ScholarWorks@GSU

Exploring a Model of Social Support and Nonsupport among LGBTQ Youth with and without Parent Consent

Authors	Kiperman, Sarah
Citation	Kiperman, Sarah. "Exploring a Model of Social Support and Nonsupport among LGBTQ Youth with and without Parent Consent." Dissertation, Georgia State University, 2018. https://doi.org/10.57709/12223961
DOI	https://doi.org/10.57709/12223961
Download date	2026-03-06 21:48:22
Link to Item	https://hdl.handle.net/20.500.14694/3692

ACCEPTANCE

This dissertation, EXPLORING A MODEL OF SOCIAL SUPPORT AND NONSUPPORT AMONG LGBTQ YOUTH WITH AND WITHOUT PARENT CONSENT, by SARAH KIPERMAN, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education and Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

____
Kris Varjas, Psy.D.
Committee Co-Chair

____
Joel Meyers, Ph.D.
Committee Co-Chair

____
Don Davis, Ph.D.
Committee Member

____
Cirleen DeBlaere, Ph.D.
Committee Member

____
Brian Dew, Ph.D.
Chairperson, Department of Counseling and Psychological Services

____
Paul A. Alberto, Ph.D.
Dean
College of Education and Human Development

AUTHOR'S STATEMENT

By presenting this dissertation as a partial fulfillment of the requirements for the advanced degree from Georgia State University, I agree that the library of Georgia State University shall make it available for inspection and circulation in accordance with its regulations governing materials of this type. I agree that permission to quote, to copy from, or to publish this prospectus may be granted by the professor under whose direction it was written, by the College of Education and Human Development's Director of Graduate Studies, or by me. Such quoting, copying, or publishing must be solely for scholarly purposes and will not involve potential financial gain. It is understood that any copying from or publication of this prospectus which involves potential financial gain will not be allowed without my written permission.

____

Sarah Kiperman

NOTICE TO BORROWERS

All dissertations deposited in the Georgia State University library must be used in accordance with the stipulations prescribed by the author in the preceding statement. The author of this dissertation is:

Sarah Elizabeth Kiperman

Counseling and Psychological Services

College of Education and Human Development

Georgia State University

The director of this dissertation is:

Dr. Kris Varjas & Dr. Joel Meyers

Department of Counseling and Psychological Services

College of Education and Human Development

Georgia State University

Atlanta, GA 30303

CURRICULUM VITAE

Sarah Kiperman, ED.S.

ADDRESS: 5496 Kingsfield Drive
West Bloomfield, MI 48322

EDUCATION:

Ph.D	2017	Georgia State University School Psychology
Ed.S	2015	Georgia State University School Psychology
M.Ed.	2013	Georgia State University School Psychology
M.A.	2011	New York University Educational Psychology
B.A.	2009	Indiana University, Bloomington Theater & Drama, English, and Psychology

PROFESSIONAL EXPERIENCE:

2017 – Present	Adjunct Professor: Research Methods and Evaluation New York University, New York, NY
2017 – 2018	Clinical Specialist: Post Doctoral Fellowship Astor Services for Children and Family, Rhinebeck NY
2016 – 2017	Doctoral Intern: APA/APPIC Doctoral Internship Astor Services for Children and Family, Rhinebeck, NY
2015 – 2017	Board Member: LGBTQ Youth Organization Real Youth, Atlanta, GA
2015 - 2016	Course Manager: CPS 2500 Career Development and Life Planning Georgia State University, Atlanta, GA
2015 – 2016	Student Clinician: Play Therapy in the Schools Advanced Practicum Cobb County Public Schools, Marietta, GA
2015	Course Teaching Assistant: CPS 8600 Advanced Play Therapy Georgia State University, Atlanta, GA
2014	Course Instructor: CPS 2500 Career Development and Life Planning Georgia State University, Atlanta, GA
2013 – 2017	Course Instructor: CPS 3200 Diversity and Human Relations Georgia State University, Atlanta, GA
2013 – 2014	Student Clinician: School Psychology Advanced Practicum Gwinnett County Public Schools, Suwanee, GA
2012 – 2013	Student Clinician: School Psychology Practicum Clayton County Public Schools, Jonesboro, GA

SELECTED PUBLICATIONS AND PRESENTATIONS:

Wood, L., **Kiperman, S.,** Esch, R., Leroux, A. J., & Truscott, S. D. (2016). Predicting dropout

using student- and school-level factors: An ecological perspective. *School Psychology Quarterly, Advance online publication available.* 1-15, http://dx.doi.org/10.1037/spq0000152.

Varjas, K., **Kiperman, S**., & Meyers, J. (2016). Disclosure experiences of urban, ethnically diverse LGBT high school students: Implications for school personnel. *School Psychology Forum, 10*(1), 78-92.

Kiperman, S., Black, M. S., McGill, T. M., Harrell-Williams, L. M., Kamphaus, R.W. Predicting behavior assessment system for children – Second edition self- report of personality child form (BASC-2 SRP-C) results using the behavioral and emotional screening system student form (BESS SF): A replication study with an urban, predominantly Latino/a sample. (2014). *Journal of Psychoeducational Assessment. 32*(2), 1-10, doi: 10.1177/0734282914529200.

Kiperman, S., Varjas, K., Meyers. J., Howard, A. (2014). LGB youth's perceptions of social support: Implications for school psychologists. School Psychology Forum, 18(1), 1-16.

Varjas, K., Meyers, J., **Kiperman, S.,** Howard, A. (2013). Technology hurts? Lesbian, gay, and bisexual youth perspectives of technology and cyberbullying. Journal of School Violence, 12(1), 27-44, doi: 10.1080/1538820.2012.721665.

Ashby, J., Wood., L., & **Kiperman, S.** (2017) Ethics in play therapy consultation and supervision. R. L. Steen (Eds.), *Emerging Research in Play Therapy, Child Counseling, and Consultation, pgs 213-230.* New Orleans, LA: *IGI Global.*

Carrion, C., **Kiperman, S.,** Leroux, A.. (2017, April). Peer Norms as a Predictor of Academic Achievement: An Ecological Perspective. Paper presentation for the *American Educational Research Association Conference* in the Counseling and Human Development Division, San Antonio, TX.

Kiperman, S., Haggaray, G., Henry, S., Varjas, K., & Meyers, J. (2017, February). LGBTQ Youth: Context and reasons for labels. Paper presentation for the *National Association for School Psychologists Conference*, San Antonio, TX.

Kiperman, S., Varjas, K., & Meyers, J. (2016, February). Social support and nonsupport types and impact for LGBTQ youth. Poster presentation for the *National Association of School Psychologists Conference*, New Orleans, LA.

Kiperman, S. & Blinder, M. (2015, September). Cyberbullying: Computing the threats. Professional development presentation at *The Annual Conference for The Boy Scouts of America: Build an Adventure 2015*. Marietta, GA.

Kiperman, S., Galeano, E., Bailey, C., Perkins, C., Varjas, K., & Meyers, J. (2015, March). School Climate and Bullying: How Teachers Can Make A Difference. Professional development presentation for *Georgia State University* Teaching Cohort. Atlanta, GA.

Kiperman, S., & Kamphaus, R.W., (2015, February). Predictive validity of the BESS student form and BASC-2 SRP. Poster presentation for the *National Association of School Psychologists Conference*, Orlando, FL.

Kiperman, S., Howard, A., Varjas, K., & Meyers, J. (2014, February). Social support for LGB youth: Who and what matters. Paper presentation for the *National Association of School Psychologists Conference*, Washington, D.C

Professional Societies and Organizations

2012-Present	American Psychological Association
2011-Present	National Association of School Psychologists
2011-Present	Georgia State University Student Affiliates in School Psychology

EXPLORING A MODEL OF SOCIAL SUPPORT AND NONSUPPORT AMONG LGBTQ YOUTH WITH AND WITHOUT PARENT CONSENT

by

Sarah Kiperman

Under the Direction of Dr. Joel Meyers and Dr. Kris Varjas

ABSTRACT

Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth can benefit from protective factors (e.g., social support). While a framework of LGBTQ youth social support and nonsupport exists (e.g., Kiperman, Varjas, Meyers, & Howard, 2014), findings were exploratory and demonstrated limited generalizability. A transformative framework indicates research should include LGBTQ youth without parent consent in addition to those with consent, as they have limited representation in literature.

Chapter one is a systematic review of counseling/psychotherapy interventions practices with LGBTQ youth overtime. Inclusion/exclusion criteria yielded a full review of *n* = 15 studies from *N* = 3,025 sources. Some reviewed variables include: recruitment methods, consent procedures, treatment type, design/measurement, and outcomes. Results identified (*n* = 2) studies that practiced behavior modification in the 1970's and 1990's, while studies meeting current ethical treatment types (e.g.,

affirmative, culture specific, strength based) (n = 8), occurred from the 2000's to present day. Few studies identified consent procedures (n = 4). This chapter is among the first to explore characteristics of counseling/psychotherapy for LGBTQ youth chronologically.

Chapter two's qualitative analysis explored whether LGBTQ youth experiences confirmed and/or disconfirmed an existing model of LGBTQ youth social support/nonsupport types (Kiperman et al., 2014). A total of (N = 42) LGBTQ youth with (n = 21) and without (n = 21) parent consent were interviewed. Unique contributions included replacing Kiperman et al.'s (2014) concepts, *support* and *nonsupport types* with support and nonsupport *actions* (what support/nonsupport was enacted) and *descriptions* (traits or mannerisms of a provided support/nonsupport or person). Findings compared experiences of youth with and without parent consent. Samples discussed social support and nonsupport similarly, permitting use of the same codebook across samples. More youth with parent consent endorsed experiencing *appraisal, tangible/instrumental*, and *informational social support actions* compared to youth without parent consent; however more youth without parent consent endorsed *emotional* social support actions. *Social nonsupport descriptions* codes were endorsed with greater frequency by youth without parent consent or equally among both samples. Implications inform how support/nonsupport actions and descriptions may interact. Analyses of sample differences validated the need to include LGBTQ youth without parent consent in research.

INDEX WORDS: LGBTQ youth, Social support, Nonsupport, Psychotherapy, Counseling, Transformative framework, In loco parentis, Parent consent

EXPLORING A MODEL OF SOCIAL SUPPORT AND NONSUPPORT AMONG LGBTQ YOUTH WITH AND WITHOUT PARENT CONSENT

by

Sarah Elizabeth Kiperman

A Dissertation

Presented in Partial Fulfillment of Requirements for the

Degree of

Doctor of Philosophy

in

School Psychology

in

Department of Counseling and Psychological Services

in

the College of Education and Human Development

Georgia State University

Atlanta, GA

2017

Copyright
Sarah E. Kiperman
2017

DEDICATION

This dissertation is dedicated to my parents. Mom and dad, the greatest joy of my life is being your daughter. Mom, I dedicate every smile I've had along the way to you and your zest for life. The love and hope poured into each page of this project is in your honor. You remind me each day what it means to be a strong, independent and kind woman, I couldn't ask for a better role model. To my Herbie Kips, the sun shines a lot less bright without you here, but I've finished this project knowing you're guiding my every step. Thank you for modeling what hard work looks like for as long as you could, despite every challenge placed in your path. I channel you everyday of my professional career, knowing "winter, spring, summer or fall… all you have to do is call… and I'll be there… yes I will… you've got a friend". Love you always.

ACKNOWLEDGEMENTS

As the finish line of my doctoral degree appears closer, I cannot help but reflect on the many people who have made this moment possible. To my advisors, Dr. Varjas and Dr. Meyers- thank you. Dr. Varjas- you have supported my research agenda from the beginning and have inspired my love for research methodology. Thank you for never missing a NASP presentation and always giving the words of encouragement I may need. Dr. Meyers- I am so grateful for your guidance and support through my dissertation and time with GSU. You make everything seem more bearable and I believe there is a positive correlation between the number of comments you provide with each revision and how much you care. In other words… I feel pretty special. To my committee members, Dr. Don Davis and Dr. Cirleen DeBlaere, thank you for reading this incredibly long dissertation. I hope to present you with a paper plate award to express my gratitude in the near future! To the following staff at Georgia State: Dr. Catherine Perkins, Dr. Audrey Leroux, Dr. Jeff Ashby, Dr. Tiffany McNary, and Dr. Jane Brack- thank you for your mentorship and support, even when it meant going above and beyond any expectation.

My amazing friends and colleagues who lent a hand to this project! Without you, none of this would be possible. To Gabriel DeLong- I would not have had a dissertation without you. If I ever had doubt, you brought energy, hope, and more participants our way! Thank you for opening so many doors, for your time on this project, for coding, and beyond. Words cannot describe my gratitude. Shakerra Henry- thank you for your chats about life and your hard work on coding. This project would not be possible without you. Melanie Blinder- Thank you for your coding help on Chapter 1. Jo Saint- Thank you for coordinating recruitment events and for being a critical support through the dissertation process. To everyone who helped with recruitment, thank you for your time, energy, and willingness to help.

To my strong Georgia State University lady colleagues! Laura Wood, you are my partner in crime and the best office bud I could ask for. Our power hours, coffee-runs-in-the-rain, and collaboration have made for some of the best grad school memories. To Faith Zabek- I couldn't ask for a more awesome 'lil sister in the program… so glad you are my "family." Rachel Esch- your work ethic, passion, and friendship have made me a better friend and academic. Mary Sue Black- The pure goodness you bring to my life is unparalleled, thank you for teaching me humility and kindness. Carmen Carrion- you are my balance of hard work and fun wrapped up into a rock star colleague. Emilie Parham- My conference pal for always, fabulous colleague, and forever bud. Leandra Parris- You are the best 'big sister' a GSU gal could ask for. Finally, to my GSU cohort… there is not anyone else I would have wanted to go through this process with. #MFTWB #CollaborateToGraduate.

To my friends and family… you make life worth living. Thank you for being all the support I could ever need. Your unconditional love reminds me everyday the joy of coming home from a job I love, to a life I cherish. The adventures, karaoke, mahj, travel, holidays, shopping, and times spent doing nothing have formed the best memories. Special shout out to my mother, Debra Kiperman who made dinners when I could not and cheered me on during the treacherous experience of comps! That is just one example of how you are more than a mom… you are a legit, actual superhero. Thank you all for your love, encouragement, and acceptance- even in the depths of managing my dissertation. (This must mean we are all in it for the long haul!) ☺

TABLE OF CONTENTS

LIST OF TABLES……………………………………………………………………...…...v

LIST OF FIGURES…………………………………………………………...…..……..vi

1. A Systematic Review of Counseling and Psychotherapy Provisions for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth: A Chronological Analysis......... 1

Systematic Reviews of LGBTQ Populations and the Provision of Counseling and Psychotherapy 3

Recruitment and Consent for Counseling and Psychotherapy 4

The History of LGBTQ in the context of Counseling and Psychotherapy Provisions 5

Rationale for Study 7

Methods.. 8

Phases of the Systematic Review 8

Data Coding.. 13

Data Collection... 20

Results 22

Participant Information.. 27

Treatment Information 29

Treatment Targeted Aspects of Change 33

Participant Recruitment... 36

Consent Procedures 37

Research Design/Measurement... 37

Outcomes 40

Recommendations 41

Discussion 47

Limitations... 52

Implications for Practice 53

Future Directions for Research 55

References **57**

2. Exploring a Model of Social Support and Nonsupport Among LGBTQ youth with and without Parent Consent **64**

Social Support and Nonsupport **64**

LGBTQ Youth With and Without Access to Parental Consent **66**

Rationale for Study **68**

Method **69**

Participants and Recruitment 69

Instruments 71

Procedures 72

Data Analyses 74

Results **79**

Social Support Actions (Level 1) 81

Social Nonsupport Actions (Level 1) 85

Social Support Descriptions (Level 1) 92

Social Nonsupport Descriptions (Level 1) 95

Youth with and without Access to Parent Consent: Comparisons in their Experiences 98

Discussion **100**

Limitations and Future Directions 105

Implications for School Psychology Practice 107

References **110**

APPENDICES **115**

List of Tables

Table 1.1 *Study Citations and their corresponding article number found in Table 1.2*……… 23

Table 1.2 *Abbreviations from Table 1.3 & 1.4 and their corresponding terminology*………… 24

Table 1.3. *Chronological Inductive-Deductive Coding Results*…………………………………….. 26

Table 1.4. *Frequency Count of Inductive-Deductive Coding*……………………………………...... 26

Table 1.5a *Operationalized constructs and the corresponding scales to measure change for LGBTQ youth*………….……………………………………………………………………………. 39

Table 1.5b *Operationalized constructs and the corresponding scales to measure change for LGBTQ youths' psychotherapist*……..……………………………………………………… 39

Table 1.5c. *Operationalized constructs and the corresponding scales to measure change for LGBTQ youths' parents*…………….…………………………………………………………...... 40

Table 1.6 *Descriptive Summary of Studies that Implemented Counseling and Psychotherapy*…………….…………………………………………………………………….... 43

Table 2.1a *Participant Demographics*……………………………………………………………….. 70

Table 2.1b *Participant Demographics Continued*……………………………………………….….. 71

Table 2.2 *Participant Overall Report: Social Support/Nonsupport Actions and Descriptions by Parent Consent (youth with and without)- Frequency (Percent)*……………………..... 99

List of Figures

Figure 1.1 Phases of the systematic review, and the elimination process of sources……… 9

Figure 2.1 Coding Hierarchy: Social Support and Nonsupport Actions…………………….. 81

Figure 2.2 Coding Hierarchy: Social Support and Nonsupport Descriptions……………….. 92

Figure 2.3 The final model: A continuum Depiction of Social Support/Nonsupport Actions and Descriptions……..…………………………………………………………….….. 103

1. A Systematic Review of Counseling and Psychotherapy Provisions for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth: A Chronological Analysis

Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth often experience marginalization via bullying (Button, O'Connell, & Gealt, 2012), teasing (Espelage, Aragon, Birkett, & Koenig, 2008), harassment (D'Augelli & Patterson, 2001), and negative school climate (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012). LGBTQ youth also encounter stressors such as negotiating their identity development and coming out (Varjas, Kiperman, & Meyers, 2016). It has been reported that perceived discrimination among LGBTQ youth can account for increased depressive symptoms, suicidal ideation, and self-harm compared to Heterosexual, non-transgendered youth (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). While many LGBTQ youth have access to supportive relationships and lead fulfilling lives (Kiperman, Varjas, Meyers, Howard, 2014; Munoz-Plaza, Quinn, & Rounds, 2002), it is important these youth have access to effective counseling and psychotherapy, which may impact their susceptibility to mental health concerns.

The American Psychological Association (APA, 2016) defines psychotherapy as "…collaborative treatment based on the relationship between an individual and a psychologist. A psychologist provides a supportive environment that allows you to talk openly with someone who is objective, neutral and nonjudgmental, [… where goals aim to] help people of all ages live happier, healthier and more productive lives". Counseling is defined by APA (2016) as a service that helps people with physical, emotional and mental health issues alleviate feelings of distress and resolve crises while improving their sense of well-being. The American Counseling Association (ACA, 2016) added that counseling involves a professional relationship that

empowers diverse people to achieve mental health, wellness, education and career aspirations. Counseling and psychotherapy are the mental health services practiced within the American Psychological Association (2016) and will be the focus of discussion in this chapter.

It is important that mental health professionals treating LGBTQ youth practice competent, ethical, and beneficial counseling and psychotherapy (American Psychological Association, 2009; DeLeon, 1998). Professionals can inform their practice by reviewing documented examples (e.g., research articles, systematic reviews, or meta-analyses) of counseling and psychotherapy with LGBTQ youth. Mental health professionals should also be informed about issues in counseling and psychotherapy that are particularly relevant to LGBTQ youth clients such as consent procedures. LGBTQ youth may be harmed if they prematurely disclose their sexual orientation/gender identity to their parents by the requirement that parents sign forms to consent for their child receiving counseling or psychotherapy. Learning about consent procedures and options can inform practitioners how to ethically engage LGBTQ youth in counseling and psychotherapy practice and research. Furthermore, a historical review of psychotherapy and counseling implementation with LGBTQ youth could inform how context may greatly inform service provision. The current study seeks to review counseling and psychotherapy practices enacted with LGBTQ youth, how these youth are recruited and can consent, and how these practices have contextually occurred. To address these aims, the remainder of this introduction reviews of three areas: (1) prior systematic reviews on counseling and psychotherapy with LGBTQ youth, (2) consent procedure practice with LGBTQ youth, and (3) historical perspectives on counseling and psychotherapy with LGBTQ youth community.

Systematic Reviews of LGBTQ Populations and the Provision of Counseling and Psychotherapy

Various systematic reviews have explored aspects of counseling and psychotherapy for LGBTQ adults (e.g., Byrd & Nicolosi, 2002; King, Semlyen, Killaspy, Nazareth, & Osborn, 2007; Serovichet al., 2008; Woodward & Willoughby, 2014); however, Woodward and Willoughby (2014) conducted the only study to convey findings relevant to LGBTQ youth. Specifically, counseling and psychotherapy treatment recommendations for practicing family therapy with LGB youth were made and included: using psychoeducation to inform parents of their child's coming out, meeting the child client's needs, being culturally sensitive and accepting, promoting family cohesion and acceptance, fostering new, affirming traditions, including family members in therapy, and assessing the their ability to communicate and handle crises.

King and colleagues (2007) systematic review explored counseling and psychotherapy provisions with LGBT adults. While the King et al. (2007) had a table reviewing sample characteristics, recruitment techniques, sample sizes, definitions of sexual orientation and gender identities of participants, the type of counseling/therapy, study outcomes of interest, and prevalence/findings section. Key findings from this review found "gay affirmative" therapies to be common, where gay affirmative therapy refers to "therapists regard[ing] LGBT lifestyles positively, were knowledgeable and non-prejudiced about LGBT issues and provided therapy that did not pathologies minority sexual identities" (King et al., 2007, P. 8). Studies rarely indicated how these practices were implemented or how they adjusted their curriculum to meet the cultural needs of LGBT clients.

While Woodward and Willoughby (2014) review recommendations for therapy with LGB youth and King et al (2007) review counseling and psychotherapy practices with LGBTQ adults, there remains a dearth of research that reviews how counseling and psychotherapy have been implemented with LGBTQ youth. This chapter seeks to inform what counseling and psychotherapy methods/techniques have been implemented, as the King et al (2007) exclaims, however, this study seeks to understand these experiences with LGBTQ youth.

Recruitment and Consent for Counseling and Psychotherapy

An ethical concern researchers and practitioners may confront with LGBTQ youth clients is how to recruit and provide counseling or psychotherapy for them when asking their parents for consent may prematurely out them or bring them harm. Having effective recruitment methods for youth without parent support is important as these youth may have limited access to resources and mental health support. Varjas et al. (2008) discuss the importance of innovative recruitment techniques of LGBTQ youth for research, given that many have not come out. More distant, anonymous recruitment methods (e.g., posting in chat rooms) were discussed as potential recruitment methods by Varjas et al. (2008) to promote youth's willingness ad confidence to discuss their lives and identities. This study, however, calls for a closer examination of recruitment strategies to inform efforts to include these youth in research. Expanding this discussion to counseling and psychotherapy practice could help provide youth with more information to access services they may need.

Obtaining consent from a parent or guardian for youth under 18-years-old to participate in counseling or psychotherapy is typically a mandatory practice, however, the federal mandate *45 CFR 46.408(c)* now allows for researchers to waive traditional consent and use *in loco parentis* procedures instead. I*n loco parentis* procedures are designed to protect the rights of

minors where an accepting adult figure, independent of the counseling or psychotherapy study is informed of a youths' involvement in lieu of their parent (e.g., Varjas et al., 2008). Currently, there is a dearth of research that has systematically reviewed consent practices for LGBTQ youth in research or counseling and psychotherapy. This review explores whether consent and recruitment methods are discussed differently for research compared with counseling and psychotherapy; as well as identifies current practices used in research on counseling and psychotherapy practice with LGBTQ youth.

The History of LGBTQ in the context of Counseling and Psychotherapy Provisions

LaSala (2013) documented that the psychology community has been transitioning from a from an agenda that blames LGB youth towards a more supportive agenda. A 'blaming' agenda has referred to problems as exiting within the child, such as the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM) considering homosexuality a disorder until 1973. The blaming agenda has also referred to counseling and psychotherapy's practice of attempting "to 'cure'[ing] Homosexuals by transforming them into Heterosexuals" (e.g., conversion or reparative therapies) (Hicks, 1999; Serovich et al., 2008). In contrast, the transition to a more supportive agenda has begun to emphasize treatments adopting an affirmative framework (that fosters acceptance), where LGBTQ youth clients are encouraged to accept and integrate their sexual orientation and gender identities into their sense of self and where families are included in the therapeutic process to learn how to affirm their child. Gender Dysphoria persists as a classified disorder in the current DSM-5 (APA, 2013). Gender Dysphoria refers to individuals' experiencing clinically significant distress for at least six months due to not identifying with the gender identity (male or female) others perceive them to be. The presence of Gender Dysphoria in the DSM-5 may suggest a more progressive social agenda around sexual

orientation issues (e.g., removing ‘homosexuality’ from the DSM-5), compared to gender identity, which has continued pathology.

To illustrate the transition towards acceptance and away from blaming the LGBTQ youth community, several organizations have actively sought to clarify their ethical stance against LGBTQ pathology. *Just the Facts Coalition* stated their rejection of reparative therapy, that homosexuality was not a mental disorder, and that a cure was not necessary (APA, 2009). The American Psychological Association addressed reparative therapy with a *Task Force on Appropriate Therapeutic Responses to Sexual Orientation* statement that conveyed these practices yield ineffective and harmful results (APA, 2009). APA Task force on Appropriate Responses to Sexual Orientation (2009) published a resolution that opposed portrayals of LGB people as mentally ill who seek treatment for their sexual orientation. APA’s (2009) official rejection of reparative therapy was necessary as previous practices (during the LGBTQ blaming eras) had limited commentary as it was consistent with societal norms and expectations. The societal shift towards acceptance and away from blaming of the LGBTQ community deemed these practices unethical and in dissonance with societal expectations- thus calling on APA’s need to clarify their stance on counseling and psychotherapy (LaSala, 2013).

This section depicts a historical perspective by pairing actions of APA with the social context in which they occurred. The historical (and ongoing) shift from blaming to acceptance of the LGBTQ community could greatly relate to the counseling and psychotherapy experiences of LGBTQ youth, however limited research has explored these practices while accounting for the historical context in which they occurred. This chapter seeks to inform this gap by bringing attention to article content related to its publication year.

Rationale for Study

The previous introduction indicates that there is a dearth in systematic reviews that evaluate the consent procedures, recruitment methods, measurement, outcomes, and characteristics of implemented counseling and psychotherapy with LGBTQ youth. In addition, there has been limited documentation of historical issues in counseling and psychotherapy for LGBTQ youth. This chapter presents a systematic review of implemented counseling and psychotherapy with LGBTQ youth. This study seeks to address gaps in the literature by answering the following research questions:

1. What counseling and psychotherapy practices documented in research have been implemented with LGBT youth and how have they evolved over time?
2. What recruitment and consent procedures have been used for investigations of counseling and psychotherapy when treating LGBTQ youth clients? How have these practices changed over time?
3. How have studies that investigate counseling and psychotherapy with LGBTQ youths' described research designs and measurement strategies used. How have these research designs and measurement strategies changed over time?
4. What counseling and psychology services were found to evoke significant change in LGBTQ youth, and how have reports of significant change evolved over time?
5. What recommendations were made to suggest how counseling and psychotherapy provisions could yield the most effective experiences for LGBTQ youth clients?

Methods

Phases of the Systematic Review

This systematic review followed recommendations from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines by Liberati and colleagues (2009). These guidelines recommend conducting systematic reviews via a four phase process: (1) *identification*, (2) *screening*, (3) *eligibility*, and (4) *included*. The PRISMA methods were used to clearly depict how articles were systematically included in this study using this four-phase process, as shown in *Figure 1.1*.

