

the Behavior Therapist

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Sexual and Gender Minority Mental Health: A Spotlight on Resilience (Part Two)

Richard LeBeau and Lucas Zullo,
University of California, Los Angeles

IN APRIL 2022, we put out a call for submissions for a special issue of *the Behavior Therapist* (*tBT*) focusing on resilience among sexual and gender minority (SGM) populations. We received so many relevant, high-quality, and thought-provoking submissions in response to this call that we immediately knew we would have enough material to fill two full issues of *I*. This special collection spans the January 2023 issue (Volume 46, Issue 1; LeBeau & Zullo, 2023), which featured the first set of 5 articles, and this issue (Volume 46, Issue 3), which features a second set of 4 articles.

As we stated in the introduction to the first part of the special collection, although the mental health disparities adversely affecting SGM people are extremely well documented in the literature, far less has been written about resilience and positive experiences among SGM people. By emphasizing positive aspects of the SGM experience, we seek to inspire hope and to remind readers of the many strengths within the SGM community that can be effectively leveraged during the delivery of evidence-based care to optimize clinical outcomes.

An Overview of Part Two of the Special Issue

The second part of the special issue opens with an article by Craig and colleagues (2023) that examines facilitators and barriers to imple-

[continued on p. 99]

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Dr. Jessica L. Schleider | Scaling Single-Session Interventions to Bridge Gaps in Mental Healthcare Ecosystems

The discrepancy between need and access to mental health services is uncontested. An estimated 57% to 67% of adults experiencing mental illness in the United States do not receive needed services. The need-to-access gap is even wider for children and adolescents: Up to 80% of youths with mental health needs go without services each year. Even among those who do access care, treatment is often brief: international service-use data suggests that the modal number of sessions attended is just one. This creates a need to quantify and capitalize on what can be accomplished therapeutically, given appropriate targeting and structure, in a short period of time. Therefore, this talk will outline recent innovations in single-session interventions (SSIs) for mental health problems, including the evidence supporting their effects; how they might yield clinically-meaningful change; resources for delivering evidence-based SSIs; and where, when, and how they can be delivered. Understanding SSIs' promise creates an opportunity for a paradigm shift in our field's thinking about constructing services for broad-scale impact. SSIs can operate as stand-alone services or as adjunctive services within existing care systems; as such, learning to study and provide SSIs may improve the reach of effective mental health interventions while mitigating problems linked to long waiting lists, global provider shortages, and high costs of traditional care.

Dr. Jessica L. Schleider, Stony Brook University, founded and directs the Lab for Scalable Mental Health.

11 a.m. – 12:30 p.m. Eastern
10 a.m. – 11:30 p.m. Central
9 a.m. – 10:30 a.m. Mountain
8 a.m. – 9:30 a.m. Pacific

INSTRUCTIONS for AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Submissions must be accompanied by a Copyright Transfer Form (which can be downloaded on our website: <http://www.abct.org/Journals/?m=mJournal&fa=TB T>): *submissions will not be reviewed without a copyright transfer form*. Prior to publication authors will be asked to submit a final electronic version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of the published materials shall be assigned exclusively to ABCT. Electronic submissions are preferred and should be directed to the editor, Richard LeBeau, Ph.D., at rlebeau@ucla.edu. Please include the phrase *tBT submission* and the author's last name (e.g., *tBT Submission - Smith et al.*) in the subject line of your e-mail. Include the corresponding author's e-mail address on the cover page of the manuscript attachment. Please also include, as an attachment, the completed copyright transfer document.

menting affirmative cognitive behavioral group interventions for SGM youth and young adults. The article represents a unique and important contribution to the literature through its inclusion of a large and diverse sample, its mixed-method design, and the collection of data from both clinicians ($N = 24$) and participants ($N = 334$). Key take-home messages for clinical practice are presented, including the importance of acknowledging intersectional identities, modeling affirmation, implementing emotion-regulation strategies during difficult conversations, and encouraging opportunities for peer engagement outside of sessions.

In the second article, Scott and colleagues (2023) present qualitative data from 22 transgender and nonbinary (TNB) individuals who reported being in a romantic relationship during their gender transition. Thematic analyses revealed several themes regarding positive benefits of receiving support from a romantic partner during gender transition, including validation and increased intimacy. The article is notable for its thoughtful, in-depth exploration of an understudied topic and the concrete clinical recommendations for those working with members of this understudied and historically marginalized group.

In the third article, Ergas and colleagues (2023) examine the relationship between aspects of minority stress (i.e., outness, heterosexist experiences, and internalized stigma) and stress-related growth among 107 sexual minority adults. Their results suggest that the degree to which an individual is “out” is strongly related to positive stress-related growth (after accounting for the deleterious aspects of discrimination in response to identity disclosure) and that there are meaningful differences in positive stress-related growth between sexual minority subgroups. A strength of this arti-

cle is its theoretically grounded examination of well-validated constructs in a sample that is significantly more diverse in terms of race, ethnicity, sexual orientation, and gender identity than we typically see.

The fourth and final article (Peng et al., 2023) is an exploration of the impact of media on the mental health of youth. The article reports results from two studies. The first is a qualitative study with 18 teenagers that explored media consumption and knowledge and attitudes about mental health. The second is an experimental study with 106 teenagers that examined the impact of “second-screen” content (i.e., supplemental media affiliated with a narrative) on attitudes, knowledge, and information-seeking behaviors. The diverse sample allowed for the authors to examine differences between SGM teenagers and cisgender and heterosexual teenagers. Among their findings are that sexual minority youth are more accepting and aware of mental health issues than their cisgender and heterosexual peers, that TNB teenagers have lower knowledge of effectively handling stress and having helpful conversations about mental health compared to their cisgender peers, and that “second-screen” content can help improve attitudes toward mental health among SGM teenagers (particularly when delivered by peers).

We believe that the 9 articles featured in the two special issues are important contributions to the clinical science literature and serve as timely and important reminders of the tremendous strength and diversity inherent in SGM people. We were delighted by the quality and quantity of articles received in response to our call and are tremendously grateful to all who contributed their time and effort to the creation of this special issue. We welcome any questions or comments on the articles featured in this issue of *tBT*.

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Facilitating Resilience Across the Intersections: Participant- and Clinician-Identified Barriers and Facilitators to the Delivery of an Affirmative Cognitive Behavioral Group Intervention to LGBTQ+ Youth and Young Adults

Shelley L. Craig, Rachael V. Pascoe, Vivian W.Y. Leung, Laura Foran,
Factor-Inwentash Faculty of Social Work, University of Toronto

LESBIAN, GAY, BISEXUAL, transgender, queer, and other sexual and/or gender diverse (LGBTQ+) youth and young adults are at an increased risk of experiencing prejudice and victimization related to their identity status. This increased stress leads to a disproportionate prevalence of mental health concerns, such as depression, anxiety, and suicidal ideation, when compared to their heterosexual and cisgender peers (Kuper et al., 2018; Lucassen et al., 2017; Meyer, 2003). Yet, despite these disparities, LGBTQ+ youth manifest significant resilience (Tull et al., 2021), often in the absence of responsive and competent clinical care (Spivey & Edwards-Leeper, 2019). Empirical evidence consistently points to cognitive behavioral therapy (CBT) as an effective evidence-based intervention for youth experiencing a wide range of mental health concerns in both individual and group therapy contexts (Rith-Najarian et al., 2019; Sun et al., 2019). Affirmative CBT, which highlights the value of the LGBTQ+ identities and recognizes the role of anti-LGBTQ+ stigma on individual well-being, has emerged as a therapeutic approach that can address mental health symptoms, while simultaneously improving resilience factors (Craig & Austin, 2016).

While affirmative CBT holds the potential to deliver nonpathologizing and validating mental health care to LGBTQ+ youth (Wandrekar & Nigudkar, 2019), and encouraging research has emerged that seeks to evaluate CBT interventions that target the unique needs, experiences, and stressors of LGBTQ+ youth (Craig, et al., 2021; Hall et al., 2019; Pachankis, 2018), most studies focus on client outcomes. Although such research is critical to the development of affirmative CBT, further exploration of participating clinicians and youth is needed to illuminate some of the barriers and facilitators that may contribute to implementation effectiveness. Consequently, this paper details the results

of a mixed-methods study of data derived from a clinical trial of affirmative CBT with LGBTQ+ youth. This research sought to articulate the barriers and facilitators of affirmative CBT group therapy from the perspectives of clinicians and youth participating in the same groups.

Critical CBT Implementation Factors

Previous research has identified some commonalities across CBT implementation approaches. Ringle et al. (2015) found that facilitators of community-based CBT with youth included motivated clients and the presence of clinical supervision, while barriers included youth with multiple complex psychosocial issues, multiple minority identities, and lack of organizational support. Intervention factors such as the structure of CBT appeared to have a mixed impact, with several clinicians reporting it was helpful, while some found the structure limiting. Cox et al. (2020) found that CBT interventions offered in the community, when compared to research sites, tended to adhere less to treatment fidelity, thus compromising the quality of intervention content and process. These findings suggest the importance of assessing and strengthening CBT treatment delivery processes.

Group-Based CBT Intervention Delivery

Group-based CBT can offer universality (a feeling that participants are not alone in their experiences), positive peer modeling, reinforcement of positive norms, and opportunities to practice skills in a social setting (Manassis et al., 2002). Group-based CBT, identified as a resilience-enhancing program for adolescents with anxiety or depression (Dray et al., 2017), specifically enhances factors such as self-efficacy and esteem, cognitive flexibility, coping and regulation, and social support (Şahin & Türk, 2021). The group context

facilitates peer learning and acquisition of CBT goals, such as restructuring cognitive distortions and enhancing the use of effective skills, along with the benefits of group work for youth, including collaboration, cohesion, and responsibility between members (Stewart et al., 2007).

Youth-Level Barriers and Facilitators to LGBTQ+ Affirmative CBT

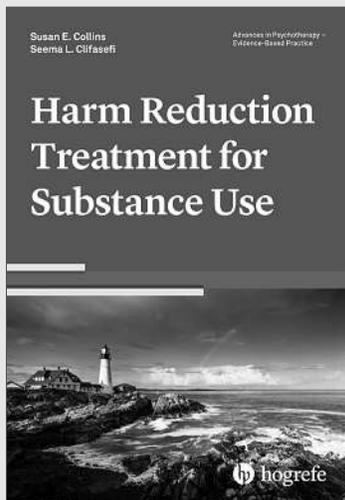
Specific to affirmative CBT, barriers such as a lack of knowledge about LGBTQ+ needs and intersectional identities and experiences have been suggested in studies with youth (Craig et al., 2016). Intersectionality, an integral aspect of affirmative interventions, refers to the understanding that oppression is affected by multiple and interwoven systems, such as gender, sexual, and racial identities (Crenshaw, 2013). Parents and caregivers are critical to adolescent mental health overall and can enable access to clinical services, yet many have persistent rejecting attitudes and behaviors (Hall et al., 2019). Parents may not offer support for their child's participation in LGBTQ+ -related programs, or they may disapprove of their child's desire for mental health support due to stigma (Austin et al., 2021). In one of the few studies that explore the implementation of affirmative CBT, LGBTQ+ youth report that not feeling a strong connection to the LGBTQ+ community, having mental health challenges unrelated to their LGBTQ+ identity, receiving mental health treatment through another provider, an intervention age range that spanned too many developmental stages (e.g., ages 15–30), the time commitment, and hesitation to participate in a psychotherapy group were barriers to their attendance in a CBT intervention (Hall et al., 2019). Clinician identity also had an impact on the therapeutic experience of youth. In their study of an affirmative CBT intervention in India, Wandrekar and Nigudkar (2019) found that youth reported being more comfortable and engaged because of the dual identities of the group facilitators as both members of the sexual and gender minority community and as clinical experts.

Clinician-Level Barriers and Facilitators to LGBTQ+ Affirmative CBT

Concerning clinical skills, clinicians with higher client ratings of a therapeutic alliance, observer-rated CBT competence, positive client outcome expectations, and client-assessed treatment credibility were reported as most effective (Westra et al., 2012). Further, greater CBT competence

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heartset of HaRT and the three treatment components: measurement and tracking of patient-preferred substance-related metrics, harm-reduction goal setting and achievement, and discussion of safer-use strategies. This volume walks practitioners through all components, provides example scripts for use in daily practice, and illustrates the work through case studies and input from community members. Handouts are available for use in daily practice. This is essential reading for clinical psychologists, psychotherapists, and researchers who encounter people who have substance-use problems.



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was associated with better client mid-treatment outcome expectations, which in turn were associated with improved posttreatment outcomes. Fjermestad et al. (2016) identified that the therapeutic alliance is particularly critical to establish during the early stages of CBT, as it predicted treatment satisfaction and outcomes for youth with anxiety disorders. Conversely, Zandberg et al. (2015) found that discrepancies between the clinicians and youth on alliance scores did not affect treatment response. Other challenges to offering effective CBT interventions include a lack of adequate clinician training and supervision and clinician beliefs (unsupported by the evidence) that CBT can be harmful or unsuitable for some clinical populations (Wolitzky-Taylor et al., 2018). Clinicians' positive attitudes toward CBT contributed to greater client readiness to change (Lewis et al., 2011), while those reporting favorable feelings and attachment toward their clients found them less challenging (Westra et al., 2012). In contrast, early negative reactions to clients contributed to power struggles and clinician frustration, which in turn were associated with client resistance (Westra et al., 2012). Client resistance is considered a primary barrier to effective CBT delivery from the staff perspective (Amodeo et al., 2011), so it is important to address this potential issue in the design and delivery of CBT interventions.

Facilitators and Barriers of Time-Limited Interventions

Research also points to barriers associated with relatively short, time-limited interventions, where deeply ingrained beliefs such as internalized homophobia may not be significantly altered (Ross et al., 2008). The perception that CBT approaches may overlook the structural inequities encountered by oppressed populations, in favor of an emphasis on individual orientation and cognitive restructuring (Hays, 2009), means that clinicians must recognize that such inequities (e.g., racism or homophobia) may have an impact on the effectiveness of CBT (Hays), and collaboratively help clients make changes that decrease the stress of environmental problems while increasing personal strengths and supports (Craig et al., 2013). Specifically, providing LGBTQ+ youth with affirmative CBT that acknowledges the contribution of systematic oppression to mental health symptoms is vital (Craig & Austin, 2016; Hall et al., 2019). While emerging research evidence supports the efficacy of

affirmative CBT for LGBTQ+ youth and adults, there is a dearth of literature examining the specific factors that can enhance implementation and support client resilience. By exploring the barriers and facilitators of affirmative CBT from multiple perspectives (clinicians and youth participants), this research may enhance implementation, clinical supervision, and training efforts.

Methods

Data for this study were culled from 3 years (2018–2021) of an implementation trial (NCT04318769) of AFFIRM, an eight-session affirmative CBT group intervention. As the first evidence-based intervention tailored to address LGBTQ+ youth mental health, AFFIRM reduces depression while enhancing resilience-enhancing factors such as coping, stress appraisal, active coping, emotional support, positive framing, planning, and hope by addressing minority stress in an affirmative CBT framework (Craig, Eaton, et al., 2021; Craig, Leung, et al., 2021). AFFIRM has been systematically adapted (Craig & Austin, 2016) for the LGBTQ+ population to incorporate an LGBTQ+ affirmative clinical stance and recognition of the external source of anti-LGBTQ+ discrimination that leads to minority stress and resultant mental health disparities (Craig et al., 2013). Therefore, the AFFIRM intervention focuses on helping participants understand how they have internalized (that is, incorporated into their thinking patterns) external systemic anti-LGBTQ+ oppression, how to identify and address their cognitive distortions, increase prosocial and proactive behaviors, and the use of CBT techniques (e.g., thought records, ABCD method) and activities (e.g., coping behaviors, connecting to affirmative resources) to embrace an LGBTQ+ affirming worldview. AFFIRM consists of eight 2-hour group sessions: *Sessions 1–2*: introduction to CBT and exploring minority stressors; *Sessions 3–4*: cognitive restructuring; *Sessions 5–6*: coping skills, behavioral activation, setting goals and building hope; and *Sessions 7–8*: social support, self-compassion, and integration of new skills (Craig & Austin, 2016).

Since 2018, the 8-session AFFIRM intervention has been delivered 56 times (16 community sites and online) in developmentally appropriate groups (e.g., age 14–17, 18–24, and 25–29). In response to the COVID-19 pandemic, the AFFIRM group intervention shifted to a telehealth

format using Zoom videoconferencing software (Craig, Leung et al., 2021). Given the utilization of the same clinicians and similar results across traditional and telehealth implementations, this study integrates data from both delivery approaches. The study was approved by the University of Toronto Research Ethics Board (Protocol ID# 35229).

Youth Participants

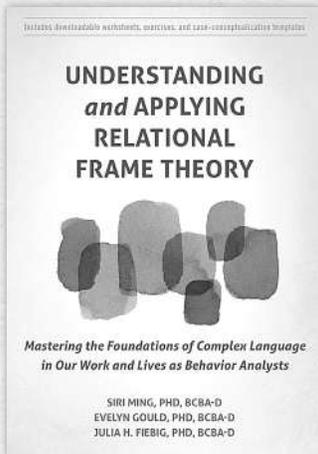
LGBTQ+ youth participants ($N = 334$) ranged in age from 11–29 ($M = 20.19$), with 76% of participants reporting having been born in Canada and 51% reporting at least 1 newcomer or immigrant parent. Gender identities included cisgender (28.8%), transgender (28.1%), nonbinary (27.2%), gender queer (7.8%), agender (3.9%), and sexual orientations as bisexual (20.7%), queer (17.7%), gay (17.1%), pansexual (14.1%), and lesbian (15.0%). Youth ethnic/racial identities included White (59.3%), Asian (20.4%), Black (13.2%), Mixed Race (11.4%), Latinx (6.0%), Indigenous Peoples (5.1%), and Middle Eastern and North African (4.8%). Over 35% of participants reported moderate to severe depression, 31% had previously attempted suicide, and 74% were accessing other LGBTQ+ youth services, such as LGBTQ+ youth drop-in centers, Gay-Straight Alliances/Rainbow Clubs through their school, online communities, and LGBTQ+ specific individual counseling. The majority of LGBTQ+ youth (61.32%) identified as having both a nonheterosexual sexual orientation and a noncisgender gender identity.

Clinician Participants

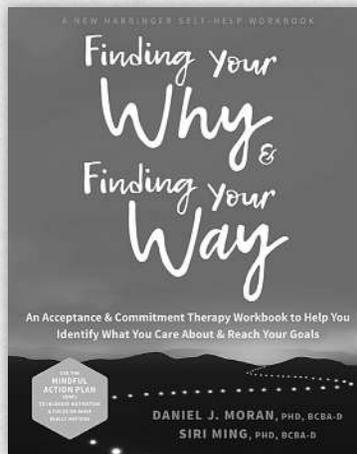
Clinicians ($N = 24$) identified as cis-female (33.3%), cis-male (33.3%), non-binary (25%), and trans (8.3%). Clinician sexual orientations included gay (33.3%), queer (29.2%), lesbian (16.7%), bisexual/pansexual (12.5%), and straight (8.3%). Clinicians identified their race as White (54.2%), Asian (20.8%), Black (8.3%), Mixed Race (8.3%), Latinx (4.2%), and Indigenous (4.2%). Clinicians' education ranged from Ph.D. ($I = 2$) to BSW ($n = 3$) with the majority holding master's degrees in social work or psychology. All had a minimum of 2 years of clinical experience with LGBTQ+ or youth populations and some knowledge of group facilitation. All participants completed the 16-hour AFFIRM training, which has been found to increase competence in the delivery of affirmative CBT (Craig, Leung, et al., 2021). All groups were co-facilitated and

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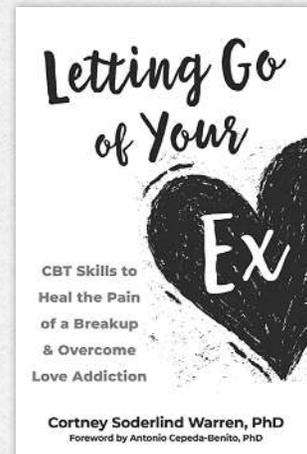
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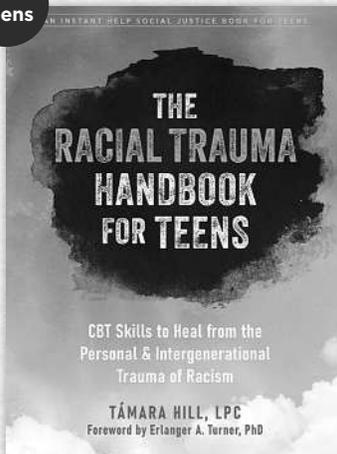


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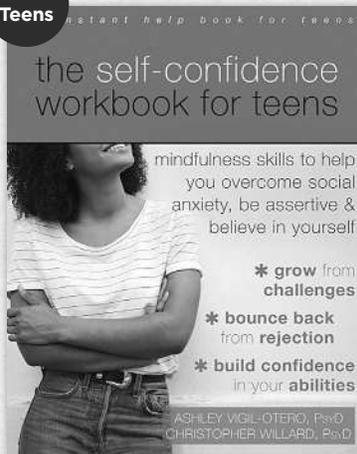
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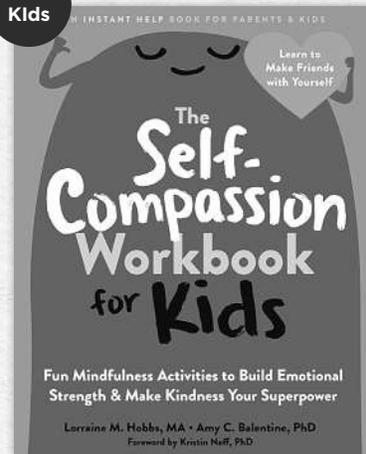
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strategically paired to provide a diverse dyad of identities and training (e.g., matching a more experienced CBT clinician with a newer clinician with more LGBTQ+ group experience). Clinical coaching was provided weekly and implementation fidelity procedures (e.g., reviewing recordings) were integrated.

