

Investigating the Effect of Group Process on Depression for LGBTQIA Adolescents

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May 12, 2017

**Abstract**

This quantitative study implements secondary data to analyze the impact of a psychoeducational group on reported depression scores from teenagers identifying on the LGBTQIA spectrum.

Teenagers participating in this group completed Beck's Depression Inventory, 2<sup>nd</sup> Edition (BDI II) before entering the group then completed another BDI II after completing the 12 week group.

A paired samples t-test was used to investigate the relationship between reported depression scores and participation in the group. Results corroborated previous findings that group participation impacts reported depression scores, but further research is needed to determine specific causation of the changes in scores.

## **Literature Review**

Struggles associated with identification and expression of non-normative sexuality or expression are widely researched and documented. Individuals who identify with a sexual minority label such as being lesbian, gay, bisexual, transgender, queer, intersex, or asexual (LGBTQIA), questioning one's sexual or gender identity, among others, often report more emotional adjustment and behavioral difficulties than heterosexual individuals (Williams, Connolly, Pepler, & Craig, 2005). These difficulties stem from more use of emotional, physical, spiritual, and cognitive resources for LGBTQIA teens, leaving LGBTQIA teens more prone to depression than their heterosexual peers (Williams et al., 2005). A commonly accepted, well researched and financially efficient way of treating depression is in group settings (Chiang et. al, 2015; Feng, et. al, 2012; Sochting, 2014; Watkins et. al, 2011). This literature review will first briefly define and explain the period of adolescence for heterosexual individuals to provide a base of general knowledge of this period of change and growth that both heterosexual and LGBTQIA teens encounter. Specific developmental trajectory and challenges for LGBTQIA teens will then be reviewed with particular attention on identity development. Then, the mental illness of depression will be explored. Additionally, the effect of group process will be examined giving attention to specific markers of how process is observed in groups. Finally, the relationship between depression and the LGBTQIA adolescent population will be investigated.

## **Adolescence**

Adolescence is a time of physical and psychological growth, transition, and identity discovery. Culture plays a significant impact on how long adolescence lasts, but most Western countries view this time period starting with puberty and ending at age eighteen (Seagrave &

Grisso, 2002). For the purpose of this literature review, adolescence will mean the period of development between age twelve to eighteen. During these six years of development, teens experience rapidly changing bodies that can as much as double in size while they also develop more adult like physical features (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). They are also becoming sexually mature, which includes physical changes as well as new feelings about their bodies, sexuality, intimate relationships and gender identity (MacNish, 2015). Christie and Viner (2005) briefly explained different theorists' ideas about adolescent development. Sigmund Freud focused on psychosexual development, seeing adolescence as a recapitulation of the development of sexual awareness in infancy (Christie & Viner, 2005). Jean Piaget studied cognitive development, as abstract thinking marks the transition to independent adult functioning (Christie & Viner, 2005). Erik Erikson investigated psychosocial development and identified the tensions around the development of personal identity as central to the notion of adolescence (Erikson, 1968). These three pioneers in developmental psychology advanced the understanding of adolescence. Expanding on Erikson's psychosocial model, the biopsychosocial approach acknowledges that adolescence has biological (puberty and sexual development) as well as psychological and social elements (Arnett, 2015).

Arnett (2015) described biological, cognitive, and social changes that come with adolescence. Biologically, adolescence is indicative of the expansive physical growth, changes to the sex organs, height, weight, and muscle mass, as well as major changes in brain structure and organization (Arnett, 2015). Additional physical changes include the body of an adolescent doubling during puberty, the most expansive growth since childhood (MacNish, 2015). Changes in sex organs occur during this time, such as the growth of testes and penis in males and uterus and vagina in females. Secondary sex characteristics such as the growth of pubic hair, deepening

of the voice and development of sweat glands occur in both sexes. Gender specific sex characteristics include breast development and widening of hips in females and broadening shoulders in males (MacNish, 2015). These changes, along with cognitive and social changes, impact how adolescent identity is formed and solidified.

