DISSERTATION

BUILDING CONNECTION AND REDUCING ISOLATION: A GROUP THERAPY INTERVENTION FOR LGBTQ+ YOUNG ADULTS

Submitted by

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ABSTRACT

BUILDING CONNECTION AND REDUCING ISOLATION: A GROUP THERAPY INTERVENTION FOR LGBTQ+ YOUNG ADULTS

LGBTQ+ people experience poor mental health outcomes relative to their non-LGBTQ+ peers, which may be exacerbated by chronic disconnection from self and others that results from discrimination and other minority stressors. Many LGBTQ+ people find strength and relief from mental health concerns by connecting with supportive, affirming communities. These findings are aligned with relational-cultural theory, which posits that people are wired to be in connection with one another, and that building mutually empathic relationships is central to healing. Although research supports that connecting with LGBTQ+ community is beneficial, there is a paucity of research on how LGBTQ+ people connect with community, what barriers exist to doing so, and how clinicians may help facilitate these healing connections. The present study consisted of two parts. Focus groups were conducted to better understand the nuances of LGBTQ+ community connection and to develop proof of concept for a group therapy intervention for LGBTQ+ emerging adults using both the focus group data and existing scholarship and theory on LGBTQ+ group therapy and relational-cultural theory/therapy. Focus group data was coded using qualitative content analysis and incorporated into the development of a 6-session group intervention, which was then implemented with a group of LGBTQ+ young adults in Colorado. Group therapy participants completed measures of relational health, depression, anxiety, social isolation, sense of LGBTQ+ community, and loneliness before, during, and after the intervention. Changes in scores were analyzed using repeated measures ANOVA and effect sizes were estimated; medium to large effects were found in the direction of

symptom reduction, reduced loneliness and isolation, and improved relational health and sense of community. Implications for future research and clinical practice are discussed.

Keywords: LGBTQ+, relational-cultural theory, counseling, group therapy, sense of community

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Introduction

LGBTQ+ Mental Health Disparities

In many contexts, lesbian, gay, bisexual, transgender, and other queer/questioning (LGBTQ+) individuals have a higher prevalence of poor mental health outcomes such as depression and anxiety relative to their non-LGBTQ+ peers (Bostwick et al., 2010). Researchers have explained these disparities with minority stress theory, which posits that stressors related to marginalized sexual orientation or other identities (e.g., microaggressions, violence, internalized homophobia, anticipating rejection from others, and more) understandably contribute to poor psychological and physical health outcomes among sexual minority people (Meyer, 1995; Frost, Lehavot, & Meyer, 2015). Various studies have documented the existence and the effects of these minority stressors, showing that LGBTQ+ people continue to face violence (Meyer, 2010), employment discrimination (Sears & Mallory, 2011), housing discrimination (Friedman et al., 2013), microaggressions (Balsam et al., 2011; Resnick & Galupo, 2019; Woodford et al., 2015), and homelessness (Corliss et al., 2011) as a result of their identities.

LGBTQ+ identities, including both gender and sexual orientation identities, have been and continue to be stigmatized, criminalized, and pathologized in hetero- and cis-normative society (Drescher, 2015; Rogers, 2020). The psychology community is complicit in this process, with earlier editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 2013) classifying same-sex attraction as characteristic of a "disturbance" and a mental disorder until 1973. The *DSM* further categorized elements of gender dysphoria and transgender identity as disordered starting in 1980 (Daley & Mulé, 2014). Although it is now outlawed in some states and territories, conversion therapy – a series of harmful hetero- and cis-normative psychological interventions intended to suppress or change

the sexual orientations and/or gender identities of LGBTQ+ people – is still practiced today (Singh & Dickey, 2016). The history and current state of pathologization and attempted "conversion" of LGBTQ+ people are an integral part of LGBTQ+ history, including many other instances of discrimination and prejudice by researchers and clinicians alike. It further underscores the importance of developing and utilizing LGBTQ+-affirming and non-pathologizing psychotherapy interventions for clients across the spectra of sexual orientation and gender identities.

Minority stress theory was an important contribution to understandings of LGBTQ+ health disparities, in particular because those who are prejudiced against LGBTQ+ people could erroneously conclude that LGBTQ+ identity itself was the cause of disparate outcomes, framing queerness as a moral shortcoming and even a choice worthy of mental and physical consequences (Lewis, 2009; McGovern, 2012). Thus, studying and knowing the underlying causes of such disparities – all symptoms of a heterosexist, cissexist society, rather than inherent psychopathology linked to non-normative sexual and gender identities – is crucial in understanding how and why such disparities manifest. It is also helpful in developing interventions that accurately address the issues faced by the impacted community.

Alongside these disparities and the interventions designed to increase wellbeing for LGBTQ+ people, it is essential to consider intersectionality. Intersectionality is a term coined by Crenshaw (1989; 1991) to refer to a concept that many activists and scholars of color had previously described (e.g., Combahee River Collective, 1977). Crenshaw initially referenced this idea in the context of working with Black women in the legal system; she observed that, although they experienced anti-Black racism as well as sexism, they also experienced unique forms of oppression because of being both Black and women simultaneously. Intersectionality

thus refers to the notion that each person holds multiple identities at once – including but not limited to sex, gender, sexual orientation, socioeconomic status, race, ethnicity, national origin, ability status, language, religion, and body size – which concurrently inform that person's experience in the world. These identities can be associated with privilege and/or marginalization, and when combined they are linked to an individual's material, emotional, and cognitive experiences. Notably, the way that these identities combine to inform experience and resources is known to relate to the ways in which social categories reflect power dynamics, structural oppression, multiple forms of discrimination, inequitable access to resources, and more (Else-Quest & Hyde, 2016). Thus, intersectionality should not be used to conclude that the differences in experiences and resources by intersection of identity are solely a product of individual characteristics of the people holding the identities; it should instead be used to more deeply understand the contextual factors that produce a person's or group's behavior and outcomes.

The concept of intersectionality is supported by research among LGBTQ+ people. Studies of the lived experiences of LGBTQ+ people of color, for example, suggest that their experiences are informed by existing at the intersection of marginalized sexual/gender identities and marginalized racial identities, highlighting the ways in which the experiences of LGBTQ+ people are not uniform and depend on other identities, abilities, resources, and experiences. In a review of LGBTQ+ scholarship from Canada, Sadika and colleagues (2020) found that, although an intersectional perspective was often missing from broader LGBTQ+ scholarship, studies that addressed it tended to suggest that LGBTQ+ people of color experienced unique forms of marginalization, both for their sexual orientation and gender identities among their families and racial/ethnic communities, as well as for their racial/ethnic identities within predominantly White LGBTQ+ spaces. These lived experiences and research findings suggest that the combination of

one's identities may further inform the quality of connection and ability to connect with the broader LGBTQ+ community.

Chronic Disconnection from Self and Others

LGBTQ+ individuals may be at further risk for disconnection from self (Asakura & Craig, 2014; Beagan & Hattie, 2015) as well as from others (Asakura & Craig, 2014; Yang et al., 2018). This may be explained in part by documented depression-related disparities between LGBTQ+ people and their non-LGBTQ+ counterparts; many people experience social disconnection and depressive symptoms in tandem (i.e., with perceived disconnection contributing to the severity of symptoms; Sherry et al., 2008). Similarly, social disconnection can be a feature of anxiety as well as depression; one study suggested that those with depression and/or anxiety had poorer social functioning than those without the diagnoses, including smaller social networks and less social engagement (Saris et al., 2017). Additionally, recent research suggests that experiences of disconnection and isolation are associated with poor outcomes such as depression (Noguchi et al., 2021).

However, other elements of this disconnection from self and others appear to be a unique issue for LGBTQ+ people specifically. In a series of interviews with spiritual or religious LGBTQ+ people, multiple respondents endorsed a sense of disconnection from their own bodies, and many others reported separating or denying elements of themselves and their identities (Beagan & Hattie, 2015); others still became disconnected from large social support networks (e.g., friends, families, religious communities) after coming out. Similarly, an analysis of videos for the *It Gets Better* social media campaign – a campaign in which LGBTQ+ adults shared their lived experiences of being LGBTQ+ in childhood and adolescence – yielded many narratives suggesting disconnection (Asakura & Craig, 2014). For example, many incidentally or

strategically cut themselves off from family and peers in the face of bullying, rejection, and other forms of hostility – real and anticipated. Some described a sense of loneliness as a result of this isolation. Disconnection also occurs among LGBTQ+ older adults, who report feeling isolated, being left out, and lacking companionship at rates substantially greater than their non-LGBTQ+ counterparts (Yang et al., 2018). Furthermore, LGBTQ+ people of color may be especially likely to experience disconnection, both within and outside of LGBTQ+ spaces (Sadika et al., 2020). One study investigated the concept of "conflicts in allegiances" among LGBTQ+ people of color, referring to times when they felt anxiety about keeping their racial/ethnic identities and experience separate from their LGBTQ+ ones, or in which they felt betrayal of one identity when preference was given to the other (Sarno et al., 2015). The authors found that higher conflicts in allegiances were associated with heterosexism from family (especially from one's mother) as well as with experiences of racism in the LGBTQ+ community; they further noted that the highest levels of conflicts in allegiances were experienced by LGBTQ+ people of color who were strongly behaviorally involved with their racial/ethnic identity but minimally involved with their LGBTQ+ identity.

Creating LGBTQ+ Community

On the other side of chronic disconnection from self and others are those who are connected with community and connected to themselves; these people tend to report more favorable outcomes than those who are not. For example, one study suggests that higher levels of self-connection were associated with more life satisfaction and less burnout among students (Klussman et al., 2020). Many other studies have supported the notion that connecting with others is also beneficial for mental health. One study suggested that social group membership decreased depressive symptoms short-term as well as protected against depressive symptoms

across several years (Cruwys et al., 2013). In another study of college students, high social connectedness was related to higher self-esteem and lower levels of depressive symptoms (Williams & Galliher, 2006).

One of the ways in which LGBTQ+ people have shown resilience in the face of discrimination and chronic disconnection has been in creating or seeking affirming communities. This is reflected in the concept of chosen family, which refers to a group of people who are mutually emotionally supportive and close but who relate to one another intentionally, often in the absence of legal or biological relationships (Frost et al., 2016). Research supports the benefits of LGBTQ+ people connecting specifically with other LGBTQ+ people in many contexts. Thematic analysis of questionnaires completed by LGBTQ+ individuals revealed a sense that, though not usually legitimized as "real family" by heterosexist peers and biological family members, chosen families were stable and supportive groups (Haines et al., 2018). Indeed, LGBTQ+ people indicated that they tended to access support from chosen family members who shared LGBTQ+ community membership for everyday social support (Frost et al., 2016). Although many LGBTQ+ people felt comfortable accessing support for everyday matters from non-LGBTQ+ peers and family members, they showed a preference for turning to LGBTQ+ friends for support in matters related to their sexual orientation (Doty et al., 2010); this sexual orientation-specific support appeared to act as a buffer against sexual minority stress. Similarly, connecting with others with shared identities, including LGBTQ+ identities, appears protective against depressive symptoms and low self-esteem (i.e., among Latinx lesbians and gay men; Zea et al., 1999).

