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

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

THIS SPECIAL ISSUE of *the Behavior Therapist* (*tBT*) focuses on resilience among sexual and gender minority (SGM) populations. As the mental health disparities adversely affecting SGM people are extremely well documented in the literature, our vision for this issue was to instead focus on the resilience and positive experiences of SGM people. By emphasizing this positive narrative, it was our goal for this special issue to inspire hope and to remind readers of the many strengths within the SGM community that can be effectively leveraged during the delivery of evidence-based care to optimize clinical outcomes.

We cast a wide net for the special issue, putting out calls for submissions on social media and to ABCT Special Interest Groups (SIGs) and professional listservs. Our hope was that this would result in articles representative of the profound diversity that exists within the SGM community, including the intersection of these identities with factors such as race, ethnicity, age, national origin, and medical comorbidities. We were thrilled to receive emails from authors expressing support of this message of resilience that we hope comes through in the articles selected for this entry in *tBT*. In fact, we received so many high-quality submissions that we had to expand the special issue into two special issues. We are delighted to share the first five articles in this issue.

[continued on p. 3]

the Behavior Therapist

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Is it time to have student members vote in the election of ABCT officers?

The Leadership and Elections Committee (Angela Fang, Chair; committee members: Angela D. Moreland, Vaishali V. Raval, Michelle Roley-Roberts, and Carrie Masia Warner), informed by input from our SIG leaders and Board members, are considering an amendment to our Bylaws, Article V on "Voting," to include students (as well as all other membership categories) as voting members for the election of ABCT officers. This will require a Bylaws change.

At this time, they are asking all members to review the draft proposal of the Bylaws Amendment here (which will be available for public comment until March 31, 2023) and provide feedback by completing this online form:

https://services.abct.org/i4a/forms/index.cfm?id=42

INSTRUCTIONS *for* AUTHORS

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

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

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

An Overview of Part 1 of the Special Issue

Our special issue begins with an article by Bybee and colleagues (2023), highlighting posttraumatic growth experienced by couples facing cancer, with a unique finding for SGM couples. Specifically, results demonstrated that the experience of minority stress was linked to these couples attributing their current dyadic strength and durability to prior life events more than non-SGM couples. In other words, the minority stress experience may bolster dyadic strength among SGM couples, which may equip them to be resilient in the face of significant stressors such as navigating a cancer diagnosis.

The special issue then continues with three articles exploring risk and protective factors for suicidality among SGM populations. First is an article by Lopez and colleagues (2023) that presents results from a literature review exploring the relationship between fluidity of sexual orientation and risk and protective factors for suicide among adolescents and young adults. This review identified specific patterns of fluidity that may be associated with risk and resilience, which may inform a clinician's case conceptualization of a client's suicidality. Next, Rabasco et al. (2023) examined protective factors specific to transgender and gender diverse (TGD) adults and the relation of these factors to suicidal thoughts and depressive symptoms. Results indicated that gender acceptance and gender congruence were key predictors, with gender acceptance predicting lower depressive symptoms and suicidal ideation severity and gender congruence predicting lower depressive symptoms. Findings support the critical value of affirming therapy for TGD adults, as well as access to gender-affirming medical care. In the third article, Hoelscher and colleagues (2023) utilize ecological momentary assessment methodology to measure gender minority resilience and suicidal ideation over the course of 3 weeks. Results from the study identified within-person changes in resilience as a predictor of within-person changes in daily suicidal ideation. This may shed light on potential clinical pathways to target during therapeutic interventions for individuals experiencing suicidality.

The first part of the special issue concludes with an article by Sloan and colleagues (2023), describing the development and implementation of a Dialectical Behavioral Therapy (DBT) skills training group for TGD veterans. The article provides a comprehensive overview of the process of creating an affirming DBT skills group, with an emphasis on the role of cultural humility. In many ways, the article by Sloan et al. provides an example of a type of care that harnesses the spirit of resilience woven into each of the articles that come before it.

We believe that each of these articles featured in this first part of the special issue contains important reminders of the strength and resilience of SGM people that can often be overlooked in our field, which historically overemphasizes a deficits-focused lens. We were delighted by the volume and strength of the submissions received during the solicitation process and wish to express our appreciation for the many individuals who contributed their time and effort to the creation of this special issue. We welcome any questions or comments on the articles featured in this issue of *tBT*.

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Bybee, S.G.J., Cloyes, K.G., Mooney, K.B., Supiano, K.P., Baucon, B.R.W., & Ellington, L. (2023). Shoulder-to-Shoulder: How cancer affects the intimate relationships of SGM and non-SGM couples. *the Behavior Therapist, 46*, 4-15.

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Webinar

Dr. Jessica L. Schleider

Scaling Single-Session Interventions to Bridge Gaps in Mental Healthcare Ecosystems

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

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

https://elearning.abct.org/

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

Shoulder-to-Shoulder: How Cancer Affects the Intimate Relationships of Sexual and Gender Minority and Non-SGM Couples

Sara G. J. Bybee, Kristin G. Cloyes, Kathi B. Mooney, Katherine P. Supiano, *University of Utah, College of Nursing*

Brian R. W. Baucom, *University of Utah*

Lee Ellington, *University of Utah, College of Nursing*

COUPLES IN WHICH ONE or both partners receive a diagnosis of cancer often experience a wide array of emotions, including shock, disbelief, anxiety, and a sense of vulnerability (Gorman, 2018). Both cancer patients and their partners can experience depression, anxiety, and distress as they face a potentially life-threatening illness (Caruso et al., 2017; Mehnert et al., 2018). For some, the addition of cancer-related stress into their relationship is more than the couple can withstand and the relationship dissolves (Song et al., 2014; Stephens et al., 2016), while for others, facing cancer as a couple may bring partners closer together and reaffirm their commitment to one another (Acquati et al., 2021).

For sexual and gender minority (SGM) couples in which one or both partners identify as lesbian, gay, bisexual, transgender, queer, or another sexual or gender minority (National Institutes of Health [NIH], 2019), cancer-related stress may be compounded by minority stress experienced due to membership in a historically disadvantaged group (Meyer, 2003). Minority stress—at both the individual and the structural level—places these individuals at greater risk for negative psychological outcomes such as depression, anxiety, and suicidality (Meyer & Frost, 2013).

Paradoxically, minority stress may also inoculate individuals from future stress by increasing coping and stress management skills. In fact, among SGM populations, minority stress may be associated with resilience (Bower et al., 2021) and post-traumatic growth (PTG; Cardenas et al., 2018)—the positive change that occurs through the struggle with a highly stressful or traumatic event (Tedeschi & Calhoun, 1995). PTG is associated with lower levels of anxiety, depression, long-term distress, and better overall well-being, suggesting it may reduce the effect of cancer-related stress (Aderhold et al., 2019). The five domains of PTG are appreciation of life, personal strength, new possibilities, relating to others, and spiritual or existential change (Tedeschi & Calhoun). The relationship between stress and PTG is curvilinear: as stress increases, so does the possibility for PTG, but only up to a certain point. Excessive stress and/or inadequate coping skills or social support can impede PTG (Calhoun & Tedeschi, 2006).

Despite a substantial evidence base on how heterosexual couples cope with cancer (Aizer et al., 2013; Traa et al., 2015) as well as the potential for PTG among cancer patients and partner caregivers (Li et al., 2020; Lim et al., 2019), there is limited research regarding how SGM couples cope with cancer (Kamen et al., 2015a) and even less qualitative research examining any differences in cancer-related stress between SGM and non-SGM couples. There is some research on the differences in cancer-related distress between SGM and non-SGM individuals. For example, Matthews et al. (2002) found that lesbian women reported higher stress surrounding their cancer diagnosis than did heterosexual women. In addition, lesbian women were less satisfied with the care they received from their physician and with the accessibility and availability of emotional support (Matthews et al., 2002). Similarly, LGBT cancer patients demonstrated worse depression and greater relationship difficulty than non-LGBT cancer patients (Kamen et al., 2015b).

Despite this research on the individual patient level, there are very few studies on any differences between SGM and non-SGM couples facing cancer. Research with SGM couples tends to be conducted with gay men facing prostate cancer and lesbian women facing breast cancer (Boehmer & White, 2012; Simon Rosser et al., 2016) and focuses on cancer survivorship (Thompson et al., 2020). Therefore, this study sought to address the gap in the existing literature and examine any differences between SGM and non-SGM couples' lived experiences of cancer-related stress and their ability to cope with cancer as a couple. Furthermore, this study sought to expand the current literature by focusing on couples instead of individuals, including all types of cancers, and expanding the eligibility criteria to include individuals diagnosed at any stage of the disease.

Conceptual Framework

This study was informed by the Developmental-Contextual Model of dyadic coping (DCM), which posits that dyadic coping may differ across the lifespan, during specific historical times, and during different stages of a chronic illness (Berg & Upchurch, 2007). By overlaying the theory of PTG onto the DCM, the development of PTG can be seen as the result of a couple's dyadic process from the shared appraisal and response to life course stress (including cancer-related and minority stress). This study utilizes this integrated conceptual framework to understand how life course stress and PTG of a cancer patient are associated with their partner's life course stress and PTG and with their well-being as a couple. The purpose of this study was to (a) explore how couples' past experiences of stress and current cancer-related stress affect their PTG and their relationship and (b) examine similarities and differences between the experiences of SGM and non-SGM couples.

Methods

Sample and Setting

A community advisory board (CAB) met quarterly to provide input on recruitment flyers and strategies, interview questions, study procedures, and interpretation of results. This CAB contained six individuals with overlapping expertise: three were experts in oncology, one was an expert in LGBTQ+ aging, one was a cancer survivor, and one was a community member. Half of the CAB self-identified as LGBTQ+. CAB members were selected through the authors' professional connections and were chosen so that the CAB contained community members and professionals, as well as LGBTQ+ and non-LGBTQ+ members. In addition, the board was selected to reflect a population of individuals both with and without a history of cancer.

Recruitment and Informed Consent

This study was reviewed and all procedures were approved by the University of Utah Institutional Review Board (IRB

Practical, evidence-based guide to using time-out safely and effectively

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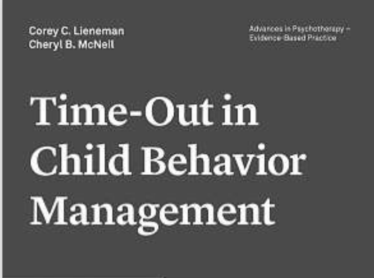

Corey C. Lieneman / Cheryl B. McNeil

Time-Out in Child Behavior Management

Advances in Psychotherapy – Evidence-Based Practice, vol. 48
2023, x + 116 pp.
$29.80
ISBN 978-0-88937-509-3

This book is essential reading for psychologists, therapists, students, and anyone who works with children and their families. It is a compact, comprehensive guide to understanding, administering, and teaching caregivers to implement time-out effectively for child behavior management. Readers will learn about time-out's history and scientific research base, particularly with respect to child age, cultural groups, and presenting concerns. Practitioners will appreciate the focus on applied research highlighting the efficacy of specific time-out parameters, such as duration, location, and handling escape. Overviews of behavioral parent training programs that include time-out are also provided. The authors then share their expertise in the use of time-out in parent–child interaction therapy (PCIT), both conceptually and by using an in-depth case study. They also thoroughly examine controversial issues related to time-out, from theoretical and practical standpoints. The appendix provides the clinician with hands-on tools: step-by-step diagrams for administering time-out and managing escape, handouts for parents about issuing effective instructions, and a list of further resources.

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#00133699). Couples were eligible if both partner members agreed to participate and at least one partner self-reported a diagnosis of cancer at any point in their life. Care partners were significant others or romantic partners who provided the patient with some level of support. SGM couples were defined as couples in which at least one person identified as lesbian, gay, bisexual, transgender, queer, or another sexual or gender minority (LGBTQ+).

A two-pronged approach was taken by recruiting patients online as well as through Huntsman Cancer Institute (HCI) electronic medical records. HCI is a National Cancer Institute–designated comprehensive cancer center serving a five-state region in the Intermountain West. Online recruitment strategies included using ResearchMatch™ (Harris et al., 2013)—an online national health volunteer registry—posting announcements on appropriate listservs and websites, and sharing study announcements with community organizations serving SGM cancer survivors and other contacts.

In-person recruitment of participants was not possible due to the global pandemic. For HCI patient recruitment, (1) electronic medical records were reviewed to identify eligible cancer patients, (2) potential participants were emailed with an invitation to participate in the study, (3) follow-up emails were sent 2 weeks later, and (4) patients were called 1 week after the second email had they not responded. Study recruitment flyers were posted on HCI's website, throughout the building, provided to caregiver support groups, and to medical teams. The CAB and enrolled participants also participated in chain referral sampling.

Participants indicated their interest in completing a couples' interview through a REDCap© questionnaire (Harris et al., 2009). If both partners in a couple were interested, they were given additional information, consent documents, and an opportunity to ask questions. For both dyad members, written consent was obtained prior to scheduling an interview and verbal consent obtained prior to conducting the interview (Wittenborn et al., 2013). This study proposed to recruit 32 individuals (16 couples) (Guest et al., 2016), with equal samples of SGM and non-SGM couples. Couples were enrolled on a rolling basis until the minimum sample was obtained for each group.

Data Collection

Potential participants completed a brief eligibility questionnaire via REDCap© and, if eligible, they were directed to complete a separate REDCap© survey including a demographic questionnaire, health questionnaire, and validated survey instruments utilized in the larger parent study (results reported elsewhere). All participants first completed demographic and health information questionnaires. Dyadic semistructured interviews were then conducted with SGM

Table 1. Semistructured Interview Questions

Construct being assessed	**For all couples:**
	Tell me about how you met each other.
Life course stress/dyadic coping	Thinking about your life prior to the cancer diagnosis, what was the greatest challenge that you have faced as a couple and how did you deal with the situation?
Dyadic coping & wellbeing/PTG	Did that challenge change how you and your partner support one another or cope with stress?
Life course stress/dyadic coping	Had you faced highly stressful or traumatic situations as a couple prior to the cancer diagnosis? If so, how did that experience affect the way that you handle stress as a couple?
Cancer-related stress/Dyadic coping & wellbeing	How has cancer-related stress affected your relationship? Has it changed the way you cope as a couple?
Dyadic coping & wellbeing	How does your partner's overall mood and wellbeing affect your own mood and wellbeing? How does it affect your relationship?
Cancer-related stress/PTG	How do you feel the cancer experience has changed your evaluation of everyday stress?
PTG	How has your worldview or outlook on life changed throughout the cancer journey?
PTG	Have you experienced any changes as individuals that have not been experienced as a couple? If so, how does this change affect the other, as well as the relationship?
PTG	What is the most positive aspect of going through cancer?
PTG/dyadic coping & wellbeing	What else do you want me to know about your relationship coping in the context of cancer?
	Additional questions for SGM couples:
Minority stress	Have you experienced any challenges specifically related to being an SGM (use participants' own label) couple? How does this affect your current stress level?
Minority stress/cancer-related stress/dyadic coping	If so, has couple-level discrimination/stigmatization affected your ability to cope with cancer-related stressors?
Minority stress/cancer-related stress	Do you feel that your cancer experience has been affected by your identification as an SGM (participants' own label) couple? If so, how?
Minority stress/dyadic coping & wellbeing	How has couple-level minority stress affected your relationship?
Dyadic coping	Is there any type of support that you did not receive during your cancer journey that would have been helpful?
Minority stress/cancer-related stress	Would it have been helpful to have some type of support group/resource specific to your LGBTQ+ identity?
Minority stress/cancer-related stress/dyadic coping	Is there anything else that you want me to know about your relationship and how identifying as an SGM (use participants' label) couple has affected your ability to cope with cancer as a couple?

Table 2. Final Codebook

Individual PTG		
Appreciation of life	This domain of PTG was expressed by individuals who felt that facing cancer resulted in a new appreciation of life, a change in their priorities, or a realization that their time on earth is limited.	"But in a way, you know what, it made me realize some of the important things in life and I've redefined how I was living my life. So, you know, you got to look for something good in every bad things that presents you." "Well, it makes you appreciate every day a little bit more." "It's instilled a sense of purpose to my life."
Relating to others	This domain of PTG involved an individual feeling closer to others in their life and feeling that they developed stronger relationships due to their experience of cancer. Participants described learning who their true friends were, who they could count on, and having a greater sense of empathy.	"I have just been like absolutely blown away by how much support we've gotten from people." "I think we've developed more of a— you know, I'd like to think we've always been somewhat empathetic of others. But I think we've developed a greater empathy for others." "It hasn't been as stressful as you would think for us because of all the support we have."
New possibilities	This domain of PTG entailed an individual meeting new people or becoming involved in a new activity that they would not have been introduced to if it weren't for experiencing cancer.	"[Patient] did write a book that's published by [Publisher] about her cancer experience." "What I have seen is [Patient] has become like a consultant to several friends and family going through it." "I am part of a support group where we all have metastatic breast cancer, and we've just formed such a tight bond."
Spiritual or existential change	This domain of PTG involved an individual either questioning their faith/spirituality/religion or feeling a strengthening of these beliefs. Participants also experienced existential changes such as questioning life/death/the meaning of life (or greater understanding of these things) and feeling greater harmony with the world.	"I'm only a little bit spiritual and since this craziness, you know, this journey, this cancer journey started, I kind of feel like the reason I'm alive, like why would God spare me with such an ominous, you know, horrible diagnosis, horrible prognosis of what I had and yet here I am today, you know, six years later and I statistically shouldn't be here. So I think that God, if there's anything that I could say kept me alive."
Personal strength	This domain of PTG was expressed when individuals felt that due to facing cancer, they were now stronger as a person.	"I can take what life hands me. I can deal with it, and I'm not afraid. Probably less afraid. Because when you hear that you have a cancer diagnosis that's scary, but I feel less scared about things that scared me." "I think when she got sick, I found out that I was stronger than I ever thought I could be"
Dyadic PTG		
Appreciation of partner	This dyadic domain of PTG occurred when one partner expressed appreciation for the other partner or for their relationship as a result of going through cancer together. Couples used downward social comparison to compare their relationship to others' and felt that their relationship is better/stronger.	"But as far as our relationship with dealing with the cancer, I think from early on, I was probably a little more appreciative and a little kinder than I had been in the past. It was like, 'Well, I guess I shouldn't pick the fight on this one. It's not important.'" "[Partner]'s been extremely helpful, and he's been enthusiastically supportive and helpful. It's sort of like I'm his job, and he's just really helpful."
Dyadic strength or durability	This dyadic domain of PTG was described by couples who felt stronger as a result of facing cancer together; couples also affirmed the durability of their relationship.	"I feel like we just— there's nothing that I feel like we can't talk about or do together now…I do think it strengthened that—we really are a team, and if one of us has to face something, we're gonna face it together." "It brought us together. You know, when he first

(Table 2 continued on next page)

(Table 2 continued)

Dyadic PTG		
		got diagnosed we were seeing each other but in a way it brought us together."
Dyadic possibilities	Entailed a couple discussing new things they may not have otherwise gotten into had they not experienced cancer. This included end-of-life planning and arranging trusts, selling businesses, etc. The focus for this code is on actions the couple takes/will take.	"We started painting together and doing arts and crafts, not as much as we should, but, yeah, things like that we really enjoyed and would help us be distracted or play with our dogs. They're really good for helping you cope."
Dyadic priorities	This dyadic domain involved discussion around how the couple's priorities have changed as a result of cancer; this domain focused on shifts specifically in thinking or internal processes, not new activities/experiences.	"We're going to go with cancer treatment now instead of house shopping." "We want to be able to help make a difference out of all of the pain that we've gone through and come out on the other end." "Beforehand, we were not intentional about our time together. We just have to make sure that we're intentional about our time together."
Dyadic spiritual or existential change	This domain of dyadic PTG involved greater spirituality/sense of connection/faith that the couple developed, or questioning of religion/faith as a couple due to the cancer experience. Couples also described existential threats to their very couplehood due to cancer and questioned who they were if they no longer had their partner.	"Neither one of us believes in God. Neither one of us prays, has any religious affiliation. We both are non-denominational. We're both going to be cremated…To me, that's comforting, to be married to somebody who understands [that] I don't believe I could be somebody who's up in heaven, and he feels the same way. We've grown a lot closer that way in relation to our dogma or lack of dogma." "Maybe we're not going to be here to celebrate our 60th anniversary. So, am I going to be the one left alone and how's that going to work out?"
Dyadic normalizing or adjusting	This domain occurred when a couple discussed how their worries/preoccupation with cancer changed over the cancer trajectory. Couples discussed feeling as if cancer was just another part of their lives, that they don't think about it as much as they used to, or that it is no longer a crisis.	"I used to tell people that I was only a cancer patient once every three months, and that was when I had to go for the checkups. I've pretty successfully not thought about it on a daily basis." "I think as you can get further from like a recurrence or something, then it becomes more and more distant. And it's just life as usual, and chemo, and, you know, this and that, and it's just not that much of an issue, really."

and non-SGM couples to obtain an in-depth understanding of couples' experiences (see Table 1 for interview guide). The interviewer (SB) was a Ph.D. candidate and licensed clinical social worker with extensive training in conducting interviews and focus groups. SB also brought experience as an oncology social worker and as the co-chair of the Rainbow Research Group, a special interest group of the Gerontological Society of America focused on issues related to LGBTQ+ aging.

Interviews were conducted using video-conferencing software and were recorded with participant consent. Couples were asked to discuss their prior experiences of life course stress and how a diagnosis of cancer previously and currently affected their relationship. Participants were asked about how life course stress may have affected their ability to cope with the diagnosis of cancer and how prior dyadic life course stress influenced their current coping. For SGM couples, interview questions also explored stressors specifically related to sexual orientation or gender identity. To maximize participation and recognize their contribution, each dyad member received a $25 electronic gift card after completing the dyadic semistructured interview.

Data Analysis

Demographics

SPSS Version 27 software was used to perform descriptive statistics, including frequency distributions, means, and standard deviations to summarize sociodemographic and cancer-related characteristics (IBM Corp., 2018). Chi-square tests of independence were run to compare these characteristics between SGM and non-SGM groups.

