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Strategies employed by sexual minority adolescents to cope with minority stress

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Abstract

Sexual minority adolescents (SMA) experience disparities in health and behavioral health outcomes, including high rates of depression, anxiety, self-harm, substance use, HIV risk behavior, suicidal ideation, and suicide attempts. These outcomes are commonly attributed to minority stress. Stress experiences are different for SMA than their adult counterparts. For example, disclosing their sexual orientation may be more likely to result in homelessness because these youth more often live with parents or other family members. Although stress in this population has been explored in previous research, very little is known about how SMA cope. Relying upon an adolescent coping model, this study examined the coping strategies, responses, and resources of SMA related to stress. Forty-eight racially and ethnically diverse SMA (age 14–19) were recruited for 90-minute tape-recorded interviews. The semi-structured interviews were guided by a life history calendar. Recordings were transcribed verbatim and entered into QSR NVivo. All transcripts were coded by two members of the research team and went through a consensus process. Forty-three unique coping statements emerged that fit with the Compas model of adolescent coping. SMA cope with minority stress in similar ways to heterosexual youth coping with general stress, but findings suggest that SMA may also use different kinds of coping resources. Although further research is needed, the present study identified a variety of ways SMA cope with stress and can inform future research on the development interventions.

Keywords

coping; sexual minority adolescents; minority stress; behavioral health

Sexual minority adolescents (SMA) experience disparities in a number of life domains when compared to their heterosexual peers. For example, SMA experience higher rates of internalizing psychopathology including depression, anxiety, and suicidal ideation (Anhalt & Morris, 1998; Haas et al., 2010; Hendricks & Testa, 2012) and externalizing behaviors such as substance use (Marshall et al., 2008; Moon, Fornili, & O'Brian, 2007), HIV risk behavior (Goodenow, Netherland, & Szalacha, 2002), self-harm, and suicide attempts (Coker, Austin, & Schuster, 2010; Saewyc, 2007). Adolescents who identify as a sexual minority are 3 to 4 times more likely to meet criteria for an internalizing disorder and 2 to 5 times more likely to meet criteria for externalizing disorders than their heterosexual peers (Fergusson, Horwood, & Beautrais, 1999). These youth also more frequently report lower academic achievement (D'Augelli, Pilkington, & Hershberger, 2002; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Poteat et al., 2014) and higher rates of eating disorders and obesity (Austin, Nelson, Birkett, Calzo, & Everett, 2013) than their heterosexual peers.

The poor outcomes found among sexual minorities are commonly attributed to the presence of unique psychosocial stress experiences (Hatzenbuehler, 2011; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Meyer, 2003). The minority stress theory (Meyer, 2003) posits that an array of unique and chronic psychosocial stressors affect sexual minorities and contribute to negative behavioral health patterns. These include both proximal and distal stressors such as negative events, negative attitudes toward homosexuality, and discomfort with one's sexual orientation (Rosario, Schrimshaw, Hunter, & Gwadz, 2002). Studies have tested the utility of minority stress theory (e.g., Clatts, Goldsamt, Yi, & Gwadz, 2005; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Marshal et al., 2011; Rosario et al., 2002). Additionally, a growing body of literature has found differences in minority stress by racial and ethnic identification (e.g., Cochran, Peavy, & Robohm, 2007) and subgroup differences across sexual orientation groups (Eaton et al., 2012; Friedman et al., 2011), although these differences have not been universally detected (Kertzner, Meyer, Frost, & Stirratt, 2009; Mustanski, Garofalo, & Emerson, 2010).

Adolescents who identify as sexual minorities require special attention in research. Adolescence is a critical period during which individuals establish long-term trajectories of health, as youth are solidifying their sexual identities during this period (Mustanski, Kuper, & Greene, 2013) and stigmatizing experiences during adolescence are known to disrupt the achievement of developmental tasks and contribute to negative outcomes (Goldbach et al., 2014; Radkowski & Siegel, 1997). Further, the experiences of SMA may differ in significant ways from their adult counterparts. For example, the experience of coming out, or disclosing one's sexual orientation, as an adolescent may be stressful in the context of two often compulsory social environments: home and school (D'Augelli, 2006; Goldbach et al., 2014; Rice et al., 2014; Russell, Franz, & Driscoll, 2001). Negative parental reactions to an adolescent's sexual minority identity can create stress in the home, sometimes resulting in youth homelessness (Clatts et al., 2005; Rice et al., 2014; Rosario, Schrimshaw, & Hunter, 2012). Further, SMA often attend schools where pervasive homophobic bullying is common and teachers may not readily intervene (Gay, Lesbian & Straight Education Network [GLSEN], 2012). Youth who are (or are perceived to be) a sexual minority are more likely to be bullied in school, which has been correlated with high rates of absenteeism, lower educational attainment, depression, and suicidality (GLSEN, 2012; Ybarra, Mitchell, Kosciw, & Korchmaros, 2014). Further, structural factors (e.g., the absence of protective school policies) may contribute to poorer mental health patterns for SMA (Hatzenbuehler, 2011). Yet despite experiencing an average of two heterosexual incidents a week (Swim, Johnston, & Pearson, 2009), the large majority of sexual minorities do not report outcomes much different from their peers (Masten, 2001).

Coping Processes for Sexual Minority Adolescents

The most commonly cited model used to organize the coping patterns of individuals is presented by Compas and colleagues (e.g., Compas, 1987; Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Compas et al., 1999). According to this model, several dimensions of adolescent stress response exist, including both voluntary coping and involuntary physiologic and emotional responses. Voluntary coping includes conscious responses that are intentionally oriented toward regulating cognitive, behavioral, emotional,

or physiological responses to a stressor or controlling the stressor itself, whereas involuntary coping occurs outside of conscious awareness (Tobin, Holroyd, Reynolds, & Wigal, 1989). Both voluntary and involuntary responses to stress are further categorized by engagement (i.e., directed at the stressor or stress reaction) and disengagement (i.e., stressor avoidance) strategies. Compas et al. (2001) explained that coping should be further distinguished from a similar concept of competence, or coping resources. Whereas coping strategies are behaviors and thoughts that are enacted to respond to stress, coping resources are social and personal tools used to support the coping process.

