the third time, as well as the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) and an exit survey developed by the researcher.

Treatment fidelity was an important consideration in this study as the researcher and volunteer facilitators needed to adhere to the specifications of the intervention in order to ensure the effects of the intervention are what are being measured (Gall et al., 2007). Based on the recommendations provided by Gall and colleagues, treatment fidelity was maximized in the following ways: (a) a facilitator handbook was provided with instructions as to how to implement the intervention along with standardized curriculum; (b) the researcher conducted standardized in-person training with the facilitators; and (c) facilitators were required to keep a log of group session content in order verify uniformity in the application of the group curriculum.

Instrumentation

Demographic Questionnaire. A demographic questionnaire was developed by the researcher to determine age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+ status, as well as ratings of perceived peer and parental support (Appendix F). As noted, both intervention and control group participants completed this form at the beginning of the study. The demographic questionnaire was reviewed by colleagues before being administered to participants in order to provide support for face validity and readability.

Hearth Hope Index. In order to measure participants' changes in hope at the conclusion of the investigation, the study included the *Herth Hope Index* (HHI; Herth, 1992; Appendix G). Other measures of hope focus on hopelessness rather than the presence of hope (e.g., Beck *Hopelessness Scale*; Beck et al, 1974), or exclusively on one's perception of their ability to achieve goals (e.g., the *Hope Scale*; Snyder et al., 1991; *Children's Hope Scale*; Snyder et al., 1997). The HHI, however, measures variables aligned to the broader aim of the intervention, to also increase a general, non-time-oriented sense of positive expectancy and a sense of interconnectedness. Therefore, the global concept assessed by the HHI was the most appropriate for this investigation.

The HHI consists of 12-items on a four-point Likert agreement scale (i.e., strongly disagree, disagree, agree, strongly agree), thereby presenting respondents with a force-choice as to whether they fall on the positive or negative side of a variable. Example items from the HHI include: (a) "I have a positive outlook toward life"; (b) "I have a sense of direction"; and (c) "I feel my life has value and worth." Higher scores indicate participant *increases* in hopefulness. A minimum score on the HHI is 12 and the maximum score is 48.

The HHI is an abbreviated version of the 30-item *Herth Hope Scale* (HHS; Herth, 1991). Herth (1992) notes that the purpose of the HHI is to capture the multidimensionality of hope as measured by the HHS while "reducing the number and complexity of items so as to render the tool more clinically useful" (p. 1252). The HHI was designed to parallel the same three subscales as the original HHS: (a) cognitive-temporal, the sense that desired outcomes will realistically be achieved at some point in the future; (b) affective-behavioral, a feeling of confidence regarding the likelihood of a positive future; and (c) affiliative-contextual; a recognition of the interconnectedness between both self and others and self and spirit.

Brief COPE. The instrument selected to measure changes in the coping strategies that participants employ before, during, and after the investigation was the *Brief COPE* (Carver, 1997; Appendix H). The *Brief COPE* is a 28-item instrument that measures participants' coping behaviors by examining participants' prevalence of 14 conceptually distinct coping reactions: (1) active coping; (2) planning; (3) using instrumental support; (4) using emotional support; (5) venting; (6) self-distraction; (7) positive reframing; (8) humor; (9) acceptance; (10) religion; (11) behavioral disengagement; (12) self-blame; (13) denial; and (14) substance use. Each of the 14 subscales includes two questions; total scores for the *Brief COPE* range from 0-112. Response options are on a 4-point Likert frequency scale: (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." Example statements from the *Brief COPE* include: (a) "I've been getting emotional support from others"; (b) "I've been expressing my negative feelings"; and (c) "I've been criticizing myself."

The *Brief COPE* was *not* designed to be interpreted in terms of total scores. Therefore, for the purposes of this investigation, the *Brief COPE* was used to distinguish between participants' *Adaptive Coping* (i.e. positive coping behaviors) based on higher total scores on

questions related to subscales 1-10 (active coping; planning; using instrumental support; using emotional support; venting; self-distraction; positive reframing; humor; acceptance; and religion) and participants' *Maladaptive Coping* (i.e. negative coping behaviors) based on higher total scores on factors 11-14 (behavioral disengagement; self-blame; denial; and substance use). These two coping categorizations (adaptive and maladaptive coping) differentiate between positive and negative coping strategies (Hampel & Petermann, 2005). Prior research supported the use of the *Brief COPE* to assess adaptive and maladaptive coping (e.g., Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006).

The *Brief COPE* is an abbreviated form of a parent instrument to measure coping, the *COPE*, which was developed by the same author (Carver, 1989). The shortened version was selected because it is the only coping skills instrument found by the researcher that measures the desired breadth of coping behaviors without containing a burdensome amount of questions. While brief, much information is obtained about participants' positive and negative coping strategies. In addition, the *Brief COPE* has the advantage of being built from acknowledged theoretical models: (a) the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984), and (b) the *Behavioral Self-regulation Model* (Carver & Scheier, 1988).

Life Attitudes Schedule Short Form. Intensity of participants' suicidal ideation and proneness (i.e., an individual's propensity to engage in suicidal behavior) was measured by *Life Attitudes Schedule Short Form* (LAS-SF; Rohde et al., 1996; Appendix I). The LAS-SF includes measures for subtle and overt self-destructive, risk-taking behaviors, as well as life-extending behaviors. Responses fall on a continuum of positive and negative actions, thoughts, and feelings. The original LAS-SF utilized a true/false scale; however, for the purposes of detecting changes in suicidality with greater sensitivity over the course of this investigation, the LAS-SF

was replaced with a 4-point Likert scale wherein 1 = "Not at all true of myself," 2 = "Slightly true of myself," 3 = "Mostly true of myself," and 4 = "True of myself." The LAS-SF is comprised of 24 items and takes approximately five minutes to complete. Higher LAS-SF scores indicate participant *decreases* in suicidality. A minimum LAS-SF score is 24 and the maximum score is 96. The LAS-SF is ideal for this investigation *not* only for its breadth of proneness measures in a short form format, but for its non-stigmatizing and non-alarming title, "life attitudes." It was anticipated that similar measures to the LAS-SF that incorporate "suicide" would limit engagement from participants and participating organizations.

The LAS-SF was designed to be a brief version of its parent instrument, the 96-item *Life Attitude Schedule* (*LAS*; Lewinsohn et al., 1995). The short form consists of the same four subscales as the original instrument: (a) *Death Related*, suicide and death related items and reasons to live; (b) *Health Related*, items that measure illness, lack of self-care, and wellness; (c) *Self Related*, items that measure self-worth, self-image, self-enhancement, and self-promotion; and (d) *Injury Related*, items that measure injury-enhancing, risk-taking, and safety related thoughts, feelings, and behaviors. Example items on the LAS-SF include: (a) "I expect to have a long and interesting life"; (b) "killing myself would solve many of my problems"; and (c) "I think I am worthless." The LAS-SF is *not* intended to serve as a suicidal intent intake and does not assess participants' presence of a suicide plan, access to means, imminent threat, or prior attempts. Data analysis with the LAS-SF was based on instrument total scores, and total scores for each of the four subscales.

Therapeutic Factors Inventory Short Form. In order to assess the level of group therapeutic factors that participants experienced at the conclusion of the intervention, the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011; Appendix J) was

administered at the conclusion of the final session. The TFI-S is a 19-item instrument categorized into four subscales: (a) instillation of hope; (b) secure emotional expression; (c) awareness of relational impact; and (d) social learning. Participants provide responses on a seven-point Likert scale (i.e., strongly disagree to strongly agree). Higher scores indicate participant *increases* in a personal experience of overall group effectiveness as based on Yalom's (2005) 11 therapeutic factors. A minimum score on the TFI-S is 19 and the maximum score is 133. Example TFI-S statements include: (a) Things seem more hopeful since joining group; (b) I feel a sense of belonging in group; and (c) this group empowers me to make a difference in my own life. The TFI-S is a shortened version of its parent instrument, the *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000), which included 99 items. Data analysis for the TFI-S included instrument total scores and total scores for each of the four subscales.

Data Analysis

The dataset for the investigation included one independent variable (i.e., placement in the intervention group or the control group) and four continuous dependent variables: (a) intervention and control group participants' hope (as measured by the HHI; Herth, 1992); (b) coping skills (as measured by the *Brief COPE*, Carver, 1997); (c) suicidality (as measured by the LAS-SF; Rohde et al., 1996); and (d) intervention group participants' experience of group therapeutic factors (as measured by the TFI-S; Joyce et al., 2011). Additional variables from the demographic questionnaire include participants' age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, as well as ratings of perceived peer and parent/guardian support.

For the first research question, the aim was to determine whether LGBTQ+ adolescents who receive the eight-week group intervention increase their levels of hope and positive coping

skills, and decrease their negative coping skills and suicidality from prior to the intervention as compared to LGBTQ+ adolescents in the control group who do *not* receive the intervention. To answer this question, the researcher conducted a repeated measures multivariate analysis of variance (MANOVA). MANOVA is used when the researcher wishes to test a hypothesis that one or more independent variables have an effect on two or more dependent variables (Tabanick & Fidell, 2007). Total instrument scores and total subscale scores were examined. In order to determine the practical significance of the intervention, special attention was paid to effect sizes.

A standard multiple linear regression (MLR) was calculated to determine whether there was a predictive relationship between scores on the post-test HHI and the post-test *Brief COPE* Adaptive Coping scale as independent variables, and the post-test LAS-SF as the dependent variable. It was anticipated that as post-test scores on the HHI and *Brief COPE* Adaptive Coping scale rise, so would post-test scores on the LAS-SF, essentially measuring if an increase in hope and positive coping skills has an impact on suicidality. Both intervention and control groups' scores on these instruments were examined. Furthermore, a Pearson Product Moment Correlation (two-tailed) was used to calculate whether there was relationship between the presence of group therapeutic factors and levels of hope, positive coping skills, and suicidality for participants in the intervention group. The Pearson correlation also highlights the strength of the relationship and what percentage of the variance in scores can be accounted for by the linear relationship with each instrument (Tabanick & Fidell, 2013). Lastly, a one-way between groups analysis of variance (ANOVA) was used to calculate whether there was a relationship between participants' demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, perception of peer support and perception of parental support) and levels of hope, coping skills, and suicidality.

Ethical Considerations

The following safeguards were in place to ensure that the investigation was conducted in an ethical manner:

1. Approval for the study and all materials used (e.g., curriculum, permission forms, advertising flyers, etc.) was obtained from the University of Central Florida's IRB, dissertation co-chairs, and committee members, prior to the implementation of the investigation.
2. Participants were fully informed of their rights regarding their involvement in the investigation, including the voluntary nature of their participation and ability to withdraw from the study at any time without penalty.
3. Participants were informed of the limits of confidentiality in a group setting, due to the inability on the part of the facilitator to guarantee that participants will not disclose content from the sessions. Facilitators discussed and reviewed the importance of confidentiality during group sessions. Furthermore, participants were informed of the facilitator's role as a mandated reporter, and that confidentiality would need to be broken in cases of suicidal intent, threats to harm another individual, or knowledge of the abuse of a protected population (e.g., minors, the elderly, and adults with special needs).
4. Data from the instruments did *not* include identifying information in order to ensure participants' confidentiality. To assist in data analysis, each participant was assigned a unique code identifier known only to the researcher. Participants were also informed that data from the study may be presented in a public forum, but that individual data will remain confidential.

Potential Limitations of the Study

Though efforts were taken to limit threats to internal and external validity within this experimental investigation, limitations exist:

1. The novelty effect presents a threat to internal validity, which occurs when participants alter their behavior because the intervention produces excitement and enthusiasm. Given that a primary purpose of this group is to produce hope (also referred to as "expectancy"), the novelty effect may be a difficult threat to internal validity to address.
2. Although several measures were taken to ensure treatment fidelity (i.e., facilitator training, standardized curriculum, and group content record-keeping), it would be unrealistic to expect complete treatment fidelity. Each group possessed unique group dynamics due to the individual personalities of the participants. Therefore, there is the potential that content outside of the curriculum may was introduced which may have influenced the findings of the investigation. Additionally, the individual characteristics of the group facilitators (e.g., disposition, leadership style, warmth, etc.) also likely had an impact on group outcomes.
3. The data collection instruments used in this investigation rely on self-report. Therefore, the data may reflect social desirability bias or a lack of self-awareness that may have influenced the study results.
4. Gall and colleagues (2007) note that there is an inherent difficulty in identifying target or accessible population parameters for groups that are partially "hidden" in society, which is often the case for LGBTQ+ youth due to fear surrounding rejection, safety, and stigma. By relying on participants that openly self-identify as LGBTQ+ to some degree, there is a risk the data from this investigation is from a biased sample.

5. Lastly, all data collection instruments have some measurement error despite available evidence demonstrating sounds psychometric properties in terms of reliability and validity.

Chapter Summary

This chapter detailed the rationale and relevance of an investigation to examine the impact of a group counseling intervention with LGBTQ+ older adolescents. The primary constructs of hope, coping, suicidality, and therapeutic factors were explored and operational definitions were provided. Furthermore, experimental research design has been explained. Ethical considerations and potential limitations to the study have been described. In sum, the primary objectives of this study were to: (a) investigate differences in hope, coping skills, and suicidality with participants in the intervention groups and non-participants; (b) investigate differences in hope, coping skills, suicidality, and experience of group therapeutic factors with participants in the intervention groups; and (c) explore the relationship between hope, coping skills, suicidality, and participants' demographic variables. Among the LGBTQ+ adolescent population, there is a lack of empirically supported interventions for mental health professionals to turn to, and little knowledge regarding the relationship between the above constructs. Therefore, there is a need to conduct research to contribute to the knowledge base of what improves outcomes among LGBTQ+ youth, and why.

CHAPTER TWO: LITERATURE REVIEW

The present study investigated the impact of an eight week group counseling intervention on LGBTQ+ older adolescents' (ages 18-20) levels of hope, coping skills, and suicidality, as compared to LGBTQ+ adolescents who do *not* receive the intervention. In addition, for participants in the intervention group, the presence of group therapeutic factors was measured to determine its impact on hope, coping, and suicidality. Lastly, the relationship between participants' hope, coping, suicidality, and demographic information was explored. Therefore, the following review includes literature on the theoretical background of and empirical support for each of the identified constructs: (a) hope; (b) coping; (c) suicidality; and (d) group therapeutic factors. Special attention is placed on literature that pertains to the LGBTQ+ and adolescent population.

Hope

> *You have to give them hope. Hope for a better world, hope for a better tomorrow, hope for a better place to come to if the pressures at home are too great. Hope that all will be all right.*
>
> *–Harvey Milk, 1978*

Origins of Conceptualizing Hope

The origins of hope as a construct in research begin with the opposing ends of a spectrum: hopelessness and helplessness. Building off of prior investigations into the learned helplessness of animals, Hiroto and Seligman (1975) conducted experiments with human participants exploring the difference between avoidable and unavoidable negative stimulus on participants' ability to complete cognitive exercises. Similar to previous research, results indicated that participants who experienced the unavoidable negative stimulus demonstrated decreased ability to complete tasks related to their perception that they did not have any control

over their environment (Hiroto & Seligman). It was from this research that correlations between hope and depression began to be explored.

Abramson, Seligman, and Teasdale (1978) developed a theory that the degree and behavioral manifestations of helplessness were determined by individual perspectives of "why" adverse events happen to them, and indicated key factors in how participant perspectives influenced feelings of helplessness. For example, if the experience was considered to be stable (e.g., "it's going to last forever") versus unstable (e.g., "this is a temporary situation"), then the feelings of helplessness would be long-lasting. Secondly, if considered to be global (e.g., "it's going to undermine everything") rather than specific (e.g., "this is unique to this situation"), then helplessness will be general. Lastly, if the cause was considered to be internal (e.g., "it's something about me") and not external (e.g., "this was caused by something or someone else"), then the helplessness would also be marked by a loss of self-esteem. The pattern between these factors would account for an individual's general expectations for the future. Beck and colleagues (1963, 1967, 1974) have devoted similar attention to the role hopelessness plays in pessimism, depression, and suicide, and defined hopelessness as a set of cognitive schemata involving negative expectations concerning one's self and future. The development of these causal attributions eventually inspired questions regarding the opposite end of the spectrum, and as a result Seligman began exploring the complimentary construct of "expectations" (Seligman, 1991; Buchanan & Seligman, 1995). Seligman's work has been echoed by others interested in investigating hope, optimism, coping, and well-being.

Conceptually, hope in psychotherapy was discussed by scholars as early as the 1950s. Menninger (1959) described hope as a basic but elusive ingredient permeating all facets of the daily work of helping professionals, in teaching, in healing, even in diagnosing. In *Man's Search*

for Meaning, Frankl (1963) describes the importance of identifying a purpose in life to feel positively about as a means of survival. Frankl, who was himself a survivor of a Nazi concentration camp, noted the role of how fellow prisoners imagined their future outcomes affected their ability to endure such conditions. Extending these observations to applications in psychotherapy, Frankl espoused the idea that to hope is an exercise of will, not entirely subject to one's conditions, and can be present even in the most severe conditions (Frankl, 1963). Hope, however, has long been maligned as a concept that is too vague or complex to measure. A meta-analysis of hope in nursing literature conducted by Kylmä, and Vehviläinen-Julkunen (1997), for example, highlighted eight distinct characteristics that have informed the definition of hope: (a) a unique personal experience; (b) a human capacity; (c) an inner readiness; (d) a need; (e) a state of being; (f) a source of reforming human experience; (g) an individual characteristic; and, most notably, (h) an absence of hopelessness and despair. Yet in the past three decades much scholarly attention has centered on determining operational definitions for hope, constructing theories of hope, and developing instruments to measure hope.

Theories and Definitions of Hope

There are distinct advantages in determining an operational definition for hope, as such definitions lead to the ability of researchers to identify high hope individuals in order to learn from them. Is hopefulness simply a state of being, or is there an active effort at play that aids in the attainment of positive life outcomes? Furthermore, defining hope helps to determine correlates with other variables. What is the relationship between hope (or lack thereof) and related, but distinct constructs such as optimism, self-efficacy, depression, and suicidality? Scholars have focused on defining, understanding, and measuring hope in order to identify interventions that increase individuals' levels of hopefulness, thereby increasing well-being and

the ability to thrive in adverse circumstances (e.g., Averill, Catlin, and Chon, 1990; Dufault and Martocchio, 1985; Snyder, 2002; Stotland, 1969). In the next section, a brief history of hope theory in counseling and psychology that serve as the foundation for the current investigation is provided.

Prior to the examination of the varying theories on hope, it bears noting that hopefulness (i.e., the presence of hope) and hopelessness (i.e., the absence of hope) are two distinct concepts. The absence of one trait does *not* necessarily preclude the existence of the other; they are *not* inverses of one another. While much scholarly attention is focused on hopelessness and it's link to depression, suicidal ideation, and completed suicide (Abramson, Metalsky, & Alloy, 1989; Abramson et al., 2000; Alloy & Abramson, 1999; Beck, Brown, & Steer, 1989; Brown, Beck, Steer, & Grisham, 2000; Forman, Berk, Henriques, Brown, & Beck, 2004; Kuo, Gallo, & Eaton, 2004), linking the *presence* of hope and its subsequent effects on individuals' thoughts and behavior in empirical research is becoming increasingly prevalent in scholarly literature. Therefore, what follows is a review of theory and research by scholars who have focused on the presence of hope rather than hopelessness.

Stotland (1969) provides the first integrated conceptual models for hope, identifying hope as the expectation to attain a specific goal. Specifically, hope is defined as "an expectation greater than zero of achieving a goal" (p. 2). A key element of Stotland's model of hope, therefore, is that a minimum level of goal importance must be present in order for hope to be experienced. In Stotland's model, hope is action-oriented—a cognitive motivational force—that contains three primary elements: (a) temporality, in that hope includes positive consideration of future outcomes; (b) desirability, in that hope is considered to be goal-oriented and subsequently accompanied by a positive attitude; and (c) expectancy, the belief that the desired future outcome

is both possible and *probable*. Essentially, Stotland states that the degree of hopefulness an individual experiences is proportional to the perception of probability in achieving a specific goal. Although Stotland's model provides a conceptual framework for understanding hope, Stotland's work is descriptive and conceptual in nature; therefore, lacking necessary empirical support.

Hope is also described as an affective experience that informs behavior and cognitive processes. Averill, Catlin, and Chon (1990), for example, described hope as being an emotional experience, and therefore can be episodic in nature. They posited that "hope is a relatively short-term response tendency, usually initiated and terminated by specific environmental conditions" (p. 93). Averill and colleagues conducted a study asking participants from the United States to describe various aspects of hope, as well as a recent personal experience of hope (as cited in Averill et al., 1990). Results indicated four primary components of hope: (a) priority, in that the object of one's hope must involve interests of significant importance; (b) prudential, meaning the object of one's hope must be considered at least somewhat realistic and attainable; (c) action, which refers to a sense of personal agency and willingness to obtain the object of one's hope as a goal; and (d) moralistic rules, in that the object of one's hope is typically considered individually and socially acceptable; if not, an individual's hope is considered to be misplaced (as cited in Averill et al.) In a follow-up study, Averill and colleagues investigated the classification of hope as an emotion and compared it to anger and love. Participants identified five major similarities between hope, anger and love: (a) all are difficult to control; (b) they affect the way people think; (c) they motivate behavior; (d) they lead people to act in uncharacteristic ways; and (e) they are experiences universal to humans. When the same study was conducted with a sample of Korean participants, however, they experienced hope as controllable, intellectual, voluntary, and

permanent. In other words, hope was *not* an emotional experience. In sum, one's culture plays a significant role in how hope is conceptualized and experienced.

Snyder's theory of hope (Snyder, 2002; Snyder, Cheavers & Michael, 1999; Snyder, Rand, & Sigmon, 2002) has received considerable attention over the years. In this model, hope is conceptualized as a cognition containing goal-directed thinking. Specifically, hope is defined as "a cognitive set that is based on a reciprocally derived sense of successful (a) agency, which refers to goal-directed determination (e.g., "I can do this!"; and (b) pathways, the act of planning on ways to meet goals (e.g., "Here's how I can go about achieving this"; Snyder et al., 1991). In other words, where there is a will there is a way (Snyder et al., 1991, p. 570). Additionally, goals can be approach oriented, as in taking proactive steps like going back to school, or preventative, such as maintaining a significant relationship. Goals, much like the "priority" component of Averill's theory of hope (1990), must also be perceived as significant enough to warrant the effort required for their undertaking (Lopez, Snyder, & Pedrotti, 2003). Moreover, in Snyder's theory, hope is considered to be stable and potentially dispositional, in that hopeful individuals have more enduring self-appraisals regarding their ability to achieve their goals.

Snyder and colleagues have also developed instruments in order to empirically measure the presence of hope, including: (a) the *Hope Trait Scale*, a measure of agency and pathway thinking (Snyder et al., 1991); (b) the *Hope State Scale*, designed to assess goal-directed cognition in a specific moment (Snyder et al., 1996); and (c) the *Children's Hope Scale*, which measures agency and pathway thinking among youth aged 6-16 (Snyder et al.,1997). Each of the instruments possesses adequate to strong reliability and validity, and are used extensively in empirical research with diverse populations. Although hope through this lens is viewed to be an almost entirely cognitive process, Snyder (2002) has emphasized that emotion does play a role in

how hope is manifested. When willpower and waypower related thinking become activated in the pursuit of one's goals, these thoughts are likely to be affected by positive or negative emotions related to the perceived likelihood of goal attainment. For example, for an individual who conceptualizes a goal, the perception of success results in higher hopefulness, lending credence to further agency and pathway thinking. Emotions, therefore, serve as a reinforcing feedback loop for hope that can sustain motivation. In a meta-analysis on hope in the helping professions, researchers found that in a comparison of Snyder's *Hope Scale* (1991) to other instruments that measure hope, the sole focus on goals represented the most narrow view of the concept (Schrank, Bird, Rudnick, & Slade, 2012). What Snyder's theory fails to account for is hope in the absence of distinct goals or a sense of assuredness that one's hopes will come to fruition.

Other theories conceptualize hope as a much more complex and nuanced construct than an emotion or a goal. Similar to Frankl's (1963) description, hope can also be a non-time-oriented coping mechanism that helps one to transcend suffering, and can exist regardless of the possibility of goal achievement (Farran, Herth, & Popovich, 1995). Dufault and Martocchio (1985) define hope as a "multidimensional dynamic life force characterized by a confident *yet uncertain* expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant" (p. 380). Hope in this sense is a complex act of interweaving thoughts, emotions, and actions that develop over time; it is a process, rather than a trait. Within this definition, Dufault and Martocchio distinguish between two related but distinct spheres: generalized and particularized hope. Generalized hope refers to a desire for an indeterminate positive future development (e.g., "it gets better"), and serves to: (a) provide motivation to keep going in difficult times; and (b) function as a coping mechanism that protects against despair.

Conversely, particularized hope involves a specific and valued future outcome. Hope in this state also aids in constructive coping in that it motivates one to overcome obstacles in order to reach the object of hope. Furthermore, these two dimensions are viewed as sharing six common dimensions: (a) affective, the emotions that accompany hope; (b) cognitive, the process of identifying and object of hope and perceptions about how to achieve it; (c) behavioral, the actions taken toward the hoped-for object; (d) affiliative, defines as the sense of connection to others as this related to hope; (e) temporal, the extent of the inclusion of the past, present, and future in the hoping process; and (f) contextual, considerations to the situation in which hope has manifested (Dufault & Martocchio, 1985).

The *Herth Hope Scale* (HHS) and *Herth Hope Index* (HHI; a brief version of the HHS) are modeled after Dufault and Martocchio's multidimensional theory of hope (Herth, 1991; Herth, 1992). The instruments are designed to capture "a more global sense of hope," "hope despite diminished or absent interpersonal relations," "hope as a sense of 'being' available and engaging in relationships" rather than "'doing' for oneself and others", and "potential hope for controlling behavioral and emotional responses" not necessarily events and experiences (Herth 1992, p. 1252). Unlike other theories, this description leaves room for defining and measuring hopes that extend outside of personal wants, such as altruistic hope directed toward an entire community. Hope in this sense is also identified hopefulness as a coping mechanism.

Differences between the various conceptualizations of hope notwithstanding, there are several commonalities. Each theory acknowledged that hope involves, as least partially: (a) a future focus on potential positive outcomes; (b) the personal significance of the object of hope; (c) the cognitive nature of hope in terms of thoughts and perceptions; and (d) the affective nature of hope, in how emotions influence the degree of hope (Averill et al., 1990; Dufault and

Martocchio, 1985; Lopez et al., 2003; Snyder, 2002; Snyder et al., 1991; Snyder et al., 1999; Snyder et al., 2002; Stotland, 1969).

LGBTQ+ youth and hope theory. Averill and colleagues' (1990) theory of hope as an emotion has several implications for work with LGBTQ+ youth. Firstly, understanding hope as an affective process suggests that hope is a flexible rather than innate trait than can be fostered through intervention. Secondly, given that the hopes of these youth often involve living in a world that is no longer opposed to affectional orientation and gender identity and expression based on moral ground, the emphasis on moralistic rules in hope seems to disagree with the realities of this population. To say that hopes are "misplaced" when they conflict with current societal standards denies the legitimacy of desiring not to be the object of societal condemnation. Lastly, it is important to understand that hope has a multicultural component, and therefore personal conceptualizations of hope will likely differ depending on individual cultural backgrounds.

Snyder and colleagues' (1991; 1999; 2002) goal-focused theory of hope also falls short of capturing how hope is conceptualized among LGBTQ+ youth. The concept of "it gets better," a current driving force in the LGBTQ+ community (It Gets Better Project, 2010), is focused on the hope—and not necessarily the certainty—that one's situation will eventually become less difficult to endure. This conceptualization is more of a larger, enduring notion of hope, and could be absent any specific future goals. For example, an adolescent who is experiencing family rejection for their LGBTQ+ status may experience hope that their loved ones may one day become more accepting. This hope leads to more effective coping despite not having specific, attainable goals or a perceived pathway toward achieving this change in the relationship. Goals may be a factor in hope, but for the purposes of this research "hope" is defined by a general

sense of positive future expectancy. This concept of hope differs from optimism or faith, in that it can be situation-specific and does not necessarily extend to an all-encompassing worldview that things tend to work out for the best. In other words, an individual can have hope that one's family circumstances will improve without feeling optimistic about the odds.

Ultimately, based on the realities of the LGBTQ+ adolescent population, a more global and interpersonal definition and measurement of hope better serves this investigation, which is represented by Dufault and Martocchio's (1995) multidimensional theory of hope. Consequently, a review of the empirical literature on hope with adolescents follows.

Empirical Research on Hope

The majority of research on hope has been conducted in the medical field (Castañeda, Carrion, Kline, & Martinez Tyson, 2010; Lalor, Begley, & Galavan, 2009; Rhodes, Bernays, & Terzic, 2009; Olson, 2011). Only recently has such research emerged as a specific focus in the field of mental health (Schrank, Stanghellini, & Slade, 2008; Schrank, Bird, Rudnick, & Slade, 2012). The following review highlights key scholarly offerings examining hope in the helping professions.

Schrank and colleagues (2012) conducted a systematic literature review on the role of hope in mental health services, with a focus on identifying correlations between hope and other variables, as well as factors that serve as predictors of hope; they found 38 quantitative studies that reported cross-sectional association between hope and other variables. The most frequent positive associations included self-efficacy, self-esteem, empowerment, spirituality, quality of life, and social support. On the other hand, negative correlations included anxiety, depression, general psychopathology, barriers to employment, and family problems (Schrank et al., 2012). Similar observations were found in qualitative research, as the importance of relationships was a

consistent theme. Specifically, participants identified the importance of mutual support among peers and helping professionals, as well as feeling validated and understood by others (Houghton, 2007). A trusting relationship with a helping professional who listens and values the client is also key in the development of hope (Kirkpatrick et al., 1995). Other factors, such as self-esteem (Noh et al., 2008) and a sense of meaning and personal philosophy (McCann, 2002) also emerged as important correlates of hope in qualitative research. Therefore, hope was correlated with other protective factors such as social support and self-esteem, lending support to the necessity of an intervention to increase hopefulness.