Data Collection

Study data were derived from the AFFIRM clinical trial mixed method survey and acceptability measures that were collected through the Qualtrics online survey platform. In addition to the key outcome (e.g., Beck Depression Inventory) and client satisfaction measures that are reported elsewhere (Craig, Eaton, et al., 2021), LGBTQ+ youth participants completed a series of brief open-ended questions following intervention completion. Questions included (a) What was most helpful about AFFIRM?; (b) What was least helpful about AFFIRM?; (c) What would you recommend to improve AFFIRM?; (d) What would make it easier to attend this program?; and (e) Describe your overall experience in AFFIRM. In total, all measures took approximately 30 minutes to complete and LGBTQ+ youth participants were provided with gift cards (\$30 for posttest completion). Clinicians completed fidelity measures that included post-group process notes that included open-ended questions such as (a) your overall reaction to the session; (b) obstacles/challenges in delivering AFFIRM; (c) what worked in session?; (d) where did the youth engage?; (e) what feedback did you receive from youth?; and (f) how will you address issues moving forward? Clinicians also provided a written or verbal summary of the group sessions during clinical supervision meetings.

Data were analyzed using descriptive statistics in SPSS Version 28 and deductive thematic analysis using NVivo was used to explore participant and clinician experiences of LGBTQ+ affirmative CBT. Drawing from previous research and clinical experience, the data were analyzed through the lens of the question, *What are the barriers and facilitators to the effective implementation of LGBTQ+ affirmative CBT delivered in groups?* Coding was conducted by two clinicians (MSW-level clinicians with experience in LGBTQ+ affirmative clinical practice and qualitative research) and one clinical researcher (Ph.D. candidate with clinical and intervention research experience). The purpose of the research and relevant codes were discussed during

an initial 3-hour meeting, after which coders generated, reviewed emerging themes, and noted a high level of interrater reliability. Reviewers met again for two 3-hour meetings to discuss their individually completed qualitative analysis and to define themes. Themes were organized into barriers and facilitators from either youth or clinician data and examples were provided.

Results

LGBTQ+ Youth-Identified Implementation Factors

Youth-reported barriers and facilitators to their engagement in the affirmative CBT group, along with direct quotes illustrating the themes, are reported in Table 1. The use of clinician behavior or language was a particularly important theme, as participants sought clarity and accessibility in the communication of concepts coming from clinicians and other participants. For example, challenges to participant engagement included clinicians who appeared overly confident about their knowledge of LGBTQ+ issues or youth experiences, were not attentive to participant identities or seemed to not be utilizing active listening. Additional barriers included a lack of consistent definitions for frequently used terms related to identity and stigmatizing experiences as well as a lack of acknowledgment and affirmation of intersectional identities. Sessions that involved mainly didactic or psychoeducational instruction, without enough time for practice, were also noted as challenges. For example, youth noted that for intense or serious sessions specifically (e.g., discrimination discussions), in addition to talking about those experiences, providing time in which skills to counter the impact of those experiences would be useful. Other identified barriers included peer-to-peer interactions, such as when other group members invalidated identities or experiences or mental health complications that made it challenging to fully engage with the content. From a structural perspective, another theme surrounding barriers included stigmatizing environments, such as groups that took place in medical settings or schools, which participants traditionally associated with anti-LGBTQ+ policies and experiences. Relatedly, environments that did not have adequate representation of LGBTQ+ identities (e.g., posters, intake paperwork, clinicians) felt like a deterrent for some members to access services.

Aspects of affirmative CBT that facilitated LGBTQ+ youth growth included the increase in social support, as LGBTQ+ youth noted that by the end of their AFFIRM group, they felt like they were a part of an affirming community where they could access other members for support. Youth participants also reported that the development of skills in collaboration with their peers (e.g., learning together) was critical. As well, the acknowledgment of participants' intersectional identities (such as sexual and gender identities, race, and geographic differences) during discussions of CBT concepts was an important facilitator for feeling validated and included.

Clinician behaviors that enhanced LGBTQ+ youths' experiences include the use of the structure of CBT to guide the group through the content, while staying somewhat flexible, and reminders related to group schedules and activities, which kept them engaged and feeling important in the overall group process. The structure of CBT, including the use of ground rules and directive facilitation (e.g., clinician interruption of harmful discussions), also enabled the youth to feel more secure in the groups. Additionally, CBT content and facilitation that furthered group engagement included specific examples that were tailored to the LGBTQ+ and intersectional experiences of group participants as well as the acknowledgment of minority stress. The consistent use of affirmations, modeled first by the clinicians, and by their peers as the groups progressed, encouraged their participation. LGBTQ+ youth also appreciated that many clinicians shared similar identities and served as role models, which in turn enhanced their own hope for the future.

Clinician-Identified Implementation Factors

Based on clinician process notes, barriers and facilitators were identified that are presented in Table 2, along with examples from the data. Barriers that were identified by the AFFIRM clinicians included youth's abilities to engage in the content. For example, clinicians noted that skillful facilitation was needed to manage any emerging trauma symptoms, disrupt participants' harmful behaviors or language, encourage the application of their CBT skills, or modify pacing to ensure content was understood. Clinicians also noted that group members had differential amounts of knowledge of CBT, which required skillful bridging during the sessions. In some cases, group members who stated they had

experience in CBT had to be encouraged to engage in a process of unlearning, to learn the affirmative CBT concepts offered in AFFIRM. Finally, timing was a challenge at times as clinicians had to process the emotional needs of the group while balancing the delivery of the manualized content.

Clinician-identified facilitators of affirmative CBT included the application of emotion-regulation techniques during discussions about minority stressors as well as opportunities for peer engagement outside of sessions, which improved group cohesion and support. For example, some members connected to one another by joining the same online communities (such as Discord and WhatsApp groups), sharing social media, and planning in-person field trips. As well, the engagement of group members using multiple methods (e.g., social media, text, email) helped encourage attendance and the group's sense of belonging. Finally, clinicians noted the importance of integrating the application of CBT skills with LGBTQ+ experiences by

grounding them in the intersectional identities of group members.

Discussion

This study integrates important insights from LGBTQ+ youth and clinicians that can enhance affirmative CBT implementation efforts. Although there are some consistent results related to the delivery of LGBTQ+ affirmative CBT, many of the themes are related to the integration of content. With an eye toward resilience, three key findings will be discussed: integrating intersectionality, establishing social support, and ensuring an affirmative therapeutic alliance.

Integrating Intersectionality

Intersectionality is an embedded concept in the content of the AFFIRM intervention with a focus on coping with minority stressors while acknowledging and applying CBT skills to the challenges that emerge from other identities and experiences. For example, ethnic and racial

minority LGBTQ+ youth encounter intersectional forms of minority stress, such as simultaneous racism in the LGBTQ+ community and homophobia within their racial and ethnic communities (Meyer et al., 2021; Page et al., 2022), and such experiences should be addressed in affirmative practice (Austin et al., 2018). In addition to ensuring that intersectionality is embedded in the affirmative CBT content, integrating intersectional approaches throughout delivery was important to both clinicians and youth participants. Intersectional delivery requires clinicians to carefully assess the identities and experiences of the group participants to fully explore both their differences as well as their shared thoughts, feelings, and behaviors during the sessions. Specifically, validating youth individual identities and minority stress-related experiences, while targeting the universal processes (e.g., increasing coping and goal setting), is critical to the success of CBT interventions (Pachankis et al., 2015). For example, AFFIRM works with partici-

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Table 1. LGBTQ+ Youth-Identified Barriers and Facilitators to Affirmative CBT

Barriers	Description	Example
Overconfident or misgendering clinicians	Expressing familiarity with terms, “showing off,” or not listening.	<ul style="list-style-type: none"> • “A substitute facilitator misgender[ed] someone I care about despite having gone over pronouns and the person wearing a pronoun tag.” • “[The clinicians] weren’t supportive with correcting people when they messed up my pronouns.” • “There was one leader who gave a lecture about identities instead of listening.”
Stigmatizing environments	Offering groups in medical settings, schools, or settings that are not accessible to youth or LGBTQ+ individuals.	<ul style="list-style-type: none"> • “Being in a medical clinic [was undesirable]” • “It’s not a very gay friendly space.”
Lack of affirmation or representation for intersectional identities	Clinicians only focusing on sexual orientation while not incorporating or recognizing other intersecting identities of participants.	<ul style="list-style-type: none"> • “More Black facilitators, please, it is so important.” • “I believe considering applying other aspects of our identities into the group even more would be helpful.”
Members that invalidate identities	Participants demonstrating racial insensitivity or actively stigmatizing members. Participants demonstrating internalized and projected transphobia.	<ul style="list-style-type: none"> • “Without naming anyone, I find that although we established shared agreements, some people remained judgy towards other participants.” • “Sometimes there are questions about my culture that I don’t want to answer.” • “A trans participant shared what they thought about their identity and it was tough for me as trans to hear.”
Existing mental health complications	Participants with unaddressed concurrent mental health issues.	<ul style="list-style-type: none"> • “A certain person attending the group gave me bad anxiety.” • “I have a lot of mental health issues that make it harder to concentrate.”
Sessions with less practice	Group sessions that just offer discussion, with no opportunity for skills building	<ul style="list-style-type: none"> • “Have break out groups with a facilitator in each group to share skills.” • “I think making space for general discussion would help structure the group better so that discussion and teaching are separate parts and I can stay more focused/engaged. There was lots of great discussion and I wanted to have space for that, but it felt like it took away from the skills learning a lot of the time which was what really helped me.”
Complex language used by clinicians/other participants	Clinicians and other participants not explaining their experiences or not making connections between thought and underlying feelings and behaviors.	<ul style="list-style-type: none"> • “I have had troubles processing some of the material, but I think that is more because of how I think than how the material was presented (the language could be made clearer, less technical, and less ambiguous in places by the facilitator).” • “We didn’t always connect our thoughts to our feelings and behaviours – which is important.”
Lack of consistent definitions	No definitions provided for terms that are used frequently.	<ul style="list-style-type: none"> • “Several times, especially with check-in, we ran into questions where definitions were different between how I defined something vs. how the facilitators defined something, so being a bit more up front with definitions would also be helpful to avoid confusion.”
Groups that focused on the negative	Sessions that made participants feel sad and less hopeful in their own abilities to deal with their days.	<ul style="list-style-type: none"> • “If facilitators could make a better effort to keep some of those negative comments down, that would be great. Mind you I didn’t bring it up so it’s not like anyone has done anything wrong.”

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Table 1 *continued*

Facilitators	Description	Example
Feeling like part of a community	Reduced isolation and social support as part of an affirming community, with support to draw on and learn from.	<ul style="list-style-type: none"> • “[AFFIRM] connected me to the LGBTQ+ [community], gave me the courage to seek my own happiness, gave me a chosen family that I will keep in touch with, etc. I always came out of a session feeling refreshed and supported and loved and lighter. I looked forward to seeing everyone’s faces on screen and to chat about things that directly affect our community and ourselves personally, and to talk them out and practice ways to get support and surround ourselves with the right people and to use coping mechanisms that work for us... It gave me social interaction and everything I could have needed during those times.”
Integration of identity intersections	Addressing different sexual, gender, race, geographic identities and their connection to the content.	<ul style="list-style-type: none"> • “[AFFIRM] helped me find reassurance with both my gender and sexual orientation due to the activities and the representation and supportive participants and members. This in turn caused less stress and improved my overall well-being.” • “It’s been really nice to have a 2 hour video call each week where I get to see other trans folks, including one of the facilitators, most of whom are neurodiverse. It definitely felt like a degree of community.”
Consistent structure	Offering a consistent culture (e.g., starting group on time, sessions following a determined structure). Conveys respect for youth and their time and can calibrate expectations, allowing participants to plan for their sessions.	<ul style="list-style-type: none"> • “Routines have been super helpful, and the weekly structured meetings with clear times and expectations that the facilitators set were a great way to anchor my routine.”
Frequent affirmation of participants	Affirmations provided by clinicians, and later other participants, themselves	<ul style="list-style-type: none"> • “[AFFIRM] helped with the extra support of having others just say that you are valid in a way that feels genuine and affirming to your identity since the rest of the time most people won’t say this or won’t know how to properly express it.”
Frequent reminders to participants	Reminders delivered via email and text helped participants feel cared for and reminded them to complete their action plans/homework	<ul style="list-style-type: none"> • “[AFFIRM] was online so it was very easy to attend and reminders where sent out ahead of time as well to make sure we knew we were important and to do the homework.”
Ground rules that ensure respect	Ground rules were consistent throughout the sessions, and were adapted as needed, delivered in a kind and warm way, and helped participants feel welcome and safe	<ul style="list-style-type: none"> • “The friendly safe space that set ground rules about mutual respect was really important.”
LGBTQ+ facilitators and content	Clinicians acted as role models for some members, and gave them hope for the future	<ul style="list-style-type: none"> • “I got to connect with other queer/LGBT+ students in my community. I also appreciated that the facilitators were also smart, kind and fun LGBTQ+ people that had gone to school. I also really enjoyed learning CBT techniques with a focus on how they relate to being LGBTQ+. It helped to motivate me to learn and grow.”

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Table 1 *continued*

Facilitators	Description	Example
CBT activities and skills	Activities and skills were relevant to participants' specific lives and easier to apply	<ul style="list-style-type: none"> • "It [gave] me tools to push through stress and to push through depressive downs." • "I feel like I can mitigate stress much better now that I have the skills to combat stress."
Peer engagement	Hearing from peers about how they apply CBT activities strategies and tools (from the workbooks) was helpful for learning and integration.	<ul style="list-style-type: none"> • "I also feel better knowing there are more people that are experiencing the same thing as me and trying out these new skills and I am not alone in the way I feel."

Table 2. Clinician-Identified Barriers and Facilitators of Affirmative CBT

Barriers	Description	Example
Emerging trauma symptoms	Skillful facilitation was required to navigate emerging trauma symptoms from LGBTQ+ minority stressors and other life experiences, such as refugee histories, racism, and familial violence.	<ul style="list-style-type: none"> • "There were times that youth were sharing too much of their trauma and then others felt sad or triggered. I should have stepped in more quickly."
Ability to engage with CBT	Group members shared a range of experiences (e.g. information processing, neurodiversity, previous experiences) that were a barrier to their ability to engage with CBT topics.	<ul style="list-style-type: none"> • "It went well although we worked hard as some of the neurodiverse group members struggled with the planning ahead parts." • "Questions/challenges from the group members who did not initially understand the content. Some anxiety running high about this and as a result they posed a lot of questions, but generally the session yielded a lot of interesting discussion." • "Being mindful of different ways of learning (literal vs analogies)."
Knowledge of CBT	Groups that had members with a strong foundation in CBT participated in groups with members with no experience (e.g. knowledge, unlearning previous experiences), which resulted in clinicians needing to bridge gaps and manage content for all levels of knowledge.	<ul style="list-style-type: none"> • "Members reported that they had previously engaged with CBT concepts and one participant asked for additional information and offered to be a third facilitator. Yet eventually they engaged more deeply in the material instead of needing to be the "expert"."
Timing	Clinicians had to ensure all material was covered within the allotted time.	<ul style="list-style-type: none"> • "Keep eye on time and moderate conversations to allow for better time management." • "Frustrated by issues with time management, I need to balance discussion and content."

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Table 2 *continued*

Facilitators	Description	Example
Utilizing regulation and grounding techniques	Clinicians found that incorporating grounding moments when the group became activated was helpful to regulate and refocus on the skills.	<ul style="list-style-type: none"> • “It ran smoothly and the activity of identifying and throwing away negative messages was powerful for participants. It was a heavy topic for the day and ending with a grounding activity seem very important. We ended on a good note.”
External linkages	Member-to-member interactions that were external to the group fostered support and cohesion (e.g., WhatsApp groups, Instagram, TikTok sites, member-initiated field trips).	<ul style="list-style-type: none"> • “Overall a positive start to the group – many of the participants share common interests and they have already shared IG addresses so that they can chat with one another outside of the group.” • “Final session was very touching as the participants really formed strong bonds. Participants have decided to stay in touch to continue supporting each other.”
Mutual affirmation	Encouraging member-to-member mutual aid, affirmations, and celebrating each other’s accomplishments.	<ul style="list-style-type: none"> • “Overall positive. Really felt like we consolidated the cognitive-behavioural skills introduced and practiced last week. Youth were great at supporting each other in disputing thoughts. Very heart warming!” • “Room was warm and inviting; participants shared a lot of tender moments both in sharing and supporting one another.”
Multiple methods of engagement	Offering multiple opportunities for engagement through verbalizing, online chat, dyads, individual work, or group discussions.	<ul style="list-style-type: none"> • “This group is entirely neurodiverse and opted to use the chat function for some of the group.” • “Very positive. Folks began to share more and participated in dyads.”
Engaging at the intersections	The intentional integration of other identities into discussions by clinicians.	<ul style="list-style-type: none"> • “The meet and great really made a positive impact given a sense of reservedness and quietness among this bunch of youth. I really enjoyed facilitating a deeply rich and intersectional conversation on identities and stress. Looking forward to more!” • “The diverse lived experiences and identities in the group brought it to life and we worked to connect their feelings and understanding within and across individuals and groups and create a community.”

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pants to simultaneously support youth self-exploration while cultivating key mechanisms for resilience such as positive framing and planning to foster better mental health and hope for the future (Gaudiano, 2008; Tull et al., 2021). Finally, representation emerged as an important aspect of intersectionality in this research, which parallels the call for inclusive and diverse clinicians who reflect the identities of the participants (Wandrekar & Nigudkar, 2019).

Establishing Social Support

Prolonged engagement (e.g., reaching out to LGBTQ+ youth between sessions through texts and emails to remind them of their action plans) enhanced youth feelings of support. The encouragement of member-to-member interaction and the

establishment of mutual aid (Gitterman, 2004) are important components of group engagement and subsequent treatment improvement (Gillis et al., 2016; Ogrodniczuk & Piper, 2003). In addition to these internal processes, study participants described connection through social media, which furthered their feelings of social support. Although not always espoused in groups due to challenges related to subgroups and unprocessed events (Fehr, 2003), given the rise in technology use, clinicians must prepare to work toward the resolution of group challenges (e.g., member exclusion) that may also involve external interactions. Discussion of outside contact can be an empowering process for youth as they can determine their own parameters before embarking on outside engagement (Yarhouse & Beck-

stead, 2011). Facilitating such social support in a structured CBT group may enhance LGBTQ+ youth resilience given the isolation that still is encountered by this population (Craig, Eaton, et al., 2021; McDonald, 2018).

Ensuring an Affirmative Therapeutic Alliance

Overall, affirmative practice contributes to the improved mental health of LGBTQ+ clients through a strengthened therapeutic alliance (Alessi et al., 2019). Ensuring that LGBTQ+ youth participants are provided with enough time to process their experiences and discuss the curricula has been identified as an important aspect of CBT group implementation (Hall et al., 2019). The importance of acknowledging the potentially negative impact of minority

stress, such as transphobia, on the lives of LGBTQ+ people while keeping the session focused on clients' strengths is an important clinical skill that underlies affirmative practice (Alessi, 2019; Craig, Iacono et al., 2020; Pachankis, 2018). Strengths-based interventions have been found to validate LGBTQ+ identities and enhance self-esteem and resilience (Craig & Furman, 2018). Skillful group facilitation and teaching of CBT skills through an affirmative practice lens were critical to effective delivery in this study. For example, clinicians may first explore LGBTQ+ youths' stressors, obstacles, and opportunities, and the need for possible changes, followed by cognitive restructuring and behavioral adaptations, while simultaneously enhancing their resilience factors and encouraging positive reinterpretation through affirmative statements and goal setting. Such approaches can contribute to personal growth, coping, and healthy adjustment (Craig, Leung, et al., 2021).

Barriers to the therapeutic alliance during affirmative CBT groups can include clinician behaviour such as negative actions or responses (e.g., misgendering) or inaction (e.g., allowing harmful behavior to continue). To address challenges in the group process, clinicians can emphasize the use of inclusive language and terminology, increase self-awareness of one's own biases, and adequately address misinformation and misconceptions of clients when practicing affirmative CBT (Wandrek & Nigudkar, 2019). This study found that youth desired clinician engagement to disrupt disempowering dynamics, concepts, or practices, and uphold the group agreements. These practices are especially important during the early stages of groups when the therapeutic alliance is being formed and clinicians are required to set the culture and tone (Rutan et al., 2019). As the alliance strengthens throughout the group, however, members may begin to take more responsibility for maintaining the established expectations themselves. Consequently, it is important for clinicians to clarify roles and expectations with the group members. Finally, other barriers that emerged during this study (e.g., the high needs of some group members and the need to balance the needs of the remaining group members) can be mitigated by attention to group dynamics and skillful facilitation. The efficacy of CBT groups, and therefore the resilience of its members, is enhanced through the integration of group therapy processes that attend to group

dynamics, cohesion, and development (Satterfield, 1994).

Given the challenges of affirmative CBT implementation, clinicians may want to seek further training and supervision to maximize the opportunities to improve the mental health of LGBTQ+ youth (Craig, Iacono, et al., 2020). As LGBTQ+ populations report negative experiences in therapeutic relationships, such as microaggressions, that contribute to reduced engagement in therapy (Shelton & Delgado-Romero, 2011), it is suggested that clinicians engage in educational training that engenders competence.