Beyond one-on-one interactions with LGBTQ+ peers, LGBTQ+ people across contexts benefitted from larger LGBTQ+ communities and networks of support. For example, LGBTQ+

peer networks promoted LGBTQ+ youth wellbeing in one study (Doty et al., 2010), and access to Gay-Straight Alliances (GSAs) in schools were associated with better mental health and substance use outcomes for LGBTQ+ youth compared with those whose schools lacked a GSA (Poteat et al., 2012). Among the same *It Gets Better* videos analyzed by Asakura and Craig (2014), LGBTQ+ adults who experienced disconnection from self and others earlier in life drew resilience later on from surrounding themselves with supportive peers, including informal connections and LGBTQ+-specific groups.

Relational-Cultural Theory

Based on the literature described, it is clear that LGBTQ+ people experience mental health disparities, in part resulting from minority stressors specific to sexual and gender minority individuals. While many have experienced chronic disconnection from self and others, many LGBTQ+ people have also developed close relationships and communities with accepting others and LGBTQ+ peers, which improve outcomes. Thus, it follows that fostering the development of LGBTQ+ communities and mutually supportive relationships would help improve mental health outcomes and reduce disconnection and isolation among LGBTQ+ individuals. Therapy is one potential site for this development. However, many LGBTQ+-affirmative therapies were developed in the context of individual therapy (e.g., Pachankis et al., 2016). Furthermore, many traditional theories of counseling place focus on personal introspection and developing individual strategies for coping and reducing stress (Jordan, 2001; Jordan, 2010).

Relational-cultural theory (RCT) is an understanding of human development and psychological wellness that centers mutual empathy and connectedness with others (Jordan, 2001; Jordan, 2010). Whereas mainstream theories of counseling – echoing messages from U.S. society as a whole – often emphasize self-sufficiency and independence, RCT prioritizes the

development of authentic connection with others as a measure of mature functioning. Per relational-cultural theory, tendency toward chronic disconnection and isolation can be a result of systemic oppression, hyper-individualism in society, as well as interpersonal and broad societal messages about what identities and behaviors are acceptable (Jordan, 2010). Because moments of disconnection are inevitable in relationships, RCT frames these moments as opportunities for the individuals involved to work to intentionally repair and strengthen the relationship. It further acknowledges a "relational paradox" in which people tend to crave relationships and authentic connections while also consciously or subconsciously employing strategies to limit connection and bring only some parts of themselves into their relationships – often developed as protective strategies from past experiences of disconnection and rejection in relationships (Frey, 2013; Jordan, 2010).

Relational-cultural theory gave way to relational-cultural therapy, which aims to put RCT principles into practice in the context of a therapeutic relationship. It has been utilized in both individual (e.g., Stiver et al., 2001) and group counseling settings (e.g., Lenz et al., 2012; Sassen et al., 2005). Relational-cultural therapies have emphasized several types of interventions and techniques to coincide with the principles of RCT. For example, one aim of relational-cultural therapy is to identify and shift "negative relational images". Relational images are conceptualized as the expectations all people develop for connection and relationship with others (Jordan, 2001). Negative relational images can take many forms and result from a variety of disconnecting, non-empathic, or inauthentic relational experiences, and the goal of a relational-cultural therapist is to help move clients back into connection by acting with compassion, authenticity, and responsiveness, thus modifying their relational images. Jordan clarifies how this process works:

> Most people think of authenticity as being about total honesty and spontaneous expression. This actually is quite nonrelational. It does not take into account the possible impact on others of our expression of affect or thinking. Therapeutic authenticity is based on the development of an understanding of the patient, a caring about the impact of what we share on the patient, and careful clinical consideration based on our work, our understanding of what would be therapeutic for the patient. (2001, p. 98)

Another relational-cultural intervention is related to addressing shame. Whereas guilt surrounding specific events or circumstances can sometimes function to motivate people to repair relationships and make amends, shame tends to be more encompassing and can prompt people to avoid bringing substantial parts of themselves into present and future relationships (Jordan, 2001). Jordan posits that responding empathically to a client's experiences – in contrast to receiving judgment, ridicule, or other responses that induced shame in the past – helps to heal shame and allow the client to become more authentic and less disconnected in the therapeutic relationship and eventually in other relationships outside of the context of therapy.

RCT for LGBTQ+ People

Because of the emphasis in RCT on relationships and integration of systemic oppression into the framework of the theory and associated therapy, it may be a particularly good fit for counseling interventions with people who hold one or more marginalized identity. Indeed, RCT was revised early on to expand beyond the experiences of White, heterosexual, class-privileged, able-bodied, and cisgender women, incorporating perspectives from people experiencing marginalization across one or more domains, such as poor women and women of color (Jordan, 2010). Since then, RCT has been conceptually applied to therapeutic work with LGBTQ+ individuals, though the literature is limited. Those who have applied the relational-cultural

framework to LGBTQ+ individuals have noted that it appeared to be a culturally responsive way of addressing LGBTQ+ clients, including those with multiple marginalized identities (Flores & Sheely-Moore, 2019). Flores and Sheely-Moore identified that LGBTQ+ people often experience chronic disconnection from their authentic selves as well as from others, which can contribute to or maintain anxiety and shame in relationships and in general. Singh and Moss (2016) also applied RCT principles to working with LGBTQ+ individuals. Similarly, they note how RCT specifically addresses elements of marginalization and internalized oppression; they describe how, although minority stress theory helps to explain the mental health experiences of LGBTQ+ people, RCT provides an applicable framework for competent counseling work in response to the understanding that minority stress theory provides. They identify connections between LGBTQ+ individuals' experiences of disconnection and isolation due to existing in a heterosexist, cissexist society and the aims of RCT to understand and remedy disconnection. Further, they note that addressing shame, an important element of RCT, may be particularly relevant for counseling LGBTQ+ clients because of pervasive cultural shame and interpersonal shaming behavior that uniquely impact LGBTQ+ people. Finally, although both of these publications helped show how RCT might be applied to therapeutic work with LGBTQ+ people, with Flores and Sheely-Moore including a single case example, neither involved the specific development and testing of RCT-based interventions with LGBTQ+ clients.

COVID-19, Mental Health, and Social Isolation among LGBTQ+ People

Scholars have drawn attention to the specific risks that the novel coronavirus disease (SARS-CoV2) of 2019 and beyond (i.e., the COVID-19 pandemic) have posed for LGBTQ+ people. In a survey of LGBTQ+ college students across many U.S. universities at the outset of the COVID-19 pandemic, almost half of participants indicated that they had immediate family

members who either did not know about their LGBTQ+ identity/identities, or who were aware but not supportive of them; further, sixty percent reported experiencing unfavorable outcomes such as depression and anxiety since the start of the pandemic (Gonzales et al., 2020). A study investigating the psychosocial effects of the pandemic in Chile showed that many LGBTQ+ people, particularly those with identities like pansexual, queer, and gender non-conforming, experienced more adverse outcomes than their heterosexual counterparts and, at times, their lesbian and gay peers as well (Barrientos et al., 2021). Fish and colleagues (2020) analyzed text-based chats among youth from the spring of 2019, when guidelines for social distancing and quarantining were first announced as safety measures for reducing transmission of COVID-19. They found that, although all youth were affected by the COVID-19 pandemic and the social distancing measures that came alongside it, LGBTQ+ youth were experiencing specific stressors such as living with unsupportive family members, feeling restricted in their gender expression at home, being unable to access gender-affirming medical care indefinitely, feeling unable to access their usual LGBTQ+-specific (in-person) social support, being misgendered and deadnamed by people in their households, and lacking access to online mental health care (i.e., using video calls) due to fear of being overheard by parents. Importantly, many of the participants in this study also indicated that they found creative ways to connect with friends, chosen family, and LGBTQ+-specific resources online, such as using video calls, texts, and social media. Similar concerns were noted in broader LGBTQ+ populations, with scholars calling for particular attention to mitigating social isolation among LGBTQ+ individuals during the COVID-19 pandemic (Salerno et al., 2020).

Consistent with the core concepts of RCT, and acknowledging the effects of the pandemic, one recent study investigated the experiences of LGBTQ+ adults across the U.S.

related to cultivating community during COVID-19 (Abreu et al., 2021). Authors found that, despite the limitations resulting from the pandemic, many LGBTQ+ people reported engaging in activism, advocating for others, rejecting capitalist notions of individuality, cultivating meaningful community, checking in on one another's mental health, and attempting to center the most marginalized community members in their advocacy. This study reaffirms the importance of community as a value among LGBTQ+ adults and further underscores the need for opportunities to connect with other LGBTQ+ in the face of disconnecting and distressing events such as the COVID-19 pandemic.

Present Study

From the existing literature, a narrative emerges which suggests that, although people tend to benefit from community and authentic connection with others, many LGBTQ+ people are not accessing these meaningful connections, at times because of past experiences of hostility and rejection that led them to only bring "acceptable" parts of themselves into their relationships. As disconnection is associated with poor mental health outcomes, this chronic disconnection may be a factor in maintaining mental health disparities between LGBTQ+ and non-LGBTQ+ people. Whereas many traditional theoretical orientations to the practice of psychotherapy seem to echo U.S. society's values of individualism and self-sufficiency, RCT proposes principles for therapeutic intervention that focus on creating and maintaining mutually empathic, authentic connections with others. Scholars have suggested that this framework may apply particularly well for LGBTQ+ individuals because so many have a history of chronic disconnection and shame. For some LGBTQ+ people, this disconnection has been exacerbated by the COVID-19 pandemic, preventing many from accessing their usual social support networks and forcing some to stay in intolerant and/or hostile environments. Although the principles of RCT can be applied

in an individual setting, using the therapist-client relationship as the primary site for creating new, healthier relational images, group therapy interventions provide a unique opportunity for LGBTQ+ individuals to connect with multiple others in new ways, facilitated by a therapist. No such group intervention exists, despite the potential clinical relevance for LGBTQ+ communities.