Semistructured Interviews

Dyadic semistructured interviews were recorded using video-conferencing software and transcribed verbatim by profes-

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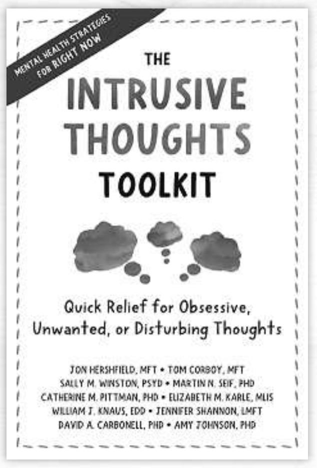

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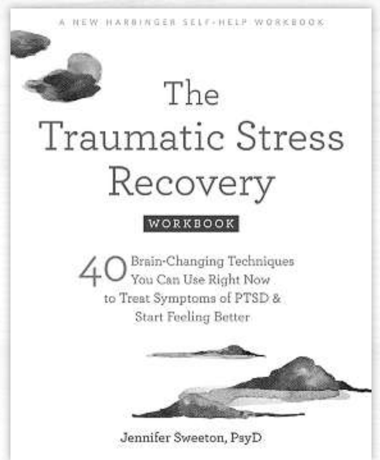

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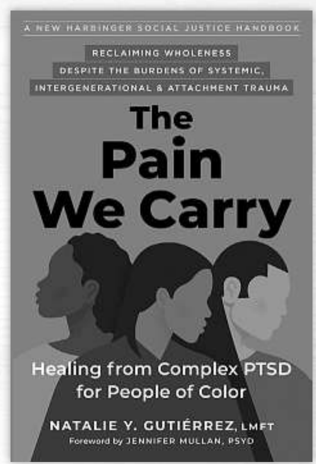

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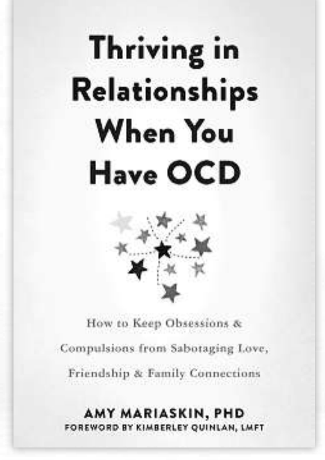

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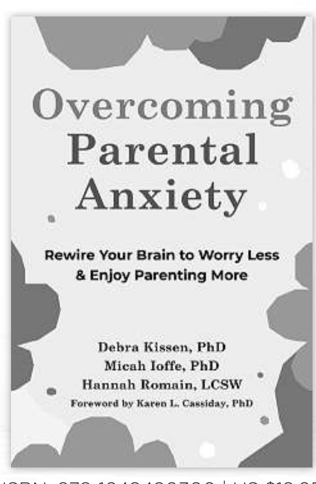

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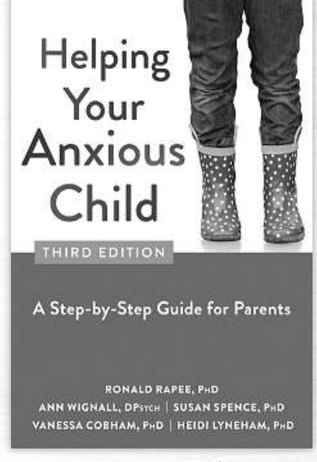

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sional transcriptionists. Transcripts were checked for accuracy, deidentified, imported into NVivo 12 qualitative analysis software (QSR, 2018), and analyzed using an interpretive descriptive approach. This approach describes the phenomena of interest, and discovers relationships, patterns, and associations within the phenomena (Thorne, 2016). As transcripts were analyzed, initial findings informed subsequent interview questions in an iterative process. The five domains of PTG (relating to others, new possibilities, personal strength, spiritual or existential change, and appreciation of life) served as a priori codes for an initial directed content analysis (Assarroudi et al., 2018). Transcripts were coded by labeling examples of these five domains and noting life course stress within these domains. As the transcripts were coded, inductive approaches helped identify other recurring themes related to PTG, coping, and dyadic processes. One of the authors (SB) served as the main coder while additional oversight was provided by the other authors who were all nationally recognized scholars. SB had prior experience in qualitative analysis.

All five domains of PTG utilized as a priori codes were identified in the transcripts. However, these five domains did not completely encapsulate couples' experiences in dealing with and growing from cancer; the researchers identified a separate set of six codes was identified. The deductive codes were compared to codes identified inductively, a list of possible codes was identified, and first impressions of the data were documented. Code labels were compared to identify similarities and differences, and codes were either combined into higher-order codes based on similarity of concept or organized into distinct codes if they represented different concepts (Abdul-Razzak et al., 2014; Thorne et al., 2010).

These deductive and inductive codes were used to generate a codebook containing the labeled codes, definitions, and example quotations from the transcripts that illustrated each code (Saldaña & Omasta, 2018). Once the initial codebook was developed, a second coder was brought onto the team. This coder (MR) was a study coordinator for the Hospice Today Project who also had experience conducting research with LGBTQ+ individuals with cancer. To assess intercoder reliability, four full-length transcripts (two from SGM couples and two from non-SGM couples) were randomly selected, representing 16.7% of the data (Campbell et al., 2013). In calculating intercoder agreement, the following steps were taken to address the unitization problem—defined as "identifying appropriate blocks of text for a particular code or codes" (Campbell et al., p. 297).

The four transcripts were first coded using the first set of codes and then coded again using the second set of codes. This involved highlighting the unit of coding and labeling it with one of the codes from the codebook. When all four transcripts were fully coded, the results were saved, the names of codes were removed, and the units of coding were left highlighted. The second coder then coded all four transcripts by applying a single code to each highlighted section. This process of "unitization" allowed for greater interrater reliability, as coders were not guessing the length of text comprising a code; instead, they focused on identifying the code used in that section. Using NVivo 12 software, interrater reliability was calculated based on this initial round of coding, producing a Cohen's Kappa of 0.82, which demonstrates excellent agreement (Landis & Koch, 1977).

After calculating intercoder agreement based on the four transcripts, the two coders met to compare codes, any discrepancies were discussed, and decisions were made jointly about the final code. A detailed codebook was kept throughout this process, including the codes and definitions, example quotations, and any decisions or changes made to the codebook based on the two coders' results. The revised codebook that contained both the five a priori codes and the six inductively derived codes was then used by the first coder to code the remaining 20 transcripts (see Table 2 for codes and exemplar quotes). Coding frequencies were summarized using descriptive statistics and compared across SGM and non-SGM groups using chi-square tests of independence to produce comparative descriptions of SGM and non-SGM groups' experiences related to each PTG domain.

When all transcripts had been coded for these 11 codes, on a third pass through the data, the life course stress (including cancer-related and minority stress) described by couples in relation to these PTG domains was examined. In this way, life course stress served as an a priori code used to examine the relationship between couples' PTG and life course stress. Memo writing helped identify and interrelate themes, compare SGM and non-SGM couples' life course stress, and record analytic decisions as a type of audit trail (Thorne, 2016).

Results

Recruitment Source

Couples who participated in the dyadic semistructured interviews had been recruited through personal connections with the research team (n = 6, 25%), through ResearchMatch and other public advertisements (such as through the National LGBT Cancer Network) (n = 10, 41.7%), and through electronic health records or advertisements posted at HCI (n = 8, 33.3%).

Interview Characteristics and Demographic Data

Dyadic semistructured interviews were conducted between December 2020 and April 2021. A total of N = 24 interviews were conducted (12 with SGM couples and 12 with non-SGM couples). Interviews lasted on average 48.2 minutes (SD = 7.3, range 37.8 – 65.6 minutes). Participants were on average 56.4 years old (SD = 12.8, Range = 32-76), had been in their relationship for 26.5 years (SD = 14.7, Range = 7-51), and were Caucasian (n = 41, 85.4%). Participants identified as female (n = 26, 54.2%), male (n = 21, 43.8%), and transgender male (n = 1, 2.1%). The sexual orientation of participants was heterosexual (n = 25, 52.1%), gay (n = 6, 12.5%), lesbian (n = 13, 27.1%), bisexual (n = 2, 4.2%), and pansexual (n = 1, 2.1%). Of the cancer patients who knew the stage of their disease (n = 18, 75%), half were diagnosed with stage IV cancer (n = 9, 37.5%). The majority of cancer patients did not know their prognosis (n = 17, 70.8%) and had received their diagnosis over 12 months prior (n = 19, 79.2%; see Table 3 for demographic and health characteristics).

Differences in Characteristics Between SGM and Non-SGM Participants

SGM participants were younger (M = 50.9, SD = 10) than non-SGM participants (M = 62.0, SD = 13.1; $t[48] = 3.3$, $p = .002$) and had been with their partners for fewer years (SGM M = 19.1, SD = 10.1 vs. Non-SGM M = 33.3, SD = 15.2; $t[48] = 3.7$, $p =$ .001). Results from conducting chi-square tests of independence on the categorical variables collected in the demographic and health information questionnaires demonstrated that SGM participants were more likely to self-report "other" mental health diagnoses (diagnoses other than anxiety, depression, bipolar disorder, and schizophrenia) (n = 6, 25%) than non-SGM participants (n = 0, 0%; χ^2 (1, N = 48) = 6.8, $p = .009$). Using free-text, two SGM (4.2%) participants (who were a couple) reported being diagnosed with

borderline personality disorder. In addition, one SGM (2.1%) participant reported the following diagnoses respectively: attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. One (2.1%) SGM participant did not report their diagnosis but stated that it was "added by a non-mental health provider" without their knowledge or consent and that they disagreed with the diagnosis.

A greater number of SGM individuals (n = 21, 87.5%) reported a religious affiliation than non-SGM individuals (n = 6, 25%; χ_2 (6, N = 48) = 27.4, p < .001). SGM participants were also more likely to have employer sponsored health insurance (SGM n = 15, 62.5% vs. non-SGM n = 9, 37.5%) and less likely to have Medicare and or Medicaid than non-SGM participants (SGM n = 8, 33.3% vs. non-SGM n = 13, 54.2%; χ^2 [1, N = 48] = 11.8, p = .038). Finally, SGM participants with cancer were more likely to report prognoses of twelve months or more (SGM n = 5, 41.7% vs. non-SGM n = 1, 8.3%) whereas non-SGM participants with cancer were more likely to report unknown prognoses (non-SGM n = 11, 91.7% vs. SGM n = 6, 50.0%; χ^2 [4, N = 24] = 4.1, p =.043). There were no statistically significant differences in gender, race, education, income, depression, anxiety, bipolar disorder, other chronic illnesses, cancer type, cancer stage at diagnosis, time since diagnosis, past cancer treatment, or current cancer treatment (see Table 3).

PTG Domains Across All Couples

All five original domains of PTG were identified in the interview data. Appreciation of life was the individual PTG domain with the highest number of codes across all transcripts (n = 72), and appreciation of partner was the dyadic PTG domain identified most frequently (n = 89). The following six inductively generated dyadic PTG domains were more specific to the couple's relationship rather than each individual's experience within a larger sociocultural context: dyadic strength or durability, appreciation of partner, dyadic priorities, dyadic possibilities, dyadic existential or spiritual change, and dyadic normalizing or adjusting.

Individual PTG

Appreciation of life, the individual domain of PTG most frequently discussed by participants, was expressed by individuals who felt that the stressful or traumatic event (facing cancer) resulted in a new appreciation of life, a change in their priorities, or a realization that their time on earth is limited. *Relating to others* was another commonly mentioned individual PTG domain that occurred when participants felt closer to others in their life, developed stronger relationships, learned who they could count on, and developed a greater sense of empathy due to cancer. *New possibilities* were described by participants as meeting new people or becoming involved in a new activity (such as mentoring other cancer patients) that they would not have been introduced to if it had not been for the experience of cancer. *Personal strength* was expressed when participants felt stronger than they thought they were and felt unafraid about things that used to scare them. *Spiritual or existential change* occurred when individuals either questioned their faith, spirituality, or religion, or strengthened these beliefs. This domain also included existential changes such as questions about life, death, and the meaning of life (or greater understanding of these things) or feeling greater harmony with the world.

Dyadic PTG

In addition to experiences consistent with the original five domains of PTG, participants highlighted the following newly identified dyadic domains of PTG: *Appreciation of one's partner* was described by participants as a new sense of appreciation for their partner due to the experience of cancer. While this domain was similar to the individual domain of appreciation of life, it differed in that the shift in thinking occurred within the relationship instead of within the greater sociocultural environment. Couples also used downward social comparisons to compare their relationship to others and felt that their relationship was better. In the domain of *dyadic strength or durability*, couples discussed how their partnership strengthened as a result of experiencing cancer together. Couples discussed how they grew closer to one another and talked about the durability of their partnership, noting that they would be together forever, despite any hardships.

Dyadic priorities were present when couples talked about how their priorities shifted or changed as a result of having experienced cancer together. This domain of dyadic PTG focused explicitly on the couple's changes in thinking or shifts in cognitive processes. Some couples discussed how facing cancer shifted their priorities such that they now want to give back and help others. Couples described *dyadic possibilities* as new things they may not have otherwise gotten into had they not experienced cancer. While similar to dyadic priorities, this domain focused on new actions couples had taken or planned to take in the future, including new activities that they engaged in together, such as putting together photo albums, painting, and doing arts and crafts. Others discussed taking steps to arrange their affairs or solidify their end-of-life plans. *Dyadic spiritual or existential change* included couples' descriptions of greater spirituality, sense of connection, or faith, or questioning of religion/faith as a result of having dealt with cancer. Additionally, couples also revealed, having faced cancer, an existential threat to their very couplehood such that partners questioned who they were if they no longer had their partner and what life would be like without them. Couples discussed *dyadic normalizing or adjusting* in that their worries or preoccupation with cancer changed over the cancer trajectory—cancer became a part of their lives, they didn't think about it as much as they used to, or they felt that it was no longer a crisis.

Similarities and Differences of PTG Experiences of SGM and Non-SGM Couples

Both SGM and non-SGM couples experienced growth in each of the individual and dyadic domains of PTG. The domains with the greatest difference between SGM and non-SGM couples were new possibilities and dyadic strength or durability. Non-SGM participants were twice as likely to discuss experiences of new possibilities at the individual level (non-SGM n = 26 vs. SGM n = 13, χ_2 [1, N = 24] = 2.15, p = .142) and SGM couples discussed dyadic strength or durability 1.3 times as frequently as non-SGM couples (SGM n = 42 vs. non-SGM n = 33, χ_2 [1, N = 24] = .73, p = .39).

Comparisons of Life Course Stress of SGM and Non-SGM Couples

Couples' experiences of prior life course stress and how these experiences may have contributed to PTG were explored. Both SGM and non-SGM couples described prior traumas or highly stressful events experienced individually and dyadically. Couples explained how experiences of trauma, loss, and stress contributed to their innate sense that they would always be there for one another. Previous dyadic traumas included stillbirths, miscarriages, the death of family or friends, caregiving for dying parents, and drug abuse. One couple stated, "That was a joining thing" when describing how dealing with drug abuse affected their relationship.

Despite the universal experience of individual and dyadic stressors, SGM and non-SGM couples showed some differences in the types of life course stress experienced and how they perceived it affected their relationship. While only SGM couples were asked about minority stress, despite racial minorities in both the SGM and non-SGM samples, non-SGM couples did not spontaneously report any minority stressors. Non-SGM couples who shared experiences of life course stress seemed more hesitant than SGM couples to attribute any psychological growth to these prior dyadic stressors and described any changes as minimal or merely extensions of an already strong relationship. For example, one non-SGM couple described a highly stressful situation in which they had to conduct an intervention for a family member who was an alcoholic. When asked if the experience of approaching this stressor together brought them closer, the couple responded, "I don't know if it was closer because that's just how we operate. That's how we've always operated."

Conversely, in describing their life course stress, SGM individuals and couples frequently described how minority stress led to both individual and dyadic PTG. On an individual level, one participant who identified as SGM and a racial and ethnic minority described how the intersectionality of these minority statuses made them more resilient. They stated, "I was already a minority where I was growing up, because as a Chicana, there were a lot of other Latinos, but I was growing up in a time when there were a lot more black people in my neighborhood before more Latinos were coming in, so I did have to deal with biases that were thrown towards immigrants, however adding on there that a lot of people would call me tomboy. So I do think that it built my character to be like 'It doesn't matter' even though it did hurt many times, but growing up in [City] there weren't a lot of people that had come out when I was young."

In terms of prior minority stress experienced on a dyadic level, SGM couples recounted experiences tied to stigma, discrimination, and living in a gender-conforming society. In one interview, an SGM couple who identified as lesbian described a difficult situation in which one dyad member's parents sued her for joint custody of her own child because they disapproved of her same-sex relationship. Another lesbian couple was forced to move across state lines to escape harassment and intimidation from the Ku Klux Klan. A lesbian couple recalled a frustrating situation when they were told that they had to document 6 months of infertility to qualify for fertility treatments: "They were like, if you've had unprotected sex for 6 months, then you count as infertile. And I was like, well, I've been having unprotected sex for over 10 years, and we haven't gotten pregnant, because my partner's a woman. She [the person in human resources] didn't know what to do."

While the majority of SGM couples received competent and respectful care, some SGM couples admitted experiencing minority stressors during their cancer treatment. One lesbian couple described how the partner caregiver was not out at her work and therefore did not qualify for family medical leave when the patient was undergoing cancer treatment. Other couples reported being treated disrespectfully during medical appointments. One patient was physically separated from other patients because of a nurse's homophobia. She recalled, "The head nurse in the chemo clinic, one of the oncology nurses, did not like homosexuals, and she made it extremely clear on the very first day that she would never, ever, ever be treating me. She would sit me over in the corner, away from everybody else." Another cancer patient described being overlooked while she waited for radiation based on her gender-nonconforming appearance.

Despite minority stressors, SGM couples were more likely than non-SGM couples to attribute increased dyadic strength or durability to their experiences of life course stress. One SGM couple poignantly stated: "As a couple, as a whole, whenever there is a challenge to us from outside, we are shoulder-to-shoulder. You're not going to penetrate us, it's not going to get between us. We're going to come together and fight it together." In sum, while all couples reported prior life-course stress, SGM and non-SGM couples differed in the type of stressors experienced and the effect on their relationship.

Discussion

Interpretive descriptive analysis of the interview transcripts reveals that while helpful in describing couples' experiences facing cancer, the original domains of PTG delineated by Tedeschi and Calhoun (1995) do not entirely capture how couples can experience PTG. For example, under the original domains of PTG, a couple's description of how they became closer since cancer, and individuals learning who their true friends were, would both be categorized as "relating to others" (Tedeschi & Calhoun). However, the experience of becoming closer within a relationship is dyadic, while discovering one's true friends focuses on the person in relation to their greater sociocultural environment. Labeling this domain of PTG as either individual or dyadic helps illuminate the process of developing PTG and provides a more in-depth understanding of the ways PTG can be experienced.

This study also demonstrated how couples' prior experiences of life course stress can serve as a foundation for their ability to manage cancer-related stress (Calhoun & Tedeschi, 2006). While the experience of prior couple-level stress was universal, SGM couples' experience of minority stressors related to their SGM status is unique and may explain why they discussed dyadic strength and durability more frequently. This is consistent with other studies demonstrating that same-sex couples report better dyadic coping and marital satisfaction than heterosexual couples (Meuwly et al., 2013; Riggle et al., 2008). That is, there may be something specific to minority stress that primes SGM couples for experiencing PTG in the area of dyadic strength or durability (Pepping et al., 2019). The fact that SGM couples in this study had significantly more mental health diagnoses of "other" yet disclosed dyadic strength and durability more than their non-SGM peers may provide additional evidence of the power that comes from being an SGM couple. One possible explanation for this enhanced dyadic PTG is that for couples where both individuals identify as LGBTQ+, minority stress is inherently tied to their identity (Meyer, 2003) and therefore may represent a greater threat to one's worldview than other stressors. It makes sense then that SGM couples also experienced greater PTG in the form of dyadic strength or durability, as PTG is positively correlated with stress.

Implications for Practice

The findings from this study suggest that clinicians need to better understand the importance of a dyad's previous and current stress in determining how the couple is coping with and/or growing through the experience of cancer. Care partners should be integrated into patients' routine care (Kent et al., 2016) and attention paid to couples' prior experiences in managing dyadic stress (including minority stress). Providers should understand how cancer-related and

Table 3. Demographic and Health Characterists

Variables		Non-SGM (*n* = 24)	SGM (*n* = 24)	Total (*n* = 48)	Difference between groups
Age	M (SD), Range	62.0 (13.1), 34-76	50.9 (10), 32-70	56.4 (12.8), 32-76	t= 3.3, p=.002
Gender	Male	n= 12 (50%)	n= 8 (33.3%)	n= 20 (41.7%)	χ^2= 2.9, p=.399
	Female	n= 12 (50%)	n= 14 (58.3%)	n= 26 (54.2%)	
	Transgender male	-	n= 1 (4.2%)	n= 1 (2.1%)	
	Non-binary	-	n= 1 (4.2%)	n= 1 (2.1%)	
Sexual orientation	Heterosexual	n= 24 (100%)	n= 1 (4.2%)	n= 25 (52.1%)	χ^2= 44.2, p=.000
	Gay	-	n= 6 (25%)	n= 6 (12.5%)	
	Lesbian	-	n= 13 (54.2%)	n= 13 (27.1%)	
	Bisexual	-	n= 2 (8.3%)	n= 2 (4.2%)	
	Queer	-	n= 1 (4.2%)	n= 1 (2.1%)	
	Pansexual	-	n= 1 (4.2%)	n= 1 (2.1%)	
Race	Caucasian	n= 20 (83.3%)	n= 21 (87.5%)	n= 41 (85.4%)	χ^2= 1.0, p=.599
	Asian	n= 1 (4.2%)	-	n= 1 (2.1%)	
Other race (free-text)	Armenian	-	n= 1 (4.2%)	n= 1 (2.1%)	
	Caucasian & Japanese	n= 1 (4.2%)	-	n= 1 (2.1%)	
	Latina/Chicana	n= 1 (4.2%)	n= 1 (4.2%)	n= 2 (4.2%)	
	White & Native American	-	n= 1 (4.2%)	n= 1 (2.1%)	
	I don't know	n= 1 (4.2%)	-	n= 1 (2.1%)	
Religion	Catholic	n= 5 (20.8%)	-	n= 5 (10.4%)	χ^2= 27.4, p=.000
	Jewish	n= 3 (12.5%)	-	n= 3 (6.3%)	
	LDS	n= 4 (16.7%)	-	n= 4 (8.3%)	
	Protestant	n= 6 (25%)	n= 1 (4.2%)	n= 7 (14.6%)	
	Unaffiliated/Other	n= 6 (25%)	n= 21 (87.5%)	n= 27 (56.2%)	
	Missing	-	n= 2 (8.3%)	n= 2 (4.2%)	
Education	HS/GED/some C/T*	n= 8 (33.3%)	n= 8 (33.3%)	n= 16 (33.3%)	χ^2= 4.1, p=.25
	College graduate	n= 8 (33.3%)	n= 4 (16.7%)	n= 12 (25.0%)	
	Post-graduate/professional	n= 8 (33.3%)	n= 11 (45.8%)	n= 19 (39.6%)	
	Missing	-	n= 1 (4.2%)	n= 1 (2.1%)	
Income	≤$24,999	n= 4 (16.7%)	n= 4 (16.7%)	n= 8 (16.7%)	χ^2= 3.3, p=.511
	$25,000-$75,000	n= 10 (41.7%)	n= 11 (45.85)	n= 21 (43.75)	
	≥$75,000	n= 10 (41.7%)	n= 9 (37.5%)	n= 19 (39.6%)	
Years together	M (SD), Range	33.3 (15.2), 7-51	19.1 (10.1), 9-44	26.5 (14.7), 7-51	t= 3.7, p=.001
Insurance	Employer/Individual	n= 9 (37.5%)	n= 15 (62.5%)	n= 24 (50%)	χ^2= 11.8, p=.038
	Medicare/Medicaid/Both	n= 13 (54.2%)	n= 8 (33.3%)	n= 21 (43.7%)	
	No insurance/Other	n= 2 (8.3%)	-	n= 2 (4.2%)	
	Missing	-	n= 1 (4.2%)	n= 1 (2.1%)	
Mental health diagnoses	Anxiety (yes/no)	n= 7 (29.2%)	n= 13 (54.2%)	n= 20 (41.7%)	χ^2= 3.1, p=.079
	Depression (yes/no)	n= 7 (29.2%)	n= 13 (54.2%)	n= 20 (41.7%)	χ^2= 3.1, p=.079
	Bipolar (yes/no)		n= 1 (4.2%)	n= 1 (2.1%)	χ^2= 1.0, p=.312
	Schizophrenia (yes/no)	-	-	-	
	Other diagnosis (yes/no)	-	n= 6 (25.0%)	n= 6 (12.5%)	χ^2= 6.8, p=.009
Other chronic illness		n= 8 (33.3%)	n= 12 (50%)	n= 20 (41.7%)	χ^2= 1.4, p=.242
				TOTAL n= 24	
Patient cancer characteristics					
Cancer type	Breast	n= 2 (16.7%)	n= 2 (16.7%)	n= 4 (16.7%)	χ^2= .23, p=.89
	Prostate	n= 2 (16.7%)	n= 1 (8.3%)	n= 3 (12.5%)	
	Other	n= 10 (83.3%)	n= 9 (75%)	n= 19 (39.6%)	
Stage of diagnosis	Stage I	-	n= 2 (16.7%)	n= 2 (8.3%)	χ^2= 3.6, p=.478
	Stage II	n= 1 (8.3%)	n= 2 (16.7%)	n= 3 (12.5%)	
	Stage III	n= 2 (16.7%)	n= 2 (16.7%)	n= 4 (16.7%)	
	Stage IV	n= 6 (50.0%)	n= 3 (25%)	n= 9 (37.5%)	
Prognosis	>12 months	n= 1 (8.3%)	n= 5 (41.7%)	n= 6 (25.0%)	χ^2= 4.1, p=.043
	Don't know	n= 11 (91.7%)	n= 6 (50.0%)	n= 17 (70.8%)	
Time since diagnosis	< 12 months	n= 2 (16.7%)	n= 2 (16.7%)	n= 4 (16.7%)	χ^2= 1.34, p=.510
	>12 months	n= 10 (83.3%)	n= 9 (75.0%)	n= 19 (79.2%)	
Past cancer tx	Chemo (yes/no)	n= 8 (66.7%)	n= 10 (83.3%)	n= 18 (75%)	χ^2= 0.35, p=.551
	Radiation (yes/no)	n= 5 (41.7%)	n= 4 (33.3%)	n= 9 (37.5%)	χ^2= 0.14, p=.712
Current treatment	Surgical (yes/no)	n= 8 (66.7%)	n= 8 (66.7%)	n= 16 (66.7%)	χ^2= 0.00, p=1.0
	Other treatment (yes/no)	n= 3 (25.0%)	n= 3 (25%)	n= 6 (25%)	χ^2= 1.1, p=.296
	Chemo (yes/no)	n= 4 (33.3%)	n= 5 (41.7%)	n= 9 (37.5%)	χ^2=0.14, p=.712
	Surgical (yes/no)	-	n= 1 (8.3%)	n= 1 (4.2%)	χ^2= 1.0, p=.312
	Palliative care (yes/no)	n= 2 (16.7%)	-	n= 2 (8.3%)	χ^2= 2.1, p=.149
	None/Other (yes/no)	n= 6 (50%)	n= 5 (41.7%)	n= 11 (22.9%)	χ^2= .50, p=.477

minority stress can be a risk or a protective factor for couples, and use this to draw on their strengths. Furthermore, SGM couples' experiences of minority stress (particularly in medical settings) highlight the importance of training providers in providing LGBTQ+ competent care.