In addition to the relationship between hope and protective factors, there is also evidence to suggest that hope is strongly and positively correlated with psychological health (Cheavens, Feldman, Woodward, & Snyder, 2006). Gilman, Dooley, and Florell (2006), for example, examined the relationship between hope and several psychological indicators in a sample of 341adolescents enrolled in the 6^{th}-12^{th} grade. Using the *Children's Hope Scale* (CHS; Snyder et al., 1997), students were categorized into three groups: (a) high hope individuals; (b) average hope individuals; and (c) low hope individuals. The researchers concluded that individuals in the high and average hope groups reported less psychological distress, higher personal adjustment, and increased global satisfaction with life than adolescents in the low hope groups; a moderate effect size of .24 is reported for these differences (Gilman et al., 2006). This study was limited, however, in that the researchers employed a cross-sectional methodology, precluding the authors' ability to make causal inferences regarding hope's relationship to mental well-being. Furthermore, the sample consisted of participants from two schools in the southeast, potentially limiting the generalizability of the findings to that specific region. Nevertheless, the data

identified that high hope may be a key factor in the development of psychological health, prompting the need for further research in this area.

Schrank and colleagues (2008) further highlight the need for additional research into the predictive aspects of hope in their meta-analysis of hope in psychiatry literature. The study identified 151 applicable studies on hope in that they: (a) explicitly addressed the conceptualization of hope; or (b) involved the development or validation of a measurement tool for hope; or (c) they reported the assessment of hope in clients. Of these, only 11 studies investigated hope as a predictive variable for differing outcomes. The wide variety among these studies in terms of client populations, interventions, and outcome measures, however, made aggregation inappropriate, although the researchers noted that overall, no negative effects of hope were identified. Moreover, hope was shown to have a positive or neutral effect on depressive symptoms, anxiety, distress, coping, and general wellbeing (Schrank et al., 2008). The study did *not* include books, conference presentations, or articles that did not explicitly address hope as a primary aim, however, which may have resulted in a loss of information. Despite this limitation, the meta-analysis sheds light on the abundance of conceptual frameworks and lack of empirical evidence for hope as a predictive variable in other factors of mental health.

Hope and therapeutic intervention. Schrank and colleagues (2012) examined the available literature on strategies and interventions to increase hope. What the authors determined is that little empirical evidence is available in this area, and few successful interventions with a primary focus in increasing hope were identified. Changes in participants' levels of hope are most often examined as a secondary outcome. A closer examination of the studies examined in the meta-analyses yields interesting findings.

For example, Cheavens and colleagues (2006) conducted an eight session group therapeutic intervention designed to increase hope among adult participants (n = 32). Similar to the present study, the investigation utilized a randomized, waitlist control trial design and used a community sample. Moreover, the study utilized a strengths-based approach, employing the use of activities that identified and strengthened participants' existing assets. The content of each two hour group session was divided into four parts: (a) discussion of the prior week, typically in regards to the outcome of homework assignments (30 minutes); (b) psychoeducation involving the teaching of a new hope-related skill each week (20 minutes); (c) discussion regarding the applications of this skill to participants' lives (50 minutes); and (d) assignment and brief discussion of the next week's homework assignment (e.g., increased exercise, improving interpersonal relationships, changing occupations).

The results of this pilot study revealed that the participants experiences increases in agency thinking as a component of hope (i.e., the thoughts an individual has regarding their ability to begin and continue movement toward an identified goal), life meaning, and self-esteem as well as reductions in symptoms of depression and anxiety ($p < .05$) when compared to participants in the waitlist control groups (Cheavens et al, 2006). In addition to the small sample size, however, the implications of this study are also limited by how the authors of define and measure hope as "the cognitive process through which individuals pursue their goals" (p. 61), which differs significantly from the more global and nuanced definition of hope used in the present study. In addition, the majority of participants (n = 18) met the criteria for one or more Axis-I disorders per the DSM-IV (e.g., major depressive disorder, social phobia, generalized anxiety disorder) despite the strength-based focus of the intervention. Nevertheless, the results of this investigation identify the potential effectiveness of a brief intervention designed to increase

participants' hope and other related psychological strengths. Another promising element of this research is that the investigation resulted in the reduction of depressive symptoms and anxiety, despite not being a specific target of the intervention. These findings demonstrate the influence the presence of hope may have on other psychological constructs.

Although these investigations provide important implications regarding interventions to increase hope, it should be noted that these studies all involve participants who have been diagnosed with moderate to severe mental disorders. It was presumed that there would be some overlap between these individuals and the other populations in terms of successful approaches to increase hope, but it must be kept in mind that LGBTQ+ youth likely have their own unique needs. Nevertheless, Schrank and colleagues (2012) identified five promising interventions to increase hope as an outcome of their meta-analysis of hope-related intervention research, including: (a) collaborative strategies for issues management; (b) fostering relationships; (c) peer support; (d) helping clients to develop and pursue goals; (e) specific interventions to support multiple positive factors such as self-efficacy, self-esteem, spirituality, and well-being (Schrank et al., 2012). As such, elements of these findings have been incorporated into the group counseling intervention curriculum that was used in this study (e.g., activities that build peer connectedness, teaching adaptive coping strategies, identifying long-term goals, building self-efficacy, etc.).

Further research explores the effect of hope-building interventions specifically with adolescents. The *Penn Optimism Program* (POP; Shatte, Gillham, & Reivich, 2000), is a 12 week school-based intervention designed to increase hope and optimism via training in cognitive and behavioral techniques. Various techniques within cognitive behavioral therapy are utilized, including decatastrophizing, evaluating evidence and generating alternatives, and thought

disputing. Other elements involve the teaching of coping strategies (e.g., relaxation), problem-solving, and social skills. The program consists of small groups (10-12 children each) with weekly sessions lasting 90 minutes (18 hours total). In a quasi-experimental investigation of POP's effectiveness among youth in the fifth and sixth grade identified as at-risk for depression (n = 118), children who had completed the intervention demonstrated fewer symptoms for depression than children who did not (Gillham, Reivich, Jaycox, & Seligman, 1995). A repeated measured ANCOVA using participants' baseline depression scores as a covariate established the differences between groups as statistically significant, *(*F [1, 48] = 8.390, $p < .01$). Longevity of the intervention has been established, in that participants continued to complete instruments to measure levels of depression (i.e., the *Child Depression Scale* [RCDS; Reynolds, 1989] and the *Reynolds Adolescent Depression Scale* [RADS; Reynolds, 1986, 1992) every six months for two years following the intervention. In fact, the largest differences in scores were at the 24 month mark (F [1, 48] = 10.43, $p < .01$), signifying POP's success as a preventative intervention (Gillham et al.).

That Shatte and colleagues (2000) only measured the level of depressive symptoms, however, is a significant limitation of this study. Despite the program's use of optimism in the title and success in preventing depressive symptoms, it is difficult to infer POP's ability to build hope and positive expectancy for the future. The authors used no instruments to measure these variables and their changes among participants. Although it appears that participants gained a sense of optimism from the intervention, no data exists to directly support the notion. Despite these limitations, the researcher has selected specific promising elements of the POP intervention to incorporate into the group curriculum used in the study, including: (a) teaching positive

reframing as a cognitive coping technique; (b) experiential learning of self-relaxation techniques (e.g., deep breathing exercises); and (c) fostering members' problem-solving skills with peers.

In summary, the majority of studies on hope involve a population of participants with severe mental disorders (e.g., schizophrenia, posttraumatic stress disorder, psychosis), and serious health diagnoses (e.g., cancer and HIV). Nevertheless, little is known about identifying and fostering hope among individuals without such critical conditions, especially among youth. No investigations were found by the researcher that involve hope as a variable among LGBTQ+ youth. In addition, no studies have investigated changes in other variables based on changes in hope. Therefore, an examination of an intervention's impact on LGBTQ+ adolescents' hope, coping skills, and suicidality represents a needed contribution to the scholarly knowledge base.

Coping

Theories and Definitions of Coping

Lazarus and Folkman. Lazarus and Folkman (1984) provide the most well-known theory of coping, and define the construct as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Coping is a process that involves three components: (a) *primary appraisal*, the process of perceiving a threat to oneself; (b) *secondary appraisal*, the process of generating a potential response to the threat; and (c) *coping*, the active process of putting a response into practice. However, the coping process is not always linear or complete. For example, simply realizing that an acceptable coping response is readily available should the potential threat occur may result in finding the initial event to be less ominous or discouraging. Conversely, finding that one coping strategy is less effective than anticipated may result in an amplification of how the initial threat is perceived, thereby resulting in a reappraisal

of one's coping response. The coping process may cycle in what is known as a stressful transaction (Lazarus and Folkman).

Minority stress and coping. Meyer (1995) posits that in addition to coping with personal adverse events, minorities such as the LGBTQ+ population must face additional societal stressors. The combination of discrimination, prejudice, and stigma experienced by individuals results in hostile social environments that increase the likelihood experience stress on their coping system. Minority stress is characterized by three conditions, in that it is: (a) *unique*, an additive to day-to-day stressors and is distinctive among stigmatized populations; (b) *chronic*, in that it is relatively stable over time as an underlying cultural structure; and (c) *socially-based*, stemming from social processes, institutions, and structures beyond individual influence (Meyer, 2003). Minority coping is conceptualized in that it involves managing stressors that stem from their stigmatized status in society. While coping strategies at an individual level vary, minority coping involves developing a sense of kinship and unity among fellow members of their community, thereby reducing stigmatization and providing personal validation; this strategy is known as "group-level" coping (Meyer, p. 677). An LGBTQ+ identity may then become a source of strength and resilience when it is associated with opportunities for social support and coping; these factors have the potential to reduce the impact of stress (Branscombe, Schmitt, & Harvey, 1999; Crocker & Major, 1989; Meyer, 2003; Miller & Major, 2000). Therefore, counseling in a group environment may address the presence of additional minority stress among LGBTQ+ adolescents.

Empirical Research on Coping

Ueno (2005) analyzed data from the National Longitudinal Study of Adolescent Health (n = 12,579; Harris et al., 2003) and examined the available peer-reviewed literature that addresses

the mental health differences between adolescent sexual minorities and majorities. Notably, the study determined that identifying as a sexual minority was associated with higher levels of psychological distress than heterosexual participants at the bivariate level, and remained a significant predictor even after socio-economic status was accounted for. In terms of coping strategies that had a buffering effect, LGBTQ+ youth were less likely to experience psychological distress when they: (a) received support from close friends; and (b) had close friendships with other individuals who identify at LGBTQ+. Yet the author also found that sexual minority adolescents do not typically belong to closely knit friendship networks with other LGBTQ+ youth. These findings may be limited, however, by the survey modality which relied on youths' perceptions of their friends' affectional orientation, which may not have been accurate. Nevertheless, these findings provide support for the necessity of increased opportunities for LGBTQ+ youth to form friendships with other self-identified LGBTQ+ youth, as these relationships serve as a protective factor for psychological distress.

Coping and therapeutic intervention. Research identifies that increase focus in coping research must be devoted to the development of therapeutic intervention to increase successful coping capabilities and increased social support (Liu & Mustanski, 2012; Meyer, 2003). Studies have explored the impact of coping intervention groups on participants with HIV that included members of the LGBTQ+ community (e.g., Carrico et al., 2006; Carrico, Antoni, Weaver, Lechner, & Schneiderman, 2005; Chesney, Chambers, Taylor, Johnson, & Folkman, 2003; Hansen et al., 2006; Smith, Tarakeshwar, Hansen, Kochman, & Sikkema, 2009). Sikkema and colleagues (2013) examined the impact of the *Living in the Face of Trauma* (LIFT) group intervention, which integrates specific coping skills training based on the theory of stress and coping (Lazarus & Folkman, 1984) and focuses on the reduction of avoidant coping strategies in

order to decrease traumatic stress. A sample of 247 men and women with HIV and who had experienced sexual abuse as a minor participated in a randomized controlled trial. Participants were either assigned to the 15-session LIFT intervention or the comparison intervention, an HIV support group. Each of the men in the study reported having sex with men (n = 117) and there were four participants who indentify as transgender; researchers did *not* report overall LGBTQ+ status of female participants. Participants in the LIFT intervention group experienced greater decreases ($p < .02$) in traumatic stress than participants in the support intervention; similar results were obtained at 12 month follow-up (Sikkema et al., 2013). Though this study does *not* focus on hope or suicidality as outcome variables, the findings provide support for the efficacy of group interventions that implement instruction in active coping strategies rather than providing traditional support group characteristics alone.

Suicidality

Theories and Definitions of Suicidality

Suicide is the ultimate expression of hopelessness. Metalsky, Joiner, Hardin, and Abramson (1993) define hopelessness as the "expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur, with the further expectation that nothing is going to change this situation for the better" (p. 101). Suicidality refers to a range of behaviors, including: (a) *completed suicide*, as in taking one's life; (b) *suicidal ideation*, one's thoughts about suicide ranging from fleeting thinking to detailed planning; and (c) *suicide proneness*, the engagement in overtly suicidal behavior as well as risk-taking and potentially injury-producing behaviors, coupled with a lack of engagement in health and safety behaviors, or self-enhancement behaviors (Lewinsohn et al., 1995). Rohde and colleagues (2003) refer to suicide proneness as life attitudes, which is comprised of the spectrum of life-enhancing and life-

endangering behaviors. Traditionally, suicidality is assessed by determining by considering past suicide attempts (e.g., has the individual tried to kill themselves in the past), past suicidal ideation (e.g., has the individual had past thoughts about killing themselves), and present suicidal ideation (e.g., is the individual currently considering committing suicide). In the past two decades suicide proneness as a risk-factor has become more prominent in scholarly literature (Graber & Brooks-Gun, 1995; Lewinsohn et al., 1995; Rohde et al., 2003). Behaviors within suicide proneness are comprised of thoughts, feeling, and actions which include not taking care of one's body, fixating on the concept of death, feeling that life is not worth living and engaging in high levels of risky behavior (Rohde, Lewinsohn, Seeley, & Langhinrichsen-Rohling, 1996). A key advantage of measuring life attitudes is that is allows for earlier prediction of possible suicide (Rohde et al., 2003).

Empirical Research on Suicidality

In a multi-state study involving 1,742 high school students, Rohde and colleagues (2003) demonstrated that life attitudes and suicidality (as measured by the LAS-SF; Rohde et al., 1996) had a correlational relationship with lifetime suicidal ideation, past attempts, and current depression. However, this study was cross-sectional; therefore causal or predictive conclusions cannot be made. Regardless, the LAS-SF shows promise in being able to identify youth who are at-risk for suicide.

King and Merchant (2008) conducted a review of the empirical literature concerning social and interpersonal variables as risk factors for adolescent suicidality. They found that there is substantial evidence for the role social integration and peer support plays in mitigating suicidal ideation and proneness Specifically, increased social support functions as a "protective buffer in the presence of adversity" (King & Merchant, p. 183). Therefore, interventions designed to

address adolescent suicidality are more impactful when offered in a group format with like-minded peers.

Suicidality and LGBTQ+ youth. The challenges LGBTQ+ individuals face are well-documented. Empirical evidence identifies LGBTQ+ adolescents are especially vulnerable to depression, suicidal ideation, self harm, and other negative coping behaviors such as drug use and sexual risk-taking (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Liu & Mustanski, 2012; Mathy, 2003; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Spirito & Esposito-Smythers, 2006). Furthermore, adolescents are at-risk, as suicide is the third leading cause of death among this age group (Centers for Disease Control and Prevention, 2010). Specifically, LGBTQ+ youth are two to seven times more likely to attempt suicide than non-LGBTQ+ youth, with risk factors like isolation, lack of hope, and negative coping skills contributing to increased ideation and attempts (Suicide Prevention Resource Center, 2008). A partial explanation for these elevated negative outcomes may be explained by the environment LGBTQ+ youth are exposed to. Specifically, LGBTQ+ high school students experience frequent instances of homophobic remarks, verbal and physical harassment, and assault, and this victimization result in these students feeling unsafe, isolated, and depressed (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012) In addition, individuals who identify as LGBTQ+ exhibit hopelessness and an inability to cope with these difficult circumstances (King et al., 2008; Rutter, 2006; Van Heeringen, & Vincke, 2000).

King and colleagues (2008) conducted a meta-analysis of the prevalence of mental disorder, substance misuse, suicide, suicidal ideation and deliberate self-harm in lesbian, gay, and bisexual (LGB) individuals. The review spanned articles published between 1966 and 2005. Notably, the authors founds that LGB individuals were two time likelier than heterosexuals to

attempt suicide (pooled relative risk [RR] ratio for lifetime risk 2.47; CI 1.87-3.28), at least 1.5 times likelier to experience depression and anxiety disorders (RR range 1.54-2.58), and at higher risk for such maladaptive coping behaviors as suicidal ideation, substance misuse, and deliberate self-harm . Lifetime prevalence of suicide attempt was high in gay and bisexual men (RR 4.28; CI 2.32-7.88). Although the authors note that several of the reviewed studies were *not* as methodologically rigorous as desired, the analysis provided further support for the elevated risks the LGBTQ+ community faces, and subsequent need for clinical strategies that reduce suicide proneness.

Despite ample evidence indicating the need for mental health interventions to reduce suicidality tailored for LGBTQ+ youth, there is a lack of empirical knowledge on the subject. In 2007, the American Foundation for Suicide Prevention in partnership with the Suicide Prevention Resource Center and Lesbian Medical association assembled to address the need for increased understanding of the needs of LGBTQ+ clients (Haas et al., 2011) The conference, which also included mental health researchers, clinicians, policy advocates, and educators, came to the conclusion that there is a significant gap between knowledge and practice, and that much more research is needed regarding interventions that reduce suicide risk for this population. In addition, after a review of the available literature on this topic in research databases (i.e., Academic Search Premiere, Education Full Text, ERIC, PsycArticles, and PsycInfo), few empirical studies were identified by the researcher. Moreover, no studies were found that investigate group interventions to increase hopefulness with LGBTQ+ youth. Essentially, the problem has been identified, but mental health professionals are left with few evidence-based practices to turn to in order to help their clients.

Given that negative experiences and subsequent suicide rates for the LGBTQ+ adolescent population are of significant concern to helping professionals (Haas et al., 2011; Liu & Mustanski, 2012; Spirito Esposito-Smythers, 2006), there is a need for additional empirical evidence regarding interventions that impact hope, coping, and life attitudes. Promising interventions identified in the available literature include: (a) fostering relationships; (b) peer support; (c) goal-setting; and (d) developing protective factors like self-esteem, self-efficacy, and general well-being. Therefore, activities that foster these factors were incorporated in a supportive group format for the current investigation. For coping, Stone and Neale (1984) highlighted the primary components that assist in positive coping behaviors: (a) acceptance; (b) social support; (c) catharsis; (d) direct action; (e) relaxation; and (f) situation redefinition (e.g. reframing). Some of these conditions are met by virtue of the group environment (Yalom & Leszcz, 2005), while others were increased through a variety of activities. Finally, suicidal ideation is mitigated by the presence of protective factors like (a) positive expectancy (i.e., hope); (b) positive coping strategies; and (c) peer-based support.

Suicidality and therapeutic intervention. Although the literature identifies the relationship between suicidality, adolescence, and LGBTQ+ status, *no* empirical research on interventions designed to prevent or address this issue with LGBTQ+ youth were identified. Therefore, inferences must be made from related intervention studies.

Rohde, Jorgensen, Seeley, and Mace (2004) investigated the effects of a pilot coping skills intervention on life-threatening behaviors in a sample of juvenile offenders. *The Coping Course*, developed by the researchers, is a 16 session group intervention designed to provide participants with positive coping strategies that they can employ to manage stress more effectively. A total of 76 individuals participated in the randomized control trial, completing pre

and post assessments measuring suicidality via the LAS-SF (Rohde et al., 1996), coping skills (Rohde et al., 1990), and optimism (the *Subjective Probability Questionnaire*; Muñoz and Lewinsohn, 1976). Significant condition x time effects ($p < .05$) were present for suicidality (particularly in the death-related and self-related domains as factors of the LAS-SF). On the other hand, no significant differences were observed for coping skills or optimism. It should be noted, however, that as this was a pilot investigation, and small sample sizes (therefore, inadequate power) limited the researchers' ability to detect differences between groups (Rohde et al., 2004). The results of this pilot provide support for the need to conduct more methodologically rigorous studies that examine the impact of group interventions on participants' hope, coping, and life attitudes. Rohde and colleagues further recommended that future research include a measure of group dynamics (i.e., group cohesiveness, therapeutic alliance, and group member satisfaction), providing support for the need to examine group therapeutic factors within the present study.

In a 2001 randomized control study, Wood, Trainor, Rothwell, Moore, and Harrington (2001) examined the impact of developmental group psychotherapy on adolescents who had a history of self-harm and those who received routine care ($n = 67$). Participants completed pre-assessments and post-assessments both at six weeks and at seven months to determine changes in self-harm, depression, and suicidal thinking. The researchers noted that intervention group participants indicated fewer episodes of deliberate self-harm ($M = 0.6$, 95% CI 0.3-0.9) than participants who received routine care ($M = 1.8$, 95% CI 0.6-3.0). A strong effect was noted on the risk of being a "repeater" (engaging in two or more episodes of deliberate self-harm) at the end of the study (Wood et al., p. 1249). Although levels of depression and suicidal thinking did *not* appear to be impacted by the intervention, it should be noted that similar to the study

conducted by Rohde and colleagues (2004), the ability to determine anything but a large effect was limited by a small sample size. Therefore, this study substantiates the need for larger studies are needed to reliably detect small to moderate differences between groups when examining depression, suicidality, and related constructs.

Group Therapeutic Factors

Theories and Definitions of Group Therapeutic Factors

The subject of therapeutic factors that are unique to the group experience have been of interest to researchers for decades. Corsini and Rosenberg (1955) offered the first comprehensive analysis of group processes and dynamics in a meta-analysis of 300 conceptual scholarly works on the topic. They identified nine major therapeutic factors, which were categorized into three groups: (a) intellectual; (b) emotional; and (c) actional. Yalom (2005), however, was the first to identify group therapeutic factors based on empirical research, and classified 11 curative factors: (a) instillation of hope; (b) altruism; (c) universality; (d) imparting information; (e) development of socializing techniques; (f) corrective reenactment of the primary family group; (g) imitative behavior; (h) interpersonal learning; (i) cohesiveness; (j) catharsis; and (k) existential factors. A detailed description of each of these factors follows.

Instillation of hope. Hope in this sense describes the participants' expectation that the intervention will be effective, and is considered critical in therapeutic environments (Yalom & Leszcz, 2005). The higher this expectation is, the greater the benefit, the more positive the influence for each individual and the group as a whole. Group leaders can help foster the instillation of hope by describing the expected benefits of group at the outset, and continually highlighting participants' progress and successes throughout sessions.

Universality. Universality describes the therapeutic value in hearing that others share similar thoughts, emotions, and struggles of your own (Yalom & Leszcz, 2005). As each member self-discloses information based on their lived experiences, feelings of isolation are lifted and empathy is increased. In groups composed of individuals for whom secrecy has been an especially prevalent and isolating factor (as is often the case among LGBTQ+ adolescents), the presence of universality can be particularly therapeutic (Yalom & Leszcz).

Altruism. The giving of oneself to be of benefit to others in a group environment is a key therapeutic factor, especially for those who may consider themselves to be burdens (Yalom & Leszcz, 2005). The experience of finding that they have something unique and important to others (in terms of sharing experiences and providing support) can provide a boost to one's self-esteem.

Imparting information. Imparting information as group therapeutic factor includes direct instruction from the facilitator and the giving of advice by fellow members (Yalom & Leszcz, 2005). Group members often feel anxiety due to a lack of certainty about what they can do to improve their situation; the imparting of information, therefore, can be a curative feature of group work.

Development of socializing techniques. Although the directness of skills taught varies from group to group, social learning serves to highlight discrepancies between members' intent of a behavior and their actual impact on themselves and others (Yalom & Leszcz, 2005). The key benefit of this factor is that feedback from others often provides the needed impetus for positive change.

Corrective reenactment of the primary family group. Group members can often represent a family environment, allowing members to have the opportunity to live out family of

origin roles, thus providing insight into maladaptive behavior patterns and issues (Yalom & Leszcz, 2005).

Imitative behavior. Imitative behavior describes the tendency of group members to imitate the behaviors of the facilitator or fellow members (Yalom & Leszcz, 2005). Learning and growth can be fostered when positive examples are set (e.g., listening empathetically, providing support, self-disclosure, etc.).

Interpersonal learning. Interpersonal learning represents the ability of group members to learn from others by having one's assumptions challenged in a safe and therapeutic setting (Yalom & Leszcz, 2005).

Cohesiveness. The feelings of emotional closeness among group members is described as cohesion (Yalom & Leszcz, 2005). It is the feeling of "we-ness" that keeps members engaged in the group experience and provides a sense of belonging. Group cohesion is a key factor in individual therapeutic outcomes, and is signified by support, acceptance, and the inclination to form meaningful relationships (Yalom & Leszcz).

Catharsis. Described as a "purging of emotion," catharsis is the intense outward emotional expression of feeling that can take place during group sessions Yalom & Leszcz, 2005).

Existential factors. Perhaps the most complex factor, existential issues in the group environment are conceptualized as having five parts: (a) recognition that life can be unfair; (b) recognition that life contains pain and death; (c) recognition that one has to face life; (d) facing issues of life and death; and (e) recognition that individual responsibility is necessary for actions in life.

These therapeutic factors, particularly the instillation of hope and universality, have the potential to foster growth among LGBTQ+ adolescents in a way that individual counseling is unlikely to (Yalom & Leszcz, 2005). It is because of the identification of these therapeutic factors and subsequent supporting research that a group modality has been selected for this investigation (Butler & Fuhriman, 1980, 1983; Colijn, Hoencamp, Snijders, & Van der Spek, 1991; Wheeler, O'Malley, Waldo, Murphey, & Blank, C., 1992). Groups, in and of themselves, have the potential to increase hopefulness and increase peer connectedness among members. It is anticipated that increased levels of individual therapeutic factors and the experience of therapeutic factors as a whole will have a positive relationship with participants' hope, coping, and suicidality.

Empirical Research on Group Therapeutic Factors

Yalom, Tinklenberg, and Gilula (1968) examined group therapeutic factors with a small sample of group counseling client (n = 20). Using Q-sort methodology (rank order of a heterogeneous set of items), participants ranked the group therapeutic factors identified by Yalom at that point as follows: (1) Interpersonal Learning; (2) Catharsis; (3) Cohesiveness; (4) Self-Understanding; (5) Interpersonal Learning; (6) Existential Factors; (7) Universality; (8) Instillation of Hope; (9) Altruism; (10) Family Reenactment; (11) Guidance; and (12) Identification. Though the updated conceptualization of group therapeutic factors (Yalom, 2005) differs somewhat from this earlier version (e.g., 11 instead of 12 factors), findings include that of the top five ranked factors, three reference the value of interaction with other individuals (Yalom et al.). From these findings, Yalom developed the 60-item *Curative Factors Questionnaire* (1970), which was used in a replication study (n = 17) conducted by Sherry and Hurley (1976). Among the notable findings are that: (a) all of Yalom's 10 top items also ranked above the

median (30.5); and (b) of the 5 items that both studies consistently placed in the top 10, eight were from Yalom's *Interpersonal Input* category and the remaining two were from his *Catharsis* category. Though both studies involved small sample sizes, the findings identify that both learning from other group members and expressing oneself emotionally in a group environment are perceived as helpful traits by participants in group counseling.

In a study of the relationship between group therapeutic factors and ethnic identity development, Johnson and Lambie (2013) identified significant relationships between these variables at the conclusion of a six-week multicultural several personal growth group. Using the TFI-S (Joyce et al., 2011), the researchers identified the following positive correlations between group therapeutic factors and ethnic identity development: (a) Instillation of Hope, $n = 63$, $r = .43$, $p < .05$ (18.5% of the variance explained); (b) Secure Emotional Expression, $n = 63$, $r = .39$, $p < .05$ (15.2% of the variance explained); (c) Awareness of Relational Impact, $n = 63$, $r = .47$, $p < .05$ (22.1% of the variance explained); and (d) Social Learning, $n = 63$, $r = .46$, $p < .05$ (21.2% of the variance explained). The findings from this study, however, may have limited generalizability to LGBTQ+ youth as the sample ($n = 94$) was restricted to Master's level counselors-in-training. Nevertheless, support is provided for the integration of activities that foster group therapeutic factors throughout the current investigation's intervention curriculum.

Chapter Summary

An overview of the primary constructs of the present study was provided, including: (a) hope; (b) coping; (c) suicidality; and (d) group therapeutic factors. In addition, findings from available empirical studies were provided for each construct. Overall, the majority of literature in these subjects is conceptual or correlational in design, and researchers highlight the need for intervention research as the next step with the LGBTQ+ adolescent population.

CHAPTER THREE: RESEARCH METHODOLOGY

The purpose of this research investigation was to identify the impact of an eight-week group counseling intervention on LGBTQ+ older adolescents' levels of: (a) hope (as measured by *Herth Hope Index* [HHI; Herth, 1992]); (b) coping skills (as measured by the *Brief COPE* [Carver, 1997]); and (c) suicidality (as measured by the *Life Attitudes Schedule Short Form* [LAS-SF; Rohde, Lewinsohn, Seeley, & Langhinrichsen-Rohling, 1996]). Specifically, the investigation tested the hypothesis that the group counseling intervention would promote higher hopefulness and positive coping skills scores in the LGBTQ+ older adolescent participants, while reducing participants' negative coping skills and suicidal ideation scores. In addition, the correlation between the LGBTQ+ adolescent participants' presence of group therapeutic factors (as measured by the *Therapeutic Factors Inventory Short Form* [*TFI-S*; Joyce, MacNair-Semands, Tasca, & Ogrodniczuk, & John, 2011]) scores to their levels of hope, coping, and suicidality was investigated. Furthermore, the investigation examined the relationship between LGBTQ+ adolescents' hope, coping, and suicidality scores, and the impact of participant demographic variable on outcome scores.

The research methodology section of this chapter presents a detailed description of the research design and method for the study. Characteristics of the intervention group participants, control group participants, and facilitators are discussed, and threats to internal and external validity are reviewed. Furthermore, procedures for implementing the intervention are described, including details regarding participant recruitment, the institutional review board (IRB) approval process, and procedures for promoting treatment fidelity. In addition, the rationale for the selection of data collection instruments is offered, including the psychometric properties that support the reliability and validity of the assessments with diverse samples. The chapter

concludes with a discussion on ethical considerations and potential limitations of the study. In summary, this chapter provides information in the following areas: (a) research design; (b) overview of procedures; (c) sampling procedures and population sample; (d) characteristics of the intervention; (e) data collection procedures; (f) instrumentation; (g) research hypothesis and questions; (h) methods of data analysis; (i) ethical considerations; and (j) limitations to the study.