Although research on adolescent minority stress is increasing, including recent meta-analyses (Burton et al., 2013; Goldbach et al., 2014; Marshal et al., 2011; Marshal et al., 2012), research on how SMAs cope with these stressors is less prevalent. Generally, the presence of social support from friends and family is known to be positive (Cox, Vanden Bergh, Dewaele, & Vincke, 2010; Goldfried & Goldfried, 2001). Grossman et al. (2009) found that lesbian, gay, bisexual, and transgender (LGBT) youth tend to use escapism and avoidance to distance themselves from school violence, which aligns with disengagement strategies proposed by Compas et al. (2001). Another study explored coping among eight gay rural adolescents and found isolation practices and identification of supportive teachers were helpful in mitigating negative outcomes (Yarbrough, 2009). Some additional studies on coping have been conducted with older youth. For example, a recent European study found that young adults used cognitive restructuring and self-destructive behaviors such as cutting and suicide to cope with stress (Scourfield, Roen, & McDermott, 2008). Another study found that identifying as an ethnic minority was protective for mental health outcomes, particularly among SMA girls (Consolacion, Russell, & Sue, 2004).

Relying on ethnic identity as a coping process, as found by Consolacion et al. (2004), suggests that there may be unique coping strategies that minority youth employ. Some research has explored coping strategies among adolescents in a cultural context but has primarily focused on racial and ethnic identity without including sexual minority status (e.g., McLoyd, 1998; Romero & Roberts, 1998; Sellers & Shelton, 2003). For example, Latino youth report that ethnic identity affirmation is a resource for coping with discrimination (Edwards & Romero, 2008) and may moderate the relationship between discrimination and well-being (Greene, Way, & Pahl, 2006). Well-being in Hispanic adolescents also appears to be influenced by *familismo*, which can buffer against negative mental health outcomes (Ayón, Marsiglia, & Bermudez-Parsai, 2010; Parsai, Voisine, Marsiglia, Kulis, & Nieri, 2009; Santiago-Rivera, 2003). Whether SMA differ in their coping processes by race, ethnicity, and sexual minority identity warrants attention in the literature.

Poor coping is linked to behavioral health problems (Garcia, 2010; Rew, 2005), and “the ability to adapt to stress and adversity is a central facet of human development” (Compas et al., 2001, p. 87). A better understanding of the coping strategies that SMA employ, particularly those that differ from traditional coping methods described in the general adolescent literature, would enhance current affirmative treatment approaches (e.g., Alessi, 2014; Pachankis & Goldfried, 2010) and may lead to the development of more targeted intervention efforts. Thus, the present study used a qualitative approach to examine coping statements made by 48 racially and ethnically diverse SMA. Through this analysis, we

sought to (a) determine whether the coping methods reported by participants aligned with general coping theory (i.e., Compas et al., 2001) and (b) whether differences in coping methods appear to exist across sexual orientation and racial/ethnic groups.

Methods

The current qualitative study was exploratory in nature. The purpose of the study was to explore differences in minority stress experiences across sexual orientation (lesbian, gay, and bisexual) and racial and ethnic identification (Hispanic, non-Hispanic White, African American, Asian American). After each stress domain was explored with youth, a summative question was asked to explore how youth had coped with the experiences they had just described. This qualitative analysis examined responses to these questions and other coping strategies offered without prompt during the interview process.

Study Sites

Consistent with community sampling recommendations (Kral et al., 2010; Meyer & Wilson, 2009), a formative assessment was conducted with support from a small grant and included 25 key informant interviews. The assessment was conducted at four local organizations that cater to a large number of SMA. Based on findings from the formative process, it was determined that recruitment for interviews with youth should occur at three LGBT youth-serving agencies in the Los Angeles, CA, area and at one school site. These locations were selected in part because they serve racial and ethnically diverse youth in geographically unique settings. Together, the included agencies directly serve more than 3,000 SMA each year, more than 50% of whom identify as a racial and ethnic minority.

Instrument

Because numerous milestones during childhood interact to influence the experiences of SMA (e.g., coming out to friends before coming out to parents), the semi-structured interview was guided by a life history calendar (Caspi et al., 1996). This approach encourages participants to identify salient life experiences related to growing up, including reflection on periods both before and after coming out to various people (parents, friends), significant moments in their life (e.g., first kiss with an individual of the same or different sex), and their potentially changing effect on psychosocial stress and well-being throughout their life. Further, the life history approach is appropriate for research on populations that have experienced significant trauma or belong to a stigmatized group (Harold, Palmiter, Lynch, & Freedman-Doan, 1995) and has been successfully used in other studies with racially and ethnically diverse youth (Chanmugam, 2011) and SMA (Fisher, 2012; Fisher & Boudreau, 2014). The chronological structure of the interview increases participants' ability to recall both events and associated feelings and acknowledges the fluid and developing aspects of sexual identity formation (Diamond, 1998).

The life history calendar used in the present study was developed in an Excel worksheet, printed on a poster-size paper, and laminated so that participants could draw, write, or otherwise note their responses as they spoke with the research interviewer. The calendar was organized with years across the top row, with the current year listed at the far left and

counting down for 15 years. Key statements about stress domains were listed along the first column. To build the list of key stress statements the research team relied on the extant literature on both domains of minority stress (e.g., Goldbach et al., 2014; Hatzenbuehler, 2011; Meyer, 2003) and existing instruments used in its previous research. This process identified an initial set of nearly 200 questions related to sexual and gender identity, life experiences, and stress commonly found among SMA.

As a group, the research team organized these questions into relevant conceptual domains. After removing duplicate questions, we organized these questions into nine key domains (life landmarks; sexual minority milestones; lesbian, gay, bisexual, transgender, and queer [LGBTQ] expressions; home life; peer group; school; spirituality; race and ethnicity; and community connection). To support the interview process, an interview protocol was developed to both guide the interviewer and provide probing questions to support the inquiry of each domain. For example, although the calendar displayed only “Home Life: How it is at home” and “Home Life: LGBTQ Expression/milestone reactions and responses,” the interview guide included both an initial probing question of “What is your life like at home/with your family?” and probes such as “How has this changed over time?” “What reactions have you gotten from individual people because of being LGBTQ?” and “What does support look like to you?” After a draft of the calendar and the interview protocol was developed, it was sent to a panel of recognized experts in the field of LGBTQ behavioral health for feedback. Based on expert feedback, the protocol was further adapted, presented to agency partners for approval, and finalized for use.

Recruitment and Procedures

During a 3-month time frame, the principal investigator and bilingual research assistants were made available in private offices provided by the participating agency partners for drop-in hours and appointments set for youth through agency partners. Agency staff members posted flyers and sent e-mails through listservs and via online social media (e.g., Facebook). Staff members conducted a preliminary screening of participants and referred eligible individuals to meet with a member of the research team. Upon introduction, the interviewer privately reviewed a consent form and asked for verbal agreement. Because SMA are a vulnerable population and some individuals in their network (parents, friends) may not be aware of their sexual minority status, written parental consent was not required by the affiliated institutional review board. Interviews were audio recorded and interviewers were asked to summarize respondent comments on a question-by-question basis to aid in analysis. Interviews lasted approximately 90 minutes. Youth were offered a \$20 incentive for participation and as many as three \$10 incentives for referring additional youth.

