HHS Public Access

Author manuscript

J Gay Lesbian Soc Serv. Author manuscript; available in PMC 2024 February 06.

Published in final edited form as:

J Gay Lesbian Soc Serv. 2023 ; 35(4): 434–455. doi:10.1080/10538720.2022.2148036.

Be YOU!: A Collaborative Effort to Address Minority Stress for LGBTQ+ Youth in School Settings

Jessica N. Fish,
University of Maryland

Sarah Kapostasy,
Out Youth, Austin Texas

Stephen T. Russell
University of Texas at Austin

Abstract

LGBTQ youth often experience unsafe school climates and are at greater risk for compromised mental health relative to their heterosexual and cisgender peers. The psychological mediation model posits that these health inequities are produced by minority stress, which operates through several key mechanisms: rumination, emotion regulation, and coping. Efforts towards designing social services that might address these mechanisms, and thus improve LGBTQ youth wellbeing, are limited. Informed by empirical research and therapeutic practices, *Be YOU!* was conceived as a school-based empowerment program that provides LGBTQ youth with an accessible, safe space where they build skills to reduce rumination and promote emotion regulation and coping strategies for dealing with minority stressors. Developed collaboratively between a local LGBTQ youth center, a local school-based community organization, and university researchers, the *Be YOU!* partnership effectively circumvented barriers to accessing social services for LGBTQ youth. Findings from the pilot program evaluation showed that youth participation was associated with increased emotion regulation and decreased rumination. The practical impact on and positive feedback from LGBTQ youth suggest that there are measurable benefits and long-term promise in strategic multi-sector partnerships that address social services needs of LGBTQ youth and strengthen their ability to navigate minority stress.

Keywords

LGBTQ youth; mental health; community-based organization; school-based programs

Introduction

LGBTQ young people face multi-systemic barriers to health equity that undermine positive development, mental health, and wellbeing (Hatzenbuehler & Pachankis, 2016; Stephen

Corresponding Author: Stephen T. Russell, stephen.russell@utexas.edu.

Declaration of Interest Statement
The authors report there are no competing interests to declare.

T. Russell & Fish, 2019). Despite this knowledge, interventions to promote the general well-being of LGBTQ youth are scarce (Coulter et al., 2019). There is growing knowledge of the policies and practices that characterize safe and supportive school environments for LGBTQ youth (Stephen Thomas Russell & Horn, 2017), yet less attention has focused on the role of social services provided by community centers and other community-based programs designed for LGBTQ youth (Fish, Moody, Grossman, & Russell, 2019; Williams, Levine, & Fish, 2019). LGBTQ community centers have existed and offered supportive and affirming spaces for sexual and gender minority young people for decades (Herdt & Boxer, 1993; Movement Advancement Project, 2018), and the role that these centers can play in the lives of LGBTQ youth is of increasing importance as contemporary cohorts of LGBTQ people are coming out at younger ages than ever before (Newport, 2018; Phillips et al., 2019; Stephen T. Russell & Fish, 2016).

We document the success of an empowerment program for LGBTQ youth called *Be YOU!* (Young, Outspoken, Unbreakable), born out of a four-year collaborative partnership between an LGBTQ youth center, a community organization embedded in a school district, and university researchers. The partnership was guided by principles of engaged university-community partnership (Sherrod, 1999), believing that informed and invested community members, including social service providers and researchers, are distinctly situated to collectively advance research and practice given their respective expertise at the intersection of individual and community wellbeing. Informed by Hatzenbheuler's (Hatzenbuehler, 2009) psychological mediation model, *Be YOU!* was designed to target three key mechanisms of the link between minority stress and compromised wellbeing: rumination, emotion regulation, and coping strategies. The collaborative team developed an empirically-informed curriculum and evaluation strategy for the year-long pilot program offered in 9 middle and high schools by LGBTQ youth center staff to 51 students in Central Texas during the 2017–2018 school year.

In the following sections, we describe the school experiences of LGBTQ youth and then review promising approaches for understanding and addressing LGBTQ youth mental health and wellbeing. These discussions provide the practical motivation and theoretical foundation behind the development of the *Be YOU!* program. We then describe the design, implementation, and evaluation of the program. Drawing from the strengths of each of the collaborative partners, *Be You!* offers a model for community-based youth and LGBTQ organizations to partner with school-based mental health providers to support the mental health and wellbeing needs of LGBTQ youth. Finally, we discuss the practical implications of the outcomes, highlighting the role of the collaborative partnership in expanding and amplifying social services for LGBTQ youth.

LGBTQ Youth School Experiences

A substantial literature documents hostile school climates for LGBTQ students, often characterized by victimization and bullying. The most recent National School Climate Survey (an online survey of LGBTQ youth) found that over half of LGBTQ students reported feeling unsafe at school because of their sexual orientation, and over one-third reported missing at least one day of school in the past month due to feeling unsafe (Kosciw,

Clark, Truong, & Zongrone, 2020). National statistics from the Youth Risk Behavior Survey show that 33% of LGB students reported being bullied on school property, almost twice the rate reported by heterosexual students (Kann, 2018).

In this context, efforts are needed to address discriminatory bullying and promote positive school climates, and several promising school-wide policies and practices exist (Day, Ioverno, & Russell, 2019). Gender and Sexuality Alliances (GSAs; formerly Gay-Straight Alliances) have been present in many schools across the country and typically focus on social support, raising awareness, or educating peers and school staff about LGBTQ issues (Poteat, Scheer, Marx, Calzo, & Yoshikawa, 2015). They have shown efficacy in reducing victimization and increasing feelings of safety for LGBTQ young people (Ioverno, Belser, Baiocco, Grossman, & Russell, 2016). GSAs have been mainly independent of community-based organizations that have distinctive expertise in serving LGBTQ youth; they are typically run by school staff who may not have formal mental health training or who may be unaware of the unique needs and experiences of LGBTQ young people (Poteat et al., 2015).

For individual students, counseling-focused services for LGBTQ students in schools provide crucial support (Singh & Kosciw, 2016) yet remain focused mainly on individuals. In fact, most evidence-based interventions that address LGBTQ youth's mental health are individual-focused (Coulter et al., 2019). Individual-focused interventions are an essential component for alleviating LGBTQ youth's mental health vulnerabilities, but new efforts are needed to meet school-wide and community-level intervention goals (Kazdin, 2017). Schools represent an opportunity to reach youth who may not otherwise have access to social services such as those offered in community-based organizations or centers. Although there is strong evidence of effective support for LGBTQ youth through school-based policies and practices (Day et al., 2019), these strategies rely on school personnel (or students themselves) and thus largely involve educational resources and strategies (e.g., teacher training; access to curriculum or resources) rather than social services for which community-based organizations have expertise. *Be YOU!* represented a strategy for developing a program to reach youth at school – youth that might not make their way to the resources distinctly available in an LGBTQ youth center (Pachankis, Clark, Jackson, Pereira, & Levine, 2021).

