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Psychotherapeutic interventions for LGBTQ + youth: a systematic review

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ABSTRACT

LGBTQ + youth are at elevated risk for suicidality, substance use, and other mental health concerns. Evidence-based psychotherapeutic interventions are often the first line treatment for mental health concerns. However, there is limited research examining the effectiveness of such interventions among LGBTQ + adolescents. This systematic review synthesizes extant literature examining psychotherapeutic interventions for LGBTQ + adolescents with mental illness and/or substance use. Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, studies were assessed for inclusion eligibility. Researchers consulted three electronic databases, yielding a total of 666 results. Ten studies, with interventions ranging from drug use prevention to school-counseling, met inclusion criteria. Seven studies implemented adaptations to standard intervention protocol to make intervention content more accessible to LGBTQ + clients. Outcomes included decreased depressive symptoms, substance use, and social isolation. Significant design and methodological limitations were present across most studies, with four using a case study design and only two using a randomized controlled trial design. The review highlights preliminary evidence supporting the use of mental health interventions for LGBTQ + youth. However, more rigorous research is needed to determine if adapted interventions that include population-specific concerns of minority stress are more effective than treatment as usual.

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Introduction

The World Health Organization (WHO) ranks suicide as the third leading cause of death for adolescents (ages 10–19) worldwide (WHO, 2017). The WHO estimates that in 2015 alone, 67,000 adolescents completed suicide (WHO, 2017). Paralleling these global statistics, suicide has been identified

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as the third leading cause of death among adolescents aged 15–19 in the United States (U.S.), accounting for approximately 15.2% of total deaths in this age group (Heron, 2013; WHO, 2018).

Researchers have long reported an elevated risk of suicidal behaviors for individuals who self-identify as LGBTQ+[1] (Haas et al., 2010; King et al., 2008; Liu & Mustanski, 2012; Marshal et al., 2011; Remafedi et al., 1998; Russell & Joyner, 2001). Rates and risk of suicidal ideation, suicide attempts, and non-suicidal self-injury (NSSI) among LGBTQ+-identifying youth are double those of their non-LGBTQ+-identifying peers (Bakken & Gunter, 2012; Center for LGBT Evidence-based Applied Research (Center for LGBT EBAR), 2009; Marshal et al., 2011; Russell & Joyner, 2001). A 2016 study reported the lifetime prevalence of suicidal behavior among lesbian and gay youth to be 31%, far exceeding the national rate of 4.1% (Russell & Fish, 2016). Similarly, compared to heterosexual and cisgender youth, LGBTQ + youth are four to six times more likely to carry out a suicide attempt that requires medical treatment (i.e. an attempt that ends in injury, overdose, or poisoning) (Aranmolate et al., 2017). High rates of suicidality have also been documented among adolescents identifying as bisexual, with one study finding that bisexual youth were five times more likely to report suicidality than their heterosexual peers (Marshal et al., 2011). Even higher rates have been reported among trans and gender diverse (TGD) individuals. A survey from the National Center on Transgender Equality found that 40% of TGD adults indicated having made a suicide attempt in their lifetime, 92% of which were made during their adolescence (James et al., 2017). Rates of NSSI are also consistently higher among non-heterosexual youth, with one school-based study reporting that 18% of respondents identifying as LGB engaged in deliberate NSSI, compared to 5% of those identifying as heterosexual (Bakken & Gunter, 2012).

Background

LGBTQ + population in the United States

The LGBTQ + community (Lesbian, Gay, Bisexual, Transgender, Queer, plus various identities across the spectrums of sexual orientation and gender identity) is comprised of individuals who identify outside of hetero- and cisnormative sexual orientations and genders (American Psychological Association (APA),), 2018; Terrace Joint Commission (TJC),), 2011). Sexual orientation is defined as one's attraction to another, as well as choice of sexual partner. Gender identity refers to the gender with which one identifies internally and often aligns with the pronouns one chooses to use, while gender expression refers to the way in which individuals express that

gender identity through outward appearance, dress, and behavior. Because the terms 'gender' and 'sex' are often conflated, it is important to note that an individual's gender identity may or may not be congruent with their assigned sex at birth (APA, 2018; TJC, 2011). Though the percentage of people in the U.S. who identify as LGB is approximately 3.5% or ~9 million individuals, the percentage of individuals in the U.S. who report past sexual behavior with a same sex partner is substantially higher (approximately 8.2%) (The Williams Institute (TWI), 2011). Similarly, among youth, approximately 8% or 1.3 million high school students reported identifying as at LGB + in a recent national survey (Kann et al, 2016).

Further, it is estimated that the transgender community comprises approximately 0.3% of the overall U.S. population (TWI, 2011). While this percentage appears to be small, it translates to approximately 697,529 transgender individuals living across the U.S. For youth, this estimate is significantly higher, with approximately 1.8% of youth identifying as TGD in a 2017 survey (Kann et al., 2018). However, this estimate only measures the percentage of individuals who identify specifically as transgender. It does not extend to individuals who are genderfluid or genderqueer, nor does it account for those who do not publicly identify as transgender. Due to stigma and risk of discrimination and violence, LGBTQ + statistics tend to underestimate the number of individuals who identify as LGBTQ + or generally outside of cisnormative or heteronormative expressions of gender identity and sexual orientation.

Mental health and substance use

Compared to heterosexual adolescents, LGB youth not only experience disproportionate rates of suicidality, they also experience heightened rates of other mental health concerns, such as depression, anxiety, and substance abuse (Scannapieco, Painter, & Blau, 2018; Day et al., 2017; Russell & Fish, 2016; Marshal et al., 2008; Hatzenbuehler et al., 2012; Russell & Joyner, 2001). There is currently insufficient data on mental health and substance use diagnoses among TGD youth to estimate the prevalence of these conditions. However, preliminary studies suggest that the prevalence of mental health disorders among TGD youth are, at minimum, equivalent to that of LGB youth (Haas et al., 2010; Mustanski et al., 2010). These heightened rates of mental illness and substance use among LGBTQ + adolescents are particularly concerning given that approximately 90% of all suicides are completed by individuals who have received prior mental health diagnoses (Bertolote & Fleischmann, 2002).