Research Design

An experimental, repeated measures design was employed to examine the noted research hypotheses. Experimental research designs are the most rigorous design in determining the cause and effect relationship between independent and dependent variables (Gall, Gall, & Borg, 2007). Moreover, experiments that incorporate randomized control provide evidence that the observed effects are due to the intervention rather than other variables (Gall et al., 2007). Therefore, the investigation employed random assignment into intervention or control groups. The online tool offered at www.randomizer.org was used to identify intervention group participants versus control group participants (Urbaniak & Plous, 2012). Moreover, the use of pre-test, mid-test, and post-test measures aided in assessing the level of extraneous influence on participants' outcomes, and to increase the power of the statistical analysis (Dugard & Todman, 1995; Pallant, 2010). The study also utilized waitlist control groups rather than no-treatment control groups as the waitlist control group design allows for *all* of the participants to experience the benefits of receiving the intervention (West & Spring, 2007). Nevertheless, a limitation of using a waitlist control group design is that control group participants may *not* be content to wait to experience the intervention and may seek other interventions on their own (potential threat to internal validity; West & Spring, 2007).

Mitigating Threats to Internal Validity

Internal validity describes the process of ensuring that the study is designed to examine what the researcher intends on investigating by controlling as many variables as possible (Shadish, Cook, & Campbell, 2002). Though randomized controlled trial design protects against several common threats to internal validity (e.g., history, maturation, selection), there are additional factors that can threaten the internal validity of an experimental study (Gall et al., 2007). These threats to internal validity and how they may impact the investigation are presented next.

Instrumentation fatigue. A common threat to internal validity is related to participants' tendency to alter their responses to instruments over a period of time due to becoming bored or tired with filling out assessments (Gall et al., 2007). Therefore, care was taken to select short-form versions of instruments in order reduce the total amount of time participants needed to spend filling out assessments during the intervention.

Treatment fidelity. Treatment fidelity was also an important consideration in this study as group facilitators needed to adhere to the specifications of the intervention in order to ensure the effects of the intervention are what was being measured (Gall et al., 2007). Based on the recommendations provided by Gall and colleagues (2007), treatment fidelity was maximized in the following ways: (a) a handbook was provided with instructions as to how to implement the intervention along with standardized curriculum; (b) the researcher conducted in-person training with the volunteer facilitators; and (c) facilitators were required to keep a log of group session content in order verify uniformity in the application of the group curriculum.

Contamination. Contamination as threat to internal validity occurs when intervention and control groups communicate with one another, thereby "muddying that waters" between

group effects (Gall et al., 2007). To avoid contamination, control group members were put on a waitlist to participate in the same intervention after the conclusion of the study, and participants were informed about the effect of contamination on research results.

Attrition. When participants drop out of a study prior to its completion, the differences measured may be more related to the differences in characteristics between those who remained in the group versus those who decided to leave (Gall et al., 2007). Therefore, measures were taken to encourage participant retention, including: (a) linking the intervention to trusted organizations and individuals known to participants; (b) offering accessible times and locations for the participants; (c) ensuring facilitators have prior experience and training in creating a safe, non-judgmental atmosphere for LGBTQ+ youth in counseling; (d) making frequent contact such as meeting reminders the day before, and emails or texts to participants after missed sessions; (e) ensuring that facilitators were committed to running the group for the entire duration in order to maintain the continuity of the relationship; and (f) marketing the intervention as a tool for positive development rather than addressing a deficit, which reduces stigma for participating (Davis, Broom, & Cox, 2002; Hunt & White, 1998; Robinson, Dennison, Wayman, Pronovost, & Needham, 2007). For participants in the control groups, the researcher provided verbal and written reminders regarding the pre-test, mid-test, and post-test dates.

Mitigating Threats to External Validity

A significant threat to experimental designs is posed by external validity, the extent to which the findings can be applied to other settings (Gall et al., 2007; Shadish et al., 2002). These threats to external validity and how they were addressed in the investigation are presented next.

Population validity. Until the study can be replicated, population validity (i.e. the extent to which findings can be applied to anyone other than those who participated in the study) for the

current intervention is low (Gall et al., 2007). Support for population validity can be increased; however, by eventually providing the intervention in multiple regions across the country with a diverse sample of participants.

Ecological validity. Defined as the extent to which the results can be generalized to multiple settings, ecological validity represents an additional concern (Gall et al., 2007). By providing a standardized group curriculum and instructions, adhering to one treatment intervention, ensuring the pre-test, mid-test, and post-test measures were administered several weeks apart, and replicating the real-life environments that future administrations of this intervention are expected to take place, support for ecological validity was increased.

Representative design validity. Providing a standardized group curriculum and instructions, adhering to one treatment intervention, ensuring the pre-test, mid-test, and post-test measures were administered several weeks apart, and replicating the real-life environments that future administrations of this intervention also served to increase representative design validity. Representative design validity involves designing an intervention that mimics the environments in which learning typically occurs, and how participants typically learn (Gall et al., 2007).

Despite these measures, threats to external validity are known as a "necessary evil" of experimental design, and the research findings must be interpreted knowing that not all threats to external validity can be prevented by nature of the research design (Gall et al., 2007).

Procedures

Recruitment

Prior to the recruitment of participants, the researcher received approval from an Institutional Review Board (IRB) to conduct the study (Appendix A). Study participants were recruited via flyers (Appendix D) and in-person announcements at LGBTQ+ related events and

organization meetings throughout the greater Orlando, Florida area. In addition, study details were announced via email distribution lists and announcements were posted on LGBTQ+ related social media websites (Appendix C). Participants were also referred on an individual basis to participate in the investigation.

Each participant completed a formal pre-screening interview conducted by the investigator in order to assess overall readiness and motivation to be a part of a group environment, as well as the applicability of potential participants' concerns to the elements of the intervention (Appendix E). Characteristics for exclusion to participate in the investigation included: (a) being under the age of 18; (b) a suicide attempt within the last 12 months; or (c) active drug abuse in order to minimalize facilitator liability and to trigger referrals for individual counseling and/or more appropriate groups to match the intensity of the individuals' need. Informed consent was also reviewed with potential participants during the screening, and hard copies were provided to participants for their records (Appendix B). The researcher emphasized that participation in the study was voluntary, participants could withdraw at any time without penalty, and that all collected data was confidential (i.e., assigned alpha numeric codes known only to the researcher were used to connect participants to assessment data in place of names), and stored in a locked cabinet in a locked office. Participants were also made aware that they would be randomly selected to participate in either the intervention group or the waitlist control group. Furthermore, participants were made aware of minimal risks associated with the study, such as experiencing triggering events and intense emotions, as well as the potential for breach of confidentiality by fellow group members (though members were repeatedly reminded of the importance of confidentiality throughout the course of the intervention). Other than the intervention itself, participants did *not* receive any additional incentives for participation. The

intervention was offered through two mental health centers located in the greater Orlando Metropolitan area.

Data Collection

Data collection for the investigation occurred between September 2013 and December 2013. Approval to conduct the study was received by the Institutional Review Board prior to the collection of any data. Data were collected from participants at three points during the investigation: (a) a pre-assessment, completed during the first week of the study; (b) a mid-assessment, completed after the fourth week of the study; and (c) a post-assessment, completed on the eighth week of the study. The data collection instruments were provided to the participants (intervention and control group) in a manila envelope, and the participants were instructed to *not* include identifying information on either the envelope or the assessments themselves in order to ensure confidentiality. Each participant was assigned a unique code identifier known only to the researcher, which also facilitated the ability to connect each of the participants' three data collection interval scores by assigning a letter noting group placement, a unique participant number, and an number noting whether the assessment was a pre, mid, or post test (e.g., participant A37-1, A37-2, A37-3). Assessment packets took approximately 10-15 minutes to complete. Data were stored in a locked desk in the researcher's office.

Intervention group participants completed each of the assessments immediately following the first, fourth, and eighth group sessions. Waitlist control group participants had three options for completing the data collection packets during the first, fourth, and eighth week of the investigation: (a) they could have the assessment packet mailed to them along with a self-addressed stamped envelope for returning the completed instruments; or (b) they could pick-up and drop-off the assessment packet at a designated location, or (c) they could make an

appointment with the researcher to complete the assessment packet in a neutral location. The mailed envelopes included only the individual participant's code identifier in lieu of their name.

Sampling Procedures and Population Sample

Sampling procedures

The target population for the investigation were older adolescents, defined for the purposes of this study as being between the ages of 18-20, who also identify as lesbian, gay, bisexual, transgender, queer, or otherwise as minority in regards to affectional orientation or gender identity/expression (LGBTQ+). Due to the difficulty in estimating the total population of LGBTQ+ late adolescents living in the United States, or even in a particular community, the researcher recruited participants from an accessible population of individuals who could realistically be included in the sample, by identifying potential participants from specific universities, community centers, and organizations located within the greater metropolitan Orlando, Florida area. The sample was recruited during May through August, 2013 through via flyers, emails, posting on social networking sites, face-to-face announcements, and individual referral.

Population sample

Any older adolescent who identifies as lesbian, gay, bisexual, transgender, queer, or otherwise as a minority in terms of affectional orientation or gender identity was eligible for this study. An "older adolescent" was defined as an individual between the ages of 18 and 20. Individuals who were 17 years of age or younger were excluded from this study but were considered for future research.

The desired sample size for this study was determined by the determination of significance at the .05 alpha level and adequate power at .80. An *a priori* power analysis was

conducted for this study, taking into account the effect size, the sample size, the number of groups, and the number of measurements in the study. Per the recommendation of Balkin and Shepris (2011), the free statistical program G*power was used to conduct the analysis (Faul, Erdfelder, Lang, & Buchner, 2007). Given that the parameters of the study include two groups (i.e., assignment to either the intervention or the control group), three measures (i.e., pre-test, mid-test, and post-test), and within-between interaction multivariate analysis of variance (MANOVA) in data analysis with significance at the .05 alpha level, desired power at .8, and an anticipated medium to large effect size (> .14; Cohen, 1988), the study required a minimum sample size of 32 participants. Therefore, the minimal sample size for adequate power was met (n= 34), thereby decreasing the likelihood of Type II error, and increase the ability to generalize results (Balkin & Sheperis, 2011).

Group Counseling Intervention

The primary goal of the group counseling intervention curriculum was to increase hope, coping skills, and reduce suicidality in LGBTQ+ older adolescent participants. Strategies and interventions to increase hope are *not* prevalent in the available research, and are described in qualitative studies (Shrank & Bird, 2011). No studies were found that described experimental research that implemented interventions to increase hope in LGBTQ+ adolescents, lending additional credence to the importance of this study. That said, the most promising interventions identified in the available literature include: (a) fostering relationships; (b) peer support; (c) goal-setting; and (d) developing protective factors like self-esteem, self-efficacy, and general well-being (Shrank & Bird). Therefore, activities that foster these factors were incorporated in a supportive group format. For coping, Stone and Neale (1984) highlighted the primary components that assist in positive coping behaviors: (a) acceptance; (b) social support; (c)

catharsis; (d) direct action; (e) relaxation; and (f) situation redefinition (e.g. reframing). Some of these conditions are met by virtue of the group environment (Yalom & Leszcz, 2005), while others were increased through a variety of activities. Finally, suicidal ideation is mitigated by the presence of protective factors like (a) positive expectancy (i.e., hope); (b) positive coping strategies; and (c) peer-based support. A copy of the intervention curriculum is provided in Appendix K.

LGBTQ+ older adolescent participants that were randomly selected to participate in the intervention in group counseling did so over eight consecutive weeks, one session per week, with each session lasting approximately 60 minutes. Group sizes were restricted to five to six participants, as with larger groups the opportunity for member interaction and relationship development decreases, and becomes leader rather than member centered (Gladding, 2012). An interactive, experiential format was selected for the group intervention based on empirical support identifying that such delivery methods promote higher client satisfaction, increased response to the intervention, and greater retention of learning (Emer, McLarney, Goodwin, & Keller, 2002; Greene & Cole, 1991). Furthermore, the use of psychoeducation was used to foster positive participant outcomes. Psychoeducation in group interventions involves the conveying of information to the group participants and fostering of their skill development for the purpose of promoting interpersonal growth and preventing future difficulties among those who may be at risk for developing future problems (Association for Specialists in Group Work, 2000; Brown, 1997; Gladding, 2012). Specifically, psychoeducational group work with adolescents decreases psychological symptoms (e.g., anxiety, interpersonal sensitivity; Wang, 1997), alleviates depression (Gaynor & Lawrence, 2002), increases self-esteem (Wells, Miller, Tobacyk, & Clanton, 2002), and improves coping strategies and resources (Hayes & Morgan, 2005). In

addition, a strength-based approach (e.g., identifying group participants' existing strengths and developing resiliency) was employed as this therapeutic method is beneficial in improving adolescents' life satisfaction, overall well-being, and group cohesion (e.g., Harris, Brazeau, Clarkson, Brownlee, & Rawana, 2012; Proctor et al., 2011).

The first session of the group curriculum was focused on introductions and an icebreaker, explaining the goals of the group; discussion regarding what brought members to the group, and general rapport building. In addition, the informed consent and limits/exceptions to confidentiality was reviewed. Furthermore, the participants completed four data collection instruments: (a) a participant demographic questionnaire (Griffith, 2013); (b) the *Herth Hope Index* (HHI; Herth, 1992); (c) the *Brief COPE* (Carver, 1997); and (d) *Life Attitudes Schedule – Short Form* (LAS-SF; Rhode et al., 1996). Emergency resources for the participants were also discussed and disseminated at the first group meeting, including a national suicide hotline and additional local community resources. Group intervention sessions two through four focused on participants identifying current coping skills and improving their positive coping skills (e.g., creating a wellness wheel, diaphragmatic breathing, and positive reframing). Immediately following the fourth group intervention session, participants completed mid-point assessments for the HHI, *Brief COPE*, and LAS-SF. Group intervention sessions five through seven focused on the participants building hope (e.g., hopes for the future art assignments, a letter to themselves from the future, and goal-setting). The eighth group intervention session (the termination meeting) focused on: (a) reviewing the participants' progress since the beginning of group; (b) discussing how they planned to continue their progress now that group intervention was concluding; and (c) facilitating a metaphorical "gift exchange" activity in which participants express "gifts" they would like to give or felt they received from other group members and/or the

group facilitator. At the conclusion of the eighth group intervention session, the participants completed the HHI, *Brief COPE*, and LAS-SF for the third time, as well as the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) and an exit survey developed by the researcher.

Treatment fidelity was an important consideration in this study as the researcher and volunteer facilitators needed to adhere to the specifications of the intervention in order to ensure the effects of the intervention are what are being measured (Gall, Gall and Borg, 2007). Based on the recommendations provided by Gall and colleagues, treatment fidelity was maximized in the following ways: (a) a facilitator handbook was provided with instructions as to how to implement the intervention along with standardized curriculum; (b) the researcher conducted standardized in-person training with the facilitators; and (c) facilitators were required to keep a log of group session content in order verify uniformity in the application of the group curriculum.

Instrumentation

A total of five instruments were used over the course of the investigation. Three instruments (i.e., the HHI, the *Brief COPE*, and the LAS-SF) were administered as pre-test, mid-tests, and post-tests to both the intervention group and control groups participants in order to determine differences between the groups and the cause-and-effect relationship of the intervention. Additionally, a brief demographic questionnaire developed by the researcher was administered during the first week of the investigation to both groups in order to record participant characteristics such as age, gender, race/ethnicity, affectional orientation, gender identity/expression, and perceived level of peer support and parental support. Lastly, intervention group participants completed the TFI-S at the conclusion of the final group session in order to

determine the strength of group therapeutic factors experienced by participants. Care was taken to select validated short forms or abbreviated versions of longer instruments in order to reduce the total time required to complete the scales. The following includes a description of these instruments in greater detail.

Demographic Questionnaire

A demographic questionnaire was developed by the researcher to determine age, ethnicity, biological sex, gender identity, affectional orientation, and level of disclosure about one's LGBTQ+ status, as well as ratings of perceived peer and parental support. As noted, both intervention and control group participants completed this form at the beginning of the study. The demographic questionnaire was reviewed by colleagues (i.e., dissertation co-chairs) before being administered to participants in order to provide support for face validity and readability.

Hearth Hope Index

In order to measure participants' changes in hope at the conclusion of the investigation, the study included the *Herth Hope Index* (HHI; Herth, 1992). Other measures of hope focus on hopelessness rather than the presence of hope (e.g., Beck *Hopelessness Scale*; Beck et al, 1974), or exclusively on one's perception of their ability to achieve goals (e.g., the *Hope Scale*; Snyder et al., 1991; *Children's Hope Scale*; Snyder et al., 1997). The HHI, however, measures variables aligned to the broader aim of the intervention, to also increase a general, non-time-oriented sense of positive expectancy and a sense of interconnectedness. Therefore, the global concept assessed by the HHI was the most appropriate for this investigation.

The HHI consists of 12-items on a four-point Likert agreement scale (i.e., strongly disagree, disagree, agree, strongly agree), thereby presenting respondents with a force-choice as to whether they fall on the positive or negative side of a variable. Example items from the HHI

include: (a) “I have a positive outlook toward life”; (b) “I have a sense of direction”; and (c) “I feel my life has value and worth.” Higher scores indicate participant *increases* in hopefulness. A minimum score on the HHI is 12 and the maximum score is 48.

The HHI is an abbreviated version of the 30-item *Herth Hope Scale* (HHS; Herth, 1991). Herth (1992) notes that the purpose of the HHI is to capture the multidimensionality of hope as measured by the HHS while “reducing the number and complexity of items so as to render the tool more clinically useful” (p. 1252). The HHI was designed to parallel the same three subscales as the original HHS: (a) cognitive-temporal, the sense that desired outcomes will realistically be achieved at some point in the future; (b) affective-behavioral, a feeling of confidence regarding the likelihood of a positive future; and (c) affiliative-contextual; a recognition of the interconnectedness between both self and others and self and spirit.

Psychometric Properties of the Hearth Hope Index. In a study of adults in poor health (n = 172), Cronbach’s alpha for the HHI was found to be .97, indicating high internal consistency, with a .91 test/re-test reliability at two weeks indicating stability over time (Herth, 1991). Criterion validity was established by comparing the HHI to its parent instrument, the HHS (.92). In addition, all 12 items loaded into the original three factor model as demonstrated by the HHS. Furthermore, a negative correlation with the *Hopelessness Scale* (Beck et al., 1974) was achieved as well (-.71).

Since its dissemination, the HHI has been used in more than 40 published research studies and 15 doctoral dissertations (Phillips-Salimi, Haase, Kintner, Monahan, & Azzouz, 2007). Total scores of the HHI had acceptable internal consistency in a sample of 127 adolescents and young adults at various stages of cancer treatment (.84) and those newly diagnosed (.78; Phillips-Salimi et al., 2007), and a sample of 641 college-aged women with

eating disorders (.93; Boisvert, 2005). Research findings identify that the factor structure of the HHI may be different with adolescents and young adults when compared to adults, supporting a one factor structure with this population (Phillips-Salimi, 2007). Therefore, total mean scores were used to in the analysis rather than the original three factor structure. Mean scores (rather than sum scores) are helpful when participants inadvertently do not provide a response to some items; this procedure reduces variability between those participants who have missing responses and those that do not, making the score estimates and subsequent data analyses more precise (Tabanick & Fidell, 2007). Overall, the HHI was found to be a practical instrument with evidence of reliability in measuring hope. No studies were found that have used the HHI with a sample of LGBTQ+ youth.

The Brief COPE

The instrument selected to measure changes in the coping strategies that participants employ before, during, and after the investigation was the *Brief COPE* (Carver, 1997). The *Brief COPE* is a 28-item instrument that measures participants' coping behaviors by examining participants' prevalence of 14 conceptually distinct coping reactions: (1) active coping; (2) planning; (3) using instrumental support; (4) using emotional support; (5) venting; (6) self-distraction; (7) positive reframing; (8) humor; (9) acceptance; (10) religion; (11) behavioral disengagement; (12) self-blame; (13) denial; and (14) substance use. Each of the 14 subscales includes two questions; total scores for the *Brief COPE* range from 0-112. Response options are on a 4-point Likert frequency scale: (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." Example statements from the *Brief COPE* include: (a) "I've been getting emotional support from others"; (b) "I've been expressing my negative feelings"; and (c) "I've been criticizing myself."

The *Brief COPE* was *not* designed to be interpreted in terms of total scores. Therefore, for the purposes of this investigation, the *Brief COPE* was used to distinguish between participants' *Adaptive Coping* (i.e. positive coping behaviors) based on higher total scores on questions related to subscales 1-10 (active coping; planning; using instrumental support; using emotional support; venting; self-distraction; positive reframing; humor; acceptance; and religion) and participants' *Maladaptive Coping* (i.e. negative coping behaviors) based on higher total scores on factors 11-14 (behavioral disengagement; self-blame; denial; and substance use). These two coping categorizations (adaptive and maladaptive coping) differentiate between positive and negative coping strategies (Hampel & Petermann, 2005). Prior research supported the use of the *Brief COPE* to assess adaptive and maladaptive coping (e.g., Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006).

The *Brief COPE* is an abbreviated form of a parent instrument to measure coping, the *COPE*, which was developed by the same author (Carver, 1989). The shortened version was selected because it is the only coping skills instrument found by the researcher that measures the desired breadth of coping behaviors without containing a burdensome amount of questions. While brief, much information is obtained about participants' positive and negative coping strategies. In addition, the *Brief COPE* has the advantage of being built from acknowledged theoretical models: (a) the *Transactional Model of Stress and Coping* (Lazarus & Folkman, 1984), and (b) the *Behavioral Self-regulation Model* (Carver & Scheier, 1988).

Psychometric Properties of the Brief COPE. Reliability and validity support for the *Brief COPE* are derived from a study of Hurricane Andrew survivors (n = 168) at three, six, and 18 months after the event (Carver, 1997). An exploratory factor analysis revealed a nine factor structure similar to the original *COPE*: (1) substance use; (2) religion,; (3) humor; (4) behavioral

disengagement; (5) use of emotional support and use of instrumental support; (6) active coping; planning; and positive reframing; (7) venting and self-distraction; (8) denial and self-blame; and (9) acceptance (one item formed its own factor, while the other item loaded onto the active coping factor [.52] with a strong secondary loading [.47] in the acceptance factor). Cronbach's alpha for factor varies from .52 - .90. Reliability coefficients that fall below .70 do *not* demonstrate adequate internal reliability (Nunnally, 1978); therefore, this factor structure was not used in the data analysis of the current investigation. Test re-test reliability over the course of the three administrations ranged from .50 to .90, indicating adequate stability over time (Carver, 1997). Convergent and discriminate validity was also supported using the *Life Orientation Test*, *Rosenberg Self-Esteem Scale*, *Personal Views Survey*, *Jenkins Activity Survey*, and *State-Trait Anxiety Inventory* (Carver et al., 1989).

Krägeloh (2011) noted that since its original publication and until 2009, at least 399 studies have collected empirical data using the *Brief COPE*. Moreover, several studies using the *Brief COPE* indicate support for its use with minors, including a sample of 171 adolescents who have been exposed to terrorism (Moscardino, Scrimin, Capello, Altoè, & Axia, 2008), 64 pediatric patients (Piazza-Waggoner et al., 2006), and 90 secondary school students (Yusoff, 2011). This latter study also yielded information about the reliability and validity of the *Brief COPE*, determining the items had overall high internal consistency and yielded a nine factor structure (Yusoff). 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). Despite the instrument's use among researchers, it is important to note that each population is expected to have its own unique factor structure (Carver, 1997).

Life Attitudes Schedule Short Form

Intensity of participants' suicidal ideation and proneness (i.e., an individual's propensity to engage in suicidal behavior) was measured by *Life Attitudes Schedule Short Form* (LAS-SF; Rohde et al., 1996). The LAS-SF includes measures for subtle and overt self-destructive, risk-taking behaviors, as well as life-extending behaviors. Responses fall on a continuum of positive and negative actions, thoughts, and feelings. The original LAS-SF utilized a true/false scale; however, for the purposes of detecting changes in suicidality with greater sensitivity over the course of this investigation, the LAS-SF was replaced with a 4-point Likert scale wherein 1 = "Not at all true of myself," 2 = "Slightly true of myself," 3 = "Mostly true of myself," and 4 = "True of myself." The LAS-SF is comprised of 24 items and takes approximately five minutes to complete. Higher LAS-SF scores indicate participant *decreases* in suicidality. A minimum LAS-SF score is 24 and the maximum score is 96. The LAS-SF is ideal for this investigation *not* only for its breadth of proneness measures in a short form format, but for its non-stigmatizing and non-alarming title, "life attitudes." It was anticipated that similar measures to the LAS-SF that incorporate "suicide" would limit engagement from participants and participating organizations.

The LAS-SF was designed to be a brief version of its parent instrument, the 96-item *Life Attitude Schedule* (*LAS*; Lewinsohn et al., 1995). The short form consists of the same four subscales as the original instrument: (a) *Death Related*, suicide and death related items and reasons to live; (b) *Health Related*, items that measure illness, lack of self-care, and wellness; (c) *Self Related*, items that measure self-worth, self-image, self-enhancement, and self-promotion; and (d) *Injury Related*, items that measure injury-enhancing, risk-taking, and safety related thoughts, feelings, and behaviors. Example items on the LAS-SF include: (a) "I expect to have a long and interesting life"; (b) "killing myself would solve many of my problems"; and (c) "I

think I am worthless." The LAS-SF is *not* intended to serve as a suicidal intent intake and does not assess participants' presence of a suicide plan, access to means, imminent threat, or prior attempts. Data analysis with the LAS-SF was based on instrument total scores, and total scores for each of the four subscales.

Psychometric Properties of the Life Attitudes Schedule Short Form. The LAS-SF was normed with a sample of 206 high school students. Cronbach's alpha for the LAS-F was .84, indicating acceptable internal consistency. Internal consistency for each of the four subscales ranged from .58 - .67. Criterion validity was established by comparing the LAS-SF to its parent instrument, the *LAS*; total score correlated .93 with the original. Similar to the original instrument, males were shown to demonstrate more injury-related behaviors than females. Furthermore, though the LAS-SF was designed *not* to be synonymous with hopelessness, the total score measures significantly correlate with the *Hopelessness Scale* ($r = .61$). Moreover, the LAS-SF items were selected on the basis of non-significant associations with gender; nevertheless, male participants scores significantly higher than females (7.34 vs. 5.46; $t\,(185) = 3.00$, $p < .01$). This phenomenon of males scoring higher than females has been echoed in subsequent research with the LAS-SF (Klibert, 2008).

A study with 1,742 high school students provides further support for the psychometric robustness of the instrument, and provides evidence that scores on the LAS-SF can help to identify youth with a history of suicidal ideation and attempts (Rohde, Seeley, Langhinrichsen-Rohling, & Rohling, 2003). Ellis and Trumpower (2008) echoed these findings in a sample of 318 undergraduate students, in that students reporting current suicidal ideation scored significantly higher on the LAS-SF than students with no suicidal ideation. Though the LAS-SF has been used in limited studies, it has been demonstrated to be a psychometrically

sound measure of suicidal thoughts and behaviors, especially among adolescents and young adults.

Therapeutic Factors Inventory Short Form

In order to assess the level of group therapeutic factors that participants experienced at the conclusion of the intervention, the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) was administered at the conclusion of the final session. The TFI-S is a 19-item instrument categorized into four subscales: (a) instillation of hope; (b) secure emotional expression; (c) awareness of relational impact; and (d) social learning. Participants provide responses on a seven-point Likert scale (i.e., strongly disagree to strongly agree). Higher scores indicate participant *increases* in a personal experience of overall group effectiveness as based on Yalom's (2005) 11 therapeutic factors. A minimum score on the TFI-S is 19 and the maximum score is 133. Example TFI-S statements include: (a) Things seem more hopeful since joining group; (b) I feel a sense of belonging in group; and (c) this group empowers me to make a difference in my own life. The TFI-S is a shortened version of its parent instrument, the *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000), which included 99 items. Data analysis for the TFI-S included instrument total scores and total scores for each of the four subscales.

Psychometric Properties of the Therapeutic Factors Inventory Short Form. The TFI-S was normed on a sample of 380 adults participating in group therapy (Joyce et al., 2011). Despite being a newer instrument, confirmatory factor analysis demonstrated support for the four factor structure. Reliability was acceptable for the subscales, with Cronbach's alpha ranging from .71 - .91. Test-retest reliability ranges from .28 - .93 ($p < .001$) on each of the TFI subscales (Lese & MacNair-Semands, 2000). Construct validity for the TFI-S is also supported (Joyce et

al., 2011; MacNair-Semands, Orgrodniczuk, & Joyce, 2010). Further support for the TFI-S is demonstrated in a quasi-experimental study of counselors-in-training participating in multicultural growth groups (n = 94); alpha coefficients for each of the four subscales were as follows: (a) instillation of hope (.65); secure emotional expression (.52); awareness of relational impact (.88); and (d) social learning (.88), indicating adequate to questionable internal consistency (Johnson & Lambie, 2013).

Research Hypothesis and Exploratory Questions

The purpose of this research investigation was to compare mean differences in LGBTQ+ older adolescents' hopelessness, coping skills, and suicidality scores who participate in an eight-week group counseling intervention as compared to LGBTQ+ older adolescents who do *not* participate in the group intervention. Specifically, the following research questions and hypotheses guided investigation:

Primary Research Question and Hypothesis

What is the impact of an eight-week group counseling intervention on LGBTQ+ older adolescents' (ages 18-20) levels of hopefulness (as measured by the *Herth Hope Index* [HHI; Herth, 1992), coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the *Life Attitudes Schedule Short Form* [LAS-SF; Rohde, et al., 1996]) as compared to LGBTQ+ older adolescents who do *not* receive the intervention?

It was hypothesized that for the intervention group, there would be increases in scores related to hopefulness and positive coping behaviors, and a decrease in negative coping behaviors and suicidality when compared to pre-test scores, and when compared to the control group. No significant differences in scores were expected for the control group.

Exploratory Research Questions and Hypotheses

Exploratory research question 1. What is the relationship between LGBTQ+ older adolescents' (ages 18-20) self-reported levels of hopefulness (as measured by the HHI [Herth, 1992]), positive coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the LAS-SF [Rohde, et al., 1996])? It was hypothesized that higher scores in hopefulness and positive coping skills would correlate with lower scores in suicidality.

Exploratory research question 2. What is the relationship between the presence of group therapeutic factors total and subscale scores (as measured by the *Therapeutic Factors Inventory Short Form* [TFI-S; Joyce et al., 2011]) and levels of hopefulness (as measured by the HHI [Herth, 1992]), coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the LAS-SF [Rohde, et al., 1996]) in a sample of LGBTQ+ older adolescents (aged 18-20)? It was hypothesized that there would be a positive relationship between group therapeutic factors and hopefulness, coping skills, and suicidality.