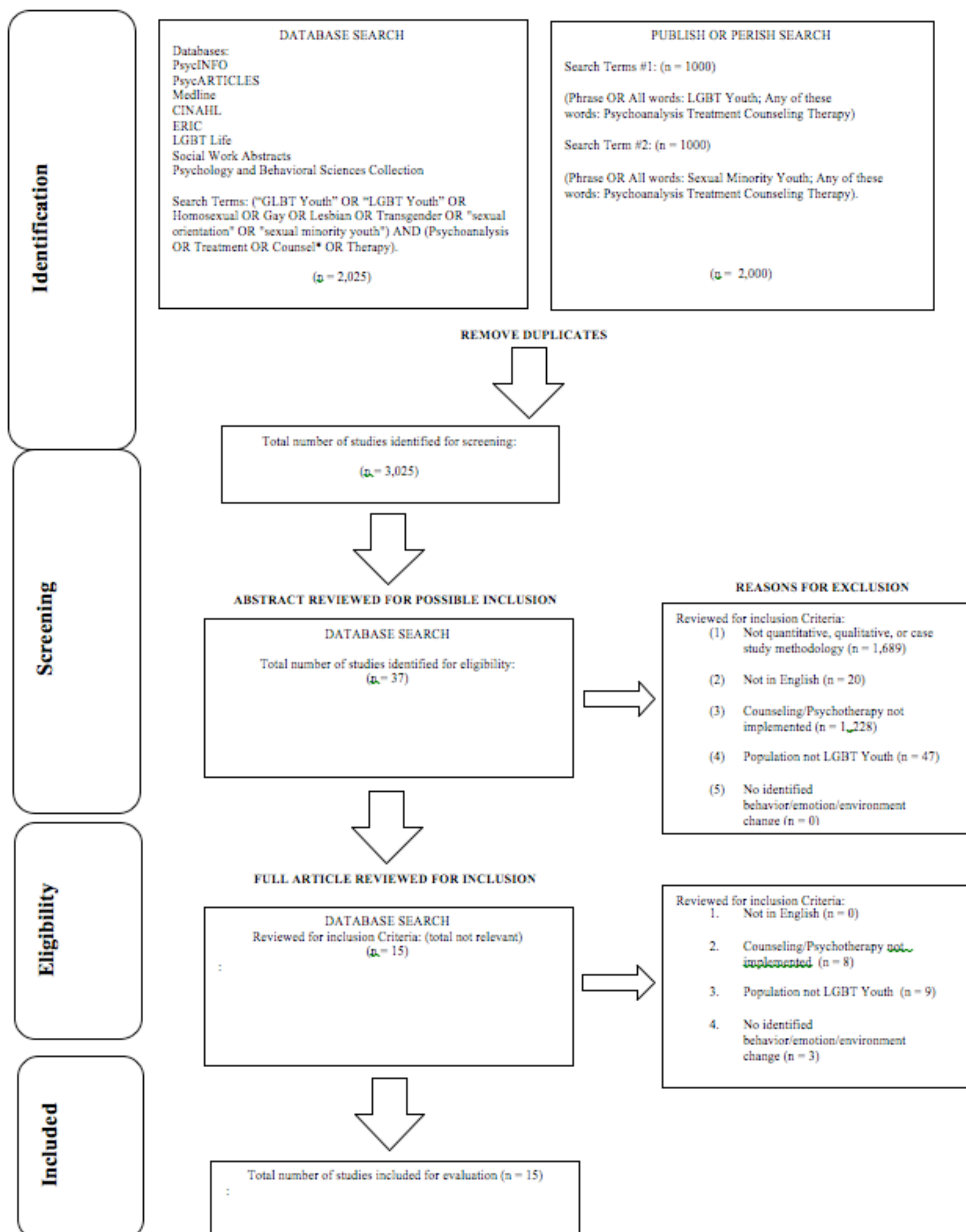

Figure 1.1 Phases of the systematic review, and the elimination process of sources

Identification. In the *identification phase*, researchers used web-based databases and search engines to identify sources to review. First, Boolean search terms were entered into the EBSCOhost system to search the following databases: PsycINFO, PsycARTICLES, Medline, CINAHL, ERIC, LGBT Life, Social Work Abstracts, Psychology and Behavioral Sciences Collection. The first author modeled this search based on similar search techniques conducted by Woodward and Willoughby (2014). The remaining authors edited and agreed upon the search terms. Three independent criteria (separated by "and") were used in the Boolean search that addressed (1) sexual orientation and gender identity labels, (2) the youth population of interest, and (3) counseling and psychotherapy provisions. The Boolean search terms were: *(LGBT OR Homosexual OR Gay OR Lesbian OR Bisexual OR Transgender OR "sexual orientation" OR "sexual minority" OR Queer OR YMSM OR YFSF OR MSM OR FSF) AND (Youth) AND (Psychoanalysis OR Treatment OR Counseling OR Therapy OR Psychotherapy).* The search terms YMSM, YFSF, MSM, and FSF refer to "young men who have sex with men", "young females who have sex with females", "men who have sex with men", and "females who have sex with females" respectively.

Second, researchers used the web-based database Publish or Perish to identify sources (Harzing, 2010). In the Publish or Perish program, the researchers used two sets of search terms: *(1) LGBT Youth AND Psychoanalysis, Treatment, Counseling, Therapy, Psychotherapy; (2) Sexual Minority Youth AND Psychoanalysis, Treatment, Counseling, Therapy, Psychotherapy*. These terms were identified based on recommendations by Harzing (2010) for conducting search results in Publish or Perish. After all of the articles were retrieved ($N = 4{,}025$), duplicate copies were eliminated using endnote's "find duplicate" feature, and then by importing all sources into

excel and reviewing similar sources by hand. Concluding this process, the total number of unique, merged sources produced was (n = 3,025) as indicated in *Figure 1.1*.

Screening: Setting limits; applying inclusion criteria. In the *screening phase*, researchers began with the unique, merged sources identified in the identification process (n = 3,025). Researchers eliminated sources by assessing whether information from abstracts met the inclusion criteria. The following inclusion criteria were developed by the research team. First, the studies had to include one of the following methodologies: qualitative (methodologies such as interviews, open-ended questions, or formal qualitative methodologies such as phenomenology or narrative frameworks), quantitative (methodologies using statistical analyses), or case studies (commentary by the narrating author/service provider). Both published (e.g., peer reviewed articles) and unpublished sources (e.g., theses and dissertations) were included. Second, the studies had to be written in English. Third, the studies had to implement and evaluate counseling or psychotherapy. Studies were viewed as implementing counseling and psychotherapy, when the words “therapy” “psychotherapy” “counseling” or “treatment” were used to describe the intervention, or when a therapy approach/technique is explicitly implemented (e.g., cognitive-behavioral approach or desensitization techniques). Various terms were included in the search (e.g., therapy, psychotherapy, counseling and treatment) to account for sources that referred to counseling or psychotherapy by a different label (e.g., treatment or intervention). Nevertheless, “treatment”, when referring to medical findings and not counseling or psychotherapy, was viewed as not relevant to this search. Implementation refers to participants actively receiving an intervention rather than proposing an intervention or treatment without active implementation. Fourth, studies had to describe the targeted population for change as LGBTQ youth. This inclusion criterion was not met when a study’s sample population

contained a normative culture sample (e.g., Heterosexual or Cisgender youth), when one or more participants were younger than 10 or older than 25, or when the target of change was family members of LGBTQ youth or others who were not the youth themselves. Fifth, studies had to identify a behavior, emotion, or environmental concern being modified and/or addressed via therapy for LGBTQ youth. Sixth, researchers had to conduct the study in the United States. This inclusion criterion was not met when studies conducted cross-national analyses, even when a represented culture was the United States.

The researchers applied the inclusion criteria sequentially, using each criterion in the same order to note whether an article met each criteria. The first time an article did not meet an inclusion criterion it was excluded, and further eligibility criteria were not explored. The researcher documented which criterion item yielded each source ineligible in *Figure 1.1,* per methodology recommendations of Liberati et al. (2009) . The higher criterion frequencies found in *Figure 1.1* related more to their sequence in determining eligibility rather than the frequency of each criterion's presence in each article. In the screening phase the first author found 37 sources met inclusion criteria and 2,988 were excluded.

Eligibility: Reviewing full text. For the *eligibility phase*, researchers reviewed the full text of sources retained in the screening process. If researchers were unsure whether articles met inclusion criteria from the screening phase, they were retained. Whole texts were evaluated in the eligibility phase with the same inclusion criteria as the screening phase since some criteria may not have been included in the abstracts. Two researchers independently evaluated the 37 articles for review. They determined the criterion item, (from the screening phase) where each article was no longer eligible. Researchers compared whether they indicated the same criterion for each article to be excluded and also identified articles that did not meet exclusion criteria, and were

regarded as *included* (Maggin, Johnson, Chafouleas, Ruberto, & Berggren, 2012). Their findings yielded a percent agreement index (Maggin et al., 2012), which depicted how well the researchers matched in their coding and data analysis decision-making. Percentage agreement indices are calculated by dividing each unit of agreement by the total units upon which one can agree. In the eligibility phase's percentage agreement index, a *unit of agreement* refers to researchers identifying the same criteria at which an article is excluded or included. This index aims to depict the authors' ability to yield similar, reliable findings. The percentage agreement index attained was 100% where there were 37 articles for researchers to match in their agreement of inclusion and exclusion criteria, and all 37 were agreed upon (Maggin et al., 2012).

Inclusion: Included articles for review and analysis. The *inclusion phase* references the total number of relevant sources that are included in the systematic review analyses. As indicated in *Figure 1.1,* a total of 15 sources met inclusion criteria, while 22 were excluded at this phase.

Data Coding

The researchers conducted descriptive analyses to yield a detailed summary of findings from the 15 included articles, found in the appendix. The descriptive analyses present similar categories as previous studies that have reviewed counseling and psychotherapy and LGBTQ culture (e.g., King et al., 2007; Liberati et al., 2009; Woodward & Willoughby, 2014). The categories included in this chapter from previous studies include the following: *Participant Information, Population Label*, *Participant Recruitment, Consent Procedures, Treatment*, *Treatment Type, Treatment Beneficiaries, Targeted aspect of change*, *Treatment Goal, Sample-Specific Goal, Research Design/Measurement*, *Outcomes,* and *Recommendations* (King et al., 2007; Woodward & Willoughby, 2014). The authors included additional categories they viewed

as important in understanding the counseling and psychotherapy experiences of LGBTQ youth. These categories include the following: *Participant Recruitment, Consent Procedures,* and *Treatment Beneficiaries.* The researchers used inductive coding within each category by reviewing the articles and generating codes that represented the included data (Nastasi, 2009). The codes are depicted in chronological order in *Table 1.3* while *Table 1.4* depicts each code's frequency.

Publication year. *Publication year,* references the year each source was published. The articles are presented in chronological order in *Table 1.3* (inductive-deductive coding) and *Table 1.6* (descriptive analysis).

Participant information. The *participant information* category refers to how the study described participants. Included in the participant information categories are *Population Label, Participant Age Range,* and *Sample Size.*

Population label. The *population label* category refers to how the study labels the recipients of treatment (e.g., LGBT youth). In *Table 1.3* and *Table 1.4*, Population labels were coded with the following codes: H = Homosexual, P = a pathological reference found in the DSM (e.g., Gender Identity Disorder, Gender Dysphoria), LGBTQ = When participants are referenced with terms including Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning, GN = Gender nonconforming, or MR = when Multiple labels were used (e.g., LGBT and ethnicity). Note that "Homosexual" was not included within the "pathological" code because it was removed from the DSM, but at one point was considered a pathological label (APA, 2013).

Participant age range. *Participant age range* was reported as the range in ages or school grades (e.g., 8th grade) of the participants in the study. When age ranges were unspecified but studies explicitly stated participants were high school aged, the code HS was applied.

Sample size. The *sample size* was reported as the total number of participants receiving an intervention in each study.

Participant Recruitment. Participant recruitment refers to how participants became involved in the study. Participant recruitment included the following codes: ITP = In prescribed treatment (where the psychologist discussed a completed counseling or psychotherapy case where the client was placed in therapy by a parent or others), ITV = In treatment voluntarily (where the psychologist discussed a completed counseling or psychotherapy case where the client was already seeing the clinician voluntarily or by their own choosing), CI = Convenience sample (where participants are located where the study is taking place, such as in school, but they are not actively involved in therapy prior to the study's implementation), CA = Commercial advertisement (e.g., flyers, brochures, advertisements, commercials), and S = Snowballing (when people in a study refer other people to participate in the same study).

Consent Procedures. Consent procedures refer to the consent practices used by each study. Consent procedures were analyzed via the following codes: IP = In Loco Parentis (youth advocates, allies to the LGBTQ community sign a form in lieu of parent consent acknowledging adult awareness of participation), WC = Waived consent (parental consent not required and alternative procedures not specified), PC = Parental consent (parent/guardian consent required for youth to participate), and NA = Not Addressed (consent procedures not discussed).

Treatment. The treatment category references characteristics of the overall treatment. Included in the Treatment category are *Treatment Type* and *Beneficiaries*.

Treatment type. The category, *treatment type*, refers to how the studies label the type and subtypes of therapy, counseling or psychotherapy being provided. The codes are titled with the same discourse used by the studies, but the researchers also operationalized each code to clarify their meaning. The treatment types were analyzed via the following codes *Table 1.3* and *Table 1.4:* BM= Behavior modification (altering behavioral patterns via techniques such as biofeedback and positive/negative reinforcement), P= Psychoanalysis/Psychodynamic (therapy techniques that call on interactions between the conscious and unconscious elements of the mind to evoke change), PE= Psychoeducational (inclusion of teaching components in treatment aimed at empowering clients and their families), C= Counseling (general, unspecified type), MI= Milieu (therapeutic community with whom clients receive therapy), ME= Medicinal (when medicine was used as a part of treatment), A= Affirmative (promoting acceptance of self rather than changing one's identity to Heterosexual or Cisgender and not diminishing their identity), SB= Strength based (promoting awareness and fostering of one's strengths), CI= Culture informed therapy (explicit modifications to treatment that make it culturally relevant to the client) , QT= Queer theory informed therapy (discussing gender and sexual orientation as normed social constructions), CC= Client centered (understanding and incorporating the client's world views, where they are actively involved in their treatment), CBT= Cognitive behavioral therapy (specific therapy used to challenge negative thoughts of self and the world to alter unwanted behaviors and/or thoughts), TGS= True gender self-therapy (views gender nonconforming as healthy; encourages parents to ask kids about gender and to foster their

identity), AB= Attachment based family therapy (relies on attachment theory and enforces secure attachment style for parents with their child, grounded in trust and empathy).

Beneficiaries. The category, *beneficiaries*, refers to which individuals or groups are targets of the treatment. This category was not included in *Table 1.6* as descriptive data since it was combined within *treatment goal*. *Beneficiaries* were parsed out into its own category in *Table 1.3* and *Table 1.4*. Researchers concluded that the Beneficiaries category was important information to include following their descriptive analysis that has not typically been presented in reviews on similar topics, so they developed inductive codes to explore this aspect of counseling and psychotherapy. In *Table 1.3*, these data were coded with the following codes: F= Family Involvement (when any family members is involved in the treatment plan), S= School Peers Involvement (when any peers from the school community are involved in the treatment plan), C= Community Involvement (when any community involvement outside of school settings are involved in the treatment plan), or AC= Adolescent client (when only the adolescent is involved in the treatment plan).

Targeted aspects of change. The categories within *targeted aspects of change* refer to what the studies aim to change for the LGBTQ youth. These categories include *Treatment Goals* and *Sample-Specific Goals.*

Treatment goals. The *treatment goals* category refers to what the treatment aims to change for the participant when it is implemented. *Treatment goals* was analyzed via the following codes: M= Mainstream to culture norms (goals of assimilating the client to normative culture by addressing their nonconformity); AI= Affirm Identity (goals of fostering acceptance of oneself in contrast to idealizing a Heterosexual or Cisgender ideal, not diminishing their identity), MO= Modify Environment (goals of changing aspects within the environment to

benefit LGBTQ youth); PE= Psychoeducate (goals of instilling knowledge or skills through explicitly stated psychoeducation), and O= Other (goals of treatment are unclear or not stated).

Sample-specific goals. The *sample-specific goals* category refers to each article's description of the symptomologies, diagnoses, cognitions, and/or behaviors unique to participants prior to and throughout treatment that would be addressed through therapy. The following codes were used to depict the trends in *sample-specific goals:* EB= Effeminate behaviors (goals of reducing traits that were considered more feminine by nature, in males), D= Drug Use (goals of eliminating or reducing drug and/or substance use), I= Internalizing concerns (goals of reducing the presence of internalizing concerns such as anxiety and depression), SE= Self Esteem (goals of improving one's self esteem or self-worth), S= Suicidal (goals of eliminating suicidal ideation, enactments of suicide, or suicide attempts), US= Unsafe Sex Behaviors (goals of reducing unprotected sex and improving safe sex habits), IH= Internalized Homophobia/Heterosexism (goals of addressing biases and judgments related to homophobia and heterosexism), FC= Family concerns (goals of reducing family related stressors), RP= Resilience Promotion (goals of increasing and strengthening one's ability to cope with potential stressors), and DR= Dropout (goals of preventing youth leaving school before graduating).

Research Design/Measurement. The category, *research design/measurement*, refers to each assessment that was used to evaluate change in the LGBTQ youth (e.g., qualitative interviewing, BASC social emotional measures). For inductive-deductive coding in *Table 1.3* and *Table 1.4*, the codes for *research design/measurement* included: CS= Case study (a therapist's descriptive recount of individual cases), QUAL= Qualitative (using only qualitative methodology or open ended answers), QUAN= Quantitative (using only quantitative methodology or measures/scales to depict the results), and MM= Mixed methods (using a

combination of qualitative and quantitative methods for research design). *Table 1.5a, 1.5b,* and *1.5c* also pertains to the research design/measurement category, and depicts the scales used in each quantitative study along with the operationalized terms that the scale aims to quantify and depict.

Outcomes. The *outcomes* category refers to the reported outcomes of the treatment. For the inductive-deductive coding process, in *Table 1.3* and *Table 1.4,* outcomes were analyzed with the following codes: CH= Change noted (findings only indicated change), NCH= No changes noted (findings only indicated no change), CH&NCH= a combined notation of changes outcomes (findings indicated a combination of detected change and no change in the client).

Recommendations. The *recommendations* category indicates what each study explicitly endorses as a result of implementation of their intervention. The inductive-deductive coding included the following codes: B= Behavior change (using operationalization, reinforcement, and punishment to foster Heterosexual lifestyle/behaviors), Ed= Education (calling for cultivating knowledge of the LGBTQ youth and/or others), Prev= Prevention (recommending prevention efforts, e.g., for HIV via safe sex), CS= Culture Specific Framework (encouraging modifications of therapeutic methods originally intended for use with normative culture to ensure relevance for the LGBTQ youth population), PP= Pop Culture (incorporating pop culture into therapy), PD= professional development (Urging therapists to seek professional development opportunities), R= Client/therapist relationship (Fostering and valuing the relationship between the client and therapist), SB= Strength-Based (Calling for a focus on what is going right in someone's life in therapy), Eco= Ecological Involvement (Incorporating parents, schools, GSA's etc. into therapy to promote a healthier environment for the LGBTQ youth), and CT= Continued therapy

(encouraging practitioners to not discontinue therapy following one coming out or transitioning as ongoing stressors may persist following these major events).

Data Collection

All included studies were imported and reviewed in an excel spreadsheet by a research team member. The same author conducted screening, eligibility, and inclusion steps in the PRISMA eligibility process. The devised inclusion and exclusion criteria from the section, *Screening: Setting limits; applying inclusion criteria* in the methods, were used to eliminate and include sources in the screening, eligibility, and inclusion phases (Liberati et al., 2009). A researcher developed the coding domains for the descriptive (*Table 1.6)* and coding analyses (*Table 1.3*) and reviewed them with the research team. Codes were reviewed by enacting the percentage agreement index. The researchers used an inter-rater reliability percent agreement index (Maggin et al., 2012) that was described in the *Eligibility: Reviewing full text* section to convey how well the coders agreed in each inductive-deductive coding domain. Percentage agreement indices were calculated for each code from T*able 1.3*, however indices were not applied to the open coding in *Table 1.6*. In the descriptive summary analyses (*Table 1.6*), researchers collaborated on each article for the summary table to ensure code operationalization accuracy, and used methods to obtain consensus (collaborated discussion, until consensus reached) for all articles (Larsson, 1993). For results in *Table 1.3*, researchers independently coded each article, compared their results to reach a percentage agreement index, and used consensus coding to address codes where disagreements occurred (Larsson, 1993). As a result, all coding presented in this study depict 100% agreement via collaboration between raters. An upcoming section (*Inductive-Deductive coding, Table 1.3*) discusses the achieved inter-rater reliability percent agreement index for the inductive-deductive coding.

Descriptive Analysis, *Table 1.6*. In descriptive analysis, the research team operationalized the following categories: *publication year, population label,* p*articipant age range*, s*ample size,* t*reatment type,* t*reatment beneficiaries, targeted aspect of change*, *treatment goal,* s*ample-specific goal,* r*esearch design/measurement*, *outcomes,* and *recommendations*. These categories definitions are located within the data collection section of the methods.

The research team enacted an iterative coding process (Miles & Huberman, 1994). An iterative coding process involves redefining open code definitions until both researchers' reported findings match based on their understanding of the code definition and what to report. Researchers collaborated following every article and implemented an iterative process of editing the codebook and reassessing their coding (Miles & Huberman, 1994). After completing this process with each article, researchers independently provided summaries for each descriptive code and collaborated to achieve consensus in the reported codes (Larsson, 1993; Miles & Huberman, 1994).

Coding, *Table 1.3*. The coding scheme developed out of the descriptive analysis in *Table 1.6* (Nastasi, 2009). The findings from the descriptive analysis were reviewed and developed into a coding scheme based content within each article and based on how findings have been presented in articles with similar content (e.g., King et al., 2007; Woodward & Willoughby, 2014). Open codes, (distinct concepts or categories) were operationalized by the research team (Miles & Huberman, 1994). The researchers applied the codes to the first five articles to assess the quality of the codebook. In applying the codebook, researchers consulted the summarized findings in *Table 1.6*, and then consulted the original article if more information was needed. The codes were revised for clarification purposes using an iterative coding process (Miles & Huberman, 1994). No changes in the codebook were noted after reviewing the fifth article. Once

the codebook was clarified, the research team independently coded all articles but compared their results after completing their independent coding of each source. When comparing their independent coding, percentage agreement indices were attained where each article was designated as an opportunity to match within each code. Given that some codes could have multiple codes that applied (e.g., a treatment goal could include modifying the environment and psychoeducating the clients), the research team needed to report the same combination of codes for each article to be considered a unit of match within the percentage agreement index. There were a total of 15 opportunities to match within each code as there were 15 studies included in this review. Researchers set the coding threshold of 80%, based on standards assigned by Bakeman and Gottman (1987) meaning if they reached at least 80% in their percentage agreement index for each unit described above, they could continue independently coding. If the researchers demonstrated a percentage agreement index below 80%, they would review the next article together to ensure sufficient codebook development. They compared their results and yielded the following percent agreement indices for each code: *Study Type* (100%), *Recruitment Type* (100%), *Consent Procedures* (100%), *Population Label* (93%), *Participant Age Range* (100%), *Treatment Type* (86%), *Treatment Beneficiaries* (93%), *Treatment Goal* (93%), *Sample-Specific Goal (86%), Research Design/Measurement* (100%), *Outcomes* (86%) and *Recommendations* (80%).

Results

The results of this study are structured to inform the research questions that guide this investigation (e.g., what counseling and psychotherapy methods have been practiced over time, what consent and recruitment procedure have been used over time, how have they been measured over time, what studies yielded change in their clients over time, and what

recommendations have been provided for treating LGBTQ youth over time). Findings present each category, their definition, the codes within them, the codes' frequency, along with the year and context in which the codes occur. *Table 1.3* uses the first column to depict the categories discussed in the results. The first row in the table depicts the article number that corresponds to each source, found in *Table 1.1*. The second row of *Table 1.3* lists the publication year of each article. Articles in this review are presented in the chronological order in which they were published to underscore the "over time" aspect of all research questions. Each column after the first depicts the findings of each code relevant to each study. *Table 1.2* depicts each acronym with the full words they represent in the coding tables. *Table 1.4* depicts the frequency count of each code. The first column of *Table 1.4* depicts each category reviewed in the results. Within each row, codes and their frequencies are provided.

Table 1.1 *Study citations and their corresponding article number found in Table 1.2.*

Article Number	Article Citation
1	McKinlay, Kelly, Patterson, 1978
2	Gonzalez, 1979
3	Uribe & Harbeck, 1992
4	Remafedi, 1994
5	Babinski & Reyes, 1994
6	Stone, 1999
7	Nyulund, 2007
8	Wynn & West-Olatunji, 2008
9	Duarté Vélez, Bernal, Bonilla, 2010
10	Craig, 2012
11	Ehrensaft, 2013
12	Diamond, Diamond, Levy, Closs, Ladipo, Siqueland, 2013
13	Craig, Austin, McInroy, 2014
14	Harvey & Fish, 2015
15	Heck, 2015

Table 1.2 *Abbreviations from Table 1.3 & 1.4 and their corresponding terminology.*

For *Population Label*, H = Homosexual, P = a pathologized reference found in the DSM (e.g., gender identity disorder), LGBTQ = When participants are referenced with terms including Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning, GN = Gender Nonconforming, MR = Multiple labels used (e.g., LGBT and ethnicity).

For *Age Range*, ages ranges provided, or HS= high school age with specific age unspecified.

For *Recruitment*, ITP= In prescribed treatment, ITV= In treatment voluntarily, CS= Convenience Sample, CA= Commercial Advertisement, SN= Snowball effect

For *Consent Procedures*, WC= Waived consent, PC= Parental Consent, A= Assent, NA= Not available

For *Treatment Type*, BM= Behavior modification, P= Psychoanalysis/Psychodynamic, PE= Psycho-education, C= Counseling, MI= Milieu, ME= Medicinal, A= Affirmative, SB= Strength Based, CI= Culture informed therapy, QT= Queer culture informed therapy, CC= Client centered, CBT= Cognitive Behavioral Therapy, TGS= True Gender Self Therapy, AB= Attachment based family therapy.

For *Treatment Beneficiaries*, F= Family Involvement, S= School Involvement, C= Community Involvement, AC= Adolescent client.

For *Treatment Goals*, M= Mainstream to culture norms; AI= Affirm Identity, MO= Modify Environment; PE= Psycho-educate, O= Other.

For *Sample Specific Goals*, EB= Effeminate behaviors, D= Drug Use, I= Internalizing concerns, SE= Self Esteem, S= Suicidal, US= Unsafe Sex Behaviors, IH= Internalized Homophobia/Heterosexism, FC= Family concerns, RP= Resilience Promotion, DR= Dropout.

For *Research Design/Measurement*, CS= Case Study, QUAL= Qualitative, QUAN= Quantitative, MM= Mixed methods.

For *Outcomes*, CH= Change noted, NCH= No change noted, CH&NCH= combination of change and no change noted.

For *Recommendations*: BM= Behavior modification, Ed= Education, Prev= Prevention, CS= Culture Specific Framework, PP= Pop Culture, PD= professional development, R= Client/therapist relationship, SB= Strength-Based, Eco= Incorporate parents, schools, GSA’s etc. into therapy, CT= Continued therapy.