Risk factors for suicide and psychopathology

Adolescents face several mental health risk factors for suicidality including hopelessness, substance abuse, depression and other mental health diagnoses, as well as a recent suicide attempt by a family member or friend (Bertolote & Fleischmann, 2002; Russell & Joyner, 2001). In addition to these universal risk factors, LGBTQ + adolescents experience vulnerabilities specific to their identification as non-hetero- and non-cisnormative individuals. These include increased peer-victimization, bullying, familial rejection, and other instances of discrimination, all of which heighten both the risk of mental illness and suicidality within this population (Bontempo & D'Augelli, 2002; Russell & Fish, 2016; Russell & Joyner, 2001; Suicide Prevention Resource Center, 2008).

Compared to other periods of time in the lives of LGBTQ + individuals, risk of suicide is highest following the disclosure of sexual orientation or gender identity to family members and peers (Center for LGBT Evidence-based Applied Research (Center for LGBT EBAR), 2009). Because adolescence often coincides with such disclosure, LGBTQ + youth are especially susceptible to such stress, and are consequently at elevated risk for suicidality (Center for LGBT Evidence-based Applied Research (Center for LGBT EBAR), 2009). Familial rejection can be particularly detrimental. One study found that youth experiencing rejection from guardians on the basis of sexual orientation are eight times more likely to attempt suicide than those with supportive guardians (Haas et al., 2010). This study also showed that TGD individuals reported experiencing various environmental stressors, such as familial rejection (particularly during adolescence) and frequent discrimination (such as not being offered a job; employment termination; and facing on-the-job harassment such as verbal abuse and purposeful misgendering) (Haas et al., 2010).

Meyer's Minority Stress Theory (2003) informs the relationship between stress and mental health, highlighting how identification as LGB increases one's awareness of and exposure to minority-related stress. The theory posits that individuals belonging to stigmatized social groups may experience mental illness as a result of marginalized social positioning. Within the LGB community, exposure to stressors such as structural discrimination, oppression, and homophobic violence can lead to hypervigilance of stressful events and vulnerability to internalized homo- or transphobia (Meyer, 2003).

House et al. (2011) theory of interpersonal trauma and mental health further validates Meyer's claims, which emphasize the relationship between victimization and suicidality within the LGB community. The authors also found that LGB individuals are at increased risk of victimization, with, for example, rates of childhood sexual abuse ranging from 15% to 28%. For

TGD-identified individuals, rates of violent victimization and sexual assault were found to be even higher (House et al., 2011). House et al. (2011) evaluated the relationship between traumatic events, minority stress, and suicidality within the LGBTQ + community and found that rates of suicidality and NSSI are higher among individuals with histories of trauma and discrimination. This study highlighted the need to mitigate homophobia and transphobia by intentionally tackling societal discrimination through community education and policy change.

In 2012, Hendricks and Testa directly adapted Meyers' theory, as they sought to address the specific experiences of TGD individuals (however their theory did not specifically speak to the experiences of individuals who identify as non-binary). In their adaptation of the model, Hendricks and Testa (2012) report that compared to their cisgender LGB counterparts, TGD individuals face elevated rates of negative external events, as well as greater vigilance when disclosing such negative events to others. Individuals within the TGD community also experience heightened rates of harassment, discrimination, and violence, with rates of sexual violence as high as 46% and physical violence as high as 60% (Hendricks & Testa, 2012). In another study conducted by Bockting et al. (2013), over 70% of their study sample of TGD individuals had experienced verbal abuse, and 37.9% had experienced employment discrimination. These markedly high rates of negative external events demonstrate the gravity of stress experienced by this community. Given the cumulative stressors associated with their identity, TGD individuals are at an even greater risk for mental health problems and suicidal behavior (Clements-Nolle, Marx, & Katz, 2006). Individuals within the TGD community in the U.S. have been found to experience disproportionately high rates of both attempted suicide (40%) and suicidal ideation (82%) in their lifetimes (James et al., 2017).

Empirically supported mental health interventions

Given the high rates of mental health concerns among LGBTQ + youth, it is pressing to identify effective evidence-based psychotherapeutic interventions for this population. Evidence-based psychotherapeutic interventions are the first-line treatment for mental health and substance use concerns for both adults and adolescents (Center for LGBT Evidence-based Applied Research (Center for LGBT EBAR), 2009). The Institute of Medicine defines evidence-based practice as the integration of leading research evidence with patient values and clinical expertise (Sackett et al., 2000). The APA Task Force (APA 2006) argues that because of the influence an individual's sociocultural context on one's self-perception and mental health, it is essential that interventions consider the age, sexual orientation, and

gender identity of their participants (APA Presidential Task Force on Evidence-Based Practice [APA EBP], APA, 2006).

Because of the detrimental impact of minority stress on the mental wellness of LGBTQ + youth, it is crucial to look at the effectiveness of evidence-based treatment models implemented within this population (APA, 2006; Austin & Craig, 2015; Trinh-Shevrin et al., 2007). However, despite strong arguments for more targeted research, there is only one systematic review to date that has examined empirically-based psychological interventions with *LGB* youth (Hobaica et al., 2018). Hobaica et al. (2018) review summarizes existing research on psychological interventions for LGB youth, ultimately emphasizing a strong need for additional research in this area. This review does not account for TGD youth, nor does it systematically review if and how interventions were adapted for LGBTQ + individuals. Given the APA Task Force recommendations, it is essential that interventions reflect research findings and respond to patients' individualized identities, strengths, challenges, and preferences (APA, 2006).

While research on the efficacy of interventions adapted for LGBTQ + youth is lacking, two recent studies support the hypothesis that population-specific adaptations of interventions may be effective among LGBTQ + individuals (Alessi, 2014; Pachankis et al., 2015). Studies by Pachankis et al. (2015) and Alessi (2014) present evidence supporting interventions that target the disproportionate distress associated with LGBTQ + identification by incorporating psychoeducation on minority stress for adults. Pachankis et al. (2015) used ESTEEM (Effective Skills to Empower Effective Men), a ten-session adapted version of transdiagnostic cognitive behavioral therapy (CBT) to promote personal agency and resiliency and reduce minority stress that contributes to mental health disparities between heterosexual and non-heterosexual males. Through this intervention, clinicians targeted internalized homophobia and concealment, as well as universal risk factors such as hopelessness and social isolation. To assist participants in identifying experiences of minority stress, treatment modules examined cognitive, affective, and behavioral reactions to minority stress, and provided psychoeducation to support participants in attributing distress to minority stress as opposed to personal failure. Alessi (2014) similarly examined the efficacy of a treatment intervention influenced by minority stress theory. In a case study, Alessi (2014) used an LGB-affirmative approach combining cognitive behavioral and psychodynamic therapies with a 25-year-old black lesbian client. Both studies determined that adopting a minority stress framework in clinical interventions is effective in addressing clients' experiences of how such stress can impact mental health, cognitive processes, and coping mechanisms. Though their studies did not include LGBTQ+ *youth*, results from Alessi (2014)

and, particularly, Pachankis et al. (2015) support the hypothesis that LGBTQ + youth would benefit from interventions adapted to respond to minority stress.