Exploratory research question 3. What is the relationship between LGBTQ+ older adolescents' (ages 18-20) demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, perception of peer support and perception of parental support) and their levels of hopefulness (as measured by the HHI [Herth, 1992]), coping skills (as measured by the *Brief COPE* [Carver, 1997]), and suicidality (as measured by the LAS-SF [Rohde, et al., 1996])?

Data Analysis

Data analysis was conducted with the Statistical Package for Social Science (SPSS) software package for Windows version 21.0 (IBM Corp., 2012). The dataset for the investigation included one independent variable (i.e., placement in the intervention group or the control group)

and four continuous dependent variables: (a) intervention and control group participants' hope (as measured by the HHI; Herth, 1992); (b) coping skills (as measured by the *Brief COPE*, Carver, 1997); (c) suicidality (as measured by the LAS-SF; Rohde et al., 1996); and (d) intervention group participants' experience of group therapeutic factors (as measured by the TFI-S; Joyce et al., 2011). Additional variables from the demographic questionnaire include participants' age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, as well as ratings of perceived peer and parent/guardian support. Data were examined prior to ensure that necessary statistical assumptions have been met prior to analysis.

Research Hypothesis

For the first research question, the aim was to determine whether LGBTQ+ adolescents who receive the eight-week group intervention increase their levels of hope and positive coping skills, and decrease their negative coping skills and suicidality from prior to the intervention as compared to LGBTQ+ adolescents in the control group who do *not* receive the intervention. To answer this question, the researcher conducted a repeated measures multivariate analysis of variance (MANOVA). MANOVA is used when the researcher wishes to test a hypothesis that one or more independent variables have an effect on two or more dependent variables (Tabanick & Fidell, 2007). Total instrument scores and total subscale scores were examined. In order to determine the practical significance of the intervention, special attention was paid to effect sizes.

Exploratory Research Question 1

A standard multiple linear regression (MLR) was calculated to determine whether there was a predictive relationship between scores on the post-test HHI and the post-test *Brief COPE* Adaptive Coping scale as independent variables, and the post-test LAS-SF as the dependent

variable. It was anticipated that as post-test scores on the HHI and *Brief COPE* Adaptive Coping scale rise, so would post-test scores on the LAS-SF, essentially measuring if an increase in hope and positive coping skills has an impact on suicidality. Both intervention group and control group participants' scores on these instruments were examined.

Exploratory Research Question 2

A Pearson Product Moment Correlation (two-tailed) was used to calculate whether there was relationship between the presence of group therapeutic factors and levels of hope, positive coping skills, and suicidality for participants in the intervention group. The Pearson correlation also highlights the strength of the relationship and what percentage of the variance in scores can be accounted for by the linear relationship with each instrument (Tabanick & Fidell, 2013).

Exploratory Research Question 3

A one-way between groups analysis of variance (ANOVA) was used to calculate whether there was a relationship between participants' demographic information (i.e., age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's LGBTQ+ status, perception of peer support and perception of parental support) and levels of hope, coping skills, and suicidality.

Ethical Considerations

The following safeguards were in place to ensure that the investigation was conducted in an ethical manner:

1. Approval for the study and all materials used (e.g., curriculum, permission forms, advertising flyers, etc.) was obtained from the University of Central Florida's IRB,

dissertation co-chairs, and committee members, prior to the implementation of the investigation.

2. Participants were fully informed of their rights regarding their involvement in the investigation, including the voluntary nature of their participation and ability to withdraw from the study at any time without penalty.
3. Participants were informed of the limits of confidentiality in a group setting, due to the inability on the part of the facilitator to guarantee that participants will not disclose content from the sessions. Facilitators discussed and reviewed the importance of confidentiality during group sessions. Furthermore, participants were informed of the facilitator's role as a mandated reporter, and that confidentiality would need to be broken in cases of suicidal intent, threats to harm another individual, or knowledge of the abuse of a protected population (e.g., minors, the elderly, and adults with special needs).
4. Data from the instruments did *not* include identifying information in order to ensure participants' confidentiality. To assist in data analysis, each participant was assigned a unique code identifier known only to the researcher. Participants were also informed that data from the study may be presented in a public forum, but that individual data will remain confidential.

Potential Limitations of the Study

Though efforts were taken to limit threats to internal and external validity within this experimental investigation, limitations exist:

1. The novelty effect presents a threat to internal validity, which occurs when participants alter their behavior because the intervention produces excitement and enthusiasm. Given

that a primary purpose of this group is to produce hope (also referred to as "expectancy"), the novelty effect may be a difficult threat to internal validity to address.

2. Although several measures were taken to ensure treatment fidelity (i.e., facilitator training, standardized curriculum, and group content record-keeping), it would be unrealistic to expect complete treatment fidelity. Each group possessed unique group dynamics due to the individual personalities of the participants. Therefore, there is the potential that content outside of the curriculum may was introduced which may have influenced the findings of the investigation. Additionally, the individual characteristics of the group facilitators (e.g., disposition, leadership style, warmth, etc.) also likely had an impact on group outcomes.
3. The data collection instruments used in this investigation rely on self-report. Therefore, the data may reflect social desirability bias or a lack of self-awareness that may have influenced the study results.
4. Gall and colleagues (2007) note that there is an inherent difficulty in identifying target or accessible population parameters for groups that are partially "hidden" in society, which is often the case for LGBTQ+ youth due to fear surrounding rejection, safety, and stigma. By relying on participants that openly self-identify as LGBTQ+ to some degree, there is a risk the data from this investigation is from a biased sample.
5. Lastly, all data collection instruments have some measurement error despite available evidence demonstrating sounds psychometric properties in terms of reliability and validity.

Chapter Summary

This chapter reviewed the research methods that were used to investigate the impact of an eight-week group counseling intervention for LGBTQ+ older adolescents on: (a) hope (as measured by *Herth Hope Index* [HHI; Herth, 1992]); (b) coping skills (as measured by the *Brief COPE* [Carver, 1997]); (c) suicidality (as measured by the *Life Attitudes Schedule Short Form* [LAS-SF; Rohde et al,1996]), and (d) presence of group therapeutic factors (as measured by the *Therapeutic Factors Inventory Short Form* [TFI-S; Joyce, et al., 2011]). The chapter provided information on the research design, overview of procedures, and description of the population and sample. Characteristics of the intervention were also discussed. Furthermore, details on data collection methods, instrumentation, research hypothesis and questions, and methods of data analysis were provided. Finally, ethical considerations and limitations to the study were addressed.

CHAPTER FOUR: RESULTS

Introduction

Chapter four details the results of an investigation that examined the impact of an eight-week group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adolescents' (aged 18-20) levels of hopefulness, coping skills, and suicidality. It was hypothesized that for the intervention group, there would be increases in scores related to hopefulness and positive coping behaviors, and a decrease in suicidality when compared to pre-test scores, and when compared to the control group. No significant differences in scores were expected for the control group. An experimental, randomized-controlled-trial research design was employed to identify differences between the intervention group and waitlist control group participants' hopefulness, coping skills, and suicidality scores.

In addition, the relationship between the LGBTQ+ participants' outcome variables (hopefulness, coping skills, and suicidality) scores was examined. It was hypothesized that higher scores in hopefulness and positive coping skills would correlate with lower scores in suicidal ideation and proneness. Furthermore, the influence of group therapeutic factors experienced by the LGBTQ+ participants in intervention group for the variables of hopefulness, coping skills, and suicidality was examined. It was hypothesized that there would be a positive relationship between group therapeutic factors and these outcome variables, especially in regards to specific group therapeutic factors such as: (a) universality; (b) group cohesion; and (c) instillation of hope. Finally, the investigation explored whether there were any relationships between LGBTQ+ adolescents' (ages 13-19) demographic information (i.e., participants' age, ethnicity, biological sex, gender identity, affectional orientation, level of disclosure about one's

LGBTQ+ status, perception of peer support and perception of parental support) and their levels of hopefulness, coping skills, and suicidality.

This chapter presents: (a) a summary of the research design; (b) a review of the sampling and data collection procedures; (c) descriptive data results; (d) preliminary data analysis procedures and assumption testing; and (e) data analyses and results for the primary and exploratory research hypotheses. In conclusion, the chapter closes with a summary of the primary findings for the investigation.

Research Design

An experimental, repeated measures design was employed to examine the noted research hypotheses. Experimental research designs are the most rigorous design in determining the cause and effect relationship between independent and dependent variables (Gall, Gall, & Borg, 2007). Moreover, experiments that incorporate randomized control provide evidence that the observed effects are due to the intervention rather than other variables (Gall et al., 2007). Therefore, the investigation employed random assignment into intervention or control groups. The online tool offered at www.randomizer.org was used to identify intervention group versus control group participants (Urbaniak & Plous, 2012). Moreover, the use of pre-test, mid-test, and post-test measures aided in assessing the level of extraneous influence on participants' outcomes (Dugard & Todman, 1995). Three data collection points (pre, mid, and post), rather than only two (pre and post) were incorporated in order to increase statistical power (Pallant, 2010). The study also utilized waitlist control groups rather than no-treatment control groups as the waitlist control group design allows for all of the participants to experience the benefits of receiving the intervention (West & Spring, 2007). Nevertheless, a limitation of using a waitlist control group design is that control group participants may *not* be content to wait to experience the intervention

and may seek other interventions on their own (potential threat to internal validity; West & Spring, 2007).

Study participants were recruited via flyers and in-person announcements at LGBTQ+ related events and organization meetings throughout the greater Orlando, Florida area. In addition, study details were announced via email distribution lists and announcements were posted on LGBTQ+ related social media websites. Participants were also referred on an individual basis to participate in the investigation. Each participant completed a formal pre-screening interview conducted by the investigator in order to assess overall readiness and motivation to be a part of a group environment, as well as the applicability of potential participants' concerns to the elements of the intervention. Characteristics for exclusion to participate in the investigation included: (a) being under the age of 18; (b) a suicide attempt within the last 12 months; or (c) active drug abuse in order to minimalize facilitator liability and to trigger referrals for individual counseling or more appropriate groups to match the intensity of the individuals' need. The intervention was offered through two mental health centers located in the greater Orlando Metropolitan area.

Treatment/Intervention

The primary goal of the group counseling intervention curriculum was to increase hope, coping skills, and reduce suicidality in LGBTQ+ late adolescent participants. An interactive, experiential format was selected for the group intervention based on empirical support identifying that such delivery methods promote higher client satisfaction, increased response to the intervention, and greater retention of learning (Emer, McLarney, Goodwin, & Keller, 2002; Greene & Cole, 1991). Furthermore, the use of psychoeducation was used to foster positive participant outcomes. Psychoeducation in group interventions involves the conveying of

information to the group participants and fostering of their skill development for the purpose of promoting interpersonal growth and preventing future difficulties among those who may be at risk for developing future problems (Association for Specialists in Group Work, 2000; Brown, 1997; Gladding, 2012). Specifically, psychoeducational group work with adolescents decreases psychological symptoms (e.g., anxiety, interpersonal sensitivity; Wang, 1997), alleviates depression (Gaynor & Lawrence, 2002), increases self-esteem (Wells, Miller, Tobacyk, & Clanton, 2002), and improves coping strategies and resources (Hayes & Morgan, 2005). In addition, a strength-based approach (e.g., identifying group participants' existing strengths and developing resiliency) was employed as this therapeutic method is beneficial in improving adolescents' life satisfaction, overall well-being, and group cohesion (e.g., Harris, Brazeau, Clarkson, Brownlee, & Rawana, 2012; Proctor et al., 2011).

LGBTQ+ older adolescent participants that were randomly selected to participate in the intervention in group counseling did so over eight consecutive weeks, one session per week, with each session lasting approximately 60 minutes. Group sizes were restricted to five to six participants, as with larger groups the opportunity for member interaction and relationship development decreases, and becomes leader rather than member centered (Gladding, 2012).

Session Descriptions

The first session of the group curriculum was focused on introductions and an icebreaker, explaining the goals of the group; discussion regarding what brought members to the group, and general rapport building. In addition, the informed consent and limits/exceptions to confidentiality was reviewed. Furthermore, the participants completed four data collection instruments: (a) a participant demographic questionnaire (Griffith, 2013); (b) the *Herth Hope Index* (HHI; Herth, 1992); (c) the *Brief COPE* (Carver, 1997); and (d) *Life Attitudes Schedule –*

Short Form (LAS-SF; Rhode et al., 1996). Emergency resources for the participants were also discussed and disseminated at the first group meeting, including a national suicide hotline and additional local community resources. Group intervention sessions two through four focused on participants identifying current coping skills and improving their positive coping skills (e.g., creating a wellness wheel, diaphragmatic breathing, and positive reframing). Immediately following the fourth group intervention session, participants completed mid-point assessments for the HHI, *Brief COPE*, and LAS-SF. Group intervention sessions five through seven focused on the participants building hope (e.g., hopes for the future art assignments, a letter to themselves from the future, and goal-setting). The eighth group intervention session (the termination meeting) focused on: (a) reviewing the participants' progress since the beginning of group; (b) discussing how they planned to continue their progress now that group intervention was concluding; and (c) facilitating a metaphorical "gift exchange" activity in which participants express "gifts" they would like to give or felt they received from other group members and/or the group facilitator. At the conclusion of the eighth group intervention session, the participants completed the HHI, *Brief COPE*, and LAS-SF for the third time, as well as the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) and an exit survey developed by the researcher.

Based on the recommendations provided by Gall and colleagues, treatment fidelity was maximized in the following ways: (a) a facilitator handbook was provided with instructions as to how to implement the intervention along with standardized curriculum; (b) the researcher conducted standardized in-person training with the facilitators; and (c) facilitators were required to keep a log of group session content in order verify uniformity in the application of the group curriculum.

Data Collection

Data collection for the investigation occurred between September 2013 and December 2013. Approval to conduct the study was received by the Institutional Review Board (IRB) prior to the collection of any data. Data were collected from participants at three points during the investigation: (a) a pre-assessment, completed during the first week of the study; (b) a mid-assessment, completed after the fourth week of the study; and (c) a post-assessment, completed on the eighth week of the study. The data collection instruments were provided to the participants (intervention and control group) in a manila envelope, and the participants were instructed to *not* include identifying information on either the envelope or the assessments themselves in order to ensure confidentiality. Each participant was assigned a unique code identifier known only to the researcher, which also facilitated the ability to connect each of the participants' three data collection interval scores by assigning a letter noting group placement, a unique participant number, and an number noting whether the assessment was a pre, mid, or post test (e.g., participant A37-1, A37-2, A37-3). Assessment packets took approximately 10-15 minutes to complete. Data were stored in a locked desk in the researcher's office.

Intervention group participants completed each of the assessments immediately following the first, fourth, and eighth group sessions. Waitlist control group participants had three options for completing the data collection packets during the first, fourth, and eighth week of the investigation: (a) they could have the assessment packet mailed to them along with a self-addressed stamped envelope for returning the completed instruments; or (b) they could pick-up and drop-off the assessment packet at a designated location, or (c) they could make an appointment with the researcher to complete the assessment packet in a neutral location. The mailed envelopes included only the individual participant's code identifier in lieu of their name.

Sampling Procedures

Sampling

The target population for the investigation were older adolescents, defined for the purposes of this study as being between the ages of 18-20, who also identify as lesbian, gay, bisexual, transgender, queer, or otherwise as minority in regards to affectional orientation or gender identity/expression (LGBTQ+). Due to the difficulty in estimating the total population of LGBTQ+ late adolescents living in the United States, or even in a particular community, the researcher recruited participants from an accessible population of individuals who could realistically be included in the sample, by identifying potential participants from specific universities, community centers, and organizations located within the greater metropolitan Orlando, Florida area. The sample was recruited during May through August, 2013 through via flyers, emails, posting on social networking sites, face-to-face announcements, and individual referral.

Response Rates

A total of 42 late adolescents meeting the criterion to participant in the investigation (e.g., self-identifying as LGBTQ+) provided their informed consent to participate in the investigation and successfully completed the pre-screening process. Notably, no participants met the criteria for exclusion in the study during the pre-screening interviews. Via random selection (www.randomizer.org), 21 participants were placed in the intervention group, while the remaining 21 were placed in the waitlist control group. Of the intervention group participants, 100% completed the pre and mid assessments, and all but one participant completed the post assessment data collection packet (95.24% response rate, $n = 20$). Of the waitlist control group participants, five individuals (23.81%) declined to continue to be a part of the study upon

learning that they were *not* been selected to be in the intervention group. In addition, three waitlist control group participants did *not* return contact with the researcher after being mailed the first assessment battery (14.29%). Therefore, a total of 13 participants remained in the waitlist control group for the duration of the study (61.91% response rate). The total sample size for the investigation that completed the data collection packets was 34 late adolescents self-identifying as LGBTQ+. Larger sample sizes are recommended for experimental research; however, studies with as few as 15 total members may be considered sound if the treatment conditions are controlled for, as is the case in this investigation (Fraenkel & Wallen, 2008).

Participants' Descriptive Statistics

A total of 34 late adolescents self-identifying as LGBTQ+ participated in the investigation. The ages of participants ranged from 18-20 (M = 18.74, SD = .79, Mdn = 19, Mode = 18), and there were only slightly more individuals who were biologically born women than men (n = 18, 52.9%). In terms of current gender identity, 16 participants identified as male (47.1%), 16 identified as female (47.1%), and 2 participants identified as transgender or genderqueer, respectively. Participants were also asked to describe their affectional orientation, with the majority of participants identifying as gay/homosexual (n = 13, 38.2%); 12 participants identifying as bisexual, pansexual, or fluid (35.3%); 5 participants identifying as a lesbian (14.7%); 2 participants identifying as questioning (5.9%); 1 participant identifying as asexual (2.9%); and 1 participant identifying as straight (2.9%; note that this was also a participant who identified as transgender). In terms of ethnicity, the majority of participants were Caucasian/White (n = 20, 58.8%), followed by Multiracial (n = 6, 17.6%), Hispanic/Latino (n = 5, 14.7%), African-American/Black (n = 2, 5.9%), and Pacific Islander (n = 1, 2.9%). Therefore, 14 of the participants self-identified as an ethnic minority (41.2%).

In addition, the demographic questionnaire included questions regarding participants' "out" status among different family and peer groups, as in to whom they had disclosed their affectional orientation or gender identity/expression. The majority of participants were out to their parents (n = 27, 79.4%), one or more siblings (n = 22, 64.7%; note, 2 participants did *not* have siblings), extended family members (n = 18, 52.9%), friends (n =34, 100%), peers and acquaintances (n = 18, 82.4%), and "most everyone they know" (n = 18, 52.9%). Furthermore, participants were asked to rate the level of support they feel they receive from their parents or guardians regarding their affectional orientation and/or gender identity on a Likert scale of 0% to 100%. On the whole, parents and/or guardians were perceived to be supportive (M = 60.29%, SD = 32.71, range 0 – 100), though 14.7% of participants selected 0%, meaning *not* supportive at all (n = 5). When asked a similar question regarding the level of support they feel they receive from friends and peers, participants indicated higher levels of support (M = 91.47, SD = 9.58, range = 70 – 100).

Twenty-one individuals participated in the eight-week group counseling curriculum between September and December of 2013. Participants were divided into four groups of five to six group members each, each with a unique group facilitator, and met once a week for 45-75 minutes. A total of 13 individuals were in the waitlist control group during the same timeframe. On the whole, the demographics of the intervention group participants did *not* differ significantly from control group participants, as indicated below in Table 1. Participants reported similar ages, orientations, ethnic identities, who they had disclosed their affectional orientation or gender identity to prior to the investigation, and levels of perceived support from parent/guardians and peers. Nevertheless, differences were identified between the treatment group and the control

group participants, including differences in male/female gender identity ratios, and less diversity in affectional orientation among the control group participants.

Table 1: *Demographic comparison of the intervention group and the control group*.

	Intervention Group		Control Group	
Demographics	*n*	%	*n*	%
Gender				
Male	11	52.4	5	38.5
Female	8	38.1	8	61.5
Transgender/Genderqueer	2	4.8	0	0
Age				
18	12	57.1	4	30.8
19	6	28.6	5	38.5
20	3	14.3	4	30.8
Orientation				
Gay/homosexual	9	42.9	4	30.8
Lesbian	3	13.3	2	15.4
Bisexual/pansexual/fluid	5	23.8	7	53.8
Questioning	2	9.5	0	0
Asexual	1	4.8	0	0
Straight	1	4.8	0	0
Ethnicity				
White/Caucasian	12	57.1	8	61.5
Ethnic Minority	9	42.9	5	38.5
Disclosed Orientation To				
Parents	17	81.0	10	76.9
One or more siblings	14	66.7	8	61.5
Extended family members	13	61.9	5	38.5
Friends	21	100	13	100
Peers/acquaintances	17	81.0	11	84.6
Most everyone	12	57.1	6	46.2
	M	*SD*	*M*	*SD*
Level of Parental Support	62.86	31.33	56.16	35.72
Level of Friend/Peer Support	90.00	8.94	93.85	10.44

Instrument Data

Hopefulness

The *Herth Hope Index* (HHI; Herth, 1992) is a 12-item assessment that was used to obtain the intervention group participants' (n = 21) and waitlist control group participants' (n = 13) levels of hopefulness using a four-point Likert scale (i.e., strongly disagree, disagree, agree, strongly agree). Negatively worded items (e.g., "I feel scared about my future") were reverse-coded to aid in consistency of statistical analysis. Higher scores indicate participant *increases* in hopefulness. A minimum score on the HHI is 12 and the maximum score is 48. With the exception of one intervention group participant who did *not* complete the final assessment battery, no missing data were observed; therefore, the HHI total scores suffice as the unit of measurement rather than mean scores.

According to Pallant (2010), values above .8 are preferable, values above .7 are acceptable, and values below .7 are too low to be considered reliable. Herth (1992) reported high internal reliability for the HHI (α = .97) and acceptable reliability for three identified subscales: (a) cognitive-temporal (CT), the sense that desired outcomes will realistically be achieved at some point in the future; (b) affective-behavioral (AB), a feeling of confidence regarding the likelihood of a positive future; and (c) affiliative-contextual (AC), a recognition of the interconnectedness between both self and others and self and spirit, as their alpha coefficients "were found to range from .78 to .86" (p. 1256). In the present study, Cronbach's alpha for the total HHI scores was acceptable with overall alpha coefficient scores for pre-test HHI scores (α = .78), mid-test HHI scores (α = .82), and post-test HHI scores (α = .86) with these data. Cronbach's alpha for the three HHI subscales; however, were *not* adequate, as the pre-test, mid-

test, and post-test coefficients ranged between .34 and .69, below the minimally acceptable standard of .7 (Nunnally, 1978; Pallant, 2010).

Intervention group participants' total scores on the HHI were: : (a) pre-test (M = 35.10, SD = 4.82, Mdn = 34.00, Mode = 31, range = 26 – 43); (b) mid-test (M = 36.81, SD = 3.71, Mdn = 37.00, Mode = 36, range = 30 – 44); and (c) post-test (M = 39.10, SD = 3.42, Mdn = 39.00, Mode = 36, range = 32 – 46). Waitlist control group participants' total scores were (a) pre-test (M = 35.15, SD = 4.56, Mdn = 33.00, Mode = 32, range = 29 – 43); (b) mid-test (M = 33.54, SD = 6.95, Mdn = 33.00, Mode = 33, range = 19 – 45); and (c) post-test (M = 33.23, SD = 7.01, Mdn = 33.00, Mode = 31, range = 19 – 44). The descriptive statistics for HHI pre-test, mid-test, and post-test scores are presented in Table 2.

Coping Skills

The instrument selected to measure changes in the coping strategies that participants employ before, during, and after the investigation was the *Brief COPE* (Carver, 1997). The *Brief COPE* is a 28-item instrument that measures participants' coping behaviors by examining participants' prevalence of 14 conceptually distinct coping reactions: (1) active coping; (2) planning; (3) using instrumental support; (4) using emotional support; (5) venting; (6) self-distraction; (7) positive reframing; (8) humor; (9) acceptance; (10) religion; (11) behavioral disengagement; (12) self-blame; (13) denial; and (14) substance use. Each of the 14 subscales includes two questions; total scores for the *Brief COPE* range from 0-112. Response options are on a 4-point Likert frequency scale: (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* designed to be interpreted in terms of total scores (Carver, 1997). Therefore, for the purposes of this investigation, the *Brief COPE* was used to distinguish

between participants' *Adaptive Coping* (i.e. positive coping behaviors) based on higher total scores on questions related to subscales 1-10 (active coping; planning; using instrumental support; using emotional support; venting; self-distraction; positive reframing; humor; acceptance; and religion) and participants' *Maladaptive Coping* (i.e. negative coping behaviors) based on higher total scores on factors 11-14 (behavioral disengagement; self-blame; denial; and substance use). These two coping categorizations (adaptive and maladaptive coping) differentiate between positive and negative coping strategies (Hampel & Petermann, 2005). Prior research supported the use of the *Brief COPE* to assess adaptive and maladaptive coping (e.g., Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006).

Moore and colleagues (2011) reported adequate internal reliability for the *Brief COPE* subscales Adaptive Coping (α = .78) and Maladaptive Coping (α = .70). In the present study, Cronbach's alpha for the *Adaptive Coping* total scores was higher with overall alpha coefficient scores for pre-test scores (α = .81), mid-test scores (α = .83), and post-test scores (α = .85) with these data. Cronbach's alpha for *Maladaptive Coping* was also acceptable with overall alpha coefficient scores for pre-test scores (α = .88), mid-test scores (α = .84), and post-test scores (α = .84; Pallant, 2010) with these data.

Adaptive coping. The *Brief COPE* (Carver, 1997) was used to obtain intervention group participants (n = 21) and waitlist control group participants' (n = 13) propensity to engage in positive coping behaviors. The *Brief COPE* consisted of 20 questions using a four-point Likert frequency scale. Higher scores indicate participant *increases* in frequency in engaging in positive coping behaviors (e.g., seeking emotional support, positive reframing, and humor). A minimum score on the *Brief COPE* is 20 and the maximum score is 80. With the exception of one intervention group participant who did *not* complete the final data collection packet, *no* missing

data was observed; therefore, total *Brief COPE* Adaptive Coping scores suffice as the unit of measurement rather than mean scores.

Intervention group participants' total scores on the *Brief COPE* for Adaptive Coping were: (a) pre-test (M = 50.62, SD = 9.20, Mdn = 53.00, Mode = 53, range = 33 – 65); (b) mid-test (M = 56.43, SD = 8.88, Mdn = 60.00, Mode = 62, range = 39 – 67); and (c) post-test (M = 58.45, SD = 7.24, Mdn = 58.00, Mode = 58, range = 48 – 70). Waitlist control group participants' total *Brief COPE* scores were (a) pre-test (M = 49.85, SD = 7.68, Mdn = 47.00, Mode = 45, range = 41 – 64); (b) mid-test (M = 49.00, SD = 7.45, Mdn = 49.00, Mode = 44, range = 36 – 61); and (c) post-test (M = 47.85, SD = 8.01, Mdn = 50.00, Mode = 50, range = 34 – 58).The descriptive statistics for the *Brief COPE* Adaptive Coping pre-test, mid-test, and post-test scores are presented in Table 2.

Maladaptive coping. The *Brief COPE* (Carver, 1997) was also used to obtain intervention group participants' (n = 21) and waitlist control group participants' (n = 13) propensity to engage in negative coping behaviors. The *Brief COPE* consists of eight questions using a four-point Likert frequency scale. Lower scores indicate participant *decreases* in frequency in engaging in negative coping behaviors (e.g., self-blame, denial, and substance use). A minimum score on the *Brief COPE* is eight and the maximum score is thirty-two. With the exception of one intervention group participant who did *not* complete the final assessment battery, no missing data was observed; therefore, total *Brief COPE* Maladaptive Coping scores sufficed as the unit of measurement rather than mean scores.

Intervention group participants' total scores on the *Brief COPE* for Maladaptive Coping were: (a) pre-test (M = 15.52, SD = 6.24, Mdn = 13.00, Mode = 13, range = 8 – 31); (b) mid-test (M = 14.10, SD = 5.05, Mdn = 14.00, Mode = 10, range = 8 – 27); and (c) post-test (M = 12.05,

SD = 3.66, *Mdn* = 10.50, Mode = 9, range = 8 – 19). Waitlist control group participants' total scores were (a) pre-test (*M* = 14.77, *SD* = 5.18, *Mdn* = 13.00, Mode = 13, range = 9 – 26); (b) mid-test (*M* = 17.15, *SD* = 6.34, *Mdn* = 17.00, Mode = 20, range = 8 – 32); and (c) post-test (*M* = 16.23, *SD* = 6.15, *Mdn* = 15.00, Mode = 13, range = 8 – 32). The descriptive statistics for the *Brief COPE* Maladaptive Coping pre-test, mid-test, and post-test scores are presented in Table 2.

Suicidality

The *Life Attitudes Schedule – Short Form* (LAS-SF; Rhode et al., 1996) is a 24-item assessment used to obtain the intervention group participants' (*n* = 21) and waitlist control group participants' (*n* = 13) levels of suicidal ideation and proneness (i.e., an individual's propensity to consider suicide, engage in suicidal behavior, and likelihood of attempting suicide). The original LAS-SF utilized a true/false scale; however, for the purposes of detecting changes in suicidality with greater sensitivity over the course of this investigation, the LAS-SF was replaced with a 4-point Likert scale wherein 1 = "Not at all true of myself," 2 = "Slightly true of myself," 3 = "Mostly true of myself," and 4 = "True of myself." Negatively worded items (e.g., "I enjoy thinking about death" and "Killing myself would solve many of my problems") were reverse-coded to aid in consistency of statistical analysis. Higher LAS-SF scores indicate participant *decreases* in suicidality. A minimum LAS-SF score is 24 and the maximum score is 96. With the exception of one intervention group participant who did *not* complete the final assessment battery, no missing data were observed; therefore, total LAS-SF scores suffice as the unit of measurement rather than mean scores.

According to Pallant (2010), values above .8 are preferable, values above .7 are acceptable, and values below .7 are too low to be considered reliable. Rhode and colleagues (1996) reported good internal reliability for the LAS-SF (α = .84), while reliability for four

identified subscales fell below acceptable reliability coefficient ranges: (a) *Death Related*, suicide and death related items and reasons to live (α = .67); (b) *Health Related*, items that measure illness, lack of self-care, and wellness (α = .62); (c) *Self Related*, items that measure self-worth, self-image, self-enhancement, and self-promotion (α = .58); and (d) *Injury Related*, items that measure injury-enhancing, risk-taking, and safety related thoughts, feelings, and behaviors (α = .67). In the present study, Cronbach's alpha for the total LAS-SF was acceptable with overall alpha coefficient scores for pre-test scores (α = .82), mid-test scores (α = .87), and post-test scores (α = .89; Pallant, 2010) with these data. Cronbach's alpha for the LAS-SF subscale scores were questionable to acceptable with as the pre-test, mid-test, and post-test coefficients ranged between .49 and .68, below the minimally acceptable standard of .7 (Nunnally, 1978; Pallant, 2010).