This is considered a "proof of concept" study, with goals of demonstrating relevance and feasibility of the intervention to be developed, as well as directions for larger future studies (e.g., Swartz et al., 2009). It can be considered similar to an "Early Phase 1" trial in drug research, an exploratory study that evaluates "how and whether" an intervention affects participants before standard trials (National Institute of Health, n.d.). The focus for this study was on emerging adults, usually operationalized as people between the ages of 18 and 29 (Munsey, 2006). Emerging adulthood may be a particularly important and helpful time to provide intervention, as it is often characterized by exploration in the domains of education, career, friendships, romantic relationships, worldview, values, and more (Wagaman et al., 2014). For LGBTQ+ people, this emerging adult identity development is sometimes also situated in the context of questioning gender roles and hetero- and cis-normative relationship structures, as well as navigating oppressive systems and discrimination (especially for those who are at the intersection of multiple marginalized identities). Salvatore and Daftary-Kapur (2020) noted that LGBTQ+ emerging adults may be especially prone to risky and dangerous behavior during this period, due in part to lack of social bonds and the effects of oppression.

Aim 1

The first aim of this study was to better understand what LGBTQ+ community means to actual LGBTQ+ young adults in Colorado. This aim was intended to deepen existing research on

sense of LGBTQ+ community, to assess the needs of the regional community, and to help develop a culturally sensitive, affirming, and needs-responsive group therapy intervention, described in Aim 2. This important information was obtained using focus groups designed to prompt various LGBTQ+ Colorado community members to share their experiences, needs, and desires related to relevant concepts of community and connection. Their contributions in the focus groups were coded and used to develop the content and process of the therapy group itself. As this process was meant to focus on information-gathering, no specific hypotheses were generated.

Aim 2

The second aim of this study was to develop and conduct a telehealth group therapy intervention for LGBTQ+ young adults, with a specific focus on decreasing social isolation and increasing authentic, growth-fostering connection. I hypothesized that this intervention would, by increasing connection, also decrease adverse outcomes such as depressive and anxious symptoms over the course of the study. Because there is no current research documenting existing group therapy interventions that are designed specifically to reduce isolation and increase connection among LGBTQ+ people, this represents an original contribution to the field of counseling, and specifically to the scholarship on LGBTQ+-affirmative therapy. Following the development of the group therapy intervention in alignment with community input in the form of focus groups – along with LGBTQ+ group therapy best practices and RCT concepts and techniques – I hypothesized that participants in the group intervention would experience reductions in symptoms of depression and anxiety between the beginning of the intervention and the end. I further hypothesized that they would experience increased participation in growth-

fostering relationships, decreased social isolation and loneliness, and increased sense of LGBTQ+ community between the beginning and end of the intervention.

Statement of Positionality

Critical self-reflection, including reflection on identity, lived experience, biases, worldview, and more, is essential to all ethical research. I value this reflexivity personally and among the members of my research team. Thus, in accordance with recommendations from several authors (Holmes, 2020; McCrudden & Marchand, 2020), I am including a statement of positionality here. This statement is intended to highlight my own social identities and experiences that I believe are relevant to this research; those who read this study can use these disclosures to better understand the research itself and to think critically about how my identities and biases may have impacted the development and results of this project. It is also a representation of the self-reflection I have engaged in, and will continue to engage in, throughout the duration of this project.

I identify as a White, non-Hispanic, queer, cisgender woman. As a White and non-Hispanic person, I hope to prioritize ensuring that all aspects of my study do not replicate dynamics of racial oppression, including silencing of people of color, perpetrating microaggressions, and elevating the voices of those with the most privilege within a community. Similarly, I hope that people across all dimensions of privilege and oppression, including race, ethnicity, religion, body size, ability, gender, and socioeconomic status can be heard and recognized as important to the successful development of this study. However, I also recognize that my perspective on this project is a fundamentally White and cisgender perspective (among other axes of privilege, including familial wealth, body size, ability status, and more) and that I

am likely to miss aspects of my research that could have negative impacts that fall disproportionately on the most marginalized individuals within a community.

As a queer woman, I have experienced periods of connection and disconnection with the LGBTQ+ community that are inextricable from my interest in this line of research. I recognize that my experiences of connection are likely aided by my privilege, including my White privilege, cisgender privilege, thin privilege, and able-bodied privilege. Similarly, my experiences of disconnection are bound to differ from those who are excluded or ostracized from community because they are experiencing racism, transphobia, fatphobia, xenophobia, and/or other forms of oppression from within the LGBTQ+ community. Thus, it is important that I do not design and conduct an intervention that would fit best only with my own particular experiences of connection and disconnection. By conducting focus groups, utilizing a team of coders, integrating a co-facilitator during the intervention, and committing to constant reflection on dynamics of and intersections of oppression, I aimed to reduce my personal biases and center the needs of the community as a whole.

Through this project, I attempted to centralize the importance of seeking a sample that is representative across domains of identity. Beyond simple representativeness, it is important to me to specifically include and elevate perspectives from LGBTQ+ community members who are marginalized within the community. Understandably, barriers to recruitment among marginalized and multiply marginalized individuals within a community exist. For example, many members of various marginalized communities have developed distrust of researchers, including psychologists, because of a problematic history of racism, homophobia, transphobia, sexism, ableism, fatphobia, and more from psychological, medical, and research communities (e.g., Drescher, 2015; Jaiswal & Halkitis, 2019; Kost & Jamie, 2022). Thus, I aimed to ensure

that my research did not replicate these dynamics while recognizing that, due to my privileged perspectives across many dimensions of identity, there may be ways in which I contributed to research that centralizes dominant perspectives within LGBTQ+ research. It is also worth noting that my geographic positionality may have limitations; Colorado itself is predominantly White (61.6%; U.S. Census Bureau, 2021). Furthermore, because most of my connections came from Fort Collins and Denver areas, most participants are likely to come from these cities; in 2020, Fort Collins was 86.3% White (U.S. Census Bureau, 2020b) and Denver was 72.2% White (U.S. Census Bureau, 2020a). Although I aimed to recruit a diverse and representative sample for both, I know that these factors impacted my ability to do so.

I am aware that many multiply marginalized people within the LGBTQ+ community may understandably be wary of research and/or groups that are led by more privileged individuals or that are not meant only for individuals who hold certain marginalized identities or combinations thereof (e.g., only for LGBTQ+ people of color; only for transgender and non-binary individuals). I recognize these desires for more specific group offerings as valid. Based on the history of psychological research and treatment, which has been characterized by abuse toward, pathologization of, and exclusion of various marginalized groups (Davis et al., 2016; Winston, 2020), any experience ranging from disinterest, reluctance, or refusal to participate is understandable in this context. History aside, many researchers and clinicians continue to perpetuate dynamics of oppression through lack of culturally appropriate theory and practice, microaggressions, and even outwardly oppressive behavior toward participants and clients. This context is important to understand why many members of the broader LGBTQ+ may not want to participate in research like this. My approach was to balance this understanding and context with

the hope that this study did not replicate historical and current dynamics of oppression as much as possible.

Finally, I utilized relational-cultural theory and therapy as a guide for the development of this project. The use of this lens likely influenced the collection of focus group data and the ways that the intervention is crafted around said data. For example, the focus group interview questions were inspired, in part, by RCT core concepts, meaning the data from the focus groups naturally reflects the same concepts. This conflicted somewhat with the choice to engage in qualitative content analysis, which was intended to remain true to participants' self-described experiences without imposing a specific framework. In an attempt to mitigate biases, coders of the focus group data were not trained in RCT and were instructed to code the data based on existing scholarship on qualitative content analysis. Thus, I expected that this conflict was minimal, understandable in the context of the study, and of little import to the quality of the project.

Structure of Document

Following this introductory section, I will begin by describing the methods and reporting results from Aim 1 of the study (i.e., the focus group study). I will then transition to describing the methods and results of the group therapy intervention related to Aim 2, first outlining how the results of the focus groups were used to inform the group protocol alongside other materials (e.g., group therapy best practices). Because aspects of the methods of Aim 2 were dependent on the results from Aim 1, these methods and results sections are described separately and chronologically. However, because the aims were closely related, findings and conclusions are discussed together. Appendices at the end of the document contain relevant materials, including

full versions of the measures administered in Aim 2, initial and revised group therapy protocols, and more.

Method (Aim 1: Focus Groups)

Approval for the study procedure was obtained from Colorado State University's Institutional Review Board (IRB). Approval was first obtained for Aim 1; once the materials and procedure for Aim 2 were developed based on the data collected in Aim 1, IRB approval was also obtained for Aim 2.

Focus Groups

I conducted focus groups to gather information about the needs of LGBTQ+ community members, to better understand how others experience sense of LGBTQ+ community/how they relate to others in that community, what they would want from a group therapy intervention, and more. Focus groups are valuable in this context because, when the facilitator is able to create a permissive space for participants, the focus group discussion can yield rich and honest dialogue, including agreements and disagreements, about relevant topics for people with something in common (Krueger & Casey, 2014). They can provide data beyond quantitative analysis by allowing people to respond in their own words, on their own terms, at whatever level of detail they decide; further, they can provide data beyond that of an individual interview in the sense that hearing from others may prompt them to consider their own experiences and opinions in new ways. They are often used for purposes such as understanding the needs and resources of specific communities, assessing reactions to ideas or services, evaluating existing programs or products, and more (Krueger & Casey, 2010); the focus groups for this study serve the dual purposes of learning about the connection/isolation needs and experiences of LGBTQ+ adults and soliciting reactions to the general idea for a group therapy intervention to target authentic connection.

Participants

Participants for focus groups were recruited from multiple sources. Because the target age range for the group therapy intervention was emerging adulthood, operationalized as ages 18 to 29, recruitment for the focus groups utilized the same inclusion criteria. Similarly, because the group intervention was intended for members of the LGBTQ+ community in Colorado, participants for focus groups were recruited from the Colorado LGBTQ+ community as well.

Recruitment for these groups utilized a variety of community connections, such as Queer Asterisk (an LGBTQ+-run non-profit providing counseling services, community programming, and more), Colorado State University's Pride Resource Center, LGBTQ Student Resource Center (serving Metropolitan State University of Denver, Community College of Denver, and University of Colorado at Denver), University of Northern Colorado's Gender & Sexuality Resource Center, (centers providing programs and services for LGBTQ+ students on their associated campuses), The Center on Colfax (a large LGBTQ+ community center in Denver), and more. I obtained letters of support from relevant groups and organizations prior to recruitment whenever possible. These letters indicated each group or organization's understanding of my project and commitment to support the recruitment process using their relevant resources and populations served. A sample letter of support from one participating organization is included in Appendix A. Recruitment consisted of distributing PDF flyers containing relevant study information (i.e., purpose/format, compensation, inclusion criteria) and a link to indicate interest in and be screened for the study.