Addressing LGBTQ Youth Mental Health and Wellbeing

There is clear evidence of a decline in the age of coming out (Floyd & Bakeman, 2006; Martos, Nezhad, & Meyer, 2015), and for contemporary LGBTQ youth, coming out now coincides with a developmental period characterized by heightened self- and peer-regulation (Brechwald & Prinstein, 2011), particularly with respect to sexuality and gender (Payne & Smith, 2016). These developmental processes are associated with the higher rates of peer victimization and school bulling described above (Espelage, Hong, Rao, & Thornberg, 2015; Robinson, Espelage, & Rivers, 2013). Thus, the declining age of coming out amplifies interpersonal and intrapersonal processes that elevate risk for poor mental health (Stephen T. Russell & Fish, 2016, 2019). Not surprisingly, LGBTQ youth evidence higher rates of poor mental and behavioral health relative to their heterosexual and cisgender peers (Marshal et

al., 2008; Plöderl & Tremblay, 2015; Stephen T. Russell & Fish, 2016).Yet there is a dearth of evidence-based intervention programs that specifically address LGBTQ youth mental health and wellbeing (Coulter et al., 2019).

The minority stress model has been an important conceptual framework for understanding LGBTQ-related health inequities (Goldbach & Gibbs, 2017; Meyer, 2003). It describes how experiences with anti-LGBTQ stigma, discrimination, and violence – otherwise known as minority stressors – compromise the positive development, mental health, and wellbeing of LGBTQ-identified individuals. Hatzenbuehler's (Hatzenbuehler, 2009) psychological mediation model expands upon the minority stress framework, identifying specific cognitive mechanisms that link minority stressors with poor mental health. The model describes how mounting experiences with stigma create potentials for intrapersonal processes such as emotion dysregulation and cognitive rumination, which in turn increase the risk for psychopathology. These processes may therefore offer focal points for intervention (Hatzenbuehler, 2009). That is, bolstering emotion self-regulation or disrupting rumination may be strategies to combat the negative effects of stigma on the health and wellbeing of LGBTQ youth. Together, perspectives on the developmental experiences of LGBTQ youth, minority stress, and psychological mediation are critical for improving LGBTQ population health and necessitate LGBTQ-specific health promotion social services.

Much focus of LGBTQ youth positive development and health promotion has been on programs by and for schools. Much less has been researched in the area of the LGBTQ youth centers (Allen, Hammack, & Himes, 2012; Fish et al., 2019; Williams et al., 2019). LGBTQ community centers exist and provide programming and support across the U.S. (Movement Advancement Project, 2018; Williams et al., 2019), and should be called upon as experts in the development and evaluation of programs to address LGBTQ youth mental health in community settings (Pachankis et al., 2021). LGBTQ youth centers offer the potential to deliver health promotion strategies tailored for LGBTQ youth that might mitigate the impact of minority stress on mental health and wellbeing for youth in ways that likely carry forward across the life course. Further, if activated within schools, there could be potential to reach many more under-served LGBTQ students than are served in typical LGBTQ youth centers.

The Current Study

The goal of the current study is two-fold. The first is to document the development and delivery of the *Be YOU!* program as well as the potentials for addressing LGBTQ youth health inequity through partnerships that bring the expertise of LGBTQ-focused community organizations into the school setting, guided by theoretical and empirical research. The second is to evaluate the pilot of the *Be YOU!* program. For the evaluations, we tested whether key constructs of the psychological mediation framework (i.e., rumination, emotion regulation, and coping; Hatzenbuehler, 2009) were improved among youth who attended the program. We also assessed the degree to which the program impacted youth self-esteem. Specifically, we hypothesized that youth who participated in the program would experience a reduction in rumination and an increase in emotion regulation, coping, and self-esteem from pre-program baseline to program completion. Findings from the study provide insights

for school and community-based social service providers, who can collaborate to maximize their engagement with and impact on LGBTQ youth in their communities. This includes strategies for partnership and the implementation of programs that address the specific experiences and needs of LGBTQ youth.

Method

Program Development and Design

The collaboration that led to *Be YOU!* emerged after several years of relationship-building between (a) an LGBTQ youth center with (b) a school-based community organization that links schools and community resources to support vulnerable students, which facilitated the implementation of the program, and (c) a university research group. Motivated by the intention to reach under-serviced LGBTQ youth, youth center staff partnered with university researchers to develop a program model led by social services professionals with mental health expertise and extensive experience working to address the social and emotional needs of LGBTQ youth in school settings.

LGBTQ youth center leadership had identified the need to reach youth who faced barriers to participation at their community center location. Many youth travel from throughout Central Texas to receive services and support at the center, yet some youth lack family support, access to transportation, or financial means to access the physical location. Concerns about program visibility and access were particularly important at the time the program was developed and implemented: Texas was in the middle of a heated political conflict over the use of public bathrooms for transgender and gender diverse people – a public debate that took place at the state capitol less than 5 miles from the LGBTQ youth organization involved in this study and within close proximity to many of the schools that hosted the program. The heightened visibility of LGBTQ issues due to the political context presented yet another barrier for some youth to access the community center.

The solution was to apply the skills and knowledge from the LGBTQ youth center within schools. The intention was to offer a psychoeducational program tailored for LGBTQ students, on campus during the school day, and reach youth who otherwise were not able to access the LGBTQ youth center programs and services. Partnering with the school-based community organization offered the possibility for *Be YOU!* to be offered in conjunction with existing community-based resources in schools. Further, the lead facilitators of *Be YOU!* were licensed and trained mental health providers with explicit expertise in LGBTQ youth. Thus, the collaboration brought a distinct set of resources to a school setting.

The LGBTQ youth center staff were informed by the latest science on supporting LGBTQ youth health (Stephen T. Russell & Fish, 2016) and schooling (Stephen Thomas Russell & Horn, 2017), guided by the psychological mediation model (Hatzenbuehler, 2009). They had a prior partnership with the school-based community organization to facilitate GSAs for LGBTQ students at local area schools. The mission of the school-based community organization is to prevent truancy and help vulnerable youth stay in school; their programs embedded in schools focus on removing barriers to student success through individual counseling or support, life skills and literacy, and mentoring. They understood the value of

the GSA to enhance the community of support for youth enrolled in their programs, and thus were committed to assist in the delivery and evaluation of the *Be YOU!* program. Finally, the university researchers were guided by principles of engaged university-community partnership (Sherrod, 1999); they understood the paucity of research on the influence of LGBTQ community centers in the lives of LGBTQ youth, as well as the potential of university-community partnerships to address the needs of youth in school-related settings (Mahoney et al., 2010).

The majority of the curriculum content was developed collaboratively to address key mechanisms that link minority stress and poor mental health (Hatzenbuehler, 2009) and drew heavily from the Guidelines for Psychological Practice with LGBTQ+ Clients published by the American Psychological Association (American Psychological Association, 2015). *Be YOU!* blends several programmatic and therapeutic approaches, including Cognitive Behavioral Therapy (Austin & Craig, 2015), mindfulness, music therapy (Bain, Grzanka, & Crowe, 2016), art therapy, narrative therapy, drama therapy (Wilson, 2011), Acceptance and Commitment Therapy (Yadavaia & Hayes, 2012), and positive psychology (Horne, Puckett, Apter, & Levitt, 2014). Facets of these approaches were woven together with attention to principles of group psychotherapy and best practices in LGBTQ-affirming psychotherapy (Lytle, Vaughan, Rodriguez, & Shmerler, 2014; Proujansky & Pachankis, 2014).