The following codes in *Tables 1.3* and *1.4* were provided to address the first research question (What counseling and psychotherapy practices documented in research have been implemented with LGBT youth and how have they evolved over time?): *population label, age range, sample size, treatment type, beneficiaries, treatment goal, sample-specific goals.* These codes inform the sample and treatment characteristics provided. Research question two (What recruitment and consent procedures have studies implementing counseling and psychotherapy used when treating LGBTQ youth clients and how have these practices changed over time?) was answered via the codes: *recruitment* and *consent procedure*. Research question three (How have studies that use counseling and psychotherapy with LGBTQ youths' described research designs and measurement strategies used and how have research designs and measurement changed over time?) was addressed by the following code: *research design/measurement.* The fourth research question (What counseling and psychology provisions were depicted as evoking significant change in their clients, and how have reports of significant change evolved over time?) was addressed by the code: *outcomes.* The fifth research question (What recommendations were made to inform how counseling and psychotherapy provisions could yield the most effective experiences for LGBTQ youth clients?) was addressed by the code: *recommendations.* P*ublication year* was documented to account for *change over time*.

Table 1.3 *Chronological Inductive-Deductive Coding Results*.

Codes	Articles														
Article Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Publication Year	1978	1979	1992	1994	1994	1999	2007	2008	2010	2012	2013	2013	2014	2015	2015
Participants															
Population Label	H	H	LGBTQ	LGBTQ	P	LGBTQ	LGBTQ	MR	MR	MR	GN/P	LGBTQ	MR	LGBTQ	LGBTQ
Age Range	17	15	HS	13-21	19	18	17	18	16	14-18	10	14-18	13-20	15-18	HS
Sample size	1	1	S1: 50 S2: 342	139	1	1	1	1	1	162	1	10	263	2	10
Recruitment	ITP	ITV	CS/SN/CA	CA/SN	ITP	ITV	ITP	ITV	ITP/CS	ITV/CS	ITP	CS	CS	ITP	CS
Consent Procedures	NA	NA	NA	WC/A	NA	NA	NA	NA	NA	NA	NA	PC/A	PC/A	NA	WC/A
Treatment															
Treatment Type	BM	P	C/PE	C/PE	ME/BM/MI	P	CI/QT	CI/CC	CBT/CI	SB	TGS	AB	A	SB	CBT/PE
Beneficiaries	AC	AC	AC/S/C	AC	AC	AC	AC	AC	AC	AC	AC	AC/F	S/AC	F/AC	AC
Targeted Aspects of Change															
Treatment Goal	M	O	PE/MO	PE	M	AI	AI	AI	AI	AI	AI	AI/MO	AI	AI	AI
Sample-Specific Goals	EB	D/I/IH/FC	SE/S/D/I/RP/DR	D/US	S/I/EB	IH	SE/IH/RP	I/IH/FC/RP	I/IH/FC	FC/I/RP	I/RP	S/I/FC/RP	RP	FC/IH/RP	RP/I/IH
Research Design/ Measurement	CS	CS	QUAL	MM	CS	CS	CS	CS	QUAN	MM	CS	QUAN	QUAN	CS	MM
Outcomes	CH	NCH	CH&NCH	CH	NCH	CH	CH	CH	CH&NCH	-	CH	CH&NCH	CH&NCH	CH	CH&NCH
Recommendations	BM	--	ED/PREV	CS/PREV	CT	--	PP	ED/PD	CS/R	R/SB	CT	ECO	ECO/CS	ECO/R	ECO

Note. See Table 1.2 for a corresponding list of words to the abbreviations in Table 1.3 and 1.4.

Table 1.4. *Frequency Count of Inductive-Deductive Coding*

Publication Year	1970-1979	1989-1989	1990-1999	2000-2009	2010-2015									
(n)	(2)	(0)	(4)	(2)	(7)									
Population Label	P	H	GN	LGBTQ	MR									
(n)	(2)	(2)	(1)	(7)	(4)									
Age Range	10	13	14	15	16	17	18	19	20	21	HS			
(n)	(1)	(2)	(4)	(6)	(6)	(7)	(7)	(3)	(2)	(1)	(2)			
Sample Size	1	2	10	>150										
(n)	(8)	(1)	(2)	(4)										
Recruitment	ITP	ITV	CS	SN	CA									
(n)	(6)	(4)	(6)	(2)	(6)									
Consent Procedures	NA	PC	WC	A										
(n)	(11)	(2)	(2)	(4)										
Treatment Type	A	AB	BM	C	CBT	CC	CI	P	PE	MI	ME	QT	SB	TGS
(n)	(1)	(1)	(2)	(2)	(2)	(1)	(3)	(2)	(3)	(1)	(1)	(1)	(2)	(1)
Treatment Beneficiaries	AC	C	F	S										
(n)	(15)	(1)	(2)	(2)										
Treatment Goal	AI	M	MO	O	PE									
(n)	(10)	(2)	(2)	(1)	(2)									
Sample Specific Goals	RP	D	DR	EB	FC	I	IH	S	SE	US				
(n)	(9)	(3)	(1)	(2)	(5)	(9)	(7)	(3)	(2)	(1)				
Research Design/ Measurement	CS	MM	QUAL	QUAN										
(n)	(8)	(3)	(1)	(3)										
Outcomes	CH	CH&NCH	NCH											
(n)	(8)	(5)	(2)											
Recommendations	BM	CT	CS	ECO	ED	PP	PD	PREV	R	SB				
(n)	(1)	(2)	(2)	(4)	(2)	(1)	(1)	(2)	(3)	(1)				

Publication Year.

Search limits were set from 1900-present day. The first included article within this search appeared in 1978. Of the 15 included sources, two articles reported on counseling and psychotherapy in the 1970's (*n* = 2; 13%), with no sources identified in the 1980's. Documentation of counseling and psychotherapy with LGBTQ youth was present in the 1990's (*n* = 4; 27%), 2000's (*n* = 2; 13%) and the 2010's (*n* = 7; 47%). The initial presence of studies in the 1970's could relate to the greater attention to Homosexuality's removal from the DSM while the greatest frequency of studies in the 2010's could speak to the acceptance of the LGBTQ youth and their need for mental health services (Office of Surgeon General, 2001).

Through the remaining results, codes will be discussed by the decades in which they occurred. To convey each code's prevalence by decade, frequency counts will be reported as (*n* = *a* of b), where *a* denotes the number of studies indicating that code in the stated decade, and where b indicates the total number of studies included in this review from that decade. The following seven codes will address the first research question: *what counseling and psychotherapy practices documented in research have been implemented with LGBT youth and how have they evolved over time?*

Participant Information

Population label. Population label refers to the terms used in articles to denote the population of interest being studied. The *Pathological* code (*n* = 2) appeared once in the 1990's as Gender Identity Disorder (Babinski & Reyes, 1994) and once in the 2010's. The later study used the non-pathological label, "Gender Nonconforming youth", but also referenced "the gender dysphoric child", which is currently in the DSM-5 (Ehrensaft, 2013; APA, 2013). The code, *Homosexual* (*n* = 2), was referenced only in the 1970's. A majority of studies (*n* = 7)

referenced the population they serve as *Lesbian, Gay Bisexual, Transgender and/or Queer (LGBTQ)*. This label appeared in the 1990's (*n* = 3 of 4), 2000's (*n* = 1 of 2) and 2010's (*n* = 3 of 7). Furthermore, some studies applied *multiple label use* (*n* = 4), where participants were labeled with their sexual orientation or gender identity, and with an additional identity characteristic such as their ethnicity (e.g., "multiethnic sexual minority"). *Multiple label use* was first referenced in 2008, with the remaining three references appearing in the 2010's. Since 2000, researchers (*n* = 8 of 9) have used population labels (e.g., multiple label use or LGBTQ) that are less laden with pathology while studies with publication years closer to Homosexuality's removal from the DSM in the 1970's may use more pathological terms for the participant label.

Age range. The age range code conveys how studies have historically conceptualized "LGBTQ youth" in terms of age. Some studies (*n* = 2) discussed youth as being high school aged, while others provided actual age ranges (*n* = 5). Studies that reported age ranges (*n* = 4 of 5) were from the 2010's and the 1990's (*n* = 1 of 2) (Remafedi, 1994). The span of LGBTQ youth participant age ranges across all studies included ages from 10-21 years.

Sample size. Several studies had a single participant design (*n* = 8). Single case design, included case studies (descriptive analyses of a single client in therapy, based on the perspective of the researcher) and approaches like applied behavior analysis with one participant. These studies were present in the 1970's (n = 2 of 2), the 1990's (n = 2 of 4), the 2000's (n = 2 of 2), and in the 2010's (n = 2 of 7). Harvey and Fish, (2015) had two participants while other studies contained larger sample sizes (*n* = 6). Larger sample sizes ranged from 10 participants to 392. These studies were documented in the 1990's (n = 2 of 4) and the 2010's (n = 4 of 7). Studies with larger sample sizes may appear more frequently in the 1990's and 2010's as demands for advanced quantitative methodology grow among the research community.

Treatment Information

Treatment type. Eight studies used a single treatment type (*n* = 8), while the remaining studies (*n* = 7) used a combination of treatments to inform their counseling and psychotherapy approach. Additional treatment types that are not counseling and psychotherapy (e.g., medicinal and psychoeducation) were included, to inform what services are provided in tandem. Behavior modification (n = 2) was present in the 1970's (*n* = 1 of 2) and 1990's (*n* = 1 of 4), which aimed to decrease effeminate behaviors associated with Homosexuality or Gender Nonconforming individuals (Babinski & Reyes, 1994; McKinlay, Kelly, Patterson, 1978). Studies used psychodynamic/psychoanalysis (*n* = 2) in the 1970's (*n* = 1 of 2) and 1990's (*n* = 1 of 4), (Gonzalez, 1979; Stone, 1999) where therapists related client self-report to their subconscious desire for same sex relations. One study combined behavior modification with milieu and medicinal treatments to control his aggressive behaviors (which included "homosexually acting out") (Babinski & Reyes, 1994).

Psychoeducation (*n* = 3) was present in the 1990's (*n* = 2 of 3) and focused on HIV prevention of LGBTQ clients, while promoting education and community settings to amend their discrimination-based perspectives on LGBTQ issues. Both of these studies also used counseling, with specific techniques unspecified (*n* = 2) as a combined provision of counseling/psychotherapy (Uribe & Harbeck, 1992; Remafedi, 1994). The most recent study that incorporated psychoeducation aimed to equip LGBTQ youth with coping skills to manage their experiences of marginalization (Heck, 2015).

Several studies exhibited culture focused and affirmative methods (*n = 9)*, with prevalence in the 2000's (*n* = 2 of 2) and 2010's (*n* = 7 of 7). These studies exhibited the following treatment types: attachment based family therapy (*n* = 1), affirmative approach (*n* = 1),

client centered ($n = 1$), cognitive behavioral therapy ($n = 2$), culture informed therapy ($n = 3$), strength-based ($n = 2$), queer culture informed therapy ($n = 1$), and true gender self-therapy ($n = 1$). A study exhibiting attachment based family therapy worked with LGBTQ youth and their families to understand their family dynamics (Diamond et al., 2013). Youth were taught to have limits with their parents (e.g., knowing when to walk away to avoid overwhelming stress), while remaining empathetic to their parents' needs (e.g., learning the coming out process is significant for parents and to give them time to adjust). Parents were conversely informed about coming out and how to be supportive of their child.

Culture-specific counseling and psychotherapy treatments (e.g., culture informed therapy, true gender self-therapy, queer culture informed therapy, and client centered) aimed to address the culture specific needs of LGBTQ youth clients that may be overlooked in typical therapy (Wynn & West-Olatunji, 2008). One study used culture informed therapy and a client centered framework to foster the client's values and norms and to accentuate interconnectedness, cultural awareness, and authenticity (Wynn & West-Olatunji, 2008). Nyland's (2007) study used queer culture informed therapy and asked clients to identify a pop culture/fictional icon as a role model to help clients make meaning and take action in their own lives. True Gender Self Therapy was used by Ehrensaft (2013) to address stressors related to client body changes, to affirm their present gender identity, and to build coping strategies. True Gender Self Therapy made a point of keeping clients in therapy after their gender transition, to help them cope with unanticipated stressors associated with this part of the developmental process.

The treatment types, *affirmative* ($n = 1$; 1 of 7) and *strength based* ($n = 2$; 2 of 7) were present in the 2010's. Affirmative and strength based treatment types aimed to validate LGBTQ youth clients' identities as LGBTQ and focus on the positive aspects of themselves, respectively.

Craig, Austin, and McInroy, (2014) used affirmative treatment with multiethnic sexual minority youth who were taught resilience tools to manage unsupportive environments given their likely exposure to marginalizing experiences. Harvey and Fish (2015) conducted a strength-based study where youth cultivated their personality, resilience, and resource strengths to promote their self-worth. This practice aimed to lessen effects of their exposure to oppression.

Cognitive behavioral therapy (CBT) was present in the 2010's (*n* = 2; 2 of 7). CBT aimed to amend negative views based on experiences of rejection, negative societal views, and identity struggles (e.g., concealing who participants were). Cognitive tools helped reframe how participants perceived stressors, while not changing their sexual orientation or gender identity.

Within the context of this review, both studies attempting to modify participants' behaviors occurred in the 1970's and 1990's, while nine out of nine studies exhibiting culturally responsive practice occurred in the 2000's and onward. LaSala (2013) and the Office of the Surgeon General (2001) noted an American societal shift towards acceptance of the LGBTQ community, which could relate to the later presence of these studies in the review.

Treatment beneficiaries. The code, treatment beneficiaries informs who actively engaged in counseling and psychotherapy as clients over time. All studies (*n* = 15) provided counseling and psychotherapy to the primary client (the LGBTQ youth); however, several studies also incorporated family members (*n* = 2), the community (*n* = 1), and the LGBTQ youths' schools (*n* = 2). Uribe and Harbeck (1992) reported findings on educating the public about LGBTQ youth to promote awareness among community and school environments in the 1990's. The remaining studies with additional beneficiaries (e.g., family members, community, and schools) were documented in the 2010's (*n* = 3; 3 of 7).

School involvement in counseling and psychotherapy served to develop their acceptability and sensitivity to LGB issues (Uribe & Harbeck, 1992). Uribe & Harbeck (1992) implemented Project 10, a counseling program aimed to influence the discriminatory perceptions of communities and schools. The community was involved in this study via publicity about the intervention. They were educated with brochures in community, articles in the newspaper (The Los Angeles Times), and media coverage on television. Content of the coverage was related to the intervention being implemented in a school setting. Project 10 attempted to break through the "wall of silence" with LGB issues to normalize views of LGB culture (Uribe & Harbeck, 1992, pg. 19). School involvement included: training teachers, administrators, and counselors how to administer the intervention and how to address discrimination. Students were directly involved via discussions in health classes, and by watching the documentary "What if I'm Gay" (Uribe & Harbeck, 1992, pg. 24). These activities fostered acceptance and understanding.

Families were involved to reconcile their beliefs about their child's sexual orientation (or gender identity), their own religious influences, their own fears, family rejection due to others' disappointment in their child, and concerns about their child's welfare (Diamond et al., 2013). Counseling occurred alone with parents, to allow candid discussion about their shame, fear and anger. One study described family (particularly parents) inclusion in one-on-one counseling/psychotherapy using attachment-based family therapy as a way to develop empathy and support of their children (Diamond et al., 2013). Studies that involved only the adolescent as the client in counseling or psychotherapy were present in the 1970's (n = 2 of 2), the 1990's (n = 3 of 4), the 2000's (n = 2 of 2) and the 2010's (n = 4 of 7). While client only sessions appear throughout the decades of included articles, a majority of studies in this review with additional beneficiaries occurred in the 2010. This finding could refer to LaSala's (2013) indication of

societal acceptance of the LGBTQ community, and could represent the accepting modern perspective of incorporating others (e.g., family) in counseling and psychotherapy rather than assuming 'problems' are only within the LGBTQ client.

Treatment Targeted Aspects of Change

Treatment goal. Treatment goals were documented to understand the objectives of counseling and psychotherapy for their LGBTQ youth clients and how these goals have changed over time. Two studies documented goals of mainstreaming (*n* = 2) clients to normative culture and away from their Heterosexual tendencies. Techniques used to achieve mainstreaming included modeling masculine (gender appropriate) behaviors, providing videotaped feedback, and repetitive rehearsal (behavior modification techniques) (McKinlay et al., 1978). Babinski and Reyes (1994) implemented mainstreaming goals in a hospital setting. These studies appeared in the 1970's (*n* = 1 of 2) and the 1990's (*n* = 1 of 4).

Psychoeducation was described as a treatment goal (*n* = 2) in the 1990's (*n* = 2 of 4). Psychoeducation goals served to inform LGBTQ youth about combating feelings of inadequacy or how to manage self-destructive behaviors. Community settings benefited from psychoeducation goals, which aimed to directly lessen perceptions of discrimination towards the LGBTQ community and to indirectly develop a more positive social climate for LGBTQ youth (Uribe & Harbeck, 1992).

Each study from 1999 onward had goals of affirming LGBTQ youths' identities (*n* = 10; 1990's *n* = 1 of 4; 2000's *n* = 2 of 2; 2010's *n* = 7 of 7). Affirming identities refers to encouraging youth to work through issues, while promoting acceptance and pride in their

LGBTQ identity. The goal, modifying LGBTQ youth's environment (*n* = 2) co-occurred with other treatment goals (e.g., mainstreaming or affirm identity) when it was reported in the review.

One study had a treatment goal, "other" and was only present in the 1970's (*n* = 1 of 2) (Gonzalez, 1979). The study's primary purpose was to address the client's psychosis, however, addressing their sexual orientation through therapy was a targeted behavior as well. The presence of affirmative studies in more recent years within this review could align with the acceptance and normalization of LGBTQ culture in society, while goals of mainstreaming clients toward normative culture demands was present in studies from the 1970's and 1990's could relate to the labeling of "homosexuality" as a disorder by the DSM until the early 1970's, the marginalization of LGBTQ community with the HIV/AIDS epidemic, and the lacing acceptance of the LGBTQ community at during these decades.

Sample-specific goals. Sample specific goals depict how studies described participants' presenting concerns and how they changed over time. Counseling and psychotherapy were most frequently sought to remediate internalizing concerns (*n* = 9) and to foster resilience (*n* = 9). Studies also conveyed clients as presenting with internalized homophobia/heterosexism (*n* = 7), family concerns (*n* = 6), drug use (*n* = 3), suicidal actions or thoughts (*n* = 3), effeminate behaviors (*n* = 2), self-esteem (*n* = 2), unsafe sex behaviors (*n* = 1), and dropout risk (*n* = 1).

Of the discussed sample specific goals, addressing effeminate behaviors appeared in the 1970's (*n* = 1 of 2) and 1990's (*n* = 1 of 4) (Babinski & Reyes, 1994; McKinlay et al., 1978), while family concerns (fc) and resilience (rp) appeared in the 2000's (FC *n* = 1 of 2; RP *n* = 2 of 2) and 2010's (FC *n* = 4 of 7; RP *n* = 6 of 7). Family concern refers to worrying about a client's identity, or struggling with values that perceive homosexuality as sinful (Duarté-Vélez, Bernal,

& Bonilla, 2010). Sample specific goals of resilience were addressed by working on problem solving and developing coping skills (Craig et al., 2014). Resilience was discussed as a preventative tool, for situations that had not yet occurred, and as an intervening mechanism for situations that have already transpired.

Internalized homophobia and internalizing concerns was documented in each decade. Internalized homophobia frequencies include: 1970's (n = 1 of 2), 1990's (n = 1 of 4), 2000's (n = 2 of 2), 2010's (n = 3 of 7); and internalizing concerns frequencies include the following: 1970's (n = 1 of 2), 1990's (n = 2 of 4), 2000's (n = 1 of 2), 2010's (n = 5 of 7). Articles from the 1970's and 1990's tended to discuss participants' internalized homophobia or internalized concerns (n = 4 of 6) as mental illness due to sexual orientation and gender identity (e.g., Babinski & Reyes, 1994; Gonzalez, 1979; McKinlay, Kelly, Patterson, 1978). Conversely, a study from the 2010's (Diamond et al., 2013, p. 98) discussed how treating internalizing concerns via attachment based family therapy was thought to change parent's parenting techniques to be more supportive of their youth, as LGBTQ youth's internalizing concerns were related to stress from their parents.

Among the included articles in this study, addressing effeminate concerns appeared in articles from earlier decades, where stigmatization around 'being more manly' was the ideal and effeminate men were viewed as deviant (LaSala, 2013). Targeting family concerns and resilience in the 2000's and 2010's could relate to the acceptance agenda around LGBT youth where families are incorporated into therapy to learn to accept their LGBTQ youth member. Resilience could relate to societal trends of strength based empowerment of the LGBTQ community rather than blaming them for their identity.

Participant Recruitment

The participant recruitment category and the consent procedures category answer research question two: What recruitment and consent procedures have studies implementing counseling and psychotherapy used when treating LGBTQ youth clients and how have these practices changed over time? A total of ten studies reported recruiting youth from therapy where the authors of the articles were the therapists discussing their sessions and findings. The youth in these treatments received counseling and psychotherapy voluntarily ($n = 6$) or by prescription from someone else (e.g., parents) ($n = 4$). Voluntariness was interpreted when therapists would note that a client "came to see me of his own volition" or when indication of free will was involved in their counseling and psychotherapy participation (Gonzalez, 1979, pg. 64). Prescribed treatment referred to when youth attended therapy involuntarily, per the demand of someone else such as a parent (e.g., Babinski & Reyes, 1994; McKinlay, Jelly, & Patterson, 1978) or when parents would initiate their therapy (e.g., Ehrensaft, 2013). Youth who were in treatment voluntarily appeared in articles from the 1970's ($n = 1$ of 2), 1990's ($n = 1$ of 4), 2000's ($n = 1$ of 2), and 2010's ($n = 1$ of 7). Also, youth were in prescribed treatment for articles from the 1970's ($n = 1$ of 2), 1990's ($n = 1$ of 4), 2000's ($n = 1$ of 2), and 2010's ($n = 3$ of 7). Youth's voluntary or involuntary inclusion in counseling and/or psychotherapy appears without patterns over the decades. This could indicate youth continue attending counseling and/or psychotherapy both voluntarily and involuntarily.

Convenience sample recruitment methods were implemented ($n = 6$) in the 1990's ($n = 1$ of 4) and the 2010's (n= 5 of 7). Convenience samples were attained from schools' GSAs (e.g., Heck, 2015) or students within a school piloting a counseling and psychotherapy program (Uribe & Harbeck, 1992). Snowball recruitment techniques were implemented ($n = 2$) in the 1990's ($n =$

2 of 4) where participants recommended therapy to others (e.g., Remadfedi, 1994). Commercial advertisement (*n* = 2) occurred in the 1990's (*n* = 2 of 4) where newspaper articles and commercials garnered interest from the community (Uribe & Harbeck, 1992). Presence of media recruitment in the 1990's could relate to media coverage related to the HIV/AIDS epidemic of this time, while convenience samples occurring in most of the documented articles from the 2010's could relate to further developments in ways to recruit LGBTQ youth in ways limiting potential outing or disclosing of their identity. Limited discussion in articles was provided to inform how the specific recruitment methods were enacted.

Consent Procedures

Consent procedures were often not discussed or available in articles (*n* = 11). Four articles discussed consent procedures. These four articles indicated using assent procedures with youth participants (*n* = 4) and appeared concurrently with either parental consent (*n* = 2) or waived consent (*n* = 2) procedures. Articles that mentioned implementing waived consent and assent procedures occurred in the 1990's (*n* = 1 of 4) and the 2010's (*n* = 1 of 7). Parental consent and assent procedures appeared in the 2010's (*n* = 2 of 7). None of the articles specified using in loco parentis, where a youth advocate or adult ally to the LGBTQ community signed a form in lieu of parent consent. Details around the procedures of waived consent were limited and indicated "parent consent was not required" (Remafedi, 1994).

Research Design/Measurement

Research design and measurement was reported to convey the methodology used to track and report progress of clients in counseling/psychotherapy over time, and was the single category used to depict research question three: How have studies that use counseling and psychotherapy with LGBTQ youths' described research designs and measurement strategies used and how have

research designs and measurement changed over time? The most frequent methodology used to track clients' progress was via *case study* where therapists' enacted their own descriptive narrative of progress (*n* = 8) based on their perceptions. While a case study is a can be a type of qualitative data, it was differentiated as its own research design category to note its vast representation among the included studies. This was followed by *quantitative methods* where scales and statistics were identified units of data analysis (*n* = 3), *mixed methods*, the combination of qualitative and quantitative methods (measures/scales and statistics) (*n* = 3), and *qualitative methods* (*n* = 1), where participants were asked open-ended questions in surveys and interviews where data enlisted analyses beyond a descriptive narrative account. Case study methodology was documented through all decades, while a majority of articles (*n* = 5 of 7) with more empirical results (e.g., qualitative, quantitative, and mixed methodologies) appeared in the 1990's (*n* = 2 of 4) and 2010's (*n* = 5 of 7). The later presence of qualitative, quantitative, and mixed methodologies articles in this review could be due to increasing research standards and rigor as these methods incorporate more rigorous methodology.

Quantitative methods were used to track change in participants, therapists' perspectives, and parents' well being. These changes were documented via measures, which are included in *Tables 1.5a, 1.5b,* and *1.5c*. These tables include the operationalized constructs that were assessed and the corresponding scales used to measure the constructs' change. Qualitative analyses were often gathered via interviews and surveys with closed and open-ended questions. The questions aimed to understand LGB youths' experiences, problems and attitudes related to school settings (Uribe & Harbeck, 1992), their experiences related to physical/domestic abuse and home life (Craig, 2012), and to attain feedback about an implemented intervention

curriculum (Heck, 2015). The methods for analyzing qualitative data were often not included in the articles.

Table 1.5a. *Operationalized constructs and the corresponding scales to measure change for LGBTQ youth*

Construct	Scale (Source)
AIDS Knowledge and Risk Susceptibility	AIDS knowledge questionnaire (DiClemente, Zorn, Temoshok, 1986)
Attachment patterns to parent, romantic partner and best friend	The Relationship Structures Questionnaire RSQ (Fraley, Heffernan, Vicary, & Brumbaugh, 2011)
Depression	Children's Depression Inventory (Kovacs, 1992)
Depressive symptoms	Beck Depression Inventory-II. The BDI-II (Beck, Steer, & Brown, 1996)
Dysfunctional Attitude	Dysfunctional Attitude Scale (Weissman, 1979)
Personal competence with stressful situations	Proactive Coping Inventory (Greenglass et al., 1999)
Program Acceptability	Adapted Helpfulness Questionnaire (Beardslee, 1990)
Self-Esteem	Rosenberg Self-Esteem Scale (Rosenberg, 1965)
Self-Concept	Pier-Harris Children's Self Concept Scale (Piers & Herzberg, 2002)
Social connectedness/closeness in social relationships	Social Connectedness Scale (Lee & Robins, 1998)
Substance Use	Lifetime, annual, and quarterly substance use survey (Johnston, O'Malley, Bachman, 1988)
Suicidal Ideation	Suicidal Ideation Questionnaire-JR. The SIQ-JR (Reynolds, 1987)
Negative Criticism by Family and family Emotional involvement	Family Emotional Involvement and Criticism Scale (Shields, Franks, Harp, McDaniel, & Campbell, 1992)
Youth's perception of their alliance with psychotherapist	Psychotherapy Alliance Scale (Bernal, Padilla, Pérez-Prado, & Bonilla, 1999)

Table 1.5b. *Operationalized constructs and the corresponding scales to measure change for LGBTQ youths' psychotherapist*

Construct	Scale (Source)
Interviewer's perception of youth's depression severity	Child Depression Rating Scale Revised (Poznanski & Mokros, 1996)

Table 1.5c. *Operationalized constructs and the corresponding scales to measure change for LGBTQ youths' parents*

Parent's quality of relationship as a couple	Dyadic Adjustment Scale Dyads (Spanier, 1976)
Feelings of Burden	Burden of Illness Scale (Coyne et al., 1987)
Coping skills and perceived family harmony	Coping Skills and Family Harmony Scale (Rodríguez-Soto, Rivera-Medina, & Bernal, 2007)

Outcomes

The outcomes of studies were reported to inform research question four by identifying whether the interventions in studies yielded change, no change, or mixed outcomes (indicative of some aspects changing and others not) for participants; and to convey how these reports have changed over time. Many studies had self-reported findings by the therapist, where the discussed change comes from their perspectives. Studies noted change as occurring (*n* = 7), not occurring (*n* = 2), and as having mixed outcomes (with some change and no change reported) (*n* = 5). One study reporting no outcomes regarding the mental health gains made in their participants, but reported outcomes related to participants' satisfaction with the intervention components. Change was reported in the 1970's (*n* = 1 of 2), in the 1990's (*n* = 2 of 4), 2000's (*n* = 2 of 2), and in the 2010's (*n* = 2 of 7). No change was reported in the 1970's (*n* = 1 of 2) and 1990's (*n* = 1 of 4). While one study demonstrated mixed findings in the 1990's, the remaining mixed findings studies were documented in the 2010's (*n* = 4).