Initially, I intended for each focus group to consist of between five and eight people; this range was recommended for personal or potentially sensitive topics, and/or topics with which participants are expected to have experience (Krueger & Casey, 2010). However, this number

was modified to accommodate no-show rates after early focus groups in which five or more participants signed up for a group but only three to four participants attended. The choice to move forward with and utilize the data from the smaller (e.g., three- to four-person) groups was supported by scholarship from Toner (2009), who discusses the validity of small focus groups. She notes that small focus groups, in her experience, tended to follow similar stages of group development compared to typical, larger groups. She also discusses the ways in which choosing not to conduct smaller groups (i.e., ones with larger anticipated turnout, similar to my own) could further the literal and symbolic erasure of marginalized narratives. I agreed that denying small groups of participants the chance to share their experiences – and to be compensated for doing so – could in fact contribute to the loss of important data and even a sense of exclusion among participants who cannot contribute as a result.

Based on initial estimates of having five to eight participants per group, I planned for a total of between three and six focus groups. This estimate originated from a study by Guest and colleagues (2017) suggesting that three to six focus groups typically allowed for the identification of ninety percent of existing themes within a dataset. This would allow for a total of between fifteen and forty-six participants. Thus, when adjusting for the lower-than-expected number of participants in the focus groups, and with the support of my dissertation committee, I adjusted the expectations to recruit a minimum of 15 participants, translating to a minimum of 5 groups. In total, 6 focus groups were conducted. One group was not included in data analysis because of a discovery after the group that the participants were all from one geographic location outside of the U.S. and therefore did not meet the inclusion criteria for the study. Thus, 5 of the 6 focus groups were coded and used in the development of Aim 2.

For the purpose of understanding relevant concepts and experiences across a range of people in the LGBTQ+ community, recruitment allowed for participation from people of all genders, races/ethnicities, sexual orientations, and other intersecting identities. Demographic information about this sample is provided in Table 1. Screening procedures are described below.

Procedure

When participants initially indicated interest in the study, they completed a brief survey meant to confirm their eligibility for the study (i.e., ensuring they were LGBTQ+, age 18-29, and in Colorado). Participants indicated comfort with being audio recorded for the purpose of transcribing and coding the material; those who were not comfortable with audio recording were not eligible to participate in the focus groups. Participants who were eligible were then redirected to a pre-focus group survey, during which they signed consent forms (i.e., for the focus group study and eventual audio recording) and provided demographic information. Demographic questions and response options can be found in Appendix C. From the pre-focus group survey, participants were directed to Calendly (https://calendly.com/), an online appointment-scheduling platform that allowed participants to sign up for available focus group slots without revealing their names and emails to other group members.

For reasons related to safety in the COVID-19 pandemic and overall accessibility, focus groups were held virtually, using the video call service Zoom. The Zoom license used for this study was compliant with the Health Insurance Portability and Accountability Act (HIPAA). Research on virtual focus groups suggests that this format can be especially conducive to reducing barriers for disabled participants and allowing for people to meet across geographic locations (Stewart & Shamdasani, 2017). Each focus group was semi-structured and lasted for approximately an hour and a half. Participants were compensated for their time and

Table 1. Demographic characteristics of the focus group sample (Aim 1).

		Count
Race	Asian	1
	Black	2
	Black and White	1
	Black, Native/Indigenous, and White	1
	White	10
	Another race ("Mixed")	1
	Do not wish to respond	1
Ethnicity	Hispanic or Latinx	2
	Not Hispanic or Latinx	14
	Do not wish to respond	1
Gender*	Cis	1
	Female	1
	Male	5
	Non-binary	3
	Non-binary/transgender	1
	Non-binary/transgender man	1
	She/they	1
	Trans man	1
	Transfeminine non-binary	1
	Transmasc non-binary	1
Sexual Orientation	Biromantic asexual	1
	Bisexual	5
	Demisexual lesbian	1
	Gay	3
	Lesbian	1
	Panromantic demisexual	1
	Pansexual	1
	Queer	2
	Queer/gay	2

*In Aim 1, gender and sexual orientation were both assessed using a write-in option for the purpose of increasing inclusivity. However, some of the responses in the gender category reflected pronouns (e.g., "she/they"), sex terminology (e.g., "female" and "male"), or were otherwise lacking clarity (e.g., "cis"). Participants' responses were reported in this table exactly as they appeared in the survey. However, we cannot be sure based on this data how these participants identified in terms of what would be considered gender terms (e.g., "cisgender woman", "non-binary", "transmasculine", etc.).

contributions, with each participant receiving a payment of $30 (based on an estimated $15 to $20 per hour, including time spent completing surveys and attending the focus group) in the form of Visa gift cards.

Up to eight participants at a time were allowed to sign up for a given focus group meeting via Calendly. Each group was co-facilitated by myself and one other trained researcher. The start of each focus group was dedicated to reviewing confidentiality procedures (i.e., asking participants to keep the identities of the other participants confidential), explaining the format and topic of the group, and allowing facilitators and participants to introduce themselves. Further, they were informed of guidelines for the group, including avoiding interrupting one another, encouraging participants to express both agreement and disagreement with others' answers, and providing all participants the opportunity to share.

Due to the semi-structured nature of the group, the facilitators sometimes allowed for more time than initially planned on questions that appeared to generate more interest, and less time on questions that did not generate much participation. They also used follow-up and clarifying questions in response to participant contributions. Overall, facilitators followed a script with the questions of interest, as well as ideas for possible follow-up questions or comments to redirect conversation as needed. After the first and second focus groups were conducted, small modifications to the wording of questions were made, following a recommendation made by Krueger and Casey (2010). Focus group interviews were automatically transcribed for the purpose of coding afterward. Zoom's built-in transcription service was used to capture the dialogue from the focus groups; these automatically generated transcripts were then reviewed and edited for accuracy before coding. This review involved reading the transcripts alongside the audio recording, ensuring that the text of the transcript matched researchers'

impressions of what was said and correcting perceived errors in the automatically generated text. It also involved the addition of appropriate punctuation to help coders better understand the cadence and structure of the text.

Lastly, focus group participants were sent a follow-up survey in which they were asked to provide an email address to which they would like to receive their gift card. This survey link was provided to participants in the chat feature of the Zoom call after the focus group concluded. Visa e-gift cards were purchased via Vanilla Gift and emailed to all participants who provided an email address within one week of their participation.

Questions

The questions asked during each focus group reflected common guidelines for open-ended questions and semi-structured groups. For example: avoiding questions that can be answered with single words such as "yes" or "no", varying the types of questions, avoiding questions that simply ask "why?", keeping questions conversational, and ordering the questions so that early questions set the stage for the later, more specific ones (Krueger & Casey, 2010; Krueger & Casey, 2014). The questions were further informed by the purpose of the study, to eventually develop and administer a group therapy intervention that would serve to increase authentic connection and reduce isolation among LGBTQ+ young adults. With this aim in mind, the first set of questions centered on better understanding LGBTQ+ young adults' experiences of connection, isolation, and authenticity within the LGBTQ+ community. The full list of updated questions, along with the entirety of the focus group script for co-facilitators, can be found in Appendix B. Below is the updated list of questions, following revisions made after the first few groups.

- In a sentence or two, how connected do you feel to the broader LGBTQ+ community? (7 minutes)
    - If you do feel connected in any capacity, tell us about what that community looks like for you – about how many people? What are their relationships to you?
    - How satisfied are you with your current level of connectedness to the community/to what extent are you seeking more connection?
- What have your experiences been like connecting with other LGBTQ+ community members?
    - What has been difficult about it? – what made it difficult? (3 minutes)
    - What has been rewarding about it? – what made it rewarding? (3 minutes)
- What parts of your identity, personality, or experiences have you felt unsafe or uncomfortable bringing into relationships with other LGBTQ+ people (if any)? (6 minutes)
- What tools, skills, or spaces do you use that help you build authentic connection with other LGBTQ+ community members?
    - What additional tools/skills/spaces do you feel like you would need to have more authentic connections like this? (6 minutes)
- Tell me about a time when you felt most connected to the LGBTQ+ community. (6 minutes)

The second set of questions involved soliciting specific feedback on the development of the aforementioned group therapy intervention. Thus, these questions were prefaced with a brief (i.e., approximately two minutes) explanation of the intended length, focus, and goals of the

therapy group. The explanation of the group therapy intervention, along with this list of questions, can also be found in Appendix B.

- To what extent would a group like this meet your needs or the needs of other LGBTQ+ young adults that you know? (4 minutes)
- What would you want to make sure was included in this group? What would you *not* want this group to include? (5 minutes)
- What would you most want the facilitators of this group to know? (6 minutes)
- Any other reactions to or ideas for this group? (5 minutes)

Qualitative Content Analysis

Audio from each focus group was transcribed to facilitate analysis. The coding team consisted of three undergraduate students and postbaccalaureate students who were trained in the specifics of the coding process. As the primary researcher for this project, I opted not to code the data alongside the other coders. This choice was made for several reasons. The first was to minimize my inherent bias in coding the data. Prior to co-facilitating the focus groups, I spent time gathering and reading about RCT, best practices for group therapy, best practices for therapy with LGBTQ+ populations, and existing therapy groups with LGBTQ+ clients. Thus, I wanted to ensure that my preexisting notions of how this group could look would affect how I developed codes, in a way that might allow for bias and create distance from participants' actual input and stated needs, in favor of coding in alignment with my own ideas. Further, I wanted to be a resource that each coder could access should they need help understanding how to code and practicing coding on the data. By remaining separate from the coding team, I was better able to support the coders in developing their own codes because I had not developed my own, which I would have risked imposing on the coders when they reached out for help. The coding team

members were not asked to provide their personal social identities, but it is worth noting that their positionality, as with any research, affected the coding process in ways that may not be visible or clear. For example, I trained all coding team members, and all of them have received higher education from the same institution, which may affect the coding process and artificially increase the similarity of codes among team members.