Limitations

This study has several limitations that should be noted. Although part of the same clinical trial, data from all implementation years were included. Over time the clinicians likely became more skilled in their delivery of affirmative CBT while minor modifications to the delivery approach (e.g., creating a brief voluntary orientation session, creating clinician trainings to expand awareness of intersectionality) may have reduced early participation barriers. As the AFFIRM intervention was delivered uninterrupted during the COVID-19 pandemic, results for in-person and online groups were analyzed together in this study. The utilization of telehealth resulted in increased geographic diversity and included those who had access to technology. Finally, these results do not include feedback from participants lost to attrition, despite attempts to contact those participants and invite them to engage in the research process. Those participants who did not participate in the final research may have experienced unique barriers, not captured in this research.

Conclusion

Participant and clinician barriers and facilitators are important to explore for effective affirmative CBT delivery. The careful cultivation of a therapeutic alliance that attends to intersectional identities and experiences can enable positive engagement and impact on LGBTQ+ youth mental health. To ensure optimal success, clinicians should be well trained in core CBT processes, affirmative practice, and LGBTQ+ youth mental health while concurrently integrating these approaches into affirmative CBT implementation.

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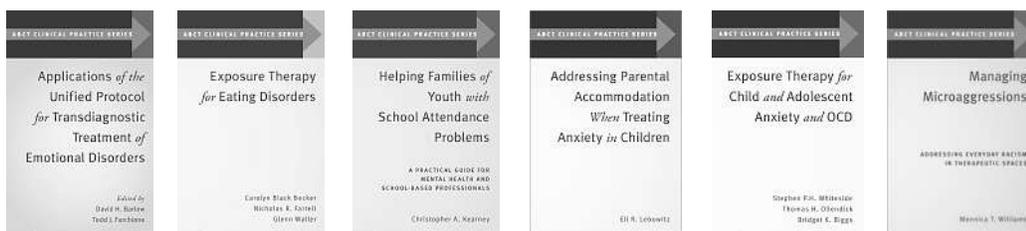
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“The Sense of Falling in Love Again”: Transgender and Nonbinary Individuals’ Positive Experiences in Romantic Relationships During Gender Transitions

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TRANSGENDER is an umbrella term that refers to individuals whose gender identities differ from their sex assigned at birth (American Psychological Association [APA], 2015). Transgender individuals can have genders that are binary (e.g., woman or man) or nonbinary (e.g., genders that are not strictly female or male, fluctuating between genders, or more than one gender; APA, 2015; Galupo et al., 2017). Transgender and nonbinary (TNB) individuals face chronic forms of stress associated with their marginalized gender identities, often referred to as gender minority stress (Hendricks & Testa, 2012). These compounding and chronic stressors result in significant mental health disparities, including increased risk for suicidality, depression, and substance use (James et al., 2016; McKay, 2011; Reisner et al., 2014).

Gender minority stress may be particularly heightened for TNB individuals while pursuing a gender transition. Gender transitions refer to the broad range of steps TNB people may pursue to better align their social presentation and physical bodies with their gender identities. These steps may include disclosing one’s TNB identity to others, socially transitioning (e.g., changing clothes, name, pronouns), pursuing various medical transition steps (e.g., gender-affirming hormones or surgeries; Tatum et al., 2020), and legal affirmation (e.g., changes to legal name and gender markers; Reisner et al., 2016). During a gender transition, TNB individuals often encounter negative reactions from others when they disclose and begin to live in their affirmed gender identity more consistently. Common negative reactions can range from lack of acceptance to rejection and isolation from family, friends, employers,

and other social circles (Klein & Golub, 2016; Pellicane & Ciesla, 2022).

Given the heightened nature of gender minority stress during gender transitions, medical providers and clinicians would benefit from knowing about protective factors that could buffer against the effects of these stressors. One potential protective factor is close, supportive relationships. For example, research has established that parental acceptance and closeness with TNB youth are associated with lower levels of suicidality, depression, and PTSD (see Brown et al., 2020, for review). However, when parental rejection occurs, social support from other relationships (e.g., friends and community support) may be central to TNB individuals in terms of finding consistent support for their gender identities (Sherman et al., 2020).

While close relationships (e.g., parent-child) have been studied among youth, less is known about the potential protective aspects of romantic relationships for TNB adults. Research on romantic relationship functioning has established that supportive romantic relationships can buffer against stress and that high relationship quality predicts better psychological well-being (Cooper et al., 2021; Pieh et al., 2020; Sarno, Dyar, et al., 2021). Further, dyadic coping—referring to the way partners communicate, cope, and support one another through stressful experiences (Bodenmann, 2008)—has been shown to reduce the impact of sexual minority stress on same-gender couples (Randall, Tao, et al., 2017; Randall, Totenhagen, et al., 2017; Sarno, Bundy, et al., 2021). Some research also suggests that the form of partner support matters, such that emotional forms of support (providing empathy and validation) may be more protective compared to

problem-solving forms of support (offering solutions or advice; Randall, Tao, et al., 2017). Therefore, it is important to behaviorally define forms of partner support when understanding how romantic partners may help their TNB partners cope with minority stress.

Beyond the literature on dyadic coping, romantic partners may also play a more central role in providing emotional support to TNB individuals in particular for several reasons. For one, being in a romantic relationship while pursuing a gender transition may be relatively common, with research suggesting that as many as 50% of transgender men currently in romantic relationships started their current romantic relationship after their current romantic relationship started (Meier et al., 2013). Second, TNB individuals are likely to disclose their gender identity to their romantic partners before disclosing to people across other important life domains, such as work and broader social circles. As such, the level of support from one’s partner may be central for many TNB individuals, especially early in gender transitions. Third, TNB individuals often face significant barriers to accessing affirming mental health care during a transition, such as lack of financial resources and few available culturally competent health care providers (Hines, 2007; Pulice-Farrow et al., 2017, 2019; Whitman & Han, 2017). In the absence of adequate mental health care, TNB people may rely even more on their romantic partners for emotional support.

To date, researchers have yet to thoroughly assess the benefits of being in a romantic relationship during a gender transition. Instead, the majority of research on gender transitions in romantic relationships has focused on the experience of the (primarily cisgender) partner, and the findings have mostly been discouraging (Giammattei, 2015; Joslin-Roher & Wheeler, 2009; Norwood, 2013; Platt & Bolland, 2018). For example, some studies have focused on how intimate partners of TNB individuals often experience strong negative emotions following an initial gender disclosure and caution that many relationships end due to a gender transition (Giammattei; Norwood). These studies have been useful in identifying challenges that some TNB individuals and their partners experience. However, the disproportionate focus on the negative effects of gender transitions on romantic relationships furthers a deficit-based, as opposed to strengths-based, narrative about TNB relationships and often centers on the partner’s

rather than the TNB individual's perspective.

More recently, scholars have begun to challenge this stigmatizing narrative by highlighting how many partners of TNB individuals not only accept their partner's gender identity, but can also provide meaningful, gender-affirming support. For example, Pulice-Farrow et al. (2019) analyzed qualitative data to identify the types of microaffirmations (i.e., daily behaviors, language, and gestures that affirm an individual's identity; Flanders, 2015) that romantic partners could provide to TNB individuals. Through their study, Pulice-Farrow et al. (2019) found that romantic partners could validate their TNB partner's gender identities through acknowledging and using their cisgender privilege to pro-

tect their partner, centering their partner's identity (as opposed to their own reactions), affirming their partner's gender presentation (through language and milestones), and helping their partner process their identity. Although this study was not specific to the gender transition process itself, many of these behaviors highlighted the way romantic partners could support TNB individuals. However, more research is needed to identify the benefits of being in a romantic relationship during a gender transition in particular. As such, the current study sought to understand how having a romantic partner could benefit TNB individuals during their gender transition. We also sought to define these benefits and forms of support through behavioral examples and in ways that could

translate to clinical recommendations for couples going through the gender transition process together.

Methods

Participants

Participants included 13 transgender men/transmasculine individuals, 5 nonbinary/gender fluid individuals, and 4 transgender women/transfeminine individuals who reported being in a romantic relationship at some point during their gender transition (e.g., initial disclosures of TNB identity, social or medical transition steps). Forty-six percent of participants reported being in a previous relationship while transitioning (M relationship length = 1.3 years; M years since the relationship ended = 3.3 years) and 60% reported currently being in a relationship where they had pursued a transition (M length of current relationships = 2.4 years). Of note, a few participants reported both a previous and current relationship that qualified for the study and are reported in both categories. Participants provided information about their romantic partners' genders, which included: 50% cisgender women, 25% cisgender men, 10% transgender men, 10% nonbinary, and 5% transgender women (see Table 1 for comprehensive demographic information).

Procedure

Participants were recruited through social media (postings from the research team's professional pages and TNB-focused social media groups), professional online listservs (APA Division 43 and 44), and snowball sampling. Potential participants completed a brief screening survey to obtain informed consent and information about the individual's romantic relationship history and demographics. Eligible participants completed an hour-long semistructured interview via Zoom with the first author between December of 2020 to February 2021. Ethical approval was provided by the local university Institutional Review Board.

During the interview, participants responded to a semistructured interview that asked about the positive and negative experiences of being in a romantic relationship during a gender transition. For this study, we focused on answers derived from questions related to positive experiences, such as "What do you think are some of the positive benefits of transitioning while in a romantic relationship?" and "What, if anything, was helpful from your

Table 1. Participant Demographics

Demographics	%	<i>M</i>	<i>SD</i>
Age (in years)		26.9	8.8
Annual Personal Income			
Under 4,999	22.7		
5,000-19,999	22.7		
20,000-39,999	27.3		
40,000-49,999	13.6		
Over 70,0000	13.6		
Educational level			
High school/GED	40.9		
Associates	4.5		
Bachelors	31.8		
Masters	22.7		
Gender Identity			
Transgender men/Transmasculine	59.1		
Transgender women/Transfeminine	18.2		
Nonbinary/Gender Fluid	22.7		
Current relationship while transitioning			
Yes	60		
No	40		
Current relationship length (in months)		16.2	14.7
Previous relationship while transitioning			
Yes	45.5		
No	54.5		
Previous relationship length (in months)		28.8	28.6
Sexual Orientation			
Gay	9.1		
Lesbian	9.1		
Queer	31.8		
Bisexual	9.1		
Pansexual	18.2		
Demisexual	4.5		
Heterosexual	18.2		
Race/Ethnicity			
African American/Black	4.5		
Native American	4.5		
European American/White	72.7		
Hispanic/Latinx	18.2		

partner during this time?” Participants received a \$40 electronic Amazon gift card for their time.

Data Analytic Approach

We used an inductive thematic analysis approach to code deidentified interview transcripts (Braun & Clarke, 2006; 2013), with a focus on identifying the benefits of being in a romantic relationship while transitioning. First, members of the four-person coding team independently coded one-third of the interviews to establish potential relationship-salient themes. Next, the team met to discuss salient and frequent concepts within the dataset. A consensus of initial themes was established after several meetings in which each team member explained their thought processes while coding in relation to the data and the thematic definitions. Disagreements in codes were resolved through open discussion and returning to the transcripts to reach an agreement. The remaining two-thirds of interviews were then randomly assigned among the four coding team members, with each interview being coded by two coders. The team also chose representative quotes that depicted the breadth of participant experiences.

Several checks were included in the data analysis process in order to increase the credibility of our results. Initially, at the end of each interview, participants were provided with the opportunity to reflect on their experiences and add any additional comments to make sure that they were captured by the data. They were also able to provide feedback that was used to improve the present study. Second, throughout the data analysis process, the research team discussed the themes and made all decisions via consensus. Due to the range of our collective experiences across race, gender, gender presentation, relationship experiences, and sexual orientation, we came to these discussions with different perspectives. The four-member coding team was composed of all queer identities and included two transmasculine persons and two cisgender women, and two White and two Hispanic individuals. Authors of the current paper included a variety of genders (transmasculine, nonbinary, and cisgender women), racial/ethnic identities (White, Hispanic, and Asian), and sexual orientations (e.g., lesbian, queer, heterosexual).

Results

Participants provided self-generated data regarding the benefits of being in a romantic relationship during a gender transition. Through thematic analysis, we identified five relationship-salient themes: (1) validation of identity; (2) communication; (3) education and awareness of TNB issues; (4) advocacy, and (5) improved connection and intimacy. Although we provide some representative quotes in the following results section, a more comprehensive overview of our thematic structure and representative quotes is provided in Table 2. Results are described using direct quotes from participants, and are accompanied by their self-identified gender label(s), race/ethnicity, and age.

Validation of Identity

Many participants described their partner actively validating their gender as a benefit to being in a romantic relationship while pursuing a gender transition. Oftentimes, these validations were expressed at critical times in the relationship, such as when the participant disclosed their TNB identity for the first time or as the participant pursued new transition steps. Some of these validations were broad, such as: “I’m attracted to you, not to any specific thing about you” (White, nonbinary, late 20’s). Four subthemes were identified within this theme that exemplified more specific forms of partner validation, including: (1) encouragement of transition; (2) celebration of gender; (3) safe space for gender; and (4) positive impact of partner’s gender/sexual minority identity.

- Encouragement of Transition

Some participants described how their romantic partners encouraged them to explore or begin a gender transition. Some participants described this as direct encouragement by a romantic partner to consider if they identified as TNB and if a gender transition would help them feel more authentic and comfortable. Oftentimes, romantic partners were the first to acknowledge their partner’s authentic gender identity and reassure their partners that they would support them through their transition. Some participants reported that their partners encouraged them to experiment with ways to express themselves (e.g., new names or clothing) in the supportive environment of their partner’s presence.

- Gender Is Celebrated

This theme refers to how some participants described their partners as going beyond acceptance of their transition to celebrating their gender throughout their transition. Partners did this by expressing happiness and joy at the participant’s transition as well as seeking opportunities where the participant’s gender felt affirmed, seen, and actively celebrated (e.g., attending pride events, going out to TNB-friendly spaces). Other examples included willingly helping the participant with transition steps (e.g., teaching their partner how to put on makeup, taking care of a partner after surgery). Other participants described daily “gender-affirming things” (White, transmasculine, late 20’s), such as buying their partner small gifts (e.g., affirming clothing), to show love and support of the participant.

- Creation of Safe Space for Gender

Participants described their partner’s creation of psychologically and emotionally safe spaces for the participant’s gender. One participant specifically stated that their partner “created that space” for their gender and that their partner told them “I just want to understand you. I just want to help you.” (White, nonbinary, late 20’s). Some participants described how their partners encouraged them to talk through their experiences of gender and discuss what a gender transition could mean for them emotionally and psychologically. This safe space could include pursuing gender-affirming activities in private, trying on clothing, changing names, or using different pronouns, before the participant disclosed their affirmed gender to others. Other activities could include engaging in affirming sexual activities together. Several participants described the mental health benefits of their partner creating a safe environment for them to openly express their gender and that this often contrasted with other aspects of the participant’s life (e.g. families-of-origin or work environments). This safe space helped participants feel more assured, confident, and validated in their genders.

- Positive Impact of Partner’s Sexual or Gender Minority Identity

Some participants described an additional benefit of having a partner who identified as a gender or sexual minority themselves. For some participants, this included being in a relationship with another TNB individual, which several participants described as beneficial because their part-

Table 2. Representative Quotes of Major Themes and Subthemes

Major Theme	Subthemes	Representative Quotes
Validation of Identity		“[My partner] really encouraged me to just be my best self and, you know, that’s probably the best thing that she could have ever done” (White, transfeminine, early 30’s).
	Encouragement of Transition	“[My partner] made it incredibly safe for me to even think about [transitioning]. So, it was more of, you know, she almost gave me language to think about whether or not that felt like a better fit for me” (White, non-binary, late 20’s).
	Celebration of Gender	“I had an extremely easy time with [my current partner] where he was pretty happy to just hear what I wanted and how I felt, and really spent just a lot of time talking about the day to day.” (White, nonbinary, late 20’s).
	Safe Space for Gender	“I think the biggest benefit is that she sees me. I haven’t medically transitioned, I’m not on T, and I’m hoping to get top surgery post-COVID, but there’s so many places in which I’m not seen as masculine. I’m out in basically every spectrum of my life, but my work is not super affirming, [...] it’s very consistently transphobic. And so, someone who, at the end of the day, no matter what, I come home to and she sees me. She knows who I am or, it sounds hokey, but she sees my soul, is such a big benefit, is such a big bolster to my mental health.” (White, transmasculine, late 20’s).
	Positive Impact of Partner’s Sexual/Gender Minority Identity	“We definitely openly talked about his change of just personal identity just in terms of before he was more someone who had dated cis women and had played around with cis men and identified as openly bisexual, but you know, meeting me and dating and having a romantic relationship with someone going through this process kind of led him more to the pansexual side of things.” (White, transfeminine, late 20’s).
Communication		“It’s nice to have somebody who understands that something makes me uncomfortable. He understands because [my partner is transgender too] and it also would make him uncomfortable. And so, it’s like you don’t even have to say some of this stuff sometimes because he understands.” (Native American, transmasculine, early 20’s)
	Gender Dysphoria	“I was able to actually just articulate what I was feeling.” (Hispanic, transmasculine, early 30’s).
	Physical Intimacy	“There’s a lot of checking in and making sure that the language is okay. And setting the expectation that, like, if I do something that you don’t like or if I do something dysphoric, I need you to let me know immediately, because this is supposed to be fun and things go really well or go really poorly, depending on how it’s going, but I need you to immediately tell me if I do something wrong so that we can fix it, or if you need to tell me that we need to stop. I want these expectations to be clear for how we go about doing this.” (White, transmasculine, 18-24 years old).
		“Physical intimacy is important. It’s like physical intimacy validates who you identify as. It’s incredible, especially early in transition, I have to say. It’s been just something that’s added so much more joy and ease to my life.” (White, transfeminine, late 20’s).

continued on next page

Table 2 continued

Major Theme	Subthemes	Representative Quotes
Education and Awareness of Trans Issues		“[My partner] has spent more time in the trans community than I have just by the nature of who she went to school with and her life experiences. And, you know, there's probably stuff that maybe that we've both known about me for a long time, but there's a difference between knowing that and then also having language that's recognizable and being able to pair those two together.” (White, nonbinary, late 20's).
Advocacy		“I often didn't feel comfortable enough doing it myself, correcting [others] and [my partner] would be there for me, helping me.” (Hispanic, transmasculine, 18-24 years old).
Improved Connection and Intimacy		“It's the best it's ever been in our [relationship]. I think that a lot of that has to do with just me being true to myself. If I'm able to be true to myself and actually love myself for the first time in my life, I'm able to be a better partner and to love her more and just be closer overall.” (White, transfeminine, 30's).

ner could relate to their experience. Other participants discussed the benefit of having a sexual minority partner who was attracted to more than one gender (e.g., plurisexual identities such as bisexual or pansexual). Specifically, participants found that having a plurisexual partner made it easier to navigate changes in sexual orientation labels for both partners as well as sexual orientation labels for the couple (e.g., going from being seen as a lesbian couple to a queer couple with a transmasculine partner and cisgender woman). Having a plurisexual partner also helped some participants feel more assured that their partner would remain attracted to them as they transitioned.

Communication

The second major theme involved the role of open and nonjudgmental communication between partners, which participants described as particularly helpful during a gender transition. Some participants named this theme in broad terms, such as stating that relationships had to have “open communication” (Hispanic, nonbinary, early 20's). We also identified two communication subthemes related to gender dysphoria/euphoria and physical intimacy.

• Gender Dysphoria and Euphoria

The first subtheme involves how participants communicated with their partners about experiences of gender dysphoria and euphoria, both within and outside the relationship. This could include discussions regarding negative experiences TNB par-

ticipants experienced with other people that evoked feelings of dysphoria and having their partners respond with affirmation and support. Within the relationship, this could involve talking about how certain behaviors (e.g., language, touch) from the partner could evoke feelings of dysphoria as well. At the same time, participants described how particular compliments or gestures could evoke feelings of gender euphoria. Direct communication about which behaviors evoked dysphoria or euphoria helped couples feel emotionally closer to one another and helped participants navigate complex emotions during this process.

• Physical Intimacy

The second subtheme involves how participants discussed physical intimacy with their romantic partners, particularly surrounding sex and intimate touch in the context of a gender transition. Many participants described communication about physical intimacy as an ongoing process to create an emotionally safe environment where both partners could share their desires surrounding sex. Communication was most effective if both partners communicated about their sexual likes and dislikes in positive, open, and nonjudgmental ways. Several participants also mentioned the importance of using chosen language regarding different body parts. This open communication regarding sex allowed both partners to experience more joy and satisfaction in their sexual relationships.

Education and Awareness of Transgender and Nonbinary Issues

The third major theme participants described was their partner's education and awareness of TNB issues. Participants reported that it was beneficial to have a partner with previous knowledge of TNB issues so that the TNB participant did not need to act as an educator. This knowledge could come from personal experience, such as being TNB themselves, or spending significant time in TNB communities. Other participants described how their partners participated in educational workshops (e.g., SafeZone; Ebelhar, 2021) or put in the initiative to obtain additional education resources early in their gender transition. Participants viewed their partners' efforts to learn more about TNB issues as affirming commitments to their relationship.