Of the 7 studies that noted change, a majority (*n* = 6) were case studies with therapist self-reported descriptive analysis as the methodology. A majority (*n* = 6) of these studies also had sample sizes of one or two LGBTQ clients. Conversely, most of the studies (*n* = 4) with

mixed findings used mixed methods, as well as qualitative and quantitative methodologies; and had greater sample sizes to denote statistical significance and saturation of qualitative data.

Recommendations

Recommendations were reported to answer research question five, to identify what practitioners and researchers should reportedly do when providing counseling and psychotherapy to LGBTQ youth. One study recommended using behavior modification (*n* = 1) in the 1970's (*n* = 1 of 2) to foster mainstream behaviors (e.g., more masculine behaviors for Gay men or consistent dress with one's gender designated at birth). Studies that called for a prevention framework (*n* = 2) occurred in the 1990's (*n* = 2 of 4). Both studies informed safe sex promotion around HIV and AIDS.

Some studies recommended educating LGBTQ youth about their identity and related risk factors (*n* = 2). These two studies occurred in the 1990's (*n* = 1 of 4) and the 2000's (*n* = 1 of 2). One study suggested incorporating pop culture into counseling and psychotherapy in the 2000's (*n* = 1 of 2). Other studies recommended continued therapy (*n* = 2), where practitioners and researchers were urged not to end treatment prematurely. Continued therapy appeared in a case study that focused on resolving psychosis in the 1990's (*n* = 1 of 4) and in a case study involving gender identity in the 2010's (*n* = 1 of 7) (Ehrensaft, 2013). Ehrensaft (2013) indicated treatment should not end immediately following the completion of one's gender transition as identity development and new, marginalizing experiences may come up that require processing. Babinski and Reyes, (1994) recommended continued therapy since their client was not responding to psychotherapy and continued showing symptoms of psychosis.

Studies also recommended enacting a culture specific framework (*n* = 3) in the 1990's (n = 1 of 4) and 2010's (n = 2 of 7). Studies called for interventions to address developmental and

social issues unique to LGBTQ youth (e.g., Remafedi, 1994) and due to youths' exposure to marginalization and discrimination (Duarté-Véle et al., 2010; Craig et al., 2014).

Several articles from the 2010's recommended incorporating others from the LGBTQ youths' environment into treatment (*n* = 4 of 7). Two studies recommended working with parents to help them accept their child's sexual orientation or gender identity, to educate them about their child's oppressed experiences, and to foster their support of their LGBTQ youth (Diamond et al., 2013; Harvey & Fish, 2015). The other studies suggested schools should foster accepting atmospheres for their LGBTQ students (Craig et al., 2014; Heck, 2015). Heck (2015) discussed GSA's as ideal places to offer LGBTQ youth services since they are considered safe spaces in schools to access services and find supportive relationships.

Studies that emphasized the importance of having a meaningful client/therapist relationship (*n* = 3) were identified in the 2010's (*n* = 3 of 7). Another study by Craig (2012) recommended enacting a strength-based approach in the 2010's (*n* = 1 of 7), where focusing on clients' strengths (e.g., hobbies, school performance, etc.) helps to build rapport and develop positive self perceptions.

In considering how these findings appear across time, recommendations for behavior modification were present in earlier studies of this review, and accord with the standards of marginalizing the LGBTQ community and favoring heterosexual lifestyles (LaSala, 2013). The studies that recommended educating LGBTQ youth about risk factors were present in the 1990's and 2000's, when HIV/AIDS intervention and prevention were prevalent conversations. Finally, recommendations to incorporate others into the LGBTQ youths' therapeutic experience (e.g., family) and for the LGBTQ youth to have meaningful relationships with their therapist calls on the societal acceptance of the LGBTQ community where the focus turned from changing the

LGBTQ youth client and towards altering their environment to better suit their mental health (LaSala, 2013).

Below is Table 1.6, which depicts the descriptive analysis of the included studies.

Table 1.6 *Descriptive Summary of Studies that implemented Counseling and Psychotherapy*

#	Citation *Study Type*	Participants	Treatment Type	Targeted Aspect of Change	Recruitment/ Consent/ Research Design/ Measurement	Outcomes/Recommendations
1	(McKinlay, Kelly, Patterson, 1978) *Case Study*	**Population Label** Male Homosexual adolescents **Participant Age Range** 17-year-old **Sample Size** N = 1	Behavior modification via role-playing, modeling, instruction, rehearsal, and videotaped feedback and/or reinforcement: Social skills training & Assertion training for homosexuals	**Treatment Goal** Enhance social adjustment and appropriate (assertive) social skills. This was the selected treatment, since the participant did not want to change or address his sexual preference. **Sample-Specific Goal** Targeted behaviors for training: • Poor eye contact • Absence of appropriate requests for others to change unreasonable behavior • Lack of firm refusal when confronted with unreasonable behavior Improve Overall: • Effeminate mannerisms • Lack of assertiveness in conflict situations • Interpersonal skills Client goal: improve social relationships	**Recruitment** In treatment, prescribed **Consent** N/A **Research Design/Measurement** • Role play scene ratings were used to report and track intervention progress with the following behavior observations: ○ Eye contact ○ Request for new behavior ○ Overall affect ○ Gestures ○ Average speech duration	**Outcomes** Most components were achieved and maintained at reasonably high levels. The client was able to generalize his learned skills. **Recommendations** Behavioral social skills training was recommended as a useful technique to enhance social adjustment of individuals demonstrating "homosexual preferences", given their "deficient repertoire of assertive skills" (McKinlay et al., 1978, p. 169)
2	(Gonzalez, 1979) *Case Study*	**Population Label** Adolescents dependent on hallucinogenic as a defense against homosexual fantasies **Participant Age Range** 15-year-old **Sample Size** N = 1	Clinical Psychoanalysis	**Treatment Goal** Discuss dilemmas emerging from youth's efforts to separate from family, integrate their sexuality into their identity, manage relationships, and life goals. Goal of these discussions remains unclear. **Sample-Specific Goal** • Drug and substance use: marijuana, LSD, Mescaline • Ran away from home • Failing grades • Anxiety and depression • Fear of homosexuality, *projected by therapist*	**Recruitment** In treatment, voluntarily **Consent** N/A **Research Design/Measurement** Therapist's self-report	**Outcomes** During therapy changes: • More anxious and depressed • Would turn to drugs to cope with his "fear of being a man" Post therapy: • Initial resistance lead to strongly developed ego, superego, and ego ideal. • Therapist felt client still had female thoughts • Became more involved in school and sports. Experienced gratification from being active. **Recommendations** *None provided*

3	(Uribe & Harbeck, 1992) *Qualitative*	**Population Label** Self-Identified Lesbian Gay and Bisexual teens in schools. **Participant Age Range** • Sample 1: 16-18 years old • Sample 2: high school students **Sample Size** • Sample 1 (N = 50 LGBT students) • Sample 2 (N = 342 all high school students)	Counseling and educational program	**Treatment Goal** • Reduce effects of anti-gay and lesbian discrimination, dropout prevention, and raise awareness regarding insensitivity to LGBT youth. • Gave all youth information. Intervened for needs of LGBT youth **Sample-Specific Goal** LGBT Youth • Low self-esteem • Feelings of isolation • Alienation • Inadequacy • Self-Destructive Behavior (i.e., suicide attempts and substance abuse) • School dropout	• Involvement: o Attendance at training session and materials available. • Student response: o Student contact with project 10 coordinator • Interviews	**Outcomes** • Effect on high school students, based on interview questions: o 51% positive o 11% negative o 38% unsure • More than 300 students noted increased understanding and tolerance of homosexuality **Recommendations** There is a need for more intensive education about safe sex practices among teenage who are gay.
4	(Remafedi, 1994) *Quantitative*	**Population Label** Gay and bisexual adolescents **Participant Age Range** 13-21 years old **Sample Size** N = 139	• HIV/AIDS risk reduction counseling • Peer Education Program	**Treatment Goal** • Learning Objectives: o HIV myths o HIV transmission prevention methods o Risks and benefits of HIV antibody testing o Adverse effects of alcohol and drug use on risk reduction • Behavioral Objectives: o Avoidance of substance use in	• T/F AIDS knowledge questionnaire (DiClemente, Zorn, Temoshok, 1986) • Lifetime, annual, and quarterly substance use survey (Johnston, O'Malley, Bachman, 1988) • Personal Experience Screening Questionnaire • Interview Questions on: o Sexuality	**Outcomes** • 65% subjects had more bi/homosexual friends at post test • 43% revealed their orientation to more friends at post test • Knowledge and attitudes o Pre and post intervention, realistic beliefs about risks of sexual behaviors were reported • Substance Abuse o Substance use severity score **Recommendations** • Treatments must address LGBT youth's unique developmental and social issues, which differ from heterosexual teen and gay adults • HIV prevention and safe sex initiatives should be coupled with positive adult role models and healthy socialization with peers in a safe environment.
5	(Babinski & Reyes, 1994) *Case Study*	**Population Label** Adolescent male transvestite OR Gender identity disorders in adolescents **Participant Age Range** 19-year-old **Sample Size** N = 1	Psychiatric Hospital Unit • Thorazine • Tegretol After: Residential Treatment Center • Behavior modification • Group and milieu therapy sessions • Individual Therapy	**Treatment Goal** *See sample specific* **Sample-Specific Goal** • Hospital Treatment due to: o Suicidal o Psychotic symptoms • Therapy following hospitalization to remediate: o Inappropriate, intrusive, belligerent behavior o Homosexual acting out o Obsessed with being a girl, claimed to have a uterus	Therapist's self-report	**Outcomes** Following Hospitalization: • No improvement documented. Transferred to inpatient facility. • Released once suicide risk dissipated. Inpatient Facility • Discharged from therapy program because he aged out. Did not remediate concerns. • Readmitted to hospital because he contemplated suicidal ideation and did not feel like himself. • Able to get along with classmates by end of treatment **Recommendations** • Intensive case manager with 24-hour availability is ideal for this client.
6	(Stone, 1999) *Case Study*	**Population Label** Gay Youth **Participant Age Range** 18-year-old **Sample Size** N = 1	Supportive Psychodynamic treatment	**Treatment Goal** • Help process experience of coming out within the context of client's own history • Support client in immediate problems of functioning • Strengthen capacity for further growth and development **Sample-Specific Goal** • Internalized homophobia • Negotiating coming out process • 'Unhealthy views' of himself (e.g., "dirty", "unnatural", and "limitations' of being gay") • Primary and middle school teachings embedded thoughts that he will likely "go to hell" due to	Therapist self-report	**Results** • Made the decision (showed ownership of own thoughts) to travel, to focus on himself, his family, and to get perspective on life. • Came out to parents, and encouraged conversation with them • Regulated self-esteem and morale • Developed authenticity • Still considered at risk for negative outcomes at conclusion of therapy. **Recommendations** *None provided*

				sexual orientation		
7	(Nylund, 2007) *Case Study*	**Population Label** Queer Youth **Participant Age Range** 17-year-old **Sample Size** N = 1	[Queer] Culture studies informed therapeutic approach	**Treatment Goal** Achieve self-empowerment and identity construction/affirmation by incorporating popular culture **Sample-Specific Goal** Parent's concerns: • Foster son's low self-esteem and depression from past families Steven (child's) concern: • Isolation experienced from heterosexism and homophobia as his gay identity develops	Therapist's self-report	**Outcomes** • Harry Potter became an ally that prompted acceptance of client's gay identity. • Client began searching for support in the community (like Harry had in Hermione, Ron and Hagrid). He found support in a local team LGBT support group and joined his school's GSA. **Recommendations** • Media texts are useful clinical tools. They unmask problems and construct new therapeutic possibilities • Popular culture texts can yield literary metaphors (e.g., central to narrative therapy)
8	(Wynn & West-Olatunji, 2008) *Case Study*	**Population Label** Gay African American Male **Participant Age Range** 18-year-old **Sample Size** N = 1	• NTU Psychotherapy • Culture Centered framework • Client Centered	**Treatment Goal** • Empower client. • Uncover underlying issues and facilitate interventions. • Promote authenticity, confidence, and balance by uniting body, mind, and spirit. Promote interconnectedness and cultural awareness. • Develop understanding of one's life purpose. **Sample-Specific Goal** • Sadness and Loneliness • Lacked acceptance of self • Isolation, due to cultural (sexual orientation differences) • Assumed he had limited support from family regarding his attraction to males, because in church homosexuality is a sin	Therapist self-report	**Outcomes** • Developed confidence in actualization phase • Developed assertiveness about his cultural needs with white, gay peers • Developed boundaries and communication with family (family now knows about his life enough to fulfill their curiosity) • Less anxious about his sexuality • More comfortable embracing "same-gender-loving" identity • Found additional resources (church) to help integrate spiritual beliefs with identity • Client terminated therapy because goals were met: improved mood, not lonely anymore, increased self-worth, confidence, and spiritual development • Willing to return to counseling if needed **Recommendations** • Incorporate LGBT issues into curriculum • Interact with LGBT youth and attend professional development to improve responsiveness to these diverse clients
9	(Duarté-Vélez, Bernal, Bonilla, 2010) *Case study and Quantitative*	**Population Label** Gay, Christian, Latino Adolescent **Participant Age Range** 16-year-old **Sample Size** N = 1	Cognitive behavioral therapy with cultural modifications	**Treatment Goal** Treatment of depression adapted to address concerns relevant developmentally and culturally to Puerto Rican adolescents. **Sample-Specific Goal** • Major depression disorder • Anxiety disorder, otherwise not specified • Internalized homophobia • Stress related to sexual minority status, due to rejection from peers at school since childhood, his core beliefs and dysfunctional attitudes about himself, and dealing with religious tones of Christianity within a conservative and machismo Puerto Rican family o Dissonance with father: he is described as antagonistic and restricting of participant	<u>Measures for Child</u> o Children's Depression Inventory (Kovacs, 1992) o Pier-Harris Children's Self Concept Scale (Piers & Herzberg, 2002) o Dysfunctional Attitude Scale (Weissman, 1979) o Family Emotional Involvement and Criticism Scale (Shields, Franks, Harp, McDaniel, & Campbell, 1992) o Psychotherapy Alliance Scale (Bernal, Padilla, Pérez- Prado, & Bonilla, 1999) o Child Depression Rating Scale Revised (Poznanski & Mokros, 1996) o Interviews <u>Measures for Parent</u> o Dyadic Adjustment Scale Dyads (Spanier, 1976) o Burden of Illness Scale (Coyne et al., 1987) o Coping Skills and Family Harmony Scale (Rodríguez-Soto, Rivera-Medina, & Bernal, 2007) o Interviews	**Outcomes** <u>CHILD</u>: • Piers Harris: 20 → 24 • Family Emotional Involvements and Criticism Scale: 28 → 31 • Perceived Criticism Scale: 17 → 26 <u>MOTHER</u>: • Beck Depression Inventory: 13 → 2 • Family Coping Skills and Harmony Scale: 68 → 75 • Burden of Illness Scale: 55 → 42 • Dyadic Adjustment Scale: 17 → 25 <u>Descriptive Results</u> • More personal acceptance, less internalized homophobia • Integration of sexual identity into overall identity • reported feeling more relaxed, secure, open, and happier due to therapy • No longer displayed MDD symptomology • Continued displaying Nonspecified Anxiety Disorder and Attention Deficit Disorder and Hyperactivity symptoms. • Increased self-concept • Perception of family criticism increased from baseline. **Recommendations** • Therapeutic relationship is needed to allow honestly and speaking without censuring. • Need for of best available evidence, clinical expertise, and consideration of client's needs, culture, and characteristics

10	(Craig, 2012)
	
	Mixed Methods
		Population Label
		Multiethnic sexual minority youth (MSMY)
		
		Participant Age Range
		14-18 years old
			Strength-based case management (SBCM)	**Treatment Goal**
				Help multi-ethnic sexual minority youth solve problems and reduce barriers to their overall functioning.
				
				Sample-Specific Goal
				• 86% participants: hostility from family due to sexual orientation
				• 73%: economic issues
					Psychosocial and quantitative assessment (specific types unknown). The following questions were asked:
					• Closed-ended risk factor questions
					  o Have you experienced physical abuse?
					  o Is there a history of
						Outcomes
						High engagement by participants, hypothesized this is due to strength focus of intervention.
						
						Recommendations
						Strength focus encouraged to yield positive relationships with case-manager and positive outcomes for participants.

#	Study	Population	Intervention	Goals	Measures	Outcomes / Recommendations
		Sample Size N = 162		• 67%: mental health concerns impacting well-being (e.g., depression, poor self image, substance abuse) • 61%: family concerns unrelated to sexual orientation • 51%: physical, sexual, emotional, domestic abuse	domestic violence in your family? • Open-ended questions ○ Please describe your concerns/problems about your home and family life for: family, health and mental health, school, and community	
11	(Ehrensaft, 2013) *Case study*	**Population Label** Gender nonconforming youth OR The gender dysphoric child **Participant Age Range** 10-year-old **Sample Size** N = 1	True Gender Self Therapy	**Treatment Goal** Build/Affirm Gender identity and resilience against hostile experiences. Also explore authentic identity **Sample-Specific Goal** • Burdened by stress of growing up related to body changes and gender reassignment • Post Transition: ○ Loneliness ○ Missed old friendships that were left behind with gender reassignment.	Therapist Self Report	**Outcomes** • Client was able to come out of gender and protective shell • Described as successful transition • Decreased signs of stress, distress, and disruption **Recommendations** • Therapy does not end with the transition, must continue • Delayed body changed allowed for integrated gender identity with a better match between body and psyche • "Going stealth" should be evaluated on case by case basis. It can have repercussions
12	(Diamond, Diamond, Levy, Closs, Ladipo, Siqueland, 2013) *Quantitative*	**Population Label** Lesbian, Gay and Bisexual Adolescents **Participant Age Range** 14-18 years old **Sample Size** N = 10	Attachment based family therapy Adapted model for LGB (ABD-LGB)	**Treatment Goal** Help adolescents assert needs and set limits, while remaining empathetic to struggles of parents, who experience a coming out process as well. Address invalidating parent responses. **Sample-Specific Goal** • Suicidal ideation • Depressive symptoms • Material attachment related anxiety • Avoidance	• Suicidal Ideation Questionnaire-JR. The SIQ-JR (Reynolds, 1987) • Beck Depression Inventory-II. The BDI-II (Beck, Steer, & Brown, 1996) • The Relationship Structures Questionnaire RSQ (Fraley, Heffernan, Vicary, & Brumbaugh, 2011)	**Outcomes** • High treatment retention • Significant decreases in: ○ Suicidal ideation *F(2,18) 18.78, p .001, d 2.10* ○ Depressive symptoms F(2, 18) 4.59, p .03, d .90 • No significant decreases in: ○ Maternal attachment–related anxiety and avoidance F(2, 12) 2.75, p ns, d .98 **Recommendations** • Substantial need to work with parents through their fears, disappointment, shame, and anger with their child's sexual orientation. Parents became empathetic and available to their children. • Conversations with both parents and adolescents about the meaning, process, and implications of acceptance were important
13	(Craig, Austin, McInroy, 2014) *Quantitative*	**Population Label** Multiethnic sexual minority youth (MSMY) **Participant Age Range** 13-20 years old **Sample Size** N = 263	Affirmative supportive safe and empowering talk (ASSET): Affirmative school-based group counseling	**Treatment Goal** Promote resiliency and safe, supportive environments. **Sample-Specific Goal** Promote resiliency and safe, supportive environments.	<u>Brief psychosocial assessments (pre and post tests):</u> • Rosenberg Self-Esteem Scale (Rosenberg, 1965) • Social Connectedness Scale (Lee & Robins, 1998) • Proactive Coping Inventory (Greenglass et al., 1999) • Acceptability survey	**Outcomes** • General linear modeling indicated significant increases in: ○ Self-esteem (Wilks' k = 0. 955,F 2.221 = 10.465, p = 0.001) ○ Proactive coping (Wilks' k = 0.964, F 2.216 = 8.168, p = 0.005) increased. • General linear modeling indicated constant (insignificance) with: social connectedness (Wilks' k = 0.987, F 2.98 = 1.277, p = 0.261) • High involvement, low dropout (11%). • Treatment perceived as helpful and fun. **Recommendations** • School-based delivery recommended to achieve accessibility and intervention in context of youth's natural environment • Include affirmative content • Programs must address culture specific needs of LGBT, ethnic youth clients.
14	(Harvey & Fish, 2015) *Case Studies*	**Population Label** Queer youth **Participant Age Range** 15-18 years old **Sample Size** N = 2	Family therapy informed by strength-based three stage collaborative change model	**Treatment Goal** Cultivate hidden resilience, identify untapped resources, and use these strengths to lessen oppression in their lives. **Sample-Specific Goal** • Case study 1: 'Jamal' ○ Parent/child tension, in a once positive relationship. ○ Jamal denied gay identity. ○ Withdrawn and mute ○ Mom had internalized racist, misogynistic, homophobic beliefs • Case Study 2: 'Charity' ○ Resented therapy as a means to getting hormones for gender transition. ○ Develop affirmed identity after internalizing family abuse	Therapist's self-report	**Outcomes** <u>Client 1</u> • As child/parent relationship improved, tension dissipated. • Client came out to mother in a safe, calm context (could not do before therapy) • Developed identity as gay man in therapy and in social contexts • Connected with Churches that affirmed his identity • Mom felt transformed. She confronted cultural messages of shame regarding homosexuality and rebuilt relationship with her son. <u>Client 2</u> • Therapy was the first place she heard something positive about herself. She was called "brave". It was impactful. • Took pride in her own initiative and independence. • Mom eventually accepted her whole identity; dad did not.

						Recommendations • Have parents and youth recognize each other's strengths and weaknesses to foster respect and understanding of oppression • Create safe, respectful places to allow for honest, difficult, and complex discussions • Love and acceptance are important. Fostering this is often enough • Promote family's ability to recognize, care for, and love their queer children.

15	(Heck, 2015)
	
	Mixed Methods
		Population Label
		Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Youth
		
		Participant Age Range
		10-12th graders (ages not provided)
		
		Sample Size
		N = 10
		With inconsistent attendance.
			Mental health promotion with cognitive behavioral therapy (psychoeducation, affect regulation, cognitive coping skills, and disclosure related decision making)	**Treatment Goal**
				Achieve the following goals:
				• Develop awareness skills with significant minority stressors
				  o With prejudiced events
				  o Anticipation of prejudice or rejection
				  o Concealment of struggles
				  o Internalization of negative societal views
				• Develop cognitive coping skills and disclosure related decision making (or problem solving)
				• Address adolescent depression (treatment and prevention)
				
				Sample-Specific Goal
				None provided
					• 13-item feedback form
					  o 10 items: acceptability
					  o 3 items: open-ended constructive feedback
						Outcomes
						Qualitative Findings:
						• Categorizing the stressors in my life "helped me to put things into perspective"
						• "The relaxation techniques definitely helped me out, and I will make my best effort to use them"
						Quantitative Findings
						• Highly rated ideas:
						  o Session was enjoyable, relevant, informative and helpful
						  o I have a better understanding of stressors in my life
						  o I will use the skills I learned.
						• Lower rated ideas:
						  o I am better able to cope
						  o I want to learn more about how to be healthy.
						
						Recommendations
						GSAs are great spaces to provide services and pilot interventions for LGBT Youth

Discussion

LGBTQ youth may seek out counseling or psychotherapy related to their experiences of marginalization, and identity development with regard to coming out and the disclosure process (Goodrich & Luke, 2009). Given the historical stigmatization of the LGBTQ youth community in America, practitioners and researchers should be informed of the counseling and psychotherapy implemented with these youth so they can provide services that are ethical, relevant and culturally appropriate. This chapter is the first to systematically review counseling and psychotherapy provisions for LGBTQ youth and to explore both the chronological context and the characteristics of the service provisions received by these youth.

There are several unique contributions from this study. First, it's important to consider that only 15 studies were found eligible to be reviewed. This indicates the urgent call for more research in the area of LGBTQ counseling and psychotherapy so researchers and practitioners can have access to more empirical and evidence based practices to inform their work. The dearth

of studies on LGBTQ youth counseling and psychotherapy could relate to LaSala's (2013) point that society has recently demonstrated acceptance towards the LGBTQ youth community. This could indicate recent acceptability of enacting counseling and psychotherapy with these youth. It could also relate to recruitment or consent/assent limitations with this population (Varjas et al., 2008).

Although this chapter is limited in its ability to make generalizable claims about the historical context of each study, it is among the first to contextualize LGBTQ youth counseling and psychotherapy practice findings within a historical framework. LaSala's (2013) commentary on the societal shift from a blaming agenda towards an affirming one for LGBTQ youth mirrors several of the articles included in this review. While the King et al. (2007) article shares each study's publication date, a historical context was not provided.

Another unique finding of this chapter is that it is among the first to explore enacted counseling and psychotherapy practices with LGBTQ youth. While King et al. (2007) presents a descriptive analysis of counseling and psychotherapy practices with LGBTQ adults, this study uses a combination of descriptive and coded findings with LGBTQ youth. The current study offers unique findings with regard to each research question answered.

The first research question, *what counseling and psychotherapy practices documented in research have been implemented with LGBT youth and how have they evolved over time, this study was the first to systematically identify the types of implemented therapy for LGBTQ youth.* In considering similar studies (e.g., King et. al., 2007), types of counseling and psychotherapy were considered as whether clients used mainstream services or specialized services rather than exploring the specific types of psychotherapy or counseling in which the clients engaged. In the current chapter, specific practices such as behavior modification (McKinlay, Kelly, & Patterson,

1978) and psychodynamic/psychoanalysis (e.g., Gonzalez, 1979) were implemented to reduce homosexual or gender diverse tendencies in the client. It is important to note that behavior modification and psychoanalysis have been used to evoke positive change with youth in other circumstances (e.g., Skinner, Shapiro, Turco, Cole & Brown, 1992; Weitkamp et al., 2014). Affirmative, culturally responsive methods were also implemented and include: True Gender Self Therapy (Ehrensaft, 2013), Queer Culture Informed Therapy (e.g., Nylund, 2007), and Cognitive Behavioral Therapy with Cultural Modifications (e.g., Duarte-Velez, Bernal, & Bonilla, 2010).

The second research question focused on recruitment and consent procedures. King et al. (2007) summarized the recruitment methods for each included study. Since their study was focused on LGBT adults and often targeted venues specific to adult populations (e.g., bars) there remained a dearth of research on recruitment methods for LGBTQ youth. The current chapter identified recruitment methods for LGBTQ youth as including convenience samples through GSA's, snowball sampling, commercial advertisement, and proposing research participation while youth were in therapy for LGBTQ relates issues. As indicated by Varjas et al. (2008), studies either asked youth or their parents directly to participate when their identity was already disclosed in therapy or a GSA, or via indirect methods of youth sharing study information with other youth who they knew were out or via mass advertisement. Studies that provided information on their recruitment methods included minimal information about the steps/process implemented to replicate their practices.