Rothwell (2010) summarizes one common process of qualitative coding of focus groups, in which researchers code for qualitative content. This approach is considered inductive and atheoretical, in that the codes are derived from the content of the focus group interviews and not from prior theory (Forman & Damschroder, 2007). Qualitative content analysis involves close readings of each transcript by all members of the coding team (Forman & Damschroder, 2007; Rothwell, 2010). Upon reading, coders generated codes that represent categories of content discussed in a given focus group. Coders began by dividing the transcripts of the focus groups into meaning units. Each meaning unit was summarized into a "condensed meaning unit", typically involving removing redundancies and filler language from the initial text. Each of the subsequent steps of coding involved another level of abstraction from the focus group text. In the next step, condensed meaning units were translated into "codes", representing further distillation of a main idea or ideas. The codes were further placed into "categories", and from those categories, major "themes" were derived (Roller, 2019). This form of coding is considered an iterative process, such that new codes were added as coders moved into later transcripts and as new themes emerged that were not captured by the initially generated codes. Once individual coders completed all 5 transcripts, all members of the coding team met with me to discuss codes and reach consensus. Forman and Damschroder (2007) note two main options for seeking agreement among coders after content analysis. The first option involves seeking agreement by

quantifying reliability between coders. The second option involves discussion and resolution of discrepancies, without attempting to measure the similarities and differences between coders. For the purpose of this study, we selected the second option. Following a largely constructivist philosophy, a primary aim of the focus groups was to better understand LGBTQ+ young adults' experiences of connection and disconnection without directly imposing a theory onto these experiences. The intent of this project was to integrate relational-cultural theory and other relevant counseling theories and interventions into Aim 2 because of theoretical fit with the population and issues of interest; however, this study was also conducted to better understand relevant community members' experiences and build an intervention from their unique experiences as well. Because little is known about LGBTQ+ young adults' experiences of connection to and disconnection from LGBTQ+ community, it was crucial that the initial focus group data was coded flexibly, without confining potential meanings within existing theory and knowing that relevant theories could later be integrated as needed.

Thus, the consensus process began with the coders and I meeting together to review their codes. We discussed differences and similarities between codes. In many cases, individual team members had created similar codes, so meeting time was largely spent deciding on concise and accurate wording for themes and categories that incorporated the most important concepts conveyed in the text. We also spent time discussing which categories belonged to a particular theme and so forth (i.e., decisions about hierarchy and categorization within the codes). At times, team members' codes differed in meaningful ways; in these cases, we discussed each code's accuracy and relevance, ultimately arriving at consensus on how to code the data. Sometimes, consensus involved the creation of two categories, one to reflect each coder's perspective. Other times, it involved selecting one code that appeared to fit the data best after discussion among all

team members, or a new category was created based on a blending of the concepts identified by each coder. Once coding was complete and consensus was reached, the coding team and I worked to place the data back in context, and in this case, determine how the findings from the focus groups could apply to the development of the group therapy intervention. Importantly, consensus was an iterative process, meaning that the coding team revisited older transcripts and recoded sections of text as newer and more precise codes were identified throughout the process.

The following are examples of how I imagined that focus group data may be used to inform the development and refinement of the intervention itself, prior to conducting the groups. If multiple participants indicate a certain common relational barrier to accessing LGBTQ+ community, I may develop a part of a session of the intervention to explore ways of overcoming that barrier. If participants indicate similar adverse experiences while among LGBTQ+ community members, the intervention could be tailored to address how to respond to unwelcoming environments and how to decide whether to continue accessing LGBTQ+ community in that particular environment or with those people. If multiple people share similar experiences of finding welcoming communities, their experiences could be provided in de-identified ways to participants as anecdotes of ways to connect with community. Although the group therapy intervention may address similar topics in other ways, having focus group data to refine the delivery and support the inclusion of those elements will likely help the intervention be more relevant to participants. Please refer to the section entitled “Group Therapy Intervention” within the “Aim 2: Group Therapy Intervention” heading for details on how the codes and other concepts and best practices informed the development of the therapy group content and process.

Results (Aim 1: Focus Groups)

Participants

A total of five usable focus groups were conducted, each containing two to five participants each. In total, 17 participants contributed to the focus groups. Demographic characteristics of the sample can be found in Table 1.

Overview: Connection and Disconnection

The first several questions asked to participants during the focus groups centered on experiences of connection to and disconnection from the LGBTQ+ community. Three major themes emerged, described in detail below. Participant quotes have been edited for clarity (i.e., some filler language and redundancies that did not substantially affect the meaning of the speech were removed).

Perceived Connection to Community

In response to the first interview questions regarding current level of connection to LGBTQ+ community and the associated satisfaction, three main categories emerged, each of which was repeated across various participants.

Connection via close relationships. First, most participants reported feeling connected to the LGBTQ+ community primarily via their close, personal relationships. They cited friends, partners, mentors, neighbors, and family members as examples of the relationships through which they experienced connection to community.

Disconnection from broader community. In contrast, most participants simultaneously reported feeling disconnected from the broader LGBTQ+ community, with many noting that they were unsure what it meant to be connected to a nationwide or global community.

Connecting this category with the idea of connection via close relationships, one participant noted:

> *There's this nebulous idea of community, it's just this idea that there are other queer people out there in the world who exist who I may not know, but I feel connected through more of, like, knowing that there are other people out there who I might not have met in real life but are still alive on the planet. There's the group of five to ten people who I might hang out with one-on-one…we're part of a larger community, but in this moment it's just the two of us.*

Desire for more connection. Lastly, while some participants expressed relative satisfaction with their current level of connection to the LGBTQ+ community, several participants expressed a desire for more connection – via close relationships, to a larger and more encompassing sense of community, or both.

Barriers to Connection

Participants were also prompted to identify barriers to connection with other LGBTQ+ community members. These barriers ranged from discrimination, physical distance, and lack of gathering spaces to fear and limiting beliefs about oneself and others. Categories of barriers mentioned by multiple focus group participants are discussed in detail below. It is worth noting that many of these categories were related to one another and not always described as separate by participants.

Phobias and "-isms". Across identities, participants noted instances of phobias (i.e., transphobia, biphobia, fatphobia, ace-phobia etc.) and "-isms" (i.e., racism, ableism, etc.) within the LGBTQ+ community. Each form of discrimination that emerged multiples times during the focus groups is discussed in detail below. A participant effectively summarized a persistent

question on the minds of individuals who hold marginalized identities within the LGBTQ+ umbrella: “Am I truly going to be accepted in a space that claims it’s accepting?…I tend to really watch a space and see if it’s safe before I enter it”.

Transphobia. Several trans and non-binary participants described experiences of transphobia within the LGBTQ+ community, noting that, for many community members, acceptance tended to stop at sexual and romantic orientations but did not extend to expansive gender identities. Aligned with other themes related to safety, invalidation, and fear of rejection, many trans individuals worried about the timing of disclosure of their gender identity, with some opting to talk openly and in depth about their gender identities only with other trans people. One participant stated:

> *I’ve noticed some gay people aren’t as open to wanting to date people who are trans, which I’ve never understood…I would say that being trans is definitely the hardest thing that has made me feel the most unsafe, especially when it comes to relationships, because you never know when the proper time to bring it up is, and you never know how they’re going to react.*

Others discussed experiences specific to their non-binary identity, noting:

> *I’m non-binary and I kind of identify as trans but not really, so my identities are in a lot of gray areas, and I feel like sometimes I’m uncertain if I’m going to be accepted or if I’m going to be considered queer enough to be a part of different spaces.*

Biphobia. Bisexual participants described various invalidating messages they had received from within the LGBTQ+ community about their sexual orientation. One participant said that, in her relationships with other women, she felt like expressing her attraction to men was met with discomfort and judgment.

Fatphobia. Multiple participants briefly acknowledged the fatphobia present within the LGBTQ+ community, identifying that thinness was a standard or ideal commonly upheld by peers.

Ace-phobia. Participants on the asexual spectrum described difficulties within the community specific to this identity. One participant who identified as demisexual stated that they tended to struggle with the focus on sex and sexuality within the queer community, noting some community-wide messages that "if you're not super into sex, you must not be very progressive or accepting or you have some weird trauma that happened to you", contributing to stigma and judgment.

Racism. Various participants across racial and ethnic backgrounds acknowledged racism within the community. One participant stated:

> *I'm Black, so within the community, skin color and race tend to bring a kind of discrimination… people of the same color tend to to relate with each other. I don't know, it's one community- it* should *be one community, you know, but that's how it really goes in our community.*

Other participants referenced how racism may interact with other marginalized identities in acknowledgement of intersectionality, discussed in depth later.

Ableism. A few participants further referenced ableism among other LGBTQ+ people. Ableism was sometimes related to the theme of lack of inclusive physical gathering spaces, addressed again later on. A participant described his own experiences, stating:

> *I also have a disability, so that's also one of the things that I'm very concerned about people reacting poorly to and that doesn't feel safe bringing into relationships with*

LGBT people. Especially because a lot of LGBT spaces aren't very physically accessible, or events.

Lack of acknowledgment of intersectionality. Echoing the individual "-isms" and phobias discussed above, various participants also acknowledged issues with the LGBTQ+ community as a whole not adequately acknowledging or accounting for the intersecting identities of community members, thus preventing meaningful connection. One described having a stronger expectation for understanding intersectionality among queer community members, noting:

I feel like most of the toxicity that's been talked about comes from the cisgender gay White men that don't see the need to, like- that is their one identity that's already been marginalized and then they don't see the need to expand and learn more about the things that other people in the community face that are intersections between race and culture and gender and sexuality and how all that comes together to oppress some people more than others. And I feel like there can be a lack of people realizing their need to acknowledge that and learn from that…they're like, "I'm queer so I'm oppressed in the same way that every other queer person is".

Ignorance and misconceptions. A broad category of responses among participants was related to ignorance and misconceptions within the community. Although this sometimes intersected with the aforementioned, often overt phobias and "-isms", responses in this category also encompassed reports of invalidation and microaggressions fueled by lack of knowledge – for example, about the fluidity of identities within the LGBTQ+ community.

Feeling invalidated and unwelcome. Similarly, participants sometimes reported feeling invalidated and unwelcome alongside experiences of discrimination, such as biphobia and

transphobia. Other times, the exact reason for feeling unwelcomed was not clear. One participant referenced attempts to connect with a campus meetup group, stating:

> *It wasn't like they weren't nice, but it wasn't the most welcoming community I've been a part of. No one was actively seeking out talking to me, and I was very awkward and didn't know how to talk to them.*

This excerpt also appeared alongside the theme of difficulty entering tight-knit communities, discussed later on.

Judgment and lack of acceptance. Participants revealed another similar yet distinct barrier to connection. As with invalidation and lack of welcoming environments, this judgment and lack of acceptance was sometimes perceived in conjunction with phobias and "-isms". Other times, participants wished the community was "nicer to each other" and lamented "infighting" among LGBTQ+ peers.