The *Be YOU!* curriculum aimed to balance two fundamental truths: (1) the stress faced by minority youth is not their fault, but rather, is caused by systemic injustice; and (2) marginalized youth need to learn positive coping strategies in order to support their social and emotional wellbeing. To achieve this balance, *Be YOU!* (Young, Outspoken, Unbreakable) sets the stage for youth to discuss daily stressors, which systemically affect LGBTQ populations at a disproportionate rate, in a manner that is neither shaming nor blaming of individuals themselves. Once the “externalizing” of minority stress was accomplished, the curriculum offered a dual approach (see Table 1). The “Outspoken” Lessons worked to support youth in developing agency to have influence in their relationships and in the world around them. Activities guided youth to practice assertive communication in support of healthy relationships, to promote self-acceptance and empowerment, and to infuse a hopeful outlook of the future. The “Unbreakable” Lessons offered guidance to youth on how to raise awareness of their mental health condition and care for their inner selves; activities were designed to enhance youth’s awareness of their internal states, and to help them develop a strong repertoire of coping strategies to support wellbeing and develop resilience.

Procedures, Recruitment, and Data Collection

The *Be YOU!* curriculum was piloted in 9 middle and high schools (grades 6–12) in Central Texas during the 2017–2018 school year. The program consisted of 20, 1-hour sessions delivered weekly by counseling professionals and trained graduate student interns to groups of 5–10 students. The program was open to any student who wanted to participate, provided on campus, and offered on a rotating time schedule to minimize student absenteeism from any one course. Youth who participated were referred to the program by social service

personnel, school counselors, teachers, and/or other school personnel, and were identified as those who appeared to be having emotional difficulty, potentially related to the feeling of "not fitting in," which affected their school performance. Thus, the program was tailored for the unique needs of LGBTQ youth but was not specifically limited to youth who self-identified as LGBTQ.

Student recruitment and parental consent were coordinated through the LGBTQ youth center's partnership with the school-based community organization whose mission was to improve school retention among vulnerable young people. Every year, this organization provides a letter to parents outlining their program schedule for the year and allow parents to opt-in or -out of their child(ren)'s participation. Although parental consent for program participation was not required, parental consent for research participation was necessary; procedures were approved by the school-based community organization's Institutional Review Board (IRB). De-identified data was provided to the university research group, and the University of Texas IRB approved the project as exempt from review. Consistent with prior research (Dodd, 2009), safety concerns related to LGBTQ identity disclosure for some students precluded their participation in research. As a result, the number of students who consented to participate in the research (n=34) was lower than the number of students who participated in the program overall (n = 51). Another challenge was student safety on school campus. According to staff and student self-report, some of the participating schools were perceived to be unsafe for some LGBTQ youth. Therefore, program recruitment materials and consent forms emphasized that the program was designed to address minority stress for those who "felt different." Along with the existing knowledge of the Program Managers of the school-based community organization, this strategy helped successfully recruit youth who represented diverse sexual and gender identities, youth questioning gender and sexuality, and allies.

To document the efficacy of the *Be YOU!* curriculum, researchers designed a pre-post intervention evaluation. Prior to the implementation (September 2017; Wave 1) and directly upon completing the intervention (May 2018; Wave 3), data were collected from participants using a questionnaire that gathered basic sociodemographic characteristics, their program experiences, and assessment of constructs of interest.

Measures

Data came from several sources: (1) questionnaires completed by participants at the beginning and end of the 2017–18 school year, (2) records of program attendance documented by program staff, and (3) individual student's school records which were used to match with their sociodemographic and attendance data.

Rumination.—The twenty-two-item Rumination Response Scale-Short Form (Treynor, Gonzalez, & Nolen-Hoeksema, 2003) measured constructs related to brooding, reflection, and depression. The RRS is one of the most common measures of rumination and has been used with adolescent samples (Idsoe, Keles, Olseth, & Ogden, 2019; Sloan, Moulding, Weiner, Dowling, & Hall, 2021). Participants rated how often they experienced specific thoughts or actions, such as "Think about all of your shortcomings, failings, faults,

mistakes," on " a four-point Likert scale ranging from 0 (almost never) to 3 (almost always). Items were averaged, so that higher scores reflect more rumination, for a possible range of 0–3. Cronbach's alphas were .93 and .92 at Waves 1 and 3, respectively.

Emotion Regulation.—We use the six-item reappraisal subscale from the Emotional Regulation Questionnaire (Gross & John, 2003), which was designed to measure respondents' tendency to regulate their emotions through cognitive reappraisals. The measure has been well-tested with older adolescents and young adults (Gross & John, 2003; Melka, Lancaster, Bryant, & Rodriguez, 2011) but less often with young adolescents (Gómez-Ortiz, Romera, Ortega-Ruiz, Cabello, & Fernández-Berrocal, 2016). Participants responded to items such as "When I want to feel more positive emotion, I change what I'm thinking about" on a seven-point Likert scale ranging from 0 (strongly disagree) to 6 (strongly agree). Items were averaged for a possible range of 0–6, where higher scores reflect greater emotion regulation; Cronbach's alphas were .88 and .86 at Waves 1 and 3, respectively.

Youth Coping.—The 31-item Youth Coping Index (McCubbin, Thompson, & McCubbin, 1996), was designed to explore adolescent coping behaviors that result from normal adolescent stress. It identifies the behaviors adolescents find helpful in managing problems or difficult situations. Students rated the frequency of their behavior such as "Talk to a teacher or counselor at school about what bothers you" on a five-point Likert scale ranging from 0 (never) to 4 (most of the time). We calculated the average across items where higher scores reflect greater coping, for a possible range of 0–4. Cronbach's alphas were .78 and .86 at Waves 1 and 3, respectively.

Self-esteem.—We use 5 items from the positive factor of the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Items include, "I feel that I am a person of worth, at least on an equal plane with others." And "I take a positive attitude toward myself." Responses are reported on a 4-point Likert scale from 0 (strongly disagree) to 3 (strongly agree). Items were summered and averaged to where higher scores indicate greater self-esteem, with a possible range of 0–3. Cronbach's alphas were .86 at Wave 1 and .90 at Wave 3.

Program attendance.—Program staff recorded the total number of program sessions attended by each participant.

Sociodemographic characteristics.—Program intake forms included self-reported sexual identity, gender identity, race/ethnicity, grade level, and self-rated school climate for LGBTQ+ students.

Analytic approach

Paired-samples t-tests were conducted to compare participants' pre- and post- program mental health and wellbeing. For program outcomes with significant pre-post program changes, multiple linear regression analyses were then used to examine the association between post- and pre-program responses and program attendance. The sample size varied slightly for regression models due to missing data for a small number of respondents (see

Table 2). Due to the small sample size, multivariate analyses did not control for individual or school characteristics. Post-hoc analyses showed that results did not change in models that controlled for sexual identity, gender identity, or race/ethnicity (each tested in separate models) as well as when adjusted for school climate and grade level (tested together). Finally, to illuminate patterns in the statistical results, we reviewed responses to open-ended questions provided by participants in the post-program survey.