Limitations

This study is limited by the relatively small, purposively, and theoretically derived sample of participants, limiting its generalizability. The sample may be biased because stronger, healthier couples may have been more likely to participate in a dyadic study. Couples were primarily White and were in long-term, committed relationships, which may also limit the generalizability. Also, data were not collected on couples' experiences of couples therapy and it is therefore unknown if attending couples therapy contributed to greater PTG. While all subgroups of SGM populations were purposely included due to their prior exclusion from research, this study combines the experiences of lesbian, gay, bisexual, and other sexually and gender diverse couples despite the possibility that their subgroup experiences may greatly vary. In the dyadic semistructured interviews, only SGM couples were asked specific questions about minority stressors (as this study was interested in minority stress related to identifying as LGBTQ+). Because the same set of questions were not asked to non-SGM couples, this study may underestimate the actual experience of minority stress in the non-SGM group. Furthermore, this study may include a historical bias as it was conducted during the COVID-19 pandemic—some participants stated that the pandemic changed their priorities or their appreciation of life, which may have influenced their perceptions of experiencing PTG related to cancer.

Conclusion

Although couples facing cancer are at risk of adverse psychological outcomes, the experience of PTG as a result of facing cancer is promising. The five original domains of PTG did not entirely capture how couples can experience PTG. Categorizing PTG as either individual or dyadic helps illuminate the process of PTG and provides a more nuanced understanding of the ways PTG can develop simultaneously on different levels. In this study, both SGM and non-SGM couples experienced all domains of individual PTG and dyadic PTG. SGM and non-SGM couples described similar experiences of prior life course stressors, PTG, and resulting positive effects on the relationship. The main differences in the experiences of SGM and non-SGM couples were in the minority stressors encountered by SGM couples related to their sexual orientation and gender identity and how these experiences may foster dyadic strength or durability. This study highlights the importance of including partner caregivers in all aspects of a patient's care and identifies minority stress as a unique conduit to dyadic PTG.

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Fluidity of Sexual Orientation and Factors That Influence Suicide Among Youth and Young Adults: A Narrative Review of Longitudinal Studies

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SUICIDE IS THE FOURTH LEADING cause of death among youth and young adults globally (World Health Organization [WHO], 2021). Sexual minority (i.e., lesbian, gay, bisexual, queer, and questioning [LGBQ+]) youth and young adults are at increased suicide risk relative to heterosexual peers, with the highest rates of risk occurring during young adulthood (di Giacomo et al., 2018; Fish et al., 2019). It is theorized that the interpersonal and systemic discrimination, bias, and prejudice (i.e., minority stress) sexual minority youth and young adults often experience increases risk for negative mental health outcomes (e.g., emotion regulation difficulties, depressive symptoms, substance use, etc.) and financial hardship (e.g., less likely to be offered jobs, lower salaries relative to heterosexual peers, etc.), which simultaneously increases risk for suicide (Coope et al., 2015; Franklin et al., 2017; Hatzenbuehler, 2009; Meyer, 2003; Sabia, 2015). With this framework as the foundation, a growing body of empirical work has examined factors that buffer against (e.g., social support, self-esteem), or bolster risk (e.g., mental health concerns) for, suicide among this group (see Gorse, 2022; Haas et al., 2010; Holman & Williams, 2022). However, sexual orientation is a multifaceted construct and is often fluid over time, particularly during adolescence (Fish & Pasley, 2015; Rosario et al., 2006). Understanding how individual and temporal fluidity in sexual orientation is related to risk and protective factors for suicide during this critical developmental period may help inform tailored and affirming suicide prevention efforts.

Developmental Trajectories of Sexual Orientation

Sexual orientation is often defined by three related facets: identity (e.g., "lesbian"), attraction (i.e., romantic feelings towards another person), and behavior (i.e., being involved romantically and/or sexually with another person; Austin et al., 20007; Friedman et al., 2004). Recent models of sexual development emphasize the importance of sexual milestones (e.g., awareness of attraction to a particular sex and/or gender, self-identification as gay, etc.), with some considering sexual development to peak in mid to late adolescence (for an overview, see Fish & Pasley, 2015; Rosario et al., 2006; Talley et al., 2015). For instance, sexual minority individuals often recall feeling "different" early in life and later gaining awareness of same-sex attractions, though this is not necessarily related to when someone may begin to identify as LGBQ+ or engage in same-sex behaviors (Fish & Pasley; Rosario et al.). Indeed, there can be significant variability in the timing of these milestones across individuals (Fish & Pasley; Rosario et al.). For many individuals, identity, attraction, and behaviors may stabilize and eventually align (e.g., identifying as a gay man who is solely attracted to and engages in romantic relationships with men); conversely, for others, these facets of sexual orientation may continue to change and remain discordant, even into adulthood (Fish & Pasley; Rosario et al.). Sexual orientation fluidity (heretofore referred to as *fluidity*), defined as temporal changes in sexual identity, attraction, and/or behavior, may stem, in part, from interpersonal and systemic discrimination (see Fish & Pasley; Rendina et al., 2019; Talley et al. for a full discussion). Whether fluidity represents a normative part of development, a reflection of societal pressures, or a combination of factors, its relation to protective and risk factors for suicide remains unclear. Still, fluidity has been directly linked to risk for suicidal ideation (SI) among adolescents and young adults (Fish & Pasley). To better inform suicide prevention efforts among sexual minorities, the current review aimed to (a) synthesize existing research examining fluidity and its relation to protective and risk factors for suicide during adolescence to young adulthood, (b) identify patterns of fluidity that may be associated more strongly with specific protective and risk factors, (c) highlight limitations of existing research, and (d) provide recommendations for future research.

Method

First, a list of protective and risk factors for suicide among youth and young adults generally, as well as sexual minorities specifically, was compiled from three recent review articles (i.e., Franklin et al., 2017; Gorse, 2022; Haas et al., 2010). A more general review on mental health among LGBQ+ individuals was also reviewed (Plöderl & Tremblay, 2015). Search terms (see Appendix, p. 23) were then created from this list and used in PsycInfo and PubMed. Publication dates were restricted to 2000–2022 to coincide with the research reviewed by Haas et al. and Gorse. Consistent with the definition for the period that encapsulates adolescence and young adulthood offered by several research teams (The Society for Adolescent Health and Medicine; Sawyer et al., 2018; Tillman et al., 2019), eligible studies included youth and young adults ages 11 to 35 at baseline. Additional inclusion criteria for studies were: (a) published in peer-reviewed journals; (b) longitudinal (i.e., at least two time points of assessment); (c) written in English; (d) quantitative in nature; (e) sexual orientation (as defined by identity, attraction, or behavior) assessed at least twice across time during study; (f) full access to manuscript by the authors; and (g) measurement of a noted protective or risk factor as outlined by the reviews described above. Following the identification of relevant studies, their reference sections were checked for additional studies that met inclusion criteria. Thirty-nine studies were identified, and 14 met inclusion criteria.

Results

Based on existing literature, one protective factor (i.e., self-esteem) is reviewed. In contrast, multiple risk factors are examined, including SI, mental health symptoms (i.e., depressive/anxiety symptoms), substance/alcohol use, psychosocial factors (i.e., emotion regulation difficulties, stress, internalized homophobia), and socio-economic factors. Results are summarized here, and additional details for each study can be found in Table 1.

Protective Factors

Two studies examined the relation between fluidity and self-esteem. In a sample of urban youth, Bauermeister (2010) did not find a relation between flu-

idity, as defined by dating behavior, and self-esteem across a 1-year span. However, they found that males, but not females, who reported a same-sex relationship at both baseline and a 1-year follow-up reported greater self-esteem than males who did not report a same-sex relationship at either timepoint. Using data from the National Longitudinal Study of Adolescent to Adult Health (Add Health), a U.S.-based, nationally representative, multiwave study (i.e., Waves I–IV) beginning in 1994, Oi and Wilkinson (2018) identified four groups based on fluidity across Waves I–IV: (1) individuals who engaged in a same-sex experience (SSE) during adolescence but not adulthood ("adolescence only"), (2) individuals who engaged in a SSE during adulthood but not adolescence ("adulthood only"), (3) individuals who engaged in SSE during both adolescence and adulthood ("adolescence and adulthood"), and (4) individuals with no SSE ("no SSE"). They found that, among males, fluidity did not predict changes in self-esteem. Conversely, relative to females in the "no SSE group," females in any of the other three groups reported lower self-esteem prospectively.

Risk Factors

Suicidal Ideation

The relation between SI and fluidity was examined in three studies, all using Add Health data. Needham (2012) found that, among females, those who reported either consistent or inconsistent attraction to females were at greater odds of experiencing SI at Wave I relative to females who consistently reported attraction to only males. Among males, those who consistently reported some attraction to males reported greater odds of experiencing SI relative to males who consistently reported attraction to only females. However, fluidity was unrelated to odds of reporting presence (versus absence) of SI over time for either males or females. Fish and Pasley (2015) built upon this work by using mixture modeling to identify five latent groups using attraction, behavior, and identity across Waves I–IV as indicators. Analyses revealed two heterosexual groups (i.e., "heterosexual early daters" and "heterosexual later daters") and three sexual minority groups (i.e., "heteroflexible," "later bisexually identified," and "LG[B]"). The heteroflexible group was characterized by shifts in attraction/identity along with low endorsement of same- or both-sex behavior. The later bisexually identified group was characterized by greater same-sex behavior relative to the heteroflexible group and more likely to engage in same-sex relationships over time. Finally, the LG[B] group displayed a consistent trend toward both- and same-sex attraction across Waves I–IV. These classes were then used to predict trajectories of presence (versus absence) of SI over Waves I–IV. All three groups were more likely to report SI than either heterosexual group. Finally, in the aforementioned study that examined the relation between fluidity and self-esteem, Oi and Wilkson (2018) found that females in the "adulthood only" group (i.e., engaged in an SSE during adulthood but not adolescence) were more likely to expe-

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Table 1. Descriptions of Studies Included in Review

Author(s), Year	Age Range at Baseline	Total Sample Size/Type	Factors Used to Define Sexual Orientation Fluidity	Protective Factors Assessed	Risk Factors Assessed
Bauermeister et al. (2010)	15-19	350; urban sample recruited from LGBT youth centers	Behavior	Self-esteem	Anxiety symptoms Depressive symptoms Internalized homophobia
Everett (2015)	18-26	11,243; Add Health subsample	Identity		Depressive symptoms Suicidal ideation
Fish & Pasley (2012)	13-18	12,679; Add Health subsample	Attraction Behavior Identity		Alcohol use Depressive symptoms Suicidal ideation
Katz-Wise et al. (2017)	22-30	1,461; GUTS subsample	Identity		Depressive symptoms
López et al. (2021)	11-14	177; community sample from two metropolitan areas	Identity		Depressive symptoms Emotion regulation difficulties
Needham (2012)	11-21	8,322; Add Health subsample	Attraction		Depressive symptoms Heavy drinking Marijuana use Cigarette use Suicidal ideation
Newcomb et al. (2012)	16-20	246; urban sample	Identity		Alcohol use
Oi & Wilkinson (2018)	16-17 "on average"	15,678; Add Health subsample	Attraction Behavior	Self-esteem	Depressive symptoms
Ott et al. (2013)	12-27	8,652; GUTS	Identity		Binge drinking Marijuana use Cigarette use
Pollard et al. (2011)	14-18	6,203; Add Health subsample	Attraction		Cigarette use
Redcay et al. (2019)	25-34	4,758; Add Health subsample	Attraction Identity		Anxiety symptoms Depressive symptoms Stress
Sabia (2015)	18-24	2,858; Add Health subsample	Identity		Personal earnings
Soloski et al. (2018)	11-21	Four Add Health subsamples (participants could be included within one or more subsamples: 794 2,726 3,882 4,831	Attraction Behavior		Binge drinking

(Table 1 continued on next page)

(Table 1 continued)

Author(s), Year	Age Range at Baseline	Total Sample Size/Type	Factors Used to Define Sexual Orientation Fluidity	Protective Factors Assessed	Risk Factors Assessed
Ueno (2010)	"people under 20"	12,056; Add Health subsample	Attraction Behavior Identity		Binge drinking Depressive symptoms Drug use

Note. Add Health = National Longitudinal Study of Adolescent to Adult Health; GUTS = Growing Up Today Study

rience SI prospectively than the no SSE group. Conversely, fluidity was not prospectively associated with SI among males in any group.

Mental Health Symptoms

Most studies that examined the relation between fluidity and mental health concerns focused on depressive symptoms, with the following six studies using Add Health data. Like Oi and Wilkson (2018) above, Ueno (2010) created 4 groups to categorize fluidity, though they also included identity to create these groups. Relative to females in the "no SSE" group, those in the "adulthood only" and "adolescence and adulthood" groups demonstrated greater depressive symptoms prospectively. In contrast, relative to males in the "no SSE" group, only males in the "adulthood only" reported greater depressive symptoms prospectively. Needham (2012) examined relations between fluidity in attraction and depressive symptoms. Relative to females with consistent heterosexual attraction, females who reported consistent attraction to females or those who reported a transition to some degree of same-sex attraction, experienced greater depressive symptoms. In contrast, relative to males with consistent heterosexual attraction, males who reported consistent attraction to males or a transition from a same-sex attraction to heterosexual attraction experienced greater depressive symptoms. Everett (2015) restricted the Add Health sample to only include respondents who were interviewed at Waves III/IV and completed a measure of depressive symptoms at both waves. Individuals who reported a change towards a more same-sex oriented identity from Wave III to Wave IV (e.g., heterosexual to gay) reported greater depressive symptoms versus those who did not. Additionally, changes in depressive symptoms were stronger among those who identified as exclusively heterosexual or bisexual at Wave III. Conversely, individuals who reported "mostly gay/lesbian" identities at Wave III and then reported changes toward more same-sex-oriented identities reported decreases in depressive symptoms at Wave IV. In the aforementioned study conducted by Fish and Pasley (2015), the three sexual minority groups (i.e., "heteroflexible," "later bisexually identified," and "LG[B]") generally reported greater depressive symptoms relative to the two heterosexual groups (i.e., "heterosexual early daters" and "heterosexual later daters"). Timing of identification also impacted depressive symptoms: individuals who reported onset of same-sex attraction and behavior in adulthood (versus adolescence) were at risk for greater depressive symptoms.

More recently, in the aforementioned Add Health study conducted by Oi and Wilkinson (2018), males who reported SSE in "adolescence only" and "adolescence and adulthood" reported greater depressive symptoms prospectively relative to males who reported "no SSE." Among females, those who reported SSE in "adulthood only" or "adolescence and adulthood" reported greater depressive symptoms prospectively relative to females who reported "no SSE". Finally, Redcay et al. (2019) examined the impact of fluidity on depressive and anxiety symptoms using Add Health data. Like Everett (2015), Redcay et al. used Waves III and IV to a create a variable identifying individuals who reported a different identity at each wave. However, Redcay et al. also used all four waves to create a separate variable to assess fluidity of attraction. They found that inconsistent (versus consistent) identity, but not attraction, predicted greater depressive symptoms at Wave IV. Fluidity did not predict anxiety symptoms.

Three of the eligible studies examined relations between fluidity and depressive symptoms in non-Add Health samples, with two also assessing anxiety symptoms. Bauermeister et al. (2010) found that fluidity, as defined by behavior, did not predict changes in depressive or anxiety symptoms among males or females in an urban sample of youth. Katz-Wise et al. (2017) calculated change scores based on variations in identity across seven waves of data (1999–2013) using a subsample from the Growing Up Today Study (GUTS), a U.S.-based population survey of youth beginning in 1996. At Wave 2010, among females identifying as "mostly heterosexual," greater fluidity since 1999 was associated with greater depressive symptoms. No relations between fluidity and depressive symptoms were found among males during the same period. Fluidity was also unrelated to anxiety symptoms among males or females during the same period. López et al. (2021) examined relations between changes in identity and trajectories of depressive symptoms from early to middle adolescence over a 3-year period (i.e., five measurement waves) in a community-based sample of youth. Identity, assessed at Waves 3-5, was used to create three groups: (1) youth who identified as "100% heterosexual" across all assessments (i.e., "consistent majority identity"), (2) youth who identified as a sexual minority (i.e., "mostly heterosexual," "bisexual," "mostly homosexual," "100% homosexual," or "not sure/questioning") across all assessments, and (3) youth who identified as a combination of minority and majority identities across assessments (i.e., "inconsistent sexual identity"). Relative to youth

in the consistent majority identity group, those in the consistent minority identity group, but not inconsistent minority group, reported greater depressive symptoms over time.

Substance and Alcohol Use

Several of the studies using Add Health data described previously also examined relations between fluidity and substance/alcohol use. Ueno (2010) found that, relative to females with "no SSE," females with SSE during "adulthood only" and "adolescence and adulthood" were at increased risk for binge drinking and drug use. No such relation was found among males. Needham (2012) found that males that transitioned from a same-sex to differing-sex attraction were at increased risk of cigarette use, but not heavy drinking or marijuana use, prospectively. No such relations were found for females, regardless of their pattern of sexual attraction over time. Pollard et al. (2011) used attraction at Wave I and III to categorize fluidity and examined its impact on latent trajectories of cigarette use across Waves I–III. They found that females who identified as non-heterosexual (versus exclusively heterosexual) were at increased risk of cigarette use. No such results were found for males. More recently, Fish and Pasley (2015) found that LG[B] identified individuals reported the lowest levels of alcohol use in adolescence but the highest levels of alcohol use in adulthood relative to any other sexual minority or heterosexual groups. The other two sexual minority groups (i.e., heteroflexible, later bisexually identified) reported greater alcohol use in both adolescence and adulthood relative to either of the heterosexual groups (i.e., heterosexual early daters, heterosexual later daters). Soloski et al. (2018) examined the impact of changes in romantic attraction and behavior on binge drinking risk among males and females. They also examined this relation in four separate Add Health subsamples that varied as a function of different inclusion criteria based on various sexual orientation indicators. Specifically, samples varied on whether they included only participants that self-identified as LGBQ+ or whether they reported other experiences consistent with a sexual minority orientation (i.e., experiences of same-sex attraction or romantic behavior). In two of their subsamples, they found that timing of same-sex behavior (i.e., experiences that occurred closer to young adulthood versus adolescence), but not attraction, among females predicted greater risk of binge drinking. No such relations were found among males in any sample.

Two additional studies examined substance/alcohol use in non-Add Health samples. Newcomb et al. (2012) assessed fluidity, as captured by changes in identity, as well as quantity and frequency of alcohol use five times over the span of 2.5 years in an urban sample. Fluidity did not predict alcohol use. Ott et al. (2013) utilized data from the GUTS study described previously, and examined rates of marijuana, nicotine, and alcohol use. They calculated two "mobility measures" based on changes in identity across 5 waves of data. For the first ("M"), a score was calculated based on the number of changes in identity between each wave. For the second ("Trajectory"), a score was calculated based on the direction of change in identity (e.g., from heterosexual to lesbian) between each wave. Four trajectory groups were created. Specifically, individuals with no changes in identity across 3 or more waves were categorized as "Immobile." Individuals who reported changes from a sexual minority (e.g., gay) at baseline to heterosexual identity across subsequent waves were categorized as "Toward Completely Heterosexual." Conversely, individuals who reported changes from a heterosexual to sexual minority identity were categorized as "Toward Completely Homosexual." Finally, individuals who did not report a consistent trend toward either a heterosexual or sexual minority identity were classified as "Multidirectional". Relative to females who did not report changes in identity (i.e., "Immobile"), females in all other trajectory groups demonstrated increased risk of marijuana and cigarette use during adolescence and young adulthood. Additionally, relative to females in the Immobile group, females in the Multidirectional and Toward Completely Heterosexual Group were at increased risk for binge drinking in young adulthood. Relative to males in the Immobile group, only those in the "Multidirectional" and "Toward Completely Homosexual" groups were at increased risk of marijuana and cigarette use, particularly during young adulthood. No relations between identity and binge drinking among males were found.