Harmful standards and expectations. Intertwined with judgment, "-isms", and phobias, participants identified various harmful standards and expectations within the community that they experienced as a barrier to connecting with others, especially when they themselves did not align with the broader community standards or ideals. For example, many identified the expectation to drink alcohol at queer gatherings as a harmful expectation, aligned with the theme of lack of inclusive spaces, discussed below. One participant, whose discussion on this topic is largely captured in their quote within the sub-theme of acephobia, acknowledged sexual expectations (i.e., pressure to engage in "hookup culture") as problematic. The thin ideal was also discussed as a harmful standard within the LGBTQ+ community, connected with the prior discussion on fatphobia.

Lack of inclusive spaces. One understandable contributor to these common experiences of lack of acceptance and sense of being unwelcome is lack of inclusive queer spaces, especially physical gathering spaces. Lack of inclusivity held different meanings for participants. Across groups, many commented on the presence of drinking- and partying-focused LGBTQ+ spaces like bars and clubs. Although some indeed found connection in these spaces, many noted that they wanted more LGBTQ+-specific sober spaces. Others discussed the physical inaccessibility of LGBTQ+ event spaces, such as the participant whose response is captured in the ableism sub-theme of "-isms" and phobias. Another participant expressed a desire for more queer spaces not centered around or led by schools. Finally, some participants acknowledged the helpfulness of certain existing, inclusive queer spaces – in this case, an all-gender housing community within their university – and wished for more, noting high demand and low supply of such spaces. "An expansion of programs that are already working would be pretty cool," one participant said.

Lack of proximity. Several participants indicated that physical location often served as a barrier to connection. Especially when living in rural and/or Southern U.S. locations, when spending time with unsupportive families of origin, and moving away from existing queer social circles, LGBTQ+ young adults struggled to feel connected to community. This also connected with the theme of lack of inclusive physical gathering spaces, which prevented people from accessing local community even when it did exist near them.

COVID-19 pandemic. Consistent with research suggesting that the COVID-19 pandemic presented unique challenges to LGBTQ+ young people, many participants identified that the pandemic prevented them from being able to connect in-person with community members. One person reported: "For me, COVID has been really isolating just in general. It's hard, it's just dissuaded me from going out in the community and making new friends".

Pitfalls of virtual connection. For many, connecting with community online offered a creative solution to isolation, both in general and related to the COVID-19 pandemic, which is discussed in depth as a contributor to connection. However, participants also identified some downfalls of relying solely on virtual connection, especially when connecting from unsupportive, unsafe home environments.

> *Right at the start of the pandemic…I ended up having to move back in with my parents who are not super great – they're pretty homophobic and transphobic… I was still talking to my friends, I was still messaging my partner, I had all the virtual connection, but at my parents' house, you can't talk about being queer at all. If I say, "oh, her girlfriend" or "his boyfriend", the temperature drops 10 degrees. It's not even active hostility, it's just like talking to a wall and that's very, very isolating. That was probably the most isolated I felt in a very long time.*

Another participant echoed the difficulty of using virtual connection when in an unsafe home environment in reference to the group therapy intervention specifically, noting the following:

> *I think if the group is going to start out on Zoom or be fully on Zoom, the facilitator should know that where a person is in space could not necessarily always be safe for them. I imagine maybe a 20-year-old person is living at home with their parents who aren't accepting or the person isn't out to their parents yet and they're having conversations with people online… if [someone] were to walk through my door…they'd be able to see your faces on the screen.*

Uncertainty about where community already exists. Many focus group members reported knowing that queer community existed – and even existed in proximity to them – but

were unsure how to locate those spaces. One commented on the loss of organized spaces after leaving school, stating:

> *There's also just way fewer spaces where you can find people to meet up with. I feel like when you're in a more preset school environment like an undergrad program or high school and things like that. There were events that were made specifically for that, but there aren't really any once you hit grad school or once you're done with organized schooling in general. There's not a lot of community events that are really geared towards adults that much, so it's just difficult to find spaces.*

Difficulty entering tight-knit communities. When participants were able to locate community, they often experienced challenges connecting because they perceived LGBTQ+ friend groups as intimidatingly close-knit. This difficulty was sometimes attributed to the existing communities appearing unapproachable themselves, whereas others reflected their own uncertainty about how to effectively enter and establish themselves within those groups.

Differing identities and experiences. The LGBTQ+ community encompasses many people across a broad range of gender, romantic, and sexual identities in addition to various intersections of racial, ethnic, religious, and other identities. Some focus group participants reported feeling like holding differing identities served as a barrier to rewarding connection within the community. Some described the difficulties of bringing their religious identities and histories into conversation with other LGBTQ+ people. As discussed earlier, others preferred to keep conversations about the details and nuances of their gender identities among other trans and non-binary peers: "Occasionally you get weird comments from people who don't really get it as much, even if they are also queer". In comparison, individuals in the more privileged social position (in this case, cisgender people) reported that they may similarly avoid these topics of

conversation (i.e., gender identity); however, rather than avoiding them for fear of invalidation, as may be the case with trans people, they report avoiding them for fear of saying or doing something that harms the more marginalized person in the interaction. This theme emerges again under categories of fears that act as barriers to connection. Finally, some referenced differing levels of identity development and exploration as a potential barrier, such that it may be more difficult to connect with community members who have not reflected on their identities and values as deeply.

Differing opinions. Along the same lines as differing identities and experiences, diverging opinions between community members prevented connection and created disconnects, according to participants. One said:

> *I feel like I have very different views from [community groups and organizations] on what queer liberation looks like and the ways that that can be achieved… my views won't always align with the people in the more broad community.*

They shared that this experience sometimes prevented them from seeking new connection, instead relying on existing connections among peers with known shared values.

Pitfalls of shared trauma as dominant form of connection. Some participants lamented the fact that sharing about difficult and even traumatic experiences specific to LGBTQ+ identity was such a common form of connection within the community. While they acknowledged that it is indeed a way to create connection (discussed further in the section on contributors to connection), this form of connection was often experienced as difficult. A participant captured this complexity well, saying:

> *Definitely one of the difficult parts is getting to hear about the kind of trauma LGBTQ people go through that may be unique to their situation and sort of understanding that*

this is just how it is sometimes. But at the same time, it is really a strong connection to have with someone when you can relay these stories to them and they actually understand them and get them, and that's pretty powerful in itself too.

Fear. Focus group members discussed fear as a powerful emotion that could serve to prevent connection with LGBTQ+ community members. Indeed, many participants also converged around what they were most afraid of when initiating or sharing within connections.

Fear of rejection. Although some participants highlighted fear of rejection from non-LGBTQ+ peers as a contributor to overall hesitancy to connect with anyone authentically, focus group members also acknowledged unique fears of being rejected by other LGBTQ+ individuals. Sometimes this prevented people from connecting in the first place. For others, it meant hiding important parts of themselves and their opinions for the sake of keeping connection intact; one participant discussed wanting to "go in line with whatever [community members] want or whatever they don't want for fear of being rejected".

Fear of judgment. Similarly, even when participants did not worry about outright rejection, they still feared being judged by fellow queer community members. In reference to this judgment, a focus group member said, "often, it comes a lot from straight people, but I think when it comes from the community, it feels a little more impactful". Another participant described their experience entering the community as follows: "They want to size you up, they want to put you on some kind of probation for a period of time, then after you seem good, that's when they take you in".

Fear of not being "queer enough". One specific form of judgment emphasized by participants was the fear that they would not be considered "queer enough" to be accepted into LGBTQ+ spaces. This was common among participants who perceived their identities to fall

within “gray areas” such as bisexual, demisexual, pansexual, and non-binary. One participant with some of these identities shared that, because of this fear, they “exclude [themselves] even before anyone has excluded [them]”. Interestingly, even a participant with more historically welcomed and included identities (e.g., a cisgender gay man) questioned whether he was queer enough for certain spaces:

> *I think as a cis man, sometimes I’ll go to a gay meetup…and I feel that sometimes maybe I’m the only cis man in the room as far as I can tell…and I wonder that too, if I even necessarily fit in or if this space was necessarily meant for me.*

Fear of disagreement or harm. Participants expressed various fears around disagreeing with community members, causing harm to others, and crossing boundaries. For example, some expressed hesitance around discussing certain topics (e.g., trans experiences, religion and spirituality) for fear of offending others despite attempting to remain open and inclusive. One participant reflected that not being certain who is part of the community is itself a barrier to connecting, and uncertainty about how to confirm community membership without crossing boundaries emerged as a further barrier:

> *One thing that’s always been tough that I think about all the time is…you want to ask someone if they’re part of the community, but you don't want to offend someone, even though I don’t think it’s offensive…you don’t want to overstep…just the challenge of being like, “are you are you not [part of the community]?” There’s a wall, there is a line that you feel like you can’t cross even though you might both be part of the community together.*

Contributors to Connection

Focus group facilitators prompted participants to discuss contributors to connection with other LGBTQ+ people as well, many of which reflected experiences or values opposite to the ones represented in the discussion of barriers. As with barriers, categories of contributors mentioned by multiple focus group participants are discussed in detail below, and many categories were related to one another and not discrete.

Mutual support. Various participants acknowledged some form of mutual support as critical to connection. Per focus group members, support came in a myriad of forms. Some simply reflected on reciprocally supportive relationships with friends and peers. Two sub-themes emerged within this category: uplifting one another and relying on one another.

Uplifting one another. The notion of uplifting other queer people was common among participants. *"*I feel like just comes with a lot of morale boosting and just general uplifting each other and wishing the best for each other just because we know that we've had similar experiences," one noted. Another reflected the following: "If I see someone I know is queer or LGBTQ, I tend to want them to succeed more. I always tend to uplift them more".

Relying on one another. Ability to rely on one another was also identified as important and rewarding tool for building meaningful connection with community. One participant referenced a supportive practice, facilitating reliance on one another, contained within the all-gender housing floor at their university:

> *People just drop off old clothes that don't fit them anymore, or toothpaste or food and snacks and stuff like that, and people will come grab them and put their stuff there…even though we're not really talking while we do it, it's just this unspoken bond that everyone has, so I think that's really cool.*

Active affirmation of identity by others. Having other LGBTQ+ explicitly validate and support one's identity, especially during stages of identity change and exploration, was also considered a contributor to connection. One participant recalled an experience in which they told their friends about wanting to use a new name; they stated that, the following day, their friend casually referred to them by their new name without incident, leading to an increased sense of connection. Another shared how, in new spaces, other people sharing their pronouns helped to create a norm of asking rather than assuming and again leading to identity affirmation and deeper connection.