Results

Sample characteristics are presented in Table 3. The sample of participating students was diverse in terms of sexual identity (39.29% straight; 10.71% bisexual/pansexual/queer;; 21.43% gay/lesbian), gender identity (58.62% female; 14.71% transgender; 6.9% non-binary; 17.65% male), race/ethnicity (50% Hispanic; 21.88% White), grade level (11.76% 6^{th} grade; 11.76% 7^{th} grade; 20.59% 8^{th} grade; 55.88% 10^{th} through 12^{th} grade), and self-rated school climate for LGBTQ+ students (10.00% totally queer and trans friendly; 40.00% mostly supportive; 46.67% safe, but not always supportive; 3.33% Unsafe). The sample had a mean age of 14.35 (SD=2.20). On average, participants attended 13.32 of the 20 sessions.

Correlations among constructs of interest are presented in Table 4. Baseline values of each construct were strongly and positively correlated with post-program scores for rumination ($r = .51$, $p < .01$), emotion regulation ($r = .61$, $p < .001$), and self-esteem ($r = .63$, p < .01) while a moderate positive correlation was observed for coping ($r = .55$, $p < .001$). These results suggest relative stability in target constructs but also substantial potential for change. Rumination at Wave 3 was strongly and inversely associated with Wave 3 emotion regulation ($r = -.45$, $p < .05$) and program attendance ($r = -.47$, $p < .01$). Wave 3 coping was also moderately positive correlated with Wave 3 emotion regulation ($r = 38$, $p < .05$). Wave 1 self-esteem was moderately and inversely related to Wave 1 rumination ($r = -.48$, p < .01), and Wave 3 self-esteem was moderately and inversely related to Wave 3 rumination ($r = -.43$, $p < .05$) and positively related to W3 emotion regulation ($r = .48$, $p < .05$) and coping ($r = .37$*, $p < .05$).

Results from paired t-tests comparing pre- and post-program cognitive process and mental health are presented in Table 5. There was a marginally significant decline in rumination, $t(30) = 2.00$, $p = .055$, and a statistical increase in emotion regulation, $t(28) = 2.73$, $p = .011$. There was no change over the course of the school year in coping or self-esteem.

Results from the multivariate regression models testing factors associated with changes in rumination and emotion regulation are presented in Table 2. Results affirmed that program attendance was significantly associated with the reduction in rumination ($\beta = -.04$, $p < .05$); in other words, youth who participated most in the program had the greatest reduction in rumination. Consistent with correlation results, the effect was specific to rumination – we did not observe and effect between program attendance and emotion regulation.

Finally, on the post-program survey, youth were asked: “How has your participation in the *Be YOU!* program had an impact on you?” Written responses affirmed the findings related

to decreased rumination: “It has made me feel better about myself and helped me work on anger and stress”; “It has made me more calm.” Consistent with the findings related to increased emotion regulation, youth wrote: “It has helped me by being able to know what to do when I’m sad or angry”; “It helps me with my emotions”; “I enjoyed having a group setting where I could talk about my problems. Hearing other people’s perspectives helped me ground myself and be more realistic.”

Discussion

We document the development and evaluation of a school-based program aimed at improving LGBTQ youth health – a four-year long project that brought together LGBTQ youth center staff, a school-based youth-serving community organization, and university researchers. Guided by the goals of university-community partnerships for engaged research and community service (Sherrod, 1999), and the psychological mediation model (Hatzenbuehler, 2009), the *Be YOU!* program was developed to target processes that have been implicated in the link between minority stressors (e.g., discrimination, stigma) and psychopathology: rumination, emotion regulation, coping skills, and self-esteem. Findings from the program evaluation suggest that the curriculum showed promising signs of efficacy in increasing emotion regulation and decreasing rumination, and that program attendance was statistically related to the degree to which rumination was reduced from baseline to program completion. The program was explicitly designed to address these cognitive facets, and indeed contributed to a reduction in these processes, offering insight into the power of evidence-informed programs for improving LGBTQ youth mental health.

Notably, we did not observe a statistical increase in coping skills or self-esteem. It may be premature to expect that this specific behavior would change over the course of one school year. It is possible that program participation reduced negative processes but had a less direct influence on promoting positive adjustment such as coping or major shifts in their sense of self-esteem. Given the duration of the program (one 9-month school year), it is encouraging to see immediate reductions in negative psychological processes, yet indicators of positive adjustment such as coping and self-esteem might not be as responsive to short-term interventions or as malleable compared to other mechanisms (Masten, 2001). Self-esteem, in particular, may be difficult to shift in the context of broader social forces (e.g., policies, rhetoric, family) that continue to stigmatize sexual and gender diversity. Nevertheless, if changes in rumination and emotion regulation can be sustained, shifts in coping and self-esteem may be detected over longer periods of time. Of course, more research is necessary to support these suppositions. Still, participating youth’s written feedback supports our findings on how the curriculum impacted rumination, emotion regulation, also coping strategies, and self-esteem (e.g., “It has helped me by being able to know what to do when I’m sad or angry”).

More broadly, our findings suggest that programs tailored to the unique needs of LGBTQ youth can help disrupt the cognitive pathways that link LGBTQ-specific minority stressors to mental health problems (Goldbach & Gibbs, 2017; Hatzenbuehler, 2009; Stephen T. Russell & Fish, 2016). However, programs targeted at LGBTQ youth are still a rarity; even fewer are community- or school-based (as opposed to individual-focused; Coulter et al.,

2019). Though crucial, individual-focused interventions cannot always meet the needs of the growing LGBTQ youth population, because many LGBTQ youth will not have direct access; thus, community-based interventions for LGBTQ youth are necessary and pressing (Fish, 2020). The *Be YOU!* program offers a promising example of a partnership in the development and evaluation of a meaningful program in the lives of LGBTQ youth.

The success of this program highlights the utility of partnerships between LGBTQ-focused organizations, schools, researchers, and other youth service agencies. The partnership between these entities demonstrates a strategy for reaching LGBTQ youth who may not otherwise have access to LGBTQ community services (e.g., youth who are not out to parents, youth still questioning their sexual and gender identities, and youth with limited transportation, etc.). LGBTQ youth centers are adept at working with LGBTQ young people and can connect LGBTQ youth to LGBTQ-specific resources and other local services that may be uniquely helpful to them. Additionally, support for LGBTQ young people in schools is often hampered by school-related bureaucracy and policy (Lugg, 2003) – issues that do not constrain community organizations. Strategic partnerships are crucial in the process of developing programs tailored for LGBTQ youth such as *Be YOU!* – even more so in case of program scale up.

Reflecting upon the process of program development and delivery, it is critical to consider the context in which this program was implemented. Recent and compelling evidence has showcased the impact of discriminatory public anti-LGBTQ rhetoric on rates of discriminatory (homophobic bullying) among young people (Hatzenbuehler, 2009; Paceley et al., 2021). The rhetoric from the bathroom legislation was a palpable presence in the local news and dominated the minds of many in the Central Austin area, including youth. It is notable that, even against the state political backdrop, *Be YOU!* was able to successfully deliver social services urgently needed by LGBTQ youth. In addition to youth's willingness to participate, program execution would have been much more difficult without the efforts from all involved parties in this partnership.