Psychosocial Factors

Two studies discussed previously examined a general psychosocial suicide risk factor. Redcay et al. (2019) found that fluidity did not predict stress as assessed at Wave IV of Add Health. López et al. (2021) found that youth who consistently identified as a sexual minority, but not youth with inconsistent sexual identities, reported greater emotion regulation difficulties relative to youth who consistently identified as a sexual majority in a community-based sample.

One aforementioned study examined a psychosocial factor specific to sexual minorities. Bauermeister et al. (2010) examined the relation between fluidity and internalized homophobia. They found that, among female youth, but not males, those who had denied a same-sex relationship at baseline, but reported one or more at follow-up, experienced greater internalized homophobia versus those without any same-sex relationship.

Socio-Economic Factors

Using Waves III and IV of Add Health data, Sabia (2015) examined the relation between fluidity, as defined by either identity or attraction, and personal earnings. Females who transitioned from a heterosexual identity at Wave III to bisexual identity at Wave IV reported lower earnings relative to females who consistently identified as heterosexual. No such relation was found among females who transitioned from a bisexual or heterosexual to a lesbian identity during the same period. Relatedly, there was no relation between consistency of identity (i.e., bisexual or lesbian at Waves III and IV) and personal earnings among females. Conversely, among males, consistently identifying as either bisexual or gay, versus consistently identifying as heterosexual, was associated with lower earnings. Additionally, relative to males who consistently identified as heterosexual, males who moved away from an identity that denotes greater same-sex attraction (e.g., gay to bisexual) also reported lower earnings.

When fluidity was assessed as changes in attraction, rather than identity, between Waves III and IV, results differed to some degree. Females who changed from heterosexual or bisexual attraction at Wave III to exclusively same-sex attraction at Wave IV earned less wages relative to females who consistently reported attraction to males. This was also the case for females who consistently reported attraction to both males and females. Males who consistently reported only same-sex attraction across Waves III and IV earned less wages relative to males who consistently reported attraction only to females. No such relation was found among males of any other group.

Discussion

To coalesce our understanding of the relation between fluidity and protective as well as risk factors for suicide from adolescence to adulthood, we reviewed 14 studies. Notably, most studies did not assess fluidity in the same manner, making it challenging to identify patterns of fluidity that may be related to specific buffers against, or risk factors for, suicide. Nonetheless, some tentative conclusions are offered below.

This review revealed that the relation between fluidity and factors that protect against suicide were seldom examined in existing research. Indeed, self-esteem was the sole protective factor assessed in relation to fluidity (Bauermeister et al., 2010; Oi & Wilkinson, 2018) and results across the two studies were inconsistent. Different study samples (i.e., an urban sample versus Add Health sample) and use of different methods to assess fluidity may have contributed to discrepant results. Overall, the small number of studies in this area precludes conclusions about the relation between fluidity and self-esteem.

In contrast, all 14 studies included in this review assessed relations between fluidity and various suicide risk factors. Three of these studies examined SI specifically and used Add Health data. Two of those three studies (Needham, 2012; Oi & Wilkinson, 2018) used experimenter-derived categories of fluidity. Fluidity was associated with increased odds of SI among females in both studies, and one (Oi & Wilkinson) found this association among males. One study that used a data-driven approach (Fish & Pasley, 2015) to categorize fluidity found that all three latent sexual minority groups (i.e., heteroflexible, later bisexually identified, and LG[B]) examined were at greater odds of SI relative to the heterosexual groups. Though analyses were not stratified by sex, participants were predominantly females in the three sexual minority groups. These preliminary results suggests that fluidity may increase risk for SI, particularly among females.

Depressive symptoms were most consistently studied in relation to fluidity in the studies reviewed. Specifically, nine studies examined depressive symptoms, with six using Add Health data (Everett, 2015; Fish & Pasley, 2015; Needham, 2012; Oi & Wilkinson, 2018; Redcay et al., 2019; Ueno, 2010) and three using other samples (Bauermeister et al., 2010; Katz-Wise et al., 2017; López et al., 2021). Most studies conducted with Add Health data found that fluidity was associated with greater depressive symptoms. One study found that this relation was only present among individuals with particular identities (i.e., "exclusively heterosexual" or "bisexual") at baseline (Everett, 2015). The timing of same-sex behavior may have also played a factor in the relation between fluidity and depressive symptoms (see Fish & Pasley). Conversely, only one of the three studies conducted with non-Add Health data corroborated this relation between fluidity and depressive symptoms, and only among females who identified as "mostly heterosexual" at baseline (Katz-Wise et al., 2017). Three of these studies also examined the association between fluidity and anxiety symptoms, but no relation was found using Add Health data (Redcay et al.) or other samples (Bauermeister et al.; Katz-Wise et al.). Overall, these studies suggest that fluidity increases risk for depressive symptoms, though sexual identity, timing of sexual developmental milestones (e.g., adolescence vs adulthood), and sex may be potential moderators of this relation.

Substance use was the second most studied risk factor in relation to fluidity. Six studies examined substance and alcohol use, with four using Add Health data (Fish & Pasley, 2015; Needham, 2012; Pollard et al., 2011; Ueno, 2010) and two using other samples (Newcomb et al., 2012; Ott et al., 2013). Overall, many found that fluidity was associated with greater substance and/or alcohol use. There was some evidence that this relation was stronger among females than males (e.g., Ott et al.; Pollard et al.). However, Soloski et al. (2018) demonstrated that the relation between fluidity and alcohol use was also partially dependent on the criteria used to create sexual minority groups within the Add Health data. Therefore, fluidity may be linked to substance use, particularly among females, though additional research is needed to draw stronger conclusions in light of Soloski et al.'s findings.

Few studies examined the link between fluidity and psychosocial risk factors. One study examined stress (Reday et al., 2019) and another other emotion regulation difficulties (López et al., 2021). Neither found a relation between fluidity and either construct. However, in the latter study, fluidity could not be examined within the group that consistently identified as LGBQ+ during the study (e.g., a change from identifying as gay to bisexual) due to a modest sample size. One study (Sabia, 2015) examined the relation between fluidity and personal earnings and found that fluidity was associated with lower earnings among males and females, though these findings varied as a function of how fluidity was defined (i.e., use of identity versus attraction). Finally, a single study examined internalized homophobia (Bauermeister et al., 2010) and found that, among females, but not males, a transition from heterosexual to same-sex behavior was associated with greater internalized homophobia. Given the dearth of studies on the relation between fluidity and psychosocial risk factors, no conclusions can be drawn at this time.

Clinical Implications

Insights from this review may inform evidence-based practices with LGBQ+ individuals. First, results suggest that it is important to ask clients about their identity as well as their attraction to and romantic involvement with others when assessing sexual orientation. It may also be helpful to explore how clients conceptualize their sexual orientation both currently and over the course of their life. This conversation may be affirming to an LGBQ+ client. By creating an affirming space, clinicians may, in turn, be able to gather more detailed information on interpersonal and systemic stressors that have triggered and/or maintained factors that influence their client's suicide risk (e.g., depressive symptoms, substance use, SI, etc.). Relatedly, exploring these concerns from an intersectional lens (e.g., how their sex may have affected their experiences as a sexual minority) may offer further validation and inform understanding of a client's experience as a sexual minority. Finally, clinicians may benefit from trainings aimed at bolstering knowledge of LGBQ-affirmative cognitive behavioral therapy strategies, which improve treatment outcomes in this group (see Pachankis et al., 2022).

Limitations of Current Research and Recommendations for Future Directions

Though this review offers a novel contribution to the literature, it is subject to limitations that deserve mention. Consistent with broader trends in research with sexual minority individuals (see Gorse, 2022), few studies were included to examine the relation between fluidity and protective factors. Yet, protective factors may help further our understanding of mechanisms underlying this relation and inform intervention efforts. For example, both theoretical and empirical work from social psychology on in-group and out-group

bias suggests that some protective factors, such as social support, may be particularly sensitive to fluidity (see Everett et al., 2015; Riek et al., 2006). Perceptions of social support may, in turn, influence suicide risk (López et al., 2021). Second, assessment of fluidity varied widely between studies, even among those that used the same dataset (e.g., Add Health). As demonstrated by Soloski et al. (2018), the inclusion criteria used to define sexual minority groups may significantly alter results. To address these concerns in future research, the use of multiverse techniques (Harder, 2020; Steegen et al., 2016) is recommended. Multiverse techniques involve the use of multiple methodological strategies (e.g., using different data analytic approaches, selection of participants to include in a subsample from population data, etc.) within a single dataset and reporting of all results. Such an approach may help further our understanding of which strategies have significant implications for study conclusions (Harder, 2020). Additionally, to further refine definitions of sexual orientation and generate best assessment practices, further qualitative research on how youth and young adults understand sexual orientation is warranted. Prior qualitative work suggests that attraction, rather than behavior or identity, may be particularly important when assessing sexual orientation among youth and young adults (Austin et al., 2007; Friedman et al., 2004). It is possible that youth and young adults of today may conceptualize sexual orientation differently than those at the beginning of the 21st century. Third, the studies reviewed included large intervals of time between assessments, with the shortest time being 6 months (see Newcomb et al., 2012). Relatedly, most studies reviewed relied on Add Health data. As suicide risk can vary significantly, even over the span of a day (Franklin et al., 2017), intensive longitudinal designs may help elucidate how fluidity is proximally related to buffers against, and risk for, suicide. Furthermore, the use of data-driven approaches (e.g., mixture models, see Fish & Pasley, 2015) may help researchers readily identify how latent patterns of fluidity may be related to suicidality. Finally, to encourage more equitable research practices, the use of advisory boards with LGBQ+ individuals is recommended (see Haddad et al., 2022).

Suicide is a leading cause of death worldwide, and sexual minorities are at increased risk. The current review sought to synthesize literature on the relation between fluidity and factors for suicide from adolescence to adulthood. Most work has focused on fluidity as a risk factor for depressive symptoms. Preliminary evidence suggests that fluidity may also increase risk for SI and substance use. Significantly less work has examined the relation between fluidity and protective factors. Future work in this area may help inform interventions among this marginalized group.

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Appendix

Methods

List of Search Terms

- Search terms (the 5 sets of key words will be connected by "and" operator)
  - First set of key words; include all of these with "or" in between each one: "sexual identity" OR "sexual orientation" OR "sexual minority" OR "LGB*" OR "GLB*"
  - Second set of key words; include all of these with "or" in between each one: "Youth" OR "adolescen*" OR "young adult*"
  - Third set of key words: Include all of these with "or" in between each one: "suicid*" OR "protective factor" OR "risk factor" OR "minority stress" OR "discrimination" OR "prejudice" OR "bias" OR "victimization" OR "mental disorder" OR "anxiety" OR "depress*" OR "substance" OR "hope*" OR "abuse" OR "maltreatment" OR "emotion regulation" OR "emotion dysregulation" OR "rejection" OR "support" OR "family" OR "connect*" OR "thwarted belongingness" OR "perceived burdensomeness" OR "acquired capability" OR "poverty" OR "homelessness"
  - Fourth set of key words: "change" OR "mobility" OR "fluid*"
  - Fifth set of key words: "longitudinal" OR "prospective"

Note: The asterisk (*), also known as the truncation wildcard, was included for specific terms within the search engines to broaden results (e.g., suicid* includes results that contain words such as "suicide", "suicidal", "suicidality").

Protective Factors for Suicidal Ideation and Depressive Symptoms Among Transgender and Gender Diverse Adults

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TRANSGENDER AND GENDER diverse (TGD) individuals have a gender identity that differs from the conventional construction of gender associated with the sex they were assigned at birth (Bouman & Arcelus, 2017; Chang et al., 2018; Richards et al., 2016). Transgender and gender diverse individuals are at disproportionate risk for depression, as well as suicidal thoughts and behaviors, when compared to their cisgender counterparts (e.g., Dhejne et al., 2016; James et al., 2016). Previous research has found that TGD individuals have a four-fold risk of depressive disorders compared with cisgender individuals (Witcomb et al., 2018). Similarly, disproportionate risk has been found for suicidal thoughts and behaviors within the TGD population. Lifetime prevalence rates of suicidal ideation for TGD individuals are between 40% and 70% (Marshall et al., 2016; Testa et al., 2017). These rates of suicidal ideation are far higher than those found within the general population, which range from 12% to 14% (Kessler et al., 1999; Nock et al., 2013).

Various models have been developed to account for risk and resilience factors TGD individuals experience for various health outcomes, including suicide risk and depression. Meyer's (2003) minority stress model posits that the excess stress an individual faces as a part of a marginalized population, through various distal and proximal stressors, confers risk for negative health outcomes. The minority stress model also highlights resilience factors, such as connectedness to other minority group members, that can ameliorate stress and associated negative mental health outcomes. Although the minority stress model was originally developed with a focus on sexual minority individuals, Testa et al. (2015) expanded upon the minority stress model with the gender minority stress and resilience model, which includes specific distal and proximal minority stress and resilience factors faced by TGD individuals. Distal minority stress factors include gender-related nonaffirmation, victimization, harassment, and discrimination (e.g., legal and medical discrimination regarding changes in name, difficulties accessing safe restrooms, and inability to receive gender-affirming care). Proximal minority stress factors within this model include the internal processes that distal factors can give rise to, including gender dysphoria, internalized transphobia, and pressure to conceal one's gender identity (Lindley & Galupo, 2020; Testa et al., 2015). Gender dysphoria is the discomfort or distress experienced when an individual's gender identity and sex assigned at birth is not aligned (Coleman et al., 2022). Gender dysphoria can lead to a feeling of disgust with or disconnection from one's body, which are associated with suicidality and depressive symptoms (Colizzi et al., 2015; Cooper et al., 2020; Foote et al., 2008).

Research has identified minority stressors, such as gender dysphoria and discrimination, as risk factors for depression and suicidal ideation among TGD populations (e.g., Khobzi Rotondi, 2012; Pellicane & Ciesla, 2022; Tankersley et al., 2021; Virupaksha et al., 2016; Williams, 2017; Wolford-Clevenger et al., 2018); however, there is far less research on protective factors for these outcomes (Tankersley et al., 2021). Among the general population, research has found that factors such as positive emotion regulation strategies, family alliance, self-acceptance, and future optimism are negatively associated with depression (Breton et al., 2015; Brewer et al., 2016; Kassis et al., 2017; Milot Travers & Mahalik, 2019; Roohafza et al., 2014). Related protective factors have been identified for suicidal ideation, including school and family connectedness, social support, and feelings of resilience (e.g., Elbogen et al., 2020; Glenn et al., 2018; Kaminski et al., 2010; Kim et al., 2020). Research investigating potential protective factors in TGD populations has largely focused on the same constructs, identifying similar associations (e.g., Bariola et al., 2015; Edwards et al., 2020; Freese et al., 2018; Johns et al., 2018; Meza Lazaro & Bacio, 2021; Puckett et al., 2019; Snooks & McLaren, 2021; Trujillo et al., 2017; Zhang et al., 2021).

Although much of the work in this area is focused on general protective factors (e.g., social support), there are protective factors that are specific to one's TGD identity, such as connection to the TGD community, as highlighted in the gender minority stress and resilience model (Testa et al., 2015). Further theory has organized TGD-specific resiliencies into group resilience factors (i.e., family acceptance, community belonginess, positive TGD role models, TGD activism) and individual resilience factors (i.e., self-acceptance, identity pride, transition-related strengths), as outlined in the transgender resilience intervention model (TRIM; Matsuno & Israel, 2018). Research applying the full TRIM model is scarce, but some of its singular components (community connectedness, community pride, and medical or social transition) have been found to protect against negative mental health outcomes in TGD individuals (Cogan et al., 2020; Moody et al., 2015; Olson-Kennedy & Warus, 2017; Torres et al., 2015; Vance et al., 2014).

Access to desired medical and/or social transition, such as changing one's name or hormone therapy, is an individual resilience factor that a number of qualitative and quantitative studies have shown is associated with reduced depressive symptoms, suicidal ideation, and suicidal behaviors (e.g., Bailey et al., 2014; Malta et al., 2020; Moody et al., 2015; Russell et al., 2018; Tomita et al., 2019; Tucker et al., 2018). Transition has been identified as a way of facilitating gender congruence or feeling comfortable with the agreement between one's external appearance and gender identity (Kelly et al., 2022; Kozee et al., 2012; Owen-Smith et al., 2018). Higher rates of gender congruence are associated with lower anxiety and depression (Wu et al., 2022). Although there is a lack of research specific to gender congruence as a protective factor for suicidality, gender dysphoria, the inverse of gender congruence, has been found to be associated with suicidal thoughts and behaviors among TGD people, suggesting that gender congruence may be a relevant protective factor for suicide within this population (Bailey et al., 2014; Cooper et al., 2020).

Gender acceptance, an individual resilience factor identified in the TRIM model, is distinct from gender congruence, in that it focuses on the extent to which one accepts their gender identity and holds pride in that identity, rather than the perception that one's external appearance represents their gender identity (Kozee et al., 2012). However, they are related constructs. Visual conformity with one's affirmed gender is more common among those who report a greater sense of pride and acceptance in

their gender identity (To et al., 2020). In qualitative work conducted with TGD people of color who had experienced trauma, pride in one's gender identity was identified as a key resilience factor in response to trauma (Singh & McKleroy, 2011). However, there has been minimal research conducted on the specific impact of gender acceptance on suicidality and depression among TGD people. One study found that pride in one's identity did not predict change in suicidal ideation over time (Rabasco & Andover, 2021). However, other research found that pride in one's gender was negatively correlated with depressive symptoms (Testa et al., 2017). The lack of work in this area points to gender acceptance as an important avenue for future research on TGD-specific protective factors related to suicidality and depression.

Finally, connection to the TGD community is a group resilience factor noted in the TRIM model. One study found that connectedness to the TGD community predicted a decrease in suicidal ideation 1 month later (Rabasco & Andover, 2021). In another study of over 3,000 TGD adults, awareness of and engagement with other TGD people was associated with reduced suicidality (Testa et al., 2014). Furthermore, Puckett et al. (2019) found that TGD individuals with high levels of community connectedness reported lower levels of depressive symptoms compared to other groups in the study. Peer support from other TGD individuals has been found to buffer the effect of social stigma on psychological distress among TGD people (Bockting et al., 2013). Taken together, this work points to the protective effect of TGD community connectedness on various negative mental health outcomes.

In sum, there is a limited body of research on TGD-specific protective factors for suicidality and depression among TGD individuals. In order to protect against these negative mental health outcomes, is essential to acknowledge and identify those unique strengths and experiences of TGD people that can be built and strengthened, rather than simply focusing on reducing risk factors. In addition, although some previous research has examined gender congruence, gender acceptance, and community connectedness in relation to negative mental health outcomes, there is a lack of research on how internal (e.g., gender acceptance, gender congruence) and external (e.g., connection to the TGD community) TGD-specific resilience factors may compare to one another and interact to protect against suicidal ideation and depressive symptoms. For example, are gender congruence and gender acceptance equally as protective against these negative outcomes? Does a higher level of connection to the TGD community strengthen the protective effects of gender congruence and/or gender acceptance? By providing a better understanding of how TGD-specific resilience factors protect against depression and suicidal ideation, TGD-affirming clinicians will be able to build and nurture those domains of resilience that are particularly protective, especially when working with clients at high risk for suicide.

Therefore, the present research aimed to examine the relationship between both individual and group TGD-specific protective factors and depressive symptoms and suicidal ideation, respectively. Specifically, gender congruence and gender identity acceptance were investigated as predictors of the separate outcomes of depressive symptoms and suicidal ideation severity. It was hypothesized that gender congruence and gender acceptance would both predict lower depressive symptoms and suicidal ideation severity, respectively. In addition, in order to test the interaction between group and individual TGD resilience factors, connection to the TGD community was included as a moderator of the relationships between gender acceptance, gender congruence, and suicidal ideation severity and depressive symptoms. It was hypothesized that connection to the TGD community would moderate these relationships, with the relationship between predictors (gender congruence and gender acceptance) and outcomes (suicidal ideation severity and depressive symptoms) significant only at medium and high levels of TGD community connection.

Methods

Participants

The sample consisted of TGD adults (N = 180). Participants were recruited from TGD-specific online forums, also known as subreddits (including r/transgender and r/asktransgender), on Reddit.com, an online social networking website. Participants were recruited as part of a larger study on the risk and protective factors for suicidal thoughts and behaviors among TGD adults. Participant inclusion criteria included a self-reported TGD gender identity, ability to

Table 1. Sample Characteristics (n = 180)

	Mean (*SD*) or %	*N*
Age	26.08 (6.87)	-----
Gender		
Trans Woman	55.0%	99
Trans Man	18.3%	33
Gender Non-Conforming	5.0%	9
Gender Queer	5.0%	9
Other	16.7%	30
Race		
American Indian or Alaska Native	1.1%	2
Asian	7.2%	13
Native Hawaiian or Other Pacific Islander	0.6%	1
Black or African American	2.8%	5
White or Caucasian	76.7%	138
Multiracial	6.1%	11
Other	5.7%	10
Ethnicity		
Hispanic or Latinx	10.6%	19
Non-Hispanic or Latinx	89.4%	161
Sexual Orientation		
Asexual	5.6%	10
Bisexual	21.1%	38
Gay	7.8%	14
Heterosexual	13.3%	24
Lesbian	15.0%	27
Pansexual	18.9%	34
Queer	10.6%	19
Other	7.7%	6

read English, being 18 years old or older, and a valid email address. There were no exclusion criteria for the study.

Participants in the sample were 18–55 years old, with an average age of 26.01 years old (SD = 6.90). The majority (76.7%, n = 138) of the sample identified as White, and 89.4% (n = 161) identified as non-Hispanic/Latinx. Participants mainly identified as trans women (55%, n = 99) or trans men (18.3%, n = 33). Participants endorsed a variety of sexual orientations, with the most common being bisexual (21.1%, n = 38) and pansexual (18.9%, n = 34). See Table 1 for additional information on participant demographics.

Procedure

Permission to post to TGD specific Reddit.com forums was obtained from the forum moderators before recruitment messages were posted. All data were collected using Qualtrics survey software. Once participants passed the screening questions (which assessed for TGD identity, age, and ability to speak and read English) and informed consent, they were asked to complete a series of questionnaires. The survey took participants approximately 30–60 minutes to complete and, at the end of the survey, all participants were presented with a debriefing form and provided with LGBTQ+ specific crisis hotline numbers. Those who completed a valid survey received a $5 Amazon.com electronic giftcard for their participation. Data quality was ensured by including a captcha (a test to determine whether participants were human) at the beginning of the survey and validity items throughout the survey. A survey was considered valid when five out of the seven validation items were answered correctly (e.g., "Select 'always' for this item."). The University's Institutional Review Board approved the study protocol, and informed consent was obtained from all study participants.

Measures

Demographic Questionnaire

Participants were asked to indicate their age, gender, race, ethnicity, sexual orientation, and state or country of residence (for U.S. and international residents, respectively).

Beck Scale for Suicidal Ideation (BSS; Beck & Steer, 1991)

Suicidal ideation severity was measured using the BSS, a 21-item self-report measure. The first 19 questions of the BSS measure suicidal ideation in the past week, with a higher score indicating a higher level of suicidal ideation severity. Items 20 and 21 on the BSS measure suicidal behaviors; these items were not examined in the current research. The BSS is widely used in suicide research and has demonstrated excellent validity and reliability (Brown et al., 2000). In the present study, internal consistency of the BSS was good (Cronbach's alpha = 0.83).