Shared identities and experiences. Some participants felt that sharing similar identities and personal experiences was facilitative of connecting with community. In terms of shared experiences, participants referenced both talking about past experiences they had in common with others, as well as sharing new experiences together in the present moment (e.g., hiking together). A few referenced how simply being in spaces knowing that others are LGBTQ+ or trans, for example, helps them feel more connected. This could take the form of friends, coworkers, mentors, and more. One stated:

> *Seeing someone and knowing that they're queer is just having that instant bond with them of knowing that we're pretty likely to have gone through some similar experiences and know a good amount about what we each value and our life experiences.*

Participants referenced different elements of sharing identities and experiences that helped them feel connected, discussed below.

Shared adversity creates empathy. Echoing the quote above, shared experiences created connection, and participants noted that talking about LGBTQ+-specific hardship with fellow

community members could be especially connective. One participant verbalized his experience of this phenomenon:

> *I think it's an empathy we feel for each other…we just kind of assume that they probably have been through like similar universalities, such as bullying, harassment, or- just being queer in general comes with so much microaggressions from every community you can think of…it just kind of makes you sympathetic and empathetic and feel a better sense of community.*

Shared non-LGBTQ+ identities. Particularly for people with multiple marginalized identities, sharing identities beyond just LGBTQ+ identity was helpful at building connection. Participants specifically referenced connecting over shared experiences of racism, as well as neurodivergence, emphasizing the overlap between the LGBTQ+ community and elements of neurodiversity such as autism and attention-deficit/hyperactivity disorder (ADHD).

Act of sharing is connecting. Discussed in the barriers section, participants identified difficulty and sadness associated with sharing trauma from LGBTQ+ peers. However, many also noted that the act of sharing traumatic, adverse, or just LGBTQ+-specific experiences was inherently connecting. One said, "it is really a strong connection to have with someone when you can relay these stories to them and they actually understand them and get them, and that's pretty powerful in itself". Another noted that this was in part constructed by a sense that non-LGBTQ+ peers could not understand such experiences in the same way.

Shared interests. In addition to shared experiences and identities, shared interests also helped LGBTQ+ people connect with one another. These shared interests did not need to relate specifically to the LGBTQ+ experience. One participant described connecting with others via an

app for LGBTQ+ naturalists and others talked about connecting through art. Others mentioned connecting over media, especially LGBTQ+ media, such as films and television shows.

Non-judgment and acceptance. Just as judgment and lack of acceptance were identified as barriers to connection, their opposites were considered contributors. Non-judgment was described as facilitative of authenticity, discussed below as another contributor to connection.

Authenticity. Ability to be one's authentic self around others was considered both an indicator of and contributor to connection. This was closely related to other contributors, such as active affirmation of identity by others. One sub-theme emerged, representing a crucial way in which participants gauged whether they were able to show up authentically with others.

Not needing to explain or prove oneself. Some participants discussed how powerfully connecting it was to have LGBTQ+ friends who did not require them to explain their identities or prove their queerness, in a way that allowed for authenticity and helped them feel that they did not have to hide parts of themselves. One described this as follows:

> *Something that's hugely rewarding about having LGBT friends is that I don't have to explain my identity to them; they understand. I don't have to justify why this identity is real, or that it exists. They just accept it. And they might have questions… I can feel comfortable exploring if I have questions and it feels really safe, like I don't need to defend anything. I can just be as I am and that's okay.*

Another reported a similar sense:

> *My relationships feel like the most authentic if I'm in situations when I vocalize or somehow identify that I am queer and there's no prying, like, "oh, who do you like? Who are you interested in? What is your gender?"…kind of the acceptance of me being like*

"I'm queer" and then them not expecting anything else out of me, no further explanation, just like, "oh, you're part of that community, you're queer, whatever that may mean to you is totally valid and you don't need any further expectation or explanation". That's when my relationships and spaces and connections feel the most valid…when I'm not expected to have to prove myself to for my identity.

Safety. Safety was not explicitly defined by group members, and group members did not always define what specific dynamics, actions, or spaces created a sense of safety. Regardless, many referenced the concept as important to connection. They appeared to discuss safety across domains, including physical and emotional/psychological safety.

Humor. Some participants appreciated use of humor in their relationships with other LGBTQ+ people. They specifically referenced the importance of humor about adversity, especially related to their experience as LGBTQ+ people; one noted that sharing trauma and using humor to "make it less serious" when appropriate helped her connect.

Creative self-expression. A few participants reported that forms of creative self-expression, such as art, writing, and performance, helped them express their queer identities and thus connect with LGBTQ+ community, noting that witnessing others' creativity also helped them connect. A focus group participant shared about this, stating:

I'm an artist and I think sharing my art can be hugely helpful in building connections with anybody. Over the past two years, I've processed so much of my identities through my art and when I share my art, I think it invites a lot of conversations, and I think I've realized things about myself through seeing other people's art, especially queer artists' art. We don't have to have the same story or the same experience to feel that there's something really beautiful and poignant in this creative space of self-expression…even

just listening to a song and feeling really moved by it – you may never have met the artist, but there's something there. I think about the activism that happens through art and performance art, like drag and parades and all of the art that comes out of that as just another testament to the message and the soul, the essence of what a person is trying to share.

Proximity. Physical proximity to LGBTQ+ friends and known queer community was important to facilitate connection, just as lack of proximity was identified as a barrier to connection. Although many sought and found connection via online spaces, discussed later, in-person connections were viewed as critical for many. Participants found these nearby connections via local groups, organized events, activism, and by coincidence through non-LGBTQ+-specific spaces like work and school, each of which will be discussed below.

Events. Many participants agreed that LGBTQ+-focused events were helpful in connecting, though some discussed lack of events and lack of marketing around events as barriers to seeking these structured spaces for connection.

Pride. One form of event referenced by several focus group participants across groups as deeply connecting was Pride (i.e., Pride parades, festivals, and related events which usually take place during Pride month). Focus group members largely discussed Pride as an event which captured many of the other themes and concepts critical to connecting with LGBTQ+: safety, authenticity, creative self-expression, proximity, acceptance, and more. One person described Pride as "the most connected I think I've ever felt" and another referred to Pride month as "probably the best I ever feel as a queer person". This participant said:

I just remember people performing on the stage and everyone around me just ear-to-ear smiling. I mean, everyone was happy because everybody knew why they were there. There was one consensus: that we're happy to be alive, we're happy to be our true selves.

Organized groups. Similarly, organized LGBTQ+ groups were considered facilitative of connection. Many specifically referenced university-supported student organizations and all-gender housing initiatives.

Social media and online spaces. Especially in the absence of consistent, known, local community, participants often turned to social media platforms and other forms of online communication to connect with queer community. A participant from one group discussed why they believed online spaces were particularly effective, noting that "people are sometimes more able to be open and share that aspect of themselves without being as afraid of judgment from people they know in the real world being weird about it". Another stated that online spaces "helps us know that there's others out there, other than just here. Like there's a whole bigger community that you didn't know or think of until you saw it, and I think that's pretty cool".

Although many made general reference to using the Internet or online spaces in general to connect, specific spaces and forms of connection included a "trans-focused Instagram account", texting, an app called iNaturalist with a dedicated space for LGBTQ+ users, queer-specific Facebook groups, watching LGBTQ+ YouTube creators, websites sharing information on local Pride events, Twitter, and Discord.

Activism. Some participants discussed cultivating a sense of LGBTQ+ community via activism. This helped people connect with new individuals and also instilled a broader sense of connection to community. One participant stated:

Speaking up against homophobia – I think to an extent it's made me acquire friends and made me feel more connected to the community, because once people see that, "okay, this is someone that can speak up for us, this is someone that can stand up to things", it's something where people want to come to you… that has carved a niche for me in the community and that has made me feel connected to people – and ultimately connecting people to me more than anything else.

Inexplicable gravitation toward other LGBTQ+ people. Across groups, various participants attempted to capture the difficult-to-describe joyous, serendipitous connection that comes from inexplicably gravitating toward other queer people even before knowing with certainty that they share an LGBTQ+ identity. "We always just find each other," one person noted in reference to other queer people in her environment, and a different participant referred to this phenomenon as the "coincidental, just magnetic piece of it where it seems like we all kind of find each other somehow". Another shared a specific experience of finding other LGBTQ+ people during a brief, seasonal employment position:

I was in [name of state] for about half a summer and the running joke was that our entire lodge was some variety of queer…all of us are random seasonal workers that just showed up here and we're like, "wait, you too?", "wait, you?". That was really funny, and it does keep happening where you just run into people.

Building on existing connections. Finally, a few participants noted that building on existing connections was one helpful way to increase overall sense of connection to community and expand one's network of personal LGBTQ+ friendships. "Once you know some people in the community, it is easier, I think, to find more people and connect with them," one person

stated; another in the same focus group reflected that “once you have one connection, it tends to multiply”.

Overview: Suggestions for Group Therapy Intervention

Following the questions exploring barriers and contributors to connection, focus group facilitators paused the focus groups and briefly shared the general idea underlying the eventual development of a therapy group addressing these topics. The subsequent questions asked participants to provide feedback and input on the group intervention. Their suggestions and opinions are reported below, spanning a variety of domains including group content, process, structure, accessibility, and more. Discussion of the decision-making process surrounding which suggestions to implement and adapt will take place in a later section on the development of the group therapy intervention.

Content

Participants provided numerous suggestions regarding possible content areas for the group to cover in some form.

Addressing unmet needs in the community. One broad category of suggestion from participants was that the group should address unmet needs within the LGBTQ+ community. One participant, for example, noted that some LGBTQ+ community members experience symptoms of mental illness and may also have social/interpersonal skill deficits related to experiences of marginalization, so the group should address these needs. Another cited the existence of various groups for transgender and non-binary people, noting that they believed the community could use more spaces for anyone within the LGBTQ+ community:

I know a lot of local organizations that have trans-specific support groups or bi and pan support groups and stuff like that. I feel like there isn't as much of a broader and just generally queer support group that's just meant to make friends and be queer together.

Education about identities within the community. Some participants expressed interest in both facilitators and participants of the therapy group sharing about identities within the LGBTQ+ community. One was curious to learn in a formal way about specific identities, such as non-binary identities, and another was more interested in learning from group participants how they themselves experience sexual attraction, gender, and more for the purpose of exploring together.

Strategies for finding affirming spaces and navigating non-affirming ones. Broadly, the topics of seeking queer-affirming (and generally affirming) spaces and navigating non-affirming ones emerged in the earlier discussion of barriers and contributors to connection. These were briefly referenced as important topic areas for the group therapy intervention.

Inclusion of lighthearted conversation topics. Consistent with earlier discussions of the pitfalls of shared trauma as a dominant form of connection, some participants agreed that lighthearted conversation topics should be included in the group therapy intervention.