Christie and Viner (2005) described cognitive changes in adolescence, including changes to the ability to think abstractly and multi-dimensionally. Five areas of cognition that change during puberty are attention, memory, processing speed, organization, and metacognition (Christie and Viner, 2005). Selective attention, the ability to focus on one stimulus at a time, and divided attention, focusing on multiple stimuli, increase during this time period (Seagrave & Grisso, 2002). Both working memory and long term memory increase, as does processing speed. Organization and metacognition are improved due to the ability to think abstractly (Arnett, 2015). These five changes to cognitive abilities have a large impact on identity formation and personality.

There are also social changes that occur during adolescence including the formation of their identity and self-concept in relation to others. Erikson (1968) described adolescence as an exploratory period where individuals practice different behaviors and roles to discover identity and solidify roles. Self-concept, self-esteem, and sense of identity are integral to identity development (Bilbeau & Renn, 2005). Of particular importance to this literature review is the concept of gender identity. Steensma et al. (2015) defined gender identity as the extent to which a person experiences oneself to be like others of the same gender. Gender specific behaviors increase during this time in an effort to be seen as attractive to other peers due to increased interest in dating and romantic relationship (Bilbeau & Renn, 2005). In general, males tend to be

attracted to feminine hair styles, feminine shaped bodies and facial features, and feminine scents (MacNish, 2015). Females are generally attracted to males who appear masculine, strong, tough, and handsome (MacNish, 2015). Therefore, some increase in gender-stereotyped social behavior results from these efforts to be seen in peer groups as attractive.

The period of adolescence is marked with biological, cognitive, and social changes, occurring within a relatively short time period of development. Changes in appearance, the way one thinks, and the different societal expectations are difficult to traverse. One result of adolescence is the formation of gender identity and expression. In LGBTQIA teens, this part of adolescence is particularly challenging to traverse.

### **LGBTQIA Adolescent Identity Formation**

The formation of identity is one of the major developmental tasks associated with adolescence (Bilodeau & Renn, 2005). Adolescents begin to form a cohesive sense of self, achieve a balance of autonomy and belonging, and demonstrate independence while concurrently being supported by their caregivers during this period of development. Developing an individual's identity enhances their sense of psychological well-being, including feeling a sense of belonging in their own body and in their culture (MacNish, 2015). When adolescents experience accomplishments that lead to a sense of independence and connectedness, self-confidence, self-respect, and interdependence are impacted. (Corey, Corey, & Corey, 2010). Adolescents who struggle in developing their individual identity as it relates to their family, peers, community, or culture as a whole can become distressed.

Research has shown that a pertinent issue in adolescents identifying with a sexual minority is identity formation (Steensma et al., 2013; Williams et al, 2005). Identity formation

involves a process of defining what it means to be a sexual minority and understanding and accepting one's self-concept despite the stigma and discrimination surrounding the sexual minority group (Bilodeau & Renn, 2005). For LGBTQIA adolescents, identity is often developed without the support of family, forcing them to make sense of a marginalized identity and navigate potential negative experiences associated with that identity alone (DiFulvio, 2011).

A key aspect of a sexual minority adolescent's identity formation is the coming out process in which individuals overcome hiding their true identity. During the coming out process, individuals can be subject to misunderstanding, rejection, and stigmatization from both their family and peer group (Steensama et al., 2013). After a negative coming out experience, adolescents can experience many negative impacts on life wellness. These impacts include decreased academic performance, school dropout, homelessness, substance abuse, criminal activity, sexual victimization, and sexually transmitted diseases (Hatzenbuehler et al., 2005). LGBTQIA adolescents are also susceptible to numerous mental health issues that correspond with high levels of stress and rejection such as suicidality, depression, anxiety, dysregulated emotions, and behavioral outbursts (Williams et al., 2005).

This population is at risk for rejection, discrimination, decreased social connectedness, and stressful negative experiences related to their identity (Steensama et al., 2013). Adolescent growth in the realms of sexual, emotional and social development are important in understanding how identity is formed and expressed. These three areas are also important in learning the origin of depression and other mental health concerns in LGBTQIA youth.