Beck Depression Inventory-II (BDI-II; Beck et al., 1996)

Depressive symptoms were measured using the BDI-II, a 21-item self-report measure assessing depressive symptoms that may have occurred during the preceding 2-week period. A higher score indicates a higher level of depressive symptomatology. The BDI-II is one of the most widely used self-report measures of depressive symptomatology across a variety of populations (Nezu et al., 2014) and has strong psychometric properties (Beck et al., 1996). In the present study, internal consistency of the BDI-II was excellent (Cronbach's alpha = 0.92).

Transgender Congruence Scale (TCS; Kozee et al., 2012)

Gender congruence and gender acceptance were measured using the TCS, a 12-item self-report measure that assesses the degree to which TGD individuals feel genuine, authentic, and comfortable with their gender identity and external appearance over the past 2 weeks. Response options range from 1 (*strongly disagree*) to 5 (*strongly agree*). The TCS is comprised of two subscales. The gender congruence subscale includes nine items (e.g., "I am happy with the way my appearance expresses my gender identity"), while the gender acceptance subscale is comprised of three items (e.g., "I am happy that I have the gender identity that I do"). All 12 items can be averaged to yield an overall score, with a higher score indicating a higher level of comfort with one's identity and appearance. The TCS has been shown to have construct and incremental validity; however, test-retest reliability of the TCS has not been evaluated (Kozee et al., 2012; Shulman et al., 2017). In the present research, internal consistency of the TCS overall score was excellent (Cronbach's alpha = .92), as was the internal consistency of the TCS gender congruence subscale (Cronbach's alpha = .95). The internal consistency of the TCS gender acceptance scale was adequate (Cronbach's alpha = .72).

Gender Minority Stress and Resilience Measure (GMSR; Testa et al., 2015)

Current connection to the TGD community was assessed using the TGD-community connectedness subscale of the GMSR, with a higher score indicating greater connection to the TGD community. The GMSR exhibits good reliability and validity among TGD individuals (Testa et al., 2015). The internal consistency of the GMSR community connectedness subscale was good in the present study (Cronbach's alpha = 0.82).

Results

Ninety-three percent (n = 168) of the participants reported experiencing suicidal ideation in their lifetime, 78% (n = 141) reported suicidal ideation in the past year, and 56% (n = 101) reported suicidal ideation in the past week. Additional descriptive statistics are reported in Table 2. Associations between all variables are reported in Table 3.

First, two separate multiple linear regressions were conducted with gender congruence and gender acceptance as predictors and depression and suicidal ideation as outcomes, respectively. For the first multiple linear regression, with depression as the outcome, assumptions were examined. Independence of residuals (Durbin-Watson statistic of 1.94), linearity, homoscedasticity, and multicollinearity were all observed. No outliers were identified and the visual inspection of the histogram and Q-Q plot of studentized residuals showed that the distribution was approximately normally distributed. Increased gender acceptance predicted decreased depressive symptoms, $\beta = -0.32$, $t = -4.64$, $p < .001$. Increased gender congruence also predicted decreased depressive symptoms, $\beta = -0.16$, $t = -2.30$, $p = .02$.

For the second multiple linear regression, with suicidal ideation severity as the outcome, assumptions were examined. Independence of residuals (Durbin-Watson statistic of 1.78), linearity, homoscedasticity, and multicollinearity were all observed. No outliers were identified and the visual inspection of the histogram and Q-Q plot of studentized residuals showed that the distribution was approximately normally distributed. Increased gender acceptance statistically predicted decreased suicidal ideation severity, $\beta = -0.23$, $t = -3.12$, $p < .01$. However, increased gender congruence did not statistically predict decreased suicidal ideation severity, $\beta = -0.11$, $t = -1.52$, $p = .13$.

Simple linear regression analyses were also conducted with the TCS overall score. Increased gender acceptance and gender congruence statistically predicted decreased depressive symptoms, $\beta = -0.30$, $t = -4.12$, $p < .001$. Increased gender acceptance and gender congruence also statistically pre-

dicted decreased suicidal ideation severity, β = -0.21, t = -2.83, p < .01.

Finally, moderation models were then conducted using Model 1 of PROCESS, an observed variable OLS regression path analysis-modeling tool (Hayes, 2013). Connectedness to the TGD community did not moderate any of the relationships between gender congruence and gender acceptance and depressive symptoms and suicidal ideation, respectively (all p's > .12).

Discussion

The current study explored how the TGD-specific resilience factors of gender congruence and gender acceptance are associated with depressive symptoms and suicidal ideation and how those associations may be impacted by connection to the TGD community. TGD individuals face significant victimization and discrimination based on their gender identity (e.g., James et al., 2016), which has been shown to substantially increase risk for depression and suicidal ideation (e.g., Pellicane & Ciesla, 2022; Wolford-Clevenger et al., 2018; Zhang et al., 2021). However, much of the previous research has solely focused on these risk factors, without investigating how the positive aspects of one's TGD identity and experience may be leveraged to ameliorate negative mental health outcomes. Therefore, the current research extends previous research by highlighting the interaction of TGD-specific protective factors and their relationship with depressive symptoms and suicidal ideation among TGD adults.

Over 90% of the participants in the current study experienced suicidal ideation in their lifetime. Furthermore, approximately 70% of participants reported mild, moderate, or severe depressive symptoms over the past 2 weeks. Given the high rates of suicidal ideation and depression in this population, it is critical to begin to understand factors specific to TGD individuals that can protect against these negative outcomes. The current study found that increased gender acceptance was associated with decreased depressive symptoms and suicidal ideation severity, aligning with previous research in this area (Testa et al., 2017) and suggesting that gender acceptance is a key TGD-specific protective factor to cultivate. In addition, in the current study, increased gender congruence was associated with decreased depressive symptoms but not decreased suicidal ideation, differing from our hypothesis that gender congruence would protect against both depression and suicidality. These findings point to the possibility that for suicidal ideation severity specifically, gender congruence may be a less relevant protective factor when directly compared to gender acceptance. Because the current study was cross-sectional, it is unknown whether gender congruence may lead to increased gender acceptance, which then serves as a protective factor for suicidal ideation severity. Future longitudinal research could explore the temporal relationships between these variables. It is also important to note that the overall TCS score, in which gender acceptance and gender congruence items were combined, was a significant predictor of decreased depressive symptoms and suicidal ideation severity, supporting the protective benefits of both these constructs together.

The findings from the present research underscore the importance of fostering gender acceptance and gender congruence among TGD individuals, as they can help to protect against negative, and potentially life-threatening, outcomes. Previous research has shown that undergoing desired gender-affirming medical interventions (e.g., hor-

Table 2. Descriptive Statistics for Variables of Interest (n = 180)

Variables	Range	M	SD
Depressive Symptoms (BDI-II)	0–52	22.68	12.58
Suicidal Ideation Severity (BSS)	0–31	10.42	8.59
Gender Congruence (TCS subscale)	1–5	2.44	1.28
Gender Acceptance (TCS subscale)	1–5	3.62	0.89
Gender Congruence and Acceptance (Overall TCS)	1.17–5	2.74	0.92
TGD Community Connectedness (GMSR)	5–25	16.62	4.39

Table 3. Correlations Among Variables of Interest

	1	2	3	4	5	6
1. Gender Congruence	---	---	---	---	---	---
2. Gender Acceptance	.19**	---	---	---	---	---
3. Overall TCS	.42**	.97**	---	---	---	---
4. TGD Community Connectedness	.35**	.18*	.25**	---	---	---
5. BDI-II	-.36**	-.23**	-.30**	-.07	---	---
6. BSS	-.26**	-.16*	-.21**	-.08	.66**	---

Notes. TCS = Transgender Congruence Scale; TGD = Transgender and Gender Diverse; BDI-II = Beck Depression Inventory-II; BSS = Beck Scale of Suicidal Ideation
*Correlation is significant at the .05 level
**Correlation is significant at the .01 level

mone therapy) and taking steps to socially transition (e.g., changing one's name) both facilitate gender congruence and gender acceptance among TGD people (e.g., Kelly et al., 2022; Owen-Smith et al., 2018). The protective effects of desired gender-affirming medical interventions were shown in one study of 34,759 LGBTQ youth, which found that use of gender-affirming hormone therapy was associated with lower odds of recent depression and seriously considering suicide compared to those who wanted gender-affirming hormone therapy but did not receive it (Green et al., 2022). Therefore, increasing access to desired gender-affirming medical interventions and social transition steps are essential to the health and well-being of this population. Although the present study was focused on TGD-protective factors that reduce depression and suicidality, it is important to highlight the devastating impacts associated with a lack of access to gender-affirming care. Jarrett et al. (2021) found that a lack of access to gender-affirming care was associated with increased depressive symptoms and suicidal ideation among TGD individuals. In addition, a desire for future gender-affirming care, suggesting a potential discrepancy between one's current appearance and desired appearance, has been associated with higher rates of a previous suicide attempt (Zwickl et al., 2021). Taken together, the current findings and previous research reinforce the importance of increasing TGD individual's access to gender-affirming medical interventions.

Finally, the relationships between gender acceptance and gender congruence and depression and suicidal ideation were not moderated by level of connection to the TGD community. Although previous research has found that connection to the TGD community is protective against depression and suicidal ideation (e.g., Testa et al., 2014; Puckett et al., 2019), this is the first study to examine how the external resilience factor of community connection interacts with the internal TGD resilience factors of gender congruence and gender acceptance. This finding suggests that feeling comfortable and satisfied with oneself is an overarching protective factor for suicidal ideation and depressive symptoms, regardless of how much connection to the TGD community one feels.

Clinical Implications

The results from this study provide further evidence for the significant benefits of gender-affirming therapy and medical interventions for TGD individuals. Therapists have historically functioned as gatekeepers to TGD individuals accessing gender-affirming medical interventions, as medical providers and insurance companies continue to require referral letters from therapists before providing these interventions (Coleman et al., 2022). This study highlights the necessity of therapists facilitating TGD client's access to gender-affirming medical interventions, as there is clear evidence that they increase patient experience of gender congruence and acceptance (Garz et al., 2021; Kelly et al., 2022; Kuper et al., 2020; Owen-Smith et al., 2018), and the present findings provide further evidence that that increased gender congruence and acceptance are protective against depression and suicidal ideation. Therefore, clinicians have an ethical obligation to heed this evidence and support TGD clients in cultivating gender acceptance and congruence. This is aligned with the key tenets of TGD-affirming therapy (APA, 2015; Hope et al., 2022) and the practice guidelines of every United States–based major medical association and is in direct opposition with current state attempts to ban such care (Kuehn, 2022). Going further, as clinicians inherit places of power amidst the structural imbalances of marginalized populations, affirming clinicians can participate in advocacy efforts to reduce barriers to gender-affirming care, as advocacy is one of the core competencies within psychology (Gray et al., 2020).

While facilitating access to gender-affirming medical care is one method of increasing congruence and acceptance in TGD clients who seek these services, there are a number of instances where clients are unable to attain services in the given moment (e.g., affordability, life circumstances, developmental stage; Mirabella et al., 2020). There are several steps clinicians can take to help clients increase gender congruence and acceptance beyond facilitating access to gender-affirming medical interventions. One framework, the gender affirmative lifespan approach (GALA), suggests multiple additional avenues for treatment, including helping clients identify gender-congruent language for their current bodies, in addition to helping clients explore ways that help them feel gender euphoria in other parts of their body and identity. This may involve exploring avenues of gender expression (including consideration of voice therapy services; Mills et al., 2017) and, where appropriate, pleasure-oriented and empowered positive sexuality (Rider et al., 2019; Spencer et al., 2021). Last, therapists and clinicians can work to help TGD clients build other resiliencies, such as helping clients self-advocate in social situations, while working on aspects of gender congruence (Rider et al.; Spencer et al.).

Finally, it is important to note that when providing treatment to TGD clients, resilience factors should be considered in tandem with the minority stressors, such as discrimination and victimization, that TGD individuals face. For example, it is essential to help TGD clients build up areas of resilience, while at the same time validating, aiding in the navigation of, and advocating against the minority stressors they may face.

Limitations and Future Directions

The findings from the present research should be interpreted in light of this study's limitations. First, our sample was solely recruited from TGD-specific subreddits on Reddit.com. Participants may have felt more connection to the TGD community through those online communities than TGD individuals who are not active on those subreddits. Future research could use more diverse recruitment methods in order to determine whether that results in a wider range of community connection that differentially impacts the relationship between gender congruence and gender acceptance and negative mental health outcomes. Furthermore, the current study's sample was limited in terms of racial diversity, with the majority of participants identifying as White. Previous research conducted with Black and Latinx sexual minority men and TGD individuals has found that a strong connection to one's racial and ethnic community differentially impacts the relationship between LGB+ community connection and body image (Souilliard et al., 2022). This highlights how intersecting identities may change the relationship between TGD resilience factors and mental health outcomes and underscores the importance of future research in this area recruiting more participants who are people of color. Finally, the current study did not examine how TGD-protective factors may buffer the negative impacts of minority stress on depression and suicidality within this population, a worthwhile area for future research.

Conclusion

The current research examined how the TGD-specific resilience factors of gender congruence, gender acceptance, and TGD-community connection may be protective against depressive symptoms and suicidal ideation among a sample of TGD adults. Gender acceptance was significantly associated with decreased depressive symptoms

and suicidal ideation and gender congruence was significantly associated with decreased depressive symptoms. Connection to the TGD community did not moderate these relationships. These findings highlight the importance of TGD-affirming therapy that fosters gender acceptance and facilitates access to gender affirming medical interventions.

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Gender Minority Resilience and Suicidal Ideation: A Longitudinal and Daily Examination of Transgender and Nonbinary Adults

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SUICIDE REMAINS a leading cause of death in the United States, with rates rising in recent decades (Hedegaard et al., 2018). Despite garnering significant attention in research in the past 50 years, accuracy of predicting suicide remains only slightly better than chance (Franklin et al., 2017). Understanding near-term predictors of suicidal ideation (SI) is critical to understanding suicide risk as it fluctuates over time. Difficulties in predicting suicide deaths and nonlethal suicide attempts are compounded for populations whose unique experiences with SI have only recently garnered adequate empirical attention, such as sexual and gender minority people.

Transgender and nonbinary (TNB) people experience elevated rates of suicidal thoughts and behaviors, and are more likely to die by suicide, compared to their cisgender heterosexual and sexual minority (e.g., lesbian, gay, bisexual) counterparts (Guz et al., 2021; Surace et al., 2021). This is perhaps unsurprising given the degree and pervasiveness of discrimination, microaggressions, violence, and victimization that TNB people face across the lifespan (Grant et al., 2010; Truszczynski et al., 2022), which have been linked with increased risk for suicidal behavior (Clements-Nolle et al., 2006; Maguen & Shipherd, 2010). While cisgender sexual minority and gender minority individuals are commonly grouped together in empirical study, assuming homogeneous experiences across psychosocial outcomes, emerging research has evidenced that these subgroups experience unique patterns of risk and protective factors in relation to suicidal thoughts and behaviors (Horwitz et al., 2020). Thus, extant research that explores risk and resilience factors for SI among LGBTQ+ people often lacks the nuance and specificity needed to identify unique mechanisms that may confer risk for, or protect against, suicide in TNB individuals specifically.

Further, most existing research examining TNB peoples' experience with suicidality uses a risk-based, deficit-focused approach. For instance, past work has highlighted higher rates of external (distal) minority stressors such as violence, victimization, and discrimination among TNB people compared to cisgender people, and demonstrates how these stressors are associated with the presence and exacerbation of SI and suicide attempts (Flores et al., 2021; Fuller & Riggs, 2018; Goldblum et al., 2012). Internal (proximal) minority stressors, including internalized transphobia and negative expectations of others, have also been linked to elevated SI among TNB adults, which predict suicidal behavior in this population (Scandurra et al., 2020; Staples et al., 2018).

While these stressors have been implicated as risk factors for poor psychosocial well-being in gender minority people, gender minority resilience factors (e.g., identity pride, community connectedness) are understudied, particularly in relation to mental health concerns such as suicidality. Identity pride reflects positive views of one's gender identity, such as feeling special or unique, and comfort in sharing one's identity with others; community connectedness reflects interactions with and affiliation towards others who share one's gender identity (Testa et al., 2015). These constructs have been hypothesized to serve as buffers against the deleterious impacts of gender minority stressors among TNB people (Testa et al.). Work by Chang and colleagues (2021) indicates that identity pride may be an important facet of sexual and gender minority psychological well-being among LGBT people, as increased identity pride is associated with lower rates of depressive symptoms and may be an important mechanism linking discrimination and reduced social support to mental health outcomes. As deepening our understanding of suicide protective factors is paramount in informing intervention, there is a need for work aimed at increasing our understanding of resilience as it applies to TNB people who may be at high risk of suicidal thoughts or behaviors.

In addition to the limitations associated with deficit-based approaches, prior research has been dominated by studies using cross-sectional data to understand TNB suicide risk, despite the promising nature of intensive longitudinal methods such as ecological momentary assessment (EMA; Gee et al., 2020) to elucidate within-person patterns of risk as they change over time. For example, studies of historical (lifetime) minority stressors among TNB people provide limited data to understand whether these experiences precede, co-occur, or follow experiences of SI, even though identifying prospective predictors of SI is critical to modeling and predicting high-risk transition periods that require intervention. To our knowledge, no research to date has examined how momentary changes in gender minority resilience factors may predict changes in outcomes like suicidal thoughts and behaviors among TNB people. Further, multilevel analysis of potential correlates of SI allows researchers to determine the extent to which these experiences fluctuate over time (within-person change), relative to their tendency towards stability over time for a particular individual, in which case they may be more indicative of a factor that varies primarily across individuals (between-person differences).

The Present Investigation

Prior research has established the importance of investigations targeting TNB-specific risk and resilience factors as they relate to mental health outcomes. Yet, most prior research is limited to cross-sectional, between-person examinations of risk factors, resulting in a relative paucity of work examining gender minority resilience factors as potential mechanisms protective against SI. The present investigation examines (a) the extent to which gender minority resilience factors, such as identity pride and community connectedness, vary over time among TNB people, and (b) how within-person and between-person indicators of gender minority resilience predict daily SI during a 3-week EMA protocol. Specifically, we tested the following aims:

Aim 1: Characterize Fluctuations in Gender Minority Resilience

First, we considered the extent to which repeated measures of gender minority resilience factors (identity pride, community connectedness) measured daily over 3

weeks would vary at within-person and between-person levels. Using intraclass correlation coefficients (ICC), we calculated the proportion of variability in these daily resilience factors attributable to within-person, versus between-person, differences. We predicted that there would be greater between-person variance in gender minority resilience, relative to within-person gender minority resilience variability (Hypothesis 1).

Aim 2: Explore the Daily Within-Person Relationships Between Gender Minority Resilience and Suicidal Ideation

Second, we examined the associations between daily reports of gender minority resilience and aggregated daily reports of SI using dynamic structural equation modeling. Specifically, we examined how changes in resilience predicted changes in SI across days, controlling for between-person differences in overall SI and overall gender minority resilience. We predicted that within-person increases in resilience would predict within-person decreases in SI across days (Hypothesis 2).

Methods

Participants

Participants ($N = 49$) consisted of transgender and nonbinary (TNB) adults enrolled in a larger study focused on gender minority stress, resilience, and suicide risk. TNB participants were recruited online based on reported SI or suicidal behavior in the past month to take part in a virtual study involving interviews, questionnaires, and a 3-week EMA protocol. Participants self-identified as transgender or gender diverse (e.g., nonbinary, genderfluid, genderqueer), were age 18 or older, and lived in the United States. Participants were recruited via social media advertisements (i.e., Twitter, Facebook). Participants included in the present sample completed a baseline interview using web-based videoconferencing, baseline self-report questionnaires using an online data collection tool (Qualtrics), and began an EMA protocol scheduled over 3 weeks using their personal smartphone. All participants had a history of lifetime SI and 32 (65.3%) participants had at least one lifetime suicide attempt.

Procedure

Participants were recruited via online advertisements on Twitter, Facebook, or Reddit. Interested individuals who clicked on study advertisements were directed to a prescreening survey to determine eligibility for the study. This web link described study procedures in more detail and assessed inclusion criteria (below); if determined to be eligible, contact information was solicited and sent directly to the research team for scheduling purposes. Inclusion criteria were as follows: currently residing in the United States; currently owns a phone with internet access and the ability to receive text messages; ability to speak, read, and understand English; ability to access a webcam (for verification of identity at the start of the baseline session); reported SI or suicidal behavior within the past month; and age 18 years or older.

If initially eligible, interested participants were scheduled for an interview with the research team via Zoom. During the virtual assessment, the research team obtained consent from participants, completed a semistructured interview to assess lifetime and recent history of suicidal thoughts and behaviors, and guided participants through a battery of self-report questionnaires. Research staff then trained participants on completing the EMA assessments using detailed instructions and a practice set of EMA items. EMA surveys were scheduled for distribution to participants six times per day for 21 days, between participants' self-reported wake and bedtimes, with the ability to "black out" specific windows of time each day during which participants were unavailable to complete surveys. Survey notifications were scheduled by binning participants' available times each day into six windows, with one survey sent during each window. Survey notifications were sent using SMS text messages, and each survey link remained available for 30 minutes following the notification. If the participant did not click on the survey link within 10 minutes, a reminder text message was sent. Survey notifications were scheduled using proprietary software developed by the lead investigator's lab, which interfaces with Amazon Web Services to send SMS notifications containing a link to a survey on Qualtrics.

Participant safety was of paramount concern throughout the study. Graduate research assistants were trained in suicide risk assessment and safety planning procedures, which have been utilized successfully for similar studies. For the EMA portion of the study, participants were repeatedly informed both during the baseline session and at every EMA survey that responses were not monitored in real-time and were directed to contact crisis hotlines and other resources if they needed urgent support or intervention. Links to crisis hotlines, including Trans Lifeline, were provided on every page of the EMA survey. Reports of suicidal behavior generated "flags" that were sent to the research team for follow-up and safety monitoring. Details of the safety monitoring and risk management protocols are available on the Open Science Framework page for the larger study (https://osf.io/8vynm).

Participants were paid $50 via an Amazon gift card for participation in the baseline session of the study, and an additional $50 gift card for the 3-week EMA portion of the study. Participants who completed at least 80% of the distributed surveys (100 or more of 126 possible) received an additional "bonus" $25 Amazon gift card. A letter of determination was obtained which facilitated payments while ensuring participant anonymity. All study procedures were approved by the Texas Tech University Institutional Review Board (IRB#2020-686).

Study procedures, aims, measures, and recruitment strategies were designed with the input and consultation of an advisory board comprised of adult TNB volunteers. TNB adults were recruited to join the advisory board through social media advertisements and did not need to report a history of suicidal thoughts or behaviors to participate. The advisory board met virtually to discuss the overall aims of the study and to solicit feedback regarding study goals and hypotheses. Advisory board members were also sent study measures via email and solicited for feedback regarding the specific methods of assessment used as a part of the study.