Advocacy

The fourth major theme involved how participants described their partner's advocacy of them and of other TNB individuals. Advocacy was largely described as expressing support for the participant's gender identity to other people, including family, friends, and in public spaces. For example, some participants described how their partners would correct other people when they were misgendered. Other participants described how their partners would help educate other important people in the participant's life (such as in-laws, friends) about how to correctly address their partner (using correct pronouns, names, etc.). Some participants also described how their

partners educated others on how to avoid committing microaggressions, such as asking inappropriate questions. Other forms of advocacy included partners willingly taking on the additional labor of educating others about basic TNB issues, which alleviated the participant of this burden. Some participants with TNB partners also described how they would work together to advocate for each other, which strengthened their mutual dedication to their relationship.

Improved Connection and Intimacy

The last major theme involved participants describing improved connection and emotional intimacy in their romantic relationships throughout the course of a gender transition. Overall, many participants described that their relationship satisfaction and emotional connection with their partner were significantly enhanced by living in their authentic gender identity and receiving support and validation from their partner. As one participant described, they had “the sense of falling in love again, or a renewed kind of life to the relationship,” and that they “feel even more myself and obviously authentic in the relationship” (Hispanic, transfeminine, late 20’s). Similarly, several participants described improvements in their sexual satisfaction and physical intimacy with their partner. Some participants noted the surprise that they felt with this improvement, which went above and beyond their expectations. In sum, by being seen and affirmed in their authentic gender, this improved their overall connection with their romantic partner, and this enhanced connection and validation improved the participant’s well-being.

Discussion

The present study provided a qualitative analysis of TNB individual’s positive experiences associated with being in a romantic relationship while pursuing a gender transition. Findings challenge prevailing narratives that gender transitions are universally burdensome on couples and instead demonstrate how partners often support each other and may even experience enhanced intimacy throughout this process. Further, romantic relationships may provide an important avenue for coping with gender minority stress during a gender transition.

Several themes—validation of identity, communication, and enhanced intimacy—focused on the role of effective dyadic processes between partners that improved

the TNB individual’s well-being and both partners’ sense of connection. Based on our findings, themes of validation of identity and open communication are likely interconnected as they both work to foster a climate of safety and security between partners. Validation of identity was described in various forms, ranging from verbal expressions of encouragement and acceptance to affirming behaviors, such as buying their partner gender-affirming clothing or creating opportunities to celebrate their partner’s gender. These findings are consistent with research on microaffirmations in TNB individuals’ relationships, such that affirming behaviors were often displayed through daily, ongoing gestures, behaviors, and language (Pulice-Farrow et al., 2019). Findings also build on the dyadic coping literature (Bodenmann, 2008; Randall, Tao, et al., 2017), highlighting the important role of emotional support and validation between TNB individuals and their partners. Our results also expand upon the parental support literature of TNB youth (Brown et al., 2020), by highlighting how other close relationships, in this case romantic partners, can provide meaningful support to TNB adults during a gender transition.

Other themes from the current study, such as advocacy and education, focused on behaviors partners could engage in on their own, external to the romantic relationship. These behaviors included building knowledge on TNB issues so that the participant did not have to educate their partner. Knowledge could be obtained in numerous ways, including through personal experience, spending time in TNB spaces, or by pursuing additional educational opportunities. TNB-specific knowledge was closely intertwined with themes of validation of identity, as this knowledge provided partners with information to better affirm their partner’s identity. Knowledge of TNB issues was also connected to advocacy of TNB participants, as TNB-specific knowledge helped partners better engage in advocacy behaviors, such as correcting individuals who misgendered their partner, confronting inappropriate comments, and educating others about TNB issues. Advocacy also required open communication between partners regarding what forms of advocacy were desired by participants and across specific contexts.

Clinical Recommendations

Results from this study can inform relationship interventions and prevention programs based in behavioral or cognitive

frameworks. The focus of this study was on positive relational processes that occurred when both partners wanted to work together through the TNB participant’s gender transition. As such, clinical recommendations may be most appropriate for nondistressed to mildly distressed relationships seeking relationship education or relationship therapy (referred to as “relationship inventions” in this section) to navigate a gender transition. For moderately to severely distressed relationships, or for relationships in which the partner of the TNB individual is unsure or unaccepting of their partner’s transition, it would be necessary to first determine if both partners would like to work toward this goal (Giammattei, 2015).

Scott et al. (2019) discussed approaches for adapting relationship interventions for same-gender couples, and a similar framework may be useful in adapting services to best meet the needs of relationships during a gender transition. Following this approach, clinicians must first build basic cultural competence for working with TNB populations. This includes knowledge about common TNB concerns, such as the complexity and fluidity of gender identity, the nature and impact of gender minority stressors, and the common components of the gender transition process. Cultural competence also includes developing specific skills, such as using correct pronouns, chosen names, and other affirming language, as well as an ongoing attitude of self-reflection and receptivity to feedback (Chang et al., 2018). With this foundation of cultural competence, clinicians can keep the core, evidence-based components of relationship interventions while adapting content and adding novel topic areas as needed for tailoring to TNB populations. In line with this approach, the following section provides specific recommendations to facilitate support, affirmation, and enhanced intimacy for TNB individuals and their romantic partners (see Table 3 for a summary of specific skills and examples).

- **Communication Skills and Developing Shared Expectations**

Results from the current study suggest that the core components of many relationship interventions—namely, effective communication and developing shared expectations (Baucom et al., 2012; Buzzella et al., 2012; Markman & Rhoades, 2012; Scott et al., 2019; Whitton et al., 2017)—are likely salient components of relationships that successfully navigate a gender transition in their relationship. Clinicians can

Table 3. Clinical Recommendations for Working With Transgender and Nonbinary Individuals and Their Romantic Partners During a Gender Transition

Broad Clinical Strategies	Specific Relationship Skills and Resources	Clinical Examples within Context of Gender Transitions
Communication Skills	Good speaking skills; active listening; emotional validation	Teach couples effective communication skills to encourage TNB individuals to clearly communicate about their gender identity and specify desired transition steps. Encourage partners to foster such communication through demonstrating receptivity and care. Teach both partners to engage in active listening during these conversations through paraphrasing and validating emotional experiences. Practice skills in session and provide feedback on communication processes.
Developing Shared Expectations	Behaviorally define desired forms of support and advocacy; problem-solving skills	Encourage TNB individuals to define specific behaviors from their partner that elicit gender dysphoria and euphoria and to provide praise and/or constructive feedback to their partner when engaging in these behaviors. Partners can also discuss interpersonal interactions outside of the relationship that are experienced as gender minority stress, and identify the specific types of advocacy that the TNB partner wishes for from their partner when such events occur. Encourage partners to advocate for the TNB partner's needs during transition. If disagreements arise between partners related to support and advocacy, teach problem-solving skills to identify potential solutions.
Cognitive Appraisal	Identify cognitive distortions; challenge maladaptive cognitions and negative schemas	Help TNB individuals and their partners to identify cognitive distortions related to the gender transition process. Engage the couple in Socratic questions focused on cognitive distortions and negative schemas. Encourage both partners to supportively challenge maladaptive cognitions individually and together as a couple to foster more adaptive, gender affirming cognitions and schemas.
Behavioral Activation	Identify and engage in gender affirming behaviors, individually and as a couple	Encourage TNB individuals to identify and discuss interpersonal behaviors in the relationship that evoke gender euphoria, such as shopping for gender affirming clothes/items, attending TNB-affirming events, and engaging in affirming sexual practices. Work with both partners to take steps towards incorporating more of these behaviors within the relationship. If external support for the TNB partner's gender transition is low, encourage both partners to attend TNB-affirming events or engage with online support resources together.
Psychoeducation	Psychoeducational resources on TNB issues; connection to consultation and additional referrals	Provide educational resources on TNB issues that address topics such as the role of affirming language, common gender transition steps, gender minority stress, the spillover effect of stress on relationships, and how medical transition steps may affect sexual attraction and functioning. Encourage partners of TNB individuals to read materials or participate in educational opportunities to remove the educational burden of TNB individuals. Engage in consultation or provide referrals to gender affirming medical care and sexual health experts.

encourage TNB individuals to openly discuss their gender identity and desired steps in their transition process with their partner, while also encouraging their partners to express their acceptance and validation through active listening in order to foster this open communication.

Within the domain of developing shared expectations, clinicians can assist couples by having TNB individuals behaviorally define desired forms of support

from their partners. This intervention can be useful across numerous themes mentioned in this study. For example, within the theme of advocacy, clinicians can help TNB individuals behaviorally define their desired forms of advocacy from their partners and specify how these forms of advocacy may differ across settings (e.g., in public or in a small group) and with different types of people (e.g., with parents, friends, coworkers, strangers). Similarly,

within the context of sexual intimacy, clinicians can encourage TNB individuals to discuss their chosen language for body parts and to identify desired sexual behaviors that could enhance gender euphoria as well as behaviors to avoid that evoke gender dysphoria. Partners should be encouraged to communicate with each other about what sexual acts are desired in supportive, nonjudgmental ways. If partners disagree about how to approach areas

that may be affected by a gender transition, problem-solving communication skills would be useful to help couples find agreement.

- Cognitive Appraisal and Behavioral Activation

From a cognitive-behavioral perspective, clinicians can also help partners provide practical support to one another when discrimination, microaggressions, or other forms of nonaffirmation occur related to the TNB partner's gender transition. For example, partners could provide emotional support and validation for the TNB individuals in the aftermath of a discriminatory event or during a time of heightened stress. Partners could also support TNB individuals by actively challenging negative cognitive distortions should they arise (Dugal et al., 2018). For example, if a TNB individual experienced cognitive distortions regarding their ability to be loved due to their gender identity (e.g., "No one will ever love me because I'm transgender"), their partner might reply with contradictory evidence by expressing their own love for their partner and pointing out other supportive examples within the TNB partner's social circles.

Clinicians can also utilize behavioral activation strategies to assist partners in supporting one another during a transition. For example, the partner of the TNB individual can develop a repertoire of gender-affirming behaviors such as shopping together for gender-affirming clothing or celebrating their partner's gender in daily activities. If support from others (e.g., friends and family) for the TNB partner's gender transition is low, the clinician can use behavioral strategies to encourage the couple to find other sources of support, engage in shared activities like attending TNB-affirming events in their local community, or connect with online support, such as social media groups or online support groups.

- Psychoeducation and Resources

Finally, several participants mentioned that they felt affirmed when their partner was knowledgeable about TNB issues. As such, it may be useful for clinicians to have psychoeducational resources on hand to help foster this knowledge (e.g., Chang et al., 2018; Erickson-Schroth, 2022). These may include resources (e.g., brochures, online resources) about the gender transition process more generally, and how different transition steps may affect specific areas of their relationships. Further, given

that stress may be experienced by both partners during a transition (Platt & Bolland, 2018), psychoeducation about the "spillover" effect of stress may be useful by helping partners empathize with each other by understanding how stress experienced by one partner can affect relationship dynamics as a whole (LeBlanc et al., 2015). Many participants in this study discussed how aspects of medical transition—particularly gender-affirming hormones and surgeries—can affect sexual attraction, sexual functioning, and experiences of gender dysphoria or euphoria within their relationship. As such, educational resources may help prepare couples for these changes and to proactively work together to address them within the relationship. Clinicians should also be aware that some steps in medical transition, especially those involving primary sexual organs, may require partners to learn different sexual practices. Clinicians may benefit from having reliable resources and access to sexual health experts, either for consultation for the clinician or for additional referrals, should couples experience difficulties (e.g., Chang et al.; Erickson-Schroth).

Limitations and Future Directions

Limitations of the present study include that our sample was primarily White, low-income, college-educated, relatively young, and transmasculine, so caution must be taken when generalizing our findings across race/ethnicity, education levels, older adults, and transfeminine or nonbinary identities. Gender transition was also broadly defined, suggesting that future research should identify stressors and benefits of having a romantic partner across different transition steps. Many participants also focused on one, long-term relationship, which may not generalize to short-term, open, or polyamorous relationships. Participant reports were also retrospective, which can be affected by the passing of time. To build on the findings of this study, future research should work to integrate findings into clinical interventions and relationship education. Future research should also explore the statistical relationship between themes identified in the current study, including how partner affirmation, dyadic coping, and relationship quality may buffer against the effects of gender minority stress on TNB individual well-being.

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Minority Stress and Stress-Related Growth in Individuals With Marginalized Sexual Identities

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SEXUAL MINORITY individuals often encounter social stressors (e.g., discrimination, stigma, prejudice, and victimization) due to living in a heteronormative society that devalues, abuses, and invalidates members of the LGBTQ+ community (Meyer, 2003; Plöderl & Fartacek, 2009). As such, prior research has extensively focused on the heightened risk for adverse mental health outcomes resulting from minority stress experiences (e.g., Hatzenbuehler, 2009; Lee et al., 2016). A more limited literature suggests adaptive responses can also arise from experiences of sexual minority stress (Bonet et al., 2007; Vaughan & Waehler, 2010), and these may be similar to the adaptive responses to other forms of stress, including improvements in functioning (Linley & Joseph, 2004) or coping skills (Schaefer & Moos, 1992). Thus, additional research is needed to better understand the unique associations between minority stress experiences and adaptive outcomes in individuals with diverse marginalized sexual identities.

Minority Stress and Sexual Identity

Meyer's (2003) minority stress model posits the importance of both distal and proximal experiences. Distal experiences refer to discrimination, stigma, rejection, and prejudice emanating from external and interpersonal sources, whereas proximal experiences refer to intrapersonal processes such as internalized stigma or identity concealment. Each component of minority stress, as conceptualized by Meyer, describes a unique aspect of one's experience for those with marginalized sexual identities. Hatzenbuehler (2009) proposed that distal stressors (e.g., discrimination) may lead to an increase in proximal stressors (e.g., internalized stigma), consequently resulting in increased negative health outcomes, such as increased rumination, negative self-regard, and minority identity salience. Moreover, encountering greater heterosexism is consistently associated with greater psychological distress, including low self-esteem, suicidal ideation (D'Augelli & Grossman, 2001), internalized stigma (Newcomb & Mustanski, 2010), internalizing problems including depression and anxiety (Cochran

& Mays, 2000; Feinstein et al., 2012), and potentially less stress-related growth (Cox et al., 2010).

Distal and proximal experiences of minority stress differ by sexual identity (Meyer, 2007). Indeed, bisexual individuals experience unique stressors and outcomes, as compared with gay and lesbian-identifying individuals (e.g., Bostwick, 2012). Disparities in health may be due to differences in stigma and stereotyping of bisexual individuals when compared with gay and lesbian individuals (Balsam & Mohr, 2007). While bisexual individuals experience negative attitudes and hostility from the heterosexual society, similar to gay and lesbian individuals, they may experience stigma from gay and lesbian individuals as well (Brewster & Moradi, 2010; Mohr & Rochlen, 1999). For example, bisexual individuals can be told their sexual identity is illegitimate, perceived as "confused" about their sexual identity, or criticized for ways they may benefit from heterosexual privilege (Yost & Thomas, 2012), especially when they are in a different-sex relationship. Thus, bisexual individuals may encounter minority stress from both the heterosexual society and from other members of the sexual minority community, also known as dual discrimination (Bostwick, 2012), potentially leading to differences in experiences of minority stress for specific sexual identities. Notably, there remains a disproportionate focus on adverse outcomes in the existent literature as opposed to adaptation and growth across all sexual minoritized identities.

Minority Stress and Stress-Related Growth

Positive psychological processes can be associated with encountering stressors. Findings from the broader stress literature indicate, through facing adversity, individuals may adapt in ways that result in a higher level of functioning (Linley & Joseph, 2004), such as enhanced social and personal resources as well as changes in self-perception (Schaefer & Moos, 1992; Tedeschi & Calhoun, 1996). This phenomenon is often referred to as stress-related growth. Moreover, it has been suggested

that stress-related growth may be more likely to occur when stressors are associated with internal characteristics, like sexual identity, rather than external factors, such as unexpected life events (e.g., medical illness; Bonet et al., 2007).

Existing research has only begun to explore the association between growth and minority stress experiences. One factor that plays a crucial role in both adverse and adaptive mental health outcomes for sexual minorities is the degree to which individuals disclose their sexual identity (Mohr & Fassinger, 2003; Monroe, 2001). Although disclosing one's sexual identity can be a difficult and distressing process, it is also known that greater sexual identity disclosure is associated with less psychological distress (Morris et al., 2001) and a more positive LGB identity (Mohr & Fassinger, 2003; Morris et al., 2001). In fact, some individuals report that disclosing their sexual identity is a process of growth in itself (Vaughan & Waehler, 2010). Individuals can also engage in cognitive processing of a stressor event in ways that allow them to form more effective belief systems that often foster growth (Tedeschi & Calhoun, 1996). Therefore, it is possible that growth may result from heterosexist experiences where individuals are forced to challenge their core beliefs and worldviews (e.g., recognizing the importance of standing up for one's personal rights). Thus, heterosexist experiences may relate both positively and negatively with stress-related growth, but no prior research has examined this directly. Additional research is necessary to foster and enhance adaptive outcomes for sexual minorities.

The Present Study

This study examined the comprehensive, multidimensional construct of minority stress as proposed by Meyer (2003), including distal (e.g., heterosexist experiences) and proximal (e.g., outness and internalized stigma) components, as they relate to stress-related growth among individuals with marginalized sexual identities. Moreover, existing research lacks representation from individuals who identify as something other than gay or lesbian (e.g., bisexual, queer, pansexual) as well as diverse racial/ethnic and gender identity backgrounds. It was hypothesized that (1) outness, heterosexist experiences, and internalized stigma will be uniquely associated with stress-related growth. More specifically, no directional hypotheses were made for the association between both outness and heterosexist experiences with

stress-related growth due to the known adverse and adaptive outcomes correlated with these variables. However, we predict a negative correlation between internalized stigma and stress-related growth. Additionally, we also expected that (2) sexual identity will moderate the association between individual minority stress factors and stress-related growth; specifically (2a) those who identify as bisexual will demonstrate a weaker association between minority stress and stress-related growth compared with gay and lesbian individuals, given the unique adversities (e.g., dual discrimination) and greater adverse reactions to minority stress for bisexual individuals (e.g., Bostwick et al., 2012); and (2b) minority stress and stress-related growth will be similar for gay and lesbian-identifying individuals. No directional hypotheses were made for those who identify with something other than LGB (i.e., queer or pansexual), in light of the dearth of existing research for this group. Last, we conducted exploratory analyses to examine what aspects of one's identity (e.g., gender identity, sex assigned at birth, race/ethnicity, and sexual identity) may impact experiences of minority stress (i.e., outness, heterosexist experiences, internalized stigma, and stress-related growth).

First, to examine the unique variance accounted for by each additional component of minority stress for the whole sample, we examined outness as a predictor of stress-related growth, followed by the addition of heterosexist experiences, and, last, internalized stigma in the same stepwise model. This is consistent with a social psychological framework for understanding sexual stigma and an individual's internalized stigma, such that individuals first disclose their marginalized sexual identity, experience heterosexist discrimination as a result of their outness, consequently experiencing internalized stigma (Herek et al., 2009).

Methods

Procedure

This survey study was advertised through Facebook, administered online, and took approximately 45 minutes to complete. To be eligible, participants were at least 18 years of age or older and self-identified as a sexual identity other than heterosexual. All study procedures were approved by the Binghamton University Institutional Review Board. Informed consent was obtained from all participants,

and they were compensated with a \$10.00 Amazon gift card.

Participants

Participants ($N = 107$) ranged in age from 19 to 47 years ($M = 25.80$, $SD = 5.16$). There were similar proportions of individuals assigned male (43%, $n = 46$) and female (57%, $n = 61$) at birth; however, gender identity was diverse. The largest group identified as woman (46.7%, $n = 50$) and the remainder of the sample included man (34.6%, $n = 37$), transgender (15.9%, $n = 17$), agender (1.9%, $n = 2$) or nonbinary (0.9%, $n = 1$) individuals. The largest portion of participants identified as Black/African American (44.9%, $n = 48$) followed by Non-Hispanic White (32.7%, $n = 35$), Hispanic (10.3%, $n = 11$), Asian (7.5%, $n = 8$), and something else (4.6%, $n = 5$). Participants in this sample identified with a variety of marginalized sexual identities including gay (21.5%, $n = 23$), lesbian (24.3%, $n = 26$), bisexual (34.6%, $n = 37$), queer (16.8%, $n = 18$), and pansexual (2.8%, $n = 3$) individuals.

Measures

• Demographic Information

Sexual identity was assessed by asking participants to "Describe your sexual orientation" with select-response options including: Asexual, Bisexual, Queer, Gay, Lesbian, Pansexual, or Not Listed (please write in). Race/ethnicity was determined by asking participants, "What is your race/ethnicity? Please check all that apply." Participants selected among the following: Black or African American, Latinx/Hispanic, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, White/European American, Asian, or Not Listed (please write in). Finally, gender identity was assessed by asking participants, "What is your gender identity" with selection options including: Man, Woman, Transgender, Nonbinary, Gender fluid/Gender nonconforming, Agender, Not Listed (please write in).

• Stress-Related Growth (SRG)

The Stress-Related Growth Scale–Short Form (SRGS-SF; Cohen et al., 1998) is a 15-item Likert-type scale adapted from the original 50-item SRGS, assessing one's level of perceived growth following stressful events (Park et al., 1996). Instructions for this measure were modified to specifically ask about stressors relating to one's sexual identity, stating, "Think about any difficulties, stressful experiences, or discrimination you have encountered as a result of

your sexual identity when answering the following questions. Because of these events . . ." followed by the 15 items of the SRGS-SF. Ratings range from 0 (*not at all*) to 2 (*a great deal*). Total scores were determined by summing all items, with higher scores indicating a greater perception of personal growth as a result of stressful experiences related to one's sexual identity (range = 0–30). Example items include, "I learned to work through problems and not just give up." The SRGS is a well-validated measure and has been used with a similar population with modified instructions (Bonet et al., 2007). The SRGS-SF demonstrated strong internal reliability in our sample, $\alpha = .82$ but is slightly lower than the original standardization sample ($\alpha = .94$, Park et al., 1996).