Further, it is essential to consider how adaptations conducted in research studies are delivered in practice. In a 2008 article, Kazdin addresses the research-practice divide, explaining that practical clinical experience contributes to the field of mental health, as well as within the subfield of mental health research. In practice, evidence-based treatments inevitably undergo adaptation in order to meet individual patient needs; mental health research would greatly benefit from incorporating such adaptations in empirical studies. The scarcity of information on best practices with LGBTQ + youth substantiates the need to synthesize all existing literature, including case studies, as they represent one of the few sources providing insight into treatment adaptations for this community. Given the potential effectiveness of LGBTQ+-specific adaptations in clinical interventions, this systematic review also examines if and how interventions were adapted to address the specific needs of LGBTQ + youth. Unlike other recent studies examining psychological interventions with LGB youth, this review's inclusion of case studies (and experimental studies) allows for the examination of how therapists adapt interventions to fit the aforementioned needs of this patient demographic (Hobaica et al., 2018).

Study aims

Using a systematic approach, this review identifies psychotherapeutic interventions used to address mental health and substance use challenges among LGBTQ+-identified youth. Further, this review also investigates whether (and how) the studied mental health interventions were adapted to incorporate an LGBTQ+-affirmative approach.

Methods

Search method

The protocol for this review can be accessed through Prospero. The format of this review mirrors the PRISMA (Preferred Reporting Items for Systematic Reviews) framework. Figure 1 illustrates the selection process that identified studies for inclusion using the following three online databases: Web of Science, PsycInfo, and Embase. Figure 1 illustrates the selection process that identified studies for inclusion using the following three online databases: Web of Science, PsycInfo, and Embase. These databases were chosen in line with recommendations from prior literature examining systematic literature review database combinations and based on the

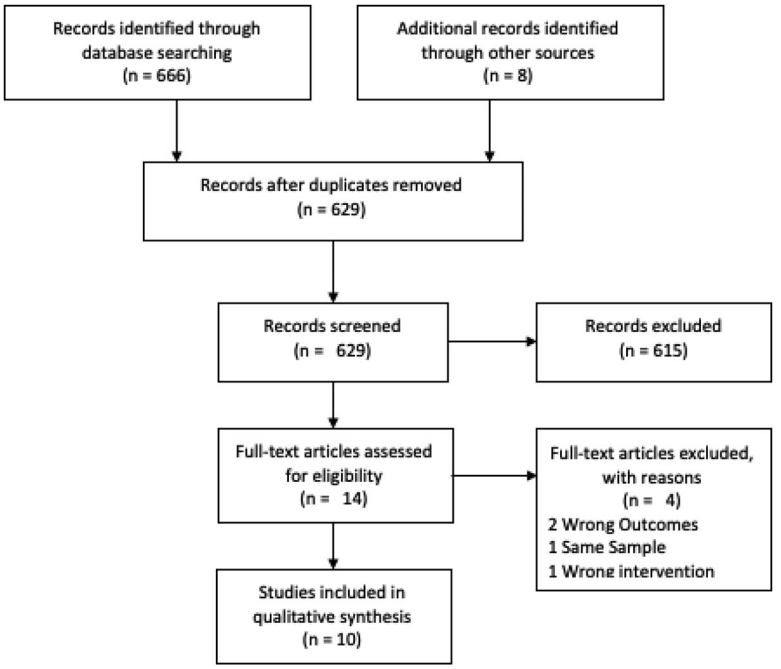

Figure 1. PRISMA flow diagram.

expansion of Embase to include all Medline citations (Bramer et al., 2016; Lam et al., 2018). Search criteria were limited to articles (qualitative or quantitative) published in peer-reviewed journals within the past 20 years. The literature search was conducted on February 1st, 2018, in which the following search terms were entered into the search field on each of the databases and selected for abstract, title, and full text: (LGB* OR 'gay' OR 'homosexual' OR 'sexual minority') AND ('adolescent' OR 'youth') AND ('therapy') using the advanced search field in each database.

Additionally, since the scope of this review is limited to interventions delivered by mental health professionals, the term 'therapy' was used to describe these interventions. The initial search elicited 666 articles from the combined databases. In addition to studies compiled through these database searches, eight studies were identified through a review of reference lists from related studies. Following duplicate merge, 629 studies were reviewed in an initial screening process (first and second authors reviewed article titles and abstracts). Due to irrelevance to the study topic or failure to evaluate a treatment conducted with LGBTQ+-identified adolescents, 615 studies were ultimately excluded. Articles were excluded if they did not meet the following inclusion criteria: provision of treatment by a mental health practitioner or delivered via a computer-based intervention and assessment of mental health outcomes. The initial screening process yielded

14 articles to be reviewed in the second stage: full text review. Four studies were excluded in this round due to two not reporting on mental health-related outcomes, one using the subset of a sample used in another included study, and one employing on a non-mental health intervention (this study was reporting on a Gay-Straight Alliance). Ten studies met full inclusion criteria and were subsequently included in this review.

Using the Methodological Quality Rating Scale (MQRS), study quality was independently assessed by two researchers based on study design, sample size, treatment procedures, assessment of mental health concerns (using psychometric measures to identify intervention outcomes), and post-intervention follow-up (Miller & Wilbourne, 2002). Following independent review of study quality, researchers met together to discuss ratings, assess level of agreement, and resolve through a consensus based discussion two instances of disagreement. The MQRS examines 12 aspects of studies, rating them on one of the following scales: 0–1, 0–2, or 0–4 which are then summed to determine a raw score. This scale awards studies one point (per category) if they demonstrate strength (judged differently for each) in the following categories: 'Quality Control,' 'Contact,' 'Collaterals,' 'Objective Dropout,' 'Attrition,' 'Analyses,' and 'Multisite;' up to two points (per category) for 'Follow-up Rate' and 'Follow-up Length,' and up to four points for 'Group Allocation' (Miller & Wilbourne, 2002).