The King et al. (2007) did not discuss consent procedures, likely due to the samples being able to consent for themselves as adults. The current chapter is among the first to review consent procedures for LGBTQ youth involvement in counseling and psychotherapy informed research.

Four articles in this chapter discussed consent procedures and only two studies used waived consent. The limited conversation around informed consent in this review points to the need to develop this conversation. Researchers and practitioners should not assume that LGBTQ youth can use typical parent consent procedures as acquiring their consent could lead to disclosing one's sexual orientation/gender identity before they are ready to disclose (Varjas et al., 2008). While only two studies waived consent, future studies should aim to replicate their procedures (e.g., in loco parentis/waived consent) to ensure voices of youth without access to parent consent represented in research.

This study is also among the first to inform what measures have been used in research to determine counseling and psychotherapy effects with LGBTQ youth. Case studies were implemented and relied on researcher's descriptive recount of the provided counseling and psychotherapy. Case study results should be interpreted with caution as the authors in these articles did not discuss implemented methods to limit their biases and to promote objectivity in their report of findings. Case studies composed six of the eight studies from the 1970's, 1990's and 2000's. Mixed methods and quantitative methods were in five of the seven studies from the 2010's. The implemented methodologies from studies in this review could relate to historical methodology standards (Nastasi et al., 2007). Nastasi et al. (2007) called for interventions with diverse populations to use a mixed methods approach to assess progress with quantitative methods and to describe cultural relevance via qualitative methods.

This study also provided a list of measures and the constructs they are designed to convey. While researchers and practitioners should reference these tables to inform the measures used in prior research with LGBTQ youth, it is important to note that the measures included were not constructed with LGBTQ youth populations. The reported measures in this chapter were not

culture specific to LGBTQ youth. To gain further insight and a thorough understanding of what measures convey, researchers and practitioners should used mixed methods approach to evaluate counseling and psychotherapy (Nastasi et al., 2007, Office of the Surgeon General, 2001).

The findings from the fourth and fifth research question inform which counseling and psychology methods have been found to result in positive change in clients and about which recommendations were made to promote effective work with LGBTQ youth in counseling and psychotherapy. The scope of this chapter is limited in its ability to deduce what aspects of the studies related to detected change in the results. However, certain studies presented as meeting the ethical standards of practice by the American Counseling (2016), American Psychological (2016) and the American Psychiatric (2013) Associations. The articles from this review that met the ethical standards of practice were the following in chronological order: Uribe & Harbeck, 1992; Remafedi, 1994; Nylund, 2007; Wynn & West-Olatunji, 2008; Duarté Vélez, Bernal, & Bonilla, 2010; Craig, 2012; Ehrensaft, 2013; Diamond et al., 2013; Craig, Austin, & McInroy, 2014; Harvey & Fish, 2015; Heck, 2015. These articles practiced cultural responsiveness, used affirmative practice, incorporated prevention efforts in addition to intervention components, and incorporated an ecological component where people in the LGBTQ youths' lives were included in counseling and psychotherapy sessions. These components of counseling and psychotherapy were also noted as recommendations that researchers and practitioners should enact in their own practice.

Studies that did not meet ethical standards of American Counseling (2016), American Psychological (2016) and/or the American Psychiatric (2016) Associations included (in chronological order): McKinlay, Kelly, & Patterson, 1978; Gonzalez, 1979; Babinski & Reyes, 1994; Stone, 1999. While we would not expect studies from the 1970's and 1990's to reflect the

same ethical values of current standards, the differing expectations may inform how social expectations of each decade or timeframe may relate to the counseling and psychotherapy practice. These studies pathologized LGBTQ youth based on their sexual orientation or gender identity when other aspects should have been documented as the primary concern (e.g., drug use or mental illness).

Limitations

Caution should be exercised when reaching conclusions from this review as only 15 studies met criteria for inclusion. The types of treatment and content of each study varied within the systematic review. The limited number of included studies and the variation of content make it difficult to discuss chronological *trends* within the data and to generalize findings beyond this study. Nevertheless, when considering each study in this review within a historical context, researchers and practitioners can make sense of certain practices that occur but conclusions and generalizations about historical contextualization cannot be made from the current study.

Meta-analysis was unable to be used since a majority of the included studies lacked pre-test/post-test data and since a majority of them were case studies with descriptive data. Samples from the studies in this review typically included high school aged youth with sexual orientation diversity. There was limited representation of youth with gender diversity and from younger age ranges. Even though sexual minority youth and gender diverse youth are included the *LGBTQ youth* construct, they are different, unique cultures (Office of the Surgeon General, 2001). Only samples from the United States were included, limiting this study's ability to be generalized internationally.

Implications for Practice

Findings from this review indicate several implications for counseling and psychotherapy practice with LGBTQ youth. Most importantly, this study identified potentially harmful techniques when working with LGBTQ youth (e.g., invalidating their identity or seeking to "cure" their sexual orientation or gender identity). Practitioners should review these studies (Babinski & Reyes, 1994; Gonzalez, 1979; McKinlay, Kelly, & Patterson, 1978; Stone, 1999) to note practices they should avoid enacting. Conversely, several studies presented ethically sound counseling and psychotherapy with LGBTQ youth, and practitioners are encouraged to review these articles as well. These studies accord with APA (2016), ACA (2016), and APA (2016) ethic standards that indicate practice should enact cultural responsiveness. Methods identified as culturally responsive in this review include Queer Culture Informed Therapy and Cognitive Behavior Therapy with Culture Modifications. The PCSIM model is an intervention method that adapts existing interventions to include culture modifications, which incorporates client perspectives in the intervention development process. For more information on PCSIM implementation, please reference Nastasi, Bernstein and Varjas (2004). Ethical practice also calls on practitioners enacting affirmative practice that validates LGBTQ youths' identity as opposed to invalidating their identity (e.g., Babinski & Reyes, 1994). Studies can also enact prevention efforts to defend against potential concerns such as marginalization by surrounding LGBTQ youth with supportive environments (e.g., gay straight alliances or engaging in family therapy to promote safe and healthy relationships for youth).

Practitioners are urged to continue exploring recruitment methods for youth to engage in therapy. Many youth who need counseling and psychotherapy services may not have the support of their parents to help them access these services (if they are not already out to them or if

parents disapprove of their identity). King and colleagues (2007) identified recruitment techniques such as snowball techniques, posting flyers, convenience samples in LGBTQ community groups, or going to bars that are explicitly supportive of the LGBTQ community. The current chapter identified recruitment methods such as approaching youth in GSAs, or involving youth in therapy per their parent's (voluntarily or not). Practitioners should consider ethical ways to advertise their counseling and psychotherapy services for LGBTQ youth, particularly those without parents who are not supportive of their identity and who know about their child's identity. Recruiting LGBTQ youth for counseling and psychotherapy via coming to talk during a GSA meeting, having flyers, or leaving contact information with LGBTQ youth groups may be an appropriate methods to engage youth in these services who may have a need.

Practitioners should also consider waiving consent in counseling and psychotherapy for LGBTQ youth. Practitioners are ethically obligated to promote beneficence and nonmaleficence. For LGBTQ youth who may need counseling and psychotherapy, requiring parent consent may bring them harm by prematurely outing them to their parents. Varjas et al. (2008) call for research to enact waived consent in research, and this chapter encourages counseling and psychotherapy providers to follow practices that medical doctors have enacted that allows youth to seek services if it will assist in improving their health and will not bring them harm (Society of Human Resource Management, 2016).

Practitioners are encouraged to measure client progress in counseling and psychotherapy with measures. Measures found to document progress in this chapter were normed on general populations, rather than specifically with LGBTQ youth (The Office of the Surgeon General, 2001). To account for potential cultural variations from the measure and to ensure validity, practitioners are encouraged to use mixed methods to track progress. Practitioners can use mixed

methods by asking participants about constructs being measures, so counseling and psychotherapy providers can understand the specific experience of their culturally diverse clients (Mertens, 2007).

While this study is limited in making generalizable conclusions based on chronology, the context in which service is delivered may influence our thoughts and biases, related to counseling and psychotherapy practice. Practitioners are encouraged to challenge their biases and to have an awareness of their own identity, when working with LGBTQ youth. While self-awareness cannot guarantee practitioner objectivity, it challenges practitioners to question the ethics and effectiveness related to their client's counseling and psychotherapy experience.

Future Directions for Research

This study presents preliminary findings on counseling and psychotherapy provisions for LGBTQ youth that have been documented in research. As there are several articles in this review depicting ethical practice, additional studies should be implemented, where the practices considered ethically sound are included (e.g., culture responsive treatment and incorporation of family and others into counseling and psychotherapy). Several articles, dissertations, and theses were excluded from this review because they did not implement counseling and psychotherapy, but included informative content regarding other mental health services for LGBTQ youth. Particularly, Martinez (2012) and Rosnik (2001) developed curricula to address high-risk behaviors and internalized homophobia in gay youth. Other studies focused on mission statements that promoted the termination of certain practices, such as reparative therapy (e.g., Grace, 2005). Future systematic reviews should be conducted on the mission statements of reparative and conversation therapy to inform the potential harm these practices can bring to LGBTQ youth and to inform the implications of counseling and psychotherapy that does not

foster the ethical obligation of nonmaleficence (ACA, 2005; NASP, 2010). Future systematic reviews should also review the content components of developed counseling and psychotherapy curricula, that have been implemented and not implemented with LGBTQ youth. Such a review could identify curriculum components, structures, or entire interventions worth implementing to inform evidence-based practice with LGBTQ youth.

Researchers should continue implementing and evaluating counseling and psychotherapy provisions with LGBTQ youth. As marginalized minors, LGBTQ youth lack representation in research. Providing a voice for these youth in research promotes further understanding of their unique experience and how to inform their counseling and psychotherapy services (Mertens, 2007). Future studies should replicate the psychotherapies implemented in the studies they deem ethically appropriate with LGBTQ youth using mixed methodology, pretest/posttest findings, a control group, and random assignment (when possible) to yield meta-analysis results.

Future studies should explore recruitment procedures in greater detail for LGBTQ youth. Recruiting LGBTQ youth can be challenging as they are minors and/or they may not be out to their friends or family. By developing researcher's understanding of ways to recruit LGBTQ youth for research, we can inform our ability to represent their voices more frequently in research. Similarly, future research should explore waived consent practices, and whether youth who implement this practice differ in their experiences from youth with access to parent consent. Youth without parent consent have limited representation in research due to minors needing parent consent to participate (Varjas et al., 2008). While including these youth and the practice of waived consent in research is important to provide these youth with a voice, comparing them and youth with access to parent consent can further depict their unique cultural experience. and the use of waived/in loco parentis consent with the LGLBTQ youth community.

References

Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of youth and adolescence, 38*(7), 1001-1014.

American Counseling Association. (2016). What is counseling? Retrieved from: https://www.counseling.org/about-us/about-aca

American Psychological Association. (2009). Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel. *APA online*. Retrieved from: http://www.apa.org/pi/lgbt/resources/just-the-facts.pdf

American Psychological Association. (2016). Therapy. Retrieved from: http://www.apa.org/topics/therapy/

American Psychiatric Association. (1973). *Diagnostic and statistical manual of mental disorders: DSM-3.* Washington, D.C: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: American Psychiatric Association.

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* Washington, DC: American Psychological Association. Retrieved from: http://www.apa.org/pi/lgbt/resources/sexual-orientation.aspx

APA Task Force on Tran*sgender, Gender Identity, & Gender Expression Non-Discrimination*. (2008). *Report of the Task Force on Transgender, Gender Identity, & Gender Expression Non-Discrimination.* Washington, DC: American Psychological Association. Retrieved from: https://www.apa.org/about/policy/transgender.pdf

APA Task Force on *Appropriate Affirmative Responses to Sexual Orientation Distress and*

Change Efforts. (2009). *Report of the Task Force on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts.* Washington, DC: American Psychological Association. Retrieved from: http://www.apa.org/about/policy/sexual-orientation.aspx.

Babinski, S., & Reyes, A. (1994). Identity formation in adolescence: Case study of gender identity disorder and treatment through an intermediate-care day hospital. *Psychiatric quarterly*, *65*(2), 121-133.

Bakeman, R., & Gottman, J. M. (1986). Observing interactions: An introduction to sequential analysis. New York, NY: Cambridge University Press.

Byrd, A. D., & Nicolosi, J. (2002). A meta-analytic review of treatment of homosexuality. *Psychological Reports, 90*(3c), 1139-1152.

Button, D. M., O'Connell, D. J., & Gealt, R. (2012). Sexual minority youth victimization and social support: The intersection of sexuality, gender, race, and victimization. *Journal of Homosexuality, 59,* 18–43. doi:10.1080/00918369.2011.614903

Craig, S. L. (2012). Strengths First: An Empowering Case Management Model for Multiethnic Sexual Minority Youth. *Journal of Gay & Lesbian Social Services*, *24*(3), 274-288.

Craig, S. L., Austin, A., & McInroy, L. B. (2014). School-based groups to support multiethnic sexual minority youth resiliency: Preliminary effectiveness. *Child and adolescent social work journal*, *31*(1), 87-106.

D'Augelli, A. R., & Patterson, C. J. (Eds.). (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York, NY: Oxford University Press.

DeLeon, P. H. (1998). Proceedings of the American Psychological Association, Incorporated, for the legislative year 1997: Minutes of the annual meeting of the Council of

Representatives. *American Psychologist, 53*, 882–939. doi:10.1037/0003-066X.53.8.882

Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2013). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings.

Duarté-Vélez, Y., Bernal, G., & Bonilla, K. (2010). Culturally adapted cognitive-behavior therapy: integrating sexual, spiritual, and family identities in an evidence-based treatment of a depressed Latino adolescent. *Journal of clinical psychology*, *66*(8), 895-906.

Ehrensaft, D. (2013). Look, Mom, I'm a Boy—Don't Tell Anyone I Was a Girl. *Journal of LGBT*

Youth, *10*(1-2), 9-28.

Espelage, D. L., Aragon, S. R., Birkett, M. K., & Koenig, B. W. (2008). Homophobic teasing, psychological outcomes, and sexual orientation among high school students: What influence do parents and schools have? *School Psychology Review, 37,* 202–216.

Goodrich, K. M., & Luke, M. (2010). The experiences of school counselors-in-training in group work with LGBTQ adolescents. *The Journal for Specialists in Group Work, 35*(2), 143-159.

Gonzalez, R. M. (1979). Hallucinogenic dependency during adolescence as a defense against homosexual fantasies: A reenactment of the first separation-individuation phase in the course of treatment. *Journal of youth and adolescence*, *8*(1), 63-71.

Grace, A. P. (2005). Reparative therapies: A contemporary clear and present danger across minority sex, sexual, and gender differences. *Canadian Woman Studies, 24*(2, 3), 145-151.

Harvey, R. G., & Fish, L. S. (2015). Queer youth in family therapy. *Family process*, *54*(3), 396-

417.

Harzing, A. W. (2010). *The publish or perish book*. Melbourne: Tarma Software Research.

Heck, N. C. (2015). The potential to promote resilience: Piloting a minority stress-informed, GSA-based, mental health promotion program for LGBTQ youth. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 225.

Hicks, K. A. (1999). Reparative therapy: Whether parental attempts to change a child's sexual orientation can legally constitute child abuse. *American University Law Review*, *49*, 505.

Kiperman, S., Varjas, K., Meyers, J., & Howard, A. (2014). LGB Youth's Perceptions of Social Support: Implications for School Psychologists. *School Psychology Forum* 8(1). 75-90.

King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). *A systematic review of research on counseling and psychotherapy for lesbian, gay, bisexual & transgender people.* Lutterworth: British Association for Counseling & Psychotherapy.

Kosciw, J. G., Greytak, E. A., & Diaz, E. M. (2009). Who, what, where, when, and why: Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence*, *38*(7), 976-988, doi: 10.1007/s10964-009-9412-.

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012*). The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* New York, NY: Gay, Lesbian, and Straight Education Network.

Larsson, R. (1993). Case survey methodology: Quantitative analysis of patterns across case studies. Academy of Management Journal, 36, 1515–1546. doi:10.2307/256820

LaSala, M. C. (2013). Out of the darkness: Three waves of family research and the emergence of

family therapy for lesbian and gay people. *Clinical Social Work Journal*, *41*(3), 267-276.

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., Clarke, M., Devereauz, P. J., Kleijen, J., & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *Annals of internal medicine, 151*(4), W65-W94.

Maggin, D. M., Johnson, A. H., Chafouleas, S. M., Ruberto, L. M., & Berggren, M. (2012). A systematic evidence review of school-based group contingency interventions for students with challenging behavior. *Journal of School Psychology, 50*(5), 625-654, doi: 10.1016/j.jsp.2012.06.001.

McKinlay, T., Kelly, D. J. A., & Patterson, J. (1978). Teaching assertive skills to a passive homosexual adolescent: An illustrative case study. *Journal of homosexuality*, *3*(2), 163-170.

Martinez, R. A. (2012). *A Group-Based Intervention to Reduce High-Risk Behaviors in Victimized Gay Youth*. (Doctoral Dissertation). Alliant International University.

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research, 1*(3), 212-225, doi: 10.1177/1558689807302811.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Sage.

Munoz-Plaza, C., Quinn, S. C., & Rounds, K. A. (2002). Lesbian, gay, bisexual and transgender students: Perceived social support in the high school environment. *The High School Journal, 85*(4), 52-63.

Nastasi, B. K., Hitchcock, J., Sarkar, S., Burkholder, G., Varjas, K., & Jayasena, A. (2007). Mixed methods in intervention research: Theory to adaptation. *Journal of Mixed Methods*

Research, 1(2), 164-182.

Nastasi, B. K. (2009). Advances in qualitative research. In T. Gutkin & C. Reynolds (Eds.), *The handbook of school psychology,* 30–53, Hoboken, NJ: Wiley.

National Association of School Psychologists (2010). Principles for Professional Ethics. Retrieved from: https://www.google.com/search?source=hp&ei=...VAH5H4Yp-X4

Nylund, D. (2007). Reading Harry Potter: Popular culture, queer theory and the fashioning of youth identity. *Journal of systemic therapies*, *26*(2), 13-24.

Office of the Surgeon General, United States Center for Mental Health Services (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the surgeon general*.

Remafedi, G. (1994). Cognitive and behavioral adaptations to HIV/AIDS among gay and bisexual adolescents. *Journal of Adolescent Health*, *15*(2), 142-148.

Rosnik, D. R. (2001). *A selected prevention program for internalized homophobia in self-identified gay and lesbian youth* (Doctoral thesis). Retrieved from Spalding University.

Serovich, J.M., Craft, S. M., Toviessi, P., Gangamma, R., McDowell, T., & Grafsky , E. L. (2008). A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy, 34*(2) 227-238.

Skinner, C. H., Shapiro, E. S., Turco, T. L., Cole, C. L., & Brown, D. K. (1992). A comparison of self-and peer-delivered immediate corrective feedback on multiplication performance. *Journal of School Psychology*, *30*(2), 101-116.

Society for Human Resource Management. (2016). FMLA: In Loco Parentis: How does

"standing in loco parentis" apply to leave eligibility under the FMLA regulations? Retrieved from: https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/fmlainlocoparentis.aspx

Stone, N. (1999). Chapter 6 Developmental Perspectives in Brief Treatment of Gay Youth. *Psychoanalytic Social Work*, *6*(3-4), 145-159.

Uribe, V., & Harbeck, K. M. (1992). Addressing the needs of lesbian, gay, and bisexual youth: The origins of PROJECT 10 and school-based intervention. *Journal of Homosexuality, 22*(3-4), 9-28.

Weitkamp, K., Daniels, J. K., Hofmann, H., Timmermann, H., Romer, G., & Wiegand-Grefe, S. (2014). Psychoanalytic psychotherapy for children and adolescents with severe depressive psychopathology: Preliminary results of an effectiveness trial. *Psychotherapy, 51*(1), 138.

Woodward, N. E.,& Willoughby, B. (2014). Family therapy with sexual minority youths: A systematic review. *Journal of GLBT Family Studies, 10*(4), 380-403.

Wynn, R., & West-Olatunji, C. (2008). Culture-Centered Case Conceptualization Using NTU Psychotherapy With an African-American Gay Male Client. *Journal of LGBT Issues in Counseling*, *2*(4), 308-325.

Varjas, K., Dew, B., Marshall, M., Graybill, E., Singh, A., Meyers, J., & Birckbichler, L. (2008). Bullying in schools towards sexual minority youth. *Journal of school violence, 7*(2), 59-86, doi: 10.11300/J370v22n02_03

Varjas, K., Kiperman, S., Meyers, (2016). Disclosure experiences of urban, ethnically diverse LGBT high school students: Implications for School Personnel. *School Psychology Forum, 10*(1). 78-92.

2. Exploring a Model of Social Support and Nonsupport Among LGBTQ youth with and without Parent Consent

As Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth negotiate their identities, they are often confronted with unique challenges (e.g., disclosure to self and others, and the coming out process) (Varjas, Kiperman, & Meyers, 2016). LGBTQ youth may also experience discrimination related to their sexual orientation and/or gender identity via bullying (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Button, O'Connell, & Gealt, 2012), teasing (Espelage, Aragon, Birkett, & Koenig, 2008), harassment (D'Augelli & Patterson, 2001; McCabe, Dragowski, & Rubinson, 2013), and negative school climate (Kosciw, Palmer, Kull, & Greytak, 2013). Despite these negative experiences, many LGBTQ youth lead well adjusted, fulfilling lives when they perceive having access to supportive relationships (Kiperman, Varjas, Meyers, & Howard, 2014; Munoz-Plaza, Quinn, & Rounds, 2002). For example, LGBTQ youth who report positive social supports have had higher educational aspirations (e.g., Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012), engaged in less drug use (Button et al., 2012; Espelage et al., 2008), and exhibited greater mental health compared to LGBT youth without these supports (Teasdale & Bradley-Engens, 2010). Since findings such as Munoz-Plaza et al. (2002) indicate that social support positively contributes to LGBTQ youths' lives, it may be important to understand how these youth experience social support.

Social Support and Nonsupport

Studies by Munoz-Plaza et al. (2002) and Kiperman et al. (2014) and have yielded qualitative findings about the supportive experiences of LGB youth. Munoz-Plaza and colleagues' (2002) findings informed *who* provided support to LGB youth (sources) and what was provided (types). They specifically noted peers and non-family adults as being more

supportive than their family members via two primary types of support: *emotional* (expressions of love, caring, trust, listening and other similar affective behaviors) and *instrumental support* (expressions of tangible resource or aid, including money, labor, time, and barter). Participants' perceived limitations to the emotional support they received from heterosexual friends to whom they disclosed their sexual orientation. Participants felt their heterosexual friends could not fully relate or understand their experience. LGBTQ youth also received valuable *informational* (expressions of advice or suggestions) and *appraisal support* (expressions of positive feedback or affirmation) from peers and adults who identified as LGBT. Parents were described as providing minimal support related to participants' sexual orientation.

Munoz-Plaza and colleagues (2002) discussed types of support consistent with the House (1981) model. Kiperman and colleagues (2014) also discussed similar support types, but created a model depicting a continuum of social support and nonsupport experiences- when in the past these constructs were studied independently of one another (e.g., Munoz-Plaza et al., 2002; Neufeld & Harrison, 2003). In this continuum, one end reflected positive experiences of support and the other end depicted poor experiences, characterized by nonsupport. An example of the continuum can be depicted via opposing constructs: open-minded (support) and close-minded (nonsupport). In Kiperman et al. (2014), participants discussed receiving support where people were open-minded and nonjudgmental (e.g., emotional support) while also discussing nonsupport experiences where participants viewed others as judgmental and close-minded (e.g., negative perceptions).

Kiperman et al. (2014) included nonsupport codes concurrently with support to present a more complete understanding of youths' social context, as people and/or experiences are rarely discussed as only supportive. Blumer and Murphy (2011) depicted poor provisions of social

support and negative interactions as nonsupport. The Kiperman et al. (2014) model confirmed Neufeld and Harrison's (2003) types: *unmet expectations* (unfulfilled offers of assistance, or unmet expectations in social interactions) and *negative interactions* (disparaging comments, and criticism of one's decisions). Kiperman and colleagues' (2014) data analyses included an additional component, *negative perceptions* (perceptions of others that lead participants to reduce their willingness to seek support from them) to inform experiences that were not depicted in Neufeld and Harrison's (2003) nonsupport types.

The Kiperman et al. (2014) model was developed using grounded theory qualitative methodology where the goal was to depict perspectives of LGBTQ youth and their perspectives; however the research on which it was based did not ask directly about support and nonsupport and did not include gender diverse youth in the sample. Further investigation is needed to inform this model's validity and depiction of LGBTQ youth perspectives by asking directly about experiences of support and nonsupport.

LGBTQ Youth With and Without Access to Parental Consent

LGBTQ youth have demonstrated that one in four LGB youth have reported some type of parental maltreatment during their childhood (Paul & Khale, 2016) and some LGBTQ youth have reported on their parents' negative response to their coming out (Varjas, Kiperman & Meyers, 2016). These adverse experiences may prevent youth from wanting to 'come out' or disclose their identity to their families in general. Additionally, parents have been documented as one of the most significant relationships from which youth receive social support- which relates to both positive and negative impacts on youth mental health (Rueger, Malecki, & Demaray, 2010). Obtaining consent from a parent or guardian for youth under 18-years-old to participate in research is typically a mandatory research practice. Many youth may be excluded

from research because having their parents or guardians sign a consent form would 'out' them and possibly provoke a harmful or uncomfortable experience (Valentine et al. 2001). Informed consent for LGBTQ youth can be a barrier that prevents them from participating in research.

It is important to include silenced voices of youth without access to parental consent because of the hardships they may encounter with their parents could lead to a significantly different lived experience for these youth when compared to those who have access to parent consent. Additionally, prior research on LGBTQ youth often depicts results based on a limited sample of youth with access to parent consent. Conclusions from such research should not be associated with the entire population of LGBTQ youth when findings specific to those without access to parental consent are unknown (e.g., Almeida et al., 2009; Kiperman et al., 2014). To combat challenges of absent voices from research, the federal mandate *45 CFR 46.408(c)* allows for researchers to waive traditional consent and use *in loco parentis* procedures instead (where an adult- not associated with the research study, but typically from a community venue that serves LGBTQ youth- signs for a youth to participate in research that has minimal risk). I*n loco parentis* procedures are designed to protect the rights of minors where an accepting adult figure is informed of youths' involvement in a study in lieu of their parent (e.g., Varjas et al., 2008). Several studies have used in loco parentis procedures (e.g., Maguen, Armistead, & Kalichman, 2000; Pilkington & D'Augelli, 1995; Rosario, Schrimshaw, & Hunter, 2012; Rotheram-Borus, Hunter, & Rosario, 1994; Whitbeck, Chen, Hoyt, Tyler & Johnson, 2004), where parent consent was waived for youth under 18, and an adult at a Community Based Organization (CBO) served *in loco parentis* to safeguard the rights of each minor in the study. These adults have been referenced as *youth advocates,* where they serve to verify youth participants understand their rights, the assent procedures, and the voluntary nature of the project. Youth advocates are

typically not active researchers, but are members of the CBO's, know about the research project and can answer questions without investment in the research. Including youth without access to parent consent in research via alternate consent procedures affords these youth an opportunity to be heard.

Rational for Study

This study explores the supportive and not supportive experiences of LGBTQ youth with and without access to parent consent from a transformative framework (Mertens, 2007). Transformative theory addresses social justice through culturally competent and sound research methodology. The transformative framework views reality as constructed by social, political, cultural, economic, and racial/ethnic values where power and privilege greatly influence the reality and lens with which we consume and create research.