Study procedures, aims, and hypotheses were preregistered on the Open Science Framework (https://osf.io/bvz65/). Aim 1 described in this paper was not preregistered and should thus be treated as exploratory. Aim 2 was preregistered as Hypothesis 4; the remaining hypotheses involve examination of minority stressors and are thus beyond the scope of this paper. Data analyses reflect the preregistered methods with one minor exception. Specifically, the preregistration notes that EMA items (binary and Likert-type) will be treated as categorical. However, because resilience was assessed using three items (see below), creation of a composite indicator of resilience required averaging the Likert-type scores across items for each day. These mean values cannot appropriately be modeled as categorical, and

resilience was thus modeled as an interval variable.

Measures

Demographic Characteristics

At the baseline session, participants self-reported their age, gender identity, race, ethnicity, and sexual orientation. To report gender identity, participants were given the option to identify as transgender man (36.7%), transgender woman (4.1%), nonbinary/gender nonconforming/gender-fluid/genderqueer (55.1%), or other (2%). Participants ranged in age from 18 to 56 ($M = 28.1$; $SD = 7.60$) and were primarily non-Hispanic/Latinx White (67.3%). See Table 1 for descriptive characteristics of the sample.

Diagnostic Interviews

Lifetime, past year, and past month suicidal thoughts and behaviors were assessed using an adapted version of the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), which was administered by trained graduate students. These data were used in the present study to determine eligibility for the EMA protocol (e.g., past month SI or suicide attempt at the time of the baseline assessment).

EMA Assessments

At the first survey opened each day, participants were asked three items from the Gender Minority Stress and Resilience (GMSR; Testa et al., 2015) measure to assess gender minority resilience at the daily level. Participants rated the following items on a scale from 1 (*not at all*) to 5 (*very much*): "My gender identity or expression makes me feel special and unique" (identity pride), "I felt connected to other people who share my gender identity" (community connectedness), and "When interacting with members of the community that share my gender identity, I feel like I belong" (community connectedness). These three items were averaged to create an indicator of daily gender minority resilience.

At each survey (up to six times per day), participants were asked to rate two items with respect to how they felt "at this moment" on a scale from 1 (*not at all*) to 5 (*very much*) as indicators of SI: "I feel that life is not worth living" and "I want to die." Ratings for these two items were averaged across responses per day to create an aggregate daily SI indicator. Although use of a small number of items to assess a construct as complex as SI can pose psychometric concerns, research suggests that single item EMA measures can have predictive utility, and the added benefit of additional items is modest at best (Song et al., 2022).

Potential Covariates

Age, race/ethnicity, and symptoms of borderline personality disorder were considered as potential covariates for grand-mean-centered resilience and SI at the between-person level. Race/ethnicity was operationalized as non-Hispanic/Latinx White (0) or another racial/ethnic identity (1) given small cell sizes for other racial/ethnic groups. Symptoms of borderline personality disorder were computed as the sum of items marked "yes" from the McLean Screening Inventory for Borderline Personality Disorder (Zanarini et al., 2003).

Data Analytic Procedures

All analyses were conducted using Mplus statistical software, version 8.6 (Muthén & Muthén, 2017) using Bayesian multilevel timeseries (dynamic) structural equation modeling (DSEM), which has several advantages for analysis of EMA data (Hamaker et al., 2018). In these models, results at the within-person level are centered for each individual such that parameter estimates reflect daily deviations from a person's own mean. For prospective analyses at the within-person level, variables were lagged across days, and autore-

Table 1. Demographic Characteristics Across Study Participants ($N = 49$)

Sample Characteristics	N	%
Gender		
Transgender man	18	36.7%
Transgender woman	2	4.1%
Non-Binary, GNC/GF/GQ	27	55.1%
Other	1	2%
Race/Ethnicity		
Non-Hispanic white	33	67.3%
Hispanic/Latinx white	6	12.2%
Black/African American	3	6.1%
Asian/Asian-American	1	2%
Biracial/multiracial/other	5	10.2%
Sexual orientation		
Asexual	3	6.1%
Bisexual	18	32.7%
Gay/ Lesbian	6	12.2%
Heterosexual	3	6.1%
Pansexual	5	10.2%
Queer	12	24.5%
Questioning	1	2.0%
Other	2	4.1%

Note. GNC = Gender nonconforming: GF = Gender-fluid; GQ = Genderqueer.

gressive effects were included to account for within-person stability over time. Thus, results reflect the extent to which within-person change in one construct (resilience) predicts within-person change in another construct (SI) from one day to the next. Results at the between-person level are centered on the group (sample) mean, such that parameter estimates reflect the extent to which an individual participant's scores deviate from the overall sample average. Results are presented using standardized coefficients followed by 95% credibility intervals, which are used to evaluate statistical significance for Bayesian models.

In the tested model, the ICC of gender resilience was calculated by dividing its between-person variance by the sum of its within- and between-person variance estimates (Aim 1). At the within-person level, resilience measured at day d was regressed on resilience at day d-1 (prior day), and SI measured at day d was regressed on SI at day d-1 (prior day). Day d SI was then regressed on day d resilience (Aim 2). At the between-person level, overall resilience was allowed to covary with overall SI.

Age, race/ethnicity, and symptoms of borderline personality disorder were tested as between-person covariates of resilience and SI in separate models. Age and symptoms of borderline personality disorder showed no significant relationships with resilience or SI and thus are not considered further in this paper. There was, however, a significant association between race/ethnicity and constructs of interest, such that non-Hispanic/Latinx White participants reported higher resilience, and lower SI, than participants from minoritized racial/ethnic groups. Thus, results are presented for the model which included race/ethnicity as a covariate.

Results

Aim 1: Characterize Fluctuations of Gender Minority Resilience

The ICC for the EMA resilience indicator was 0.75 (95% CI [0.67, 0.82]). These results indicated that approximately 75% of the variance in gender minority resilience was accounted for by between-person differences, with only 25% of the variability in gender minority resilience attributable to within-person fluctuations over time.

Aim 2: Explore the Daily Within-Person Relationships Between Gender Minority Resilience and Suicidal Ideation

Both resilience and SI showed significant auto-regressive effects over time. There was also a significant association between day d resilience and day d SI, controlling for these auto-regressive effects, such that within-person change in resilience from day d-1 to day d predicted within-person change in SI from day d-1 to day d (B = -0.07, 95% CI [-0.14, -0.01]). Specifically, higher reported resilience (relative to an individual's own mean) at the first survey of the day predicted lower average SI ratings (relative to an individual's own mean) across all surveys later that same day.

At the between-person level, we found that overall EMA-reported resilience was significantly associated with overall SI (B = -0.44, 95% CI [-0.65, -0.17]), meaning that individuals who, on average, reported higher resilience during EMA also, on average, reported lower SI. Race/ethnicity was also significantly associated with both aggregate resilience and aggregate SI, such that non-Hispanic/Latinx white individuals reported higher resilience, and lower SI, than members of minoritized racial/ethnic groups. Results for this model are displayed in Figure 1.

Discussion

Previous research has demonstrated that TNB individuals are at elevated risk of suicidal thoughts and behaviors (Herman et al., 2019). Given the unique experiences of TNB people, preventing suicide in this population requires an understanding of both specific risk and protective factors related to gender minority identities, particularly using longitudinal or prospective methodologies (dickey & Budge, 2020; Vigny-Pau et al., 2021). This is the first study to attempt to model momentary change in gender minority resilience as it relates to SI in a naturalistic context. The present findings offer some preliminary insights that may be valuable in informing our understanding of gender minority resilience and how changes in resilience may protect against SI. First, our findings indicate that gender minority resilience is best conceptualized as a relatively stable factor that varies more between people than within a person over time, at least when assessed over a 3-week interval. However, despite the relative stability of resilience in this study, we still found that, controlling for between-person differences, within-person changes in resilience from a person's own mean (typical) level were predictive of changes in endorsement of SI from one day to the next. Thus, understanding both individual differences and within-person changes in gender minority

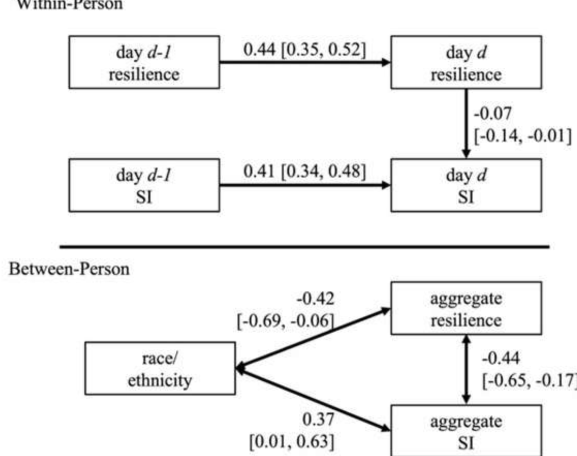

Figure 1. Visual depiction of results

Note. Results reflect standardized parameter estimates, followed by their 95% credibility interval in brackets. Credibility intervals that do not contain zero reflect statistically significant results. Single headed arrows reflect regression paths; double headed arrows reflect covariances. SI = suicidal ideation, race/ethnicity was coded such that 0 = non-Hispanic/Latinx white and 1 = members of minoritized racial/ethnic groups.

resilience factors may be critical to identify opportunities for prevention efforts aimed at reducing SI, consistent with prior cross-sectional research implicating gender minority resilience factors as protective against SI in TNB people (Rabasco & Andover, 2021).

When considering covariates, we found that neither age nor symptoms of borderline personality disorder were associated with between-persons differences in resilience or SI. This is somewhat notable given prior research showing that older age is positively associated with resilience (Breslow et al., 2015; Puckett et al., 2019) and negatively associated with SI (Yockey et al., 2020), whereas borderline personality disorder symptoms have been negatively associated with resilience (Jia et al., 2022) and strongly positively associated with SI (Paris, 2002). However, these constructs did differ across racial/ethnic groups, with non-Hispanic/Latinx White individuals reporting greater resilience and lower SI, on average, than participants from minoritized racial/ethnic backgrounds. This expands upon prior conflicting and limited literature on the relationship between race/ethnicity and SI (Wolford-Clevenger et al., 2018) and resilience (Puckett et al.) among transgender adults. Prior work has pointed to the importance of environmental stressors, such as the effects of racial discrimination, as risk factors for poor mental health and SI among people of color (Madubata et al., 2022; Polanco-Roman et al., 2021); these sociocultural factors are also likely to contribute to worse mental health outcomes among transgender people of color (Atteberry-Ash et al., 2021). TNB people from minoritized racial/ethnic backgrounds may experience marginalization both from communities of color and from the broader LGBT community (Balsam et al., 2011), which would impact reported resilience given the role of community connectedness in the conceptualization of resilience utilized here.

Implications

These findings point to several potential clinical implications. First, there is a clear need to focus on interventions designed to improve minority-specific protective and resilience factors for suicide risk in TNB people (Matsuno & Israel, 2018). When addressing suicidal thoughts and behaviors in a clinical setting, treatment providers may find it valuable to focus on promoting pride in transgender and nonbinary identities, in addition to encouraging strong community bonds. These considerations should be incorporated when developing novel TNB-affirming therapies and provide further support for existing TNB-affirming therapies (e.g., Austin & Craig, 2019; Austin et al., 2018) designed for people struggling with suicidal thoughts or behaviors. There may also be benefits to encouraging TNB clients to monitor their perceptions of these resilience factors on a daily level, as this can inform their understanding of how changes in resilience may relate to their experience of SI. While the current findings help improve our understanding of TNB individuals' experiences with suicidal thoughts, further research and prevention efforts must also consider the intersectional marginalization of TNB members of minoritized racial/ethnic groups, especially considering the distinct risk and resilience factors that may be relevant for these people (Kattari et al., 2017; Singh & McKleroy, 2011; Stone et al., 2020). Results may also inform policy decisions as they relate to legal protections for programs fostering TNB community connectedness and identity pride. For example, prior research indicates that nondiscrimination laws are associated with decreased TNB community stigma (Gleason et al., 2016), which suggests these laws may have downstream effects on individual indicators of gender minority resilience and, subsequently, risk for SI. To that end, future research and interventions should focus on targeting systematic and structural solutions for suicide among TNB people in order to avoid the common, but problematic, tendency of suicide prevention efforts to put the onus for change on individual members of marginalized groups, such as TNB people.

Strengths and Limitations

Interpretation of the present investigation should consider a few limitations. First, although consistent with other EMA studies, the generalizability of our findings may be limited due to the size of our current sample (N = 49). Thus, the potential for Type I error may be inflated; however, we argue that the potential clinical importance of these findings justifies their consideration. Further, the small sample size limited our ability to detect the potential moderating effects of race/ethnicity, socioeconomic status, and sexual orientation on the within-person association between resilience and SI, the strength of which may differ across subgroups within the TNB population. Extension of our findings in larger samples with diverse representation across racial/ethnic identities will be critical given evidence of associations between race/ethnicity and our constructs of interest, as well as prior literature showing conflicting results regarding differences in reported SI across TNB communities of color (Wolford-Clevenger et al., 2018). Second, the present study was limited to a sample of TNB people with a recent history of suicidal thoughts or behaviors, and results may not generalize to TNB people who are not regularly experiencing SI and may not translate to the ability to predict new or first onset of SI among previously nonsuicidal people. Future research should examine whether there are differences in gender minority–specific resilience between TNB people that do and do not experience SI to add to our understanding of the construct of gender minority resilience; for example, it is possible that within-person variability of resilience may be higher (or lower) for TNB people who are not experiencing acute suicidality. Third, we are unable to directly establish a causal relationship between resilience and SI; it is possible that, on the daily level, elevated SI leads to decreased perceptions of gender minority resilience, rather than vice versa. However, the fact that resilience was measured at the first survey per day, while SI was measured throughout the day, suggests that our indicators of resilience temporally precede most reports of SI being aggregated, lending credence to the possibility of a causal effect.

Finally, as with any empirical study, the characteristics of our sample should be considered with respect to generalizing results to diverse TNB populations. The present sample was primarily nonbinary (55.1%); therefore, our current findings might center the experiences of nonbinary people more specifically than individuals who identify as transgender men or women. Future research is needed to determine whether there might be heterogeneity of SI and resilience even within the TNB umbrella, especially in light of previous findings that highlight differences in the experiences of binary and nonbinary TNB people (Reisner & Hughto, 2019). Further, recruitment using online modalities, and EMA data collection requiring ownership of a personal smartphone, likely skewed our sample towards a younger, more technologically savvy population of higher socioeconomic status, with implications for understanding resilience among the broader community of TNB adults.

Despite these limitations, the present study has several strengths. First, TNB-specific and validated measures were used to

assess gender minority resilience during EMA. Second, we used naturalistic and longitudinal methods, allowing for the assessment of changes in SI related to resilience over time and at both between- and within-person levels. Third, by recruiting a sample of TNB adults with recent suicidal thoughts, the study provides valuable data on a clinically high-risk group. Fourth, collaboration with an advisory board of TNB adults during the formative stages of the larger research study likely improved the clinical and community relevance of these findings and the appropriateness of study methods and procedures for ethical engagement with members of a historically marginalized group. Finally, to our knowledge, this is the first EMA study of suicidal thoughts in TNB people to assess resilience factors, rather than focusing solely on a risk-based approach. These findings highlight the potentially beneficial effects of developing clinical and policy efforts to foster identity pride and community connectedness among TNB people as strategies to improve suicide prevention in this high-risk population.

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Development and Implementation of a Gender-Affirming Dialectical Behavior Therapy Skills Training Group for Transgender and Gender-Diverse Veterans

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TRANSGENDER and gender-diverse (TGD) people experience identity-based marginalization and invalidation within broad socio-cultural-political contexts and are disproportionately impacted by mental and physical health conditions (James et al., 2016; Valentine & Shipherd, 2018). Findings from the 2015 United States Transgender Survey (USTS; James et al., 2016) suggest inequities occur across all life domains, including disproportionate rates of poverty, homelessness, negative interactions with law enforcement, and interpersonal violence, as well as limited resources and discrimination within education, employment, and health care settings occurring against a backdrop of inadequate legal protections. Further, findings indicate that these disparities particularly burden TGD people who are multiply marginalized—particularly TGD people of color—including those who are undocumented and those who have ability concerns (James et al., 2016).

Notably, USTS respondents were more likely to identify as veterans than the general U.S. population (James et al., 2016), and veteran status is another factor that may contribute to increased vulnerability to physical and mental health disparities. Indeed, TGD veterans evidence increased rates of substance use disorders, depression, PTSD, and suicidality (Brown & Jones, 2016; Frost et al., 2021), with TGD veterans seeking care within Veterans Health Administration (VHA) showing significantly greater suicide mortality when compared to cisgender VHA patients (Boyer et al., 2021). Additionally, parallel to findings from the USTS, veterans of color, particularly Black veterans, evidence deeper disparities when compared to White veterans (Brown & Jones, 2014). Further, Blosnich and colleagues (2016) demonstrated that transgender veterans who live in geographic regions without legal protections are at increased risk for mental health problems, including mood disorders and self-directed violence. Taken collectively, available literature has illustrated multilevel systemic inequities for TGD people, including veterans, negatively impacting mental health at the individual level, reflecting general difficulties with emotional and behavioral regulation.

Two existing theories may help explain these manifestations of mental health disparities among TGD veterans. Gender Minority Stress (GMS) theory (Hendricks & Testa, 2012) posits that *distal stress factors* (e.g., identity-based discrimination and victimization; nonaffirmation of identity) directly lead to negative mental health outcomes while indirectly impacting mental health via *proximal stress factors* (e.g., concealment, negative expectations, internalized transphobia). GMS theory also highlights the importance of "community connectedness" and "pride," identifying these as *resilience factors* that may help protect against the harmful impact of distal and proximal stress factors (Hendricks & Testa, 2012). Likewise, the Biosocial Model of emotion dysregulation (Linehan, 1993) posits that difficulties with emotional and behavioral regulation are reasonable outcomes of a transactional process between biological vulnerability and an invalidating environment, suggesting that even with little biological vulnerability, chronic and pervasive invalidation can contribute to these outcomes (Koerner, 2011). While each of these theories has received much attention in the literature and has scholarly merit, each alone remains insufficient to fully explain TGD veteran health disparities. The Biosocial Model relies on biological temperament as a core component and inadequately conceptualizes marginalized experiences, although has strong evidence-based implications for treatment; on the other hand, GMS theory specifically addresses TGD veteran experiences, but does not describe transactional processes, nor does it directly make treatment recommendations.

In an effort to address each theory's limitations, an integration of GMS and Biosocial Model theories has been proposed (Sloan et al., 2017) to more comprehensively explain notable emotional and behavioral regulation difficulties that may be present for TGD people. Specifically, Sloan and colleagues suggested that emotional and behavioral regulation difficulties are completely reasonable, perhaps even expected, outcomes for TGD people due to the chronic and pervasive invalidation of their identities and experiences across levels of the socio-cultural-political environment. As such, TGD people are inherently "vulnerable" even without biological vulnerability, directly due to existing within nonaffirming environments. Likewise, understandable responses to environmental invalidation (e.g., suicidality; trauma-related symptoms) are often further invalidated and overpathologized by the environment, highlighting the transactional nature of this relationship. Therefore, treatment approaches must aim to both reduce individual-level disparities and systemic inequities while simultaneously recognizing that as these systems are well-established and deeply rooted, they are likely to change slowly. With this in mind, it is imperative to equip marginalized individuals, particularly TGD people, with affirming support and skills for coping with invalidation and other harmful experiences.

Dialectical Behavior Therapy (DBT; Linehan, 1993) is one treatment option that may be useful for working with TGD clients (Sloan et al., 2017), as it directly addresses emotional and behavioral dysregulation, focuses on skill-building, and balances acceptance/validation with change. The DBT skills training mode of treatment comprises four modules (Linehan, 2014a, 2014b)—mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills—for which specific applications to TGD-related stress and experiences have been proposed (Sloan et al., 2017). At the same time, existing skills applications are not exhaustive as only a subset of skills are discussed through the lens of minority stress, and the development of additional extensions is needed. As skills training alone is likely necessary but not sufficient to address disparities in mental health, developing affirming environments for skills training and intervening within broader contexts is imperative (Shipherd & Sloan, 2019). This prompted authors to develop a DBT skills training group for TGD veterans within a Veterans Affairs Medical Center.

Development of a TGD-Affirming DBT Skills Training Group

Here, we describe the process of developing a TGD-affirming DBT skills training group, guided by cultural humility, and focused on both therapist development and the challenges centering the experiences of TGD veterans within a healthcare system. We clarify here our rationale for embracing cultural humility throughout our approach. Tervalon and Murray-García (1998) define cultural humility as "a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician patient dynamic, and to developing mutually beneficial and nonpaternalistic partnerships with communities on behalf of individuals and defined populations." This definition effectively captures our scenario in which group leaders with identities associated with greater power and privilege (e.g., cisgender) were tasked with adapting content to meet the needs of group members whose identities are more marginalized (e.g., TGD) in society. We also clarify that while we collected program evaluation data, we do not present findings here; rather, this paper focuses solely on the development and implementation of this group. First, a TGD-affirming DBT skills training group for TGD veterans must include explicit reflection, education, and action by group therapists. We took a culturally humble approach (Hook et al., 2013; Tervalon & Murray-García,1998), embracing an interpersonal stance focusing on the needs of group members specifically and working to enhance awareness of our own beliefs/attitudes/biases and develop knowledge and skills (Sue et al., 1992; Sue, 2001). As such, group leaders committed to: (1) meeting weekly with one another for consultation and ongoing discussion, (2) reading relevant literature regarding affirming psychotherapeutic practices for TGD people, (3) advocating for TGD-specific group services, and (4) providing therapy interventions that are grounded in evidence-based practice and culturally responsive care.

Program Development Team

The first author is a staff psychologist and identifies as a White, lesbian, cisgender woman; the second author is also a staff psychologist and identifies as a White, bisexual, cisgender woman. Both first and second authors were responsible for the initial development and implementation of the group. After about 6 months, the third author, a White, bisexual, cisgender woman, who at the time was a postdoctoral clinical fellow and currently a staff psychologist, took over the second author's group facilitator role, who then transitioned to a primarily data collection and administrative role within the project. Whereas this team holds identity-based and institutional power, all three have demonstrated a commitment to allyship and advocacy for TGD equity through their work as psychologists and psychology trainees within their personal (e.g., involvement in local community organizations) and professional lives. Further, our team used institutional power to advocate for equitable services and healthcare for TGD veterans.

Our team also aimed to foster a TGD-affirming stance, rooted in cultural humility (Tervalon & Murray-García, 1998) and adopted an open and receptive style to learning both within and outside of group sessions. We worked to increase self-awareness, with particular attention to any implicit biases; for example, group therapists worked to educate themselves on TGD health and experiences without relying on group members for this education, while also balancing this independent learning with learning through active listening of group members' discussions during group sessions; additionally, group leaders invited ongoing feedback from group members regarding teaching and discussion points within group sessions. We argue that cultural humility aligns well with DBT therapist commitments (Linehan, 1993), which instruct therapists to be aware and accepting of personal fallibility and commit to addressing mistakes to best support clients. In addition to enhancing our knowledge base and eliminating biases, we effectively used cisgender and institutional privilege to promote TGD health care.

To support the delivery of a TGD-affirming DBT skills training group grounded in cultural humility, group therapists met together weekly, and at least one group leader at a given time participated in a DBT consultation team, a core component of standard DBT[1] (Linehan, 1993), and sought feedback throughout the development and implementation of this group. Group leaders used their weekly individual meetings to review the DBT teaching notes (Linehan, 2014b) and to make TGD-specific and -affirming adaptations, as well as discuss personal growth areas (e.g., using institutional power for advocacy; development of diverse teaching examples) and blind spots (e.g., lack of TGD lived experiences). In addition, group leaders were active members of a multicultural consultation team developed by a small team including first author in collaboration with other non-VA mental health professionals (see Nagy et al., 2019), which also was used as a forum for soliciting ongoing consultation.