Intervention group participants' total scores on the LAS-SF were: (a) pre-test (*M* = 73.48, *SD* = 9.82, *Mdn* = 74.00, Mode = 73, range = 50 – 87); (b) mid-test (*M* = 76.90, *SD* = 8.29, *Mdn* = 78.00, Mode = 76, range = 60 – 90); and (c) post-test (*M* = 81.40, *SD* = 6.85, *Mdn* = 82.50, Mode = 84, range = 66 – 91). Waitlist control group participants' total scores were (a) pre-test (*M* = 70.23, *SD* = 10.64, *Mdn* = 71.00, Mode = 71, range = 56 – 90); (b) mid-test (*M* = 67.69, *SD* = 13.69, *Mdn* = 68.00, Mode = 68, range = 47 – 90); and (c) post-test (*M* = 68.38, *SD* = 14.39, *Mdn* = 70.00, Mode = 54, range = 47 – 90). The descriptive statistics for LAS-SF pre-test, mid-test, and post-test scores are presented in Table 2.

Table 2: *Pre, mid, and post-test scores for the HHI, Brief COPE, and LAS-SF.*

	Intervention Group					Control Group				
Descriptive Statistics	*M*	*SD*	*Mdn*	Mode	Range	*M*	*SD*	*Mdn*	Mode	Range
Herth Hope Index (HHI)										
Pre-test	35.10	4.82	34.00	31	26-43	35.15	4.56	33.00	32	29-43
Mid-test	36.81	3.71	37.00	36	30-44	33.54	6.95	33.00	33	19-45
Post-test	39.10	3.42	39.00	36	32-46	33.23	7.01	33.00	31	19-44
Brief COPE – Adaptive										
Pre-test	50.62	9.20	53.00	53	33-65	49.85	7.68	47.00	45	41-64
Mid-test	56.43	8.88	60.00	62	39-67	49.00	7.45	49.00	44	36-61
Post-test	58.45	7.24	58.00	58	48-70	47.85	8.01	50.00	50	34-58
Brief COPE - Maladaptive										
Pre-test	15.52	6.24	13.00	13	8-31	14.77	5.18	13.00	13	9-26
Mid-test	14.10	5.05	14.00	10	8-27	17.15	6.34	17.00	20	8-32
Post-test	12.05	3.66	10.50	9	8-19	16.23	6.15	15.00	13	8-32
Life Attitudes Schedule – Short Form (LAS-SF)										
Pre-test	73.48	9.82	74.00	73	50-87	70.23	10.64	71.00	71	56-90
Mid-test	76.90	8.29	78.00	76	60-90	67.69	13.69	68.00	68	47-90
Post-test	81.40	6.85	82.50	84	66-91	68.38	14.39	70.00	54	47-90

Group Therapeutic Factors

In order to assess the intervention group participants' (n = 21) experience of group therapeutic factors at the conclusion of their group counseling experience, the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) was administered at the conclusion of the final session. The TFI-S is a 19-item instrument, and participants provide responses on a seven-point Likert scale (i.e., strongly disagree to strongly agree). Higher scores indicate participant *increases* in a personal experience of overall group effectiveness as based on Yalom's (2005) 11 therapeutic factors. A minimum score on the TFI-S is 19 and the maximum score is 133. With the exception of one intervention group participant who did *not* complete the final assessment battery and one participant who neglected to complete the TFI-S along with the other instruments in their assessment packet, no missing data were observed; therefore, the total TFI-S scores suffice as the unit of measurement rather than mean scores.

Joyce and colleagues (2011) reported acceptable internal reliability (.71 - .91) for four identified subscales: : (a) instillation of hope; (b) secure emotional expression; (c) awareness of relational impact; and (d) social learning. In the present study, Cronbach's alpha for the total TFI-S was acceptable (α = .78; Pallant, 2010). Cronbach's alpha for the TFI-S subscales was acceptable (Instillation of Hope α = .84, Secure Emotional Expression α = .78, Awareness of Relational Impact α = .85, and Social Learning α = .86; Pallant, 2010).

The measure of central tendency for total TFI-S scores (n = 19) were M = 104.21, SD = 18.32, Mdn = 111.00, Mode = 109, range = 54 – 126. In context of the one to seven agreement scale; the total TFI-S scores indicated that the intervention group participants agreed that they experienced positive group therapeutic factors: M = 5.48, SD = .96, Mdn = 5.5, Mode = 6, range = 2.84 – 6.6. The measure of central tendency for group therapeutic factors scores per subscale

were: (a) Instillation of Hope (M = 5.78, SD = 1.03, Mdn = 6.00, Mode = 6, range = 3.25 – 7.00), (b) Secure Emotional Expression (M = 5.77, SD = 1.11, Mdn = 6.00, Mode = 6, range = 3.57 – 6.85), (c) Awareness of Relational Impact (M = 5.15, SD = 1.31, Mdn = 4.50, Mode = 4, range = 2.00 – 6.80), and (d) Social Learning (M = 4.98, SD = 1.31, Mdn = 3.00, Mode = 3, range = 1.00 – 6.67).

Data Analysis and Results for Primary Hypotheses and Exploratory Research Questions

Primary Research Hypothesis

The primary aim of this investigation was to determine whether LGBTQ+ older adolescents who participated in an eight-week group intervention (as developed by the researcher) experience an: (a) increase in hopefulness; (b) increase in use of positive coping skills; (c) decrease use of negative coping skills; and (d) decrease in suicidality as compared to LGBTQ+ older adolescents in a control group who do *not* receive the intervention. To explore the hypothesis that the intervention would have a positive impact on the intervention group participants' instrument scores, a repeated measures multivariate analysis of variance (MANOVA) was used. The repeated measures MANOVA procedure is preferred when the researcher tests a hypothesis that one or more independent variables has an effect on two or more dependent variables, and when such data is gathered at multiple time points during the investigation (Tabanick & Fidell, 2007). In addition, MANOVA compares group members scores (treatment and control groups) and identifies "whether the mean differences between the groups on the combination of dependent variables are likely to have occurred by chance" (Pallant, 2010, p. 283).

Prior to analyzing the data for the research hypotheses and research questions, the researcher investigated the assumptions to test whether the data conformed to necessary

assumptions for repeated measures MANOVA: sample size, normality, linearity, homogeneity of variance, and sphericity. Tabanick and Fidell (2007) recommend the minimum sample size for MANOVA procedures is 10+ the number of dependent variables, which was satisfied by the current study (n = 34). Shapiro-Wilk's test of normality indicated that the data were normal (p > .05) for each of the measures at pre-test, mid-test, and post-test for both intervention group and control group participants. Visual inspection confirmed that the data were normally distributed with no outliers. A test of Mahalanobis distances found that the value (22.57) did *not* exceed the critical value (29.59), an indication of multivariate normality (Pallant, 2010). Moreover, an inspection of the dependent variables on a scatterplot illustrated the data conformed to the assumption of linearity. Box's M test of equality of covariance was *not* significant (p = .243); therefore, the assumption of homogeneity among variance-covariance matrices was *not* violated. Finally, Mauchly's Test of Sphericity indicated that the assumption was *not* violated for: (a) Hopefulness (p = .71); (b) Adaptive Coping (p = .40); (c) Maladaptive Coping (p = .58); and (d) Suicidality (p = .07). Therefore, after conducting the preliminary assumption testing, the researcher found that *no* serious violations existed.

Hopefulness, positive coping skills, negative coping skills, and suicidality was measured for intervention group participants and waitlist control group participants at three time points: prior to the start of the intervention (pre-test), four weeks after the start of the intervention (mid-test), and at the conclusion of the intervention (post-test). Repeated measures MANOVA confirmed that there was 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, $p < .05$. In addition, there was a multivariate effect across the within-subjects interaction between group type and time (Wilks' $\lambda = .544$, F (8, 24) = 2.51, $p < .05$). There was

no main effect identified for within-subjects time point (regardless of group), indicating that placement in the intervention group or the control group was a component as to whether a change in scores was identified for the participants (Wilks' $\lambda = .713$, $F\,(8, 24) = 1.20$, $p = .34$). Univariate between-group analysis identified a number of differences in scores based on group type over the course of the investigation. Specifically, intervention group participants' scores improved when compared to the control group in terms of: (a) Hopefulness ($F\,[2, 62] = 10.19$, $p < .05$), partial $\eta^2 = .247$; (b) Adaptive Coping ($F\,[2, 62] = 6.44$, $p < .05$), partial $\eta^2 = .172$; (c) Maladaptive Coping ($F\,[2, 62] = 4.66$, $p < .05$), partial $\eta^2 = .131$; (d) Suicidality ($F\,[2, 62] = 8.04$, $p < .05$, partial $\eta^2 = .206$). Power to detect these changes was adequate, ranging from .76 to .98. Therefore, there was improvement in each of the investigation's key measured constructs across time for intervention group participants, while control group participants' scores did *not* significantly change. Figures 1-4 provide a visual representation of the changes in participants' scores over time based on group placement.

In addition to statistical significance, the effect sizes for changes in intervention group participants' assessment scores demonstrate practical significance for the group counseling intervention. The rule thumb for interpretation of eta-squared and partial eta squared is that 0.01 denotes a small effect size, 0.06 denotes a medium effect size, and 0.14 and above denotes a large effect size (Cohen, 1988). Therefore, there is strong practical significance for the impact of the intervention on participants' Hopefulness, Adaptive Coping, and Suicidality, and medium/strong practical significance for the impact of the intervention on participants' Maladaptive Coping.

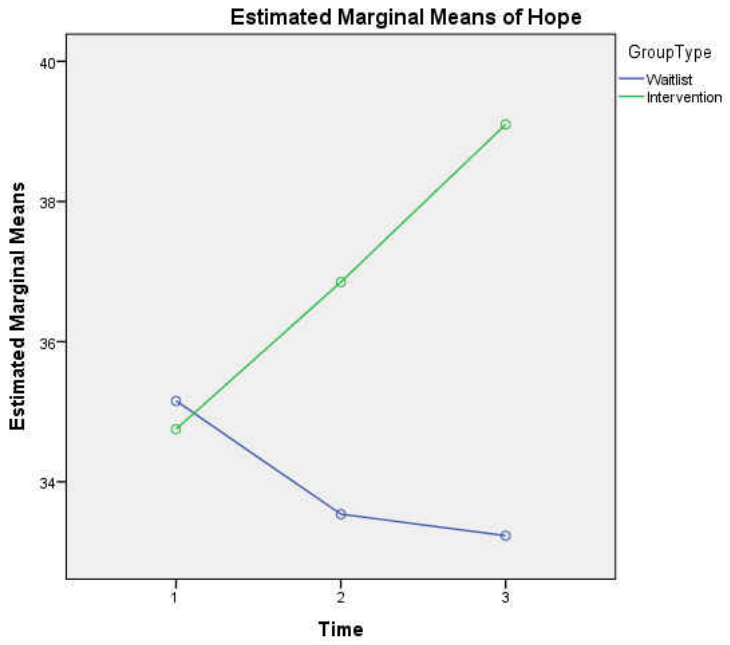


Figure 1: *Line graph – Hopefulness scores by group type at three data collection points: (1) pre-test; (2) mid-test; and (3) post-test.*

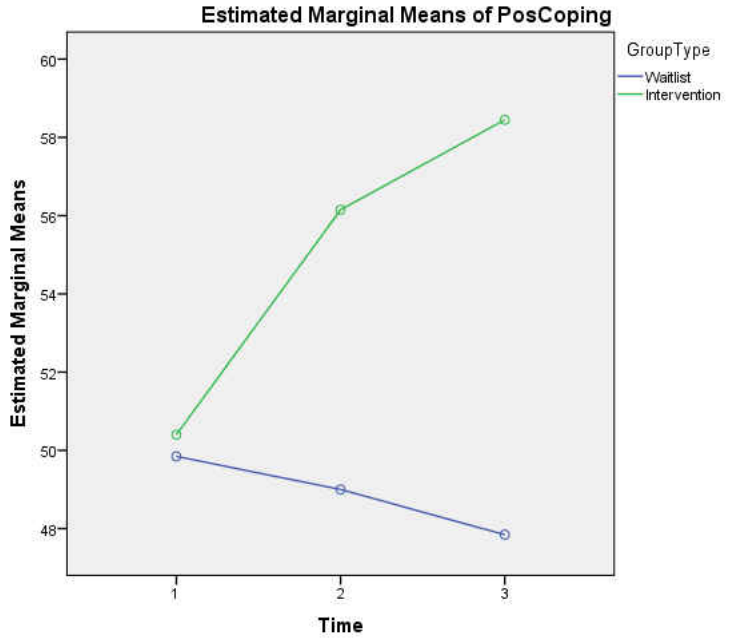


Figure 2: *Line graph – Adaptive Coping scores by group type at three data collection points: (1) pre-test; (2) mid-test; and (3) post-test.*

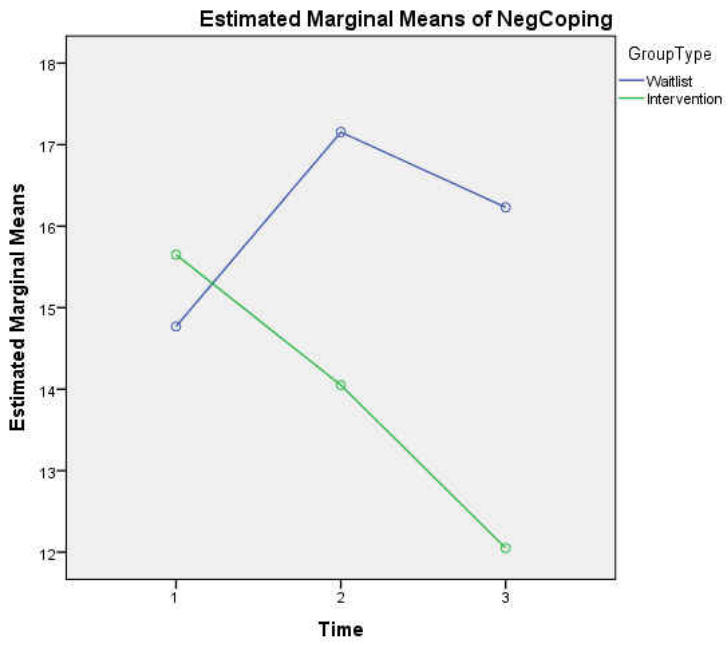


Figure 3: *Line graph – Maladaptive Coping scores by group type at three data collection points: (1) pre-test; (2) mid-test; and (3) post-test.*

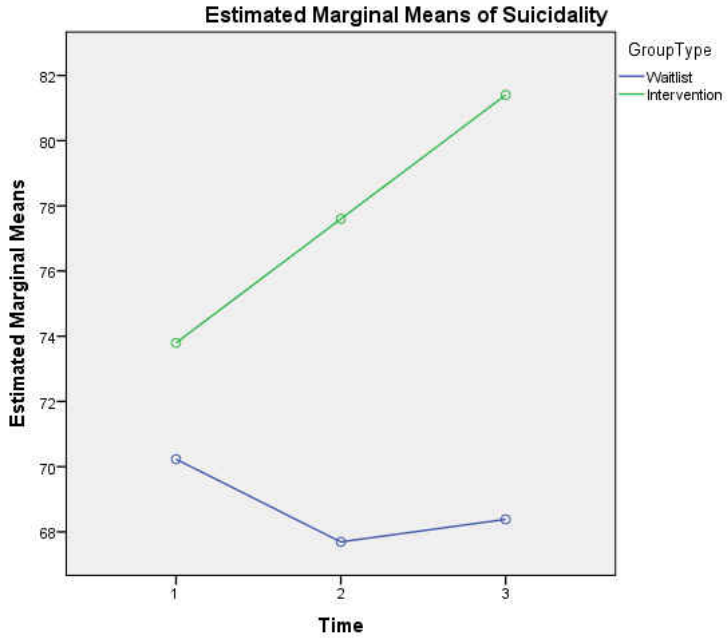


Figure 4: *Line graph – Suicidality scores by group type at three data collection points: (1) pre-test; (2) mid-test; and (3) post-test.*

Exploratory Research Question 1

It was anticipated that as participants' post-test scores on the HHI and the *Brief COPE* Adaptive Coping scales rose, so would their scores on the LAS-SF, essentially measuring if an increase in hope and positive coping skills predicted higher life attitudes (and therefore lower suicidality) scores. A standard multiple linear regression (MLR) was the statistical procedure selected to determine whether there was a predictive relationship between these variables. Additional assumptions testing was conducted to determine whether the selected analysis was appropriate. Stevens (1992) recommends that a minimum of 15 participants per predictor variable are needed for a reliable equation when conducting the analysis in social science research. For the current analysis, the suggested minimum is 30 cases is met (n = 33), as there are two predictor variables. Pallant (2010) states that multicollinearity exists when the independent variables (in this instance Hope and Adaptive Coping) are highly correlated (r = .9 or above)" (p. 151); this was not the case with these data (r = .49, p < .05). Previous analysis determined that the data are normal, linear, and contained no outliers. Therefore, after conducting the preliminary assumption testing, the researcher found that no serious violations existed and the analysis could continue.

After conducting the standard multiple regression analysis, it was found that Tolerance values were over .01 (.760) and VIF values were below 10 (1.315), further indication that multicollinearity was not an issue for these data. Furthermore, an inspection of the Probability Plot (P-P) of the Regression Standardized Residual and the Scatterplot indicated normality, linearity, and a lack of outliers (P-P plot points laid within a reasonably straight diagonal line from bottom left to top right), and homoscedasticity (the residuals were roughly rectangularly distributed within the scatterplot). Moreover, the Mahalanobis Distance maximum value (12.11)

did *not* exceed the critical value suggested by Pallant (2010; 13.82), providing further support that the data were normal.

The analysis addresses two questions: (a) How much variance in Suicidality scores was explained by scores on Hopefulness and Adaptive Coping?; and (b) Which variable best predicted Suicidality: Hopefulness or Adaptive Coping? Ultimately, the model explains 76.8% of the variance in Suicidality (adjusted r squared = .768, $p < .05$). Of the independent predictor variables, Hopefulness made the largest contribution by far (beta = .886, $p < .05$), while Adaptive Coping made a very low, and insignificant contribution (beta = -.003, $p = .98$). Therefore, Hope is the stronger predictor of Suicidality.

Exploratory Research Question 2

The second research question examined which group therapeutic factors (as measured by the TFI-S, Joyce et al., 2011) correlated with the intervention group participants' post-test scores in Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality (life attitudes). Two participants did *not* complete the TFI-S, leaving 19 participants in the sample. A Pearson Product Correlation was performed to measure the relationship between group therapeutic factors and these above constructs. In examining TFI-S total scores, there was a moderate positive correlation with *Adaptive Coping* ($r = .51$, $p < .05$, 26.0% of the variance explained). A Pearson r value greater than .5 is categorized as a large effect size (Thompson, 2002). A further positive correlation and large effect size was identified between *Adaptive Coping* and the TFI-S subscale, *Secure Emotional Expression* ($r = .52$, $p < .05$, 27.0% of the variance explained). No other correlations were identified among the remaining constructs and TFI-S total scores or subscales, Instillation of Hope, Awareness of Relational Impact, and Social Learning. Power to detect these differences was low (< .60); therefore, a failure to detect relationships may be due in part to low

sample size (Pallant, 2010). Table 3 illustrates the Pearson Product Correlation results for this analysis. In addition, the same analysis was conducted to examine the relationship between mid-test and post-test scores in Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality and TFI-S total scores; in these analyses *no* relationships were identified between the constructs and the TFI-S.

Table 3: *Pearson correlation among TFI-S (instrument total and subscales) and intervention group participants' post-test scores on Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality.*

	TFI – S Total	TFI-S Installation of Hope	TFI-S Secure Emotional Expression	TFI-S Awareness of Relational Impact	TFI-S Social Learning
Hopefulness					
Pearson Correlation	.022	.021	.173	-.038	-.198
Sig. (2-tailed)	.928	.933	.479	.879	.417
Adaptive Coping					
Pearson Correlation	.507*	.442	.515*	.296	.400
Sig. (2-tailed)	.027	.058	.024	.218	.089
Maladaptive Coping					
Pearson Correlation	-.025	-.058	-.036	.058	-.080
Sig. (2-tailed)	.921	.814	.883	.815	.745
Suicidality					
Pearson Correlation	-.033	.067	.113	-.219	-.081
Sig. (2-tailed)	.893	.785	.646	.369	.741

Exploratory Research Question 3

The final research question examined the relationship between participants' reported demographic variables and the primary constructs of interest (Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality). The demographic variables include: gender identity,

affectional orientation, ethnicity, level of disclosure about one's LGBTQ+ status, perceived level of parental support, and perceived level of peer support. A one-way between groups analysis of variance (ANOVA) was performed to measure the mean differences in Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality scores, respectively, on the following independent variables with three levels: (a) gender identity (i.e., male, female, and transgender/genderqueer); (b) affectional orientation (i.e., Gay/homosexual, Lesbian, Bisexual, Questioning, Asexual, and Straight); and (c) ethnicity (i.e., Caucasian/White, Hispanic/Latino, African-American/Black, Pacific Islander, and Multiracial). The variable *affectional orientation* was re-coded dividing it into four groups: Gay/homosexual, Lesbian, Bisexual, and Other (Questioning, Asexual, and Straight were collapsed as each category only had one representative; therefore, one category was created in order to perform one-way ANOVA tests on the variable (Pallant, 2010).

As participants originally rated their *perceptions of parental/guardian support* and *perceptions of peer support* on a continuum of 0-100%, a Pearson Product Correlation analysis was conducted to explore relationship between intervention and control group participants' ratings and the post-test scores for the primary constructs of the investigation. No relationship was identified between perceptions of parental/guardian support and: (a) Hopefulness ($r = .14$, $p = .44$); (b) Adaptive Coping ($r = .09$, $p = .62$); (c) Maladaptive Coping ($r = -.04$, $p = .83$); and (d) Suicidality ($r = .10$, $p = .58$). Furthermore, no relationship was identified between perceptions of peer support and: (a) Hopefulness ($r = -.14$, $p = .43$); (b) Adaptive Coping ($r = .02$, $p = .93$); (c) Maladaptive Coping ($r = .25$, $p = .17$); and (d) Suicidality ($r = -.21$, $p = .25$).

A one-way between groups analysis of variance (ANOVA) was conducted to explore the effect of *gender identity* on the post-test scores for the primary constructs of the investigation. Participants were divided into three groups (Group 1: Male; Group 2: Female; Group 3:

Transgender/Genderqueer). No statistically significant differences were identified for: (a) Hope (F [2, 30] = 3.10, p = .83); (b) Adaptive Coping (F [2, 30] = 3.12, p = .73); (c) Maladaptive Coping (F [2, 30] = 1.10, p = .35); or (d) Suicidality (F [2, 30] = 1.39, p = .27).

A one-way between groups ANOVA was also conducted to explore the effect of *affectional orientation* on the post-test scores for the primary constructs of the investigation. Participants were divided into four groups (Group 1: Gay/homosexual; Group 2: Lesbian; Group 3: Bisexual; Group 4: Other (Questioning, Asexual, or Straight). No statistically significant differences were identified for: (a) Hope (F [3, 29] = 2.31, p = .10); (b) Adaptive Coping (F [3, 29] = .30, p = .82); or (c) Maladaptive Coping (F [3, 29] = 1.53, p = .23). There was a statistically significant difference in Suicidality scores for affection orientation (F [3, 29] = 3.96, $p < .05$). The effect size, calculated using partial eta squared (η^2), was .29, a moderate effect (Cohen, 1988). Post hoc comparisons using the Tukey HSD test indicated that the mean score for Group 3 (Bisexuals; M = 67.92, SD = 13.42) differed from Group 2 (Lesbians; M = 81.42, SD = 10.00).

Furthermore, a one-way between groups ANOVA was conducted to explore the effect of *ethnicity* on the post-test scores for the primary constructs of the investigation. Participants were divided into four groups (Group 1: Caucasian/White; Group 2: Hispanic/Latino; Group 3: African-American/Black; Group 4: Pacific Islander; Group 5: Multiracial). No statistically significant differences were identified for: (a) Hope (F [3, 28] = .99, p = .43); (b) Adaptive Coping (F [3, 28] = .42, p = .79); (c) Maladaptive Coping (F [3, 28] = .86, p = .50); or (d) Suicidality (F [3, 28] = .57, p = .69). In summary, with the exception of Bisexuals scoring lower than Lesbians on the suicidality post-test, none of the reported demographic factors had a significant effect on the post-test scores of any of the primary constructs of this investigation.

Summary

This chapter presented the statistical analysis results for the investigation. Key findings included a significant interaction between time and group placement, highlighting that the intervention group participants experienced significant improvements on measures of hopefulness, coping behaviors, and suicidality when compared to participants in the waitlist control group. Furthermore, it was found that group therapeutic factors had a positive effect on intervention group participants' Adaptive Coping scores, but did not have an effect on Hopefulness, Maladaptive Coping, or Suicidality as hypothesized. Lastly, there was no significant differences between the demographic variables perceptions of parental/guardian support, perceptions of peer support, gender identity, or ethnicity on their hopefulness, coping behaviors, or suicidality. There was, however, a significant difference between Bisexuals and Lesbians post-test scores on Suicidality, with Bisexuals scoring significantly lower. No other significant differences were observed between sexual orientation and the other key constructs. A review and discussion of the results is presented in the following chapter with implications for education and practice, limitations of the study, and suggestions for future research.

CHAPTER FIVE: DISCUSSION

The purpose of Chapter Five is to provide an overview of the study, the research methodology, and a discussion of the results. Chapter Five expands upon the results presented in Chapter Four, and compares findings to those presented in Chapter Two. Specifically, Chapter Five integrates the results of the investigation within the context of previous research findings and theory to offer practical implications for counselors and counselor educators. In addition, a thorough review of the limitation of the study, implications for theory and practice, and recommendations for future practice are provided.

Overview

The challenges experienced by lesbian, gay, bisexual, transgender, and queer individuals, and those who otherwise identify as a minority in terms of sexual orientation and gender expression/identity (LGBTQ+) are well-documented. Research findings identify that LGBTQ+ adolescents are at higher risk of depression, suicidal ideation, self harm, and other negative coping behaviors such as drug use and sexual risk-taking than their heterosexual and cisgender peers (e.g., Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Liu & Mustanski, 2012; Mathy, 2003; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007; Spirito & Esposito-Smythers, 2006). Furthermore, adolescents as a group are at-risk for suicide as suicide is the third leading cause of death among this age group (Centers for Disease Control and Prevention, 2010). Notably, LGBTQ+ youth are two to seven times more likely to attempt suicide than non-LGBTQ+ youth, with risk factors including isolation, lack of hope, and negative coping skills contributing to increased ideation and attempts (Suicide Prevention Resource Center, 2008). A partial explanation for the elevated prevalence in suicide attempts may be attributed to the environment in which LGBTQ+ youth are exposed.

Specifically, LGBTQ+ high school students experience frequent instances of homophobic remarks, verbal and physical harassment, and assault; resulting in these young people feeling unsafe, isolated, and depressed (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). In addition, individuals who identify as LGBTQ+ exhibit hopelessness and an inability to cope with these difficult circumstances (King et al., 2008; Rutter, 2006; Van Heeringen, & Vincke, 2000). Therefore, LGBTQ+ individuals necessitate effective counseling interventions to support their feelings of hope, positive coping skills, and overall functionality; nevertheless, limited research was identified that examined the efficacy of counseling interventions with LGBTQ+ adolescent samples.

Summary of the Study

The purpose of the study was to investigate the impact of an eight week group counseling intervention on LGBTQ+ older adolescents' (ages 18-20) levels of hope, coping skills, and suicidality as compared to LGBTQ+ older adolescents who do *not* receive the intervention. In addition, for participants in the intervention group, the presence of group therapeutic factors was measured to examine the predictive relationship between group therapeutic factors and the participants' hope, coping, and suicidality scores. Furthermore, the relationship between participants' hope, coping, and suicidality scores and their reported demographic data was examined.

Theoretical Constructs

Four primary constructs guided this investigation and provided the theoretical foundation for the study: (a) hope (as measured by the *Herth Hope Index*, HHI; Herth, 1992); (b) coping (as measured by the *Brief COPE*; Carver, 1997); (c) suicidality (as measured by the *Life Attitudes*

Schedule – Short Form, LAS-SF; Rhode et al., 1996); and (d) group therapeutic factors (as measured by the *Therapeutic Factors Inventory Short Form*, TFI-S; Joyce et al., 2011).

Hope. Dufault and Martocchio (1985) define hope as a "multidimensional dynamic life force characterized by a confident *yet uncertain* expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant" (p. 380). Hope is a complex act of interweaving thoughts, emotions, and actions that develop over time; it is a process, rather than a trait. Within their definition of hope, Dufault and Martocchio distinguish between two related but distinct spheres: generalized and particularized hope. *Generalized hope* refers to a desire for an indeterminate positive future development (e.g., "it gets better"), and serves to: (a) provide motivation to keep going in difficult times; and (b) function as a coping mechanism that protects against despair. Conversely, *particularized hope* involves a specific and valued future outcome. Hope in this state also aids in constructive coping in that it motivates one to overcome obstacles in order to reach the object of hope. The original *Herth Hope Scale* (HHS) and HHI (an abbreviated version of the HHS) are modeled after Dufault and Martocchio's multidimensional theory of hope (Herth, 1991; Herth, 1992). The HHS and HHI are designed to capture "a more global sense of hope," "hope despite diminished or absent interpersonal relations," "hope as a sense of 'being' available and engaging in relationships" rather than "'doing' for oneself and others", and "potential hope for controlling behavioral and emotional responses" not necessarily events and experiences (Herth 1992, p. 1252). Unlike other theories that characterize hope in terms of personal and specific goal attainment (Snyder, 2002), the conceptualization of hope used within the current investigation leaves room for defining and measuring hopes that extend outside of personal wants, such as altruistic hope directed toward an

entire community. Hope, for the purposes of this study, also identifies hopefulness as a positive coping mechanism.

Coping. Lazarus and Folkman (1984) provide a well-known theory of coping, and define the coping construct as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Coping is a process that involves three components: (a) primary *appraisal*, the process of perceiving a threat to oneself; (b) *secondary appraisal*, the process of generating a potential response to the threat; and (c) *coping*, the active process of putting a response into practice. However, coping is *not* always a linear or complete process. For example, simply realizing that an acceptable coping response is readily available should the potential threat occur may result in finding the initial event to be less ominous or discouraging. Conversely, finding that one's coping strategy is less effective than anticipated may result in an amplification of how the initial threat is perceived, thereby resulting in a reappraisal of one's coping response. The coping process may cycle in what is known as a stressful transaction (Lazarus & Folkman).