In total, 54 participants were recruited for participation using a purposive strategy known as maximum variation sampling (Patton, 2001). In an effort to ensure diversity of sampling, as youth were enrolled the principal investigator monitored the racial, ethnic, age, and sexual identity characteristics of recruited participants. Nearing the end of study recruitment, we discontinued enrolling young gay Latino men because they had comprised more than 40% of our sample; however, no other groups were refused entry into the study. Of the 54 youth, 48 met study inclusion criteria for the present study (two did not complete, and the other four

were over the age of 19). To participate in the interview, youth were required to (a) be 13 to 19 years old; (b) speak English or Spanish; (c) self-identify as lesbian, gay, or bisexual; and (d) be willing and able to provide verbal assent. If during the course of the interview a participant also reported a gender minority status (e.g., transgender, gender queer), that participant was still included in the study.

Demographic Measures

In addition to participating in the life history calendar interview, participants were asked to provide responses to several demographic questions. Participants reported their age in years, gender identification, sexual orientation, and whether they were enrolled in school and if so, which grade level. Participants were not given a list of genders, sexual orientations, or racial identifications, but instead were able to freely answer. With regard to race, participants could indicate a race and ethnicity and also indicate a multiracial background.

Analysis

The recordings from interviews were transcribed verbatim and entered into QSR NVivo. Using a methodology rooted in grounded theory (Glaser, 1978; i.e., theory derived from data and then illustrated by characteristic examples of data), thematic analysis was conducted following a process outlined by Boyatzis (1998). This consisted of (a) generating codes to be attached to similar quotes or topics across transcripts for data reduction; (b) revising codes to become themes that fit with the nature of the data by comparing similar ideas across transcripts; and (c) determining the reliability of codes and themes by identifying both positive and negative examples of qualification. Two coders independently determined codes to be attached to text fragments representing descriptions or evaluations of stressors and coping processes. Upon consensus, with an overall interrater agreement of 92%, axial coding was used to reorganize specific text segments according to conceptual minority stress domains. These domains were inspected for conceptual fit with the a priori domains identified by the expert panel and previous research (Goldbach et al., 2014; Meyer, 2003).

Team members identified coping strategies discussed by participants. The coping strategies used by participants were then grouped into the domains of stress and coping that emerged during the coding process. Data from NVivo were then exported and combined with respondents' demographic data using SPSS version 22. This allowed each coping strategy to be dummy coded, indicating whether a respondent reported using the coping strategy or resource during the course of the interview. Frequencies for each coping item were created across the sample. Chi-square analyses of differences across gender, sexual orientation, and race were then conducted for the coping strategies, responses, and resources. Coping strategies, responses, and resources were only included in chi-square analysis if less than 20% of cells had expected cell frequencies less than five (Yates, Moore, & McCabe, 1999).

Results

Table 1 provides the demographic characteristics of the sample.

Overall, the sample was racial and ethnically diverse, with all participants reporting a primary racial identification and more than one fourth of the sample reporting a multiracial

heritage. Most participants identified as cisgender male or female and most participants identified with a gay, lesbian, bisexual, or pansexual sexual orientation.

Relying on Compas et al (2001) to organize the coping strategies (i.e., voluntary and involuntary coping, coping resources) two members of the research team agreed on the categorization of each coping strategy presented in the data. Twenty-four voluntary coping strategies, three involuntary coping responses, and 16 coping resources emerged from the interviews and are presented in Table 2 with their corresponding sample frequencies.

Voluntary Engagement Coping Strategies

Respondents discussed different voluntary engagement coping strategies. Many youth reported the use of cognitive self-talk in response to stress related to being a sexual minority: “It’ll get better soon and people will change their opinions and views [about being LGBTQ].” One youth, discussing whether his family will accept him, stated:

I just think about how in the end it’s my life. I’m going to be the one living this. It might hurt them at first, but they will learn to love it and if they don’t, I’ll learn to love them, still. If in the end, they decide to cut me out of their life, I’ll have to realize that they don’t want me. They don’t accept me, so I’ll just have to keep on moving forward.

This idea of self-encouragement was found across numerous interviews.

Respondents also reported using religious belief as an avenue to accepting themselves and coping with inner confusion: “Because I believe God made everybody, so if God didn’t want people to be gay, then God wouldn’t have made them gay.” One youth explained how his religion of origin has helped him to be accepting of all people: “I just use [Catholicism] as a firm ground for myself. That has helped bring me to realize how to accept people no matter who they are, no matter what color they are, [or] who they like.”

Beyond cognitive voluntary coping, youth also reported several behavioral coping strategies. Youth discussed their process of asking individuals in their life (e.g., teachers, family, and friends) to begin using gender ego-syntonic pronouns. Spending time with groups from the LGBTQ community (e.g., youth centers, summer camps, Gay-Straight Alliance groups) also emerged as an salient strategy for combating minority stress.

Voluntary Disengagement Strategies

Like engagement, voluntary disengagement coping strategies were both cognitive and behavioral. Almost one fourth of the sample talked about their process of denying their same-sex attraction as a way of coping with the stress of being different at some point in their life (not current). For some the denial was both internal and external when others asked about their sexual orientation. One male participant remembered when his father asked if he was gay, he denied being a sexual minority: “...and I went into my room and started crying because I really knew I was lying to myself.” More than 40% of the sample reported not coming out as a sexual minority to their family to protect themselves. Some participants felt that this secrecy was used to combat the possibility of being disowned: “I just don’t know if it’s OK to come out so I’m just going to wait until I’m older and I get to leave the house

before I tell them so if they disown me, I'm leaving the house anyways." Many participants also reported changing social environments to avoid different minority stressors. This avoidance strategy included staying in their bedroom when at home, avoiding home, and in a few cases changing schools due to bullying.

Involuntary Coping Strategies

Three involuntary coping responses also emerged that lacked the insight and self-awareness of the voluntary strategies presented. Two of these responses engaged the stress and one had the effect of disengaging from the stress. Respondents reported how being proud of being gay allowed them to be happy. This seemed to be a pride that developed involuntarily rather than purposefully. Youth also reported how their religious values built confidence and strong self-esteem, which reinforced their autonomy: "[My religion] just helped me realize that all this hatred wouldn't do anything. So I just learned to love everybody. I learned to love myself. It just helped [me] realize that you have to stay happy."