• Outness

The Outness Inventory (OI; Mohr & Fassinger, 2000) is an 11-item measure examining the degree to which one has disclosed their sexual identity to others (e.g., family, coworkers) and how openly they discuss their sexual identity with these individuals/groups. Ratings range from 1 (*definitely does not know about your sexual orientation status*) to 7 (*definitely know(s) about your sexual orientation status, and it is openly talked about*). Total scores were determined by summing all items, with higher scores indicating greater outness (range = 11–77). An example item on the OI is, "Members of my religious community (e.g., church, temple) . . ." The OI was previously validated in lesbian, gay, and bisexual adults (e.g., Mohr & Fassinger, 2003) and an aggregate of outness evidenced good reliability in this sample, $\alpha = .79$.

• Internalized Stigma

The Internalized Homonegativity Inventory (IHNI; Mayfield, 2001) is a 23-item measure examining the respondent's negative attitudes toward homosexuality in general and one's own thoughts and emotions related to their sexual identity. Analyses for this study were based on overall scores. The term "homosexuality" was altered to "LGBTQ+ identity" to be more inclusive. Ratings range from 1 (*strongly disagree*) to 6 (*strongly agree*). Total scores were determined by summing items across the total scale, with higher scores indicating more internalized homophobia (range = 23–138). This measure has been validated in gay adults (Mayfield) as well as other sexual identity subgroups (Grey et al.,

2013), and demonstrated high reliability in the current study, $\alpha = .89$.

• Heterosexist Experiences

The Daily Heterosexist Experiences Questionnaire (DHEQ; Balsam et al., 2013) is a 50-item measure assessing frequency of daily heterosexist oppression experienced by LGBTQ+ individuals. The DHEQ has been validated in diverse samples of race/ethnicity, gender, and sexual identity (Balsam et al.). Ratings range from 0 (*it bothered me not at all*) to 5 (*it bothered me extremely*). Total scores were determined by summing items across the total scale (excluding the HIV/AIDs and parenting subscales), with higher scores indicating greater heterosexist experiences (range = 0–195). Example items include, “Your family avoiding talking about LGBTQ+ identity.” Study analyses were based on the overall DHEQ frequency across 8 of the 10 subscales (excluding HIV/AIDS and parenting subscales) with $\alpha = .95$ in the current sample.

Data Analytic Plan

To gain a greater understanding of what aspects of one’s identity may impact experiences of minority stress, we first examined mean-level differences for all variables of interest (outness, heterosexist experiences, internalized stigma, and stress-related growth) based on several demographic characteristics including gender identity, sex assigned at birth, race/ethnicity, and sexual identity using t-tests and ANOVAs. These exploratory analyses may help to further contextualize how other aspects of one’s identity might impact minority stress experiences and stress-related growth. Additionally, any demographic characteristic that resulted in mean-level differences for minority stress variables or stress-related growth was also assessed as a potential moderator in our hierarchical linear regression analyses.

To examine how all variables of interest operate in relation to one another for individuals with marginalized sexual identities, bivariate correlations between all predictor and outcome variables were explored, as well as examined for the potential of multicollinearity and no concerns were found. Next, all minority stress variables (outness, heterosexist experiences, and internalized stigma) were mean-centered and entered into the hierarchical multiple linear regression analysis. This allowed for the examination of how both distal and proximal forms of minority stress relate to stress-related growth for all sexual minority indi-

viduals in our sample. Independent variables were entered into the regression equation in a stepwise fashion as it is theorized that, generally, individuals would first disclose their sexual identity (outness), which would then increase their experiences of heterosexism as a result of their sexual minority status (heterosexist experiences), and finally impact one’s internalization of these discriminatory experiences and attitudes (internalized stigma). Therefore, the unique variance accounted for by each additional variable was examined while also detecting the differential impact of various forms of minority stress on stress-related growth.

Finally, after examining the initial model of how both distal and proximal forms of minority stress associate with stress-related growth, we further expanded the model by examining whether one’s specific sexual identity moderated the relation between different components of minority stress and stress-related growth. To examine sexual identity as a moderator, we conducted a series of generalized linear models. Interaction terms between sexual identity (categorized into four groups including gay (1), lesbian (2), bisexual (3), and “something else” (4), which consisted of individuals who identified as queer or pansexual, and each minority stress variable (outness, heterosexist experiences, and internalized stigma) on stress-related growth was examined separately for a total of three moderated models, one for each of the minority stress components by sexual identity. Due to the small sample size of individuals who identified as pansexual ($N = 3$), these participants were grouped with those who identified as queer ($N = 18$). Additionally, both queer and pansexual individuals self-identified outside of lesbian, gay, and bisexual, each of which have greater representation in literature. Thus, it was important to include participants outside of these groups and explore any differences that may exist compared with LGB individuals. For significant interactions between sexual identity and any of the minority stress variables, post hoc analyses were conducted to probe for patterns of significance. This allowed us to examine differences in the strength and the direction of the associations between sexual identity, minority stress, and stress-related growth.

Results

Descriptive Data

Significant group mean-level differences existed for heterosexist experiences and internalized stigma based on gender identity (i.e., man, woman, and something else), $F(2, 104) = 3.32, p < .05$ and $F(2, 104) = 3.77, p < .05$, respectively. Specifically, men reported significantly higher levels of heterosexist experiences ($M = 37.27, SD = 8.71$) than women ($M = 31.90, SD = 11.43$). With regard to internalized stigma, those who identified as a gender other than ‘woman’ or ‘man’ (i.e., something else) reported significantly more internalized stigma ($M = 78.50, SD = 10.26$) than women ($M = 68.76, SD = 20.23$). Differences in heterosexist experiences and internalized stigma also existed based on sex assigned at birth, $t(105) = 3.23, p < .01$ and $t(105) = 3.14, p < .01$, respectively, such that those assigned male reported significantly higher levels of heterosexist experiences ($M = 37.74, SD = 7.06$) and internalized stigma ($M = 79.35, SD = 12.03$) when compared with individuals assigned female at birth ($M = 31.75, SD = 10.95$ and $M = 69.15, SD = 19.42$), respectively.

Finally, there were also mean-level differences based on race/ethnicity (i.e., Black/African American, Non-Hispanic White/European American, or something else) for heterosexist experiences and internalized stigma, $F(2, 104) = 16.92, p < .001$ and $F(2, 104) = 11.94, p < .001$, respectively. Results indicated that Black/African-American individuals reported significantly higher levels of heterosexist experiences ($M = 37.25, SD = 5.18$) than White individuals ($M = 27.37, SD = 11.89$). Similarly, individuals in the “something else” group (i.e., Latinx/Hispanic, Asian, American Indian or Alaskan Native, Native Hawaiian or Pacific Islander, or Not Listed) ($M = 38.63, SD = 8.76$) reported significantly higher levels of heterosexist experiences than White individuals. Additionally, Black/African American individuals ($M = 76.90, SD = 12.04$) and those in the “something else” group ($M = 81.88, SD = 15.28$) reported significantly more internalized stigma compared with White individuals ($M = 63.20, SD = 20.10$) but not compared with one another ($p = .43$). Notably, there were no mean-level group differences for sexual identity (i.e., gay, lesbian, bisexual, or something else) on heterosexist experiences, internalized stigma, outness, or stress-related growth ($p = .23, p = .26, p = .80, p = .20$, respectively).

Unique Associations Among Minority Stress Components and Stress-Related Growth

A hierarchical linear regression was conducted to test the hypothesis that outness, heterosexual experiences, and internalized stigma are uniquely related to stress-related growth among individuals with marginalized sexual identities. Results for the first block or Model 1, with outness as the only predictor, approached significance in relation to stress-related growth, $F(1, 105) = 3.11, B = 0.74, p = .08$. The second block or Model 2, with both outness and heterosexual experiences as predictors, explained significantly more variance in stress-related growth ($F_{change}(1, 104) = 8.01, B = -0.15, p < .01$), accounting for approximately 10% of the total variance ($R^2_{change} = .07$). Finally, the overall model (the final block or Model 3), which included all three predictor variables (i.e., outness, heterosexual experiences, and internalized stigma) was not statistically significant ($F_{change}(1, 103) = 3.26, B = -0.07, p = .07$). However, outness remained significant ($B = 1.25, p < .01$), whereas heterosexual experiences ($B = -.06, p = .41$) and internalized stigma ($B = -.07, p = .07$) did

not. Thus, hypothesis 1 is partially supported, such that outness is uniquely and positively associated with stress-related growth, even after accounting for heterosexual experiences and internalized stigma. Refer to Tables 1 and 2 for bivariate correlations and hierarchical linear regression results, respectively.

• Sexual Identity as a Moderator

To test the final hypothesis that sexual identity moderates the association between individual minority stress factors (i.e., outness, heterosexual experiences, and internalized stigma) and stress-related growth, a series of generalized linear models were conducted. Results suggest that for both heterosexual experiences, $F(3, 107) = 8.41, p < .001$, and internalized stigma, $F(3, 107) = 6.92, p < .001$, sexual identity (i.e., gay, lesbian, bisexual, or something else) moderated the relation between minority stress and stress-related growth. Post hoc analyses examining the correlations between minority stress variables and stress-related growth, split by sexual identity group, revealed several group differences. For heterosexual experiences, only the bisexual and “something else” (i.e., queer and pansex-

ual) groups showed a significant correlation between heterosexual experiences and stress-related growth ($r = -.58, p < .001; r = .52, p < .05$), respectively, but in opposite directions. Additionally, the relation between internalized stigma and stress-related growth was significant for the bisexual ($r = -.52, p < .01$), lesbian ($r = -.45, p < .05$), and “something else” ($r = .48, p < .05$) groups, but not for those who identified as gay ($r = -.10, p = .65$). Notably, the “something else” group had a positive correlation with growth whereas those who identified as lesbian, gay, and bisexual demonstrated a negative correlation. Thus, hypothesis 2 was partially supported, such that sexual identity significantly moderated the association between heterosexual experiences and internalized stigma and stress-related growth; however, it did not for outness and stress-related growth. Last, exploratory analyses for all demographic characteristics that revealed significant mean-level differences for any component of minority stress were examined as potential moderators on the relation between minority stress and stress-related growth. Therefore, gender identity, sex assigned at birth, and race/ethnicity were all included

Table 1. Correlations Among Outness, Heterosexual Experiences, Internalized Stigma, and Stress-Related Growth

Sexual Identity Subgroup	Construct	OI	DHEQ	IHNI	SRG
1. Bisexual (N = 37)	OI	-	-	-	-
	DHEQ	.542**	-	-	-
	IHNI	.462*	.786**	-	-
	SRG	-.031	-.576**	-.522**	-
2. Gay (N = 23)	OI	-	-	-	-
	DHEQ	.641**	-	-	-
	IHNI	.583*	.728**	-	-
3. Lesbian (N = 26)	SRG	.158	-.049	-.100	-
	OI	-	-	-	-
	DHEQ	.022	-	-	-
4. Something Else (N = 21)	IHNI	-.016	.686**	-	-
	SRG	.170	-.297	-.452*	-
	OI	-	-	-	-
5. Overall Sample (N = 107)	DHEQ	.532*	-	-	-
	IHNI	.297	.657*	-	-
	SRG	.524*	.517*	.484*	-
	OI	-	-	-	-
	DHEQ	.391**	-	-	-
	IHNI	.306*	.724**	-	-
	SRG	.170†	-.176†	-.236*	-
	M(SD)	3.92 (1.19)	34.33 (9.89)	73.53 (17.34)	19.84 (5.17)

Note. * Correlation is significant at the .05 p level (2-tailed). ** Correlation is significant at the .01 p level (2-tailed). *** Correlation is significant at the .001 p level (2-tailed). † Correlation is approaching significance at $p < .10$ (2-tailed).

as moderators in a series of generalized linear models by examining the interaction between those variables and minority stress variables on stress-related growth. The interaction effect was nonsignificant ($p \geq .18$) for all three demographic variables (i.e., gender identity, sex assigned at birth, and race/ethnicity).

Discussion

This study examined the association between minority stress and stress-related growth while also evaluating sexual identity as a moderator. Previous literature has established an association among internalized stigma, outness, and stress-related growth (Cox et al., 2010); however, no study has examined distal factors of minority stress, such as heterosexist experiences, along with proximal factors (e.g., outness and internalized stigma) in the same model predicting stress-related growth. Research on minority stress and adaptive responses, such as growth, is still in its infancy. Thus, this study aimed to replicate and extend previous research in a more diverse sample, including individuals who are racially/ethnically diverse, who identify outside the gender binary, and who identify with diverse sexual identities, not limited to lesbian, gay, and bisexual.

First, we observed significant mean-level variations based on sex assigned at birth and gender identity. Specifically, both males (sex assigned at birth) and those who identified as men (gender identity) had higher levels of internalized stigma when compared with other groups. Experiences of males and men may be unique from others included in this study. It is possible that the toxic aspects of masculinity, such

as the devaluation of women and homosexual individuals (e.g., Kupers, 2005), impacted males and men in this study as a result of their nonheterosexual identity or nonheteronormative gender expression. In fact, Balsam and colleagues (2014) found that men scored higher than women on the victimization subscale of heterosexist experiences. As such, maybe those who hold aspects of the masculine identity were subject to greater heterosexism (or specifically victimization), which was associated with greater internalized stigma when compared with other gender identities and sex assigned at birth. Considering the primary focus of this study was on minority stress related to sexual identity, and not gender identity or sex assigned at birth, sources underlying these gender/sex assigned at birth group differences are only speculation.

Similarly, we also observed mean-level differences based on race/ethnicity for heterosexist experiences and internalized stigma, such that Black/African American and other individuals with non-White identities experienced higher levels of heterosexist experiences and internalized stigma than White individuals. This can potentially be explained by the intersectionality theory (Crenshaw, 1989), which posits social identities (e.g., race and sexual orientation) can mutually influence one another, ultimately resulting in the interaction of identities, which forms a unique experience for dually marginalized individuals (Fattoracci et al., 2021). Our finding underscores the relevance of examining the role of dual identities, as this has the capacity to capture an individual’s experience more comprehensively. Moreover, without

exploring an individual’s multiple identities, researchers and clinicians could unintentionally misrepresent an individual’s daily experience.

Aspects of minority stress were uniquely associated with stress-related growth within the entire sample. Moreover, despite mean-level differences in minority stress experiences described previously, these associations were not moderated by sex assigned at birth, gender, or racial/ethnic identity. First, when the negative effects of internalized stigma are accounted for, heterosexist experiences were no longer significantly related to stress-related growth. Stated otherwise, the variance in stress-related growth that seemingly resulted from heterosexist experiences was better explained by internalized stigma. Consistent with the existing minority stress literature focused on adverse outcomes, it may not be the distal experiences of discrimination themselves that are associated with stress-related growth, but the proximal way individuals internalize these experiences that play a role in predicting stress-related growth (Hatzenbuehler, 2009).

Second, findings suggest that when aspects of minority stress are taken together, outness is the most robust predictor of stress-related growth and seemingly demonstrates both positive and negative components. Thus, it appears that outness may facilitate adaptive outcomes, such as stress-related growth, especially after removing the variance accounted for by the negative facets of heterosexism and internalized stigma. Importantly, this significant association was not moderated by sexual identity. This finding acknowledges

Table 2. Hierarchical Linear Regression Analysis of Stress-Related Growth

Model	B	β	<i>p</i>	R ²	R ² Change
Model 1			.08	3.11	.03
Outness	0.74†	.17†			
Model 2			<.01	8.01	.07
Outness	1.22**	.28**			
DHEQ	-0.15**	-.29**			
Model 3			.07	3.26	.03
Outness	1.25**	.29**			
DHEQ	-0.06	-.11			
IHNI	-0.07†	-.24†			

Note. * Denotes results with a $p < .05$, ** Denotes results with a $p < .01$; † Denotes results approaching significance with a $p < .10$. DHEQ = Daily Heterosexist Experiences Questionnaire; IHNI = Internalized Homonegativity Inventory. Predictor variables were grand mean centered.

the complex nature of outness for those within marginalized sexual identities, as outness can have positive and negative implications on individual functioning (Meyers, 2003; Miller & Major, 2000). For instance, disclosing one's sexual identity may subject individuals to greater instances of discrimination, stigma, and prejudice (Monroe, 2001). These experiences, if internalized, are related to less growth. Conversely, disclosure may also reduce stress and emotional fatigue for individuals as they are no longer burdened with constant vigilance about keeping their stigmatized identity hidden (Hetrick & Martin, 1987). After disclosure, individuals may have more access to positive and affirming social support within the LGBTQ+ community (Crocker & Major, 1989; Meyer, 2003). Thus, outness may provide healthy and adaptive coping opportunities, potentially bolstering stress-related growth.

Unlike sex assigned at birth, gender, and race/ethnicity, sexual identity did moderate the association between aspects of minority stress, specifically heterosexist experiences and internalized stigma, and stress-related growth. For those who identified as something other than gay, lesbian, or bisexual, there was a significant positive association between heterosexist experiences and stress-related growth, whereas bisexual individuals displayed a significant negative association. Moreover, for bisexual and lesbian individuals, there was a significant negative association between internalized stigma and stress-related growth, whereas this association was significant and positive for those identifying as "something else" (i.e., queer or pansexual). This is consistent with the existing literature demonstrating that bisexual individuals encounter unique experiences of minority stress and subsequent outcomes (Balsam & Mohr, 2007; Bostwick, 2012). Additionally, the opposite pattern of association for individuals identifying as "something else" (i.e., queer or pansexual) indicates there may be meaningful differences characteristically or experientially in this group that warrants further examination. It is possible that there are unique aspects of identifying as queer or pansexual that buffer against adverse outcomes of heterosexist experiences and internalized stigma (e.g., improved coping skills). For instance, it may be empowering (e.g., reclaiming of stigmatized terms) to self-identify with this group and allow individuals to experience growth even in the face of adversity (i.e., minority stress). For instance, "queer" has been reclaimed by the LGBTQ+ commu-

nity as an empowering identity and often serves as an umbrella term for diverse non-heterosexual identities (Callis, 2014; Curl, 2002; Worthen, 2022). Similarly, "pansexual," a term representing fluidity, has grown in representation in recent years (Zosky & Alberts, 2016), with many articles outlining how queer and pansexual identities differ from other nonheterosexual identities (e.g., Morandini et al., 2017). Considering this, additional research is necessary within these particular populations to enhance our understanding of the unique features of identifying as queer or pansexual versus lesbian, gay, or bisexual. Future studies should explore how intrapersonal processes, such as internalized stigma, mediate the association between heterosexist experiences and stress-related growth, especially for those with diverse sexual identities outside of lesbian, gay, or bisexual.

This research has multiple implications. First, sexual identity subgroups tend to be collapsed into one comprehensive subgroup (e.g., LGBTQ+). However, this does not account for the unique needs and stressors individual subgroups face (e.g., McLean, 2007; Van et al., 2019). Although we know that sexual identity subgroups face unique stressors and challenges because of their identity, it is likely they also have unique protective factors. By better delineating and exploring the specific needs of individual sexual identity subgroups, treatments can be tailored to better facilitate growth based on one's specific sexual identity.

Limitations and Future Directions

This study contained several limitations, including the cross-sectional nature of the data. Future research should conduct longitudinal designs to explore possible mechanisms in the association between minority stress variables and stress-related growth. It is also important to explore factors that may buffer against the negative consequences of minority stress and identify potential protective factors and coping mechanisms to better explain this association. Another limitation of this study is the lack of measurement specificity in determining the exact origin of various types of stigma. For example, in looking at different forms of discrimination, it is not always possible to disentangle whether a person is experiencing discrimination as a result of their gender expression, race/ethnicity, or other aspects of their sexual identity. Thus, in future research, it is important for measures to better account for an individual's

intersectional identity. Last, given the small sample size, individuals with marginalized identities outside of lesbian, gay, and bisexual were collapsed into the "something else," group, which primarily consisted of individuals who identify as queer and a smaller subset of pansexual-identifying individuals. Given the unique needs and stressors of these distinct identities, it will be important for future research to examine these sexual identities separately.

The field would also benefit from studies that deconstruct outness to better understand both the positive and negative consequences of disclosing one's marginalized sexual identity, in addition to the impact of outness on adaptive psychological processes. Finally, we did not have adequate power to split our sample into four sexual identity groups and run the comprehensive model including all minority stress variables simultaneously (instead, the moderating effects of sexual identity were examined within each aspect of minority stress in three separate models) and stress-related growth. Thus, future research should replicate this study with a larger sample size and equal representation from all sexual identity groups to compare the contributions of all proximal and distal components of minority stress and stress-related growth in the same model.

Conclusion

This investigation filled important gaps in existing literature and permitted the examination of minority stress in a sample with diverse racial/ethnic, gender, and sexual identities. This study also incorporated both proximal and distal factors as potential predictors of adaptive responses to minority stress. Findings from this study can serve as a preliminary step toward informing psychological interventions for individuals with marginalized sexual identities aimed at fostering growth as a response to experiences of chronic minority stress. Because outness predicted stress-related growth, but only after the variance from heterosexism and internalized stigma were removed, this research can hopefully inform policy change and social programming to help support more affirming environments for the LGBTQ+ community where disclosure is safer. Moreover, it is not solely heterosexism that negatively impacts outcomes within this community, but instead, the internalization of those experiences that predicts the attenuation of growth, especially for those who identify as lesbian or bisexual. Thus, targets for treatment should focus on reducing internal-

ized stigma and helping individuals develop a positive self-identity.