Along with the strengths and contributions, we have several limitations to note. First, the program evaluation was substantially underpowered to detect effects accurately. Although we did detect a pre- and post-program difference for emotion regulation, the effect of this difference was large ($d = .51$). In contrast, our effect size of the pre-post difference for rumination was .36, with a corresponding $p = .055$. Had the study been sufficiently powered, it is likely that this effect would have reached statistical significance. We surmise that this is an instance where over-reliance on p values can be problematic (Wasserstein, Schirm, & Lazar, 2019). Second, although our rumination and emotional regulation measures have been tested with adolescents, they were not originally developed for adolescence; measures specifically designed for adolescents may have captured more developmentally appropriate experiences and behaviors related to these constructs and, potentially, yielded different results. Third, power limitations also limited our ability to test differences between middle and high school students who participated in the program. Given maturational differences in peer relationships and self-regulation, there may be developmental differences in the experience and effectiveness of the program. This would be an important area for future testing. Fourth, the implementation of the program on campus during the school

year precludes us from assessing and understanding the long-term, sustaining impact of the program. Future research should consider evaluating this program model in different contexts, with different facilitators, and with different groups of youth to assess whether these findings hold and are applicable for scale-up. Fifth, the study required parental consent for research participation. Therefore, it is possible that youth who participated in the research, as well as the curriculum were more comfortable with approaching their parents for permission, which could have biased our sample towards those from more supportive families (Kiperman, 2018; Snapp, Russell, Arredondo, & Skiba, 2016).

Implications and Areas of Future research

This paper highlights the critical work of LGBTQ youth community centers as a strategy to reach youth, and the merits of strategic community, school, and research partnerships. Not only do LGBTQ youth community centers directly serve youth, many of these centers also work with other social service agencies in their communities to address the social service needs of LGBTQ young people (Allen et al., 2012; Williams et al., 2019). Given the dearth of LGBTQ-specific programs in the context of urgent need, these centers have spent enormous amounts of time and effort to develop their own programs to meet the needs of LGBTQ youth in their communities (Fish, 2020; Williams et al., 2019). Given that there are often structural (e.g., transportation) and social (e.g., unaccepting parents) forces that prevent LGBTQ youth from engaging in LGBTQ community centers (Allen et al., 2012), partnerships with schools provide a pathway to reach youth who may not otherwise have access to community centers. Although this was not formally assessed, our facilitators were staff at the local LGBTQ youth center and anecdotally shared that the youth who engaged in the school-based program were not engaging with the center—these differences in engagement are an important area of future study in that it further legitimizes the need to community-school that extend expertise for working with LGBTQ young people into schools.

Unfortunately, given the current state of science translation and publisher paywalls, many schools and social service agencies are unable to access emerging research on LGBTQ youth (Gershenson, Polikoff, & Wang, 2020) In partnership with the university-affiliated research group, the collaborative partners – who were already informed by their deep knowledge of LGBTQ youth in their community – were able to access emergent research and develop strategies to address mechanisms of known mental health vulnerabilities. Further, the research group in this partnership benefited from working with professionals who have first-hand expertise in what does and does not work for promoting mental health of LGBTQ youth. This process reflects the benefits of a critical cycle between evidence-informed practice and practice-informed research (Ammerman, Smith, & Calancie, 2014): It is our belief that these processes and partnerships are necessary to cultivate efficacious LGBTQ youth health promotion programs. In effect, they shorten the pipeline from research to practice, and streamline the development and evaluation of LGBTQ youth-focused programs. Given the urgency of LGBTQ health promotion strategies, such community partnerships represent an innovative approach to developing meaningful and effective interventions for improving LGBTQ youth mental health and wellbeing.

School-based mental health professionals who are already working in schools may partner with LGBTQ-focused community-based organizations to bring their expertise into the school setting to reach LGBTQ and all students. Further, GSAs and other organized groups that include LGBTQ students are a strategic venue for collaboration with mental health service providers to reach this distinct and often vulnerable population. Further research on the implementation and efficacy of such school-community partnerships would advance models and understanding of strategies to improve mental health for LGBTQ students and other vulnerable groups.

Conclusion

Our findings show promise in a newly developed, empirically-informed, school-based health promotion program specifically designed to address LGBTQ youth mental health needs. We also highlight the potential of collaborative efforts that bring together the strengths of community centers, schools and school-based organizations, and researchers to promote health equity for LGBTQ youth. Such an approach can advance the efforts of community-based organizations that serve LGBTQ youth, as well as school-based mental health professionals such as school counselors, school social workers, or school psychologists, to proactively address the mental health and wellbeing of LGBTQ students. We encourage others to consider how community partnerships can be used to address issues of health inequity in ways that both promote health and wellbeing among vulnerable populations and advance scientific understandings.

Acknowledgements

J.N.F. acknowledges support from the University of Maryland Prevention Research Center cooperative agreement U48DP006382 from the Centers for Disease Control and Prevention (CDC) and P2CHD041041, awarded to the Maryland Population Research Center by the Eunice Kennedy Shriver National Institute of Child Health and Human Development. S.T.R. acknowledges support from the Priscilla Pond Flawn Endowment at the University of Texas at Austin, and from grant P2CHD042849, Population Research Center, awarded to the Population Research Center at The University of Texas at Austin by the Eunice Kennedy Shriver National Institute of Child Health and Human Development. The authors acknowledge Ruoyun (Chrys) Xu who contributed to this project. The content is solely the responsibility of the authors and does not represent the official views of the National Institutes of Health.

References

Allen KD, Hammack PL, & Himes HL (2012). Analysis of GLBTQ youth community-based programs in the United States. Journal of Homosexuality, 59(9), 1289–1306. 10.1080/00918369.2012.720529 [PubMed: 23101498]

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. American Psychologist, 70(9), 832–864. (2015–55237-002). 10.1037/a0039906 [PubMed: 26653312]

Ammerman A, Smith TW, & Calancie L. (2014). Practice-based evidence in public health: Improving reach, relevance, and results. Annual Review of Public Health, 35(1), 47–63.

Austin A, & Craig SL (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. Professional Psychology: Research and Practice, 46(1), 21–29. (2015–06830-004). 10.1037/a0038642

Bain CL, Grzanka PR, & Crowe BJ (2016). Toward a queer music therapy: The implications of queer theory for radically inclusive music therapy. The Arts in Psychotherapy, 50, 22–33. 10.1016/j.aip.2016.03.004

Brechwald WA, & Prinstein MJ (2011). Beyond homophily: A decade of advances in understanding peer influence processes. Journal of Research on Adolescence (Wiley-Blackwell), 21(1), 166–179. 10.1111/j.1532-7795.2010.00721.x

Coulter RWS, Egan JE, Kinsky S, Friedman MR, Eckstrand KL, Frankeberger J, … Miller E. (2019). Mental health, drug, and violence interventions for sexual/gender minorities: A systematic review. 144(3), 20.