More than half of the sample appeared to use a disengaging coping response that involved the numbing of emotions or a cognitive process of developing apathy toward being mistreated. Across interviews, youth described minority stress (e.g., discrimination, violence) and then made statements such as "I don't care," "[It's] no big deal," and "I told myself it doesn't matter." One female identifying participant reported that "people would call [her] faggot ... but that doesn't really hurt anymore." Youth appeared to numb their emotions as a way of not becoming overwhelmed by their experiences.

Coping Resources

In addition to coping strategies, sixteen coping resources were discussed by youth. These resources included people and community and social contexts. The majority of the sample discussed the diversity and accepting nature of the LGBTQ community:

I don't know everything about the LGBT community, but I feel like they're pretty accepting of everybody, I would say. I feel like just because you're one race, it doesn't mean they're not going to accept you. ... In the LGBT community, it doesn't matter what race you are.

Youth also reported the importance of having access to LGBT youth centers as important coping resources.

"I kind of started accepting more people when I came to the [LGBTQ youth] center because there's more people with so many different backgrounds and so many identities and sexualities that I kind of accepted all of them."

One youth in talking about the stress with his family related to being a sexual minority said:

It's hard... sometimes I even dread going home. [but] the [LGBT] center here is home...that's a house. A house is not a home. This is home. Home is where there are people around you that accept you no matter what and they're always there for you. So, this is home... I can be me. I'm not judged.

Another resource presented involved both the presence of a LGBTQ family member and the knowledge that this person was accepted and treated well in the family. Knowing that other LGBTQ family members were accepted became a powerful resource: “My dad’s uncles, they were gay. ... It was really normal and everyone was so supportive and it was awesome, ‘cause they all loved them.” “My cousin is gay. ... She told me like a really nice story about [how] her dad understood when she came out. It was happy times.”

Sub-group analyses

Coping strategies, responses, and resources were compared across gender, sexual orientation, and racial identification using chi-square analyses. To maintain the statistical assumptions of chi-square analysis (80% or more cells with an expected cell count of 5 or more), only 11 coping statements could be analyzed. Chi-square analyses found no significant differences across gender, sexual orientation, or race. Frequency results suggested that adolescent girls use cognitive self-talk more frequently and may cope by not coming out to their family more frequently compared to both male and transgender/queer youth. Adolescent boys reported relying on a supportive adult at school less frequently than both female and transgender or queer youth.

Although chi-square analyses could not be used to examine subgroup differences in racial identification, several frequency differences emerged. Asian youth more frequently reported using religious values and beliefs to accept LGBTQ people. White youth were less likely to report either not coming out to their family or leaving their religion of origin due to negative messages than all other racial and ethnic categories. In addition, African American youth reported relying on a LGBTQ family member as a resource more frequently than all other racial categories.

Discussion

In response to a semi-structured interview, participants described 43 different coping strategies, responses, and resources. Youth commonly reported using cognitive self-talk, gaining new information about their sexual orientation, developing ones self-concept, and using the Internet to connect with peers as helpful coping processes. Participants in our study described supportive friends, LGBTQ friends, supportive adults and participation in a Gay-Straight Alliance as resources they used to cope. Previous research has been mixed on the importance of Gay-Straight Alliances (Goldbach et al., 2014; Heck, Flentje, & Cochran, 2013; Padilla, Crisp, & Rew, 2010); however, participation was described as positive by many of our participants.

Consistent with two other studies of coping processes employed by SMA (Grossman et al., 2009; Yarbrough, 2009) as well as Compas et al. (2001), youth commonly reported avoidant coping strategies such as avoiding stressful situations, dismissing stressors as irrelevant, and stating that they just “don’t care”. Unfortunately, research indicates that a reliance on avoidant coping strategies tend to result in poorer outcomes for adolescents over time (Herman-Stahl, Stemmler & Peterson, 1995; Seiffge-Krenke & Klessinger, 2000). Pineles et al (2013) found that individuals who experience traumatic events resulting in PTSD and rely on avoidant coping may be at greater risk of maintaining, and potentially increasing, their

PTSD symptoms within the first few months following the traumatic event. Thus, while avoidant coping may result in short term safety for the individual, more research is needed to determine its relation to poor behavioral health outcomes in this population.

In general, the coping strategies and responses of our participants were not unlike those of studies with heterosexual youth. Youth in our study relied upon both voluntary and involuntary strategies and reported approaches with engagement and disengagement. However, SMA may mobilize different coping resources to deal with minority stress, such as affiliating with the “LGBTQ community” and seeking out “LGBTQ role models”. Given that SMA are generally not raised by sexual minority parents, they generally do not learn to cope with discriminatory stress in the way that other minority groups do (Harris-Britt, Kurtz-Costes & Rowley, 2007; Hughes et al., 2006). Thus, it is not surprising that unlike their heterosexual peers, SMA may have to rely on less traditional coping resources due to the potential for families to not be supportive. Research could be focused on exploring ways to support youth and families in this process. This would be similar to research on transracial adoption practices, where “racial socialization” has been found to be protective for transracially adopted children with White adoptive parents (Leslie, Smith, Hrapczynski, & Riley, 2013).

More work is needed to examine racial, ethnic, sexual orientation and gender identity differences in stress and coping. In our study, White participants reported concealing their sexual identity to family less often than their racial and ethnic minority counterparts. Future research with larger samples should explore the importance of this finding, as some families may be less likely to be accessible to youth as they cope with minority stress. In terms of intervention development, learning more about what it means to be a sexual minority was relevant to youth in our study as they developed a positive self-identity. Although some evidence has suggested the utility of psycho-education among heterosexual youth (Perez-Figueroa, Alhassoon & Wang-Jones, 2013) and parents of LGBT adolescents (Troutman & Evans, 2014), approaches to educate and build resilience for SMA remain relatively sparse. One school-based program to build resilience in SMA, Affirmative Supportive Safe and Empowering Talk (ASSET; Craig, 2013) has shown promise in early open trials (Craig, 2014). In our study, having a supportive parent or immediate family member and spending time with an LGBTQ family member were cited as salient coping experiences, illustrating the importance of family for SMA and perhaps intervention research. Other family-focused intervention research has also found promising outcomes (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). However, a sizeable portion of our sample indicated that *not* coming out to their family was a way of coping, suggesting the lack of family support in their life. This dichotomy draws attention to the fact that not all youth feel safe in their families of origin, and may need to seek support for their experience in other life domains (e.g., school). School and community-based interventions should also be considered in research.