Results

Study design

Table 1 provides a summary of the 10 studies that met full inclusion criteria for the systematic review. Two of these used a randomized control trial (RCT) design (Grafsky et al., 2011; Schwinn et al., 2015). Grafsky et al. (2011) study was a secondary data analysis of a study that did not originally seek to examine differences between LGB and heterosexual youth (while all participants were randomized into either treatment as usual or the experimental condition, the secondary data analysis subsequently analyzed differences between groups based on identification as either LGB or heterosexual), and four used uncontrolled experimental designs (Craig et al., 2014; Craig & Austin, 2016; Diamond et al., 2012; Lucassen et al., 2015). The four remaining studies were case studies (Budge, 2015; Duarté-Vélez et al., 2010; Johnson, 2004; Perry et al., 2017). While all studies collected data pre-post intervention, only four studies collected follow-up data (Craig & Austin, 2016; Duarté-Véléz, et al., 2010; Lucassen et al., 2015; Schwinn et al., 2015).

Table 1. Study design, intervention type, and sample characteristics.

Study	Design	Sample Size (N)	Age	Sexual Orientation	Gender Identity	Racial/ Ethnic Background
CBT-based Interventions						
Craig and Austin (2016)	One Group Pre-Post	30	$\mu = 16.8$	25% Lesbian 11% Gay 18% Bisexual 21% Queer 29% Pansexual 2% Polysexual 11% Unsure	10% Trans 21% Non-Binary 8% Two-Spirit 57% Female 18% Male	25% Black 7% Latinx 18% Indigenous 24% Southeast Asian 64% White
Duarté-Vélez et al. (2010)	Case Study	1	16	Gay	Male	Latinx
Johnson (2004)	Case Study	1	17	Experienced same-sex attraction	Male	White
Lucassen et al. (2015)	One Group Pre-Post	21	$\mu = 16.5$	100% identified as LGB	48% Female 52% Male	14% Asian 71% European 10% Māori 5% Pacific
Perry et al. (2017)	Case Study	1	22	Not specified	Trans Male	Not specified
Non CBT-Based Interventions:						
Budge (2015)	Case Study	1	18	Queer	Trans Female	Latinx
Craig et al. (2014)	One Group Pre-Post	263	$\mu = 16.7$	38% Lesbian 22% Gay 33% Bisexual 4% Queer 3% Other	1% Trans+ 72% Female 27% Male	26% Black 22% Latinx 48% White 3% Other
Diamond et al. (2012)	One Group Pre-Post	10	$\mu = 15.1$	20% Lesbian 10% Gay 70% Bisexual	80% Female 20% Male	50% Black 20% Multiracial 20% White 10% Other
Grafsky et al. (2011)	RCT	268	$\mu = 18.7$	20% Lesbian, Gay, Bisexual 76% Heterosexual 4% Did Not Identify	46% Female 64% Male	Not specified
Schwinn et al. (2015)	RCT	236	$\mu = 16.1$	39% Same Sex 49% Both Sexes 6% Opposite Sex 6% Unsure Genderqueer 51% Female 33% Male	16% 7% Asian 10% Black 13% Hispanic 62% White 8% Other	

Sample characteristics

Sample sizes ranged from one to 268 participants, with the age ranging from 14 to 22. Individuals in the studies primarily identified as LGB, though a small percentage identified as TGD. In one case study, though the participant was not LGBTQ+-identified, he reported same-sex attraction,

and treatment addressed his feelings and beliefs about himself related to this attraction (Johnson, 2004). One study included a comparison group of heterosexual identified adolescents (Grafsky et al., 2011). Participants in each study presented with varying mental health concerns including depression, hopelessness, social impairment, attachment-related anxiety and avoidance, minority stress, suicidality, self-harm, and substance abuse.

Treatment procedures

Summary of studies

Treatment was administered by mental health professionals through hospital, community, and computer-based settings. In five of the studies, treatment was administered by therapists with prior experience working with LGB or TGD youth (Budge, 2015; Craig et al., 2014; Craig & Austin, 2016; Diamond et al., 2012; Duarté-Vélez et al., 2010). While most studies addressed sexual orientation and gender identity throughout the intervention, seven made specific adaptations to their interventions to address the needs of LGBTQ + clients (Budge, 2015; Craig et al., 2014; Craig & Austin, 2016; Diamond et al., 2012; Grafsky et al., 2011; Lucassen et al., 2015; Schwinn et al., 2015). Four of these interventions were conducted by therapists who had received additional training to administer the manualized intervention (Diamond et al., 2012; Duarté-Vélez, et al., 2010; Grafsky et al., 2011) (See Table 1 for an overview of treatment adaptations).

CBT-based interventions

Five of the included studies delivered CBT-based interventions in outpatient settings. One delivered group sessions in a community-based setting using AFFIRM, an adapted CBT program developed for LGBTQ + youth (Craig & Austin, 2016). The four remaining studies provided individual CBT-based sessions; three of which were delivered in person (Duarté-Vélez et al., 2010; Johnson, 2004; Perry et al., 2017), and one online (Lucassen et al., 2015). The duration of these interventions lasted anywhere from two days (Craig & Austin, 2016) to four months (Johnson, 2004), with the number of sessions ranging from seven (Lucassen et al., 2015) to sixteen (Johnson, 2004).

Two CBT-based studies included treatment adaptations to standard CBT protocol through the inclusion of LGBTQ + specific content (i.e. psychoeducation on minority stress) (Craig & Austin, 2016; Lucassen et al., 2015) while the other three studies maintained fidelity to standard CBT protocol (Duarté-Vélez et al., 2010; Johnson, 2004; Perry et al., 2017). Duarté-Vélez et al. (2010) adapted an intervention to account the client's intersecting identities of sexual orientation, spirituality, and familial role. In Perry

et al.'s study (2017), treatment addressed the client's tendency to isolate and withdraw from social activities, likely a result of early experiences of minority stress and internalized transphobia. In Johnson's study (2004), no specific treatment adaptations were made to affirm the patient's identity and experience of same-sex attraction, but Rational Emotive Behavior Therapy (REBT) assessments were completed using activating events related to the client's sexual attraction (Johnson, 2004).