### **Sexual Development**

The term 'sexual identity' covers several domains including sexual orientation, sexual behavior, gender identity and expression, sexual attraction, and biological sex (Bilodeau & Renn,

2005). The domains of sexual identity are placed along a continuum. This continuum allows individual change and alterations as time and circumstances pass (Pleak, 2009). The developmental period during which individuals typically begin to question where they belong along the sexuality spectrum is the aforementioned period of adolescence (Williams et al, 2005). Formation of sexual identity starts earlier in childhood but adolescence invites a cognitive maturation that causes individuals to question their identification with gender and sexual orientation as it relates to one's culture. Adolescents become aware of sexual feelings and in some instances, this can cause confusion about their sexual orientation and sexual attraction (Steensma, et al., 2013).

During sexual identity development, individuals identifying with a sexual minority tend to withhold their minority identity with their families, resulting in deficits in learning coping skills necessary to handle the stress of their stigmatizing experience (Bilbeau & Renn, 2005). LGBTQIA teens find this period of development to be extremely stressful due to having to navigate a socially stigmatized identity where identity development itself is difficult to traverse. The emergence of a socially stigmatized identity can lead to difficulties in emotional and social development, such as isolation and rejection in peer and family encounters, as a result (Hatzenbuehler et al., 2005).

### **Emotional Development**

Difficulty regulating emotions is a core feature of the onset of emotional and behavioral issues in adolescence (Byne et al., 2012). Adolescents face many stressors that make it difficult to self-regulate their emotions including the pressure to succeed and the need for approval from others. At the same time, adolescents are beginning to navigate life with increased freedom and finding a balance between dependence and independence; a stage of development known as

identity versus role confusion (Erikson, 1968). In this stage of adolescent development, individuals become increasingly aware of and worried about how others perceive them, resulting in self-consciousness. This heightened awareness and self-consciousness impacts self-esteem, creating an environment where teens are tremendously vulnerable. High self-esteem can act as a protective factor against mental health issues, further impacting those that exhibit low self-esteem (Steensma et al., 2013).

It is critical to help sexual minority adolescents navigate and discover their beliefs about themselves and how to adaptively manage their emotional responses to societal expectations (Dowlatabadi et al., 2016). This is especially important for LGBTQIA teens because of the aforementioned increased risk of isolation, lack of support, and stigmatization. Experiences of stigmatization can cause sexual minority adolescents to feel stressed and devalued creating low self-esteem (Bilodeau & Renn, 2005). In attempting to increase self-esteem, maladaptive coping skills may be developed, leading negative impacts to adolescent well-being, personal beliefs, and sense of control (Erikson, 1968).

### **Social Development**

Social relationships are important to the sense of self in relation to the world and others. Adolescents tend to feel as though they are misunderstood, treated unfairly, and often judged (Bilodeau & Renn, 2005). There is also a natural tendency to seek out peer groups for validation and companionship suggesting that social connectedness is crucial in adaptively progressing through adolescence (Bilodeau & Renn, 2005). Social connectedness refers to a belonging, where adolescents experience that they are cared for and empowered within familiar contexts such as home, school, and the community. MacNish (2015) explained that positive adolescent

social development influences an adolescent's well-being and self-esteem and can be found to decrease anxiety and depression.

Williams et al. (2005) highlighted that peer environments, as described by LGBTQIA adolescents, include negative and stigmatized peer relationships, bullying, and sexual or psychological harassment that make forming social relationships particularly difficult. Williams et al. (2005) suggested that depression and externalizing symptoms occur within LGBTQIA adolescents due to victimization experiences and lack of social support. According to the American Psychological Association, or APA (2005) one-third of LGBTQIA adolescents reported fearing losing friends, while approximately one-half of their participants reported the loss of friends had already taken place. The concept of social support or lack thereof is experienced in both peer and familial contexts (Williams et al., 2005). This lack of support from family can be especially impacting as basic needs of food and shelter are compromised.

The previous sections have discussed how LGBTQIA adolescents may encounter complications with psychosocial adjustment including sexual, emotional, and social development as they pertain to their identity. LGBTQIA adolescents are at risk for discrimination and a stigmatized identity that can lead to many mental health issues including depression. Defining depression with specific implications for LGBTQIA teens are highlighted in the following section of this paper.