Our study is not without limitations. Although we purposefully recruited diverse youth in terms of racial and ethnic heritage, gender, and sexual orientation, this also meant we had small subsamples within groups and may not have detected differences. Related to this, some SMA in our study identified as “queer” or “trans*”, but due to the small number of participants, we cautiously assert these findings *may* also be applicable to gender non-

conforming youth but much more research should be done to specifically identify which minority stress and coping processes are convergent and where these two groups may differ. Thus, more work is needed to better elucidate the nuanced relationships between race, ethnicity, sexual orientation, gender identity, coping and behavioral health. Moreover, the sample that was recruited from a large urban area. It is possible that youth in mature in rural areas may both experience different stresses related to being a sexual minority and utilize different forms of coping. Additionally, the purpose of the larger study from which this data were derived was to examine the minority stress experiences of youth participants, not to dig deeply into coping strategies and resources. Although participants identified a large number of coping strategies, if a youth did not describe a coping strategy, we did not press at length. Thus, it did not mean that they did not use that strategy, rather, it was not the strategy they thought of first. Some of the racial and ethnic, gender, and sexual orientation differences (or lack thereof) could be related to extraneous factors that would lead an individual to more or less frequently describe a coping strategy.

Despite these limitations, there is an important value in exploring the coping strategies described by youth, and our study highlights that further research in the area is needed. Given the 43 different coping strategies, responses, and resources used by participants in response to minority stress, the implications for both future research toward the development of intervention are evident. Understanding how sexual minority youth develop and employ coping strategies when faced with minority stress will contribute meaningfully to the prevention of behavioral health disorders in this population of high need.

References

- Alessi EJ. A framework for incorporating minority stress theory into treatment with sexual minority clients. *Journal of Gay & Lesbian Mental Health*. 2014; 18:47–66. <http://dx.doi.org/10.1080/19359705.2013.789811>.
- Anhalt K, Morris TL. Developmental and adjustment issues of gay, lesbian, and bisexual adolescents: A review of the empirical literature. *Clinical Child and Family Psychology Review*. 1998; 1:215–230. <http://dx.doi.org/10.1023/A:1022660101392>. [PubMed: 11324092]
- Austin SB, Nelson LA, Birkett MA, Calzo JP, Everett B. Eating disorder symptoms and obesity at the intersections of gender, ethnicity and sexual orientation in US high school students. *American Journal of Public Health*. 2013; 103:e16–e22. <http://dx.doi.org/10.2105/AJPH.2012.301150>. [PubMed: 23237207]
- Ayón C, Marsiglia FF, Bermudez-Parsai M. Latino family mental health: Exploring the role of discrimination and familismo. *Journal of Community Psychology*. 2010; 38:742–756. <http://dx.doi.org/10.1002/jcop.20392>. [PubMed: 20890371]
- Boyatzis, RE. Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage; 1998.
- Burton CM, Marshal MP, Chisolm DJ, Sucato GS, Friedman MS. Sexual minority-related victimization as a mediator of mental health disparities in sexual minority youth: A longitudinal analysis. *Journal of Youth and Adolescence*. 2013; 42:394–402. <http://dx.doi.org/10.1007/s10964-012-9901-5>. [PubMed: 23292751]
- Caspi A, Moffitt TE, Thornton A, Freedman D, Amell JW, Harrington H, Silva PA. The life history calendar: A research and clinical assessment method for collecting retrospective event-history data. *International Journal of Methods in Psychiatric Research*. 1996; 6:101–114. [http://dx.doi.org/10.1002/\(SICI\)1234-988X\(199607\)6:2<101::AID-MPR156>3.3.CO;2-E](http://dx.doi.org/10.1002/(SICI)1234-988X(199607)6:2<101::AID-MPR156>3.3.CO;2-E).

- Chanmugam A. Perspectives on US domestic violence emergency shelters: What do young adolescent residents and their mothers Say? *Child Care in Practice*. 2011; 17:393–415. <http://dx.doi.org/10.1080/13575279.2011.596814>.
- Clatts MC, Goldsamt L, Yi H, Gwadz MV. Homelessness and drug abuse among young men who have sex with men in New York City: A preliminary epidemiological trajectory. *Journal of Adolescence*. 2005; 28:201–214. [10.1016/j.adolescence.2005.02.003](http://dx.doi.org/10.1016/j.adolescence.2005.02.003) [PubMed: 15878043]
- Cochran BN, Peavy KM, Robohm JS. Do specialized services exist for LGBT individuals seeking treatment for substance misuse? A study of available treatment programs. *Substance Use & Misuse*. 2007; 42:161–176. <http://dx.doi.org/10.1080/10826080601094207>. [PubMed: 17366131]
- Coker TR, Austin SB, Schuster MA. The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health*. 2010; 31:457–477. <http://dx.doi.org/10.1146/annurev.publhealth.012809.103636>.
- Compas BE. Coping with stress during childhood and adolescence. *Psychological Bulletin*. 1987; 101:393–403. <http://dx.doi.org/10.1037/0033-2909.101.3.393>. [PubMed: 3602247]
- Compas BE, Connor-Smith JK, Saltzman H, Thomsen AH, Wadsworth ME. Coping with stress during childhood and adolescence: Problems, progress and potential in theory and research. *Psychological Bulletin*. 2001; 127:87–127. <http://dx.doi.org/10.1037/0033-2909.127.1.87>. [PubMed: 11271757]
- Compas BE, Stoll MF, Thomsen AH, Oppedisano G, Epping-Jordan JE, Krag DN. Adjustment to breast cancer: Age-related differences in coping and emotional distress. *Breast Cancer Research and Treatment*. 1999; 54:195–203. <http://dx.doi.org/10.1023/A:1006164928474>. [PubMed: 10445418]
- Consolacion TB, Russell ST, Sue S. Sex, race/ethnicity, and romantic attractions: Multiple minority status adolescents and mental health. *Cultural Diversity and Ethnic Minority Psychology*. 2004; 10:200–214. <http://dx.doi.org/10.1037/1099-9809.10.3.200>. [PubMed: 15311974]
- Cox N, Vanden Berghe W, Dewaele A, Vincke J. Acculturation strategies and mental health in gay, lesbian, and bisexual youth. *Journal of Youth and Adolescence*. 2010; 39:1199–1210. <http://dx.doi.org/10.1007/s10964-009-9435-7>. [PubMed: 20689983]
- D’Augelli AR. Coming out, visibility, and creating change: Empowering lesbian, gay, and bisexual people in a rural university community. *American Journal of Community Psychology*. 2006; 37:203–210. <http://dx.doi.org/10.1007/s10464-006-9043-6>. [PubMed: 16804744]
- D’Augelli AR, Pilkington NW, Hershberger SL. Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly*. 2002; 17:148–167. <http://dx.doi.org/10.1521/scpq.17.2.148.20854>.
- Diamond LM. Development of sexual orientation among adolescent young adult women. *Developmental Psychology*. 1998; 34:1085–1095. <http://dx.doi.org/10.1037/0012-1649.34.5.1085>. [PubMed: 9779753]
- Eaton DK, Kann L, Kinchen S, Shanklin S, Flint KH, Hawkins J, Wechsler H. Youth Risk Behavior Surveillance – United States, 2011. Morbidity and Mortality Weekly Report: Surveillance Summaries. 2012; 61(4):1–162. [PubMed: 22673000]
- Edwards LM, Romero AJ. Coping with discrimination among Mexican descent adolescents. *Hispanic Journal of Behavioral Sciences*. 2008; 30:24–39. <http://dx.doi.org/10.1177/0739986307311431>.
- Fergusson DM, Horwood LJ, Beautrais AL. Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*. 1999; 56:876–888. <http://dx.doi.org/10.1001/archpsyc.56.10.876>. [PubMed: 10530626]
- Fisher CM. Assessing developmental trajectories of sexual minority youth: Discrepant findings from a life history calendar and a self-administered survey. *Journal of LGBT Youth*. 2012; 9:114–135. <http://dx.doi.org/10.1080/19361653.2012.649643>. [PubMed: 22957108]
- Fisher CM, Boudreau ME. Assessing recent adolescent sexual risk using a sexual health history calendar: Results from a mixed method feasibility study. *Journal of the Association of Nurses in AIDS Care*. 2014; 25:269–275. <http://dx.doi.org/10.1016/j.jana.2012.06.011>. [PubMed: 23122903]
- Friedman MS, Marshal MP, Guadamuz TE, Wei C, Wong CF, Saewyc EM, Stall R. A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*. 2011; 101:1481–1494. <http://dx.doi.org/10.2105/AJPH.2009.190009>. [PubMed: 21680921]