Day JK, Ioverno S, & Russell ST (2019). Safe and supportive schools for LGBT youth: Addressing educational inequities through inclusive policies and practices. Journal of School Psychology, 74, 29–43. 10.1016/j.jsp.2019.05.007 [PubMed: 31213230]

Dodd S-J (2009). LGBTQ: Protecting vulnerable subjects in all studies. In Mertens D& Ginsberg P, The Handbook of Social Research Ethics (pp. 474–488). 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc. 10.4135/9781483348971.n30

Espelage DL, Hong JS, Rao MA, & Thornberg R. (2015). Understanding ecological factors associated with bullying across the elementary to middle school transition in the United States. Violence and Victims, 30(3), 470–487. 10.1891/0886-6708.VV-D-14-00046 [PubMed: 26118267]

Fish JN (2020). Future directions in understanding and addressing mental health among LGBTQ youth. Journal of Clinical Child & Adolescent Psychology, 49(6), 943–956. 10.1080/15374416.2020.1815207

Fish JN, Moody RL, Grossman AH, & Russell ST (2019). LGBTQ youth serving community-based organizations: Who participates and what difference does it make? Journal of Youth and Adolescence, 48(12), 2418–2431. 10.1007/s10964-019-01129-5 [PubMed: 31606828]

Floyd FJ, & Bakeman R. (2006). Coming-out across the life course: Implications of age and historical context. Archives of Sexual Behavior, 35(3), 287–296. 10.1007/s10508-006-9022-x [PubMed: 16804747]

Gershenson S, Polikoff MS, & Wang R. (2020). When Paywall Goes AWOL: The Demand for Open-Access Education Research. Educational Researcher, 49(4), 254–261. 10.3102/0013189X20909834

Goldbach JT, & Gibbs JJ (2017). A developmentally informed adaptation of minority stress for sexual minority adolescents. Journal of Adolescence, 55, 36–50. 10.1016/j.adolescence.2016.12.007 [PubMed: 28033502]

Gómez-Ortiz O, Romera EM, Ortega-Ruiz R, Cabello R, & Fernández-Berrocal P. (2016). Analysis of Emotion Regulation in Spanish Adolescents: Validation of the Emotion Regulation Questionnaire. Frontiers in Psychology, 6, 1959. 10.3389/fpsyg.2015.01959 [PubMed: 26779076]

Gross JJ, & John OP (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. Journal of Personality and Social Psychology, 85(2), 348–362. (2003–05897-016). 10.1037/0022-3514.85.2.348 [PubMed: 12916575]

Hatzenbuehler ML (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. Psychological Bulletin, 135(5), 707–730. 10.1037/a0016441 [PubMed: 19702379]

Hatzenbuehler ML, & Pachankis JE (2016). Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth. Pediatric Clinics of North America, 63(6), 985–997. 10.1016/j.pcl.2016.07.003 [PubMed: 27865340]

Herdt GH, & Boxer A. (1993). Children of horizons: How gay and lesbian teens are leading a new way out of the closet. Boston: Beacon Press.

Horne SG, Puckett JA, Apter R, & Levitt HM (2014). Positive psychology and LGBTQ populations. In Teramoto Pedrotti J& Edwards LM(Eds.), Perspectives on the Intersection of Multiculturalism and Positive Psychology (pp. 189–202). Dordrecht: Springer Netherlands. 10.1007/978-94-017-8654-6_13

Idsoe T, Keles S, Olseth AR, & Ogden T. (2019). Cognitive behavioral treatment for depressed adolescents: Results from a cluster randomized controlled trial of a group course. BMC Psychiatry, 19(1), 155. 10.1186/s12888-019-2134-3 [PubMed: 31117989]

Ioverno S, Belser AB, Baiocco R, Grossman AH, & Russell ST (2016). The protective role of gay–straight alliances for lesbian, gay, bisexual, and questioning students: A prospective analysis.

Psychology of Sexual Orientation and Gender Diversity, 3(4), 397–406. 10.1037/sgd0000193 [PubMed: 28042585]

Kann L. (2018). Youth risk behavior surveillance—United States, 2017. MMWR. Surveillance Summaries, 67. 10.15585/mmwr.ss6708a1

Kazdin AE (2017). Addressing the treatment gap: A key challenge for extending evidence-based psychosocial interventions. Behaviour Research and Therapy, 88, 7–18. 10.1016/j.brat.2016.06.004 [PubMed: 28110678]

Kiperman S. (2018). Exploring a Model of Social Support and Nonsupport among LGBTQ Youth with and without Parent Consent (Georgia State University). Georgia State University. 10.57709/12223961

Kosciw JG, Clark CM, Truong NL, & Zongrone AD (2020). The 2019 national school climate survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools: New York, NY et al.: GLSEN.

Lugg CA (2003). Our straitlaced administrators: The law, lesbian, gay, bisexual, and transgendered educational administrators, and the assimilationist imperative. Journal of School Leadership, 13(1), 51–85. 10.1177/105268460301300104

Lytle MC, Vaughan MD, Rodriguez EM, & Shmerler DL (2014). Working with LGBT individuals: Incorporating positive psychology into training and practice. Psychology of Sexual Orientation and Gender Diversity, 1(4), 335–347. (2014–52523-008). 10.1037/sgd0000064 [PubMed: 25544947]

Marshal MP, Friedman MS, Stall R, King KM, Miles J, Gold MA, … Morse JQ (2008). Sexual orientation and adolescent substance use: A meta-analysis and methodological review. Addiction, 103(4), 546–556. 10.1111/j.1360-0443.2008.02149.x [PubMed: 18339100]

Martos AJ, Nezhad S, & Meyer IH (2015). Variations in sexual identity milestones among lesbians, gay men, and bisexuals. Sexuality Research and Social Policy, 12(1), 24–33. 10.1007/s13178-014-0167-4 [PubMed: 27695579]

Masten AS (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56(3), 227–238. (2001–00465-004). 10.1037/0003-066X.56.3.227 [PubMed: 11315249]

McCubbin HI, Thompson AI, & McCubbin MA (1996). Youth Coping Index (YCI). In Family assessment: Resiliency, coping and adaptation: Inventories for research and practice (p. Page(s) 585–611.). Madison, Wis.: University of Wisconsin Publishers.

Melka SE, Lancaster SL, Bryant AR, & Rodriguez BF (2011). Confirmatory factor and measurement invariance analyses of the emotion regulation questionnaire. Journal of Clinical Psychology, 67(12), 1283–1293. 10.1002/jclp.20836 [PubMed: 21928369]

Meyer IH (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129(5), 674–697. (2003–99991-002). 10.1037/0033-2909.129.5.674 [PubMed: 12956539]

Movement Advancement Project. (2018). Movement advancement project | 2018 LGBT community center survey report. Retrieved January 21, 2022, from https://www.lgbtmap.org/policy-and-issue-analysis/2018-lgbt-community-center-survey-report

Newport F. (2018). In U.S., estimate of LGBT population rises to 4.5%. Retrieved January 21, 2022, from Gallup website: https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Paceley MS, Dikitsas Z, Greenwood E, McInroy LB, Fish JN, Williams ND, … Levine DS (2021). Health implications of policies targeting transgender youth. Transgender Health.