Two other studies included adaptations to treatment interventions for LGBTQ + youth. Craig and Austin (2016)'s pilot study evaluated a CBT-based intervention designed specifically for LGBTQ + youth to address psychological distress by affirming identities, addressing minority stressors, and targeting maladaptive responses to these minority stressors (Craig & Austin, 2016). Finally, Lucassen et al. (2015) piloted an adapted version of SPARX (Smart, Positive, Active, Realistic, X-factor thoughts), a computer-based CBT program for adolescents presenting with mild to moderate depression. Researchers adapted this intervention, creating Rainbow SPARX to meet the needs of LGBTQ + youth by challenging internalized homophobia and cisnormative expectations of gender presentation. Rainbow SPARX adapted 5.9% of the original SPARX script to reframe depression as a *response* to systemic homophobia rather than a *symptom* of sexual orientation.

Attachment-based family therapy for families with LGB adolescents experiencing suicidality (ABFT-LGB)

Diamond et al. (2012) study explored the effectiveness of an adaptation of attachment-based family therapy (ABFT) designed to meet the needs of suicidal LGB adolescents. A treatment development team modified the ABFT manual to include three to five additional sessions to work with parents around emotional responses to their adolescent's sexual orientation and help facilitate the acceptance process. The goal of caregiver participation was to heighten awareness of how certain responses can implicitly invalidate their adolescent's sexual orientation, as well as provide space for parents to process disappointment, pain, and fear regarding their adolescent's LGB identity.

Affirmative supportive safe and empowering talk (ASSET)

Craig et al. (2014) study offered ASSET, the first LGB affirmative school-based group counseling intervention specifically created to promote LGB youth resiliency. ASSET was developed to mitigate negative impacts of minority stress by providing participants with social connectedness, while promoting high self-esteem, enhanced coping, and confident problem

solving. Discussion-based group sessions included a warm-up activity; "hot topic" (e.g., coming out, being bullied) discussion; exploration of supportive resources in relationships with family, friends, and significant others; and practice of healthy decision making and stress coping skills. Groups were discussion-based and allowed LGB youth to share experiences, while therapists provided feedback to promote effective problem-solving and proactive coping skills.

Community reinforcement approach (CRA)

In their secondary data analysis, Grafsky et al. (2011) compared the efficacy of treatment as usual to a community reinforcement approach among LGB and non-LGB youth experiencing street homelessness. Individual CRA sessions targeted drug refusal skills, affect regulation, prosocial behaviors, relapse prevention, communication, problem solving, and self-management. Treatment was delivered through in vivo skill rehearsal and homework practice. While no adaptations were made to the CRA intervention, the intervention group was offered four additional sessions focused on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) education.

Online drug abuse prevention intervention

In their RCT, Schwinn et al. (2015) used social competency skill-building strategy and minority stress theory to inform a three-session online drug abuse prevention intervention. Intervention content was specifically tailored for LGB youth to support coping with stressors related to sexual orientation (i.e. internalized homophobia, negative reactions to disclosure, and victimization). The treatment was led by an animated narrator who guided participants through content and practice scenarios tailored to meet the needs of this targeted population. Workshop activities included games, role-playing opportunities, and writing exercises.

Psychotherapy and letter writing for gender-affirming surgery

In a case study, Budge (2015) provided individual outpatient psychodynamic and interpersonally-oriented psychotherapy to a transwoman seeking hormone therapy, with three sessions including the patient's mother. Though the client originally indicated a desire to receive gender-affirmation surgery, costs were prohibitive. This study examined how the process and outcome of psychotherapy are impacted when the psychotherapist is also a gatekeeper for assessing client's readiness for the gender affirmation process. Budge (2015) aimed to understand how this gatekeeper role impacts the efficacy of psychotherapy with TGD individuals in general, and how

Table 2. Treatment procedures, adaptations, and results.

CBT-Based Interventions:

Study	Treatment Procedure & Content	Adaptations	Results	MQRS
Craig and Austin (2016)	• 8 group sessions • CBT-based intervention administered by 6 facilitators who had ∼5 hours of AFFIRM training, at least one-year experience working with LGBTQ + youth, and identified as LGBTQ+ • Aimed to reduce depression and improve coping by understanding and modifying mood, cognition, and behavior	• Developed specifically for the LGBTQ + community • Provided psychoeducation on minority stress, targeted maladaptive responses to minority stressors, as well as helped youth develop healthy coping strategies	Depression decreased from moderate to borderline major depressive disorder on Beck Depression Inventory (BDI). Depression positively correlated with "threat appraisals" (viewing stress as harmful to oneself) and negatively correlated with "challenge appraisals" (viewing stress as an opportunity for growth) (Stress Appraisal Measure for Adolescents).	**5**
Duarté-Vélez et al. (2010)	• 12 weekly individual or joint sessions with client's mother in an outpatient setting • Treatment administered by a psychotherapist with LGB+ (non-trans) expertise • Sessions were divided into three modules: thought, activities, and interpersonal	• Ecological validity model used to inform adaptation of CBT • Treatment content addressed patient's values, preferences and contexts (i.e. cultural values of sexual orientation, spirituality and family)	Decrease in depressive symptoms following treatment based on client's self-report, with results maintained at 1 year follow up. Results indicated that client experienced higher self-acceptance (Pier-Harris Children's Self Concept Scale).	**7**
Johnson (2004)	• 16 individual outpatient sessions • Administered by clinical psychologist with no LGBTQ+-specific training • Treatment addressed depressive symptoms by targeting consequences (shame, depression) by examining underlying beliefs the client held about himself	• No systematic adaptations were made to manualized intervention • Some content of later treatment sessions targeted client's feelings about his sexuality	Relative decrease in depressive symptoms on the BDI.	**0**
Lucassen et al. (2015)	• 7, 30-minute individual computer-based modules administered by a "virtual therapist" • Relaxation training, behavioral activation, social skills training, recognizing cognitive distortions, problem solving, and	• Rainbow SPARX added a component challenging internalized homophobia and cisnormative expectations of gender, resulting in changes to 6% of program script.	Significant decrease in depression on CDRS-R, Mood and Feelings Questionnaire, and Reynolds Adolescent Depression Scale with results maintained at follow up. Significant decrease in anxiety (Spence Children's	**7**

(*continued*)

Table 2. Continued.