- Garcia AM. What does “work” mean? Reopening the debate about clinical significance. *Clinical Psychology: Science and Practice*. 2010; 17:48–51. <http://dx.doi.org/10.1111/j.1468-2850.2009.01192.x>.
- Gay Lesbian & Straight Education Network. 2011 National School Climate Survey. 2012. Retrieved from <http://glsen.org/press/2011-national-school-climate-survey>
- Glaser, BG. Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press; 1978.
- Goldbach JT, Tanner-Smith EE, Bagwell M, Dunlap S. Minority stress and substance use in sexual minority adolescents: A meta-analysis. *Prevention Science*. 2014; 15:350–363. <http://dx.doi.org/10.1007/s11121-013-0393-7>. [PubMed: 23605479]
- Goldfried MR, Goldfried AP. The importance of parental support in the lives of gay, lesbian, and bisexual individuals. *Journal of Clinical Psychology*. 2001; 57:681–693. <http://dx.doi.org/10.1002/jclp.1037>. [PubMed: 11304707]
- Goodenow C, Netherland J, Szalacha L. AIDS-related risk among adolescent males who have sex with males, females, or both: Evidence from a statewide survey. *American Journal of Public Health*. 2002; 92:203–210. <http://dx.doi.org/10.2105/AJPH.92.2.203>. [PubMed: 11818292]
- Greene ML, Way N, Pahl K. Trajectories of perceived adult and peer discrimination among Black, Latino, and Asian American adolescents: Patterns and psychological correlates. *Developmental Psychology*. 2006; 42:218–236. <http://dx.doi.org/10.1037/0012-1649.42.2.218>. [PubMed: 16569162]
- Grossman AH, Haney AP, Edwards P, Alessi EJ, Ardon M, Howell TJ. Lesbian, gay, bisexual and transgender youth talk about experiencing and coping with school violence: A qualitative study. *Journal of LGBT Youth*. 2009; 6:24–46. <http://dx.doi.org/10.1080/19361650802379748>.
- Haas AP, Eliason M, Mays VM, Mathy RM, Cochran SD, D’Augelli AR, Clayton PJ. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*. 2010; 58:10–51. <http://dx.doi.org/10.1080/00918369.2011.534038>. [PubMed: 21213174]
- Harold RD, Palmiter ML, Lynch SA, Freedman-Doan CR. Life stories: A practice-based research technique. *Journal of Sociology and Social Welfare*. 1995; 22:23–44.
- Harris-Britt A, Valrie CR, Kurtz-Costes B, Rowley SJ. Perceived racial discrimination and self-esteem in African American youth: Racial socialization as a protective factor. *Journal of Research on Adolescence*. 2007; 17:669–682. [PubMed: 20700391]
- Hatzenbuehler ML. The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics*. 2011; 127:896–903. <http://dx.doi.org/10.1542/peds.2010-3020>. [PubMed: 21502225]
- Heck NC, Flentje A, Cochran BN. Intake interviewing with lesbian, gay, bisexual, and transgender clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy*. 2013; 43:23–32. <http://dx.doi.org/10.1007/s10879-012-9220-x>.
- Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*. 2012; 43:460–467. <http://dx.doi.org/10.1037/a0029597>.
- Herman-Stahl MA, Stemmler M, Petersen AC. Approach and avoidant coping: Implications for adolescent mental health. *Journal of Youth and Adolescence*. 1995; 24(6):649–665.
- Hughes D, Rodriguez J, Smith EP, Johnson DJ, Stevenson HC, Spicer P. Parents’ ethnic-racial socialization practices: A review of research and directions for future study. *Developmental Psychology*. 2006; 42:747–770. [PubMed: 16953684]
- Kertzner RM, Meyer IH, Frost DM, Stirratt MJ. Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *American Journal of Orthopsychiatry*. 2009; 79:500–510. <http://dx.doi.org/10.1037/a0016848>. [PubMed: 20099941]
- Kosciw, JG.; Greytak, EA.; Bartkiewicz, MJ.; Boesen, MJ.; Palmer, NA. The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation’s schools. New York, NY: Gay, Lesbian & Straight Education Network; 2012.
- Kral AH, Malekinejad M, Vaudrey J, Martinez AN, Lorvick J, McFarland W, Raymond HF. Comparing respondent-driven sampling and targeted sampling methods of recruiting injection drug users in San Francisco. *Journal of Urban Health*. 2010; 87(5):839–850. [PubMed: 20582573]