### **Depression**

The Diagnostic Statistical Manual, Fifth Edition (DSM-5) gives diagnostic criteria for major depressive disorder (APA, 2013). This includes depressed mood for a period longer than two weeks resulting in impaired functioning. Specific symptoms of depression include depressed mood or irritability for most of the day, decreased interest in most activities, significant weight

change or change in appetite, changes in sleep, changes in activity level, fatigue, guilt or worthlessness, decreased concentration and suicidality (APA, 2013). Examples of depression can be seen throughout the life span and across gender and sexual identity expression. For this literature review, the focus is on adolescents affected by depression. The National Institute for Mental Health (2015) estimated twelve percent or 3 million adolescents, aged twelve to seventeen, experienced at least one episode of depression in the United States in 2014. The prevalence of adolescents that have depression in America varies depending on the source, with most studies providing a range from 4% to 20% (Abela and Hankin, 2008; National Institute for Mental Health, 2015; Thapar, Collishaw, Pine, & Thapar, 2012; Weisz, McCarty, & Valeri, 2007). Included in the estimated 3 million teens with depression are teens identifying on the LGBTQIA spectrum. Specific implications for depression and LGBTQIA teens are explained in the next section.

### **LGBTQIA Teens and Depression**

Recent literature has documented that LGBTQIA youth are more likely than their heterosexual peers to experience a range of mental and emotional health risks (APA, 2015; Craig, Austin, & McInroy, 2014; Hatzenbuehler, McLaughlin, Keyes, and Hasin, 2010; Williams, Connolly, Pepler, & Craig, 2005). LGBTQIA teens are vulnerable to high rates of depression, self-harm, suicidal thoughts, homelessness, substance abuse, and crime involvement (APA, 2015) for a variety of reasons which will be examined in the following paragraph. In addition, LGBTQIA teens are at risk for school and academic problems, which is heightened by the homophobia, harassment, victimization, and bullying they endure (Craig, Austin, & McInroy, 2014).

Due to their minority status, the period of adolescence, roughly from 12-18 years old, becomes a challenging period of life for LGBTQIA. In addition to psychological and cultural predispositions, Craig, Austin, and McInroy (2014) described isolation, lack of belonging at home, school, community, homelessness, low self-esteem and internalized homophobia as contributing factors LGBTQIA teens may also face. Amola and Grimmett (2015) described internalized homophobia as a cognitive, emotional, and behavioral process that occurs when negative attitudes and beliefs about homosexuality are personally adopted by an individual identifying on the LGBTQIA spectrum. Among LGBTQIA, low self-esteem and internalized homophobia have been found as a negative correlation between anxiety, depression, and psychological distress (Craig et al., 2014). These contributing factors and predispositions highlight the need for interventions to treat LGBTQIA teens who are experiencing depression. One such intervention, group counseling is described in the following section.

### **Group Counseling and Process**

#### **Group Counseling**

Group counseling is a modality in treating depression that uses group members' interactions with one another as a way to connect, solve problems, and grow (Feng et al., 2012). Depending on the style of the group, the therapist's role varies greatly, but the concepts of group content and group process are integral parts of group counseling (Corey et al., 2010). Content refers to the substantive aspect of group therapy, the subject matter that is discussed during sessions (Lee, 2014). Process refers to how that information is being discussed among group members and the impact on group member relationships (Olsen, 2009). The following section expands on group process and will identify eleven therapeutic factors in group therapy that facilitate change through the use of process.

## Group Process

Defining group process varies widely, but a commonly accepted and uncontroversial explanation of this term refers to the development and evolution of relationships between and among group members (Yalom & Leszcz, 2005; Beck & Lewis, 2000). Olsen (2009) described group process as how group members relate to one another and experiencing the group impacts belongingness, cohesion, trust, meaningful self-disclosure, feedback, reality testing, modeling, conflict resolution, and positive reinforcement. The group setting also provides a safe atmosphere to use as a testing ground for practicing new social behaviors with others and receiving feedback in the moment about these behaviors (Lee, 2014).