Our team sought formal feedback and consultation from other professionals with subject matter expertise in DBT and TGD health, as well as professionals with lived experience. Consulting professionals provided feedback on group development, design, measurement, and implementation within a hospital system that did not yet provide TGD veteran-specific group therapy spaces. Likewise, relevant and affirming objective measures (e.g., questionnaires) were also recommended for use within the group setting to evaluate effectiveness of the skills training intervention as it relates to improvements in emotion regulation, as well as enhanced connection to identity-based pride and resilience. Feedback from the subject matter experts and professionals with lived experience was critical in checking our blind spots and biases, as well as ensuring that we were centering the needs of TGD veterans in the development of this group.

Effective Intervention and Advocacy Within the Healthcare Setting

Notably, VHA is committed to the provision of gender-affirming services and substantiates this with dedicated national policies and programs (VHA Directive 1341; Kauth et al, 2015; Shipherd et al., 2016). Indeed, Kauth and colleagues noted much improvement within the VHA as it relates to provision of care to sexual and gender minority (SGM) veteran health,

[1]Standard DBT (Linehan, 1993) is a treatment that includes weekly individual psychotherapy, weekly skills training group therapy, between-session telephone consultation, and a weekly team consultation for therapists. Whereas standard DBT was available within the VAMC, the DBT skills training group for TGD veterans was offered as either part of standard DBT or as a stand-alone intervention depending on individual veteran presenting problems and needs.

while also noting areas for ongoing growth, particularly related to gender-affirming care. Relatedly, within the VAMC in which these authors worked, there had been no TGD veteran-specific evidence-informed therapy group interventions prior to the development of this DBT skills training group. Additionally, VHA mental health resources routinely have been developed as a way to maximize access to care for veterans, broadly. As such, creating a therapy group for a specific subgroup within the veteran population posed a challenge—creating a separate DBT skills training group for TGD veterans exclusively versus integrating TGD veterans into existing DBT skills training groups, comprised of almost exclusively cisgender participants. On the one hand, changing the structure of an existing DBT skills group to meet the needs of TGD veterans is consistent with an overall mission to make all spaces affirming to TGD (and other minoritized) veterans. On the other hand, and as previously mentioned, cultural shifts (e.g., creating an affirming environment), even with policy changes, are generally slow, which may have posed some negative healthcare experiences for TGD veterans, who likely are already managing minority stressors in their daily lives and may experience a mental health “resource” as yet another environment that is unsafe and non-affirming, even if only temporary. We expected that a TGD-specific group may inherently bolster community connectedness and a sense of pride, constructs suggested to promote resilience and protect against the effects of gender-based discrimination and invalidation on mental health outcomes (Hendricks & Testa, 2012). Therefore, group therapists demonstrated allyship and used their cisgender privilege, institutional power, informed by existing relevant literature (e.g., Valentine et al., 2021), to advocate for the creation of a TGD-specific DBT skills training group based on the rationale outlined above.

Inclusion Criteria

Inclusion criteria were: (a) veteran identifying as transgender or gender diverse; (b) veteran requesting mental health treatment; (c) veteran evidencing difficulty in at least one area targeted by DBT skills training (e.g., interpersonal effectiveness); (d) veteran has at least once-monthly contact with an individual mental health clinician (e.g., psychologist or psychiatrist) for coordination of care); and (e) veteran willing to participate in a virtual group (i.e., use of video telehealth platform). Due to challenges with access, group leaders later agreed to be flexible with the individual mental health treatment requirement in an effort to decrease barriers to care and agreed to evaluate appropriateness for group participation on a case-by-case basis.

Referral Process

Group therapists relied on several LGBTQ+ and transgender-specific avenues for group recruitment, as well as collaboration with mental health program managers. Per VHA Directive 1341 (2018), all VAMCs are required to have an appointed LGBTQ+ Veteran Care Coordinator (VCC), a role shared between the first author and two additional affiliates at the time of recruitment. The LGBTQ+ VCCs have contact with veterans seeking affirming care and therefore were helpful referral sources for TGD veterans. Next, the VAMC’s Interdisciplinary Transgender Treatment Team (ITTT), a local, decentralized service designed to offer comprehensive care to TGD veterans including primary care, psychology, psychiatry, social work, nursing, and endocrinology, collaborated with group therapists for eligible referrals.

Access and Materials

The COVID-19 pandemic exacerbated the already marked structural and systemic inequities and barriers to care for TGD individuals, including housing instability, financial losses, and delayed access to gender-affirming treatments and procedures (van der Miesen, 2020; Wang et al., 2020). According to Burgess and colleagues (2021), while telemedicine is insufficient to solve the systemic health care inequities placed on TGD individuals, it can serve to increase accessibility and access to care otherwise unavailable. Additionally, VA provides smart tablets (e.g., iPads) with high-speed internet access to any veteran in need to access appointments, an intervention that should serve as a model to other healthcare systems. After consenting to participate in the group, members were provided with DBT skills training group materials via their preferred mode: either electronic copies sent via email or electronic messaging through a VA web portal, or hard-copies sent by United States Postal Service.

Structure and Content

We collaboratively agreed to adopt a semiclosed structure, allowing new group members to join between skills training modules to facilitate access more quickly to TGD veterans who would likely benefit from DBT skills training. Likewise, this structure also allowed veterans to be referred to the group for skills training in one particular module/area, which supported a more veteran-centered approach to care. As such, participation included skills training in mindfulness and one other module, across a 4-month period (approximately 16 sessions), and group sessions were 90 minutes each. Between these periods, group leaders and members paused group temporarily (typically 1 to 2 weeks) in order to manage administration and planning and to offer any necessary outreach to incoming group members. Additionally, this structure loosely aligned with structure of psychology training programs, which allowed for rotation of group leaders; this provided more opportunities for training, which, as argued by Shipherd and Sloan (2019), is necessary to more systemically address inequities in TGD health. We ensured that a leader with more skill and experience was always present as one of the co-leaders. Each period began with an orientation session, in which group leaders and members collaboratively reviewed group guidelines, identified goals for skills training group, and discussed psychoeducation. These orientation sessions utilized materials from and were informed by existing literature (Cohen et al., 2021; Linehan, 2014a, 2014b; Sloan et al., 2017). Group members were asked to complete a packet of questionnaires, as a means of assessing benefit (see below).

Each skills training group session utilized materials from the DBT Skills Training Handouts and Worksheets volume (Linehan, 2014a), and the structure and process of each group session was largely guided by the DBT Skills Training Manual (Linehan, 2014b). Discussion and teaching points were also informed by skills applications proposed by Sloan and colleagues (2017). At the same time, group leaders recognized limitations of existing applications as not exhaustive and affirmed the importance and apparent utility of group members’ lived experiences to assist in tailoring teaching and discussion points. As such, the process within group and content delivery was a collaboration, integrating expertise of group leaders with inherent wisdom of group members and their lived experiences. For example, when teaching content from Mindfulness module, specifically “doing” and “being” mind (Linehan, 2014a), group leaders discussed tension between active work toward gender affir-

mation goals and its importance and how this, at the same time, can be exhausting; TGD group members added that constant "doing" mind as it relates to gender affirmation may also interfere with mindful observation of progress since focus is only on where one is going. Group leaders then incorporated this specific point into teaching and discussion in future group mindfulness sessions.

Administration of Measures

During initial development and planning, we collaboratively identified the importance of program evaluation to better understand the utility and benefit of this group to TGD veterans and generate data to advocate for continued implementation within the healthcare facility. Additionally, this program evaluation supported the second author's engagement with required scholarly activity (as consistent with APA-accredited Clinical Psychology Fellowship Program requirements), which in turn created an opportunity to more effectively integrate this evaluation within psychology training. Guided by cultural humility and informed by existing literature and discussions with subject matter experts, we selected the following measures: Gender Minority Stress and Resilience Measure (GMS-R; Testa et al., 2015); Subscale 3 of the Transgender Discrimination Scale, Maltreatment in Healthcare Settings (TDS-21; Watson et al., 2019); Borderline Symptom List (short version; BSL-23; Bohus et al., 2009); Difficulties in Emotion Regulation Scale (modified; DERS; Bardeen et al., 2015); Ways of Coping Checklist (WCCL; Neacsiu et al., 2010).

Limitations

We acknowledge several limitations of the DBT skills training group for TGD veterans, both with respect to development and administration. First, we developed and launched a DBT skills training group in the absence of standard DBT, which is inconsistent with evidence-based practice; at the same time, findings are mixed within the literature regarding the utility of skills training group as a stand-alone intervention, suggesting this may be feasible in some settings (Valentine et al., 2015). It is also worth noting that DBT was originally developed as a treatment for borderline personality disorder and chronic suicidality, which may or may not be present for TGD veterans who otherwise may benefit from gender-affirming applications of DBT skills. Additionally, we believed it was important to offer this resource to promote skill development and foster resiliency, as working to develop more comprehensive programming would have delayed access to a resource designed to promote coping skill development and community connectedness, which can serve as a resiliency factor (Hendricks & Testa, 2012). Second, group members presented with variable presenting problems and had a variety of treatment plans; some but not all members were engaged in standard DBT, which may have differentially influenced the degree to which each member was able to benefit from participation. Last, no group leaders to date have had TGD identities, thus limiting our full understanding of TGD experiences; we fully acknowledge our blind spots in this regard. Likewise, this paper was not written in collaboration with someone who has a TGD identity or lived experience. Having acknowledged these limitations, we reiterate that group leaders openly acknowledged their cisgender identities and lack of lived experience, and relatedly our blind spots, and leaders actively avoided relying on group members for education and awareness; likewise, group leaders also made clear the importance of having TGD voices centered within the group, and therefore discussion of lived experiences occurred both naturally and with encouragement via group members sharing during homework review and providing feedback during presentation of content at each session.

Future Directions

As this current paper describes the development and implementation of a gender-affirming DBT skills training group for TGD veterans within a VAMC, it is not a research paper. Moreover, this work focuses primarily on the logistical development and implementation and does not focus on the specific discussion and teaching points within each group session, nor does it discuss specific types of group processes (e.g., addressing therapy-interfering behavior). We fully acknowledge the importance of that content and believe it to be beyond to scope of this paper. We hope that this paper serves as a guide and resource for other clinicians, particularly those who may be working within large healthcare facilities, including VAMCs, who are working to launch or perhaps enhance services for TGD clients. Evaluation of this intervention is imperative, and we plan to analyze data collected from the measures mentioned above. Ideally, we plan to conduct qualitative interviews to better assess group members' experiences and to gather feedback regarding our tailoring of teaching and discussion points. Evaluation of gender-affirming interventions is imperative to advance the field of TGD health and to improve the lives of TGD people. Last, we hope that this paper can perhaps motivate readers to learn more about DBT skills training (Linehan, 2014a, 2014b) and its applications to minority stress (Cohen et al., 2021) and TGD experiences (Sloan et al., 2017).

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Call *for* Award Nominations

to be presented at the 57th Annual Convention in Seattle

The ABCT Awards and Recognition Committee, chaired by Sara R. Elkins, Ph.D., University of Houston Clear Lake, is pleased to announce the 2023 awards program. Nominations are requested in all categories listed below. Applicants from traditionally underrepresented backgrounds are particularly encouraged to apply. Given the number of submissions received for these awards, the committee is unable to consider additional letters of support or supplemental materials beyond those specified in the instructions below. Please note that award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Recent recipients of this award include Thomas H. Ollendick, Lauren B. Alloy, Lyn Abramson, David M. Clark, Marsha Linehan, Dianne L. Chambless, Linda Carter Sobell and Mark B. Sobell, Philip C. Kendall, Richard G. Heimberg, Patricia A. Resick, and Dean G. Kilpatrick. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Career/Lifetime Achievement" in the subject line. ***Nomination deadline:*** March 1, 2023.

Outstanding Clinician Awarded to members of ABCT in good standing who have provided significant contributions to clinical work in cognitive and/or behavioral modalities. Recent recipients of this award include Albert Ellis, Marsha Linehan, Marvin Goldfried, Frank Datillio, Jacqueline Persons, Judith Beck, Anne Marie Albano, and Cory Newman. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, and the nominee's curriculum vitae. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Clinician" in the subject line. ***Nomination deadline***: March 1, 2023

Outstanding Training Program This award will be given to a training program that has made a significant contribution to training behavior therapists and/or promoting behavior therapy. Training programs can include graduate (doctoral or master's), predoctoral internship, postdoctoral programs, institutes, or continuing education initiatives. Recent recipients of this award include the Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology, the University of Nebraska-Lincoln Clinical Psychology Training Program, the Charleston Consortium Psychology Internship Training Program, the Clinical Science Ph.D. Program at Virginia Polytechnic Institute & State University, the Florida State University's Clinical Psychology Ph.D. program, and the Beck Institute. Applications should include a nomination form (available at www.abct.org/awards) and two letters of support. Please e-mail the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Training Program" in your subject heading. ***Nomination deadline:*** March 1, 2023

Michael J. Kozak Critical Inquiry and Analytical Thinking Award "Clarity of writing reflects clarity of thinking." This statement reflects the overarching goal that Michael J. Kozak sought to achieve himself and that he vigorously encouraged others to reach as well. His penchant for critical inquiry cut across contexts: whether in providing cognitive-behavioral treatment itself, offering supervision of treatment, in scientific inquiry and writing, or in advising investigators about how to put their grant applications in the best possible position for success. Dr. Kozak was always in search of clarity. Accordingly, recipients of the Michael J. Kozak Critical Inquiry and Analytical Thinking Award from ABCT should embody this same spirit in their own work. Michael was able to achieve this high standard and promote its achievement in others with great skill and kindness, so recipients should also conduct themselves in such a way in their professional lives. This award will be given in alternate years. The recipient will receive $1,500 and a plaque. Please complete the online nomination materials at www.abct.org/awards. Then email the nomination materials as one pdf document to ABCTAwards@abct.org. Include "Michael J. Kozak Award" in the subject line. ***Nomination deadline:*** March 1, 2023.

The Francis C. Sumner Excellence Award The Francis Cecil Sumner Excellence Award is named in honor of Dr. Sumner, the first African American to receive a Ph.D. in psychology in 1920. Commonly referred to as the "Father of Black Psychology," he is recognized as an American leader in education reform. This award can be given on an annual basis, awarded in even years to a graduate student and in odd years to an early career professional within the first 10 years of terminal degree. Candidate must be a current member of ABCT at the time of the awards ceremony and priority will be given to students and

professional members of ABCT at the time of the nomination. The award is intended to acknowledge and promote the excellence in research, clinical work, teaching, or service by an ABCT member who is a doctoral student or early career professional within 10 years of award of the PhD/PsyD/EdD/ScD/MD who identifies as Black or Indigenous. The award is given to recognize that Black and Indigenous practitioners and scholars are underrepresented in clinical psychology, despite making important contributions to our field. The Francis C. Sumner Excellence Award is meant to reflect the overarching goal of ABCT supporting its members of color. The 2021 early career recipient of this award was Isha Metzger, Ph.D., and the 2022 student recipient was Tia Tyndal, M.A. The recipient will receive $1,000 and a certificate. Please complete the online nomination materials at www.abct.org/awards. Email the nomination materials as one pdf document to ABCTAwards@abct.org, and include "Francis C. Sumner Award" in the subject line. ***Nomination deadline***: March 1, 2023

Anne Marie Albano Early Career Award for Excellence in the Integration of Science and Practice

Dr. Anne Marie Albano is recognized as an outstanding clinician, scientist, and teacher dedicated to ABCT's mission. She is known for her contagious enthusiasm for the advancement of cognitive and behavioral science and practice. The purpose of this award is to recognize early career professionals who share Dr. Albano's core commitments. The 2022 recipient of this award was Anu Asnaani, Ph.D. This award includes a cash prize of $1,000 to support travel to the ABCT Annual Convention and to sponsor participation in a clinical treatment workshop. Eligibility requirements are as follows: (1) Candidates must be active members of ABCT, (2) New/Early Career Professionals within the first 10 years of receiving his/her the doctoral degree (PhD, PsyD, EdD). Preference will be given to applicants with a demonstrated interest in and commitment to child and adolescent mental health care. Applications should include a nomination form (available at www.abct.org/awards), two letters of support, the nominee's curriculum vitae, and a personal statement up to three pages. Application materials should be emailed as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Albano Award" in the subject line.
Nomination deadline: March 1, 2023

Charles Silverstein Lifetime Achievement Award in Social Justice Members of the Association are encouraged to nominate individuals who have made significant and sustained lifetime contributions to advancing social justice initiatives over many years. This award is given at the discretion of the Board of Directors and is primarily designed to recognize the critical, and often underrecognized, contributions from cognitive and/or behavior therapy (CBT) grassroots activists who are from and primarily work with minoritized and oppressed communities. In very rare instances, the award may be given to allies from the CBT field if nominations arise from minoritized members and their perspective is centered. A key element of this award is recognition that grassroots CBT activists typically have less access to power to directly change systems secondary to structural injustice and oppression. Thus, contributions to advancing social justice by grassroots CBT activists may look different than those of allies, even though grassroots activist contributions are no less important and typically confer increased risk for the individual. Eligible candidates for this award do not need to be a current ABCT member but must have a strong historic connection to the CBT field. ABCT membership at some point in the candidate's career is desirable. The awardee will be chosen by the ABCT Board of Directors. The President will verify that all materials are completed and that Board members agree with the recommendation. Nominations for this award should include a letter of nomination/support as well as a curriculum vitae of the nominee or other significant evidence of the nominee's social justice work. Application materials should be emailed as one pdf document to ABCTAwards@abct.org. Include candidate's last name and "Silverstein Award" in the subject line.
Nomination deadline: March 1, 2023

Distinguished Friend to Behavior Therapy This award is given annually to an individual or organization that supports the aims of ABCT in providing awareness, advocacy, or evidence-based behavioral health services in the field of cognitive and behavioral therapies. Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Candidates are nominated by an ABCT member and applications should include a letter of nomination/support and a curriculum vitae of the nominee. Recent recipients of this award include The Honorable Erik K. Shinseki, Michael Gelder, Mark S. Bauer, Vikram Patel, Benedict Carey, and Bivian "Sonny" Lee III. Please e-mail the nomination materials as one PDF document to ABCTAwards@abct.org. Include "Distinguished Friend to BT" in the subject line. ***Nomination deadline***: March 1, 2023

President's New Researcher Award ABCT's 2022-23 President, Jill Ehrenreich-May, Ph.D., invites submissions for the 45th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of $500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent, innovative work published in high-impact journals; and promise of contributing to cognitive and behavioral theory to advance the field. Scholars who trained in smaller labs or who work in less research-intensive environments are also encouraged to apply, as the quality and potential impact of one's work, not the number of publications, will be the focus.
Requirements: must have had terminal degree (Ph.D., Psy.D., M.D., etc.) for at least 1 year but no longer than 5 years (i.e., completed during or after 2016); must submit a peer-reviewed, empirical article for which they are the first author (in press, or

published during or after 2019); 2 letters of recommendation must be included; self-nominations are accepted; the author's CV, letters of support, and paper must be submitted in electronic form. Applicants from traditionally underrepresented backgrounds, or whose work advances our understanding of behavioral health disparities, are particularly encouraged to apply. E-mail the nomination materials (including letter of recommendation) as one pdf document to PNRAward@abct.org. Include candidate's last name and "President's New Researcher" in the subject line. ***Nomination deadline***: March 1, 2023.

Student Dissertation Awards

• Virginia A. Roswell Student Dissertation Award ($1,000) • Leonard Krasner Student Dissertation Award ($1,000)
• John R. Z. Abela Student Dissertation Award ($500)

Each award will be given to one student based on his/her doctoral dissertation proposal. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligibility requirements for these awards are as follows: 1) Candidates must be student members of ABCT, 2) Topic area of dissertation research must be of direct relevance to cognitive-behavioral therapy, broadly defined, 3) The dissertation must have been successfully proposed, and 4) The dissertation must not have been defended prior to November 2023. Proposals with preliminary results included are preferred. To be considered for the Abela Award, research should be relevant to the development, maintenance, and/or treatment of depression in children and/or adolescents (i.e., under age 18). Self-nominations are accepted, or a student's dissertation mentor may complete the nomination. The nomination must include a letter of recommendation from the dissertation advisor. Please complete the nomination form found online at www.abct.org/awards. Email the nomination materials (including letter of recommendation) as one pdf document to ABCTAwards@abct.org, and include candidate's last name and "Student Dissertation Award" in the subject line.
Nomination deadline: March 1, 2023

Graduate Student Research Grant The ABCT Research Facilitation Committee is sponsoring a grant of up to $1000 to support graduate student research. The grant will be awarded based on a combination of merit and need. Eligible candidates are graduate student members of ABCT seeking funding for an unfunded (including internal sources of funding) thesis or dissertation project that has been approved by either the faculty advisor or the student's full committee. Applications should include all of the materials listed in GSRG Application Guidelines (https://www.abct.org/membership/abct-awards/) and one letter of support from a faculty advisor. Please email the application, excluding the advisor letter, in a single pdf to the chair of the Research Facilitation Committee, Ryan Jacoby, Ph.D. Include "Graduate Student Research Grant" in your subject heading. Please ask your faculty advisor to e-mail a letter of support separately. ***Application deadline:*** March 1, 2023

Student Travel Award This award recognizes excellence among our student presenters and is intended to defray some of the travel costs associated with presenting at the convention with a cash prize of $500. This award money is to be used to facilitate travel to the ABCT convention. To be eligible, students must 1) have their symposium or panel submission for the 2023 ABCT convention accepted for presentation; 2) be a symposium presenter (i.e., first author on a symposium talk) at the ABCT annual convention; 3) be a student member of ABCT in good standing; and 3) be enrolled as a student at the time of the convention, including individuals on predoctoral internships, but excluding post-baccalaureates. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence, and innovation for the field. Two awards are given annually, with one granted to an underrepresented student member, defined broadly as race, ethnic background, sexual orientation, or discipline. Additional requirements and submission instructions are available on the Student Travel Award Application found online at www.abct.org/awards. Award winners will be announced in mid-September 2023.
Application deadline: July 22, 2023

Elsie Ramos Memorial Student Poster Awards This award is given to student first authors whose posters have been accepted for presentation at ABCT's Annual Convention. The winners each receive an ABCT Student Membership and a complimentary general registration at the next year's ABCT's Annual Convention. To be eligible, students must 1) have their poster submission for this year's ABCT convention accepted for presentation; 2) be student members of ABCT in good standing; and 3) be enrolled as a student at the time of the convention. Awards are highly competitive and preference is given to projects demonstrating student initiation and independence and innovation for the field. Three awards are granted annually. Additional requirements and submission instructions are available on the Elsie Ramos Memorial Student Poster Award Application found online at www.abct.org/awards. Award winners will be announced in mid-September 2023.
Application deadline: July 22, 2023

Outstanding Service to ABCT This award is given annually to an individual who has displayed exceptional service to ABCT. Nominations for this award are solicited from members of the ABCT governance. Please complete the nomination form found online at www.abct.org/awards/. Email the completed form and associated materials as one pdf document to ABCTAwards@abct.org. Include "Outstanding Service" in the subject line. ***Nomination deadline:*** March 1, 2023

Call *for* Applications

FELLOWS

ABCT Fellow Status for 2023

ABCT Fellows Class of 2022

Amanda Jensen-Doss, Ph.D.
Barry S. Lubetkin, Ph.D.
David C. Hodgins, Ph.D.
David W. Pantalone, Ph.D.
Kenneth E. Freedland, Ph.D.
Matthew D. Skinta, Ph.D.
Monnica T. Williams, Ph.D.
Thompson Elder Davis III, Ph.D.
Laura D. Seligman, Ph.D.