Pachankis JE, Clark KA, Jackson SD, Pereira K, & Levine D. (2021). Current capacity and future implementation of mental health services in U.S. LGBTQ community centers. Psychiatric Services, 72(6), 669–676. 10.1176/appi.ps.202000575 [PubMed: 33882684]

Payne E, & Smith MJ (2016). Gender Policing. In Rodriguez NM, Martino WJ, Ingrey JC, & Brockenbrough E(Eds.), Critical Concepts in Queer Studies and Education: An International Guide for the Twenty-First Century (pp. 127–136). New York: Palgrave Macmillan US. 10.1057/978-1-137-55425-3_14

Phillips G, Beach LB, Turner B, Feinstein BA, Marro R, Philbin MM, … Birkett M. (2019). Sexual identity and behavior among U.S. high school students, 2005–2015. Archives of Sexual Behavior, 48(5), 1463–1479. 10.1007/s10508-019-1404-y [PubMed: 31123950]

Plöderl M, & Tremblay P. (2015). Mental health of sexual minorities. A systematic review. International Review of Psychiatry, 27(5), 367–385. 10.3109/09540261.2015.1083949 [PubMed: 26552495]

Poteat VP, Scheer JR, Marx RA, Calzo JP, & Yoshikawa H. (2015). Gay-Straight alliances vary on dimensions of youth socializing and advocacy: Factors accounting for individual and setting-level differences. American Journal of Community Psychology, 55(3–4), 422–432. 10.1007/s10464-015-9722-2 [PubMed: 25855133]

Proujansky RA, & Pachankis JE (2014). Toward formulating evidence-based principles of LGB-affirmative psychotherapy. Pragmatic Case Studies in Psychotherapy, 10(2), 117–131. 10.14713/pcsp.v10i2.1854 [PubMed: 26617475]

Robinson JP, Espelage DL, & Rivers I. (2013). Developmental trends in peer victimization and emotional distress in LGB and heterosexual youth. Pediatrics, 131(3), 423–430. 10.1542/peds.2012-2595 [PubMed: 23382442]

Rosenberg M. (1965). Society and the adolescent self-image. Princeton NJ: Princeton University Press.

Russell Stephen T., & Fish JN (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. Annual Review of Clinical Psychology, 12(1), 465–487. 10.1146/annurev-clinpsy-021815-093153

Russell Stephen T., & Fish, J. N. (2019). Sexual minority youth, social change, and health: A developmental collision. Research in Human Development, 16(1), 5–20. 10.1080/15427609.2018.1537772 [PubMed: 31602178]

Russell Stephen Thomas, & Horn SS (2017). Sexual orientation, gender identity, and schooling: The nexus of research, practice, and policy / edited by Russell Stephen T., Horn Stacey S.. New York, NY: Oxford University Press.

Sherrod LR (1999). “Giving child development knowledge away:” using university-community partnerships to disseminate research on children, youth, and families. Applied Developmental Science, 3(4), 228–234. 10.1207/s1532480xads0304_7

Singh AA, & Kosciw JG (2016). Introduction to the special issue: School counselors transforming schools for lesbian, gay, bisexual, transgender, and queer (LGBTQ) students. Professional School Counseling, 20(1a), 1–4.

Sloan E, Moulding R, Weiner C, Dowling R, & Hall K. (2021). A qualitative examination of the relationship between rumination, distress, and dysregulated behaviours in vulnerable young people. Psychology & Psychotherapy: Theory, Research & Practice, 94(2), 322–340. 10.1111/papt.12297

Snapp SD, Russell ST, Arredondo M, & Skiba R. (2016). A Right to Disclose. In Advances in Child Development and Behavior (Vol. 50, pp. 135–159). Elsevier. 10.1016/bs.acdb.2015.11.005 [PubMed: 26956072]

Treynor W, Gonzalez R, & Nolen-Hoeksema S. (2003). Rumination reconsidered: A psychometric analysis. Cognitive Therapy and Research, 13.

Wasserstein RL, Schirm AL, & Lazar NA (2019). Moving to a world beyond “ p<0.05.” The American Statistician, 73(sup1), 1–19. 10.1080/00031305.2019.1583913

Williams ND, Levine DS, & Fish JN (2019). 2019 Needs assessment: LGBTQ+ youth centers and program. CenterLink. Retrieved from https://www.lgbtcenters.org/Assets/Images/PageContent/Full/2019-needs-assessment-lgbtq-youth-centers-and-programs.pdf

Wilson C. (2011). Integrating Narrative Therapy and Playback Theatre into a Drama Therapy Intervention for LGBT Adolescents. Undefined. Retrieved from https://www.semanticscholar.org/paper/Integrating-Narrative-Therapy-and-Playback-Theatre-Wilson/6b74957bfa808816f3c4197c31a2fbf69f1c28a3

Yadavaia JE, & Hayes SC (2012). Acceptance and commitment therapy for self-stigma around sexual orientation: A multiple baseline evaluation. Cognitive and Behavioral Practice, 19(4), 545–559. 10.1016/j.cbpra.2011.09.002