CBT-Based Interventions:

Study	Treatment Procedure & Content	Adaptations	Results	MQRS
	cognitive restructuring	• Changes reframed depression as a response to homophobia, rather than a symptom of sexual identity • Program appearance modified (i.e. avatar customization options were not gender specific)	Anxiety Questionnaire) and decrease in hopelessness (Kazdin Hopelessness Scale for Children) from pre to post intervention. No significant change in quality of life (Pediatric Quality of Life and Enjoyment Scale).	
Perry et al., (2017)	• 12 individual sessions in an outpatient setting over the course of treatment • Therapist (license not specified; and no indication of prior experience with LGBTQ + community) provided CBT, with a focus on behavior activation • First two treatment sessions focused on assessment and treatment planning, and sessions 3-12 focused on BA	• No systematic adaptations were made to manualized intervention • Some content addressed minority specific experiences (e.g. treatment addressed tendency to isolate and withdraw from social activities, a coping mechanism that likely developed during youth in response to anxiety about perceived gender identity)	Depression did not improve (no significant change in their BDI-II score); Increased behavioral activation than avoidance and less social impairment on Behavioral Activation for Depression Scale (self-report of behavioral avoidance, behavioral activation, and work and social impairment).	**1**

Non CBT-Based Interventions:

Study	Treatment Procedure & Content	Adaptations	Results	MQRS
Budge (2015)	• 27 individual outpatient sessions • Therapist (with prior experience with trans + youth) used WPATH SOC with interpersonal and psychodynamic approaches for letter writing	• Psychotherapist utilized WPATH Standard of Care to guide the letter writing process for a client seeking gender affirmation procedures • Adapted to meet client needs and assess transition readiness (i.e. Outness Inventory adapted for use with trans experience and gender identity)	Depression Center for Epidemiological Studies Depression Scale scores decreased; Mood, mental health, identity processes, support, and ability to experience and express emotions improved; Overall distress (K10 Self-Administered Questionnaire) decreased and sense of well-being (Schwartz Outcome Scale) increased.	**0**
Craig et al. (2014)	• 8-10 weekly school-based group counseling sessions	• Content of treatment was developed specifically for LGBTQ + youth to	Significantly positive correlation between self-esteem and social	**3**

(*continued*)

Table 2. Continued.

CBT-Based Interventions:

Study	Treatment Procedure & Content	Adaptations	Results	MQRS
	• Treatment administered by therapists with prior LGB youth experience • Intervention explored issues in students' lives; relationships with family, friends, and partners as sources of support or stress; and healthy decision making/coping	promote resilience, effective problem solving, and proactive coping skills, to reduce the potential negative impact of minority stress experiences	connectedness based on scores from the (Social Connectedness Scale). Increase in proactive coping for all participants (significant between coping, race/ethnicity, and sexual orientation) based on scores from the Proactive Coping Inventory. No significant correlation between social connectedness and gender, sexual orientation, or race/ethnicity; Participants reported treatment to be helpful.	
Diamond et al. (2012)	• 12 weekly outpatient family and individual sessions • Administered by clinical psychologists (with prior experience with suicidal LGB youth) • Intervention addressed youth hesitation to seek parental support, family conflicts impacting suicidality, parental emotional attunement, attachment disruption, and youth autonomy	• ABFT-LGB, an adaptation of ABFT, modified the existing manual to include more time working with parents to address their emotional responses to their child's sexual orientation and to facilitate parents' acceptance of their child's sexual orientation	Significant decrease in attachment-related anxiety and avoidance among 5 participants. Significant decrease in suicidal ideation for all 8 participants, half also reported a decrease in depressive symptoms. Decrease in maternal attachment-related anxiety for over half of participants with pre- and post-treatment data, with 2 experiencing decrease in maternal attachment-related avoidance.	**5**
Grafsky et al. (2011)	• 12 individual outpatient sessions • Provided in homeless youth center by licensed counselors (no	• No systematic adaptations were made to manualized intervention • Youths assigned to the intervention group were offered 4 HIV	Significant reduction in mental health symptoms and drug use for all youth (higher decreases for GLB youth) based on	**9**

(*continued*)

Table 2. Continued.

CBT-Based Interventions:				
Study	Treatment Procedure & Content	Adaptations	Results	MQRS
	experience with LGB youth indicated) • Topics: drug refusal training, affect regulation, understanding substance use, relapse prevention, communication, and self-management skills	education practice skills sessions. The curriculum for these additional sessions was developed from an eight-session, community-based HIV-prevention program.	scores from (The Form 90, BDI, and Youth Self-Report Form).	
Schwinn et al. (2015)	• 3 individual computer-based sessions (14 minutes each) • Online drug abuse prevention program guided by social competency skill-building and minority stress theory	• Intervention content tailored to help LGB youth cope with stressors related to identity (i.e., negative reactions to disclosure, victimization, and internalized homophobia) • To make treatment more accessible, clients did not need to obtain parental consent	Decrease in stress, peer drug use, and other drug use in the past 30 days. Increase in coping, problem solving, and drug-use refusal skills. No difference between intervention and control group measures in past 30-day alcohol, cigarette and marijuana use.	**8**

the mandate to receive a mental health diagnosis in order to obtain gender-affirming treatment can cause distress and further complex trauma.

Treatment outcomes [Table 2 summarizes study quality and outcomes]

CBT-based interventions

In the five studies delivering CBT-based interventions, all participants presented with depression, and many with co-occurring disorders such as anxiety (Craig & Austin, 2016; Duarté-Vélez et al., 2010; Johnson, 2004; Lucassen et al., 2015; Perry et al., 2017). Results from three of the studies indicated significant decreases in symptoms of depression, with results maintained at follow-up (Craig & Austin, 2016; Duarté-Vélez et al., 2010; Lucassen et al., 2015). Results from Johnson's study (2004) also indicated a relative decrease in depressive symptoms. Unlike the other studies included, Perry et al.'s study (2017) did not find that the behavioral activation intervention reduced patients' depressive symptoms.

Of the two studies measuring anxiety, Lucassen et al.'s study found a decrease in clients' anxiety from pre to post-intervention (Duarté-Vélez et al., 2010; Lucassen et al., 2015). However, the client in Duarté-Vélez

et al.'s (2010) study continued to meet criteria for unspecified anxiety disorder post-treatment.