Meyer (1995) posits that in addition to coping with personal adverse events, minorities such as the LGBTQ+ population face additional societal stressors. The combination of discrimination, prejudice, and stigma experienced by these individuals results in hostile social environments that increase the likelihood of experiencing stress on their coping system. Minority stress is characterized by three conditions, in that it is: (a) *unique*, an additive to day-to-day stressors and is distinctive among stigmatized populations; (b) *chronic*, in that it is stable over time as an underlying cultural structure; and (c) *socially-based*, stemming from social processes, institutions, and structures beyond individual influence (Meyer, 2003). Minority coping involves managing stressors that stem from their stigmatized status in society. While coping strategies at

an individual level varies, minority coping involves developing a sense of unity among fellow members of their community, thereby reducing stigmatization and providing personal validation; this minority coping strategy is known as "group-level" coping (Meyer, 2003, p. 677). An LGBTQ+ identity may then become a source of strength and resilience when it is associated with opportunities for social support and coping; these factors have the potential to reduce the impact of stress (Branscombe, Schmitt, & Harvey, 1999; Crocker & Major, 1989; Meyer, 2003; Miller & Major, 2000).

Suicidality. Suicidality refers to a range of behaviors, including: (a) *completed suicide*, as in taking one's life; (b) *suicidal ideation*, one's thoughts about suicide ranging from fleeting thinking to detailed planning; and (c) *suicide proneness*, the engagement in overtly suicidal behavior as well as risk-taking and potentially injury-producing behaviors, coupled with a lack of engagement in health and safety behaviors, or self-enhancement behaviors (Lewinsohn et al., 1995). Rohde, Seeley, Langhinrichsen-Rohling, and Rohling (2003) refer to suicide proneness as life attitudes, which are comprised of the spectrum of life-enhancing and life-endangering behaviors. Traditionally, suicidality is assessed by considering past suicide attempts (e.g., has the individual tried to kill themselves in the past), past suicidal ideation (e.g., has the individual had past thoughts about killing themselves), and present suicidal ideation (e.g., is the individual currently considering committing suicide). Only in the past two decades of research has suicide proneness as a risk-factor become more prominent in scholarly literature (Graber & Brooks-Gun, 1995; Lewinsohn et al., 1995; Rohde et al., 2003). Behaviors within the construct of suicidality are comprised of thoughts, feeling, and actions which include *not* taking care of one's body, fixating on the concept of death, feeling that life is *not* worth living and engaging in high levels of risky behavior (Rohde, et al., 1996).

Group Therapeutic Factors. The term group therapeutic factors refer to the positive manifestations of group experiences that engage members in the group process and facilitate personal development (Yalom & Leszcz 2005). Corsini and Rosenberg (1955) offered the first comprehensive analysis of group processes and dynamics in a meta-analysis of 300 conceptual scholarly works on the topic. They identified nine major therapeutic factors, which were categorized into three groups: (a) intellectual; (b) emotional; and (c) actional. Yalom (2005), however, was the first to identify group therapeutic factors based on empirical research, and classified 11 curative factors: (a) instillation of hope, (b) altruism, (c) universality, (d) imparting information, (e) development of socializing techniques, (f) corrective reenactment of the primary family group, (g) imitative behavior, (h) interpersonal learning, (i) cohesiveness, (j) catharsis, and (k) existential factors.

Participants

A total of 42 late adolescents meeting the criterion to participant in the investigation (e.g., self-identifying as LGBTQ+) provided their informed consent to participate in the investigation and successfully completed the pre-screening process. Notably, no participants met the criteria for exclusion in the study during the pre-screening interviews. Via random selection (www.randomizer.org), 21 participants were placed in the intervention group, while the remaining 21 were placed in the waitlist control group. Of the intervention group participants, 100% completed the pre and mid assessments, and all but one participant completed the post assessment data collection packet (95.24% response rate, $n = 20$). Of the waitlist control group participants, five individuals (23.81%) declined to continue to be a part of the study upon learning that they were *not* selected to be in the intervention group. In addition, three waitlist control group participants did *not* return contact with the researcher after being mailed the first

assessment battery (14.29%). Therefore, a total of 13 participants remained in the waitlist control group for the duration of the study (61.91% response rate). The total sample size for the investigation that completed the data collection packets was 34 late adolescents self-identifying as LGBTQ+. Larger sample sizes are recommended for experimental research; however, studies with as few as 15 total participants may be considered sound if the treatment conditions are controlled for, as is the case in this investigation (Fraenkel & Wallen, 2008).

Twenty-one individuals participated in the eight-week group counseling curriculum between September and December of 2013. Participants were divided into four groups of five to six group members each, each with a unique group facilitator, and met once a week for 45-75 minutes. To support treatment fidelity, the following steps were taken: (a) a facilitator handbook was provided with instructions as to how to implement the intervention along with standardized curriculum; (b) the researcher conducted standardized in-person training with the facilitators; and (c) facilitators were required to keep a log of group session content in order verify uniformity in the application of the group curriculum (Gall et al., 2007). A total of 13 individuals were in the waitlist control group during the same timeframe. On the whole, the demographics of the intervention group participants did *not* differ significantly from control group participants. Participants reported similar ages, orientations, ethnic identities, who they had disclosed their affectional orientation or gender identity to prior to the investigation, and levels of perceived support from parent/guardians and peers. Nevertheless, differences were identified between the treatment group and the control group participants, including differences in male/female gender identity ratios, and less diversity in affectional orientation among the control group participants.

Data collection

Data collection for the investigation occurred between September 2013 and December 2013. Approval to conduct the study was received by the Institutional Review Board (IRB) prior to the collection of any data. Data were collected from participants at three points during the investigation: (a) a pre-assessment, completed during the first week of the study; (b) a mid-assessment, completed after the fourth week of the study; and (c) a post-assessment, completed on the eighth week of the study. The data collection instruments were provided to the participants (intervention and control group) in a manila envelope, and the participants were instructed to *not* include identifying information on either the envelope or the assessments themselves in order to ensure confidentiality. Each participant was assigned a unique code identifier known only to the researcher, which also facilitated the ability to connect each of the participants' three data collection interval scores by assigning a letter noting group placement, a unique participant number, and an number noting whether the assessment was a pre, mid, or post test (e.g., participant A37-1, A37-2, A37-3). Assessment packets took approximately 10-15 minutes to complete. Data were stored in a locked desk in the researcher's office.

Intervention group participants completed each of the assessments immediately following the first, fourth, and eighth group sessions. Waitlist control group participants had three options for completing the data collection packets during the first, fourth, and eighth week of the investigation: (a) they could have the assessment packet mailed to them along with a self-addressed stamped envelope for returning the completed instruments; or (b) they could pick-up and drop-off the assessment packet at a designated location, or (c) they could make an appointment with the researcher to complete the assessment packet in a neutral location. The mailed envelopes included only the individual participant's code identifier in lieu of their name.

Discussion

Demographic Data

A total of 34 late adolescents self-identifying as LGBTQ+ participated in the investigation. The ages of participants ranged from 18-20 (M = 18.74, SD = .79, Mdn = 19, Mode = 18), and there were only slightly more biologically born women than men (n = 18, 52.9%). In terms of current gender identity, 16 participants identified as male (47.1%), 16 identified as female (47.1%), and 2 participants identified as transgender or genderqueer, respectively (5.9%). Participants were also asked to describe their affectional orientation, with the majority of participants identifying as gay/homosexual (n = 13, 38.2%); 12 participants identifying as bisexual, pansexual, or fluid (35.3%); 5 participants identifying as a lesbian (14.7%); 2 participants identifying as questioning (5.9%); 1 participant identifying as asexual (2.9%); and 1 participant identifying as straight (2.9%; note that this was also a participant who identified as transgender). In terms of ethnicity, the majority of participants were Caucasian/White (n = 20, 58.8%), followed by Multiracial (n = 6, 17.6%), Hispanic/Latino (n = 5, 14.7%), African-American/Black (n = 2, 5.9%), and Pacific Islander (n = 1, 2.9%). Therefore, 14 of the participants self-identified as an ethnic minority (41.2%).

Participants' demographics were consistent with research conducted by Kosciw and colleagues (2012) with a nationwide sample of 8,584 LGBTQ+ youth (aged 13-20). In that study, approximately half of the participants identified as female (49.6%) and the majority were White/Caucasian (67.9%). Participants' reported affectional orientation was also similar, identifying as gay or lesbian (61.3%), bisexual (27.2%), questioning or unsure (3.7%). Notable differences, however, include a higher percentage of participants whose gender identity was reported to by transgender (8.3%) or "other" gender (e.g., genderqueer, androgynous; 7.0%).

Therefore, participants in the current study identified their gender identity to be outside of the gender binary at lower rates than have been reported elsewhere. Otherwise, comparison to the investigation conducted by Kosciw and colleagues support that participants in the current study reported similar descriptive data for this population.

In addition, the demographic questionnaire included questions regarding participants' "out" status among different family and peer groups, as in to whom they had disclosed their affectional orientation or gender identity/expression. The majority of participants were out to their parents (n = 27, 79.4%), one or more siblings (n = 22, 64.7%; note, 2 participants did *not* have siblings), extended family members (n = 18, 52.9%), friends (n =34, 100%), peers and acquaintances (n = 18, 82.4%), and "most everyone they know" (n = 18, 52.9%). At the time of this investigation *no* other studies were located that requested "out" status rates among LGBTQ participants. That the majority of participants were out to family, friends, and most everyone they know, however, is indicative of the fact that more needful populations exist, as individuals who are *not* out are likely to be in greater need of intervention services, as "out" youth could be expected to have increased social support and access to helpful resources.

Furthermore, participants were asked to rate the level of support they feel they receive from their parents or guardians regarding their affectional orientation and/or gender identity on a Likert scale of 0% to 100%. On the whole, parents and/or guardians were perceived to be supportive (M = 60.29%, SD = 32.71, range 0 – 100), though 14.7% of participants selected 0%, meaning *not* supportive at all (n = 5). These acceptance levels appear to be higher than rates found by Ryan, Russell, Huebner, Diaz, and Sanchez (2010). In a study family acceptance and the health of LGBT young adults (n = 245), participants indicated low/moderate family acceptance (M = 23.9, SD = 15.2, total possible range 0-55). Higher family acceptance was

found to be predictive of greater self-esteem and social support, and a protective factor against substance abuse, depression, suicidal ideation, and suicide attempt among the participants (Ryan et al., 2010). Therefore, participants in the current study may *not* represent typical family acceptance rates, indicating that the intervention may be more beneficial for LGBTQ+ individuals who report the lower average perception of family acceptance.

When asked a similar question regarding the level of support they feel they receive from friends and peers, participants indicated higher levels of support (M = 91.47, SD = 9.58, range = 70 – 100). While *no* studies were identified that involved LGBTQ+ participants' scaled ratings of peer support, Mufioz-Plaza, Quinn, and Rounds (2002) noted via qualitative interviews (n = 12) that LGBT participants view friends and non-family adults as providing more emotional and instrumental support than parental figures, consistent with the findings from the present study.

Data Collection Instrument Descriptive Statistics

Hopefulness. The *Herth Hope Index* (HHI; Herth, 1992) is a 12-item assessment that was used to obtain the intervention group participants' (n = 21) and waitlist control group participants' (n = 13) levels of hopefulness using a four-point Likert scale (i.e., strongly disagree, disagree, agree, strongly agree). Higher scores indicate participant *increases* in hopefulness. A minimum score on the HHI is 12 and the maximum score is 48. Intervention group participants' total scores on the HHI were: (a) pre-test (M = 35.10, SD = 4.82, Mdn = 34.00, Mode = 31, range = 26 – 43); (b) mid-test (M = 36.81, SD = 3.71, Mdn = 37.00, Mode = 36, range = 30 – 44); and (c) post-test (M = 39.10, SD = 3.42, Mdn = 39.00, Mode = 36, range = 32 – 46). Waitlist control group participants' total scores were (a) pre-test (M = 35.15, SD = 4.56, Mdn = 33.00, Mode = 32, range = 29 – 43); (b) mid-test (M = 33.54, SD = 6.95, Mdn = 33.00, Mode = 33, range = 19 – 45); and (c) post-test (M = 33.23, SD = 7.01, Mdn = 33.00, Mode = 31, range = 19 – 44). The

mean HHI total scores with these data were low compared to HHI scores in a sample of adolescents with cancer (n = 42, M = 40.8, SD = 3.8; Phillips-Salimi, Haase, Kintner, Monahan & Azzouz, 2007).

In addition, Cronbach's alpha for the total HHI scores was acceptable with overall alpha coefficient scores for pre-test HHI scores (α = .78), mid-test HHI scores (α = .82), and post-test HHI scores (α = .86) with these data. Cronbach's alpha for the three HHI subscales; however, were *not* adequate, as the pre-test, mid-test, and post-test coefficients ranged between .34 and .69, below the minimally acceptable standard of .7 (Nunnally, 1978; Pallant, 2010). As the HHI is an abbreviated measure of the original Herth Hope Scale, fewer items may have contributed to low internal consistency, as well as a low sample size (Streiner, 2003). Due to reliability concerns, HHI subscales were *not* included in the overall analysis. The Cronbach's alpha total scores were consistent with prior research in that they were acceptable, though Herth (1992) reported stronger internal reliability for the HHI (α = .97) and acceptable reliability for the three identified subscales (.78 to .86).

Coping. The instrument selected to measure changes in the coping strategies that participants employ before, during, and after the investigation was the *Brief COPE* (Carver, 1997). The *Brief COPE* is a 28-item instrument that measures participants' coping behaviors by examining participants' prevalence of 14 conceptually distinct coping reactions: (1) active coping; (2) planning; (3) using instrumental support; (4) using emotional support; (5) venting; (6) self-distraction; (7) positive reframing; (8) humor; (9) acceptance; (10) religion; (11) behavioral disengagement; (12) self-blame; (13) denial; and (14) substance use. Each of the 14 subscales includes two questions; total scores for the *Brief COPE* range from 0-112. Response

options are on a 4-point Likert frequency scale: (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* designed to be interpreted in terms of total scores. Therefore, for the purposes of this investigation, the *Brief COPE* was used to distinguish between participants' *Adaptive Coping* (i.e. positive coping behaviors) based on higher total scores on questions related to subscales 1-10 (active coping; planning; using instrumental support; using emotional support; venting; self-distraction; positive reframing; humor; acceptance; and religion) and participants' *Maladaptive Coping* (i.e. negative coping behaviors) based on higher total scores on factors 11-14 (behavioral disengagement; self-blame; denial; and substance use). These two coping categorizations (adaptive and maladaptive coping) differentiate between positive and negative coping strategies (Hampel & Petermann, 2005). Prior research supported the use of the *Brief COPE* to assess adaptive and maladaptive coping (e.g., Jacobson, 2005; Moore, Biegel, & McMahon, 2011; Piazza-Waggoner et al., 2006). The Cronbach's alpha for the *Adaptive Coping* total scores was acceptable with overall alpha coefficient scores for pre-test scores (α = .81), mid-test scores (α = .83), and post-test scores (α = .85) with these data. Cronbach's alpha for *Maladaptive Coping* was also acceptable with overall alpha coefficient scores for pre-test scores (α = .88), mid-test scores (α = .84), and post-test scores (α = .84; Pallant, 2010) with these data.

Adaptive coping. The *Brief COPE* (Carver, 1997) was used to obtain intervention group participants (n = 21) and waitlist control group participants' (n = 13) propensity to engage in positive coping behaviors. The *Brief COPE* consisted of 20 questions using a four-point Likert frequency scale. Higher scores indicate participant *increases* in frequency in engaging in positive coping behaviors (e.g., seeking emotional support, positive reframing, and humor). A minimum score on the *Brief COPE* is 20 and the maximum score is 80. Intervention group participants'

total scores on the *Brief COPE* for Adaptive Coping were: (a) pre-test (M = 50.62, SD = 9.20, *Mdn* = 53.00, Mode = 53, range = 33 – 65); (b) mid-test (M = 56.43, SD = 8.88, *Mdn* = 60.00, Mode = 62, range = 39 – 67); and (c) post-test (M = 58.45, SD = 7.24, *Mdn* = 58.00, Mode = 58, range = 48 – 70). Waitlist control group participants' total *Brief COPE* scores were (a) pre-test (M = 49.85, SD = 7.68, *Mdn* = 47.00, Mode = 45, range = 41 – 64); (b) mid-test (M = 49.00, SD = 7.45, *Mdn* = 49.00, Mode = 44, range = 36 – 61); and (c) post-test (M = 47.85, SD = 8.01, *Mdn* = 50.00, Mode = 50, range = 34 – 58).

Maladaptive coping. The *Brief COPE* (Carver, 1997) was also used to obtain intervention group participants' (n = 21) and waitlist control group participants' (n = 13) propensity to engage in negative coping behaviors. The *Brief COPE* consists of eight questions using a four-point Likert frequency scale. Lower scores indicate participant *decreases* in frequency in engaging in negative coping behaviors (e.g., self-blame, denial, and substance use). A minimum score on the *Brief COPE* is eight and the maximum score is thirty-two. Intervention group participants' total scores on the *Brief COPE* for Maladaptive Coping were: (a) pre-test (M = 15.52, SD = 6.24, *Mdn* = 13.00, Mode = 13, range = 8 – 31); (b) mid-test (M = 14.10, SD = 5.05, *Mdn* = 14.00, Mode = 10, range = 8 – 27); and (c) post-test (M = 12.05, SD = 3.66, *Mdn* = 10.50, Mode = 9, range = 8 – 19). Waitlist control group participants' total scores were (a) pre-test (M = 14.77, SD = 5.18, *Mdn* = 13.00, Mode = 13, range = 9 – 26); (b) mid-test (M = 17.15, SD = 6.34, *Mdn* = 17.00, Mode = 20, range = 8 – 32); and (c) post-test (M = 16.23, SD = 6.15, *Mdn* = 15.00, Mode = 13, range = 8 – 32).

Comparing *Brief COPE* scores to those derived from other studies is problematic, as the scale's developer does not advise a particular method for second-order factoring and suggests that researchers develop their own for individual research samples (Carver, 1997). Other studies

that have divided the instrument into Adaptive Coping and Maladaptive Coping measures have included differing sub-scales; for example, Moore, Biegel, and McMahon (2011) include "self-distraction" and "venting" subscales in maladaptive coping, whereas in the current investigation these behaviors are included within the adaptive coping category. Furthermore, at the time of the investigation, no studies were identified that used the *Brief Cope* to measure coping behaviors among LGBTQ+ youth. Therefore, "typical" scores for these second-order factors within the present study cannot be established.

Suicidality. The *Life Attitudes Schedule – Short Form* (LAS-SF; Rhode et al., 1996) is a 24-item assessment used to obtain the intervention group participants' (n = 21) and waitlist control group participants' (n = 13) levels of suicidal ideation and proneness (i.e., an individual's propensity to consider suicide, engage in suicidal behavior, and likelihood of attempting suicide). The original LAS-SF utilized a true/false scale; however, for the purposes of detecting changes in suicidality with greater sensitivity over the course of this investigation, the LAS-SF was replaced with a 4-point Likert scale wherein 1 = "Not at all true of myself," 2 = "Slightly true of myself," 3 = "Mostly true of myself," and 4 = "True of myself." Higher LAS-SF scores indicate participant *decreases* in suicidality. A minimum LAS-SF score is 24 and the maximum score is 96. Intervention group participants' total scores on the LAS-SF were: (a) pre-test (M = 73.48, SD = 9.82, Mdn = 74.00, Mode = 73, range = 50 – 87); (b) mid-test (M = 76.90, SD = 8.29, Mdn = 78.00, Mode = 76, range = 60 – 90); and (c) post-test (M = 81.40, SD = 6.85, Mdn = 82.50, Mode = 84, range = 66 – 91). Waitlist control group participants' total scores were (a) pre-test (M = 70.23, SD = 10.64, Mdn = 71.00, Mode = 71, range = 56 – 90); (b) mid-test (M = 67.69, SD = 13.69, Mdn = 68.00, Mode = 68, range = 47 – 90); and (c) post-test (M = 68.38, SD = 14.39, Mdn = 70.00, Mode = 54, range = 47 – 90). Prior research with the LAS-SF has involved participants

providing responses in a true/false format (Rhode et al, 1996; Rhode et al., 2003), while participants in the current study provided responses on a four-point Likert scale, making direct comparison to other investigations difficult.

Cronbach's alpha for the total LAS-SF was acceptable with overall alpha coefficient scores for pre-test scores (α = .82), mid-test scores (α = .87), and post-test scores (α = .89; Pallant, 2010). Cronbach's alpha for the LAS-SF subscale scores were questionable to acceptable as the pre-test, mid-test, and post-test coefficients ranged between .49 and .68, below the minimally acceptable standard of .7 (Nunnally, 1978; Pallant, 2010). These reliability coefficients were consistent with prior research, as Rhode and colleagues (1996) reported acceptable internal reliability for the LAS-SF (α = .84), while reliability for four identified subscales fell below acceptable reliability coefficient ranges (.58-.67). As the LAS-SF is an abbreviated measure of the original *Life Attitudes Schedule*, fewer items may have contributed to low internal consistency, as well as a low sample size (Streiner, 2003). Due to reliability concerns, LAS-SF subscales were *not* included in the overall analysis.

Group Therapeutic Factors. In order to assess the intervention group participants' (n = 21) experience of group therapeutic factors at the conclusion of their group counseling experience, the *Therapeutic Factors Inventory Short Form* (TFI-S; Joyce et al., 2011) was administered at the conclusion of the final session. The TFI-S is a 19-item instrument, and participants provide responses on a seven-point Likert scale (i.e., strongly disagree to strongly agree). Higher scores indicate participant *increases* in a personal experience of overall group effectiveness as based on Yalom's (2005) 11 therapeutic factors. A minimum score on the TFI-S is 19 and the maximum score is 133. The measure of central tendency for total TFI-S scores (n = 19) were M = 104.21, SD = 18.32, Mdn = 111.00, Mode = 109, range = 54 – 126. In context of

the one to seven agreement scale; the total TFI-S scores indicated that the intervention group participants agreed that they experienced positive group therapeutic factors: *M* = 5.48, *SD* = .96, *Mdn* = 5.5, Mode = 6, range = 2.84 – 6.6. The measure of central tendency for group therapeutic factors scores per subscale were: (a) Instillation of Hope (*M* = 5.78, *SD* = 1.03, *Mdn* = 6.00, Mode = 6, range = 3.25 – 7.00), (b) Secure Emotional Expression (*M* = 5.77, *SD* = 1.11, *Mdn* = 6.00, Mode = 6, range = 3.57 – 6.85), (c) Awareness of Relational Impact (*M* = 5.15, *SD* = 1.31, *Mdn* = 4.50, Mode = 4, range = 2.00 – 6.80), and (d) Social Learning (*M* = 4.98, *SD* = 1.31, *Mdn* = 3.00, Mode = 3, range = 1.00 – 6.67). The mean TFI-S subscale scores with these data were high compared to TFI-S scores with other samples (e.g., Instillation of Hope, *M* = 3.61; Secure Emotional Expression, *M* = 3.06; Awareness of Relational Impact, *M* = 2.77; Social Learning, *M* = 3.22; Johnson & Lambie, 2013).

In the present study, Cronbach's alpha for the total TFI-S was acceptable (α = .78; Pallant, 2010). Cronbach's alpha for the TFI-S subscales was acceptable (Instillation of Hope α = .84, Secure Emotional Expression α = .78, Awareness of Relational Impact α = .85, and Social Learning α = .86; Pallant, 2010), which was consistent with Joyce and colleagues (2011) reported acceptable internal reliability (.71 - .91) for each of the four identified TFI-S subscales.

Research Hypotheses and Questions

Primary research hypothesis. The primary aim of this investigation was to determine whether LGBTQ+ older adolescents who participated in an eight-week group intervention (as developed by the researcher) experience an: (a) increase in hopefulness; (b) increase in use of positive coping skills; (c) decrease use of negative coping skills; and (d) decrease in suicidality as compared to LGBTQ+ older adolescents in a control group who did *not* receive the intervention. To explore the hypothesis that the intervention would have a positive impact on the

intervention group participants' instrument scores, a repeated measures multivariate analysis of variance (MANOVA) was used.

Hopefulness, positive coping skills, negative coping skills, and suicidality was measured for intervention group participants and waitlist control group participants at three time points: prior to the start of the intervention (pre-test), four weeks after the start of the intervention (mid-test), and at the conclusion of the intervention (post-test). Prior to analyzing the data for the research hypotheses and research questions, the researcher investigated the statistical assumptions to test whether the data conformed to necessary assumptions such as, normality, linearity, and homogeneity of variance and found that no serious violations existed. Repeated measures MANOVA confirmed that there was a multivariate effect for between-subjects (of the combined hope, coping, and suicidality scores) across group type (regardless of time point): Wilks' $\lambda = .702$, $F\ (4, 28) = 2.97$, $p < .05$. In addition, there was a multivariate effect across the within-subjects interaction between group type and time (Wilks' $\lambda = .544$, $F\ (8, 24) = 2.51$, $p < .05$). There was no main effect identified for within-subjects time point (regardless of group), indicating that placement in the intervention group or the control group was a component as to whether a change in scores was identified for the participants (Wilks' $\lambda = .713$, $F\ (8, 24) = 1.20$, $p = .34$). Univariate between-group analysis identified a number of differences in scores based on group type over the course of the investigation. Specifically, intervention 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 to detect these changes was adequate, ranging from .76 to .98. Therefore, there was improvement in each of the investigation's key measured

constructs across time for intervention group participants, while control group participants' scores did *not* significantly change. In addition to statistical significance, the effect sizes for changes in intervention group participants' assessment scores demonstrate practical significance for the group counseling intervention. The rule thumb for interpretation of eta-squared and partial eta squared is that 0.01 denotes a small effect size, 0.06 denotes a medium effect size, and 0.14 and above denotes a large effect size (Cohen, 1988). Therefore, there is strong practical significance for the impact of the intervention on participants' Hopefulness, Adaptive Coping, and Suicidality, and medium/strong practical significance for the impact of the intervention on participants' Maladaptive Coping.

These findings were consistent with similar studies that incorporated interventions to raise hopefulness among participants. Specifically, Cheavens and colleagues (2006) conducted an eight session group therapeutic intervention designed to increase hope among adult participants ($n = 32$). Similar to the present study, the investigation utilized a randomized, waitlist control trial design and used a community sample. Moreover, the study utilized a strengths-based approach, and employed the use of psychoeducational activities that identified and strengthened participants' existing assets. The results of this pilot study revealed that the participants had statistically significant increases in agency thinking as a component of hope (i.e., the thoughts an individual has regarding their ability to begin and continue movement toward an identified goal), life meaning, and self-esteem as well as reductions in symptoms of depression and anxiety ($p < .05$) when compared to participants in the waitlist control groups (Cheavens et al, 2006). Furthermore, the findings of the current study were consistent with the results of a quasi-experimental investigation of the *Penn Optimism Program* (POP; Shatte, Gillham, & Reivich, 2000), a 12 week school-based intervention designed to increase hope and

optimism via training in cognitive and behavioral techniques (n = 118). A repeated measured ANCOVA using participants' baseline depression score as a covariate established the differences between groups as statistically significant (F([, 48] = 8.390, p < .01).

In addition, Sikkema and colleagues (2013), for example, examined the impact of the *Living in the Face of Trauma* (LIFT) group intervention, which integrates specific coping skills training based on the theory of stress and coping (Lazarus & Folkman, 1984) and focuses on the reduction of negative coping strategies in order to decrease traumatic stress among men and women with HIV (n = 247). Participants were randomly assigned to the 15-session LIFT intervention or a comparison intervention, participants in the LIFT intervention group experienced significantly greater decreases (p < .02) in traumatic stress than participants in the support intervention; similar results were obtained at 12 month follow-up (Sikkema et al., 2013). Therefore, the results of the current investigation were consistent with prior findings regarding the efficacy of interventions designed to improve diverse participants' coping behaviors.

Rohde, Jorgensen, Seeley, and Mace (2004) investigated the effects of a pilot coping skills intervention on life-threatening behaviors in a sample of juvenile offenders. *The Coping Course*, developed by the researchers, is a 16 session group intervention designed to provide participants with positive coping strategies that they can employ to manage stress more effectively. A total of 76 individuals participated in the randomized control trial, completing pre and post assessments measuring suicidality via the LAS-SF, coping skills (Rohde et al., 1990), and optimism (the *Subjective Probability Questionnaire*; Muñoz and Lewinsohn, 1976). Significant condition x time effects (p < .05) were present for suicidality (particularly in the death-related and self-related domains as factors of the LAS-SF). On the other hand, no differences were observed for coping skills or optimism. Therefore, the results of the current

investigation were somewhat consistent with Rhode and colleagues' study, in that changes were identified in participants' suicidality scores. However, differences between participants' scores on coping behaviors and hope may be due to: (a) higher power, thereby reducing Type II error and allowing the ability to detect differences between groups; and (b) a more receptive sample of participants, in that all individuals were volunteers; participants in the study conducted by Rhode and colleagues were mandated.

Notably, no prior studies incorporated a combination of the HHI, the *Brief COPE*, and the LAS-SF to measure changes in hopefulness, coping, and suicidality scores among participants; in fact, no studies were identified that used the HHI to investigate changes in hopefulness scores of participants as a result of a group intervention experience. Nevertheless, the results of the current investigation and similar investigations provide support for the effectiveness of a brief group counseling intervention designed to impact participants' hopefulness, positive coping behaviors, and suicidality.

Research question 1. It was anticipated that as participants' post-test scores on the HHI and the *Brief COPE* Adaptive Coping scales rose, so would their scores on the LAS-SF, essentially measuring if an increase in hope and positive coping skills predicted higher life attitudes (and therefore lower suicidality) scores. A standard multiple linear regression (MLR) was the statistical procedure selected to determine whether there was a predictive relationship between these variables. Additional assumptions testing was conducted to determine whether the selected analysis was appropriate. Stevens (1992) recommends that a minimum of 15 participants per predictor variable are needed for a reliable equation when conducting the analysis in social science research. For the current analysis, the suggested minimum is 30 cases is met (n = 33), as there are two predictor variables. Pallant (2010) states that multicollinearity

exists when the independent variables (in this instance Hope and Adaptive Coping) are highly correlated (r = .9 or above)" (p. 151); this was not the case with these data ($r = 49$, $p < .05$). Previous analysis determined that the data are normal, linear, and contained no outliers. Therefore, after conducting the preliminary assumption testing, the researcher found that no serious violations existed and the analysis could continue.