In a transformative framework, LGBTQ youth are valued participants as their voices have previously been underrepresented in research and society. This study incorporates a transformative framework by representing silenced voices, enacting sound qualitative methodology, including participant groups of youth with and without access to parent consent, comparing these groups to convey their unique voices, and presenting the research using their own quotes to convey findings.

Although there has been research regarding LGBTQ youths' experience of support and nonsupport (e.g., Kiperman et al., 2014), there are two agenda items to address with the current study. First, Kiperman et al. (2014) proposed model should be confirmed or modified by research that explicitly asks about both support and nonsupport. Second, this model should include perspectives of LGBTQ youth with and without access to parent consent to compare their experience of social support and nonsupport. This study is designed to provide a richer

understanding of Kiperman and colleagues' (2014) model of LGB youth support and nonsupport experiences by addressing the following research question:

> How do the types of social support and nonsupport that LGBTQ youth (with and without parental consent) report receiving confirm, disconfirm, or extend the Kiperman et al. (2014) model?

Method

Participants and Recruitment

Sample recommendations by Creswell (2002) suggested 15-20 participants for each presented group of people should be interviewed when using grounded theory methods. The researcher recruited 42 participants to interview where one group included (n = 21) individuals with parent consent and the second group included those without (n = 21). In order to participate, youth needed to meet eligibility criteria (i.e., be between ages 14-17, identify as an LGBTQ youth, be enrolled in any kind of high school experience, and have an email address where youth would feel comfortable receiving emails pertaining to this study).

The researcher utilized purposive sampling, where members who meet specific criteria were sought out to be in the sample (Tongco, 2007). The primary researcher contacted more than 32 community based organizations (CBOs) and schools who have statements or reputations of providing support for the LGBTQ youth community. The majority of organizations were based in a major metropolitan city in the Southeast United States and others were based in metropolitan cities in the Northeast and Midwest regions of the United States. Of the 32 contacted sites, six sites agreed to participate in this project. Youth were invited to attend recruitment presentations by the researchers at the CBO's and schools and were given flyers that described the study. The CBOs' Facebook pages posted the flyers as well. The researcher attended events hosted by the

CBOs' where the study set up a recruitment table with study flyers and business cards. At these events (e.g. PRIDE, Gay Straight Alliance GSA Youth Summit) youth were screened and could participate in the study immediately on site. Recruitment also occurred via snowball sampling where participants told people they knew about the study (Biernacki & Waldorf, 1981). They shared the primary researcher's contact information that was on flyers posted in CBOs to their peers. Their peers contacted the researcher and reported hearing about the study from someone who participated. *Tables 2.1a* and *2.1b* depict the demographics of the (N = 42) participants in this study.

Table 2.1a *Participant Demographics*

	Parent Consent *n* (%)	Youth Advocate *n* (%)	Total *n* (%)
Total	21 (100%)	21 (100%)	42 (100%)
Age			
14	3 (14%)	5 (23%)	8 (19%)
15	1 (4%)	8 (38%)	9 (21%)
16	4 (19%)	6 (29%)	10 (24%)
17	13 (62%)	2 (10%)	15 (36%)
Grade			
9th	3 (14%)	9 (43%)	12 (29%)
10th	4 (19%)	5 (24%)	9 (21%)
11th	3 (14%)	5 (24%)	8 (19%)
12th	11 (52%)	2 (10%)	13 (31%)
Race/Ethnicity			
White/Caucasian	15 (71%)	12 (57%)	27 (64%)
Black/African American	3 (14%)	2 (10%)	5 (12%)
Hispanic or Latino/a	1 (4%)	3 (14%)	4 (10%)
Asian Pacific Islander	0 (0%)	1 (4%)	1 (2%)
Mixed	0 (0%)	2 (10%)	2 (5%)
Other	2 (10%)	1 (4%)	3 (7%)
Living Setting			
Urban	9 (43%)	5 (24%)	14 (33%)
Rural	2 (10%)	9 (43%)	11 (26%)
Suburban	10 (48%)	7 (33%)	17 (40%)
School Type			
Public	16 (76%)	17 (81%)	33 (79%)
Private	4 (19%)	0 (0%)	4 (10%)
Charter	0 (0%)	1 (4%)	1 (2%)
Alternative	0 (0%)	1 (4%)	1 (2%)
Home	0 (0%)	1 (4%)	1 (2%)
Online	1 (4%)	1 (4%)	2 (5%)

Table 2.1b *Participant Demographics Continued*

	Parent Consent *n* (%)	Youth Advocate *n* (%)	Total *n* (%)
Total	21 (100%)	21 (100%)	42 (100%)
Sexual Orientation Label			
Gay	2 (10%)	2 (10%)	4 (10%)
Lesbian	6 (29%)	5 (24%)	11 (26%)
Bisexual	3 (14%)	6 (29%)	9 (21%)
Pansexual	9 (43%)	8 (38%)	17 (40%)
Heterosexual	1 (5%)	0 (0%)	1 (2%)
Gender Identity Label			
Male	3 (14%)	4 (19%)	7 (17%)
Female	11 (52%)	10 (48%)	21 (50%)
Transgender (F →M)	0 (0%)	2 (10%)	2 (5%)
Transgender (M →F)	1 (5%)	0 (0%)	1 (2%)
Other	6 (29%)	5 (24%)	11 (26%)

Note. "Other" in the Gender Identity Label had a write in option. Other options youth used to identify their gender identity included Genderfluid, Nonbinary/Agender, Stem, Genderqueer, Gender-nonconforming, and Nonbinary.

Instruments

Participants completed a 20-minute survey, which was a part of a larger study, and then approximately an hour-long interview, where the shortest interview was 31 minutes and 48 seconds, the longest interview was 83 minutes and 25 seconds, and the mean interview time was 54 minutes and 16 seconds. The semi-structured interview sought to understand how the LGBTQ youth participants perceived their social support and nonsupport experiences. The main questions asked in the interview were: "Tell me about a time when you experienced others… supporting you/ being unsupportive of you, or when others acted in an unsupportive way"; "Tell me about situations that come to mind where you know others would support you if needed"; "Tell me about situations that come to mind where you know others would not support you, or when you know others would act in an unsupportive way". Participants were asked, "Tell me what terms you use to label your sexual orientation and gender identity. Tell me what those mean". These probes sought to understand how LGBTQ youth self identify and define their sexual orientation

and gender identity. Additional probes included "tell me more about that/tell me what that looked like/tell me what … means" to gain clarity and/or additional details from the participants.

Procedures

Research procedures were reviewed and approved by the university's institutional review board. Youth interested in participating contacted researchers via the phone number or email address listed on recruitment materials. The first author conducted a scripted eligibility screening (See Appendix A) with these youth to ensure they met the study criteria and to identify whether they had access to parent consent. The researcher also scheduled their interview and survey during this call. Youth were either sent a consent form for their parents to sign before they could participate or identified a youth advocate (a designated person at each CBO that partnered with this study) in lieu parent consent. Youth advocates answered questions and reviewed the research with youth and did not have direct investment in the study's outcomes. In loco parentis was enacted when prospective participants comprehended their involvement and posed minimal concern about the study. All participants provided assent and turned in their signed forms prior to their study participation.

Participants interacted with one of four research assistants for their survey and interview session. Each research assistant was trained to conduct the interview and survey session by the first author in a one-on-one training with scripts, modeling, and role-playing (Bandura, 1977). The scripts (Appendix B) indicated what the research assistants should say throughout the session and interview, along with what probes to use. The first author modeled what a session should look like for the research assistants.

Researchers enacted various interview procedures to help reduce power differentials and built rapport with participants (Thornberg et al., 2012). Specifically, researchers attributed the

role of “expert” to the participant and expressed the study’s interest in conveying participant perspectives. Participants were told they did not have to share anything they did not want to and could stop their study involvement at anytime. Researchers limited their evaluative or judgmental statements by reviewing transcripts to note judgmental statements and examples of successful interview responses to foster participants’ willingness to be honest and to talk about their experience. Research assistants established and maintained rapport via open body posture, paying attention to participants throughout their interview via paraphrasing and summarizing their thoughts, using nonjudgmental verbal and nonverbal cues, and making casual friendly conversation (Kortesluoma, Hentinen, & Nikkonen, 2003; Mayall, 2008).

Participants met one of these researchers at their CBO, the researcher’s university, or if out of state via Skype with a login created by the study. The participants met the researcher in person or over Skype and were emailed a link to take the survey utilizing the Qualtrics program (Snow & Mann, 2013) while meeting with the research assistant. Participants opened the survey from a computer or their cell phone, assented electronically, and completed the survey.

Research assistants then conducted semi-structured interviews in person or via Skype with participants. Interviews were audio-recorded by the researcher assistants. Participant involvement concluded by receiving a $15.00 stipend for their time. In person, participants received $15.00 cash and signed a receipt while Skype participants were paid via PayPal or were mailed cash. Participants who interviewed via Skype were sent receipts with their cash for them to sign and return to the researcher. They would return their signed receipt via mail or via email as a scanned image.

Four research assistants conducted the survey and interview sessions and six research assistants transcribed the audio-recorded interviews verbatim. Research assistants were provided

a template for the transcription and the audio recording. The first author reviewed all transcripts for accuracy. The transcripts were imported into MAXQDA software, a program that manages qualitative data and its analysis (Saillard, 2011).

Data Analysis

Coding. Three research assistants (including the first author) conducted coding. Coder one was a Caucasian school psychology graduate student, Heterosexual female; coder two was a mixed (Black and White) undergraduate psychology student, Gay male; and coder three was a Black school psychology graduate student, Heterosexual female. These research assistants coded types of support and nonsupport that confirmed, disconfirmed or extended the types identified in the Kiperman et al. (2014) model. The research assistants also coded for ways in which these codes may be experienced as similar or different by LGBTQ youth with and without parental consent. Coding occurred as a recursive, inductive-deductive process where researchers inductively derived themes from the data reflective of the participants' perceptions, deductively incorporated existing research such as the Kiperman et al (2014) model to develop additional themes, recursively revisited data when ideas were amended (Glaser, 1965; Schensul, Nastasi, 2009; Schensul, & LeCompte, 2013; Strauss & Corbin, 1990). The inductive-deductive coding process consisted of the following steps: open coding for codebook development, continued codebook development, and applying the finalized codebook.

Phase 1: Open Coding for Codebook Development. Open coding refers to identifying and categorizing main ideas in interview text by asking oneself, *what is happening here* or *what is the main idea* (Lincoln & Guba, 1985; Saldaña, 2013). Open coding developed from interview content rather than theory and served as the inductive content for codebook development in phase 2. The three research assistants conducted open coding while transcribing and reconvened

weekly to discuss the following process. They compared their open codes, developed definitions for these codes, agreed on applying certain open codes to similar units of data, and exposed each other to new open codes they had not considered in their own transcript review. Researchers maintained an ongoing table with a list of the open codes, their definitions, and examples from text to inform their inductive findings for codebook development. The researchers reached saturation (which refers to the point at which no new ideas can be generated due to repetition of already identified themes or the point at which all data has been reviewed) as they stopped identifying new open codes before reviewing the final transcripts (Glaser & Strauss, 1967). Although open coding tends to be an inductive process, the research assistants acknowledged their awareness of the study's research question and of the existing Kiperman et al. (2014) model through this process. Researchers' open codes also included support and nonsupport types from the Kiperman et al. (2014) model, as the research questions and current study would be based on this work. Thus, deductive coding occurred when researchers identified themes with which they were familiar, but they also open coded for novel ideas consistent with an inductive approach.

Phase 2: Continued Codebook Development. The second phase of data coding involved developing a codebook with inductive and deductive concepts. Codebooks function as guides or manuals to researchers that help them independently identify the same qualitative analyses (Bakeman & Gottman, 1986; MacQueen, McLellan, Kay & Milstein, 1998). Codebooks typically include the code name, a brief definition (to summarize the code), a full definition (to address nuances), guidelines for when to apply or not apply the code, and examples (MacQueen et al., 1998).

The three research assistants were guided by consensual qualitative research (CQR) guidelines in codebook development (Hill, Thompson, & Williams, 1997). CQR calls for

multiple researchers working together, reaching consensus, and acknowledging the representativeness of codes across cases. Researchers first reviewed the research question and considered what open codes from phase one were relevant. They deductively compared the open codes to existing concepts and models of social support and nonsupport to yield an inductive-deductive codebook. Researchers included codes that both support and contradict existing theory, to account for negative case analysis, which refers to including data that may contradict or not support the overall data scheme (Miles & Huberman, 1994). By applying negative case analysis to the data, researchers can better understand the complete experiences of participants, reduce their bias of looking only to confirm established theories, enhance validity of data interpretation and emerging theories, and provide direction for future research (LeCompte & Schensul, 2013; Morse, 2015).

Codebooks were established as reliable when researchers could independently review the same transcript and yield similar codes. Prior to this process beginning researchers designated coding blocks and methods for assessing interrater reliability. Coding blocks are predetermined segments of text to promote reliability of coding by multiple researchers (Lincoln & Guba, 1985; Saldaña, 2013). For this study coding blocks were identified as entire segments when a participant speaks, beginning after the researcher stops talking and ending before a researcher starts talking. An exception to this rule was when a participant's response could only be coded accurately by considering the researcher's question or probe to inform the participant's response.

Inter-rater Agreement (IRR) refers to the extent to which coders agree, determined by comparing their coding decisions to determine the percentage of coding agreements (Bakeman & Gottman, 1986; Nastasi, 2009). IRR helps researchers develop and refine their codebooks. Bakeman and Gottman suggest the standard 90% agreement. Researchers continued clarifying

the codebook (e.g., sharpening definitions, providing examples) until at least 90% IRR was attained, which occurred at transcript 10 (91.26% IRR attained). Researchers applied the finalized codebook to all transcripts, including those that were coded with previous versions of the codebook. The final IRR value depicts all transcripts coded with the final codebook.

Phase 3: Applying the Finalized Codebook. The third phase involved coding data with the finalized codebook while maintaining adequate reliability among coders. Each of the three research assistants were assigned a third of the transcripts to code independently, including transcripts that were coded with former versions of the codebook as they were not coded with most updated codebook. To address concerns of independent coding, researchers incorporated an accountability technique to account for possible coder drift (Bakeman & Gottman, 1986). Coder drift refers to the tendency of coders to change their interpretations of the coding scheme as they code independently. The researchers monitored coder drift by calculating IRR for 10% of each individually coded interview (Bakeman & Gottman, 1986; Nastasi, 2009). The remaining interviews were coded with 90% or higher IRR (n = 27 interviews, coder drift IRR = 92.23), with a final total IRR of 91.68%. All discrepancies were discussed by researchers and compared to the codebook definition until 100% consensus was reached (Miles & Huberman, 1994).

Trustworthiness. The current study incorporated multiple procedures to address the trustworthiness of the data. Trustworthiness refers to the steps taken to ensure data validity (the extent to which findings are consistent and other explanations can be ruled out), reliability (the extent to which findings are replicable), and objectivity of researchers (limiting researcher bias and subjectivity) (Lincoln & Guba, 1985; Miles & Huberman, 1994). The particular actions enacted by researchers to ensure trustworthiness included training research assistants for the following: interview procedures (e.g., reducing power differentials, attuning to participants, and

limiting evaluative statements) (Kortesluoma et al., 2003; Mayall, 2008), bracketing researcher biases (Miles & Huberman, 1994), IRR methods (Bakeman & Gottman, 1986), and developing a codebook (Bakeman & Gottman, 1986; MacQueen et al., 1998). Additional methods used to implement trustworthiness included an audit trail and peer debriefing (Lincoln & Guba, 1985).

Bracketing refers to a phenomenological concept that asks researchers be aware of their unacknowledged preconceptions that relate to the research or that may taint a researchers motive in their work (Saldaña, 2013). The first author had awareness of her identity as a straight female ally of the LGBTQ youth community completing her school psychology dissertation in academia. She acknowledged her transformative orientation that informs her motive to further social justice agendas for this community as a limit that could skew her interviewing, interpretation, and reporting. The research team was trained to enact bracketing to account for their unique lens during live interviews and data analysis phases of research. Two of the three additional research assistants identified as straight female allies of the LGBTQ youth community and were seeking their school psychology specialist degree at the time of their involvement. The third research assistant identified as Gay male and an ally of the LGBTQ youth community. He was an undergraduate student who ran an LGBTQ youth group in the Southeast United States. Some ways in which the research team attempted to bracket involved using participants' own words when probing in interviews. Using participants own words is considered bracketing, as using similar words denotes being on a similar page regardless of external circumstances or preconceptions (e.g., unique values or experiences).

The researchers who coded and conducted interviews enacted audit trails (Lincoln & Guba, 1985) that included detailed documentation of procedures including data gathering and coding. The audit trails included detailed summary of each interview with specific regard for

participant affect or unique qualities (e.g., one participant stated they had autism, which was noted in the audit trail), changes made to the interview protocol, and each version of the developed codebook with notes indicating where revisions were made. The researchers who engaged in each step of the study maintained audit trails.

Peer debriefing refers to the review of data and research process by someone familiar with the research or phenomena being explored (Lincoln & Guba, 1985). The first author's faculty advisors engaged in peer debriefing with the first author as experts in the methodology. One of the faculty advisors is a female full-professor in school psychology, who identifies with a transformative research framework, and actively advocates for the LGBTQ youth community. The second faculty advisor is a male Regents' professor in school psychology whose research addresses consultation, marginalized populations, and preventative mental health services in schools. They supported the first author by questioning her assumptions and interpretations. Peer debriefing among the first author and faculty advisors was an ongoing process from study development, data collection, data analysis and interpretation and dissemination.

Peer debriefing also occurred between the first author and the research assistant with whom she transcribed and coded. Their debriefing typically involved discussions of what information they hoped to convey via findings from their research. The researcher also engaged in peer debriefing following each time a research assistant conducted an interview to review their experience and prepare them for future interactions with participants. These debriefings occurred as either in-person or over the phone as conversations.

Results

The results of this study are structured to inform the study's research question: How do social support and nonsupport experiences of LGBTQ youth (with and without parental consent)

confirm, disconfirm, or extend the Kiperman et al. (2014) model? These coding schemes are presented in *Figures 2.2* and *2.3* where coding schemes for social support and nonsupport actions are depicted in *Figure 2.1*, and social support and nonsupport descriptions are in *Figure 2.2*. The following analysis includes 4 level 1 codes: social support actions, social nonsupport actions, social support descriptions and social nonsupport descriptions. Each level 1 code and their subcodes are discussed in the following results sections. Codes and subcodes are illustrated with direct quotes from participants. Prevalence of codes and subcodes are reported by including the frequency and percent of the sample that discussed each. Each code has a sentence that discusses how codes confirm, disconfirm and extend the Kiperman et al. (2014) model.

In exploring how experiences of youth with and without parent consent may be similar or different, similarities were noted as participants discussing the same social support and nonsupport, allowing researchers use one codebook/series of codes to guide the results for each population. Differences were documented as frequency variations, where youth with parent consent reported experiencing social support/nonsupport actions and descriptions more or less frequently than youth without access to parent consent. These findings are discussed last in the results section and are depicted in *Table 2.2*.

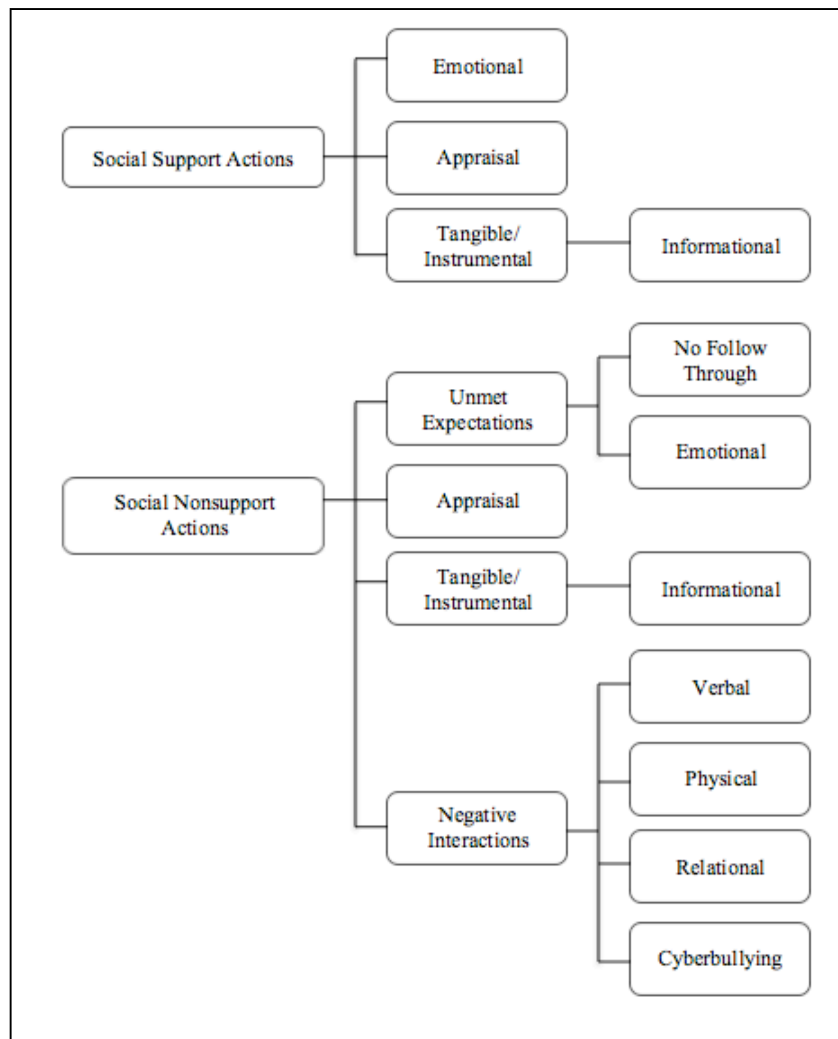

Figure 2.1 Coding Hierarchy: Social Support and Nonsupport Actions

Social Support Actions (Level 1)

Social Support actions were coded to depict ways participants perceive receiving support from others. Social support actions included the following level 2 codes: *emotional, appraisal,* and *tangible/instrumental*. The code, *tangible/instrumental* contained the level 3 code, *informational*. These codes are presented in *Figure 2.3* and are defined and discussed below.

Emotional (Level 2). *Emotional support* was coded when participants perceived groups or individuals as providing them with warmth, nurturance, assurance or an opportunity to talk (i.e., expressions of empathy, love, 'you matter'). *Emotional support* was further defined based

on motives to foster warmth between the participant and others. Findings confirm *emotional support* as support LGBTQ youth perceive receiving. *Emotional support* was reported by 97.62% of participants (*n* = 20/21 with parent consent; *n* = 21/21 with in loco parentis consent). A 14-year-old White female who was Bisexual and used in loco parentis consent procedures reported her girlfriend as providing *emotional support* as follows: “Well she is willing to be seen with me and put her arm around me in public or like that. She’ll tell people… She will be like, ‘this is my girlfriend, I’m proud to be with her’, and I do the same thing with her”. A 16-year-old, White, female, participant who identified as Lesbian and had parent consent shared the following about her girlfriend:

> “…She knows me inside and out, like completely, like if we’re Skyping, and I’m doing homework - and that’s often what happens because we Skype every single day. […] You would think that at that time, when you’re at your lowest and you feel like you’re gonna do something stupid, […] you think […] someone needs to hold me down, or hug me, or wipe my tears for me, or be the shoulder that I cry on, but she completely was, without being there physically, and that’s what’s really beautiful about the situation”.

Appraisal (Level 2). *Appraisal support* was coded to depict a participant’s perception that groups or individuals provided them with evaluations that either enhanced their self-perceptions, facilitated their accomplishments/identity development, or gave constructive feedback that was experienced positively. *Appraisal support* was coded when motives were to offer guidance, rather than fostering the emotional connection. Findings disconfirm the Kiperman et al. (2014) model’s depiction of affirmation, as the article explicitly noted constructive feedback as not being identified as supportive. This study includes *appraisal support,* as a support LGBTQ youth perceive receiving. Several participants reported experiencing *appraisal support* (71.43%) (*n* =

16 parent consent; *n* = 14 in loco parentis). A 16-year-old Hispanic participant who identified as Genderfluid and Pansexual and used in loco parentis consent procedures reported the following experience of appraisal: "I had a […] Spanish teacher, she was just so nice and so supportive. When I did come out to her, she was respectful of it and she said it doesn't matter to me who you are because you are a good person and that is was matters". Another example of *appraisal support* was stated by a 17-year-old White Pansexual female with parent consent who stated:

> "I was at a friend's house, and we were being stupid teenagers and we were drinking and smoking and I was supposed to drive home. And I was like 'I don't know what to do [… so I called by brother and he said] 'You're making bad decisions and I want you to make good decisions. So either you are going to stay there or you are going to walk home'. So I walked home, I walked home and um when I got home, my brother […] just like made me feel better about myself because when I sat on the couch, he stood in front of me, and said 'Listen, you're not allowed to make these decisions'. And just, ever since that night he has made sure that everything I do is always something that I will have a plan and I'll have some way to help myself".

Tangible/instrumental (level 2). *Tangible/Instrumental* support was coded when participants perceived groups or individuals as providing them with goods, services, help, or assistance (not inclusive of feedback- which was coded as appraisal). Such *tangible/instrumental support* could include mentorship, advocacy, fiscal assistance, shelter, car rides, etc. *Tangible/instrumental support* was reported by 83.33% of participants (n = 19 parent consent; n = 16 in loco parentis). Findings confirm the Kiperman et al. (2014) model to include *tangible/instrumental support,* as a support LGBTQ youth perceive receiving. A 15-year-old White female who identifies as Bisexual and used in loco parentis consent procedures reported

tangible/instrumental support as the following from her stepmom: “She’s taking me to go to a bi parade or a Pride Parade. […] She takes me there and she will sit there and cheer on with me or hold my hand and be right next to me and go watch the parade”. A 16-year-old, White participant who identified their gender as “other”, was heterosexual, and who used parent consent reported the following experience of *tangible/instrumental support*:

> “I hate thinking this, but I’m one of the lucky ones. […] I might not always be the most accepting of their [my parents] love and returning it, but […] at the end of the day, I have a bed to sleep on, that I know I can come back to, if I go and do drugs or alcohol I have someone I can call for a ride. Not that I’m saying I will.

Informational (level 3): Informational support was coded as a subtype of *tangible/instrumental* as receiving information was considered a service/help others provided. Informational support refers to participants’ perception that groups or individuals provided them with new, helpful knowledge or advice to address problems, questions or knowledge gaps. *Informational* support was reported by 57.14% of participants (n = 13 parent consent; n = 11 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *informational support,* as a support within tangible/instrumental support that LGBTQ youth reported receiving. A 17-year-old, White female to male Transgender participant who identified as Pansexual and used parent consent reported his friends as providing the following informational support:

> “Um, they sent me, like, um, resources that help, um, help you find labels for yourself. They, uh, sent me positivity quotes and stuff, and they, uh, also since I’ve been come, like, coming out as Trans, they’ve sent me a lot of, um, resources as well, especially for transition and finding doctors”.

Social Nonsupport Actions (Level 1)

Social Nonsupport actions were coded to depict ways in which participants perceive not being supported by others. *Social nonsupport actions* included the following level 2 codes: *unmet expectations, appraisal, tangible/instrumental,* and *negative interactions*. The code, *unmet expectation* contained the level 3 codes, *no follow through* and *emotional;* while the code *tangible/instrumental* contained the level 3 code *informational;* and the code *negative interactions* contained the level 3 subcodes *verbal, physical, relational*, and *cyberbullying*. These codes are presented in Figure 2.3 and are defined and discussed below.