The ABCT Fellows committee is pleased to announce that 9 new members have been recognized. For a complete list of all Fellows, please see https://www.abct.org/membership/fellow-members/. This past year the Fellows Committee used the revised Fellows guidelines in selecting new Fellows. In brief, ABCT Fellow Status is awarded to full members who are recognized by a group of their peers for distinguished, outstanding, and sustained accomplishments that are above and beyond the expectations of their existing professional role. Because members' career paths come with unique opportunities, the committee was sensitive to the environment in which the potential applicant was functioning, and we weighed the contributions against the scope of the applicant's current or primary career.

Multiple Routes to ABCT Fellow Status

The 2021 revision of the Fellows application materials now offers 6 areas of consideration for fellowship: (a) clinical practice; (b) education and training; (c) advocacy/policy/public education; (d) dissemination/implementation; (e) research; and (f) diversity, equity, and inclusion. Applicants for fellowship will be asked to endorse the area(s) in which they wish to be considered. These areas can be overlapping, but also have unique features. Endorsement of multiple areas does not increase the likelihood of selection as a Fellow; demonstrating outstanding, sustained effort in one area is all that is required. What guides the committee's decision making is determining if an applicant has made an exceptional, sustained contribution that goes beyond their work role expectations.

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

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

Deadline for Fellow Status Applications: June 1, 2023, is the deadline for both applicants and letter writers to submit their references. Applicants will be notified of the decision on their application by mid-October 2023. For more information, please visit the Fellowship application page **https://www.abct.org/Members/?m=mMembers&fa=Fellow**

ABCT Fellows Committee

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

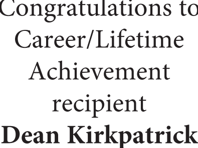
APPLICATION DEADLINE:
June 1, 2023

ABCT AWARDS & RECOGNITION

Tia Tyndal, Francis Cecil Sumner Excellence Award

Lynn McFarr, Outstanding Educator/Trainer

Anu Asnaani, Anne Marie Albano Early Career Award



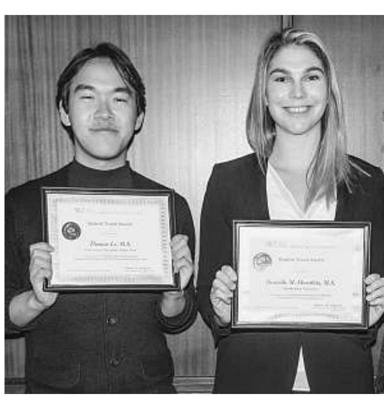
Congratulations to Career/Lifetime Achievement recipient **Dean Kirkpatrick**

Gabrielle Ilagan, Student Research Grant

Kiran Kaur, Student Research Grant Honorable Mention

Robyn A. Ellis, Leonard Krasner Student Dissertation Award

Divya Kuman, Virginia Roswell Student Dissertation Award



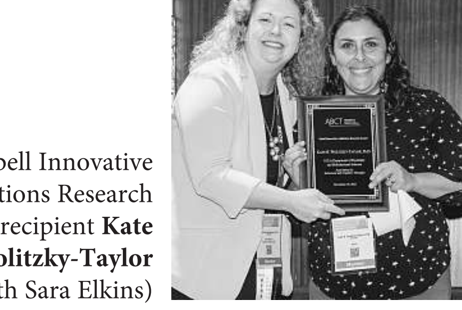
Thomas Le & **Danielle Morabito**, Student Travel Award

ABCT Champions (*left to right*): **Leah Peskin, Jonathan E. Alpert, Yesenia Ceballos, Meg Harrell** (*Champions not pictured*: Chad Wetterneck, Ted Kyle, Wounded Warrior Project)

Stephen Crane (pictured with Awards Chair Sara Elkins, *left*, and President Laura Seligman, *right*), Outstanding Service to ABCT

Susan W. White, Outstanding Mentor

Anu Asnaani (pictured with Awards Chair Sara Elkins, *left*, and President Laura Seligman, *right*) Outstanding Service to ABCT



Sobell Innovative Addictions Research Award recipient **Kate Wolitzky-Taylor** (with Sara Elkins)

Fellows (*left to right*): Laura D. Seligman, Thomas Elder David III, Barry S. Lubetkin, Matthew D. Skinta, Kenneth E. Freedland, Amanda Jensen-Doss, David H. Pantalone, Monnica T. Williams, David C. Hodgins

Elsie Ramos Memorial Student Poster Winners (*left to right*): **Ana Rabasco, Allegra Netten, Sadaf, Khawar**

ABCT's 57th Annual Convention
Seattle | November 16-19, 2023

Cultivating Joy With CBT

Call *for* Abstracts — General Sessions

Program Chair: Emily Bilek, Ph.D. | **Associate Program Chair:** Krystal Lewis, Ph.D.
ABCT President: Jill Ehrenreich-May, Ph.D.

The past few years have been difficult. COVID-19 and other health emergencies, climate change, political instability, and the worsening mental health crisis are taking a toll. Recently, a bright spotlight has also been cast on the historical and present-moment pain caused by pervasive racism and discrimination targeting minoritized and marginalized groups. These recent and ongoing challenges have greatly impacted health and well-being on a global, local, organizational, and individual scale. As a field, we are also reckoning with the ways we've contributed to injustice, navigating barriers to care, addressing mental health stigma, contending with the replication crisis, bringing attention to financial hardship experienced by many trainees and early-career professionals, and coping with professional and personal burnout.

As we work to address these challenges head-on, and atone for our roles in creating them, how can we begin to heal? How can we connect with our values and demonstrate a spirit of perseverance in our research, teaching, and clinical positions? How can we use our expertise to savor and create moments of joy in our own and others' lives? How can we improve our treatments, or construct new ones, to address injustice, to center and celebrate populations that have and continue to face discrimination, inequity, and exclusion by the mental health field? How can we cultivate and sustain our own well-being while working in a meaningful but demanding profession?

ABCT is well positioned to address these questions. The 2023 Convention will highlight advances across research, practice, and education that feature approaches to addressing inequity and injustice within our field, as well as improving mental health, physical health, meaning, and well-being in the world. Please join us in Seattle in 2023 as we say, "It's been a minute, tell me how you're healing"[1] and celebrate the convention theme of **Cultivating Joy With CBT.**

We interpret this theme broadly and encourage related submissions. Topics consistent with this theme include, but are not limited to:

- Improving well-being by reducing burden of disease (broadly defined) or overcoming large-scale challenges.
- Examining interventions that focus on improving well-being, meaning-making and fulfillment, in addition to reducing burdens.
- Increasing inclusivity to combat systemic injustice and historical exclusion of minoritized populations in research, clinical practice, and educational settings.
- Highlighting scientific advances that ignite excitement or passion for your work.
- Identifying facilitators of dissemination and/or implementation of interventions.
- Improving access to evidence-based care through technological advances or other avenues.
- Understanding risk factors and systemic barriers facing mental health professionals and identifying strategies for overcoming burnout or pandemic fatigue.
- Increasing joy in the field of mental health through teaching and/or supervision.
- Combating stigma in mental health and clinical research by centering scholars, change agents and collaborators with lived experience, including public figures.

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[1] Slatkin, B., Frederic, E., Price, L., McLaren, M., Jefferson, M., Larkins, R., Hague, S., Thomas, T.M. (2022). *About damn time* [Song recorded by Lizzo]. On Special. Nice Life and Atlantic Records.

► *Submissions may be in the form of Symposia, Clinical Round Tables, Panel Discussions, and Posters. Submissions outside of this theme are also welcome and will not be penalized. Submissions that are judged to be especially thematic will be recognized in the online program for the 2023 Convention.*

Information about the convention and how to submit abstracts will be on ABCT's website, www.abct.org, after January 1, 2023. Online submission portal for general submission will open on February 7, 2023.

Cultivating Joy With CBT

57th Annual Convention

SEATTLE

November 16–19, 2023

Call *for* Continuing Education Ticketed Sessions

Workshops & Mini Workshops | Workshops cover concerns of the practitioner/ educator/researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday. Please limit to no more than 4 presenters. Mini Workshops address direct clinical care or training at a broad introductory level. They are 90 minutes long and are scheduled throughout the convention. Please limit to no more than 4 presenters. When submitting for Workshops or Mini Workshop, please indicate whether you would like to be considered for the other format as well.

► For more information or to answer any questions before you submit your abstract, contact the **Workshop Committee Chair, workshops@abct.org**

Institutes | Institutes, designed for clinical practitioners, are 5 hours or 7 hours long, are generally limited to 40 attendees, and are scheduled for Thursday. Please limit to no more than 4 presenters.

► For more information or to answer any questions before you submit your abstract, contact the **Institute Committee Chair, institutes@abct.org**

Master Clinician Seminars | Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday and Saturday. Please limit to no more than 2 presenters.

► For more information or to answer any questions before you submit your abstract, contact the **Master Clinician Seminar Committee Chair, masterclinicianseminars@abct.org**

Research and Professional Development | Presentations focus on "how to" develop one's own career and/or conduct research, rather than on broad-based research issues (e.g., a methodological or design issue, grantsmanship, manuscript review) and/or professional development topics (e.g., evidence-based supervision approaches, establishing a private practice, academic productivity, publishing for the general public). Submissions will be of specific preferred length (60, 90, or 120 minutes) and format (panel discussion or more hands-on participation by the audience). Please limit to no more than 4 presenters, and be sure to indicate preferred presentation length and format.

► For more information or to answer any questions before you submit your abstract, contact the **Research and Professional Development Chair researchanddevelopmentseminars@abct.org**

Submission deadline: ***February 7, 2023 3:00 a.m. EST***

Submissions will be accepted through the online submission portal, which will open after January 1, 2022. Submit a 250-word abstract and a CV for each presenter. For submission requirements and information on the CE session selection process, please visit www.abct.org and click on "Convention and Continuing Education."

Preparing to Submit an Abstract

ABCT's 57th Annual Convention

The ABCT Convention is designed for scientists, practitioners, students, and scholars who come from a broad range of disciplines. The central goal is to provide educational experiences related to behavioral and cognitive therapies that meet the needs of attendees across experience levels, interest areas, and behavioral and cognitive theoretical orientations. Some presentations offer the chance to learn what is new and exciting in behavioral and cognitive assessment and treatment. Other presentations address the clinical-scientific issues of how we develop empirical support for our work. The convention also provides opportunities for professional networking. The ABCT Convention consists of General Sessions, Targeted and Special Programming, and Ticketed Events.

ABCT uses the Cadmium Scorecard system for the submission of general session events. The step-by-step instructions are easily accessed from the Abstract Submission Portal, and the ABCT home page.

An individual must limit to 6 the number of submissions in which he or she is the first author (including posters), the chair or moderator, the discussant, panelist, or an invited speaker.

Attendees are limited to speaking (e.g., presenter, panelist, discussant) during no more than FOUR events.

SUBMISSION INFORMATION

- **Presentation type**: For descriptions of the various presentation types, please visit http://www.abct.org/Conventions/?fa=Understanding_The_ABCT_Convention
- **Deadline**: Tuesday, March 14 at 11:59 p.m. PST
- **Character Limit:** Character count does not include spaces.
- **Symposia**: 13,800 characters for the entire text. The summary abstract: 2800 characters.
- **Individual presentations abstracts**: 2200 characters each; three to five presentations total.
- **Spotlight Research Presentations**: 1950 characters
- **Panel Discussions & Clinical Round Tables**: 1950 characters
- **Poster Sessions:** 2800 characters
- **Number of presenters/papers:** For Symposia please have a minimum of four presenters, including one or two chairs, only one discussant, and 3 to 5 papers. The total number of speakers may not exceed 6. Symposia are either 60 or 90 minutes in length. The chair may present a paper, but the discussant may not. Symposia are presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. For Panel Discussions and Clinical Round tables, please have one moderator and between three to five panelists.
- **Title**: Be succinct.
- **Authors/Presenters**: Be sure to indicate the appropriate order. Please ask all authors whether they prefer their middle initial used or not. Please ask all authors their degree, ABCT category (if they are ABCT members), and their email address. (Possibilities for "ABCT category" are current member; lapsed member or nonmember; postbaccalaureate; student member; student nonmember; new professional; emeritus.)
- **Institutions**: The system requires that you enter institutions before entering authors. This allows you to enter an affiliation one time for multiple authors. DO NOT LIST DEPARTMENTS. The system will ask you to attach affiliations with appropriate authors.
- **Key Words**: Please read carefully through the pull-down menu of defined keywords and use one of the keywords on the list. Keywords help ABCT have adequate programming representation across all topic areas.
- **Objectives**: For Symposia, Panel Discussions, and Clinical Round Tables, write three statements of no more than 125 characters each, describing the objectives of the event. Sample statements are: "Described a variety of dissemination strategies pertaining to the treatment of insomnia"; "Explained data on novel direction in the dissemination of mindfulness-based clinical interventions."
- **Overall**: Ask a colleague to proof your abstract for inconsistencies or typos.

For an in-depth explanation of ABCT's convention program, including the differences among ticketed, general, and special programming, visit us at: **www.abct.org > Conventions & CE > Understanding the ABCT Convention**

Questions? FAQs are at http://www.abct.org/Conventions/ > Abstract Submission FAQs

Seattle | November 16-19, 2023

At the ABCT Annual Convention, there are Ticketed events (meaning you usually have to buy a ticket for one of these beyond the general registration fee) and General sessions (meaning you can usually get in by paying the general registration fee), the vast majority of which qualify for CE credit. See the end of this document for a list of organizations that have approved ABCT as a CE sponsor. Note that we do not offer CMEs. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit. Both ticketed and general session attendees must scan in and out and answer evaluation questions regarding each session attended. For those who have met all requirements according to the organizations which have approved ABCT as a CE sponsor, certificates will be available electronically for download by logging into the convention itinerary planner or the convention app.

TICKETED EVENTS Eligible for CE

All Ticketed events offer CE in addition to educational opportunities to enhance knowledge and skills. These events are targeted for attendees with a particular level of expertise (e.g., basic, moderate, and/or advanced). Ticketed sessions require an additional payment beyond the general registration fee. For ticketed events, attendees must complete an individual evaluation form. It remains the responsibility of the attendee to scan in at the beginning of the session and out at the end of the session. CE will not be awarded unless the attendees scans in and out.

- **Clinical Intervention Training** One- and two-day events emphasizing the "how-to" of clinical interventions. The extended length allows for exceptional interaction. Participants attending a full-day session can earn 7 continuing education credits, and 14 continuing education credits for the two-day session.
- **Institutes** Leaders and topics for Institutes are selected from previous ABCT workshop presentations. Institutes are offered as a 5- or 7-hour session on Thursday and are generally limited to 40 attendees. Participants in the full-day Institute can earn 7 continuing education credits, and in the half-day Institutes can earn 5 continuing education credits.
- **Workshops** Covering concerns of the practitioner/ educator/researcher, these remain an anchor of the Convention. Workshops are offered on Friday and Saturday, are 3 hours long, and are generally limited to 60 attendees. Participants in these workshops can earn 3 continuing education credits per workshop.
- **Master Clinician Seminars (MCS)** The most skilled clinicians explain their methods and show videos of sessions. These 2-hour sessions are offered throughout the Convention and are generally limited to 40 to 45 attendees. Participants in these seminars can earn 2 continuing education credits per seminar.
- **Advanced Methodology and Statistics Seminars (AMASS)** Designed to enhance researchers' abilities, there are generally two seminars offered on Thursday. They are 4 hours long and limited to 40 attendees. Participants in these courses can earn 4 continuing education credits per seminar.

GENERAL SESSIONS Eligible for CE

There are more than 200 general sessions each year competing for your attention. All general sessions are included with the registration fee. Most of the sessions are eligible for CE, with the exception of the poster sessions, some Membership Panel Discussions, the Special Interest Group Meetings (SIG), and a few special sessions. You are eligible to earn 1 CE credit per hour of attendance. General session attendees must check in and out and answer evaluation questions regarding each session attended. General session types that are eligible for CE include the following:

- **Clinical Grand Rounds** Clinical experts engage in simulated live demonstrations of therapy with clients, who are generally portrayed by graduate students studying with the presenter.
- **Invited Panels and Addresses** Speakers well-established in their field, or who hold positions of particular importance, share their unique insights and knowledge on a broad topic of interest.
- **Mini-Workshops** Designed to address direct clinical care or training at a broad introductory level and are 90 minutes long. Mini-workshops are offered on Friday and Saturday and are generally limited to 80 attendees. Participants can earn 1.5 continuing education credits.
- **Panel Discussion** Discussions (or debates) by informed individuals on a current important topic that are conceptual in nature, rather than pertaining directly to clinical care. Examples of topics for panel discussions include (but are not limited to) supervision/training issues, ethical considerations in treatment or training, the use of technology in treatment, and cultural considera-

tions in the application of CBTs. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. These are organized by a moderator and include between three and five panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.

- **Clinical Round Tables** Discussions (or debates) by informed individuals on a current important topic directly related to patient care, treatment, and/or the application/implementation of a treatment. Examples of topics for Clinical Round Tables include (but are not limited to) challenges/suggestions for treating a certain disorder or group of patients, application of a treatment protocol or type of treatment to a novel population, considerations in applying CBTs to marginalized communities and/or minority groups. Some topics may be appropriate for either Clinical Round Tables or Panel Discussions, and authors are invited to use their judgment in making this decision. Clinical Round Tables are organized by a moderator and include between three and six panelists with a range of experiences and attitudes. The total number of speakers may not exceed 7.
- **Spotlight Research Presentations** This format provides a forum to debut new findings considered to be groundbreaking or innovative for the field. A limited number of extended-format sessions consisting of a 45-minute research presentation and a 15-minute question-and-answer period allows for more in-depth presentation than is permitted by symposia or other formats.
- **Symposia** Presentations of data, usually investigating the efficacy, effectiveness, dissemination or implementation of treatment protocols. Symposia are either 60 or 90 minutes in length. They have one or two chairs, one discussant, and between three and five papers. The total number of speakers may not exceed 6.

GENERAL SESSIONS NOT Eligible for CE

- **Membership Panel Discussion** Organized by representatives of the Membership Committee and Student Membership Committees, these events generally emphasize training or career development.
- **Poster Sessions** One-on-one discussions between researchers, who display graphic representations of the results of their studies and interested attendees. Because of the variety of interests and research areas of the ABCT attendees, between 1,100 and 1,500 posters are presented each year.
- **Special Interest Group (SIG) Meetings** More than 40 SIGs meet each year to accomplish business (such as electing officers), renew relationships, and often offer presentations. SIG talks are not peer-reviewed by the Association.
- **Special Sessions** These events are designed to provide useful information regarding professional rather than scientific issues. For more than 20 years the Internship and Postdoctoral Overviews have helped attendees find their educational path. Other special sessions often include expert panels on getting into graduate school, career development, information on grant applications, and a meeting of the Directors of Clinical Training. These sessions are not eligible for continuing education credit.
- **Other Sessions** Other sessions not eligible for CE are noted as such on the itinerary planner, in the program flipbook and on the convention app.

How Do I Get CE at the ABCT Convention?

Those attendees who have paid the licensed professional rate receive continuing education credits after completion of each session evaluation form and verification of the time scanned in and out of each session. Then, a personalized continuing education credit letter/certificate will be available for download from the convention app or the convention itinerary planner.

Which Organizations Have Approved ABCT as a CE Sponsor?

Psychology ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content.

Counseling ABCT had been approved by the National Board of Certified Counselors (NBCC) as an approved Continuing Education Provider, ACEP No. 5797. Programs that do not qualify for NBCC credit are clearly identified. The Association for Behavioral and Cognitive Therapies is solely responsible for all aspects of the programs.

Marriage and Family Therapy The Association for Behavioral and Cognitive Therapies is recognized by the California Board of Behavioral Sciences for Marriage and Family Therapies (MFT) to offer continuing education as Provider #4600.

New York State Psychologists The Association for Behavioral and Cognitive Therapies (ABCT) is recognized by the New York State Education Department 's State Board for Psychology as an approved provider of continuing education for licensed psychologists #PSY-0124.

New York State Social Workers Association for Behavioral and Cognitive Therapies (ABCT) is recognized by the New York State Education Department's State Board for Social Workers as an approved provider of continuing education for licensed social workers #SW-0657.

Continuing Education (CE) Grievance Procedure

ABCT is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. ABCT will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Coordinator of Convention and Education Issues in conjunction with the Convention Manager.

Although ABCT goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the convention staff which require intervention and/or action on the part of the convention staff or an officer of ABCT. This procedural description serves as a guideline for handling such grievances.

All grievances must be filed in writing to ensure a clear explanation of the problem.

If the grievance concerns satisfaction with a CE session the Convention Manager shall determine whether a full or partial refund (either in money or credit for a future CE event) is warranted. If the complainant is not satisfied, their materials will be forwarded to the Coordinator of Convention and Continuing Education Issues for a final decision.

If the grievance concerns a speaker and particular materials presented, the Convention Manager shall bring the issue to the Coordinator of Convention and Education Issues who may consult with the members of the continuing education issues committees. The Coordinator will formulate a response to the complaint and recommend action if necessary, which will be conveyed directly to the complainant. For example, a grievance concerning a speaker may be conveyed to that speaker and also to those planning future educational programs. Records of all grievances, the process of resolving the grievance and the outcome will be kept in the files of the Convention Manager. A copy of this Grievance Procedure will be available upon request.

If you have a complaint, contact Stephen R. Crane, Convention Manager, at scrane@abct.org or (212) 646-1890 for assistance.

Become an ABPP Board Certified Specialist in Behavioral and Cognitive Psychology

—Virtual (Zoom) Exams Available—

Why Become Board Certified?

- **"Gold standard"** of professional practice
- **ABPP** is a **"trusted credential"** (i.e., psychologists have met their board's specialty's standards and competencies)
- Potential for **increased financial compensation** (VAs, PHS, DOD, some hospitals)
- **Reflects a higher standard of expertise** over a generalist license
- **Enhances one's qualifications** as an expert witness; facilitates applying to insurance companies' networks
- **Candidates will get up to 40 CE credits** after passing the exam (# CE accepted up to the state where candidates are licensed)

3 Steps to Board Certification:

1. Submission of educational/training materials.
2. Review of a practice sample (clinical case or supervision with a student), or senior option (≥ 15 years of experience)
3. Collegial exam.

- **We encourage diversity of all types and we recognize diversity has breadth**
- We offer a **discounted application fee** for graduate students, interns, and postdoctoral residents
- We conduct exams at APA and ABCT conferences, and other locations as possible (virtual and face-to face)
- Online application: **https://abpp.org/application-information/learn-about-specialty-boards/behavioral-cognitive-psychology/**

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