As a groups progress, interactions between group members impacts relationships, self-awareness, and interpersonal functioning (Beck & Lewis, 2000). The therapist's role in the group process is that of facilitator according to Yalom and Leszcz (2005), reminding group members of boundaries and group rules that serve to provide an atmosphere of safety and security, both vital to psychological work. The role of facilitator becomes especially important when group boundaries and rules are not respected, either intentionally or unintentionally. Task drift, time and spatial boundaries, and work-role boundaries are examples of times when the group leader is valued to keep members working toward their goals (Feng et al., 2012).

To specifically see how change occurs in groups, Yalom and Leszcz (2005) described eleven group therapeutic factors that serve as facilitators of change. These eleven factors do not occur in chronological order, nor do they function separately. They are interrelated and interdependent on one another to facilitate change as the group progresses. *Instillation of hope, universality, imitative behavior, imparting of information, altruism, group cohesiveness, existential factors, catharsis, interpersonal learning, development of socializing techniques and*

the *corrective recapitulation of the primary family group* all work together and are emphasized a varying times in the group to elicit change in group members through the group process (Yalom & Leszcz, 2005). Each of these factors are briefly discussed below.

*Instillation of hope* refers to the idea that recovery and change is possible (Yalom & Leszcz, 2005). Creating this sense of optimism is an important part of group process as hope provides relief and restoration to one's being (Lee, 2014). Related to relief is the concept of *universality*. Universality is the knowledge and acceptance that others have similar struggles and that one is not alone (Olsen, 2009). These two factors of group process give rise to the possibility of symptom amelioration both through oneself and group members.

When group leaders share knowledge and provide didactic instruction, *imparting of information* occurs (Corey et al., 2010). In many groups the knowledge provided includes information about a mental illness and the process of recovery (Lee, 2014). Another way that recovery is facilitated in group settings is through *imitative behavior*. With roots in social learning theory, imitative behavior involves demonstrating alternatives to maladaptive behaviors group members have previously implemented (Yalom & Leszcz, 2005). These behaviors are meant to model effective social skills that improve interpersonal communication (Corey et al., 2010). Within the safety of the group setting, members are able to practice new skills with limited risk of rejection. This occurs when group members learn from each other and model one another's coping and recovery skills.

*Altruism* involves helping others, which in a psychotherapeutic paradigm is seen as members helping each other through struggles and boosting one another's self-esteem (Corey et al., 2010). Oftentimes, altruism renews one's sense of purpose and members find meaning in helping others. The abundance of altruism in the group setting contributes to *group cohesiveness*.

The value, unconditional acceptance, and support members get from one another results in a sense of belonging and feelings of warmth and comfort in the group, known and contributes to group cohesiveness (Yalom & Leszcz 2005).

*Existential factors* encountered in a group setting include recognizing that each individual is accountable and responsible for how he or she lives (Yalom & Leszcz, 2005). As the group progresses and interpersonal relationships improve, personal responsibility is important because the group will not last forever. Yalom and Leszcz (2005) explain that regardless of the closeness of relationships, life is still ultimately faced alone. Existential factors provide grounding that life can be unfair and unjust and that no one is immune from pain and death. Death anxiety results from a lack of awareness of the finiteness of life. Grounding groups in this framework suggests that individuals can become authors of their own personal story (Yalom & Leszcz, 2005).

Oftentimes during the reauthoring process that occurs during group, powerful emotions are uncovered. *Catharsis* is the release of these emotional tensions. Group members find relief after expressing feelings verbally and nonverbally (Yalom & Leszcz, 2005). Examples of catharsis include crying, yelling, journaling, and kicking or hitting pillows.

*Interpersonal learning* occurs when group members learn that their actions and words have power and impact others (Yalom & Leszcz, 2005). Members also become aware of particular maladaptive behavioral patterns and how their environment and social interactions have impacted their growth (Olsen, 2009).

In group therapy, members learn how others view their social skills and social interactions. *Development of socializing techniques* may uncover how their ineffective social habits impact relationships (Yalom & Leszcz, 2005). In learning new ways to discuss feelings,

concerns, and observations group members gain assertive and empathic communication skills that generalize into members' daily lives.