- Leslie L, Smith J, Hrapczynski K, Riley D. Racial socialization in transracial adoptive families: does it help adolescents deal with discrimination stress? *Family Relations*. 2013; 62(1):72–81.
- Marshal MP, Dietz LJ, Friedman MS, Stall R, Smith HA, McGinley J, Brent DA. Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*. 2011; 49:115–123. <http://dx.doi.org/10.1016/j.jadohealth.2011.02.005>. [PubMed: 21783042]
- Marshal MP, Friedman MS, Stall R, King KM, Miles J, Gold MA, Morse JQ. Sexual orientation and adolescent substance use: A meta-analysis and methodological review. *Addiction*. 2008; 103:546–556. <http://dx.doi.org/10.1111/j.1360-0443.2008.02149.x>. [PubMed: 18339100]
- Marshal MP, King KM, Stepp SD, Hipwell A, Smith H, Chung T, Markovic N. Trajectories of alcohol and cigarette use among sexual minority and heterosexual girls. *Journal of Adolescent Health*. 2012; 50:97–99. <http://dx.doi.org/10.1016/j.jadohealth.2011.05.008>. [PubMed: 22188841]
- Masten AS. Ordinary magic: Resilience processes in development. *American Psychologist*. 2001; 56:227–238. <http://dx.doi.org/10.1037/0003-066X.56.3.227>. [PubMed: 11315249]
- McLaughlin KA, Hatzenbuehler ML, Xuan Z, Conron KJ. Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. *Child Abuse & Neglect*. 2012; 36:645–655. <http://dx.doi.org/10.1016/j.chiabu.2012.07.004>. [PubMed: 22964371]
- McLoyd VC. Socioeconomic disadvantage and child development. *American Psychologist*. 1998; 53:185–204. <http://dx.doi.org/10.1037/0003-066X.53.2.185>. [PubMed: 9491747]
- Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*. 2003; 129:674–697. <http://dx.doi.org/10.1037/0033-2909.129.5.674>. [PubMed: 12956539]
- Meyer IH, Wilson PA. Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology*. 2009; 56:23–31.
- Moon MW, Fornili K, O'Briant AL. Risk comparison among youth who report sex with same-sex versus both-sex partners. *Youth & Society*. 2007; 38:267–284. <http://dx.doi.org/10.1177/0044118X06287689>.
- Mustanski BS, Garofalo R, Emerson EM. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*. 2010; 100:2426–2432. <http://dx.doi.org/10.2105/AJPH.2009.178319>. [PubMed: 20966378]
- Mustanski, B.; Kuper, L.; Greene, GJ. Development of sexual orientation and identity. In: Tolman, DL.; Diamond, LM., editors. *Handbook of sexuality and psychology*. Vol. 1. Washington, DC: American Psychological Association; 2013. p. 597–628.
- Pachankis JE, Goldfried MR. Expressive writing for gay-related stress: Psychosocial benefits and mechanisms underlying improvement. *Journal of Consulting and Clinical Psychology*. 2010; 78:98–110. <http://dx.doi.org/10.1037/a0017580>. [PubMed: 20099955]
- Padilla YC, Crisp C, Rew DL. Parental acceptance and illegal drug use among gay, lesbian, and bisexual adolescents: Results from a national survey. *Social Work*. 2010; 55:265–275. <http://dx.doi.org/10.1093/sw/55.3.265>. [PubMed: 20632661]
- Parsai M, Voisine S, Marsiglia FF, Kulis S, Nieri T. The protective and risk effects of parents and peers on the substance use, attitudes, and behaviors of Mexican American female and male adolescents. *Youth & Society*. 2009; 40:353–376. <http://dx.doi.org/10.1177/0044118X08318117>. [PubMed: 19478992]
- Patton, MQ. *Qualitative research & evaluation methods*. 3rd. Thousand Oaks, CA: Sage; 2001.
- Perez-Figueroa AM, Alhassoon OM, Wang-Jones T. The effect of psychoeducation on attitudes toward bisexuality. *Journal of Bisexuality*. 13(3):338–355. <http://dx.doi.org/10.1080/15299716.2013.813420>.
- Pineles SL, Suvak MK, Liverant GI, Gregor K, Wisco BE, Pitman RK, Orr SP. Psychophysiologic reactivity, subjective distress, and their associations with PTSD diagnosis. *J Abnorm Psychol*. 2013; 122(3):635–644. [10.1037/a0033942](http://dx.doi.org/10.1037/a0033942) [PubMed: 24016006]
- Poteat T, Logie C, Adams D, Lebona J, Letsie P, Beyrer C, Baral S. Sexual practices, identities and health among women who have sex with women in Lesotho – a mixed-methods study. *Culture, Health & Sexuality*. 2014; 16:120–135. <http://dx.doi.org/10.1080/13691058.2013.841291>.