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Beyond End Credits: Studying the Role of Narratives and Second-Screening on Adolescent Mental Wellness

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ADOLESCENCE IS A FORMATIVE stage of development and a crucial time for identity consolidation. Incidence rates for several mental health disorders, including depression, panic disorder, and schizophrenia, either “peak or display a major increase during adolescence” (Tasman et al., 2015, p. 207). Normative stressors, like the intrinsic instability of relationships along with increased sensitivity to acceptance and rejection from peers, may conflict with familial or cultural restrictions leading to increased subjective levels of stress and dysphoria (Tasman et al.), and LGBT youth may be particularly at risk (Russell & Fish, 2016). One potential way to address mental health issues among youth, given elevated screen time (Nagata et al., 2022), is through the use of narratives, or stories, to communicate health information (Frank et

al., 2015, Wilkin et al., 2007), which is investigated in this study.

The Mental Health Crisis: Sexual and Gender Minorities

According to the CDC's Youth Risk Behavior Survey Data Summary & Trends Report: 2009-2019, the percentage of high school students who in the past 12 months reported ever feeling “so sad or hopeless almost every day for two weeks or more in a row” (p. 60) increased approximately 11% in 10 years, from 26% in 2009 to 37% in 2019 (p.58), and high school students who in the past 12 months reported attempting suicide rose from 6% in 2009 to 9% in 2019 (p. 58), demonstrating an alarming upward trend.

Per Russell and Fish (2016), there is reliable evidence that mental health problems are increased among lesbian, gay, and particularly among bisexual youth. The CDC's

Youth Risk Behavior Survey Data Summary & Trends Report: 2009-2019 also noted that lesbian, gay, or bisexual students (66%) as well as students not sure of their sexual identity (47%) were more likely than heterosexual students (32%) to have experienced persistent feelings of sadness and hopelessness (p. 97). Similarly, lesbian, gay, or bisexual students (23%) and students not sure of their sexual identity (16%) were more likely to have attempted suicide compared to heterosexual students (6%) (p. 100). This data was collected before the isolation and stay-at-home orders of the COVID-19 pandemic, which could have far-reaching impacts on LGBTQ+ adolescent well-being. For LGBTQ+ youth, forced confinement in a negative home and isolation from “developmentally important social connections and identity-based resources” are associated with “compromised mental health” (Fish et al., 2020, p. 451). A study that sampled 542 lesbian, gay, and bisexual youths in diverse areas demonstrated that youths with rejecting parents had significantly more mental health symptoms than youths with accepting parents (D'Augelli, 2002).

Nonbinary youth are also at risk of adverse mental health outcomes. According to The Trevor Project, approximately a quarter of their U.S. sample of LGBTQ+

youth, aged 13–24, identified as nonbinary, and those who reported that “no one” respected their pronouns had more than twice the rate of suicide attempt than those who endorsed that all or most people respected their pronouns (The Trevor Project, 2021). Historically, there has been a general paucity of data on the mental health of transgender and nonbinary youth (Connolly et al., 2016; Price-Feeney et al., 2020); therefore, there is a significant need to fill in this research gap.

Adolescents and Media Usage

It would be difficult to discuss modern adolescent life in the U.S. without discussing digital media and screen usage, particularly within the context of the COVID-19 pandemic. One study examining self-report screen use of a diverse national sample of 5,412 participants, aged 10–14 years, found that adolescents reported a mean of 7.70 hours a day of screen (excluding school-related) use early in the pandemic, compared to prepandemic estimates of 3.8 hours a day from the same cohort at baseline (Nagata et al., 2022).

Media usage and well-being is not just about screen time, however, and there are other factors influencing adolescent media habits. A study by Moreno et al. (2022) used latent class analysis to develop profiles of media and internet use in relation to parental involvement and their associations with markers of well-being, such as physical activity, depression, and anxiety. Approximately 63% of participants, who were proposed to be called “Family-Engaged Adolescents,” were more likely to communicate with parents about their technology use and report a more positive relationship with parents compared to the “At-Risk Adolescents.” The study also found that technology use was not associated with higher rates of depression or anxiety among “Family-Engaged Adolescents” (Moreno et al.). Rather than tackling overall screen time, the focus should be on the content and parents modeling healthy behavior.

Przybylski et al. (2020) also found that moderate levels of screen time (1–2 hours a day) were associated with somewhat elevated psychosocial functioning compared to less usage. Furthermore, they found that children and adolescents would need to use TV and devices for about 5 hours a day before a parent or caregiver would be able to notice a difference in their child’s psychosocial functioning. Hence, for those concerned about the harmful effects of

screen time, calls for minimal usage of media without concern for the context may not be the answer.

The Role of Media Use in LGBTQ+ Youth

There are many positive benefits to media usage, particularly for LGBTQ+ youth (McInroy, Craig, et al., 2019; McInroy, McCloskey, et al., 2019). Media use can promote social development and connection with others, particularly during the COVID-19 pandemic (Chassiakos et al., 2016; Eales et al., 2021). LGBTQ+ youth may be more likely than their peers to explore resources and kinship online (Fish et al., 2020) and find online communities to express their identity if they are unable to do so offline (Green et al., 2020; McInroy, McCloskey, et al., 2019). A study of 6,309 LGBTQ+ respondents, aged 14–29, found that those who identified as pansexual, asexual, queer, and gender non-conforming had the highest mobile device usage and time spent online (McInroy, Craig, et al., 2019).

Narratives and Second-Screens as Vehicles to Impart Health Information

Narratives, or stories, are important for disseminating and conveying health information (Dahlstrom et al., 2017; Frank et al., 2015; Wilkin et al., 2007). They can influence attitudes through transporting the reader or viewer into a different world (Ma & Nan, 2018; Wang & Singhal, 2016). Per Chassiakos et al. (2016), “character-focused media” can help children empathize with and understand people who are different from them. In a study comparing narrative and nonnarrative messaging, it was demonstrated that a story about a person with schizophrenia promoted more positive attitudes toward people with mental illnesses than an informational article (Ma & Nan).

Attitudes are also influenced by identification with a character in narratives. Frank et al. (2015) studied the impact of a narrative film providing information about human papillomavirus (HPV) and cervical cancer prevention that focused on a young woman recently diagnosed with HPV. The study found an overall positive significant relationship between a female participant’s perceived relevance of the narrative to her own life and perceived efficacy of the HPV vaccine (Frank et al.). In a study examining suicide prevention public service announcements, Ftanou et al. (2021) found that most young people agreed that mental

health content targeting them should be delivered by or feature peers.

Since mental health is a sensitive topic, there are drawbacks and benefits of portrayals in the media. For instance, the show *13 Reasons Why* (13RW), which was released on Netflix in 2017, has been criticized for its graphic depiction of suicide in the first season and link with increases in suicide and suicide-related behaviors (Reidenberg et al., 2020). However, a study by Uhls et al. (2021) on a later season of 13RW, which focused on “sexual assault and bullying,” found that 92% of adolescents sought “information on social and mental health issues,” most frequently regarding bullying and mental health, after watching the show. This highlights that the content in media portrayals of mental health needs to be carefully considered—media can bring about information seeking, which is valuable for improving mental well-being and shaping mental health awareness.

In this day and age, media is frequently viewed on multiple platforms, which may serve to enhance the efficacy of knowledge dissemination. In a study of 136 viewers of East Los High, the first English-language “edutainment” (entertainment education or entertainment for health promotion) (Wang & Singhal, 2016, p. 1002) program in the U.S. made for Latines that features an exclusively Latine cast, creators, and writers, and the first transmedia (narrative parts arranged over disparate multiple media platforms) edutainment program created to discuss sexual and reproductive health issues, participants in the transmedia condition (compared to other conditions) had better knowledge of correct condom use over time.

Second-screen viewing (using smartphones, tablets, laptops while watching TV or movies) has increased “dramatically” in the last few years (Van Cauwenberge et al., 2014, p. 100). According to a 2013 Nielsen survey, 46% of smartphone owners and 43% of tablet owners said that they used their devices to second-screen daily while watching TV, with 20% of them reading conversations about the show on a social networking site, and nearly half of tablet owners using their device to look up information about what they are watching. Walter et al. examined second-screening and binge-watching in the context of viewers of East Los High and found that second-screening was associated with stronger identification with “characters on story-consistent attitudes” and that it increased the processing of information

(2018, p. 409). Teens often multitask on screens, and though second-screening may lead to a higher cognitive load and thus lower recall and comprehension (Van Cauwenberge et al.), it can also make the user experience more individualized (Walter et al., 2018). In Wilkin et al. (2007), the authors suggested that providing an 800-information number with a storyline motivated viewers to seek out further information. Uhls et al. (2021) also demonstrated that 33% of their viewers engaged with “informative resources produced by or affiliated with 13RW.” Hence, second-screen content, or additional content aligned to the narrative, could influence mental health outcomes, such as attitudes, knowledge, and behavioral intentions.

Present Study

The current research focused on adolescent mental health, looking at media consumption through virtual focus groups and the role of narrative plus second-screen content on mental health attitudes, knowledge, and behavioral intentions via an online experiment. We examined the following research questions in the experiment: (1) What are baseline differences in teen mental health attitudes, knowledge, and information-seeking behaviors across gender identities and sexual orientation? (2) Does the intervention (narrative + second-screen) prompt improved attitudes, knowledge, and behavioral intentions compared to the control (narrative only)? (3) Which type of second-screen content (celebrity video, peer video, or gif) is more effective? Correspondingly, we hypothesized the following:

Hypothesis 1: LGBTQ+ teens will have more positive attitudes and greater knowledge about mental health yet seek more information online and less information offline;

Hypothesis 2: Second-screen content with the narrative will be more effective than the narrative by itself; and

Hypothesis 3: Peer video will be more efficacious than the celebrity video and gif. We also explored the moderating effects of gender, sexual orientation, race/ethnicity, age, and location.

Methodology

This study incorporates online focus group sessions ($N = 18$) and a pretest/posttest experiment ($N = 106$) with teenagers across the U.S. Baseline data from the experiment was used to examine

differences in key mental health attitudes, knowledge, and behavioral intentions across gender identities and sexual orientation. We also test second-screen as an intervention compared to narrative-only and evaluate the efficacy of various supplemental content using pretest and posttest measurements.

Recruitment

Convenience sampling was used to recruit for the focus groups and experiment. Since adolescents regularly use social media, the research team posted recruitment flyers on Instagram, Twitter, and Facebook. Study announcements were also shared over email, and social media influencers with teenage audiences were contacted to share with their followers. Focus group participants received \$25 and experiment participants received \$20 in compensation.

Adolescents aged 13–17 years, English-speaking, and residing in the U.S. were eligible. In order to participate in the focus groups, individuals were required to have a computer with Internet access, microphone, and webcam. For the experimental study, interested individuals who have not seen the movie *All the Bright Places* (ATBP) (Haley, 2020) were approved for participation. Parents of qualified teenagers were notified of the study and provided informed consent for their child’s participation. Adolescents of consenting parents or guardians were asked for their assent before proceeding with the study. All experimental participants were advised with a content warning, “There will be mention of mental health struggles and/or suicide in the scene that you will watch. Please feel free to discontinue at any time.” Our research was governed by the University of California, Los Angeles, who provided ethics approval.

Design Overview

Focus groups were used to acquire context around teenagers’ second-screen behaviors, understanding of mental health, and opinions on mental health in the media. Five focus groups with 18 participants were held over password-protected Zoom meetings in September 2020. The 1-hour focus group sessions were conducted by a trained moderator, recorded using the Zoom platform, and later transcribed by a research assistant. Results from the focus groups provided insights into media use and mental health among youth and informed the experimental design.

The experiment consisted of questions regarding our key outcomes of interest: attitudes, knowledge, and information-seeking behaviors. Participants first filled out pretest questions (T1) and watched the ATBP (Haley, 2020) narrative, then were randomly assigned to one of the four conditions (control, celebrity video, peer video, and gif), which was followed by a set of posttest questions on the outcomes and demographic information (T2). Study recruitment and enrollment took place from July to December 2021. During this time, 106 participants completed the full study—82 members of the narrative plus second-screen intervention group (25 received a video from the celebrities, 27 received a video from peers, and 30 received a gif from the movie) and 24 members of the control group (narrative only, no second-screen) [see Figure 1]. On average, the experiment took about 45 minutes to complete.

Experimental Stimuli/Measures

In the experiment, the chosen narrative, ATBP (Haley, 2020), was a film that revolves around two high school students dealing with issues of grief, depression, trauma, and bipolar disorder. Stimuli consisted of the ATBP narrative and the three varying second-screen content. All participants were shown an 11-minute narrative video that combined two scenes from the movie. In the first scene, the main characters, Theodore and Violet, talked about Violet’s loss of a loved one and offered advice on the grieving process. In the second scene, Theodore was at a group therapy session for people with mental illnesses in which attendees shared their diagnoses and journeys to recovery. Theodore spoke up about his mental health and the use of running as a coping strategy.

Key messages were matched across the second-screen content: (1) Mental health issues are complex, (2) It is helpful to open up to a person you trust when you are struggling, and (3) You are not alone. The 1-minute celebrity video was obtained from the movie’s official website and featured the leading actors, Elle Fanning and Justice Smith, discussing their characters and the mental health issues they faced. The 1-minute peer video and 10-second gif were developed in partnership with film industry professionals. In the peer video, sex and race/ethnicity of the actors were matched to the celebrity video. The peer condition was designed for comparison to the celebrity conditions, testing any differences in the senders of the key messages. At

the end of each second-screen stimulus, there was a link and QR code to online mental health resources.

Attitudes

An 11-item scale (pretest $\alpha = .61$, posttest $\alpha = .62$) was used to assess positive and negative attitudes toward mental health, subscales drawn from the Attitudes Toward Serious Mental Illness Scale–Adolescent Version (ATSMI-AV) measure (Watson et al., 2005) and one item was created to correspond with the second-screen content (see Appendix). Response choices ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores represented more agreement with the attitude.

Knowledge

To assess general mental health knowledge, 12 True/False items (pretest $\alpha = .66$, posttest $\alpha = .70$) were adapted from the Youth Aware of Mental Health (YAM) intervention (Lindow et al., 2020) and three items were developed relating to the movie and second-screen content (see Appendix). Responses were scored by assigning 1 point to a correct answer and 0 points to an incorrect answer, with higher scores suggesting better general mental health knowledge (range = 0–12). More specific knowledge about mental health skills and resources was assessed using 9 items (pretest $\alpha = .56$, posttest $\alpha = .66$), also adapted from the YAM intervention (Lindow et al., 2020) and two items were created to align with the second-screen content (see Appendix). Response choices ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores represented greater awareness of resources and skills related to mental health.

Information-Seeking Behaviors

A 3-item scale was developed to assess confidence in seeking mental health information, drawn from the Mental Health Literacy Scale (O'Connor & Casey, 2015) [see Appendix]. Higher scores indicated more knowledge of how to access information and the ability to do so.

To gauge conversational frequency and sources of mental health information, participants were asked how often they have talked about mental health with someone, including friends, family, partner, teacher, school counselor, mental health professional, in the last 2 weeks, which was adapted from Uhls et al. (2021). Response choices included 0 = *not at all*, 1 = *several days*, 2 = *more than half of the days*, 3 = *nearly every day*. Then, participants were

asked where they currently go for mental health information and select all sources that apply. Response choices included (1) friends, (2) family, (3) other adult professional, (4) Internet, (5) social media, (6) television, (7) newspapers, (8) other.

Two items about conversational behavioral intention related to the stimuli were developed. The first item asked whether participants plan on discussing the issues portrayed in the movie with someone. Response choices included 1 = yes and 2 = no. If participants selected yes, then they were asked to select all of the people with whom they plan on discussing these issues with. Response choices included (1) friends, (2) parents, (3) boyfriend or girlfriend or partner, (4) a sibling, (5) other family members, (6) teacher, (7) school counselor, (8) mental health professional or someone at a mental health resource hotline.

For participants in the intervention group, two items about the second-screen content were developed specifically for this study. The first item asked whether participants would visit the informational resources given in the second-screen content. Response choices included 1 = yes, 2 = maybe, and 3 = no. If participants selected yes or maybe, then they were asked to select all of the reasons why they would visit the resources. Response choices included (1) Because I'd want to support my own well-being, (2) Because I'd want to support a friend's well-being, (3) Because I'd be curious, (4) other.

Analysis

The focus group sessions were recorded with participant permission and then transcribed. The transcriptions were analyzed using reflexive thematic analysis, which reveals patterns in qualitative data (Braun & Clarke, 2012). Two qualitative coders, a graduate student and an undergraduate student, were trained by the research team. The first coder analyzed the transcriptions to find recurring themes from the focus group sessions. The second coder went through an iterative process with the transcriptions and consolidated the themes that the first coder put together as well as added themes that were not previously identified.

In the experimental study, demographic information was analyzed using descriptive statistics and frequencies. Pretest differences by gender identity and sexual orientation, comparisons across conditions, and moderators were analyzed using a combination of statistical tests, including analysis of variance (ANOVA) and chi-square tests.

In order to examine the intervention effect, difference scores were calculated between measures at the two time points (representing increases or decreases in measures from T1 to T2) by subtracting T1 data from T2 data (T2–T1). Specifically for analyzing conversational frequency, low frequency responses (0 = not at all and 1 = several days) and high frequency responses (2 = more than half of the days and 3 = nearly every day) were recoded and collapsed prior to conducting the chi-square test for assumptions to be met. A priori power analyses were conducted using G*Power version 3.1.9.6 (Faul et al., 2007) to determine the minimum sample size required for the experimental study. Results indicated the required sample size to achieve 80% power for detecting a medium effect, at a significance criterion of $\alpha = .05$, was $N = 128$ and the required sample size to achieve 70% power for detecting a medium effect, at a significance criterion of $\alpha = .05$, was $N = 102$ for one-way ANOVA to compare the intervention and control groups. Results indicated the required sample size to achieve 80% power for detecting a medium effect, at a significance criterion of $\alpha = .05$, was $N = 108$ with 2 degrees of freedom and $N = 88$ with 1 degree of freedom for chi-square tests. SPSS version 27 was used for all analyses.

Results

Focus Groups

- Participants

Five focus groups were conducted with 18 teenagers, aged 13–17, during the fall of 2020. Participants were sorted by age and gender: 13/14-year-old girls, 13/14-year-old boys, 15/17-year-old girls, 15/17-year-old boys, and 16-year-old girls. The mean age of the sample was 15 years old. The sample consisted of 40% (7/18) male and 60% (9/18) female. Overall, 56% (10/18) participants identified as European American and 44% (8/18) identified as Hispanic/Latino.

- Key Themes

Focus group sessions revealed that 89% (16/18) of the teenage participants are multitasking and using different devices while consuming media. This showed that second-screen device usage and content engagement is common among adolescents. Participants noted looking up various topics regarding shows, such as actor information, references, and plots, during and after watching the show. This informed the experiment study design as

participants were presented with second-screen content after the ATBP narrative.

When asked to define mental health, participants often mentioned dealing with emotions and compared mental well-being to physical health. For instance, a participant (female, 15 years old) described mental health as “your emotions, things like that more than physical things that are going on things that are going on in your head that could affect your physical health, but they don’t always” and another participant (male, 17 years old) expressed that “mental health and physical health kind of go hand in hand but instead physical is having a sound body and mental health is having a sound mind.” Participants also reported that they have seen TV shows and movies portraying mental health issues, including substance abuse and depression. Adolescents appreciated these depictions because they could empathize with characters, feel less alone, and learn more about mental health. One participant (male, 13 years old) shared his experience with the show *Euphoria* and said that “On the credits of it, it says if anyone you know is struggling with suicide or they are thinking about it or self-harm or addiction go to Euphoria.org, and so I went on the website so I could find out more about it.” Moreover, participants recognized the value of mental health representations in the media, yet they did not necessarily seek out shows that reflect their own struggles. Teens mentioned that when they did, it was hard to find exactly what they were looking for.

When participants came across anything that they were unfamiliar with, they typically searched on Google and social media. One participant (female, 15 years old) conveyed that “Sometimes I won’t know what the issue is, so I’ll look it up to see what it is” and another participant (female, 13 years old) mentioned that “I usually Google it and then I don’t usually just look at one website because I know some websites don’t have all the info.” Older teenagers tended to discuss the show content with their friends whereas younger teenagers usually talked to their parents. This demonstrated that primary sources of information were online and major conversational partners were friends and parents depending on age.

When asked who they prefer to be connected to through an online mental health resource, some participants specified that they would like to first chat with a peer who has experienced similar issues and some favored speaking with a mental health professional. One participant (female, 15 years

old) specified, “I feel like maybe [a younger person] can relate more but I don’t know because I would be fine talking to a professional too because they are a professional but I feel like someone who went through it or is going through it would better understand” while another participant (female, 16 years old) stated, “I would say professional just because a while ago in my life, not now, but when I was younger, I went through that. I called the suicide hotline, and it wasn’t professional, and they laughed at me, and it was really terrible so I think a professional would be much better.”

Experiment

• Participants

Data were collected from 106 teenagers, aged 13–17, across the U.S. during the summer and fall of 2021. The mean age of the sample was 15 years old. Participants were randomly assigned to one of four conditions: control, celebrity, peer, and gif (see Table 1). In our sample, 43% (45/106) identified as male, 44% (47/106) identified as female, and 13% (14/106) identified as nonbinary. About half of the participants identified as heterosexual (52%, 55/106) and half identified as LGBTQ+ (48%, 51/106). Gay, lesbian, bisexual, pansexual, queer, and other participants were grouped together for analysis purposes. About 41% (43/106) identified as European American while the remaining was made up of 6% (6/106) African American, 23% (24/106) Hispanic/Latino, 7% (8/106) Asian American, 4% (5/106) Native American, 1% (1/106) Middle Eastern, and 18% (19/106) mixed race or other.