Finally, a few studies measured variables related to minority stress. Though there was no decrease in the Perry et al. (2017) client's depressive symptoms, patient reported acquiring new skills to reduce avoidance behaviors. Further, using a series of four scales, Craig and Austin (2016) found that participants came to identify coping with stress as a 'challenge,' rather than a 'threat' post-treatment. Patient's capacity to reflect on emotional experiences did not increase significantly from baseline to termination but did increase significantly from termination to three-month follow-up. Finally, in Johnson's 2004 study, though the client reported a decrease in depressive symptoms, internalized homophobia was reportedly maintained.

Non-CBT-based interventions

Participants in three of the five non-CBT-based studies entered treatment presenting with depression (Budge, 2015; Diamond et al., 2012; Grafsky et al., 2011). The transgender participant in Budge's study (2015) achieved a clinically significant decrease in depression, with scores at termination below the clinical threshold for depression. This client also experienced an increase in her sense of well-being and a decrease in overall distress. However, no follow-up data was collected, making it difficult to determine if treatment benefits were sustained.

At baseline, LGB-identified youth participants in Grafsky et al. (2011)'s study had significantly higher scores of depression compared to their non-LGB counterparts. Though the study found no significant outcome differences between treatment as usual and the community reinforcement approach, assessments conducted post-intervention revealed that all participants experienced a significant decrease in mental health symptoms, with LGB youth reporting an even greater decrease in depressive symptoms (Grafsky et al., 2011). Finally, Diamond et al. (2012) found that all eight participants who completed treatment reported clinically significant decreases in suicidal ideation and three of the eight reported significant decrease in depressive symptoms.

Two of the non-CBT studies addressed substance use (Grafsky et al., 2011; Schwinn et al., 2015). Similar to their results on depressive symptoms, Grafsky et al. (2011) found that at baseline LGB-identified participants presented with higher levels of substance use (other than tobacco, alcohol, or marijuana) than their non-LGB peers. There appeared to be no effect of treatment type on study outcomes as they related to substance use, but LGB youth reported greater decreases in substance use than their non-LGB counterparts (Grafsky et al., 2011). Schwinn et al.'s study (2015) found at three-month follow-up that the intervention group had experienced

decreased rates of 'other' drug use and stress in the past 30 days. Additionally, compared to the control group, the intervention group showed improved coping, problem solving, and substance-use refusal skills. However, follow-up showed no significant difference between the control and intervention groups in measures of alcohol, cigarette, and marijuana use.

For their school-based group counseling intervention, Craig et al. (2014) found that social connectedness data remained unchanged post-treatment, but that there was a statistically significant increase in self-esteem (Rosenberg Self-Esteem Scale), and proactive coping post-treatment.

Study quality

MQRS scores can be found in Table 2. Overall, the MQRS ratings for each of the reviewed studies revealed significant limitations of the study designs. Specifically, only two studies met the standard of randomization for the group allocation criterion (Grafsky et al., 2011; Schwinn et al., 2015). Due to limitations of study design, four of the ten were unable to assess for group differences nor did they use statistical analysis (Budge 2015; Duarté-Vélez et al., 2010; Johnson, 2004; Perry et al., 2017). However, most studies met the criteria for 'Quality Control,' as they followed a standardized treatment model. Unlike the other nine studies, Budge (2015) did not meet this criterion as the therapeutic intervention synthesized an interpersonally oriented therapy approach and gender affirming care guidelines that was not standardized. Moreover, none of the studies met the criteria of 'Objective' verification in more than 50% of participants, 'Independent' follow-up completed by interviewer who were blind to group allocation, or 'Multisite' replication at multiple sites with different research teams (Miller & Wilbourne, 2002).

Discussion

Despite the mounting evidence that LGBTQ + youth are at high risk for mental health concerns such as suicidality, depression and substance abuse, research examining treatment among LGB, and (particularly) TGD youth is severely lacking. This review sought to synthesize extant literature to assess the effectiveness of evidence-based psychotherapeutic interventions within this demographic.

Findings demonstrate that both CBT and non-CBT-based interventions appear promising for the treatment of mental health concerns among LGBTQ + adolescents. All reviewed interventions yielded positive change in the anticipated direction, and five studies found statistically significant

results in at least one outcome domain (e.g. depression, anxiety). Specifically, of the eight studies evaluating depression, seven found that participants experienced decreases in depressive symptoms (Budge, 2015; Craig & Austin, 2016; Diamond et al., 2012; Duarté-Vélez et al., 2010; Grafsky et al., 2011; Johnson, 2004; Lucassen et al., 2015). Additionally, both studies examining anxiety found significant reductions in participants' self-report of anxiety from baseline to post-intervention (Duarté-Vélez et al., 2010; Lucassen et al., 2015). Finally, the two studies examining substance use found decreases in participant self-report of substance use from baseline to post-intervention (Grafsky et al., 2011; Schwinn et al., 2015). However, despite the promise of these interventions to address mental health problems among LGBTQ + youth, findings from this study are limited by inconsistent measurement of treatment outcomes. Even among studies evaluating depression, five different measures of depression were used, and all studies relied on self-report data, rather than a clinical diagnostic interview to corroborate findings from self-report measures (Shean & Baldwin, 2008).

With respect to intervention adaptations for LGBTQ + youth, interventions included both surface level adaptations, altering "observable" intervention characteristics to enhance compatibility with the community, and deep adaptations, contextualizing individual experience within population-specific stress (Cabassa & Baumann, 2013). Surface level adaptations included changes to the presentation of information (i.e. Rainbow Sparx altered presentation of avatar characters to allow for gender bending). Deep adaptations allowed for the inclusion of minority stress theory, cultural and societal implications of sexuality, and internal identity conflict. For LGBTQ + youth, recommendations suggest that interventions account for experiences that specifically occur during adolescence, including identity development processes, minority stress, and the shifting cultural context in which individuals are coping and accessing social support (Austin & Craig, 2015; Goldbach & Gibbs, 2017; Russel & Fish, 2016). Considering Meyer's theory of minority stress and House et al. (2011) theory of interpersonal trauma and mental health, both of which posit that factors that marginalization, discrimination, and interpersonal stress in the lives of LGBTQ + youth leads to increased rates of self-harm and suicidality, seven of the 10 reviewed studies implemented deep adaptations to standard protocols to make intervention content more accessible. In addition, one study provided ancillary services (HIV prevention) for individuals identifying as LGB+.