Unmet expectations (level 2). *Unmet expectations* were coded when participants reported groups or individuals as not meeting their expectations or when the participants preferred that others act differently than they did. *Unmet expectations* were reported by 80.95% of participants (*n* = 18 parent consent; *n* = 16 in loco parentis). Findings confirm the Kiperman et al. (2014) model to include *unmet expectations,* as a nonsupport LGBTQ youth report receiving. A 17-year-old, White Transgender (female to male) participant who identified as Pansexual and used parent consent reported having the following experience of an *unmet expectation*:

> "Uh, I mean, it, whenever people use the wrong pronouns or, like, assume that I'm just, you know, a girl and don't even really think anything of it, uh, it makes me feel kinda disappointed, I'm just, like, "Uh huh!" It's not even worth the fight, though, most of the time. It's not worth correcting people, because you never know how they're gonna be on that, and if they aren't completely okay with that then you're gonna end up having a ten minute discussion with your grocery clerk, and that's just, it's not fun".

Another participant who was 14 years old, White, Genderfluid, Pansexual, and who had parent consent reported the following unmet expectation from a religious facility: "I went there for a positive service, and all I got was negativity."

No follow through (level 3). Researchers coded *no follow through* when participants reported groups or individuals as not following through on an explicitly stated previous commitment they made to the participant. *No follow through* was reported by 30.95% of participants (*n* = 7 parent consent; *n* = 6 in loco parentis). Findings confirm the Kiperman et al. (2014) model to include *no follow through,* as a nonsupport LGBTQ youth report receiving. A 17-year-old, White Transgender (female to male) participant who identified as Pansexual and used parent consent reported *no follow through* as the following: "Oh, my God. My principal. Dead names me ALL the time. Dead name's when you call someone, um, uh, by the name that they were given at birth, and not necessarily the one that they, um, have told you ten-thousand times that they wanna be called."

Emotional (level 3). Emotional nonsupport was coded when participants perceived groups or individuals as not providing emotional support when it is expected. Emotional nonsupport was coded when explicit statements of others not caring about the participant or disowning them were discussed. *Emotional nonsupport* was reported by 66.67% of participants (*n* = 13 parent consent; *n* = 15 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *emotional nonsupport,* as a nonsupport LGBTQ youth report receiving. A 14-year-old female of mixed race, who identified as female and Pansexual, who used in loco parentis consent procedures reported *emotional* nonsupport as the following: "[When my sister wears headphones] it feels like they are not actually listening to you, like they are listening, but at the same time they don't care enough to give you attention".

Appraisal (level 2). *Appraisal nonsupport* was coded when participants perceived groups or individuals provided evaluations that either hurt their self-perceptions, degraded their accomplishments, or gave feedback that was experienced negatively. *Appraisal nonsupport* was reported by 71.43% of participants (*n* = 15 parent consent; *n* = 15 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *appraisal nonsupport,* as a nonsupport LGBTQ youth report receiving. A 14-year-old White female participant who identified as bisexual and used in loco parentis consent procedures reported experiencing *appraisal* as the following: "My mom told me that I am too young to know what I am, like parents usually say… that I am too young to know what I am and she expresses that she doesn't' like [my girlfriend] cause she knows we are in a relationship, so she doesn't support it".

Tangible/instrumental (level 2). *Tangible/instrumental nonsupport* was coded when participants perceived that groups or individuals provided goods services or assistance in ways that devalued their identity or was experienced negatively. *Tangible/instrumental nonsupport* was reported by 42.86% of participants (*n* = 10 parent consent; *n* = 8 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *tangible/instrumental nonsupport,* as a nonsupport LGBTQ youth report receiving. A 14-year-old White female who identified as Bisexual and used in loco parentis consent procedures reported *tangible/instrumental* as the following:

> "She's tried to force it on me, like when I thought I was male she tried to force femininity on me, she would get me make up and try to take me to church and her church is like very strict because males wear suits and women wear dresses. I don't mind wearing a dress, but I don't want to be forced into wearing a dress, and she tried to force me. She definitely tried to force me to do my nails and wear make up and yeah".

Informational (level 3). *Informational nonsupport* was coded when participants perceived that groups or individuals provided new knowledge or advice that devalued their identity, conflicted with their beliefs/identity, or was experienced in a negative way. *Informational nonsupport* was reported by 35.71% of participants (*n* = 8 parent consent; *n* = 7 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *informational nonsupport,* as a nonsupport LGBTQ youth report receiving. A 17-year-old White female who identified as Lesbian and had parent consent reported *informational nonsupport* as the following:

> "It was bad. Um, he talked about how he had all these gay friends and they lived the gay lifestyle and a lot of them decided to change their lifestyle and now they're really happy and umm yeah. That's what he said I mean he was like they decided that they wanted to change their gay lifestyle like he was saying they converted like into being straight. Like to enlighten me I don't know maybe he was like 'she's so young, maybe she can change'".

Negative Interactions (level 2). *Negative Interactions* was coded when participants perceived groups or individuals as engaging in negative acts against them, which typically appeared as bullying either online or in person. Negative interactions could include exclusion bullying, hurtful comments/verbal abuse, or spreading rumors. Level 3 subcodes of *negative interactions* included *verbal, physical, relational*, and *cyberbullying*. *Negative Interactions* was reported by 71.43% of participants (*n* = 15 parent consent; *n* = 15 in loco parentis). Findings confirm the Kiperman et al. (2014) model to include *negative interactions,* as a nonsupport LGBTQ youth report receiving. One 14-year-old youth who identified as a Gay White male and used parent consent reported that he experienced the following as *negative interactions* from his classmates:

"During class, they would like to pull pranks on me, they would try to get me in trouble, they would like… we weren't allowed to have our phones at school but we could like have them in our backpacks. And um, people would take my phone and try to put it on the ground where the teacher was standing to try to get me in trouble".

Verbal (level 3). Verbal negative interactions was coded when participants perceived that groups or individuals verbally insulted them with homophobic or general slurs, verbal abuse, hurtful comments, criticism, curse words, or threats in person or in writing (not electronic). *Verbal* was reported by 80.95% of participants (*n* = 17 parent consent; *n* = 17 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *verbal nonsupport,* as a nonsupport LGBTQ youth report receiving. A 16-year-old participant who identified as White, Lesbian, and female who used parent consent reported *verbal negative interactions* as the following: "There was this gym teacher last year that like didn't, that like checked all the girls out and hit on 'em, and eventually I spoke up and uh, he ended up calling me a faggot, cause I told him that he needs to respect women". Anther youth who was 15 years old and identified as Hispanic, Genderqueer (when people do not subscribe to conventional gender distinctions but identifies with neither, both, or a combination of male and female genders), and Pansexual (attraction preference is not limited with regard to biological sex, gender or gender identity) who had parent consent shared the following from her school-based peers:

"Uh I was in class with them and uh, I think the day it started was when I was walking down the hallway and they were like "hey fat ass, what's up?" and I was like "what?" And then like it continued happening, and I think it got a little more serious when they were like "oh you should just go kill yourself" like "I don't even know why you're here," and honestly its just stupid".

Physical (level 3). Physical negative interactions was coded when participants perceived that groups or individuals physically assaulted participants (e.g., hit, kick, punch, push). *Physical* was reported by 21.43% of participants (n = 3 parent consent; n = 6 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of a *physical negative interaction,* as a nonsupport LGBTQ youth report receiving. A 17-year-old Hispanic participant who identified as Transgender (female to male) and Gay who used in loco parentis consent procedures reported *physical negative interactions* as the following:

> "Yeah my mom's best friend said she thought I was my step dad's daughter for a second and she started going off on me and I told my mom I wanted her out of the house. My mom got her out of the house but my mom was mad that I told her that so she grabbed me by my shirt and she hit my back a few times and I turned around to look at her and she gave me a bloody nose. And she made me clean it up afterwards too".

An example of *physical negative interactions* occurring in school was mentioned by a 15-year-old White, Bisexual Female who used in loco parentis consent procedures: "My peers make fun of me because of they know … that I'm bisexual and um … that they would try to hurt me you know sometimes physically you know hit me on my back or try to trip me up or anything like that".

Relational (level 3). Relational negative interactions were coded when participants perceived groups or individuals as targeting them through exclusion or rumor spreading. *Relational negative interactions* were reported by 21.43% of participants (*n* = 5 parent consent; *n* = 4 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *relational negative interactions,* as a nonsupport LGBTQ youth report receiving. A 14-year-old

White, Genderfluid, Pansexual youth who used parent consent reported *relational negative interactions* as the following:

> "These guys said 'you're actually a cool person but I can't talk to you when other people are around because we don't want to be made fun of'. I mean, I don't even know how it started. It was just something that someone made up. And then, I got surrounded so fast that I had no friends and even new people were coming to school, people would tell them about me. I had no friends. A bunch of other stuff spread off of that, so it was, there were so many things".

Cyberbullying (level 3). Cyberbullying was coded when participants perceived groups or individuals as targeting them through electronic means of bullying. *Cyberbullying* was reported by 2.38% of participants (n = 0 parent consent; n = 1 in loco parentis). Findings extend the Kiperman et al. (2014) model's by depicting *cyberbullying negative interactions,* as a nonsupport LGBTQ youth report receiving. A 15-year-old White Bisexual Female who used in loco parentis consent procedures reported *cyberbullying* as the following:

> "These people [on social media] Facebook, Kik, and Instagram, they were like stuck up you know they did not really care if you try to talk to them or spend time with them, they.. they wouldn't give a crap about you. …Um they would say if you know you're bisexual or transsexual or any kind of sexual, you know you should go and kill yourself and you know telling me things like that".

Social Support Descriptions (Level 1)

Social support descriptions (Level 1) was coded to depict how participants perceived the mannerisms or traits of those who provided support to them (description-based, rather than action based like support actions). *Social support descriptions* included the following level 2 codes: *open-minded/nonjudgmental, connected, available, sameness, unconditional regard, and genuine/authentic*. The coding hierarchy is depicted in *Figure 2.2* with social nonsupport descriptions.

Open-mindedness/nonjudgmental (level 2). *Open-minded/nonjudgmental support* was

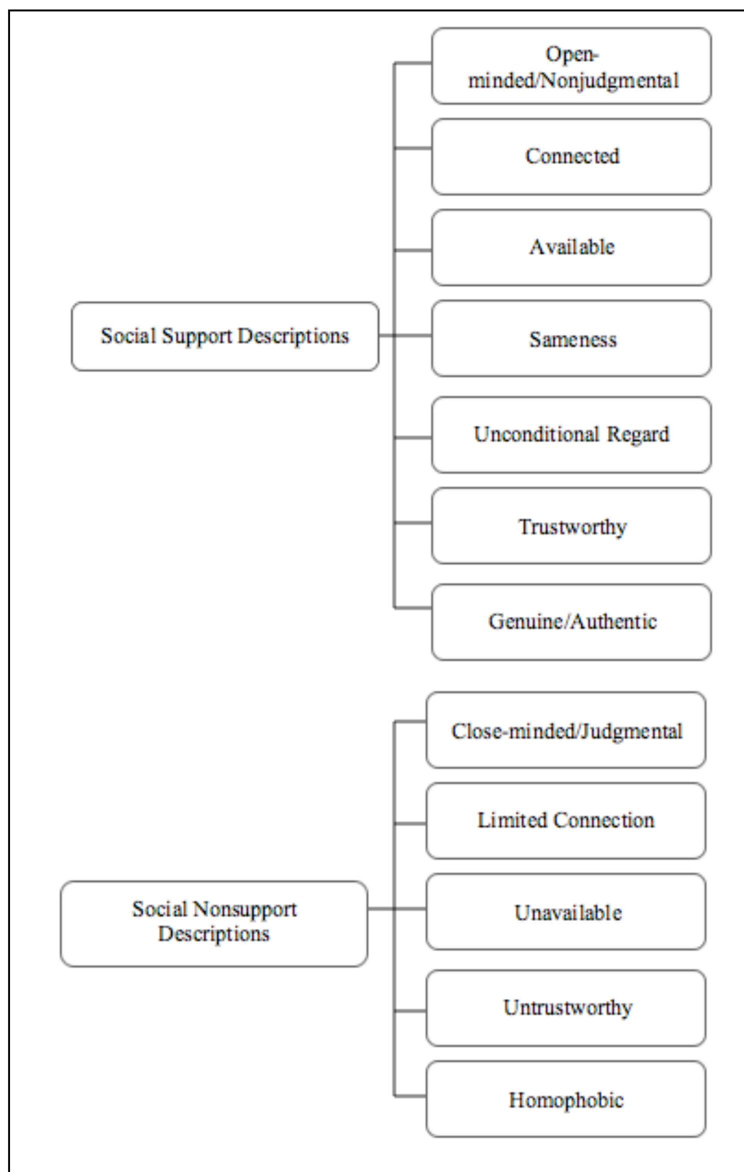

Figure 2.2 Coding Hierarchy: Social Support and Nonsupport

coded when participants perceived groups or individuals as being able to talk about anything, in a nonjudgmental way, not caring about the participant's identity. *Open-mindedness/nonjudgmental support* was reported by 85.71% of participants (*n* = 20 parent consent; *n* = 16 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *open-mindedness/nonjudgmental,* as a support LGBTQ youth report receiving. A 17-year-old Black, Nonbinary Lesbian who had parent consent reported *open-mindedness/nonjudgmental support* from her parents:

> "They like, we have like open communication about it. Like, if they have questions, they ask me. Sometimes their questions are a lil ignorant, but I mean they are just trying to figure it out. Cuz they don't know much about it. Cuz like it was never taught and no one knows really".

Connected (level 2). *Connected support* was coded when participants perceived groups or individuals as understanding them. *Connected support* was reported by 73.81% of participants (*n* = 16 parent consent; *n* = 15 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *connected support,* as a support LGBTQ youth report receiving. A 17-year-old, White Pansexual female with parent consent reported feeling *connected* as the following: "She and I have been in such similar situations our whole lives, that she can just understand me and I can understand her really easily. […] And it's like middle school girls. I don't know she is just pretty important". In this example, being similar does not refer to their sexuality or gender identity, so it was not coded as *sameness*.

Available (level 2). *Available support* was coded when participants perceived groups or individuals as being available, "always being there" or as going out of their way to be present for the participant. *Available support* was reported by 50% of participants (n = 10 parent consent; n

= 11 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *available support,* as a support LGBTQ youth report receiving. A 15-year-old, White Gay male who used in loco parentis consent procedures reported *available* as the following from his sister: "Ya know, like if I text her and say hey can we talk, she's like sure even if she's at work she'll make a few minutes to just sit down and talk to me and ask what's going on and how can she help".

Sameness (level 2). *Sameness support* was coded when participants perceived groups or individuals as having an LGBTQ+ identity that is viewed as a shared experience. *Sameness support* was reported by 78.57% of participants (*n* = 18 parent consent; *n* = 15 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *sameness,* as a support LGBTQ youth report receiving. A 15-year-old White Lesbian female who used in loco parentis consent procedures discussed *sameness support* in the following manner: "I have some friends that are gay that are supportive of course. They know what I'm going through and like what's happening and like how I feel. So they know like exactly what to say and if we want to talk about it, they know. It's just really good to have other people like you".

Unconditional regard (level 2). *Unconditional regard* was coded when participants perceived groups or individuals as loving them no matter what, doing anything for them, or still caring despite presented conditions (e.g., disclosure of one's sexual orientation). *Unconditional regard* was reported by 54.76% of participants (*n* = 12 parent consent; *n* = 11 in loco parentis). Findings extend the Kiperman et al. (2014) model's depiction to include *unconditional regard,* as a support LGBTQ youth report receiving. A 14-year-old Lesbian Hispanic female who used in loco parentis consent procedures reported *unconditional regard* as the following:

> "Um, because um, even though [my mom and I have] been through like, some situations before, um, she's always stood by me even though there's always been like, I'm getting kind of off-track here *laughter* but like she, she's just always by my side and she's always defending me no matter what".

Genuine/authentic (level 2). *Genuine/authentic support* was coded when participants perceived groups or individuals as being honest or real. *Genuine/authentic support* was reported by 30.95% of participants (*n* = 9 parent consent; *n* = 4 in loco parentis). Findings extend the Kiperman et al. (2014) model's depiction to include *genuine/authentic,* as a support LGBTQ youth report receiving. A 16-year-old White Lesbian female with parent consent reported *genuine/authentic support* as: "I think [our GSA] is […] most definitely more […] honest and [people can] be truthful about how they're feeling. And it does mean a lot because I don't have a lot of people that are like super close to me in my life".

Trustworthy (level 2). *Trustworthy* support was coded when participants perceived groups or individuals as people to whom they could confide. *Trustworthy* support was reported by 33.33% of participants (*n* = 8 parent consent; *n* = 6 in loco parentis). Findings extend the Kiperman et al. (2014) model's depiction to include *trustworthy support,* as a support LGBTQ youth report receiving. A 16-year-old youth who identifies as Nonbinary/Agender Pansexual and White who used in loco parentis consent procedures reported *trustworthy* support as the following: "Well we've known each other for like over four years now we talk, we talk like every single day, so I trust him with like everything and he trusts me too".

Social Nonsupport Descriptions (Level 1)

Social nonsupport descriptions (Level 1) were coded to depict how participants perceived the mannerisms or traits of those who provided nonsupport to them (description-based, rather

than action based like nonsupport actions). *Social nonsupport descriptions* included the following level 2 codes: *close-minded/judgmental, limited connection, unavailable, untrustworthy, and homophobic*. These codes are presented in *Figure 2.2* and are defined and discussed below.

Close-minded/judgmental (level 2). *Close-minded/judgmental nonsupport* was coded when participants perceived groups or individuals as having a limited understanding and unwillingness to acknowledge new/different perspectives. *Close-minded/judgmental* was also described as people being stuck in their ways or as being condescending. *Close-minded/judgmental* was reported by 85.71% of participants (*n* = 18 parent consent; *n* = 18 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *close-mindedness/judgmental,* as a nonsupport LGBTQ youth report receiving. A 16-year-old youth who identified as Hispanic, Pansexual and Genderfluid and used in loco parentis consent procedures reported *close-minded/judgmental support* as:

> "There are times when I don't feel comfortable like peering out of my window, like my blinds are always shut and I haven't really come out to anybody in my neighborhood. It's just uncomfortable because I just don't feel like I can really express myself and be myself without feeling like this constant judgment".

A 14-year-old who identified as a White, Lesbian female and had parent consent reported of people in her neighborhood:

> "If they don't know me, they're judging the way I look because I have short hair and I don't dress in a very feminine way so they could be judging me based upon that and making assumptions that I'm not like them. Assumptions that I'm not a good person or

I'm going to try to turn them and make them identify with how I identify. They're going to assume my identity and judge me and think that I'm a terrible person".

Limited Connection (level 2). *Limited connection* was coded when participants perceived others as not understanding or getting them. *Limited connection* was reported by 61.90% of participants (n = 11 parent consent; n = 15 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *limited connection,* as a nonsupport LGBTQ youth report receiving. A 16-year-old White Bisexual female who used in loco parentis consent procedures reported *limited connection* as: "Um, I avoid a lot of things with a lot of people because they don't know-- like I don't know how to come out to them. I don't know how they're gonna react". The same youth reported of her grandmother, "I mean my grandmother's always been really supportive of me, it's just that her roommate really isn't that supportive, like her roommate doesn't understand what it's like to be bisexual".

Unavailable (level 2). *Unavailable nonsupport* was coded when participants perceived others as being notably less present than they would like. *Unavailable nonsupport* was reported by 42.86% of participants (n = 8 parent consent; n = 10 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *unavailable nonsupport,* as a nonsupport LGBTQ youth report receiving. A 15-year-old Black Lesbian Female who used in loco parentis consent procedures reported *unavailable nonsupport* as the following:

> "My dad doesn't live with me, he lives in Florida with his other family. So like he'll like we really only like talk about school… We don't really talk about my personal life. Like, we used to talk everyday but now we talk like maybe twice a week after school *participant wipes a tear*".

Untrustworthy (level 2). *Untrustworthy nonsupport* was coded when participants perceived others as people to whom they would not confide due to prior breaching of trust or assumed limitations in their ability to trust. *Untrustworthy nonsupport* was reported by 28.57% of participants (*n* = 6 parent consent; *n* = 6 in loco parentis). Findings extend the Kiperman et al. (2014) model to include *untrustworthy,* as a nonsupport LGBTQ youth report receiving. A 14-year-old White Genderfluid, Pansexual youth with parent consent reported an example of her dad as *untrustworthy* as the following: "My dad doesn't support me in so many ways. He lies and says 'you have to do something' and then he says 'I just don't care'. Its like, distrust, and I don't feel like if you have distrust with someone if they actually care, or that they will be there for you".

Homophobic (level 2). *Homophobic nonsupport* was coded when participants perceived others as being explicitly hateful/judgmental or condescending of the LGBTQ community, where explicit reference to homophobia is made. *Homophobic* was reported by 50% of participants (n = 10 parent consent; n = 11 in loco parentis). Findings confirm the Kiperman et al. (2014) model's depiction of *homophobic nonsupport,* as a nonsupport LGBTQ youth report receiving. A 15-year-old White Bisexual male who used in loco parentis consent procedures reported his grandparents presenting with *homophobia* as follows: "I haven't told them. They don't know that I'm, uh, I'm Bisexual. Neither does my, uh, mother. Uh, they're homophobic and I'm living at their house. I would fear that they would kick me out. That would, that would really suck".

Youth with and without Access to Parent Consent: Comparisons in their Experiences

Comparing the two sample groups of youth with and without parent consent were conducted in two ways: (1) identifying whether they endorse similar constructs related to their experience of social support/nonsupport actions and descriptions; and (2) using frequency counts

to inform how many people from each sample groups endorsed specific social support/nonsupport actions and description. The researchers' analyses identified the participants as discussing the actions and descriptions of social support and nonsupport similarly. This finding allowed the researchers to apply the same codebook used to inform Figures 2.1, 2.2, and 2.3.

The researchers used frequency counts to compare the experiences of youth with and without parent consent and are presented in Table 2.2. Results in this section are descriptive due using frequency counts. While both sample groups contained 21 participants (parent consent n = 21; youth advocate- youth without parent consent- n = 21), comparing the different frequency counts of each are not generalizable and should be interpreted with caution.

Table 2.2 *Participant Overall Report: Social Support/Nonsupport Actions and Descriptions by Parent Consent (youth with and without)- Frequency (Percent)*

	Parent Consent *n*	Youth Advocate *n*	Total *n* (%)
Social Support Actions			
Emotional	*20*	*21*	*41 (92%)*
Appraisal	*16*	*14*	*30 (71.43%)*
Tangible/Instrumental	*19*	*16*	*35 (83.33%)*
Informational	*13*	*11*	*24 (57.14%)*
Social Nonsupport Actions			
Unmet Expectations	*18*	*16*	*34 (80.95%)*
No Follow Through	*7*	*6*	*13 (30.95%)*
Emotional	*13*	*15*	*28 (66.67%)*
Appraisal	*15*	*15*	*30 (71.43%)*
Tangible/Instrumental	*10*	*8*	*18 (42.86%)*
Informational	*8*	*7*	*15 (35.71%*
Negative Interactions	*15*	*15*	*30 (71.43%)*
Verbal	*17*	*17*	*34 (80.95%)*
Physical	*3*	*6*	*9 (21.43%)*
Relational	*5*	*4*	*9 (21.43%)*
Cyberbullying	*0*	*1*	*1 (2.38%)*
Social Support Descriptions			
Open-minded/ Nonjudgmental	*20*	*16*	*36 (85.71%)*
Connected	*16*	*15*	*31 (73.81%)*
Available	*10*	*11*	*21 (50%)*
Sameness	*18*	*15*	*33 (78.57%)*
Unconditional Regard	*12*	*11*	*23 (54.76%)*
Genuine/Authentic	*9*	*4*	*13 (30.95%)*
Trustworthy	*8*	*6*	*14 (33.33%)*

Social Nonsupport Descriptions			
Close-minded/ Judgmental	*18*	*18*	*36 (85.71%)*
Limited Connection	*11*	*15*	*26 (61.90%)*
Unavailable	*8*	*10*	*18 (42.86%)*
Untrustworthy	*6*	*6*	*12 (28.57%)*
Homophobic	*10*	*11*	*21 (50%)*

Frequency counts were similar among youth with and without parent consent. Researchers elected to consider a difference of four or more between the two sample's frequencies as worth reporting. The codes where frequency differences were four or greater among each sample were: *Social Nonsupport Description* code, *Limited Connection* (*PC n* = 11; *YA n* = 15) and *Social Support Description* code, *Open-minded/Nonjudgmental* (*PC n* = 20; *YA n* = 16).

Discussion

In pursuing further development of the Kiperman et al. (2014) model of a social support and nonsupport continuum, this investigation established multiple findings that confirmed, disconfirmed, and extended it. Codes within the Kiperman et al. (2014) social support and nonsupport model that were confirmed and retained were originated from the House (1981) support themes: *emotional, information, tangible/instrumental*; and the Neufeld and Harrison's (2003) nonsupport themes of *unmet expectations* and *negative interactions*. Within the Neufeld and Harrison's (2003) nonsupport *negative interaction* themes, subcodes: *verbal, physical*, and *relational* were confirmed. Additional social support codes confirmed included: *open-mindedness/nonjudgmental, connected, available,* and *sameness*. Social nonsupport codes confirmed included: *No follow through, close-minded/judgmental, limited connection, unavailable, and homophobic*. The confirmation of the previous codes indicate that youth with and without parent consent discussed these constructs as part of their experience of social

support and nonsupport from others similarly to those youth from the Kiperman et al. (2014) model.

A finding that disconfirmed the Kiperman et al. (2014) model in this study involved using the social support code, *appraisal* rather than *affirmation* as indicated by the previous study. Munoz-Plaza et al.'s (2002) and Kiperman et al.'s (2014) articles documented affirming responses as supportive, and did not reference critical feedback. Despite House's (1981) depiction of *appraisal* as support, the Kiperman et al. (2014) replaced this concept with *affirmation* since affirmation depicts the experience of being affirmed by others rather than receiving critical feedback. Nevertheless, youth in this sample discussed critical feedback as a helpful experience (e.g., being told they were making bad choices or that they are hanging out with the 'wrong crowd' where they were guided to self reflect on their choices), which could indicate the validity of conceptualizing appraisal as including critical feedback and not limiting it to affirmative statements. Thus, the current study and House (1981) reference *appraisal*, which includes critical feedback as a supportive feature.

Several findings extended findings from the Kiperman et al. (2014) model. Social support codes were added to the current study and include: *unconditional regard, genuine/authentic,* and *trustworthy*. These codes were not mentioned in the Kiperman et al. (2014) model, but were discussed by several participants in this study as a part of their supportive experiences, and were therefore included as support codes.

Codes that were added to the current study, which also extended findings of the Kiperman et al. (2014) model included: *emotional, appraisal, tangible/instrumental,* and *informational*. These codes depict *nonsupport* experiences that were initially only conveyed as support codes from the House (1981). By depicting these concepts as both supportive and not

supportive, the researchers informed how one construct can be experienced in both positive to negative ways.

Additional nonsupport codes included that extend findings include the subcode, *cyberbullying* of negative interactions. *Cyberbullying* was discussed by youth in this sample and are considered a type of bullying similar to *verbal, physical,* and *relational*. *Cyberbullying* was included to comprehensively depict the experiences of negative interactions. *Untrustworthy* was also added as a nonsupport code, to depict the negative, nonsupportive, opposing experiences of LGBTQ youth when compared to *trustworthy* support. Including the code, untrustworthy helped convey how the concept of trust could be perceived as both supportive (*trustworthy*) and not supportive (*untrustworthy*).