Research Question 1: What are baseline differences in teen mental health attitudes, knowledge, and information-seeking behaviors across gender identities and sexual orientation?

At T1 before the intervention, we examined the key mental health outcomes of interest by gender and sexual orientation.

• Attitudes

One-way between-subjects ANOVA analyses were performed to examine each mental health attitude. There were no statistically significant differences across gender. However, a one-way ANOVA revealed that there was a statistically significant difference in attitudes toward having a mentally ill relative between heterosexual and LGBTQ+ participants, $F(1, 104) = 3.966$, $p = .049$. Compared to LGBTQ+ participants (mean [M] 1.98, standard deviation [SD]

1.10), heterosexual participants ($M 2.40$, $SD 1.07$) were more likely to agree that they would not want anyone to know if they had a mentally ill relative. There was also a statistically significant difference in attitudes toward the complexity of mental health between the two groups, $F(1, 103) = 4.153$, $p = .044$. LGBTQ+ participants ($M 4.27$, $SD 1.10$) were more likely than heterosexual participants ($M 3.87$, $SD 0.93$) to agree that mental health issues are complex.

• Knowledge

There were no statistically significant differences in general mental health knowledge across gender and sexual orientation. Yet, there were a few distinctions in knowledge about mental health skills and resources. When investigating gender, a one-way ANOVA showed that there was a statistically significant difference in knowing how to handle stress between at least two groups, $F(2, 102) = 7.815$, $p = .001$. Post hoc comparisons using the Tukey HSD test showed that the mean value for nonbinary participants ($M 2.29$, $SD 1.07$) was significantly less than males ($M 3.43$, $SD 0.76$) and females ($M 3.06$, $SD 1.07$). There was no statistically significant difference between males and females. When considering sexual orientation, a one-way ANOVA uncovered that there was a statistically significant difference in knowing about mental health treatments between the two groups, $F(1, 103) = 6.988$, $p = .009$. Compared to LGBTQ+ participants ($M 4.29$, $SD 0.86$), heterosexual participants ($M 3.83$, $SD 0.93$) were less likely to know that there are several different treatment methods for mental health disorders.

• Information-Seeking Behaviors

There were no statistically significant differences of confidence in seeking mental health information across gender and sexual orientation.

A chi-square test of independence was performed to examine the relationship between gender and conversational frequency. There was a significant association between gender and conversational frequency, $\chi^2(2, N = 106) = 7.12$, $p = .028$. Majority of participants (84/106, 79%) reported low frequency of discussing mental health with someone in the last two weeks. Boys (41/106, 39%) were more likely than girls (34/106, 32%) and nonbinary teenagers (9/106, 9%) to have fewer mental health conversations. Among nonbinary participants, most (9/14, 64%) reported having infrequent mental health discussions and a few (5/14, 36%) reported

talking about mental health often with someone. This test was also performed for participants with varying sexual orientation. There was no significant association between sexual orientation and conversational frequency, $\chi^2(1, N = 106) = 1.34, p = .247$.

Across gender identities and sexual orientation, the Internet (67/105, 64%), family (45/105, 43%), and social media (44/105, 42%) were the most common sources of mental health information. More specifically, participants who identified as nonbinary reported seeking information from social media (8/13, 62%), the Internet (6/13, 46%), friends (4/13, 31%), and other adult professional (4/13, 31%). Participants who identified as bisexual reported seeking information from the Internet (16/18, 89%), other adult professional (11/18,

61%), social media (8/18, 44%), and family (8/18, 44%).

Research Question 2: Does the intervention (narrative + second-screen) prompt improved attitudes, knowledge, and behavioral intentions compared to the control (narrative only)?

To investigate the effectiveness of second-screen content, we compared the intervention and control groups. We also tested the moderating effects of gender, sexual orientation, race/ethnicity, age, and location.

Overall, the intervention did not influence general mental health knowledge and confidence in seeking mental health information. Race/ethnicity and location were insignificant moderators across hypotheses.

To assess the impact of the intervention on mental health conversations, a chi-square test of independence was performed to examine the relationship between the condition and behavioral intention to discuss the issues portrayed in the movie with someone. There was a significant association between the condition and conversational behavioral intention, $\chi^2(1, N = 106) = 4.278, p = .039$. Across conditions, more than half of all participants (55/106, 52%) reported plans to talk about the mental health issues in ATBP (Haley, 2020). Among the participants planning to have conversations, respondents in the intervention condition (47/55, 85%) were more likely than those in the control (8/55, 15%) to report plans to talk about the mental health issues in ATBP (Haley). When asked to select all the various individuals who they would engage in conversation with

Table 1. Demographics of Participants in Experiment (N = 106)

Demographics	Control (n = 24)	Celebrity (n = 25)	Peer (n = 27)	Gif (n = 30)
Age, n (%)				
13	10 (42)	7 (28)	8 (30)	5 (17)
14	5 (21)	3 (12)	3 (11)	6 (20)
15	3 (13)	4 (16)	5 (19)	6 (20)
16	3 (13)	6 (24)	6 (22)	6 (20)
17	3 (13)	5 (20)	5 (19)	7 (24)
Sex/Gender, n (%)				
Male	7 (29)	13 (52)	9 (33)	16 (53)
Female	13 (54)	8 (32)	14 (52)	12 (40)
Nonbinary	4 (17)	4 (16)	4 (15)	2 (7)
Race/Ethnicity, n (%)				
European American	12 (50)	10 (40)	10 (37)	11 (37)
African American	1 (5)	2 (8)	1 (3)	2 (7)
Hispanic/Latino	4 (17)	6 (24)	8 (30)	6 (20)
Asian American	1 (5)	0	4 (15)	3 (10)
Native American	0	2 (8)	0	3 (10)
Middle Eastern	1 (5)	0	0	0
Mixed/Other	5 (21)	5 (20)	4 (15)	5 (17)
Sexual Orientation, n (%)				
Heterosexual	9 (38)	12 (48)	15 (56)	19 (63)
LGBQ+	15 (63)	13 (52)	12 (44)	11 (37)
Gay	0	0	1 (4)	2 (7)
Lesbian	1 (5)	1 (4)	0	1 (3)
Bisexual	3 (13)	5 (20)	6 (22)	4 (13)
Pansexual	2 (8)	3 (12)	0	2 (7)
Queer	2 (8)	2 (8)	4 (15)	1 (3)
Other	7 (29)	2 (8)	1 (4)	1 (3)
Location, n (%)				
West	10 (42)	10 (40)	16 (59)	14 (47)
Southeast	0	2 (8)	2 (7)	5 (17)
Northeast	8 (33)	4 (16)	2 (7)	5 (17)
Midwest	2 (8)	3 (12)	3 (11)	1 (3)
Southwest	1 (5)	0	0	2 (7)

about these issues, participants often chose parents (34/97, 35%), friends (29/97, 30%), and a sibling (11/97, 11%).

• Moderation

Attitudes were analyzed with a 2 (Condition: Intervention vs. Control) × 3 (Gender: Male vs. Female vs. Nonbinary) between-subjects ANOVA. In particular, participants differed in attitudes toward crossing the street if they saw a mentally ill person approaching in order to avoid passing him/her/they. The main effects of condition, $F(1, 100) = 0.023, p = .880$, and gender, $F(2, 100) = 1.555, p = .216$, on attitudes were insignificant. However, there was a significant interaction between condition and gender, $F(2, 100) = 6.422, p = .002$. Although there was no overall effect of either condition or gender, there was a crossover interaction between the two variables. Simple main effects analysis showed that girls (mean difference [Mdiff] 0.69, $SD 1.25$) were significantly more likely to agree with this negative attitude than boys (Mdiff -0.29, $SD 0.95$) and nonbinary (Mdiff -0.50, $SD 0.58$) participants in the control condition ($p = .016$). In contrast, there were no significant attitudinal differences between girls with boys ($p = .240$) and nonbinary ($p = .069$) participants in the intervention condition.

Additionally, attitudes were analyzed with a 2 (Condition: Intervention vs. Control) × 2 (Sexual Orientation: Heterosexual vs. LGBTQ+) between-subjects ANOVA. Specifically, participants differed in attitudes toward feeling embarrassed if they were diagnosed with a mental health disorder. The main effects of condition, $F(1, 101) = 0.037, p = .848$, and sexual orienta-

tion, $F(1, 101) = 1.890, p = .172$, on attitudes were insignificant. However, there was a significant interaction between condition and sexual orientation, $F(1, 101) = 5.069, p = .027$. While there was no overall effect of either condition or sexual orientation, there was a crossover interaction between the two factors. Simple main effects analysis showed that LGBTQ+ (Mdiff 0.33, $SD 0.90$) participants were significantly more likely to agree with feeling embarrassed than heterosexual (Mdiff -0.56, $SD 0.73$) participants in the control condition ($p = .043$), but attitudes did not differ significantly by sexual orientation in the intervention condition ($p = .353$).

Respondents differed in awareness that they are not alone, should they ever experience mental health problems, depending on their age. This knowledge was analyzed with a 2 (Condition: Intervention vs. Control) × 5 (Age: 13 vs. 14 vs. 15 vs. 16 vs. 17) between-subjects ANOVA. The main effects of condition, $F(1, 94) = 1.211, p = .274$, and age, $F(4, 94) = 1.484, p = .213$, on knowledge were insignificant. However, there was a significant interaction between condition and age, $F(4, 94) = 3.923, p = .005$. Even though there was no overall effect of either condition or age, there was a crossover interaction between the two variables. Simple main effects analysis showed that 13-year-olds (Mdiff 0.65, $SD 1.14$) were significantly more aware that they are not alone when experiencing mental health issues than 14-year-olds (Mdiff -0.50, $SD 1.24, p = .001$) and 17-year-olds (Mdiff 0, $SD 0.79, p = .038$) in the intervention condition. This knowledge did not differ significantly by age in the control condition ($p = .076$).

Research Question 3: Which type of second-screen content is more effective?

In order to evaluate the impact of the second-screen content within the intervention group, we compared the celebrity, peer, and gif conditions. We also explored potential moderators of gender, sexual orientation, race/ethnicity, age, and location.

Overall, the different second-screen conditions did not influence general mental health knowledge, specific knowledge about mental health skills and resources, and confidence in seeking mental health information. There were no moderating effects across hypotheses.

Compared to the celebrity video, participants who received the peer video were significantly less likely to believe that people with a mental illness are strange and weird. One-way between-subjects ANOVA analyses were performed to compare mental health attitudes across the three second-screen conditions. The analysis unveiled that there was a statistically significant difference in attitudes toward thinking that mentally ill people are strange and weird between at least two groups, $F(2, 79) = 4.124, p = .020$. Post hoc comparisons using the Tukey HSD test pointed out that the mean value of attitudes was significantly different between the peer (Mdiff -0.41, $SD 0.93$) and celebrity (Mdiff 0.24, $SD 0.88$) conditions ($p = .020$). There were no statistically significant differences between the peer or celebrity with the gif condition.

To better understand the intervention's influence on information-seeking, a chi-square test of independence was performed to examine the relationship between the conditions and plans to visit the provided resources. There was no significant association between the type of second-screen content and further information-seeking, $\chi^2(4, N = 82) = 4.182, p = .382$. Across the three conditions, the majority of the participants reported that they might (45/82, 55%) or would (19/82, 23%) visit the supplemental resources provided in the supplemental content. Some (18/82, 22%) said that they would not. Among participants who said yes or maybe, the top reasons for visiting the resources were being curious (38/106, 36%), wanting to support a friend's well-being (37/106, 35%), and wanting to support one's own well-being (29/106, 27%).

Discussion

The current study examined media usage, mental health attitudes, knowledge, information-seeking behaviors, and the

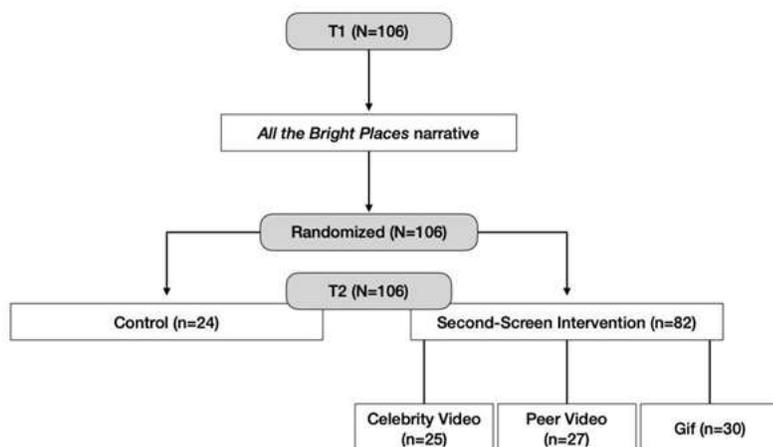


Figure 1. Experiment participation flowchart from T1 to T2

impact of media on these mental health outcomes of interest among adolescents.

Based on the focus group sessions, we found that adolescents are second-screening and consuming popular media that portray mental health. While teenagers appreciate existing shows and movies, there is demand for more diverse, relatable mental health representations. On top of that, adolescents had mixed opinions on seeking help from peers or mental health professionals. This could be an area for therapists and psychiatrists to explore in terms of finding ways to relate more with adolescents, who are hesitant about pursuing professional mental health services.

We assessed pretest attitudes, knowledge, and information-seeking behaviors across gender and sexual orientation. Our results suggest that LGBTQ+ teenagers have fewer negative attitudes toward mental health and are more informed about mental health treatment availability in comparison to heterosexual teenagers. This highlights the resiliency of LGBTQ+ youth, who may be more empathetic and knowledgeable about mental health since such issues are prevalent in the community. We also found that nonbinary teenagers are less likely to know how to handle stress and have less frequent discussions about mental health than boys and girls. This emphasizes the need for teaching coping mechanisms and tools for anxiety and encouraging more conversations about mental health among nonbinary youth. Popular sources of mental health information were the Internet and social media among sexual and gender minority teens, who are more likely to seek information online than offline.

Then, we evaluated pretest/posttest differences in mental health attitudes, knowledge, and behavioral intentions and tested moderators, such as gender, sexual orientation, race/ethnicity, age, and location. Comparing the intervention and control groups, the results suggest that second-screen content helps destigmatize mental health across gender and sexual orientation. Taken together, these findings indicate that additional content associated with the narrative serves as protective in reducing negative attitudes toward mental health among diverse gender and sexual orientation identities. Additionally, the key second-screen message that you are not alone is more effective among younger audiences. Most important, second-screen content encourages discussions about mental health issues among adolescents

and common conversational partners are family and friends.

Delving into the three intervention conditions, the results indicate that second-screen content with peers helps to normalize attitudes toward mental health compared to celebrity content. Furthermore, teens would potentially visit additional resources regardless of the type of second-screen content. Even though it may be difficult to motivate them, interesting or novel content that piques their curiosity could drive their engagement.

Limitations

There were several limitations to our study. The sample was all English speakers, hindering the generalizability of the findings. In the focus groups, participants identified as European American and Hispanic/Latino. There was lack of diverse racial/ethnic representation within the focus group participants. In the experiment, the majority of the participants were from the Western region of the U.S. Additionally, the sample size of nonbinary teenagers was limited ($n = 14$), restricting generalizability of the results. Nonetheless, our findings shed some light on an understudied population. Furthermore, we grouped LGBTQ+ in our analyses; however, we understand that each sexual orientation is unique and there are distinct challenges that each identity faces. As a note, we cannot say with certainty that the moderation component in this study is generalizable due to power limitations. The moderating effects are strongly suggestive and require replication. Follow-up studies should replicate these results with a larger sample and concentrate on solely recruiting sexual and gender minorities.

Despite these limitations, this research provides insight into adolescent sexual and gender minority mental health and serves as support for using media as a tool to positively influence adolescent mental well-being. Our findings raise awareness about the different experiences of nonbinary and LGBTQ+ youth. This study also finds that second-screen content reduces negative attitudes and sparks conversations about mental health. Peer messaging further aids in normalizing mental health. The current study calls attention to understanding adolescent sexual and gender minorities that have been generally underrepresented in research, and the positive impact that media could have on mental health.

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Appendix

Attitudes

- How much do you agree with each of the following statements?
 - If I had a mentally ill relative, I wouldn't want anyone to know (negative attitudes)
 - Most of my friends would see me as being weak if they thought that I had a mental illness (negative attitudes)
 - I would be very embarrassed if I were diagnosed as having a mental illness (negative attitudes)
 - Mentally ill people scare me (negative attitudes)
 - I would cross the street if I saw a mentally ill person coming in order to avoid passing him/her (negative attitudes)
 - I think that mentally ill people are strange and weird (negative attitudes)
 - Mentally ill people do better when they are treated with love and kindness (positive attitudes)
 - There are medications now that can help people to manage/live safely mental illness (positive attitudes)
 - People who are mentally ill could be well if they tried hard enough (positive attitudes)
 - If a relative of mine became mentally ill, I know that I could convince them to get well (positive attitudes)
 - Mental health issues are complex (someone can deal with multiple issues at once, some issues more severe than others) (message related to second-screen content)

Knowledge

- General mental health knowledge: Read each statement below and mark if you think it is true or false.
 - It is important to your mental health that you sleep regularly. (T)
 - To feel very sad and to be depressed is about the same thing. (F)
 - Physical activity has no influence on one's mental health. (F)
 - Using alcohol or drugs does not affect one's mental health. (F)
 - Only troublesome or negative events cause stress; stress is never caused by positive or joyful events. (F)
 - If one is stressed or having a hard time, it is good for your health to talk to other people about it. (T) (message related to second-screen content)
 - If one starts to lose interest in daily activities that one used to enjoy, that could be a sign of depression. (T)
 - One of the differences between being sad and being depressed, is that depression lasts longer than sadness. (T)
 - If a friend tells you about a problem, and your friend does not want you to tell an adult, then you alone should be the only one who knows about the problem. (F) (message related to second-screen content)
 - I know the name of the staff member at my school who is the person to first seek help from for a student with a mental health problem. (T)
 - A person with bipolar (manic depressive) disorder may act overly energetic at times. (T) (message related to the movie)
 - Mental illness is often shown in negative ways on TV and in movies. (T)
- Specific knowledge about mental health skills and resources: How much do you agree with each of the following statements?
 - I have a clear understanding of what may cause mental health problems.
 - I don't know where to turn, should I ever experience mental health problems. (R)
 - I know that there are several different treatment methods for mental health problems.
 - I am aware of how I feel.
 - I am able to put words on what I think and feel.
 - I know how to handle stress.
 - I am able to recognize when a mental health problem becomes too big for me to handle on my own, and therefore seek help or support from others.
 - It is helpful to open up to a person I trust if I am struggling with mental health. (message related to second-screen content)
 - I know that I am not alone, should I ever experience mental health problems. (message related to second-screen content)

Information-seeking

- Rate your degree of confidence from 0 to 100 using the slider given [0-100 (0=cannot do at all, 50=moderately can do, 100=highly certain can do)]:
 - I am confident that I can find useful information about mental illness
 - I am confident that I can participate in conversations and treatments guided by a mental health professional
 - I am confident that I can open up to a person I trust if I am struggling with mental illness.

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- . . .
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Minutes of the Annual Meeting of Members

Saturday, November 19, 2022 | Marriott Marquis, New York, NY

Call to Order

President Laura Seligman called the meeting together at 12:30 p.m. EST. Written notice of the meeting has been sent to all members

Minutes

Secretary-Treasurer Sandra Pimentel presented the minutes of the November 20, 2021 Annual Meeting of Members, which can be found in the March issue of *the Behavior Therapist* at <https://www.abct.org/journals/the-behavior-therapist-journal/> on pages 108-112. They were unanimously approved as submitted.

Expressions of Gratitude

President Seligman thanked David Tolin, rotating off as Immediate Past President; Sandra Pimentel, Ph.D., Secretary Treasurer; Amie Grills, Representative-at-Large; Katharina Kircanski, Coordinator of Convention & Education Issues; Christopher Berghoff, Self-Help Book Recommendations Committee Chair; Patricia DiBartolo, Leadership & Elections Committee Chair; Linda C. Sobell, Fellows Committee Chair; Tina Boisseau, Workshops Chair; Samantha Farris, Institutes Committee Chair; Jason Duncan, Local Arrangements Committee Chair; Emily Thomas, Associate Program Chair; Rosaura Orenogo-Aguayo, Program Committee Chair.

"We all know that to put together a program of this size takes a lot of time and dedication. This year we had 200 members help review program submissions. We also want to acknowledge our 66 Super Reviews and for the 2nd year, 49 student reviewers who helped us out this year. We offer our heartfelt thank you to the 2022 program committee members. Again, thank you."