Of the eight interventions implemented in person by therapists, five had prior experience working with LGBTQ + youth. Though we cannot isolate aspects of interventions that contributed to their effectiveness, existing

research does indicate that therapists' experience and training plays a crucial role in developing safe and affirming rapport with this community (Boroughs et al., 2015; Israel et al., 2008; Pepping et al., 2018; Troutman & Packer-Williams, 2014). Prior literature has postulated that therapist training may also influence treatment retention. In order to achieve retention, treatment must be affirming otherwise, clients may cope through "assertions of agency" by dropping out of treatment to reclaim power they feel has been stripped from them in the process (Wagaman, 2013). Future studies should assess the degree to which experience or specialized training in working with LGBTQ + youth is necessary for clinicians to establish meaningful rapport.

Overall, there were significant limitations in both the quality and design of the studies presented herein. All but two of the studies lacked randomization and a comparison group, making it impossible to determine whether or not adapted interventions are superior to treatment as usual. Furthermore, one of the two RCTs was a secondary data analysis derived from a study that did not initially examine treatment for LGB-youth (Grafsky et al., 2011). Consequently, the sample of LGB youth from the study was small and treatments developed or adapted specifically for LGB youth were not considered. Additionally, as mentioned previously, while all interventions collected pre-post data, only four collected follow-up data on participants (Craig & Austin, 2016; Duarté-Vélez et al., 2010; Lucassen et al., 2015; Schwinn et al., 2015). Further, Craig and Austin (2016) were only able to collect follow-up data on 56% of its participants. All studies were limited due to small sample sizes. Three of the studies looked at cross-cultural differences (Budge, 2015; Craig et al., 2014; Duarté-Vélez et al., 2010); while four of the studies failed to collect data on participants' ethnicity entirely (Grafsky et al., 2011; Lucassen et al., 2015; Perry et al., 2017; Schwinn et al., 2015). Cultural issues and intersectionality as they relate to the overlap of LGBTQ + identities with racial, ethnic, religious, and many other identities is a critical area to be examined in future research, as well as intentionally addressed with additional adaptations to intervention protocols.

Only four of the studies included TGD-identified participants (Budge, 2015; Craig et al., 2014; Craig & Austin, 2016; Perry et al., 2017), two of which were case studies (Budge, 2015; Perry et al., 2017). In the remaining two studies, TGD individuals only accounted for 1% (Craig et al., 2014) and 10% (Craig & Austin, 2016) of the total participant samples. For this reason, case studies were included to ensure thorough examination of all existing TGD-inclusive literature. However, because the majority of this research was comprised of case studies, it is difficult to determine effectiveness of intervention adaptations (Budge, 2015; Duarté-Vélez et al., 2010).

Moreover, despite the heightened rates of suicidal behavior among LGBTQ + youth, only two studies evaluated suicidal behavior, limiting our understanding of if and how interventions are able to address such behaviors. It is essential that future research examine the efficacy of interventions on mental health and self-harm within this population. Another limitation to these studies is the cisnormative language used to refer to males and females without distinguishing between transgender males and females and their cisgender counterparts.

Findings from this review were consistent with the results of a recent systematic review summarizing existing research on psychological interventions for LGBTQ + youth (Hobaica et al., 2018). Both reviews remark on the deficit of existing research, highlighting a pressing need for extensive future research in this area. However, this review uniquely included case studies to examine all extant literature and systematically examined adaptations made to each intervention. Given that the majority of therapeutic interventions are delivered by general practitioners, this review demonstrates how practitioners have incorporated principles of minority stress into their work with clients (Grafsky et al., 2011; Johnson, 2004; Perry et al., 2017). While not all therapists will access LGBTQ+-specific training, the adaptations outlined in this review highlight how therapists can adapt their work beyond "surface level" adaptations to ensure that it is affirming and supportive of the needs of LGBTQ + youth (Boroughs et al., 2015).

Limitations

This study had several limitations. First, the keywords used across databases may have led researchers to miss relevant studies. In the piloting of search terms, 'transgender' was included. However, the inclusion of this term significantly increased the number of irrelevant results and did not yield any additional articles examining mental health interventions among trans- + youth. As the literature in this area expands, terms related to transgender and gender diverse individuals must be included to ensure inclusion of all relevant articles. While keywords were limited, the researchers also searched reference lists from relevant studies to ensure inclusion of all recent literature. Inclusion criteria required that intervention facilitators include only licensed mental health professionals, limiting the scope of interventions included in this study. Studies reviewing other forms of interventions or supports (gay-straight alliances, peer support, mindfulness, self-help interventions) were not included, although they could show promise in helping to address mental health concerns within this community. Only published peer-reviewed articles were included, which may have not only excluded pertinent content, but could also contribute to publication bias.

Only English articles were reviewed, limiting the inclusion of articles published in other languages. Finally, the limited amount of research in this area, small sample sizes, diversity of measurement of outcomes, and lack of systematic documentation of adaptations makes it challenging to draw conclusions about the effectiveness of interventions.

Conclusion

This review provides preliminary but limited evidence supporting the use of psychotherapeutic interventions to reduce mental health concerns among LGBTQ + youth. More rigorous research is required to determine if interventions addressing the minority stress of LGBTQ + adolescents are more effective than standard treatment protocols. LGBTQ + youth face unique challenges associated with their sexual or gender identities, posing tremendous threat to their mental health status. Despite the overwhelming evidence indicating a need for more targeted interventions, LGBTQ + youth (and especially TGD youth) are largely overlooked in research. The field would benefit from conducting RCTs spanning longer time periods with larger samples of LGBTQ + youth. Further, it will be critical to ensure that treatment outcomes include an evaluation of suicidal behaviors given the disproportionate rates of suicidality within the LGBTQ + youth community. Finally, research should include a qualitative examination of participant intervention experiences to identify LGBTQ + youth perceptions of treatment adaptations.

Note

1. In an effort to standardize language throughout this paper, 'LGBTQ+' will be used to refer to individuals who identify with non-heteronormative and non-cisnormative sexual orientations, gender identities, gender expressions, or any combination of the three. Similarly, while 'transgender' will be used for those who specifically use this label to self-identify, 'TGD' (Trans and Gender Diverse) will be used to include all individuals whose gender is not the same as the sex they were assigned at birth. With recognition that these terms are limited and fail to name and include many identities that are paramount to queer and trans communities, this review will strive to account for many members of the community that are often not named in research. However, many of the studies in this systematic review only included participants identified as lesbian, gay, or bisexual. In these cases, the acronym 'LGB' will be used to maintain accuracy.

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