Feng et al. (2012) explained that group members naturally and unconsciously assume roles that correspond to previous roles in one's family. Behaviors, attitudes, communication styles, and interactions reflect what group members learned as a child. Maladaptive defense mechanisms such as rebelling, keeping quiet, distrusting others, or taking charge will appear in the group setting. Through interactions, modeling and practice of newly learned social skills, these behaviors are identified and changed. This process is known as the *corrective recapitulation of the primary family group* (Yalom & Leszcz, 2005).

As participants interact in the group, these eleven therapeutic factors describe group process and how change occurs in the group setting. Although these therapeutic factors were developed with adults in mind, Corder, Whiteside, and Haizlip (1981) report that adolescent groups encounter the same factors to facilitate change.

### **Group Counseling and Adolescent Depression**

While there is a gap in the research investigating the effect of group process and LGBTQIA depression, significant research has suggested the efficacy of group counseling and amelioration of depressive symptoms (Feng et al., 2012; Weisz, McCarty & Valeri, 2007). Much of this research has focused on manualized group treatment of depression, making similar results able to be replicated. Typical group programs include eight to twelve weeks of weekly 90-minute sessions designed to improve problem-solving skills and techniques and to cope with negative and irrational thoughts (Feng et al., 2012). In a meta-analysis of 32 group counseling interventions for depression, Feng et al. (2012) observed that group treatment of depression had an immediate and continuous effect over six months, lowering the relapse rate of depressive

episodes. Weisz, McCarty, and Valeri (2007) echoed the effectiveness of group treatment for depression in adolescents, but go a step further when they concluded that effects appear to be consistent for initial months following treatment but symptoms reappear after a year or more without treatment. This suggests that many people will need continued treatment to relearn and practice skills learned in therapy.

This literature review has attempted to establish a link between depression in LGBTQIA teens and the process of group therapy. First, the period of adolescence was described followed by sexual, emotional, and social development of LGBTQIA teens. This time of intense, expansive growth has many implications for identity. Teens who identify on the LGBTQIA spectrum encounter different identity and expression struggles when compared to heterosexual peers (Williams et al., 2005). Overtime, these struggles may develop into chronic mental health concerns including but not limited to depression (Seagrave & Grisso, 2002).

Following the discussion and highlights of adolescence for both heterosexual and LGBTQIA adolescents, depression was explored with a particular focus on the LGBTQIA adolescent community. Factors such as isolation, lack of belonging at home, school, and in the community, homelessness, low self-esteem and internalized homophobia contribute to an increased proportion of LGBTQIA teens experiencing mental health concerns (Craig et al., 2014). An attempt to explain how group therapy would impact this population was made following the highlight of predispositions that lead to higher rates of depression. While current research is limited on group process and depression in LGBTQIA adolescents, this literature review has outlined the factors that contribute to the manifestation of depression and the curative factors that lead to amelioration of depressive symptoms through the group process (Yalom & Leszcz, 2005).

## **Method**

### **Participants**

The 21 participants in this analysis were clients attending a psychoeducational group focused on gender identity and expression in the northeast United States. These clients range in age from 12 to 18. Socioeconomic status of participants is unknown, but low, mid, and high socioeconomic backgrounds are served by the outpatient clinic. Members of the group identify on the LGBTQIA spectrum, with 6 participants identifying as male, 9 as female, and 6 in transition, either from male to female or female to male. Nineteen participants identify as Caucasian, while two participants identify as Black.

### **Materials**

The Beck Depression Inventory, second edition (BDI-II) was used as both a pretest and posttest. The BDI-II is a 21 item self-report instrument that assesses the impact of depressive symptoms on daily life and functionality (Dolle et al., 2012). When scoring the BDI-II, each item has a possible value of 0, 1, 2, or 3. A total score of 0-13 signifies minimal impairment, 14-19 reflects mild impairment, 20-28 corresponds to moderate impairment, and 29-63 indicates maximum impairment due to depressive symptoms (Dolle et al., 2012). The BDI-II has been widely researched, with a reliability coefficient of .92, significant at  $p > .001$  and construct validity of .93, significant at  $p > .001$  (Dolle et al., 2012).