Program Committee

(*denotes Super Reviewers)

Lauren Alloy, Drew Anderson, *Lisa Anderson, Joye Anestis, Anu Asnaani, Alisa Bahl, Amanda Baker, Miya Barnett, *Kimberly Becker, Stephen Becker, *Emily Becker-Haimes, Kathryn Bell, *Christopher Berghoff, Noah Berman, Jennifer Block-Lerner, Heidemarie Blumenthal,

Christina Boisseau, Maya Boustani, *Lily Brown, *Timothy Brown, *Wilson Brown, Steven Bruce, Amber Calloway, Sarah Campbell, *Will Canu, Nicole Caporino, *Erin Cassidy-Eagle, Nadine Chang, Gregory Chasson, James Cordova, Torrey Creed, Kristy Dalrymple, *Carla Kmett Danielson, *Pooja Dave, Charlie Davidson, Tatiana Davidson, Thompson Davis III, Alessandro De Nadai, *Thilo Deckersbach, *Tamara Del Vecchio, Gretchen Diefenbach, *Laura Dixon, Alex Dopp, Sheila Dowd, *Anthony Ecker, Jamal Essayli, Martha Falkenstein, Kiki Fehling, Megan Hughes Feltenberger, Nicholas Forand, Stacey Forcino, Elizabeth Frazier, Steven Friedman, Patti Fritz, Matthew Gallagher, *Richard Gallagher, *Frank Gardner, Sarah Garnaat, Brandon Gaudiano, *Emily Georgia Salivar, Meredith Ginley, *Jeffrey Goodie, Amie Grills, John Guerry, *Cassidy Gutner, Lindsay Ham, David Hansen, *Rochelle Hanson, Audrey Harkness, Tae Hart, Trevor Hart, Cynthia Hartung, Sarah Helseth, Craig Henderson, *Juventino Hernandez Rodriguez, *Melanie Hetzel-Riggin, Michiyo Hirai, Daniel Hoffman, Laura Holt, Janie Hong, Cole Hooley, *Debra Hope, *Joseph Hovey, Kean Hsu, *Christopher Hughes, Ryan Jane Jacoby, Anna Jaffe, Tejal Jakatdar, Amanda Jensen-Doss, Kathryn Kanzler, Heather Kapson, Elizabeth Katz, Elizabeth Kiel, Hanjoo Kim, *Katharina Kircanski, *Evan Kleiman, Nancy Kocovski, Emily, Kushner, David Langer, *Jennifer Langhinrichsen-Rohling, Yunying Le, Penny Leisring, Greg Lengel, Matthew Lerner, Cheri Levinson, Kristen Lindgren, Danielle Lindner, Patricia Long, Danielle Maack, *Abby Mandel, Kelsey McCoy, *Larissa McGarrity, *Patrick McGrath, *Joseph McGuire, *Carmen McLean, *Alison McLeish, Daniel McNeil, Elizabeth Meadows, Douglas Mennin, *Robert Meyers, Nicholas Mian, Jamie Micco, Alec Miller, John Mitchell, Kelly Moore, *Michael Moore, Taryn Myers, *Brad Nakamura, *Amie Newins, *Michelle Newman, Roisin O'Connor, Kelsie Okamura, Bunmi Olatunji, *Tom Olino, Camilo Ortiz, Mandy Owens, Julie Owens, *David Pantalone, Freddie Pastrana Rivera, *Laura

Payne, Andrew Peckham, *Jacqueline Persons, Sandra Pimentel, Mandy Porter, Mark Prince, Jae Puckett, *Amanda Raines, Elizabeth Raposa, Carla Rash, Simon Rego, Elizabeth Reichert, Lillian Reuman, McKenzie Roddy, *Kelly Rohan, *Michelle Roley-Roberts, Halle Ross-Young, Dustin Sarver, Steven Sayers, *Kelli Scott, Ilana Seager van Dyk, *Kathy Sexton-Radek, Ashley Shaw, *Nicholas Sibrava, Matthew Skinta, Colleen Sloan, Moria Smoski, Laura Sockol, Matthew Southward, *Amanda Spray, *Susan Sprich, *Shari Steinman, Gail Steketee, Eric Storch, *Lauren Stutts, *Kimberli Treadwell, *Emily Treichler, *Shona Vas, *Clorinda Velez, Bianca Villalobos, *Jason Vogler, *Anka Vujanovic, Debbie Warman, Alia Warner, Laura Watkins, Christian Webb, Hilary Weingarden, Jeremiah Weinstock, *Brandon Weiss, *Susan Wenze, Michael Wheaton, *Kamila White, Kate Wolitzky-Taylor, Courtney Wolk, *Erica Woodin, Sheila Woody, Peggie Wupperman, *Ilya Yaroslavsky, *Matthew Young, Alyson Zalta, and Laurie Zandberg.

Student Reviewers

Lucas D. Baker, Nicole Baumgartner, Gina Belli, Rachel C. Bock, Alex Broekhuijse, Casey Brugh, Emily Carlson, Kate Clauss, Mairin Cotter, Joseph Diehl, Julianne Dumont, Katherine Escobar, Kaye "Joey" Essoe, Kalei Glozier, Shayna Greenberg, Reeve Olivia Harden, Cayla Hari, Juliana M. Holcomb, Ellen C. Joseph, Sonalee Joshi, Emily A. Kalantar, Snigdha Kamarsu, Kiran Kaur, Shelby King, Maddison Knott, Rachele Kromash, Jennifer L. Kuo, Persephone Larkin, Ella Amaral Lavoie, Clara Law, Alexandra Leong-Matern, Christina Logan, Tristan Maesaka, Marina Matsui, Kaitlin McGarragle, Emily Miller, Hannah Mitchell, Cristina Nardini, Andrea Ng, Immanuela Obisie-Orlu, Kelsey Anne Ramsey, Shira Richards-Rachlin, Jennifer S. Schild, Linda Thompson, Nataliya Turchmanovych, Kyani Uchimura, Kit Wislocki, Meirong You, and Rebeca Zapata.

President Seligman announced the appointments:

Tina Boisseau, 2022-2025 Convention & Education Issues Coordinator; Emily L. Bilek, 2023 Program Chair; Krystal M. Lewis, 2023 Associate Program Chair; Muniya S. Khanna, Ph.D., 2024 Program Chair; Susan J. Wenze, 2022-2025 Workshops Committee Chair; Aleta G. Angelosante, 2022-2025 Institutes Committee Chair; Kimberli Treadwell, 2022-2025 Self-Help Book Recommendation

Committee Chair; Taryn Myers, 2022 – 2023 Special Interest Groups Committee Chair; Antonette Zeiss, 2022-2025 Fellows Committee Chair; Gregory Chasson, Ph.D. January 2024-December 2026, Editor, *the Behavior Therapist*; and Carmen McLean, Editor, January 2025–December 2028, Editor, *Cognitive and Behavioral Practice*.

Finance Committee Report

Secretary Treasurer and Finance Committee Chair Sandra Pimentel thanked her committee members Ana Bridges, Brian Chu, Jill /Ehrenreich-May, ex-officio member Laura Seligman, and staff members Mary Jane Eimer and Kelli Long for their input and work over the past year.

The Treasurer noted that after two virtual conventions, these are tricky times. She referred to ABCT's 3-legged revenue stool of membership, convention, and publications; in the past, convention typically was the biggest contributor, but now it's publications. We are weathering this storm.

Highlights for 2022 include a projected deficit of \$300,000, which now looks like will bring in \$128,000 income over expenses. She noted the budget aligns with our strategic plan and values, citing those things we supplement, like child care at conventions since 2019, and increased speaker fees.

She noted that Publications is the strongest leg of the stool, bringing in \$358,000 income over expense; membership and convention are strong. She reminded members that we were supposed to have been in Washington this year, but the hotel went bankrupt and staff recovered nicely, including securing \$230 room rates for our block. We also saw webinar growth to \$45,000 in revenue this year.

We are projecting a deficit in 2023. Staff is our largest budget line item. We are moving forward with new staff positions, likely DEI and a communications manager. We continue our conservative investment policy, which has seen us losing only 6% on investments, far better than the market at large.

We are in good hands, she said, and thanked Mary Jane, Kelli, David, Dakota, and all the central office staff.

Academic and Professional Issues Report

Daniella Cavanaugh, reporting for Coordinator Nate Herr, noted that the Board approved the 9 books that the Self-Help Book Recommendation Committee

suggested to be included on the ABCT Self-Help Book Recommendations directory, one of our most frequently visited pages on our website. Chris Berghoff's term ended and Kimberli Treadwell takes the helm.

Nate Herr has been gathering information on PCSAS accreditation, including a conversation with Tom Rodebaugh, DCT at Washington University, which has opted to drop APA accreditation in favor of PCSAS. We plan to determine how ABCT can best provide education and information to its members about accreditation through PCSAS vs. APA, with a goal of understanding concerns from members at all career levels.

Dr. Cavanaugh noted that A&PI's committees are working to build relationships with members and diverse stakeholders (e.g., consult with, and address the needs of, our diverse membership in terms of facilitating research; develop and maintain relationships with US and Canadian funding agencies).

She noted that the World Confederation of Cognitive and Behavioral Therapies will hold the 10th World Congress, hosted by the Asian Cognitive and Behaviour Therapy Association's members: the Korean Association of Cognitive Behavioral Therapy and the Korean Clinical Psychology Association. The Congress will take place in Seoul, South Korea, over the dates of June 1-4, 2023. Dr. Cavanaugh encouraged members to submit papers and attend the congress. ABCT will be hosting the 11th World Congress in 2026. She noted that our International Associates Committee, chaired by Lata McGinn and Keith Dobson, works closely with the WCCBT. We added a new series of interviews with international CBT researchers and clinicians to our website.

Dr. Cavanaugh shared that the Friday-evening Annual Awards was a very full, very successful event under the leadership of Sara Elkins. The committee will continue to address recruitment of awards from underrepresented groups, noting that student awards have shown an increase in submissions from underrepresented groups. The committee will work to support a similar increase in demographically diverse submissions from career professionals at all levels.

Over the past year, they increased collaboration with SIGs that emphasize minoritized/ marginalized groups in order to highlight these awards and solicit additional nominations/applications. They are continuing their work on rubrics for the major award categories, with attention to

how to weight demographic data. Additionally, one of the major awards (Francis C. Sumner Award) is explicitly given to an individual identifying from a Black or Indigenous background. The Call for Awards nominations for 2023 is under way and online at abct.org.

The Academic Training and Education Standards Committee, chaired by Monnica Williams, oversees many subcommittees: Teaching Resources: This subcommittee has contributed syllabi to ABCT's website. They have been successful in gathering more syllabi for underrepresented areas, but still would like to focus on more diversity-related content or syllabi with diversity/DEI well-integrated into them. Also, they are working with CAPPs on video resources for clinical techniques, developed rubric for resources on how appropriate they are for the ABCT website. Dissemination-Implementation: They had been working on collecting surveys from training directors, and had collected at least 150 as a few months ago. Spotlight on a Mentor: Were acknowledged during the Friday evening awards ceremony. Medical Educator Directory: Under the guidance of Erin Berman, this committee merged with the ABCT Find-a-Researcher Directory group. Training Guidelines for Terminal Master's Degree: Three members will present a panel at the convention that addresses the theme of MA-level psychologists "Preparing the Next Generation of Frontline Mental Health Therapists: Assessment and Teaching of Scientific Competence for Master's-Level Health Service Psychology Students." They also submitted a manuscript in August called "Scientific Competence and Health Service Psychology Master's Training: An Outline for an Applied Methodology Course" and are waiting for feedback on the manuscript. Best Practices for Culturally Informed CBT: Andrew Bertagnolli is coordinating this initiative and we should have an update shortly on the progress of a manuscript that have been developing.

Our Dissemination and Implementation and Stakeholder Engagement Committee, chaired by Erum Nadeem, is our newest committee to ABCT's governance. They are still exploring their agenda. They have taken on the Champions Program and acknowledged 9 new champions that were acknowledged during our Awards Ceremony and added to our website, support the Program Chairs around stakeholder engagement and D&I integration into convention program, and will con-

continue to help facilitate launch of Wikipedia project.

Chair Ryan Jacoby and members of the Research Facilitation Committee Chair oversee our annual Graduate Student Research Grant award. The committee is working with ABCT staff to create a “find-a-researcher” tool so members can search the ABCT member directory to find grant collaborators, symposium speakers/discussants, etc. They continue to do quarterly researcher spotlights, which are featured on ABCT’s Forums and online (<https://www.abct.org/researcher-spotlights/>) with a focus on the GSRG winner (winter), health disparities researcher (spring), early career researcher (summer), mid-career researcher (fall).

In the past year they have recruited two new members to the committee, including one member who is knowledgeable regarding grant funding in Canada (Skye Fitzpatrick) and a second member who will serve as a liaison between ABCT and agencies that set the agenda and provide funding for activities relevant to ABCT’s core mission and values (Joseph Carpenter). Dr. Carpenter oversees ABCT’s participation in the following coalitions: Consortium of Social Sciences Associations [COSSA]; Mental Health Liaison Group (MHLG); Coalition for the Advancement and Application of Psychological Science [CAAPS]; sessions sponsored by NIH as the representative of ABCT, take meeting notes and reporting back to ABCT leadership. Lessons learned from these meetings will be shared with the broader ABCT membership as applicable.

Convention Issues Report

Katharina Kircanski thanked Stephen Crane, ABCT’s Convention Manager, for an excellent convention. She noted the safety protocols in place, and reported we have 3,700 attendees, far more than the projected 2,700, which helps to explain and leads to crowded talks.

Program Chair Rosaura Orenco-Aguayo and Associate Program Chair Emily Thomas worked with the President and ABCT staff to develop and deliver the scientific and professional program. Their many efforts are archived in the September 2022 issue of the Behavior Therapist (link here, scroll to page 216). They focused on increasing transparency to promote greater access and equity in the review and decision process; this included two virtual Town Halls; masked review process; review criteria clarified and better aligned with

NIH review criteria; steps to increase representation of diverse populations, women, and various career stages; and an a priori plan for SIG-sponsored submissions; and reviewer training.

She thanked Lily Brown and the CE Committee for expanding our webinar program; we look forward to seeing you all in Seattle, November 16-19, 2023.

Membership Committee Report

Coordinator Shari Steinman reported that the Fellows Committee, chaired by Linda Sobell, recommended eight candidates for fellow status that were acknowledged on our website and at the Awards Ceremony; Leadership & Elections Chair Patricia DiBartolo and her committee are examining alternate ways of how we handle the nomination process and hold elections; the Membership Committee developed a Membership Panel for the 2022 Convention: Incorporating Anti-racism Training in Clinical, Academic, and Hospital Settings; and the Student Membership Committee has two panels: “Integrating Identity- and Justice-Oriented Work During Graduate School and Beyond: An Intersectional Discussion” and “Getting Into Graduate School.”

She noted that the Clinical Directory & Referral Issues committee launched International Influencers project on the web; and Social Media and Networking Committee has been providing convention coverage and is working to create procedures for how to deal with urgent issues that occur online during the convention.

Publications Coordinator Report

Susan White reported that the Impact Factor for both journals continues to increase, with *Behavior Therapy* topping 4 and *Cognitive and Behavioral Practice* over 3; submissions have declined, however, and reviewers are becoming increasingly hard to find. In reaction we launched a Reviewer of the Year recognition program for the journals.

She noted that we signed a new 7-year contract with Elsevier; we selected Greg Chasson as Editor for *tBT* starting in 2024 and Carmen McLean as Editor for *C&BP* starting in 2025.

We are looking to work on podcasts in 2023 and explore Open Access journals.

In the coming years, we want to develop policies that will permit Publications and the organization as a whole to be more proactive in how we work to consider and work to reduce harms related to therapy.

Executive Director’s Report

Executive Director Mary Jane Eimer reported that our new database has permitted a smooth registration process. She noted that the convention submission process and registration are both valued and hated.

We are revisiting our policies and procedures, an initiative begun under President Seligman. This is in part an effort to increase transparency.

We hired BARE to serve as our DEI consultants. We are developing job descriptions for a new position; it’s not fully fleshed out yet but is likely to include PR and/or media outreach.

She thanked our financial advisor, Brian McGrath, who has helped us weather an incredibly difficult storm these last couple of years.

We will be holding our next strategic retreat in May.

She thanked ABCT’s staff, including Kelli Long, our bookkeeper, and Stephanie Schwartz, our Managing Editor and the staff member who does most of our fabulous design work, neither of whom are attending the convention. We hired Rachel Lamb as administrative secretary; she, Tonya Childers, and Dakota McPherson, our millennial, are manning registration. Dakota worked closely with David Teisler, our Director of Publications, to transition both our database and website to new platform. Tonya is our problem solver.

We’ve also welcomed new members from Low- and Middle-income countries and from HBCUs and LatinX institutions. We had our first set of scholarships for students in need.

We invite you to our offices here in New York. Think of them as yours because, well, they are. We have a conference room if you need a neutral space for a meeting.

President’s Report

Fifty years after Jerry Davison’s presidential address, ABCT released a public apology for the role our field played in the development and dissemination of so-called conversion therapy. We also established the Charles Silverstein Social Justice Award. While there has been much controversy around the apology and response, this apology started a national conversation in the field. While painful, I am proud that ABCT and our Board led the way. We did extensive research on the call for retractions. The Publications Committee drafted a proposed retraction policy, but has since

deferred to Elsevier's policy. Our own policies will need to be reviewed.

We hired BARE to help us with our DEI posture. They've started their work.

We have hosted two Town Halls on elections and the convention review process.

We have made strides in working with OUP to collaborate on a project to make available translations of treatment manuals. We began collaborating with SSCP and APA on a task force to examine actions that our organizations could be taking to decrease the harms that are

occurring due to the use of so-called conversion therapy and related treatments.

I think we need to align our budget with our strategic plan and our mission. ABCT went into the pandemic in a very strong financial position, fortunate for that but we need to balance risk so that we are sure that we are using members' money to fully realize the mission of ABCT.

President-Elect's Report

The President-Elect noted that she's been a member since 1996, and she wants to promote the interests of this organiza-

tion that has been her home for almost three decades.

Transition of Officers

The President welcomed Sandra Pimentel, as 2022-2023 President-Elect; Daniella Cavenagh, as 2022-2025 Representative-at-Large and liaison to Academic and Professional Issues, and Barbara Kamholz, 2022-2025 Secretary Treasurer. She then turned the gavel over to Jill Ehrenreich-May, ABCT's new President.

President Ehrenreich-May adjourned the meeting. ■

Call for Applications

FELLOWS

ABCT Fellow Status for 2023
Application Deadline: July 31

ABCT Fellow status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role. Because members' career paths come with unique opportunities, the committee is sensitive to the environment in which the applicant was functioning, and we weigh the contributions against the scope of the applicant's current or primary career.

Multiple Routes to ABCT Fellow Status

ABCT now offers 6 areas of consideration for Fellowship status: (a) clinical practice; (b) education and training; (c) advocacy/policy/public education; (d) dissemination/implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse the area(s) in which they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow; demonstrating outstanding, sustained effort in one area is all that is required. What guides the committee's decision making is determining if an applicant has made an exceptional, sustained contribution that goes beyond their work role expectations.

Who is Eligible to Apply for Fellow Status? (a) Full membership in ABCT for > 10 years (not continuous); (b) Terminal graduate degree in behavioral and cognitive therapies or related area(s); and (c) > 15 years of professional experience following graduation. Two letters of reference are required; one should be from an existing ABCT Fellow. If the latter requirement is a barrier to applying, please contact the Chair of the Fellows Committee at fellows@abct.org, who will then assist in determining how to best handle this request. The Committee encourages qualified and diverse applicants to apply.

The Fellows Committee strongly recommends that potential Fellow applicants as well as their letter writers describe the applicant's specific contributions that are outstanding and sustained. To aid in writing these letters, the Fellows Committee prepared Guidelines for Applicants and Letter Writers for how to write fellow status contributions <https://www.abct.org/Members/?m=mMembers&fa=Fellow>. While these guidelines provide examples of what the Fellows committee considers outstanding, sustained contributions, they are far from exhaustive.

Deadline for Fellow Status Applications: : July 31, 2023, is the deadline for both applicants and letter writers to submit their materials. Applicants will be notified of the decision on their application by mid-October 2023. For more information, please visit the Fellowship application page: <https://www.abct.org/Members/?m=mMembers&fa=Fellow>

ABCT Fellows Committee

Antonette Zeiss, Ph.D., Chair; Christopher Martell, Ph.D., Vice Chair; J. Gayle Beck, Ph.D.; Brian Chu, Ph.D.; Debra Hope, Ph.D.; Simon Rego, Ph.D.; Maureen Whittal, Ph.D.

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| call for nominations |

ABCT's **Champions of Evidence-Based Interventions**

This award recognizes outstanding individuals who have shown exceptional dedication, influence, and social impact through the promotion of evidence-based psychological interventions, and who have thereby advanced the mission of ABCT.

Potential Candidates Nominees should demonstrate the characteristics of champions, broadly construed, as recognized in the implementation science literature (see Knudsen et al., in the Jan. 2019 issue of *tBT*: <https://www.abct.org/journals/the-behavior-therapist-journal/>). Champions are those individuals who support, facilitate, diffuse or implement the core assets of evidence-based interventions. Champions' efforts expand the scope and impact of evidence-based interventions beyond the reach of researchers alone. They are "change agents," differentiating themselves from others by their visionary quality, enthusiasm, and willingness to risk their reputation for change. Ideal candidates should have demonstrated the following: (a) communicating a vision and impact of evidence-based psychological interventions; (b) going above and beyond in their efforts to relentlessly promote innovation; (c) actively leading positive social change; and (d) making a substantive impact. Although both members and nonmembers of ABCT are eligible for the Champions award, research faculty are typically not a fit for this award.

How to Nominate Email your nomination to **Champions@abct.org** (link to nomination form is on the Champions web page). Be sure to include "Champions Nomination" in the subject line. Once a nomination is received, an email will be sent from staff, copying the DISEC Chair. The nomination will be reviewed by DISEC, and if deemed appropriate for our program, will be forwarded to the ABCT Board of Directors for final approval. Once reviewed and approved by the Board of Directors, the nominee will be contacted directly by the President, followed up with an ABCT staff member for a final review of the copy to be posted on the ABCT website.

For full information: <https://www.abct.org/membership/abct-awards/abct-champions/>

DEADLINE: May 1, 2023