This study further extended the Kiperman et al. (2014) model, where it revised the concepts of support and nonsupport types by parsing them into support and nonsupport actions and descriptions. In the Kiperman et al. (2014, p. 79) article, types was defined as "when participants perceived someone or a group as having a positive [or negative] impact or interaction based on verbal or nonverbal cues". The researchers accounted for the broad definition of support and nonsupport types and posit two distinct codes that could inform this chapter's model (i.e. actions and descriptions) in Figure 2.3. Codes such as emotional and informational social support or unmet expectations of nonsupport depicted *actions* enacted by people to the participant. Researchers included support codes such as *open-mindedness/nonjudgmental* and *nonsupport* codes like *close-minded/judgmental* as *descriptions*, which depicted participants' descriptions of people providing support or of the support bring provided. While these codes were all discussed as support and nonsupport types within the Kiperman et al. (2014) model, the current chapter developed two distinct groups of codes to

inform a more comprehensive model of LGBTQ youth experiences to demonstrate how these concepts may interact found in Figure 2.3

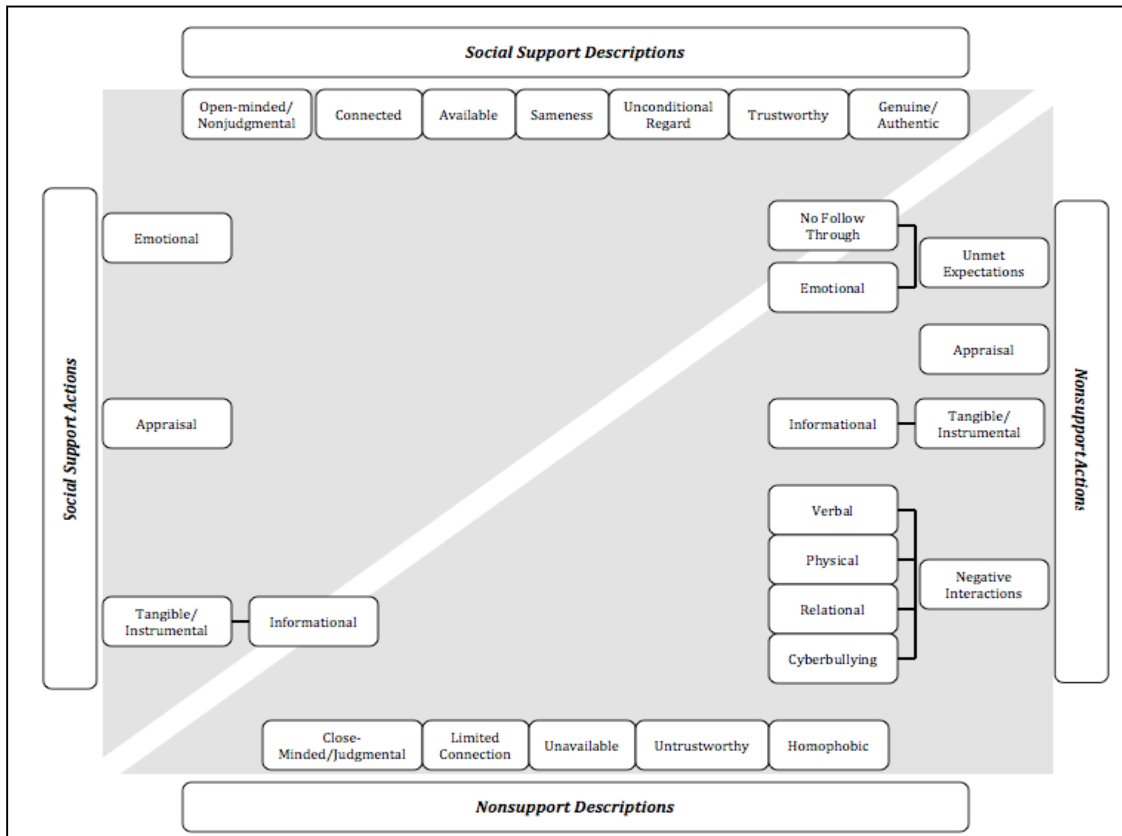

Figure 2.3 The final model: A Continuum Depiction of Social Support/Nonsupport Actions and Descriptions

Figure 2.3 also presented the depiction of LGBTQ youths' continuum of experiences. Studying social support and nonsupport together was posed in the Kiperman et al. (2014), following the independent exploration of these two constructs by Munoz-Plaza (2002), House (1981), and Neufeld and Harrison (2003). The Kiperman et al. (2014) conveyed a continuum of experiences to depict how one idea (e.g., judgment) could be presented as supportive (e.g., nonjudgmental/open-minded) and as nonsupportive (e.g., judgmental/close-minded). Similarly, the current model in Figure 2.3 shows the opposing nature of *social support* and *nonsupport actions* and *descriptions*, by having social support and nonsupport at opposing sides of the figure for each construct.

While previous studies have used in loco parentis consent procedures (e.g., Maguen et al., 2000; Pilkington & D'Augelli, 1995; Rosario et al., 2012; etc.), this was the first study that the researchers could identify that depicted a sample with equal groups of youth without parent consent. From a transformative framework, including LGBTQ youth without parent consent in research is important to depict voices that have been underrepresented. This study confronts the assumption that perceptions of LGBTQ youth with parent consent represent the perceptions of all LGBTQ youth by voicing their experiences and presenting exploratory findings of how youth with and without parent consent compare to one another. Previous research has had limited depiction of LGBTQ youth without access to parent consent, likely due to the rigorous process of implementing in loco parentis procedures, when institutional review boards have parent consent for minors as a standard expectation (Varjas et al. 2008). The researchers could only have in loco parentis consent procedures approved by the university institutional review board if researchers could demonstrate that there was limited risk for youth who participated in this study, if recruitment venues formally signed on to this project, and if a youth advocate was identified with

each site to sign a form in place of parent consent (but that was not consent itself) for youth to participate (Bankert & Amdur, 2006).

Limitations and Future Directions

This study overcame limitations of the Kiperman et al. (2014) article by including transgender youth in the sample, by having a sample where all youth were under 18 years of age, and where youth without access to parent consent were included. Despite these gains, there were limitations in the recruitment methods this study used. This study is one descriptive study using qualitative methodology. Additional studies are needed especially quantitative studies that can address the factor structure of this model will make results more generalizable. The results of the current chapter should be interpreted with caution due to its exploratory intent to inform a model of social support and nonsupport for LGBTQ youth.

Transgender youth were included, and their quotes were able to reflect their unique experiences, however, given the Creswell (2002) requirement of having 15-20 participants to represent a qualitative sample group, there were not enough youth included in the sample to yield an analysis to inform group differences of youth with diverse gender identities compared to youth with diverse sexual orientations. Future studies could explore this difference, as the exploratory findings informed social support experiences unique to gender diverse youth (e.g., when others would provide youth with information on chest binders and doctors who work with transgender youth).

Another limitation applied to recruitment procedures. Recruitment occurred in approved sites that signed contracts that were submitted to the university IRB. Many sites were apprehensive to participate because they had to sign a form that indicated their formal affiliation with the study to the IRB. These sites said they would have participated without a signed form,

which limited the researcher's ability to recruit more participants (e.g., LGBTQ schools in the southeast, neighborhoods with LGBTQ support and residence). The sample in this study was a majority White/Caucasian and resided in suburbia. Future studies should include a greater proportion of youth with diverse race/ethnicities and from different community environments (e.g., urban and rural). This study's sample included a majority middle class LGBTQ youth according to their self report survey data used in other studies. There is a significant homeless youth population that was not included in this study due to IRB limitations of requiring a formal sign on process for recruitment to occur at each site, and the sight was not willing to sign on. Future studies should aim to include these youth in their sample, which would likely require future use of in loco parentis consent procedures.

While enhancing the diversity of this sample is a goal, it is beyond the scope of this study to determine how various marginalized identity descriptions interact to inform how participants experience social support and nonsupport. Future research could address these questions where participants with multiple diverse identities are systematically recruited to explore the different, relative role each identity component contributes to their LGBTQ youth experience of support and nonsupport.

Future research should be conducted to inform the proposed model (Figure 2.3) of social support and nonsupport actions and descriptions. This is the first study to identify the revised model in Figure 2.3, and further exploration is needed to confirm the actions and descriptions identified using qualitative methods. Additionally, more qualitative and preliminary quantitative work is needed to inform the continuum of support and nonsupport experiences. What remains unclear is at what point a support become not supportive and visa versa, as well as clarifying how supportive and not supportive actions and descriptions interact.

Additional quantitative work could inform scale development of the model's social support/nonsupport actions and descriptions to see how they fit into factors. Developing factors for support/nonsupport actions and descriptions with likert values could validate the developed constructs and would allow researchers to quantitatively inform how the factors in Figure 2.3 interact. Developing scales out of this model could present a continuum of experiences via likert depiction where experiences could range from extremely supportive/nonsupportive to not supportive at all. The quantitative studies could benefit from qualitative components, by enacting a mixed methods approach to develop an in-depth understanding how social support and nonsupport influence the lives of LGBTQ youth. A mixed-methods approach is the preferred methodology of a transformative approach (Mertens, 2007), to ensure the quantitative methods are informed by the context of the culture specific sample to whom the results are applied.

Quantitative study designs should explore differences of youth with and without consent, as they relate to their experiences of support and nonsupport. Differences between groups could be assessed through significance and effect size testing to inform generalizability. Multilevel modeling could explore how social support and nonsupport inform LGBTQ youths' diverse experiences.

Implications for Practice

The proposed conceptual model in Figure 2.2, provided practitioners and researchers with a blueprint with regard to how LGBTQ youth with and without parent consent conceptualize their experiences of social support and nonsupport. It is important for practitioners to understand how LGBTQ youth's perspectives may differ from a typical youth so practitioners can address their unique needs (Office of the Surgeon General, 2001; Sue & Sue, 2013). For instance, many youth in this sample discussed coming out to others as a supportive or not supportive experience.

Practitioners should be prepared to provide supportive responses (e.g., having *informational support* by recommending LGBTQ resources and support groups or being *open-minded/nonjudgmental* throughout this discussion). Practitioners should display genuine *unconditional regard* and *open-mindedness*. If one a practitioner or researcher is *judgmental* towards LGBTQ youth, either educating oneself on the lived experiences of these youth could build cultural competence and likelihood of being an informed source of support.

It is also important for practitioners to have an awareness that there are youth without access to parent consent in the school system in need of services. Youth may be unwilling to reach out to others in fear of being 'outed'. Practitioners can make conscious efforts to recruit youth to confidential services via snowball recruitment, as this study enacted and via flyers in approved settings. Once LGBTQ youth without consent are recruited, it may be important to find out what prevents them from accessing consent, to inform what kind of support they need (e.g., *emotional, tangible/instrumental, appraisal* or *informational*). Practitioners are encouraged to exhaust efforts of advertising their services in a way that all youth can be informed of what they can access. LGBTQ youth without access to parent consent services is critical, as they may have limited supports and access to services without the support or consent of their parents.

This paper's presentation of support descriptions indicates that providers of support should be cognizant of *how* they provide support to LGBTQ youth and how these findings can be a basis for consulting with educators, parents and others about how to provide LGBTQ youth with support. *Social support* and *nonsupport descriptions* can be experienced with each *support* and *nonsupport action*, respectively. While the model of social *support* and *nonsupport actions* indicate what practitioners can do to be helpful, providing support could likely be more effective if it is provided in a way LGBTQ youth view positively. Conversely, by knowing what LGBTQ

youth view as not supportive, practitioners can make conscious efforts to avoid actions that convey nonsupport.

The sample in this study included youth without access to parent consent. Research on LGBTQ youth often generalize results to the entire LGBTQ youth community, when a critical part of the sample has been left out (youth without access to parent consent). Like researchers, it is practitioner's responsibility to advocate for all LGBTQ youth and to seek out youth who may not have the support other youth may have. Not having access to parent consent could prevent youth from engaging in activities that may heighten their parent's awareness of their sexual orientation or gender identity (e.g., a Gay Straight Alliance field trip or involvement in LGBTQ youth groups) due to parents' possible disapproval of the youth's LGBTQ identity. While practitioners may not necessarily be able to identify LGBTQ youth without access to parent consent, one way to show one's open-mindedness and lack of judgment could be to have flyers available that remind students of the confidential services available or having a symbol by one's door showing their support of the LGBTQ community. Having these items displayed could allow a youth who is not out to their parents or peers identify a safe space to seek help. Youth without access to parent consent could not feel comfortable reaching out unless they feel safe in doing so. By accounting for youth without access to parent consent, we can enact more preventative measures to protect youth who may otherwise not seek out services when needed.

References

Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation. *Journal of youth and adolescence*, *38*(7), 1001-1014.

Bakeman, R., & Gottman, J. M. (1986). *Observing behavior: An introduction to sequential analysis.* Cambridge: Cambridge University.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review, 84*(2), 191.

Bankert, E. A., & Amdur, R. J. (2006). *Institutional review board: Management and function*. Jones & Bartlett Learning. Sudbury, MA.

Blumer, M. L., & Murphy, M. J. (2011). Alaskan gay males' couple experiences of societal non-support: Coping through families of choice and therapeutic means. *Contemporary Family Therapy,* 33(3), 273-290.

Button, D. M., O'Connell, D. J., & Gealt, R. (2012). Sexual minority youth victimization and social support: The intersection of sexuality, gender, race, and victimization. *Journal of homosexuality*, *59*(1), 18-43.

Creswell, J. W. (2002). *Educational research: Planning, Conducting, and Evaluating Quantitative Research.* Prentice Hall. Upper Saddle River, NJ:

D'Augelli, A. R., & Patterson, C. J. (Eds.). (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York, NY: Oxford University Press.

Espelage, D. L., Aragon, S. R., Birkett, M. K., & Koenig, B. W. (2008). Homophobic teasing, psychological outcomes, and sexual orientation among high school students: What influence do parents and schools have? *School Psychology Review, 37,* 202–216.

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social problems, 12*(4), 436-445.

Glaser, B., & Strauss, A. (1967). Grounded theory: The discovery of grounded theory. Sociology *The Journal Of The British Sociological Association, 12,* 27-49.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The counseling psychologist, 25*(4), 517-572.

House, J. S. (1981). Notes and insights: Social support and social structure. *Sociological Forum, 2*, 135–146. doi:10.1007/BF01107897.

Kiperman, S., Varjas, K., Meyers, J., & Howard, A. (2014). LGB Youth's Perceptions of Social Support: Implications for School Psychologists. *School Psychology Forum* 8(1). 75-90.

Kortesluoma, R. L., Hentinen, M., & Nikkonen, M. (2003). Conducting a qualitative child interview: methodological considerations. *Journal of advanced nursing, 42*(5), 434-441.

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). *The 2011 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*. Gay, Lesbian and Straight Education Network (GLSEN). 121 West 27th Street Suite 804, New York, NY 10001.

Kosciw, J. G., Palmer, N. A., Kull, R. M., & Greytak, E. A. (2013). The effect of negative school climate on academic outcomes for LGBT youth and the role of in-school supports. *Journal of School Violence*, *12*(1), 45-63.

LeCompte, M. D., & Schensul, J. J. (2013). *Analysis and interpretation of ethnographic data: A mixed methods approach.* Lanham, MD: AltaMira Press.

Lincoln, Y., & Guba, E., (1985). *Naturalistic Inquiry*. Beverly Hills, CA: SAGE

MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for

team-based qualitative analysis. *CAM Journal, 10*(2), 31-36.

Maguen, S., Armistead, L. P., & Kalichman, S. (2000). Predictors of HIV antibody testing among gay, lesbian, and bisexual youth. Journal of Adolescent Health, 26(4), 252-257.

Mayall, B. (2008). *Conversations with children. Research with children: Perspectives and practices.* Abingdon, Routledge Falmer, 109-124.

McCabe, P. C., Rubinson, F., Dragowski, E. A., & Elizalde   Utnick, G. (2013). Behavioral intention of teachers, school psychologists, and counselors to intervene and prevent harassment of LGBTQ youth. *Psychology in the Schools, 50*(7), 672-688.

Mertens, D. M. (2007). *Transformative paradigm mixed methods and social justice. Journal of mixed methods research, 1*(3), 212-225.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Sage.

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25*, 1212-1222. doi:10.1177/1049732315588501

Munoz-Plaza, C., Quinn, S. C., & Rounds, K. A. (2002). Lesbian, gay, bisexual and transgender students: Perceived social support in the high school environment. *The High School Journal, 85*(4), 52-63.

Nastasi, B. K. (2009). Advances in qualitative research. In T. Gutkin & C. Reynolds (Eds.), *The handbook of school psychology,* 30–53, Hoboken, NJ: Wiley.

Neufeld, A., & Harrison, M. J. (2003). Unfulfilled expectations and negative interactions: Nonsupport in the relationships of women caregivers. *Journal of Advanced Nursing, 41,* 323–341. doi:10.1046/j.1365- 2648.2003.02530.x

Office of the Surgeon General, 2001

Pilkington, N. W., & D'Augelli, A. R. (1995). Victimization of lesbian, gay, and bisexual youth in community settings. *Journal of Community Psychology, 23*(1), 34-56.

Rosario. M., Schrimshaw, E.W., & Hunter, J. (2012). Homelessness among lesbian, gay, and bisexual youth: Implications for subsequent internalizing and externalizing symptoms. *Journal of Youth & Adolescence. 41*(5), doi: 10.1007/s10964-011-9681-3.

Rotheram-Borus, M. J., Hunter, J., & Rosario, M. (1994). Suicidal behavior and gay-related stress among gay and bisexual male adolescents. *Journal of adolescent research*, *9*(4), 498-508.

Rueger, S.Y., Malecki, C.K. & Demaray, M.K. (2010). Relationship between multiple sources of perceived social support and psychological and academic adjustment in early adolescence: Comparisons across gender. *Journal of Youth and Adolescence, 39*(47), doi:10.1007/s10964-008-9368-6

Saillard, Elif Kus. (2011). Systematic versus interpretive analysis with two CAQDAS packages: NVivo and MAXQDA. *Forum: Qualitative Social Research, 12*(1).

Saldaña, J. (2013).*The Coding Manual for Qualitative Researchers*. 3rd Ed. Sage Publishing; Thousand Oaks, CA.

Snow, J., & Mann, M. (2013). Qua*ltrics survey software: handbook for research professionals.* Retrieved from: http://www.Qualtrics.com.

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons and evaluative criteria. *Zeitschrift für Soziologie, 19*(6), 418-427.

Sue, D. W., Sue, D., & Sue, D. W. (2003). *Counseling the culturally diverse: Theory and practice. J. Wiley,* Chicago, IL.

Teasdale, B., & Bradley-Engen, M. (2010). Adolescent same-sex attraction and mental health:

The role of stress and support. *Journal of Homosexuality, 57*, 287–309. doi:10.1080/00918360903489127.

Thornberg, R., Tenenbaum, L., Varjas, K., Meyers, J., Jungert, T., & Vanegas, G. (2012). Bystander motivation in bullying incidents: To intervene or not to intervene. *Western Journal of Emergency Medicine, 13*(3), 247-252. doi: 10.5811/westjem.2012.3.11792

Tongco, M. D. C. (2007). Purposive sampling as a tool for informant selection. *Ethnobotany Research & Applications, 5,* 147-158, doi: http://hdl.handle.net/10125/227.

Varjas, K., Kiperman, S., & Meyers, J. (2016). Disclosure Experiences of Urban, Ethnically Diverse LGBT High School Students: Implications for School Personnel. *School Psychology Forum,* 10(1), 78-92.

Varjas, K., Dew, B., Marshall, M., Graybill, E., Singh, A., Meyers, J., & Birckbichler, L. (2008). Bullying in schools towards sexual minority youth. *Journal of school violence*, *7*(2), 59-86.

Whitbeck, L. B., Chen, X., Hoyt, D. R., Tyler, K., & Johnson, K. D. (2004). Mental Disorder, Subsistence Strategies, and Victimization among Gay, Lesbian, and Bisexual Homeless and Runaway Adolescents. *Journal of Sex Research, 41*(4), 329-342.

APPENDICES

Appendix A: Eligibility Script

"I'm going to ask you some questions to see if you are eligible to be in our research study about social support and nonsupport experiences of LGBTQ youth. You don't have to answer any question if you don't want to and you can stop answering questions at any time. ".

<table>
<tr><td colspan="2">1. "How old are you"?</td></tr>
<tr><td>Eligible</td><td>Not Eligible</td></tr>
<tr><td>14-17 years old</td><td>Age < (less than) 14
OR
Age > (greater than) 17 years old</td></tr>
<tr><td colspan="2">2. "How would you rate your physical attraction to others on a seven point scale; where 1 refers to being only physically attracted to someone of the same sex as yourself, 4 refers to being equally attracted to people of both sexes, and 7 refers to being only physically attracted to someone of the opposite sex as yourself. How would you rate your attraction to others?"</td></tr>
<tr><td colspan="2">1 2 3 4 5 6 7</td></tr>
<tr><td colspan="2">2a. Is the gender you express, want to express, or self-identify with the same gender you were assigned at birth?</td></tr>
<tr><td colspan="2">Yes or No</td></tr>
<tr><td>Eligible</td><td>Not Eligible</td></tr>
<tr><td>Either answered 1-5 on #2, and/or answered "no" to #2a.</td><td>Answered 6 or 7 on #2, and answered yes to #2a.</td></tr>
<tr><td colspan="2">3. "What words do you use to describe your sexual orientation to or to describe your gender identity"?</td></tr>
<tr><td>Eligible</td><td>Not Eligible</td></tr>
<tr><td>LGBTQ
Or…
Sexually interested in people of the same sex, both sexes, or unsure.
Or…
Identifies with the gender that is different from their original biological anatomy.</td><td>Sexually interested in people of the opposite sex only.
Or…
Identifies with the same gender as their original biological anatomy (and can be interested in people of the opposite sex only).</td></tr>
<tr><td colspan="2">4. For sampling information purposes: "If you had to get a form signed for you to participate by an adult, would you get it from your parent, or would you ask a youth advocate to sign a form?"</td></tr>
<tr><td colspan="2">Information provided.</td></tr>
<tr><td colspan="2">5. "Will a parent or youth advocate from [insert center name] be able to sign a consent or adult form respectively for you?"</td></tr>
</table>

Eligible	**Not Eligible**
Yes or n/a	no
6. "Which of the following youth groups are you or the person who referred you affiliated with?"	
Eligible	**Not Eligible**
Identifies one of the following groups or has parent consent (Q4): Real Youth Atlanta Unitarian Universalist Congregation of Atlanta	Is not affiliated with any of the following groups: Real Youth Atlanta Unitarian Universalist Congregation of Atlanta
7. "Are you currently a high school student in a home private or public school?"	
Eligible	**Not Eligible**
Yes (home, private, or public)	Not in school at all, or has begun college.
8. "Are you available for a two hour interview and survey session?"	
Eligible	**Not Eligible**
Yes	No
9. "Do you have an email address that only you have access to, where you would feel comfortable receiving emails related to this study?"	
Eligible	**Not Eligible**
Yes	No
10. **Script for youth with parent informed consent (question 4 answer)**: "Do you have transportation for you to get to the Center for School Safety or to the community organization you named? If not, do you have access to a computer with Skype and internet to privately complete the survey and interview?" **Script for youth with in loco parentis procedures (question 4 answer)**: "Do you have transportation for you to get to the Center for School Safety or to the community organization you named for your interview and survey session?"	
Eligible	**Not Eligible**
Yes	No
IF ALL CRITERIA WAS MARKED ELIGIBLE, THEY ARE ELIGIBLE TO PARTICIPATE IN THE STUDY.	

Instructions:

- <u>If **not eligible**, read the following:</u> *"Thanks for waiting. Unfortunately at this time, you are not eligible to be a part of our study because [discuss the item that their response yielded an ineligible participation status]. Thank you for taking the time to answer the questions. Do you have any questions for me at this time?"*

- <u>If **eligible**, read the following:</u> *"Thanks for waiting. You are eligible to be a part of Project Support. Will your parent or youth advocate be signing a form for you to do the study? [Provide corresponding form 1,2,3,4 in person, via email, or for pick up at their youth advocate at their center- based on their preference]. I will need this form filled out before your session begins. You can give it to me in person or mail it in at: Attn: Sarah Kiperman, College of Education, Counseling and Psychological Services, 9th Floor, 30 Pryor Street SW, Atlanta, GA 30303. You will give assent, your agreement to be a part of the study, at the beginning of your session. Where would you like to complete your two-hour session? [Wait for answer, for youth with youth advocate, location options are only GSU Center for School Safety, School Climate, and Classroom Management or their community organization]. Can you provide me with an email address that I can use to send you a link to the study's survey? Your email will only be used to receive the link to the survey, identify that you completed the survey, and deliver the receipt of your payment for completing the study. [Get email].*

- <u>Read **Box 1a** (in person session) **Box 1b** (Skype session).</u>

BOX 1: Parent Consent	
Box 1a **(parent consent + in person session)**	**Box 1b** **(parent consent + Skype session),**
Let's schedule a time for us to complete your session. [Schedule meeting time, date and place]. Thank you so much for your time. I will talk to you at [time] on [date] at [place], where we will complete your session. Do you have any questions at this time?"	*Let's schedule a time for us to complete your session. [Schedule meeting time, date and place]. We will be communicating via Skype for your session. The username we have for you to login with is "project.support15" and the password is "skypepassword2015". Please login 5 minutes before our scheduled time to make sure the account works okay. Thank you so much for your time. I will talk to you at [time] on [date] at [place], where we will complete your session. Do you have any questions at this time?"*

Appendix B: Interview Protocol

Introduction

Introduction: *Thank you for meeting with me. I am conducting these interviews and surveys to understand experiences of support and nonsupport. Your experiences, thoughts and perspectives are very important to me. I want to reiterate what the assent forms says, that our discussions today will be used to inform research around experiences of social support and nonsupport for LGBTQ youth. Direct quotes from today may be referenced and made public, but your name and identity will never be associated with this information for public use. Do you have any questions before we begin?*

Part 1: Survey

This is when participants will take the surveys on page 12-14.

Part 2: Social Support

Thank you for completing the survey. Now let's begin the interview.

First, please tell me how you identify with regards to your sexual orientation and gender identity.
→ Follow up: And tell me what that means or how you define that.

Question 1 (enacted support): *Let's talk about your support. Tell me about a time when you experienced others supported you.*

Question 2 (available support): *Tell me about situations that come to mind where you know others would support you, if needed.*

Question 3 (extra questions): *I'm going to ask you some questions about people who support you, that we have not yet addressed.*

- WHO
  - Who else has been supportive to you, who you have not mentioned?
    - → *Probe for specific example of when they were supportive and reference protocol above.*
  - Given the previous examples, do you tend to reach out to certain people or groups for certain situations? Who do you go to for what types of situations?
- WHERE
  - Tell me about specific times when people in your home, school, and your community were supportive of you.
    - → *Probe for specific example of when they were supportive and reference protocol above.*

Part 3: Nonsupport

Question 1*: Tell me about a time when you experienced others being unsupportive of you, or when others acted in an unsupportive way.*

***Question 2**: Tell me about situations that come to mind where you know others would not support you, or when you know others would act in an unsupportive way.*

***Question 3**: I'm going to ask you some questions about people who may not support you that we have not yet addressed.*

- WHO
  - Who else has been unsupportive to you, who you have not mentioned?
    → *Probe for specific example of when they were supportive and reference protocol above.*
- WHERE
  - Tell me about specific times when people in your home, school, and your community were unsupportive of you.
    → *Probe for specific example of when they were supportive and reference protocol above.*
- WHEN
  - When has the experience of others nonsupport towards you, been especially significant?

Following the interview (approximately 2 hours of time), participants will be paid $15.00 either in person, or via the secure money transfer system, PayPal.

[**IF A SKYPE SESSION THE RESEARCHER CONCLUDES BY SAYING**]: We are finished with our session. please log out of all open web browsers, skype accounts, and your email. Thank you for your time.