- Radkowsky M, Siegel LJ. The gay adolescent: Stressors, adaptations, and psychosocial interventions. *Clinical Psychology Review*. 1997; 17:191–216. [http://dx.doi.org/10.1016/S0272-7358\(97\)00007-X](http://dx.doi.org/10.1016/S0272-7358(97)00007-X). [PubMed: 9140715]
- Rew, L. *Adolescent health: A multidisciplinary approach to theory, research, and intervention*. Thousand Oaks, CA: Sage; 2005.
- Rice E, Gibbs J, Winetrobe H, Rhoades H, Plant A, Montoya J, Kordic T. Sexting and sexual behavior among middle school students. *Pediatrics*. 2014; 134:e21–e28. <http://dx.doi.org/10.1542/peds.2013-2991>. [PubMed: 24982103]
- Romero AJ, Roberts RE. Perception of discrimination and ethnocultural variables in a diverse group of adolescents. *Journal of Adolescence*. 1998; 21:641–656. <http://dx.doi.org/10.1006/jado.1998.0185>. [PubMed: 9971722]
- Rosario M, Schrimshaw EW, Hunter J. Homelessness among lesbian, gay, and bisexual youth: Implications for subsequent internalizing and externalizing symptoms. *Journal of Youth and Adolescence*. 2012; 41:544–560. <http://dx.doi.org/10.1007/s10964-011-9681-3>. [PubMed: 21656284]
- Rosario M, Schrimshaw EW, Hunter J, Gwadz M. Gay-related stress and emotional distress among gay, lesbian and bisexual youths: A longitudinal examination. *Journal of Consulting and Clinical Psychology*. 2002; 70:967–975. <http://dx.doi.org/10.1037/0022-006X.70.4.967>. [PubMed: 12182280]
- Russell ST, Franz BT, Driscoll AK. Same-sex romantic attraction and experience of violence in adolescence. *American Journal of Public Health*. 2001; 91:903–906. <http://dx.doi.org/10.2105/AJPH.91.6.903>. [PubMed: 11392932]
- Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*. 2010; 23:205–213. <http://dx.doi.org/10.1111/j.1744-6171.2010.00246.x>. [PubMed: 21073595]
- Saewyc EM. Contested conclusions: Claims that can (and cannot) be made from the current research on gay, lesbian, and bisexual teen suicide attempts. *Journal of LGBT Health Research*. 2007; 3:79–87. http://dx.doi.org/10.1300/J463v03n01_09. [PubMed: 18029318]
- Santiago-Rivera AL. Latinos, value, and family transitions: Practical considerations for counseling. *Journal of Counseling and Human Development*. 2003; 35:1–12.
- Scourfield J, Roen K, McDermott L. Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community*. 2008; 16:329–336. <http://dx.doi.org/10.1111/j.1365-2524.2008.00769.x>. [PubMed: 18328055]
- Seiffge-Krenke I, Klessinger N. Long-term effects of avoidant coping on adolescents' depressive symptoms. *Journal of Youth and Adolescence*. 2000; 29:617–630.
- Sellers RM, Shelton JN. The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology*. 2003; 84:1079–1092. <http://dx.doi.org/10.1037/0022-3514.84.5.1079>. [PubMed: 12757150]
- Swim JK, Johnston K, Pearson NB. Daily experiences with heterosexism: Relations between heterosexist hassles and psychological well-being. *Journal of Social and Clinical Psychology*. 2009; 28:597–629. <http://dx.doi.org/10.1521/jscp.2009.28.5.597>.
- Tobin DL, Holroyd KA, Reynolds RV, Wigal JK. The hierarchical factor structure of the Coping Strategies Inventory. *Cognitive Therapy and Research*. 1989; 13:343–361. <http://dx.doi.org/10.1007/BF01173478>.
- Troutman OA, Evans KM. A psychoeducational group for parents of lesbian, gay, and bisexual adolescents. *Journal of School Counseling*. 2014; 12(18) <http://www.jsc.montana.edu/articles/v12n18.pdf>.
- Yarborough, BJH. *Pharmacotherapy of adolescents diagnosed with mood disorders in a usual care setting*. Doctoral dissertation. 2009. Retrieved from <http://commons.pacificu.edu/spp/519>
- Yates, D.; Moore, D.; McCabe, G. *The practice of statistics*. 1st. New York, NY: W.H. Freeman; 1999.
- Ybarra, ML.; Mitchell, KJ.; Kosciw, JG.; Korchmaros, JD. Understanding linkages between bullying and suicidal ideation in a national sample of LGB and heterosexual youth in the United States.

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Table 1

Sample Characteristics (N = 48)

	<i>n</i> or <i>M</i>	% or <i>SD</i>
Age	16.27	1.38
14	4	8.33
15	12	25.00
16	11	22.92
17	13	27.08
18	4	8.33
19	4	8.33
Gender		
Male	19	39.58
Female	17	35.42
Transmale	7	14.58
Transfemale	2	4.17
Queer	3	6.25
Sexual orientation		
Gay	12	25.00
Lesbian	7	14.58
Bisexual	13	27.08
Pansexual	8	16.67
Asexual	1	2.08
Other	7	14.58
Primary racial identity		
Latino	19	39.58
African American	7	14.58
White	12	25.00
Asian	10	20.83
Mixed or other	13	27.08
Grade		
9	9	18.75
10	9	18.75
11	14	29.17
12	13	27.08
College	2	4.17
Not in school	1	2.08

Table 2**Coping Strategies, Responses, and Resources Described by Participants**

	<i>n</i>	%
Voluntary		
Engagement		
Spending time with LGBTQ community	32	66.7
Cognitive self-talk (e.g. "It will get better")	19	39.6
Learning new knowledge about sexual orientation	18	37.5
Using religious beliefs to accept LGBTQ people and self	14	29.2
Using online resources to connect with other LGBTQ people or information	12	25.0
Participating in Gay-Straight Alliance	12	25.0
Learning new knowledge about gender identity	12	25.0
Asking others to use different gender language (e.g., pronouns)	8	16.7
Identifying with a race community that feels accepting	6	12.5
Participating in an accepting religious community	6	12.5
Beginning gender transition (e.g., therapy, physical, hormonal)	4	8.3
Going to LGBTQ pride events	3	6.3
Talking with a supportive friend or adult	2	4.2
Talking with parent or other family member about crushes or relationships	2	4.2
Watching LGBTQ films, television shows, or online series	2	4.2
Disengagement		
Not coming out to family	20	41.7
Leaving a religion of origin due to negative LGBTQ messages	14	29.2
Changing social environment to avoid stressful situations	12	25.0
Denying same-sex attraction to self	11	22.9
Fighting with peers	10	20.8
Isolating self and not talking to people at school	10	20.8
Not disclosing sexual orientation or gender identity	9	18.8
Trying not to think about same-sex attraction	7	14.6
Engaging in avoidance activities (e.g., writing, reading, listening to music)	7	14.6
Involuntary		
Engagement		
Using religious values or beliefs to build confidence	9	18.8
Feeling proud to be LGBTQ	2	4.2
Disengagement		
Numbing or convincing self to be apathetic	25	52.1
Coping resources		
Supportive friend	40	83.3
Supportive parent or other immediate family member	38	79.2
LGBTQ friends or school peers	33	68.8
Accepting and diverse LGBTQ community	31	64.6
Other LGBTQ family member	14	29.2

	<i>n</i>	%
Supportive adult at school	13	27.1
LGBTQ family members treated well in family	10	20.8
Family passively shares LGBTQ information (e.g., watching LGBTQ movie)	8	16.7
Parents supportive of gender expression	7	14.6
Family actively shares LGBTQ information (e.g., discussing LGBTQ issues)	7	14.6
LGBTQ adult or role model at school	7	14.6
Parent apologizes or takes responsibility for heteronormativity	6	12.5
LGBTQ individuals treated well in family (e.g., family friend)	4	8.3
Parent supportive relative to bullying at school	4	8.3
LGBTQ presence in community (e.g., rainbow flag)	3	6.3
LGBTQ others of the same race and ethnicity	2	4.2

Note. LGBTQ = lesbian, gay, bisexual, transgender, or queer.