### **Procedure**

A quantitative design using pre and posttest secondary data was used for this research. Participants were assigned a number to preserve confidentiality. The data used was taken from an electronic record database and will examine BDI-II scores from the past two years (2014-

2016). BDI-II total scores were used, omitting any subscores. SPSS software was used to analyze the data for significance.

In SPSS, descriptive statistics and a paired t-test were performed on the data. BDI-II scores serve as the dependent variable and group participation as the independent variable. The researchers surmise that BDI-II scores will decrease following the intervention of group participation. These statistical analyses were conducted to examine whether there are statistically significant differences among depression scores following group participation.

### Results

The analysis of the raw data yielded the results found in Table 1.

Descriptive Statistics:					
	n	Minimum	Maximum	Mean	Standard Deviation
BDI Pretest	21	0	35	14.33	9.96
BDI Posttest	21	0	20	9.62	5.79
Paired <i>t</i> -test:					
	df	t	Mean Difference	<i>p</i>	
	20	2.91	4.71	0.009	
Table 1					

As seen in Table 1, depression scores decreased following group intervention. These reported symptoms of depression, as collected using BDI-II total scores showed statistically significant differences following participation in a one hour, weekly psychoeducational group that ran for 12 weeks. The descriptive statistics of the 21 participants provided a minimum pretest BDI-II score of 0 and maximum score of 35. The mean score was 14.3 with a standard deviation of 9.96. Following participation in the group, posttest BDI-II scores showed a minimum score of 0 and a maximum score of 20. The mean score following participation in the group was 9.62 with a standard deviation of 5.79.

In regards to the hypothesis predicting that participation in the group would decrease the amount of reported depression symptoms, the paired t-test providing the following results. The mean difference between the pretest and posttest is 4.71, where  $t(20) = 2.91, p = .009$ . See Table 1 for descriptive statistics and the paired t-test. These results show a statistically significant difference between BDI-II pretest scores and BDI-II posttest scores following participation in psychoeducational group. Discussion of implications and limitations of these statistics are discussed in the next section.

### **Discussion**

The results of this study echo the findings of Feng et al., (2012) and Weisz, McCarty and Valeri, (2007) in that group counseling modalities impact depression. In the present study, depression scores were lowered after group intervention; in the aforementioned studies, groups were created specifically for the amelioration of depression symptoms, where in the present study, the group attempted to educate participants about sexual and gender identity. This leaves the question of what is impacting the decrease in depression scores in the present study, as the group design did not directly seek to address depression. One such interpretation is that group process, social connectivity and relatedness help those experiencing similar challenges to find support from one another, however, more in-depth research would be needed to draw this conclusion.

### **Limitations of Findings**

The sample used in this study was a convenience sample, limiting the generalizability of the findings. Using a control group in future research would discriminate whether the group impacted decreased scores or if the change in scores was due to outside factors. The sample size was also predominately Caucasian, limiting the impact for non-Caucasian adolescents.

### **Counseling Implications**

The outcome of this research highlights the importance of providing psychoeducation about sexual and gender identity when working with adolescents to help gain a sense of understanding about the changes that occur during this time of development. While providing psychoeducation in a context of unconditional positive regard, introducing models of identity development works in a preventative manner to help adolescents understand their development in the context of societal norms. The impact of social connectivity was also highlighted in this research. Counselors must be aware of the increased need in adolescence to have social connections and provide space during psychoeducation to explore reactions brought up during the therapy process.

### **Conclusion**

Adolescents identifying on the LGBTQIA spectrum are vulnerable to high rates of depression due to psychological, and cultural predispositions as well as a lack of belonging (APA, 2015). This capstone research project has looked to identify the relationship between participating in a psychoeducational group around LGBTQIA concerns and how that impacts reported depression scores. The research conducted illustrates the impact of group psychoeducation to ameliorate reported depression symptoms, as depression scores were lowered following group intervention. Future research is required to distill the mechanism of change seen in this research but the need to provide psychoeducation with LGBTQIA adolescents is apparent.

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