After conducting the standard multiple regression analysis, it was found that Tolerance values were over .01 (.760) and VIF values were below 10 (1.315), further indication that multicollinearity is not an issue for these data. Furthermore, an inspection of the Probability Plot (P-P) of the Regression Standardized Residual and the Scatterplot indicated normality, linearity, and a lack of outliers (P-P plot points laid within a reasonably straight diagonal line from bottom left to top right), and homoscedasticity (the residuals were roughly rectangularly distributed within the scatterplot). Moreover, the Mahalanobis Distance maximum value (12.11) did *not* exceed the critical value suggested by Pallant (2010; 13.82), providing further support that the data were normally distributed.

The analysis addresses two questions: (a) How much variance in Suicidality scores be explained by scores on Hopefulness and Adaptive Coping?; and (b) Which variable is the best predictor or Suicidality: Hopefulness or Adaptive Coping? Specifically, the model explained 76.8% of the variance in Suicidality (adjusted r squared = .768, $p < .05$). Of the independent predictor variables, Hopefulness made the largest contribution by far (beta = .886, $p < .05$), while Adaptive Coping made a low, and insignificant contribution (beta = -.003, $p = .98$). Therefore, Hope was the better predictor of Suicidality compared to Adaptive Coping with these data.

These findings were consistent with prior research conducted by Gilman, Dooley, and Florell (2006) that identified a strong and positive correlation between hope and psychological

health. Gilman and colleagues examined the relationship between hope and several psychological indicators in a sample of 341adolescents enrolled in the 6^{th}-12^{th} grade. Using the *Children's Hope Scale* (CHS; Snyder et al., 1997), students were categorized into three groups: (a) high hope individuals; (b) average hope individuals; and (c) low hope individuals. The researchers concluded that individuals in the high and average hope groups reported less psychological distress, higher personal adjustment, and increased global satisfaction with life than adolescents in the low hope groups; a moderate effect size of .24 is reported for these differences (Gilman et al., 2006).

Research question 2. The second research question examined which group therapeutic factors (as measured by the TFI-S, Joyce et al., 2011) correlated with the intervention group participants' post-test scores in Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality (life attitudes). Two participants did *not* complete the TFI-S, leaving 19 participants in the sample. A Pearson Product Correlation was performed to measure the relationship between group therapeutic factors and these above constructs. In examining TFI-S total scores, there was a moderate positive correlation with *Adaptive Coping* ($r = .51$, $p < .05$, 26.0% of the variance explained). A further positive correlation was identified between *Adaptive Coping* and the TFI-S subscale, *Secure Emotional Expression* ($r = .52$, $p < .05$, 27.0% of the variance explained). No other correlations were identified among the remaining constructs and TFI-S total scores or subscales, Instillation of Hope, Awareness of Relational Impact, and Social Learning. Power to detect these differences was low (< .60); therefore, a failure to detect relationships may be due in part to low sample size (Pallant, 2010). In addition, the same analysis was conducted to examine the relationship between pre-test and mid-test scores in Hopefulness, Adaptive Coping,

Maladaptive Coping, and Suicidality and TFI-S total scores; in these analyses *no* relationships were identified between the constructs and the TFI-S ($p > .2$).

Findings from the present study were consistent with prior research that identified a relationship between group therapeutic factors and a group psychotherapeutic intervention designed to improve positive coping behaviors among 114 women with breast cancer (Andersen, Shelby & Golden-Kreutz, 2007). Characteristics of the intervention were similar to that of the present study, in that it emphasized relaxation training, problem solving, the development of positive coping behaviors, and social support. Results indicated that increased scores on the TFI predicted reduced stress and increased positive coping behaviors.

At the time of the present investigation, *no* studies were identified that explored the relationship between group therapeutic factors and hopefulness, or group therapeutic factors and suicidality. A relationship between these constructs was hypothesized given the presence of the TFI-S subscale *Instillation of Hope*. The definition of hope in terms of group therapeutic factors, however, refers to the members' expectation that the intervention would be effective (Yalom & Leszcz, 2005) rather than as "a multidimensional dynamic life force characterized by a confident *yet uncertain* expectation of achieving a future good, which to the hoping person, is realistically possible and personally significant" (Dufault & Martocchio, 1985, p. 380) as it is defined as a construct for the purposes of the current investigation. Therefore, the lack of identified correlation between HHI scores and TFI-S scores may be due to major differences in how hope is defined. Participants may *not* have expected the intervention to be effective, but still experienced increases in overall hopefulness. Moreover, the low sample size ($n = 19$) in this analysis may have increased Type II error, the failure to detect differences despite their presence.

Research question 3. The final research question examined the relationship between participants' reported demographic variables and the primary constructs of interest (Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality). The demographic variables include: gender identity, affectional orientation, ethnicity, level of disclosure about one's LGBTQ+ status, perceived level of parental support, and perceived level of peer support. A Pearson Product Moment Correlation (two-tailed) was used to examine the relationship between intervention group participants' and control group participants' demographics and their hopefulness, coping, and suicidality scores. A two-way between groups analysis of variance (ANOVA) was performed to measure the mean differences Hopefulness, Adaptive Coping, Maladaptive Coping, and Suicidality scores, respectively, on the following independent variables with three levels: (a) gender identity (i.e., male, female, and transgender/genderqueer); (b) affectional orientation (i.e., Gay/homosexual, Lesbian, Bisexual, Questioning, Asexual, and Straight); (c) ethnicity (i.e., Caucasian/White, Hispanic/Latino, African-American/Black, Pacific Islander, and Multiracial; (d) perceived level of parental support; and (e) perceived level of peer support. Several variables were re-coded prior to analysis. The variable *affectional orientation* was re-coded dividing it into four groups: Gay/homosexual, Lesbian, Bisexual, and Other (Questioning, Asexual, and Straight were collapsed as each category only had one representative; therefore, one category was created in order to perform one-way ANOVA tests on the variable (Pallant, 2010).

As participants originally rated their *perceptions of parental/guardian support* and *perceptions of peer support* on a continuum of 0-100%, a Pearson Product Correlation analysis was conducted to explore relationship between intervention and control group participants' ratings and the post-test scores for the primary constructs of the investigation. No relationship

was identified between perceptions of parental/guardian support and: (a) Hopefulness (r = .14, p = .44); (b) Adaptive Coping (r = .09, p = .62); (c) Maladaptive Coping (r = -.04, p = .83); and (d) Suicidality (r = .10, p = .58). Furthermore, no relationship was identified between perceptions of peer support and: (a) Hopefulness (r = -.14, p = .43); (b) Adaptive Coping (r = .02, p = .93); (c) Maladaptive Coping (r = .25, p = .17); and (d) Suicidality (r = -.21, p = .25). This was an unexpected finding, as family and peer support has been shown to have a profound impact on substance use, sexual health risk, depression, suicidal ideation, and attempted suicide in prior research (e.g., Needham & Austin, 2010; Ryan et al., 2010; Ryan, Huebner, Diaz, & Sanchez, 2009). A potential explanation for this lack of consistency between findings may be the small sample size of the current investigation, which increases Type II error, and subsequently the ability to detect differences. In addition, ratings of family and peer support were high among this sample when compared to other research (Ryan et al., 2010), which may further reduce the likelihood of identifying correlations among hope, coping, and suicidality.

A one-way between groups analysis of variance (ANOVA) was conducted to explore the effect of *gender identity* on the post-test scores for the primary constructs of the investigation. Participants were divided into three groups (Group 1: Male; Group 2: Female; Group 3: Transgender/Genderqueer). No statistically significant differences were identified for: (a) Hope (F [2, 30] = 3.10, p = .83); (b) Adaptive Coping (F [2, 30] = 3.12, p = .73); (c) Maladaptive Coping (F [2, 30] = 1.10, p = .35); or (d) Suicidality (F [2, 30] = 1.39, p = .27). Currently, *no* other studies were identified that examine the effect of LGBTQ+ participants' gender identity and constructs related to hope. Kertzner, Meyer, Frost, and Stirratt (2009) found no difference in coping skills or social and psychological well-being based on gender in a sample of 396 self-identified lesbian, gay, and bisexual (LGB) adults. Rhode and colleagues (2003), however, found

that males were more likely to indicate suicidal ideation and proneness on the TFI-S, and Hass and Colleagues identified that transgender youth are more likely than gays, lesbians, and bisexuals to contemplate and attempt suicide. Therefore, the findings from the current investigation are inconsistent with prior research in terms of the affect of gender identity on suicidality, which may be attributed to the small size of the current sample (males: $n = 16$; females: $n = 16$; transgender/genderqueer: $n = 2$).

A one-way between groups ANOVA was also conducted to explore the effect of *affectional orientation* on the post-test scores for the primary constructs of the investigation. Participants were divided into four groups (Group 1: Gay/homosexual; Group 2: Lesbian; Group 3: Bisexual; Group 4: Other (Questioning, Asexual, or Straight). No statistically significant differences were identified for: (a) Hope (F [3, 29] = 2.31, $p = .10$); (b) Adaptive Coping (F [3, 29] = .30, $p = .82$); or (c) Maladaptive Coping (F [3, 29] = 1.53, $p = .23$). There was a statistically significant difference in Suicidality scores for affection orientation (F [3, 29] = 3.96, $p < .05$). The effect size, calculated using partial eta squared (η^2) was .29, a moderate effect (Cohen, 1988). Post hoc comparisons using the Tukey HSD test indicated that the mean score for Group 3 (Bisexuals; $M = 67.92$, $SD = 13.42$) differed from Group 2 (Lesbians; $M = 81.42$, $SD = 10.00$). Differences in suicidality between bisexual and lesbian participants has not been identified in prior research (e.g., Kertzner et al., 2009; Russell & Joyner, 2001; Ryan et al., 2009); these findings may therefore be a phenomena unique to the current investigation due to the small sample size.

Furthermore, a one-way between groups ANOVA was conducted to explore the effect of *ethnicity* on the post-test scores for the primary constructs of the investigation. Participants were divided into four groups (Group 1: Caucasian/White; Group 2: Hispanic/Latino; Group 3:

African-American/Black; Group 4: Pacific Islander; Group 5: Multiracial). No statistically significant differences were identified for: (a) Hope (F [3, 28] = .99, p = .43); (b) Adaptive Coping (F [3, 28] = .42, p = .79); (c) Maladaptive Coping (F [3, 28] = .86, p = .50); or (d) Suicidality (F [3, 28] = .57, p = .69). Though *no* prior research was identified that explored the effect of ethnicity among LGBTQ+ youth with these specific constructs, these findings are inconsistent with prior research on the experiences of safety and victimization of LGBTQ+ youth that may have an effect on hope, coping, and suicidality. Specifically, Kosciw and colleagues (2012) identified in a sample of LGBT youth (n = 8548) that African-American/Black participants were less likely to have experienced verbal harassment, physical harassment, or physical assault because of their sexual orientation than multiracial students and White/European American students, and that Asian/Pacific-Islander participants were less likely to have experienced verbal harassment, physical harassment, or physical assault based on sexual orientation or gender expression than Hispanic/Latino, White/European American, or multiracial students. Such differences may have been difficult to identify in the current investigation, however, because of the small sample size.

In summary, with the exception of Bisexuals scoring lower than Lesbians on the suicidality post-test, none of the reported demographic factors had a significant effect on the post-test scores of any of the primary constructs of this investigation.

Limitations of the Study

Multiple limitations warrant consideration in interpreting the results of the present investigation. This section outlines limitations related to: (a) research design; (b) sampling; and (c) instrumentation.

Research Design

In all experimental research design the novelty effect presents a threat to internal validity, which occurs when participants alter their behavior because the intervention produces excitement and enthusiasm. Given that a primary purpose of the intervention was to produce hope (which could also be understood as "expectancy"), the novelty effect may have had an impact on outcome scores. In addition, although several measures were taken to ensure treatment fidelity within the intervention groups (i.e., facilitator training, providing a standardized curriculum, and group content record-keeping), it is unrealistic to expect absolute treatment fidelity. Each group possessed unique group dynamics due to the individual personalities of the participants. Therefore, there is the potential that content outside of the curriculum may have been introduced which influenced the findings of the investigation. Notably, several of the sessions went longer than the allotted 45-60 minutes as indicated by the facilitator logs. Additionally, the individual characteristics of the group facilitators (e.g., experience, disposition, leadership style, warmth, etc.) also likely had an effect on group outcomes.

Finally, subject attrition was an issue in the investigation. A total of 42 participants provided their informed consent to participate in the investigation and successfully completed the pre-screening process. Of the 21 intervention group participants, 100% completed the pre and mid assessments, and all but one participant completed the post assessment data collection packet (95.24% response rate, $n = 20$). On the other hand, of the 21 waitlist control group participants, five individuals (23.81%) declined to continue to be a part of the study, and three waitlist control group participants did *not* return contact with the researcher after being mailed the first assessment battery (14.29%). Therefore, a total of 13 participants remained in the waitlist control group for the duration of the study (61.91% response rate). Subject attrition due

to waitlist group dropouts may have created a disparity between those who remained and those who left the study; it is impossible to determine the impact as the eight waitlist group participants who dropped out only completed the pre-screening process, and provided no assessment data.

Finally, the smaller sample size of the investigation (n = 34) may indicate limited generalizability of the findings (Fraenkel, Wallen, & Hyun (2012). Furthermore, all participants were residents of the greater Orlando metropolitan area. Participant demographics were, however, consistent with prior research.

Sampling

Gall and colleagues (2007) note that there is an inherent difficulty in identifying target or accessible population parameters for groups that are partially "hidden" in society, which is often the case for LGBTQ+ youth due to fear surrounding rejection, safety, and stigma. By relying on participants that openly self-identify as LGBTQ+ to some degree, there is a risk the data from this investigation is from a biased sample (Gall et al., 2007). Specifically, the majority of participants were recruited through existing organizations that cater to LGBTQ+ youth. Participants who actively participate in LGBTQ+ related organizations, clinics, and clubs are likely differ from a sample of students who feel they are not able to disclose their LGBTQ+ status. Participants who have experienced some level of hopelessness, lack of or negative coping skills, or suicidality would stand to benefit the most from the investigation (as the intervention is targeted at improving these qualities) but the participants most in need in terms of lack of support and isolation may not have been able to participate because of the nature of their personal circumstances. Furthermore, that the majority of participants were "out" introduces bias and potentially limits the generalizability of the study, as participants who are "out" to a level of being comfortable identifying as LGBTQ+ amongst other group members and the group

facilitator likely possess different characteristics from individuals who would not be comfortable disclosing their orientation.

Instrumentation

Each of the data collection instruments used in this investigation relied on self-report. Therefore, the data may reflect social desirability bias or a lack of self-awareness that may influence the study results. Moreover, the instruments were administered multiple times throughout the investigation. A common threat to internal validity is related to participants' tendency to alter their responses to instruments over a period of time due to becoming bored or tired with filling out assessments. Though care was taken to select short-form versions of instruments, instrumentation fatigue may have influenced participants' scores. Finally, all data collection instruments have some measurement error despite available evidence demonstrating sounds psychometric properties in terms of reliability and validity.

Implications and Recommendations for Future Research

Implications

Despite the noted limitations, the results from the investigation present several implications for counseling practitioners and educators. Overall, the findings support the use of the intervention curriculum to improve LGBTQ+ older adolescents' outcomes in terms of hope, coping, and suicidality. Prior to the investigation, *no* studies were identified that investigated group counseling interventions to increase hopefulness, foster positive coping skills, or reduce suicide proneness with LGBTQ+ youth. Given the negative experiences and subsequent suicide rates for the LGBTQ+ adolescents, helping professionals require sound interventions to support these youths' functionality (Hass et al., 2010; Liu & Mustanski, 2012; Spirito Esposito-Smythers, 2006). Therefore, the findings from this study contribute to the knowledge base of

effective group counseling interventions with LGBTQ+ youth, providing school and mental health practitioners with evidence-based practice to support these youth. Specifically, the curriculum can be disseminated to provide mental health and educational professionals with the tools needed to address concerns and/or implement preventative measures among LGBTQ+ youth clients in school and clinical environments.

Given the lack of empirically investigated interventions to increase positive outcomes with LGBTQ+ adolescents, the findings from the study have the potential to make a contribution to counselor educators in their teaching of adolescent development and group counseling. The results of this study support the effectiveness of using strengths-based group interventions that incorporate psychoeducation in order to foster positive participant outcomes. Furthermore, the investigation contributes to the availability of empirical evidence in scholarly literature in counseling. A content analysis of articles within American Counseling Association (ACA) division-affiliated journals (n = 4,457) from 1998 to 2007 revealed that only 6% of counseling research articles explored effectiveness of counseling interventions (Ray et al., 2011). Therefore, the study contributes to needed evidence-based practice research in the counseling field.

Recommendations for Future Research

Although the investigation aimed to address all the research issues, there remain several recommendations for future research. Mixes methods research, sequential explanatory design in particular, would be helpful in determining the qualitative, lived experiences of the participants in the current study. Given that this is a new intervention developed specifically for the current study, it would also help identify which elements of the intervention are the most and least helpful. This information would facilitate improvements in the intervention to make future groups more impactful.

In addition, future research should include replication of the study with a higher number of participants in multiple regions in order to: (a) confirm that the findings can be replicated; (b) increase the generalizability of the findings; and (c) determine whether differences in groups are more significant with a larger sample size. A larger sample size would also likely increase the reliability of the instrumentation, particularly among the subscales. Two instruments contained subscales that could not be used in the analysis due to low reliability: the Hearth Hope Index and the Life Attitudes Schedule – Short Form. A larger sample size would allow for determining more specific findings if the subscales could be included.

Furthermore, replication of the study among younger LGBTQ+ participants (ages 13-17) is advised. Middle and high school-aged youth face additional stressors in school and at home, especially if parents and/or guardians are not affirming of their affectional orientation or gender identity, which contribute to high rates of suicidal ideation and proneness (Kosciw et al., 2012; Ryan et al., 2009; Ryan et al., 2010). Therefore, younger adolescents have more to gain from the group intervention than older adolescents. In addition, transgender and genderqueer participants are typically under-represented in research investigations involving LGBTQ+ participants, as was the case with the current investigation (n = 2, 5.9%). Until more data is gathered specifically regarding the impact of the intervention among transgender and genderqueer participants, it is difficult to determine whether the curriculum is as effective with this population as it is with lesbian, gay, and bisexual participants.

Conclusion

This investigation examined the impact of an eight-week group counseling intervention on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adolescents' (aged 18-20) levels of hopefulness, coping skills, and suicidality. An experimental, randomized-controlled-

trial research design was employed to identify differences between the intervention group and waitlist control group participants' hopefulness, coping skills, and suicidality scores. In addition, the relationship between the LGBTQ+ participants' outcome variables (hopefulness, coping skills, and suicidality) scores was examined. Furthermore, the impact of group therapeutic factors experienced by the LGBTQ+ participants in intervention group for the variables of hopefulness, coping skills, and suicidality was examined.

Key findings included a significant interaction between time and group placement, highlighting that the intervention group participants experienced significant improvements on measures of hopefulness, coping behaviors, and suicidality when compared to participants in the waitlist control group. In addition, hope was demonstrated to be a strong and significant predictor of suicidality. Furthermore, it was found that group therapeutic factors had a positive effect on intervention group participants' Adaptive Coping scores, but did not have an effect on Hopefulness, Maladaptive Coping, or Suicidality as hypothesized. Lastly, there was no significant differences between the demographic variables perceptions of parental/guardian support, perceptions of peer support, gender identity, or ethnicity on their hopefulness, coping behaviors, or suicidality. There was, however, a significant difference between Bisexuals and Lesbians post-test scores on Suicidality, with Bisexuals scoring significantly lower. No other significant differences were observed between sexual orientation and the other key constructs.

APPENDIX A: UNIVERSITY OF CENTRAL FLORIDA IRB 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: **Catherine Anne Lamb** and Co-PIs: **Sejal Barden**

Date: **September 16, 2013**

Dear Researcher:

On 9/16/2013 the IRB approved the following human participant research until 9/15/2014 inclusive:

Type of Review:	Submission Correction for UCF Initial Review Submission Form Expedited Review
Project Title:	The Impact of a Group Counseling Intervention on Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents' Levels of Hope, Coping, and Life Attitudes
Investigator:	Catherine Anne Lamb
IRB Number:	SBE-13-09480
Funding Agency:	
Grant Title:	
Research ID:	N/A

The scientific merit of the research was considered during the IRB review. The Continuing Review Application must be submitted 30days 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 9/15/2014, 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).

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:

Signature applied by Patria Davis on 09/16/2013 02:29:23 PM EDT

APPENDIX B: INFORMED CONSENT FOR GROUP PARTICIPANTS

The Impact of a Group Counseling Intervention on Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents' Levels of Hope, Coping, and Life Attitudes

Adult Participant Informed Consent

Principal Investigator(s): *Catherine Griffith, M.A.*

Sub-Investigator(s): *Glenn Lambie, Ph.D.*
Sejal Barden, Ph.D.

Faculty Supervisor: *Glenn Lambie, Ph.D.*

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

Introduction: 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 in a research study. You are being invited to take part in a research study which will include up to 200 individuals who live in the greater Orlando metropolitan area. You have been asked to take part in this research study because you are between the ages of 18-20 at the start of the investigation, and identify as lesbian, gay, bisexual, transgender, queer or otherwise as a minority in terms of sexual orientation or gender identity (LGBTQ+).

The person conducting this research is Catherine Griffith, a third year doctoral student candidate at UCF in the Counselor Education Department. Because the researcher is a graduate student, she 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 counseling intervention for LGBTQ+ youth (ages 18-20) who live in the greater Orlando metropolitan area when compared to LGBTQ+ youth who do not participate in the intervention. The study will seek to examine the effects of the intervention on participants' levels of hopefulness, adaptive coping strategies, and positive life attitudes.

What you will be asked to do in the study: You are being asked to participate in a study that measures the differences between individuals who participate in Intervention Groups and those who participate in a wait-list Comparison Groups. You will be randomly assigned to one of these two groups.

If you are selected to be in the Intervention Group, you will participate in a counseling group designed to increase hope and positive coping skills in September 2013. The groups will last approximately 60 minutes and will consist of 8 weekly sessions. Additionally, the groups will contain 4-9 additional individuals who identify as LGBTQ+. These groups will be facilitated by the principle investigator, Catherine Griffith, as well as the following trained group facilitators: Patrick Mullen, Daniel Gutierrez, and Eric Price. A standardized curriculum will be used. Because the group intervention is a counseling-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 four assessment instruments at three points during the study: (1) before the intervention has been begun at the beginning of the first scheduled group session; (2) after the fourth group session; and (3) after the intervention has concluded at the end of the last scheduled group session. Furthermore, you will be asked to complete a demographic form. 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.

If you are selected to be in the wait-list Comparison Group, you will not participate in group counseling until the first intervention has been completed. Participants enrolled in the Comparison Groups will begin the 8-week intervention in January 2014. Prior to this, you will be asked to complete four assessment instruments at three points during the study: (1) a pre-assessment in October 2013, (2) a mid-assessment four weeks later; and (3) a post-assessment in November 2013. Furthermore, you will be asked to complete a demographic form. 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 questions. These assessments may be mailed to your home or hand-delivered to you to complete, whichever is preferable.

By consenting to this study, you agree to participate in *either* group. Please also note that you are responsible for securing transportation to and from your home and the Community Counseling Clinic at UCF for each session.

Please note: If you are currently suicidal/considering taking your own life, the researchers have determined that this group intervention will not be the best fit for you. Please contact the principle investigator (information below) if you are in need of other counseling-related resources. In addition, if you are unable to attend two or more sessions, you may be considered for dismissal from the treatment group.

After obtaining your consent, you will be pre-screened via a brief individual interview with the principal investigator in order to determine your eligibility for the study. This interview will take approximately 15 minutes. The principal investigator may keep notes in a log book regarding the content of the interviews for future reference, using your initials for reference rather than your name.

During the pre-screening, you will asked whether you are considering suicide and/or have a current plan to take your own life. Should a participant indicate suicidal intent during this pre-screening, or at any point during the investigation, a verbal suicide assessment method known as SLAP will be used by the principal investigator: (a) how *specific* is the plan; (b) how *lethal* is the proposed method; (c) how *available* is the proposed method; and (d) what is the *proximity* of helping resources?

At no point will you be audio-taped or video recorded.

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 you have been assigned to the Intervention Group or wait-list Comparison Group, 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.

Location: The counseling group will be held at the UCF Community Counseling Clinic. Group session times have tentatively been set for one day a week selected during Monday through Friday, to be held in the afternoon.

Time required: We expect that you will be in this research study for one hour each time the counseling group meets throughout the fall or spring for a total of eight hours. Furthermore, time to complete assessments at the three points during the fall will take approximately 15-20 minutes. Therefore, the overall time required for participation in the study is approximately nine hours.

Risks: Participation in this study involves ***minimal risk***. Participation in group counseling involves the potential for breach of confidentiality by fellow group members. Members will be repeatedly reminded of the importance of confidentiality throughout the course of the intervention, but confidentiality cannot be guaranteed. In addition, participation in group counseling can occasionally involve intense emotions. If you exhibit especially intense emotions, your group facilitator will request to meet with you individually after the group session to assess your needs. A referral for additional counseling services may be provided.

Benefits: We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits include an increase in your level of hopefulness, adaptive coping skills, and positive life attitudes. An increase in these factors have been linked to reduced drug abuse, better school performance, a reduction in suicidality, and greater satisfaction and happiness. Furthermore, the information derived from this investigation may help inform future interventions to help improve the lives of other LGBTQ+ youth.

Compensation or payment: There is ***no compensation***, payment, or extra credit for taking part in this study.

Confidentiality: We will limit your personal data collected in this study. Efforts will be made to limit your personal information to people who have a need to review this information. We cannot promise complete secrecy. Organizations that may inspect and copy your information include the IRB and other representatives of UCF. All information that is collected will be stored in locked cabinets in the primary investigator's office. The information obtained from this research project may be used in future research and published. However, your right to privacy will be retained. The data will be de-identified if used in any future research projects at the conclusion of this study. No individuals will be identifiable from the assessment data. The computer in which the assessment data will be stored is password protected and only the primary investigator will have access.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints, or think the research has hurt you, please contact Catherine Griffith, Graduate Student, Department of Child, Family, and Community Sciences, (310)903-0898 or by email at catherinelamb@knights.ucf.edu or Dr. Glenn Lambie, Faculty Supervisor, Department of Child, Family, and Community Sciences at (407)823-2766 or by email at glenn.lambie@ucf.edu.

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. You may also talk to them for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You want to get information or provide input about this research.

Withdrawing from the study: You may decide *not* continue in the research study at any time without it being held against you. There are no adverse consequences if you decide leave the research. If you decide to leave the study, please let your group facilitator know.

The group facilitator can remove you from the research study without your approval. Possible reasons for removal include (a) failure to regularly attend scheduled group sessions, (b) breaching group confidentiality, (c) threatening the safety of other group members, or (d) the group facilitator determines that enrollment in the research study is no longer in your best interest. We will tell you about any new information that may affect your health, welfare or your choice to stay in the research.

Thank you for your interest in this study!

APPENDIX C: COLLEAGUE EMAIL

Subject: Free Group Counseling for LGBTQ+ Youth

Greetings,

My name is Catherine Griffith, and I'm a doctoral candidate in Counselor Education at the University of Central Florida. I'm contacting you today because I'm looking for individuals aged 18-20 who are interested in participating in a study examining the effects of a free 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+).

The purpose of the study is to determine the impact of an eight-week group intervention for LGBTQ+ youth to increase hopefulness and positive coping skills when compared to LGBTQ+ youth who don't participate in the intervention. Because your organization involves improving the lives of the LGBTQ+ community, I thought you might have contacts for individuals who'd be interested in taking part in this group. After a pre-screening interview to determine eligibility, participants will be randomly assigned to one of two groups: the Intervention Group, which will begin meeting for approximately one hour once a week for eight weeks starting in late September 2013, or the wait-list Control Group, which will begin meeting in January 2014. Both groups will be asked to complete brief pre-assessments in late September 2013, mid-assessments four weeks later, and post-assessments at the end of November 2013 after the 8 week group has completed. The total time commitment expected for this study is approximately 9 hours.

Groups will take place at the following location:

Community Counseling Clinic
University of Central Florida
4000 Central Florida Boulevard
College of Education and Human Performance, 192
Orlando, FL 32816-1250
Phone: (407)823-2052
Email: Communityclinic@ucf.edu

There's no cost to this group at all; this project is all about helping young people, and I'm hoping to gather data that demonstrates that it's effective in its purpose. When I worked as a school counselor and as a Gay Straight Alliance co-advisor, I remember wishing something like this was available at my site. With your organization's help, I hope to have an intervention worth disseminating at a national level.

Please note, individuals will only be able to participate if they: (a) self-identify as LGBTQ+; (b) are 18-20 years old at the start of the study; and (c) are able to commit to attending at least 6 of the 8 scheduled group sessions.

We cannot promise any benefits taking part in this research, but potential benefits include an increase in participants' level of hopefulness, adaptive coping skills, and positive life attitudes. An increase in these factors have been linked to reduced drug abuse, better school performance, a reduction in suicidality, and greater satisfaction and happiness. Furthermore, the information derived from this investigation may help inform future interventions to help improve the lives of other LGBTQ+ adolescents.

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 (310)903-0898 or at catherinelamb@knights.ucf.edu. Also, please let me know if you have contact information for anyone else you think might be interested.

Thank you so much for your time and consideration, and I look forward to hearing from you!

Take care,

Catherine Griffith
Doctoral Candidate, Counselor Education
Member, LGBTQ Reducing Disparities Project
University of Central Florida
Orlando, FL
(310)903-0898
catherinelamb@knights.ucf.edu

APPENDIX D: PARTICIPANT RECRUITMENT FLYER

Research Study Call for Participants

Resiliency & Support Group for LGBTQ+ Youth

Attention! We're looking for individuals ages 18-20 who are interested in participating in a study examining the effects of a free 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+).

The groups will take place for 8 weeks in September 2013 or January 2014, depending on which group you are assigned to (total time commitment will be approximately 9 hours) Groups will take place at:

Community Counseling Clinic @ UCF
4000 Central Florida Boulevard
Orlando, FL 32816-1250

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

- Self-identify as LGBTQ+
- Are 18-20 years old at the start of the study (September 20, 2013)
- Can commit to attending at least 6 of the 8 group sessions

We cannot promise any benefits taking part in this research, but potential benefits include an increase in participants' level of **social support**, **hopefulness**, **adaptive coping skills**, and **positive life attitudes**. An increase in these factors have been linked to reduced drug abuse, better school performance, a reduction in suicidality, and greater satisfaction and happiness.