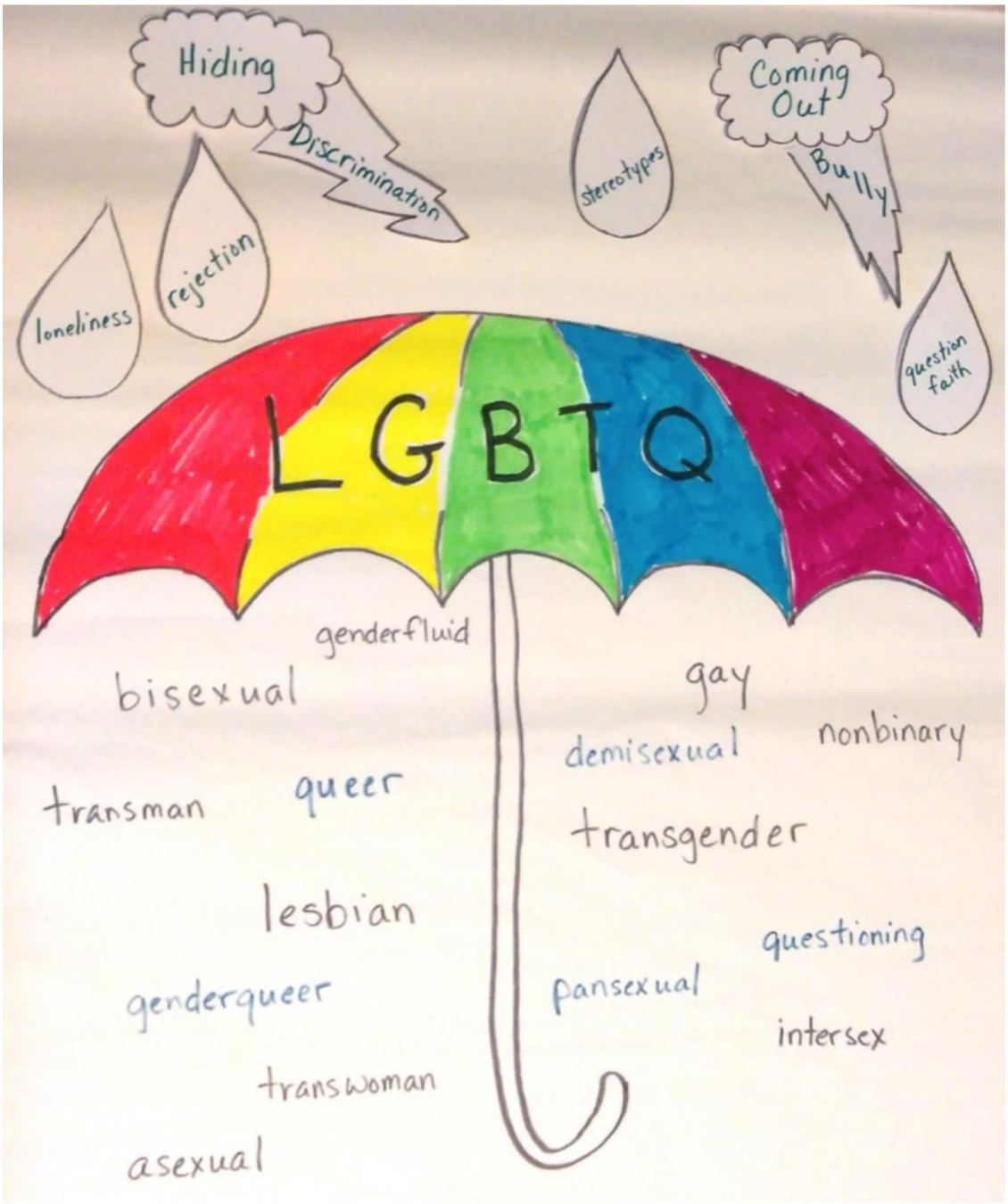

Figure 1.
Example Activity from the LGBTQ Umbrella Session

Table 1.

Unbreakable and Outspoken Lesson Plans from the Be YOU! Curriculum, Session Titles, Target Constructs, and Sample Activities

Lesson Title	Target Constructs	Sample Activities
Unbreakable Lesson Plans		
Planting Seeds	*SE*	Social Identity Wheel
My Roots	*SE*	Social Location Mapping
The LGBTQ Umbrella	*SE*	LGBTQ Umbrella **
The Storm	*R, ER*	Personal Experiences of Stress
Forrest Through the Trees	*R, ER, CP*	Seeing the Middle Path
I Can See Clearly Now	*R, ER, CP*	Negative Thoughts and Alternatives Card
Dancing in the Rain	*R,ER, CP,SE*	Body-based Coping Strategies, Sharing Music
The Rainbow I've Been Seeking	*R, ER, CP*	Identity Tensions, Affirming our Spirits
My Sunshine	*R,ER, CP, SE*	Healthy vs. Unhealthy Relationships, Loving Messages Cards
Our Stories	*R, ER, CP,SE*	Storytelling, Messages to the Group
Outspoken Lesson Plans		
How Far the Apple Fell	*R, ER*	Revising Social Location Maps
Branching Out	*ER, CP, SE*	Assertive Communication Role Play
Words of Wisdom	*R, ER, CP, SE*	Acceptance and Influence, Honoring our Values
Grassroots	*SE*	LGBTQ History and Activism
Cultivating Change	*SE*	Group Activism Brainstorm, Activism Ideas
Tending the Garden	*SE*	Choosing a Project
Ideas Blossom	*ER, SE*	Action Implementation, Managing Emotions in Advocacy/Activism
Rest in the Shade	*ER, SE*	Impact of Activism Discussion
Crystal Ball	*CP, SE*	Crystal Ball, Message in a Bottle
Next Chapter	*SE*	Presentation of Group Messages from Message in a Bottle, Celebration

SE = Self-esteem, R = Rumination, ER = Emotion regulation, CS = Coping skills.

** See example in Figure 1

Table 2.

Multivariate Regression Analysis Testing Factors Associated with Changes in Rumination and Emotion Regulation

	Rumination W3 (n = 31)			Emotion Regulation W3 (n = 29)		
Measure	***β***	***SE***	***95% CI***	***β***	***SE***	***95% CI***
Rumination W1	.36*	.14	[.06, .66]			
Emotion Regulation W1				.45**	.11	[.20, .70]
Program attendance	-.04*	.02	[−.08, −.00]	.04	.03	[−.02, .10]
Adjusted R^2	.35	.41				
F	7.82**	9.02**				

Note.

* p < .05.

** *p* < .01.

Table 3.

Sample Demographic Characteristics.

	n	%
Sexual identity		
Gay/lesbian	6	21.43
Straight	8	39.29
Bisexual/Pansexual/Queer	11	10.71
Questioning	3	28.57
Gender Identity		
Male/boy	7	24.14
Female/girl	17	58.62
Questioning	2	6.90
Non-binary	2	6.90
Other	1	3.45
Transgender		
No	21	61.76
Yes	5	14.71
I don’t know	8	23.53
Grade		
6^{th}	4	11.76
7^{th}	4	11.76
8^{th}	7	20.59
9^{th}	0	0.00
10^{th}	4	11.76
11^{th}	7	20.59
12^{th}	8	23.53
Race/Ethnicity		
Black/African American	2	6.25
Asian American/Pacific Islander	3	9.38
Hispanic/Latinx	16	50.00
White	7	21.88
Multiracial/Multiethnic	4	12.50
School Climate		
Unsafe	1	3.33
Safe, but not always supportive	14	46.67
Mostly supportive	12	40.00
Totally queer and trans friendly	3	10.00

Note. Number of participants may not add up to n=34 due to missing values.

Table 4.

Correlations for Continuous Variables

	1	2	3	4	5	6	7	8
1. W1 Rumination								
2. W3 Rumination	.51**							
3. W1 Emotion Regulation	.11	−.02						
4. W3 Emotion Regulation	−.18	−.45*	.61***					
5. W1 Youth Coping	.01	−.00	.16	.03				
6. W3 Youth Coping	−.22	−.04	.19	.38*	.55**			
7. W1 Self-esteem	−.48**	−.21	.17	.22	.21	.23		
8. W3 Self-esteem	−.34	−.43*	.19	.48*	.08	.37*	.63**	
9. Program attendance	−.19	−.47**	.25	.29	.21	.01	.42*	.31

Note.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 5.

Paired t-tests Comparing Pre- and Post- Program Mental Health & Wellbeing

		Pre-Program		Post-Program				
Measure	**n**	**M (SD)**	**95% CI**	**M (SD)**	**95% CI**	***t* value**	***p* value**	**Effect size**
Self-esteem	30	1.89 (.60)	[1.66, 2.11]	1.95 (.67)	[1.69, 2.20]	−.58	.566	.09
Rumination	31	1.39 (.61)	[1.17, 1.62]	1.18 (.57)	[.97, 1.39]	2.00	.055	.36
Emotion Regulation	29	3.01 (1.22)	[2.55, 3.48]	3.51 (.95)	[3.15, 3.87]	−2.73	.011	.51
Coping strategies	31	2.13 (.38)	[1.99, 2.26]	2.13 (.46)	[1.96, 2.30]	−.01	.993	.00