If interested or if you have any additional questions please feel free to contact the principal investigator, Catherine Griffith, at:

catherinelamb@knights.ucf.edu

APPENDIX E: PARTICIPANT PRE-SCREENING FORM

Participant Initials: _____

Group Participant Pre-Screening Form

***NOTE: Pre-screening cannot be completed until the potential participant has provide a signed consent/permission form from a parent/legal guardian**

Age: _____

Aged 18-20 on September, 3 2013? ☐ Yes ☐ No

Identifies at LGBTQ+? ☐ Yes ☐ No

Lives in the greater Orlando metropolitan area? ☐ 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 at least 6 of the 8 group sessions

☐ Actively suicidal/has a plan to take their own lives

☐ Unable to or not willing to maintain a confidential environment

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

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:_____
_____
_____

In need of additional mental health services? ☐ Yes ☐ No

If yes, referral(s) provided:_____

APPENDIX F: PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

Participant Code: _____

Group Participant Demographic Form

Age: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____(*please specify*)

Biological Sex (gender assigned at birth): ☐ Male ☐ Female ☐ Intersex

Sexual Orientation: _____(*please specify*)

Please indicate your ethnicity or race:

___ African American/Black ___ American Indian/Native American

___ Pacific Islander ___ Asian/Asian-American

___ Hispanic/Latino ___ Multiracial

___ Caucasian/White ___ Other (please specify): _____

Who have you currently personally told your sexual orientation &/or gender identity to? In other words, who are you currently "out" to? (Please check all that apply)

___ One or more parents/legal guardians

___ One or more siblings

___ Extended family members (cousins, aunts, uncles, grandparents, etc.)

___ Close friends

___ Most peers/acquaintances

___ Most everyone you know

On a scale of 0% – 100%, how supportive would you say your <u>friends and peers</u> *currently* are about your sexual orientation and/or gender identity? (circle one)

0 10 20 30 40 50 60 70 80 90 100

On a scale of 0% – 100%, how supportive would you say your <u>parents or guardians</u> *currently* are about your sexual orientation and/or gender identity? (circle one)

0 10 20 30 40 50 60 70 80 90 100

APPENDIX G: HERTH HOPE INDEX

Participant Code: _____

Herth Hope Index (HHI; Herth, 1992)

INSTRUCTIONS: Listed below are a number of statements. Read each statement and place an [X] in the box that describes how much you agree with the statement at this moment *right now*.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I have a positive outlook toward life.				
2. I have short and/or long-range goals.				
3. I feel alone.				
4. I can see possibilities in the midst of difficulties.				
5. I have faith that gives me comfort.				
6. I feel scared about my future.				
7. I can recall happy/joyful times.				
8. I have deep inner strength.				
9. I am able to give and receive caring/love.				
10. I have a sense of direction.				
11. I believe that each day has potential.				
12. I feel my life has value and worth.				

APPENDIX H: THE BRIEF COPE

Participant Code: _____

The Brief COPE (Carver, 1997)

INSTRUCTIONS: Please <u>circle one answer</u> for each statement below.
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. 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.
	1	**2**	**3**	**4**
	↓	↓	↓	↓

START HERE

1.	**I've been turning to work, school, 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 one or more stressful situations in my life.**	1	2	3	4
7.	**I've been taking action to try to make my situation better.**	1	2	3	4
8.	**I've been refusing to believe that one or more stressful situations 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 stressful times.**	1	2	3	4
12.	**I've been trying to see things 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 things less, like going to movies, watching TV, reading, sleeping, or shopping.**	1	2	3	4
20.	**I've been accepting the reality of the fact that stressful situations have 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 the stressful situations in my life.**	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 (e.g., finding the humor in it, making jokes, etc.).**	1	2	3	4

☺ Thank you for your time in completing this questionnaire! ☺

APPENDIX I: THE LIFE ATTITUDES SCHEDULE – SHORT FORM

Participant Code: _____

Life Attitudes Schedule – Short Form (LAS-SF)

(Rhode, 1996)

INSTRUCTIONS: For each of the statements below, think back over the past week and decide if the statement describes you. Circle the number that best describes how true the statement is for you.

1 = Not at all true of myself
2 = Slightly true of myself.
3 = Mostly true of myself.
4 = True of myself.

START HERE

	Not at all true of myself. (1)	Slightly true of myself. (2)	Mostly true of myself. (3)	True of myself. (4)
1. I take care of my possessions so they last will last as long as possible.	1	2	3	4
2. I choose to listen to music that has a death related theme.	1	2	3	4
3. I try to eat foods that are good for me.	1	2	3	4
4. I have gone on an occasional drinking spree.	1	2	3	4
5. I avoid unnecessary risks.	1	2	3	4
6. Several times I have driven or have been driven more than 20mph over the speed limit.	1	2	3	4
7. I rarely do things that violate my standards.	1	2	3	4
8. I spend a lot of time doing things that are unproductive or unfulfilling.	1	2	3	4
9. I look forward to life.	1	2	3	4

10.	**I enjoy thinking about death.**	1	2	3	4
11.	**I enjoy "eating right."**	1	2	3	4
12.	**I don't really care much about what I eat (e.g. fried foods, sugar, etc.).**	1	2	3	4
13.	**I enjoy spending time with people who are cautious and avoid unnecessary risks.**	1	2	3	4
14.	**Sometimes I feel so frustrated that I would like to hit my fist against the wall (or do something else that could hurt me).**	1	2	3	4
15.	**I feel good because my activities are meaningful and have purpose.**	1	2	3	4
16.	**I wish I was someone else.**	1	2	3	4
17.	**I expect to have a long and interesting life.**	1	2	3	4
18.	**Killing myself would solve many of my problems.**	1	2	3	4
19.	**It is important to brush one's teeth after every meal.**	1	2	3	4
20.	**The danger of smoking cigarettes has been exaggerated.**	1	2	3	4
21.	**The chance of my being injured in an accident in the next year is very low (less than 10%).**	1	2	3	4
22.	**Sometimes I think about injuring myself (e.g. smashing my fist into a window).**	1	2	3	4
23.	**I believe I am a good person.**	1	2	3	4
24.	**I think I am worthless.**	1	2	3	4

☺ Thank you for your time in completing this questionnaire! ☺

APPENDIX J: THERAPEUTIC FACTORS INVENTORY – SHORT FORM

Participant Code: _____

Therapeutic Factors Inventory – Short Form (TFI-S)

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

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 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 6 7
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

APPENDIX K: INTERVENTION GROUP CURRICULUM

It Gets Better: A Group Experience for LGBTQ Youth

Group Curriculum Outline

Author: Catherine Griffith

The following curriculum has been designed as a part of a dissertation study entitled: The Impact of a Group Counseling Intervention on Lesbian, Gay, Bisexual, Transgender, and Queer Adolescents' Levels of Hope, Coping, and Life Attitudes. The eight-session counseling intervention consists of interactive and psychoeducational sessions with the aim of encouraging constructive behaviors and healthy ways of coping while providing a supportive environment. Content has been selected based on empirical support for the efficacy of the activities.

The group intervention will take place over eight consecutive weeks, one session per week, with each session lasting approximately 45-60 minutes. The ideal size would be 5-8 group members. In addition to this standardized curriculum, facilitators will also receive training by the principal investigator.

Each session is briefly described in this document. If you have any questions, comments, or concerns, please feel free to contact the author Catherine Griffith at (310)903-0898 or via email at catherinelamb@knights.ucf.edu.

Group Session 1 - Introductions

Purpose:
To introduce the intervention to group members, introductions of leader/members, discuss group procedures (e.g. length of the group, duration, etc.), and to complete pre-assessments. The group will also discuss the importance of confidentiality, establish group rules, and complete an ice-breaker activity.

Objectives:
1. Group leaders and members will be able to introduce themselves to each other.
2. The group will be able to establish group rules
3. Group members will be able to begin the discussion of hope's role in their own life through an ice-breaker activity

Supplies:
Pre-assessment packets (provided by the principal investigator [PI]), and large sheet of paper or whiteboard to write group guidelines on.

Procedure:
1. Group participants will begin by filling out the pre-assessments, which is anticipated to take approximately 15-20 minutes. Instruct group members not to write their name on the packets, but to come up with their own code word or number that they can remember for eight weeks.

2. Group leaders should say their name and preferred gender pronoun (e.g., he/him, she/her, ze/zir, etc.), introduce themselves (e.g. background, experience, etc.) and talk about the purpose of the group which is to discuss and increase hope, promote positive coping skills, and improve peer-connectedness. Participants will then share their name, preferred gender pronouns, and anything else they'd like to share about their background.

3. Some students may be unfamiliar with counseling groups so it may be helpful to briefly explain how groups function, for example, "The group is a time where we can share our thoughts and feelings in a nonjudgmental environment. Many emotions may be expressed that cause comfort or discomfort, which is normal." Discuss confidentiality at this time (and exceptions thereof), length of the group (45-60 minutes), and duration of the group (8 weeks).

4. Activity #1: Have the group brainstorm how to create a safe space, group rules, and ways to hold the group accountable to each rule (e.g., showing respect for others, allowing one speaker at a time, participate to the fullest of your ability, etc.). Write group rules on a dry erase board or poster board paper for everyone to see.

5. Activity #2: Have participants get into groups of two. They will conduct short interviews of each other, and then present what they learned about their partner to the rest of the group. One key question that should be asked is, "What are you hoping to learn from/get out of this group?" (If there are an odd number of group members, one group can have three members).

6. Thank each group member for sharing, and let them know when you will be meeting next week.

Group 2 – Building Peer Connections & Introduction to Coping Skills

Purpose:
Group members will build comfort with one another and begin to create a sense of universality. To facilitate the activity "Hopes in a Hat," allow enough "air time" for each group member to self-disclose, and for other members to share their thoughts as well. Members will also begin to explore how they currently cope with stress in their life. For the "Wellness Wheel," students will need the handouts and a variety of colored markers.

Objectives:
1. Group members will be able to identify and share their hopes for the future.
2. Group members will be able to hear different perspectives of hope from other group members.
3. Group members will be able to identify and discuss their coping skills (e.g., ways they handle stress and adversity).

Supplies:
Scraps of paper (enough for each member), pens/pencils, and a hat or similar item; Wellness Wheel worksheets; colored markers.

Procedure:
1. Group leader welcomes group members back and asks a group member to summarize last week's session.

2. Activity #1: Introduce the "Hopes in a Hat" activity by asking how group members define the word hope (e.g., optimism, setting goals, faith, relief, etc.), and that you will be exploring one another's hopes in a safe, non-judgmental environment. Tell members that they will each be completing the following sentence on a piece of paper: "I am most hopeful that…" or "As an LGBTQ+ individual, the thing I hope for most is…" Collect the pieces of paper, mix them around, then invite each person to a piece of paper and read about someone's hopeful statement. One by one, each group member reads out the hope of another group member and elaborates on what the statement may also mean to them personally. When all the hopes have been read out and elaborated on, then discuss what people felt and noticed. Focus especially on what members had in common.

3. Activity #2: Members will create a "Wellness Wheel" by coloring in the percentage of wellness they feel they have in a circle with six categories: Mental, Physical, Family/Environmental, Social, Emotional, and Spiritual (see Appendix A). Once completed, members will have the opportunity to share their wellness wheels with the group. Members should also discuss the main things that they do to cope with stress in their life (positive or negative). If not already addressed, make sure to ask what unique challenges they face by identifying as LGBTQ.

4. At the end of the activity, the group leader facilitates ending process questions by asking group members:
    a. What was it like hearing about each other's lives?
    b. What kinds of feelings came up for you?
    c. How do you think the ways you cope influences your life?

5. Thank each of the group members for sharing, and let them know when you will be meeting next week.

Group Session 3 – River of Life

Purpose: This activity allows each person to be seen and heard, thus strengthening the group's trust, understanding, and appreciation for the gifts and struggles of each group member.

Objectives:
1. Group members will build trust and a sense of peer connectedness.
2. Group members will increase their knowledge of experiences that inform different perspectives.

Supplies:
Paper (at least 11 X 14 inches) for each participant and markers/colored pencils.

Procedure:
1. Group leaders should follow-up with group members regarding last week's "Hopes in a Hat" and "Wellness Wheel" activity and process more if needed.

2. Discuss how every person has a rich life story that reflects both hard places and great celebrations. Taking the time to hear those stories increases appreciation for different experiences and the perspectives that arise from these experiences. We can all learn from one another's struggles, successes, and hopes for the future.

3. Activity #1: Tell the group, "We're going to create a picture that reflects the river of your life. Like a river, your life has a certain flow. There are times when a river is rushing and flowing over the banks. At other times, the river goes over rapids and rocks or moves slowly and peacefully. Take a few minutes to consider where you have been and what has been significant in shaping the direction of your life. Lastly, where do you see your river flowing from here?" Ask participants to use the markers and paper to create a picture that describes their life journey and hopes for the future. Allow approximately 15 minutes for participants to create their pictures.

4. Ask for volunteers to share their pictures. Have them tell the group about their journey and what the images they drew represent in their life, as well as their hopes for where their river will flow in the future.

5. When everyone has finished sharing, ask a series of questions to prompt group discussion:
    a. What was it like for you to tell your story to this group?
    b. What was it like for you to hear all of these stories?
    c. What does the group have in common?
    d. What insights have you gained about our group?

6. Thank each of the group members for sharing, and let them know that next week you will begin exploring different ways to cope with stress.

Group Session 4 – Learning New Ways to Cope, Part One

Purpose: To teach members new ways of coping with stress that they may not have previously considered.

Objectives:
1. Group members will learn deep breathing techniques to let out intense emotions.
2. Group members will learn free writing techniques to calm intense emotions.
3. Group members will have the opportunity to share and learn from one another.

Supplies:
Paper to write on; breathing activity script; mid-assessment packets (provided by the PI)

Procedure:
1. Group leaders should follow-up with group members regarding last week's River of Life" activity and process more if needed.

2. Begin a discussion on what coping skills are (e.g. how we deal with stress) and explore what strategies members currently use. Inform them that they'll be learning two new way of coping: one to help let emotions out and one to help calm themselves. Explain how both strategies are sometimes important. At the end of the session, they will fill out mid-test assessments.

3. Activity #1: Ask members to think of a recent time in which they were upset. Tell them that the goal of the "Free Writing" activity will help them to express their emotions about this event in a healthy way. Each member needs to have a piece of paper and something to write with (if the space allows for it, it's best if they can spread out to find their own private space as well). The goal of this exercise is to write anything and everything that comes to mind over the next 5 minutes. Try not to over-think it and just write what's on your mind, even if it's gibberish. Members who are less comfortable with writing may consider drawing instead. When the 5 minutes is up, have members share what the experience was like for them.

4. Activity #2: Inform members that they will now learn how to calm emotions through a breathing activity. Explain how deep breathing can be used to reduce stress and as a skill to cope with future stressors. Have each member find their own private space in the room, and sit in a chair with both feet on the ground and arms at their sides. Complete the breathing activity by reading the script provided in Appendix B. It is recommended that members close their eyes, but if uncomfortable doing so they can look at the ground. When finished, similarly process the activity by asking members what the experience was like for them.

5. Process both activities by exploring whether they felt one or both was helpful, and in what specific instances they could see themselves using these coping strategies. Could these activities replace any negative ways of coping that they currently engage in?

6. Thank each of the group members for sharing. Ask participants to try out one or both of the coping strategies this coming week as an experiment.

7. Group participants will fill out the mid-assessment, which is anticipated to take approximately 15-20 minutes. Make sure each member gets the packet with the code word or number they came up with on the first week, and that they don't write their names on any of the instruments.

Group Session 5 – Learning New Ways to Cope, Part Two

Purpose:
To continue the discussion and experience of positive coping strategies. Members will learn techniques to develop resilient thoughts in response to stressful situations and adversity.

Objectives:
1. Group members will discuss how using new coping strategies has impacted their lives.
2. Group members will learn about positive reframing as a coping strategy.

Supplies:
Flipping the Coin worksheets

Procedure:
1. Welcome group members back and ask if anyone got a chance to try out one of the coping strategies (free writing or deep breathing) this past week. Process if necessary.

2. Discuss how we can sometimes cope with stress and adversity more effectively by changing the way we label the situation. Explain to members that the words we use have enormous influence. If, for example, I call a new situation a "problem," then my attitude about it is likely to be negative. If, however, I was to call it a "challenge," then you might deal with the new situation in a different way. Explain to members that "Flipping the Coin" in this way – that is, changing the words we use to help ourselves look on the positive, or 'brighter' side, rather than on the negative, or 'darker' side – is one way of helping ourselves to respond in a more positive way when faced with difficult feelings, people or situations.

3. Activity #1: Challenge students to try some "Flipping the coin!" exercises (see Appendix C for the worksheet). Can they find a positive way of reframing a negative word or phrase?

4. Activity #2: Working together in pairs, encourage members to support each other in attempting to "Flip the Coin" with a current real life challenge. Explain what they should do as follows:

> Step 1: Think of a situation that you are facing right now that is making you feel very negative. Write down everything that you are thinking and feeling on one side of the coin – the 'negative side', including how it makes you want to behave – or how you are behaving. Share your thoughts with your partner if you wish.
>
> Step 2: Now look again at the way you have described the situation and work with a friend (or alone if you wish) to see if you can find any words that seem rather negative or exaggerated. Can you change your perspective from 'the glass being half empty to it being half full? Can you try to describe the situation again in a more positive light? If you can, write down this new description on the 'positive side' of the coin. Looking at the situation in a positive way may help you to think of a more positive, creative way of responding.

5. Invite members to share their experiences. Encourage them to reflect on the reasons for their success or why they find it difficult. (Please note, it's okay if they aren't a fan of this coping strategy—not everyone is)

6. Thank members for coming. Ask participants to try out this coping strategy this coming week as an experiment. Remind participants that there are three sessions left.

Group Session 6 – Hope as a Coping Skill

Purpose:
To continue discuss the importance of hope as a coping skill, just like the others we've learned so far. Members will learn how hope can be an active process that helps with stress and adversity.

Objectives:
1. Group members will discuss the relationship between hope and coping.
2. Group members will actively foster hope by writing a letter to themselves from the future.

Supplies:
Paper and pens to write letters.

Procedure:
1. Welcome group members back and ask if anyone got a chance to try out any of the coping strategies they've learned so far (free writing, deep breathing, or flipping the coin). Process if necessary.

2. Ask participants to close their eyes (if they are comfortable doing so) and think of the future. What image first comes to their mind? How long did it take them to see something? How many of them imagined something that you want to have happen? Lead this into a discussion on hope: Is it a choice? Does it depend entirely on rational reasons to have hope? Explain how hope can be a coping skill, just like the other coping skills they have already learned.

3. Ask members if they are familiar with Harvey Milk. If not explain that he was one of the first openly gay elected politicians, and is known for being an influential advocate for the LGBTQ+ community. Read the following famous quote by Milk: "*You have to give them hope. Hope for a better world, hope for a better tomorrow, hope for a better place to come to if the pressures at home are too great. Hope that all will be all right.*" Open to discussion about why they think Harvey Milk thought hope was so vital to the LGBTQ+ community.

4. Activity #1: Explain to participants that they will be writing a letter to themselves from the future. Otherwise known as an "Older, Wiser Self Letter," they need to imagine themselves at some point in the future (could be just a few years, or even decades) at a time in which things have gotten much better: for themselves personally and society as a whole. Imagine your future selves as strong, competent, and in possession of resources and support. From the perspective of their future selves, they are to write a letter of advice and encouragement from their future selves. What advice would your future self give the present you as you manage this phase of your life? What would be said to comfort you? How would a future version of yourself suggest you take care of yourself at this moment?

5. Have members share their letters, as time allows (you will have time next week to share more letters). Ask members what they may have gained from this activity. What common themes have you noticed between members' letters?

6. Thank members for coming. Remind participants that there are two sessions left.

Group Session 7 – Hopes for Family, Peers, and Society

Purpose:
To allow group members to discuss their hopes for the future and experience and inspirational documentary regarding one family's journey to becoming accepting of their child. Additionally, groups will begin to bring closure to the counseling groups and the group members' experience.

Objectives:
1. Group members will be able to share any letters from the future left over from last week.
2. Group members will be able see how one family grew to become more accepting of their child.
3. Group members will be able to discuss their feelings about group soon coming to a close.

Supplies:
A form of media to play the video, "Always My Son" (e.g., projection screen, laptop, tablet, etc.)

Procedure:
1. Welcome group members back and ask if there is anyone else who would like to share their letter from last week. Process if necessary. Remind group members there is one session left.

2. Activity #1: Inform members that you will be watching a short documentary (15 min) entitled "Always My Son," the story of how one family with deeply help religious and personal values eventually came to integrate their love for their gay son. A laptop/tablet or similar technology will be needed for this activity. The video can be found on the Family Acceptance Project website at: http://familyproject.sfsu.edu/family-videos. Processing questions after the video could include:
    a. What are your impressions from this video? Did any specific statements stand out to you?
    b. Can you personally identify with the people or the situations in the video?
    c. What were some of the negative ways Edward (the son) coped with his situation? What else could he have done?
    d. What other places did the family find support? Do you have similar options?
    e. What was it like for you to see a family change so much out of love for their child?
    f. What about this video gives you hope for yourself or others?

3. Inform members that next week will be the last time the group meets. What are their thoughts and feelings about group coming to a close? How can they continue what they've learned outside of group?

4. Thank group members for coming.

Group Session 8 – Closure

Purpose:
The purpose of this final session is to synthesize what has been learned and gained by the group members throughout this experience. Members will also get a chance to share positive feelings and hopes for the future with fellow members. Additionally, the purpose is to bring closure to the counseling group and the group members' experience. Lastly, group members will fill out post-assessments.

Objectives:
1. Group members will be able to reflect on the group experience and influence in their lives.
2. Group members will be able to apply this knowledge in the form of advice for others.
3. Group members will be able to share positive thoughts and hopes for fellow group members.

Supplies:
Dear Group activity letter; post-assessment packets (provided by the PI).

Procedure:
1. Welcome group members back and ask if there is any unfinished business from last week. Process if necessary. Remind group members that this is the last session, and that they will be filling out post-assessments at the end.

2. Ask group members to summarize the past several weeks.

3. Use the following processing questions to help members bring closure to their group experience:
    a. What are your thoughts and feelings about this being the last session?
    b. What have you learned about yourself through this process?
    c. How can you take what you have learned about yourself beyond this group?
    d. How will you handle future challenges based on the skills you've learned in group?

4. Activity #1: Ask members if they have ever heard of or read advice columns like "Dear Abby." Inform members that since they have gained some expertise in coping by participating in group, they will now apply what they've learned by answering a letter asking for advice. After reading the letter (Appendix D), ask members what their suggestions are. Each member should get a turn to respond.

5. Activity #2: Explain to group members that one helpful way to bring a sense of closure to an experience is to share with everyone how the group has impacted you. Think of a metaphorical gift that you have received from the group (which could include specific individuals or the group as a whole). These can be things like hope, courage, laughter, an understanding of another's particular perspective etc. Share with the group the gifts you feel like you have been given. Taking turns, each member gets an opportunity to share.

6. Thank members for sharing, and commend them for all their hard work in group these last eight sessions. Express confidence that they will be able to continue to use the tools they've learned outside of group.

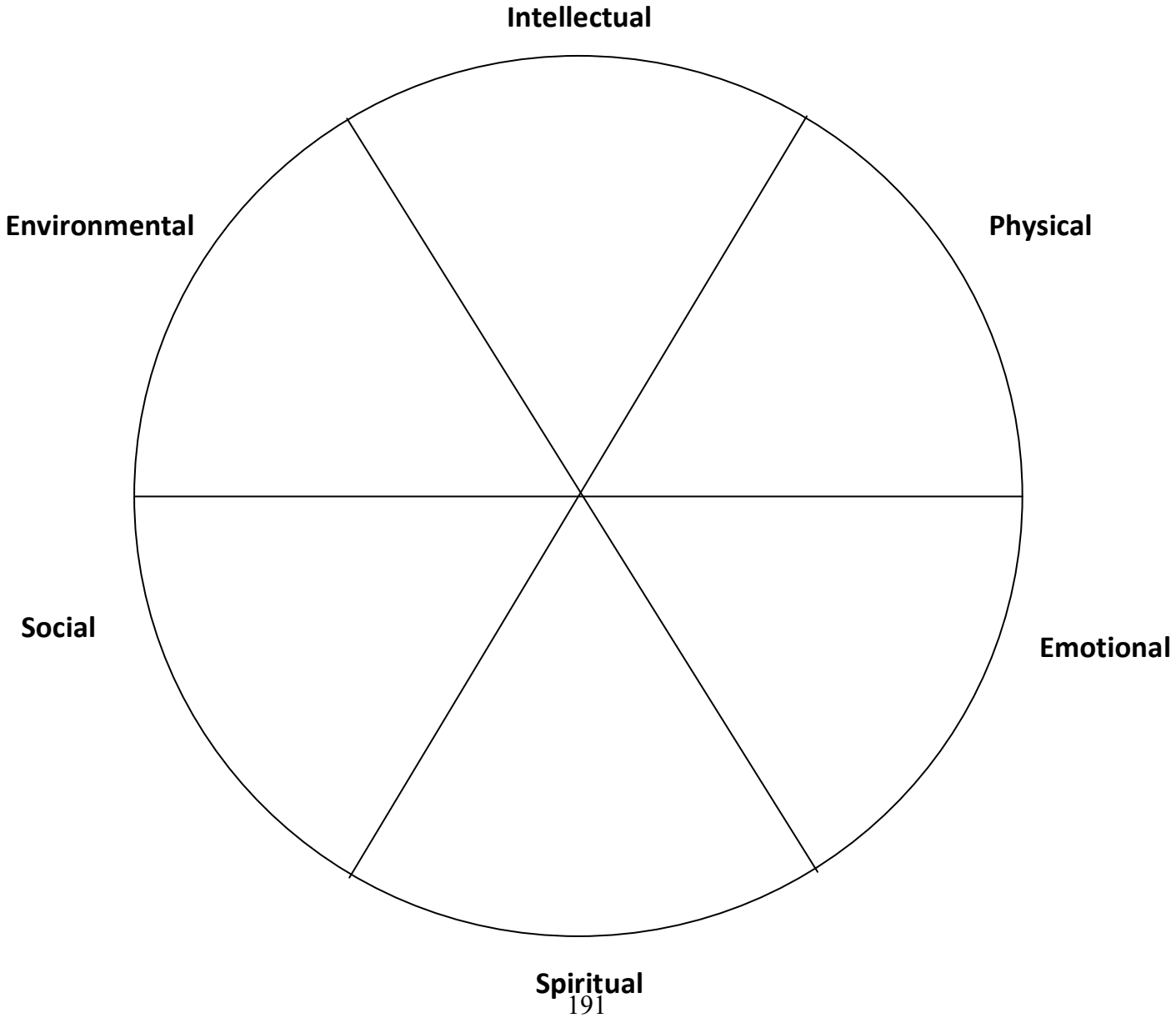
7. The last step is to fill out the post-test assessments. This should take approximately 15-20 minutes. Make sure each member gets the packet with the code word or number they came up with on the first week, and that they don't write their names on any of the instruments.

Group Curriculum Appendix A: Wellness Wheel Worksheet

My Wellness Wheel

INSTRUCTIONS: Each segment of the Wellness Wheel symbolizes an aspect of who you are and how you cope with the stressors in your life. For each segment, color in the percentage that you feel best represents the quality of your wellness in that area.

If necessary you can split categories to add in something that is missing for you. You can also re-label an area so that it is more meaningful for you.



Group Curriculum Appendix B: Breathing Activity Script

Let's relax right now. First, let your body relax a bit. Reach up, high above your head, stretching your arms... stretching your body very tall. Now let your arms relax. Place them at your sides, loosely.

Do the same thing again, but this time, breathe in as you reach up. Stretch.... and now breathe out as you relax and place your arms at your sides.

Just sit now, letting your arms rest at your sides. Close your eyes and relax.

See how your breathing can relax you by taking slow, deep breaths. Breathe in.... hold your breath.... and now breathe out, slowly. Breathe in.... and out.

Keep breathing deeply and slowly.

Place one hand on your chest and one hand on your stomach. Feel both of your hands moving up and out as you breathe in... and down as you breathe out. Feel your hands moving with your chest and stomach, gently moving in and out with each breath.

You can keep your hands there or rest them at your sides, but just keep noticing the calm, slow way you're breathing.

Imagine that there is a candle in front of you. As you breathe out, blow the air out through your mouth very slowly. Imagine that you are blowing enough air to make the flame of the candle flicker, but not enough to blow it out. You will need to blow very softly.

When you breathe in, imagine that the flame of the candle flickers and leans toward you. As you breathe out, the flame flickers and leans away.

Imagine the flame of the candle moving in and out with each breath you take.

Just relax now for a moment, feeling your body relax. Your arms and legs are very loose and relaxed.

Now you can imagine that your body is like a balloon filling up as you breathe in, and emptying as you breathe out. Let your ribs expand out to the sides, like a balloon, expanding... and then let the air out, like a balloon that is emptying. The balloon expands.... and then the air goes out.

And now, see how slowly you can breathe out. First breathe in.... and now breathe out very slowly... out... out.... out. When you can't breathe out any more air, breathe in again, and then very slowly breathe out. Breathe in energy, breathe out calm. Breathe in energy, breathe out calm.

For the next few moments, just relax, resting. Enjoy this calm feeling.

Open your eyes. Stretch your muscles if you want to, and let your body wake up. When you are totally awake, you can get back to the rest of your day.

Group Curriculum Appendix C: Flipping the Coin Worksheet

Can you change the way you think by changing the words you use?

Look at these words...can you 'flip the coin'?

−		+
obstacle	→	challenge
impatient	→	keen
cry-baby	→	
aggressive	→	
busy-body	→	
coward	→	
pushy	→	
timid	→	
boring	→	

Group Curriculum Appendix D: “Dear Group” Advice Activity

Dear Group:

I am an 18-year-old high school senior and have recently come out of the closet as gay to my family. My mother asked me if I saw a future with a woman, and that’s when I told her that I did not. She let me know that she and my father will always love me and never give up on me, but that they will never accept this. She kept asking me, "How do you know? You have never been with a girl. Maybe you're confused." I don’t know how to make them understand.

Since coming out I’ve also had a much harder time at school. I’ve always been called names and harassed a bit, but now it’s much worse. I just don't know how to cope with all this. I have no one to talk to, and I am sad all the time but I have to hide it. Please tell me what I should do and how I could make the situation better.

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