Emphasis on platonic, non-romantic relationships. Some participants mentioned that they would prefer for the group to emphasize friendships and not necessarily focus on dating or sexual and romantic relationships. One person stated:

I think emphasizing relationships that aren't romantic is also huge. Emphasizing and supporting platonic relationships within the community is super important. One little anecdote is that I have a friend who has been on a dating app trying to go on dates with women and keeps coming across profiles where it is just women looking for friends – they

just want friends who are in the community, they just want people to connect with. And it's crazy because it's a dating app, right? You think all these people are on there because they want to be dating, but this is something that- I guess it's not uncommon, and so I think that's something that a lot of people are craving.

Collaborative creative project. Aligned with discussions in the first half of the focus groups about the importance of creative self-expression as a contributor to connection, some participants introduced the idea of including a collaborative creative project for therapy group members to work on together: "something that would bring the group together and give you something tangible to hold onto". This participant reported wanting to leave group with something to remind them, "I have a community, we did this thing, I have the proof of it – that we exist, that we came together". Participants also acknowledged the difficulty of engaging with this via Zoom.

Acknowledgment of intersectionality, "-isms", and phobias. Focus group members highlighted the importance of group content acknowledging intersectionality and forms of marginalization. A participant stated:

I would say inclusivity doesn't have to be limited to just being inclusive of the queer community, so including things like inclusivity for disabled people or for people of color, that kind of thing, because you're not always going to know that there's someone who fits that criteria within the group.

Calls for facilitators to acknowledge intersectionality in the group were consistent with earlier discussions in which participants reflected that lack of acknowledgment of intersectionality, racism, ableism, and other forms of oppression within the LGBTQ+ community were

disconnecting. One participant specifically suggested inclusion of group content for how to navigate "-isms" and phobias.

Offering additional resources for support. A few participants suggested that the group should offer resources for participants. One expressed interest in exploring affirming local churches. One suggested compiling suicide hotlines and local food pantry addresses. Another reported that, if she participated in the group, she would be interested in receiving resources to continue accessing similar community support afterward.

Structure

In addition to group content, participants also shared various suggestions about the structure of the group therapy intervention, discussed below.

Pre-group survey/screening. Several participants discussed the idea of having group therapy participants complete a survey and/or screening interview prior to the actual group intervention so that facilitators can get to know participants individually first. Importantly, one participant expressed the importance of mutuality during a pre-group interview:

> *It might just be me but, for the way my brain works, the specific phrasing of "you getting to know me" feels to me like an interview. But thinking about it, if you had said "getting to know the mediator of it", where it's phrased as, "hey, I want you to come meet me so that you're comfortable coming into the group" would feel a lot less like a barrier or like a "screening me in or out" and feel more like "hey, this is what to expect, so that it can be more of a help for me, so I know what to expect in the group and also to help you so that you can get to know me a little bit".*

Small group size. Participants largely agreed that they would be most interested in participating in a relatively small therapy group, defined as no more than ten participants in one group.

Group levels or subgroups. Some focus group participants reflected that it could be helpful to create groups that were specific to certain participant identities, needs, or levels of identity exploration to increase group cohesion and comfort and reduce exposure to microaggressions and other forms of harm. One participant shared their perspective on this:

> *I feel like it can be really anxiety-provoking as someone who is recently out to go into a space where everyone already has their identities fully fleshed out and people have been already out for a few years and know themselves. So I feel like even having a group for people who are in that space and who are there with our identities and then also space for people who are still really just exploring it and having a space to explore as a group…sort of testing the waters and just getting themselves comfortable.*

In contrast, other participants liked the idea of having a group welcoming of all identities, experiences, and levels of self-understanding, noting that creating identity-specific groups (e.g., trans and non-binary groups) could lead to expectations or pressure to bond over that shared identity and could also reduce exposure to important diversity within the community.

Ground rules and expectations. Focus group members agreed that the therapy group should establish ground rules. A few ideas, discussed below, were shared by multiple group members.

No pressure to share. Some participants referenced the idea that participants should not be pressured to share anything beyond what they are comfortable sharing with the group.

Agreeing on how to navigate trauma and triggers. Participants acknowledged the likelihood that therapy group members may have differing preferences around sharing and hearing about traumatic experiences or triggering topics in the group. Thus, they described the importance of collectively seeking balance between avoiding triggers for group members while simultaneously allowing them space to discuss difficult experiences. One said:

> *I think that as long as something like that is approached with delicacy where it's necessary, being mindful and not overly cautious, being very conscientious, but also not afraid to touch on real issues if people are ready and willing to talk about that kind of thing. You know, just being able to gauge how people are doing as a whole group but also individually and making sure that the conversation is suitable for everyone and making sure that everyone's for it.*

Other participants shared the idea to check in with individual group members about their preferences on these topics during the pre-group screening interview.

Respectful, inclusive language. Several participants expressed the importance of agreeing on respectful language use among facilitators and group members, ranging from gender-inclusive terms, correct pronouns, lack of derogatory terms, and avoiding invalidation of others' identities. One focus group participant said, "language is tricky because it's kind of ever-evolving and what is stigmatized for one person might not be stigmatized for another person, but just guidelines around basic respect and dignity around language use for each other".

Confidentiality and privacy. A few participants briefly referenced the importance of maintaining privacy and confidentiality of other group members, such as by agreeing not to record or take screenshots of the Zoom sessions and agreeing not to share individuals' contributions to the group with others outside of the group.

Ground rules should be co-created. Participants also referenced the idea that ground rules can be co-created by group members to ensure that the needs of all participants in a given group are adequately acknowledged and met.

Opportunities to maintain connection after the group. Many participants expressed a strong preference that the group offer an opportunity to maintain connection with other group members following the end of the therapy intervention. Focus group members discussed potential benefits and risks to doing so. In terms of risks, one person acknowledged the possibility of "infiltration" of the group by non-LGBTQ+ individuals. However, most participants who discussed this topic expressed interest in doing so and indicated that an optional opportunity to share contact information of choice, presented at the end of the group would be most appropriate. One person noted:

> *I feel like having the thing at the end where [group members] all are able to give each other information would be really important, especially if the purpose of the group is to have those connections. And I think that, if they were to just leave the group and never see each other outside of that group, it would defeat the whole purpose.*

Facilitator Characteristics

Participants also shared about attributes they hoped therapy group facilitators would have in order to best meet the needs of group members.

Understanding of harm perpetuated within the community. Some participants acknowledged the harm perpetuated even within the LGBTQ+ community and wanted facilitators to be aware of these possibilities for harm (e.g., especially from cisgender queer people toward trans people).

Representative of broader community across identities. Multiple participants noted that it would be helpful for facilitators to hold diverse identities and be representative of group members' identities as much as possible. One person stated:

> *To the extent that is possible, I would want to try to get diverse leadership in terms of race, gender, and ability, as well as other axes of privilege. Just because the more perspectives you have, the more likely you are to see things that are going to be an issue, and you can expand your reach based on that, and also people will feel more comfortable to show up if there's someone that they perceive to have kinship or, like, "oh, that person's like me" and they're like, "no, you should come to this meeting, you should come meet these people". I feel like that would be more welcoming.*

Another participant expressed a preference for facilitators to also share an LGBTQ+ identity.

Preventing harm in group. Various focus group participants agreed that facilitators should function as mediators who prevented or addressed harm within the group. One hoped facilitators could "make sure that [the group] remains a safe space for people and it doesn't become something that isolates someone even more from the community if they feel isolated already". This theme was related to preventing harm via managing discussions of trauma and triggers in a helpful way, discussed below.

Trauma-informed. Numerous focus group members discussed the importance of trauma-informed care from facilitators of the group, especially knowing that it is common for LGBTQ+ individuals to have experienced some form of traumatic event or events.

Moderating "trauma dumping". One way that focus group participants stated facilitators could demonstrate a trauma-informed approach is by moderating how participants share trauma in the group, consistent with other participants' discussions of establishing ground

rules for how to navigate potentially triggering conversations. One participant shared the following:

> *This probably happens in any kind of therapy focus group, but "trauma dumping", for lack of a better phrase, in these kinds of situations where there's probably a lot of very common experiences I'm sure would be very, very triggering for a lot of people in the room. So maybe if facilitators- I don't know if it would be more helpful to go over it with people to try and avoid that towards the beginning, like "to stay with the group, this is something we're going to try and avoid" or to be skilled with making sure people get cut off before they go too far into the weeds, too far into the details. Because there's just a lot of shared drama and shared experiences and if one person is reacting very, very strongly, chances are a lot of the rest of the group would be too, so that's something that I would want everyone to be mindful of if I was in a group like this.*

In the first section of focus groups, participants regretted that shared trauma was a dominant form of connection among LGBTQ+ community members; aligned with that theme, another participant hoped that facilitators could help make the space "more low-key" (i.e., not completely focused on trauma).

Accessibility

Various participants provided suggestions for the group therapy intervention that would make it as accessible as possible.

Cost. Several people reported that the cost of the intervention would be an important factor in their ability to participate. One stated that any cost to the intervention would be prohibitive; others noted that "keeping it reasonable" and using a sliding scale would be helpful.

Ease of signing up. Some suggested that ease of signing up for the group was also critical. In response to a participant who expressed frustration with "unnecessary roadblocks" to mental health care, another focus group member said:

> *I understand the desire to prevent someone who might want to go cause trouble or something from the group, but generally speaking, I find that there seems to be more roadblocks in the way of queer people finding support than someone trying to go in and be disrespectful. And if something like that were to happen, I think that it could be addressed in ways that don't necessarily make it harder to access this kind of care.*

Flexible scheduling. Flexible timeframes, including options specifically tailored for group members' schedules, were important to some focus group participants as well. One referenced that many people may be unable to participate in a group like this during typical work hours, for example.

Possible Benefits of Intervention

In addition to suggestions for content, structure, and accessibility, participants also named various potential benefits of an intervention like the one described by focus group facilitators. These benefits were typically described as hypothetical due to lack of detail provided about the intervention since it was yet to be developed.

Creating connection and fostering sense of community. A few participants identified that connecting with other therapy group members, if desired, would be a benefit of the group.

Place to share experiences. Others simply noted that having a place to share about their personal experiences would be rewarding and helpful.

Queer-affirming. Some participants expressed excitement at the idea of a queer-affirming intervention. One said:

We need more queer therapy…I think queer-affirming therapy is just the baseline. I think there's more to it than that. And regardless of where this group goes, I get really excited about the idea that queer therapy just exists in the world, and I think it's fantastic and I'm so on board for it and I love that you're getting the perspectives of actual queer people and input, because I think that's really important…it's crucial, in fact.

Combatting loneliness. Some participants identified that an intervention like this would be helpful when feeling lonely.

Benefits to mental health. Participants also helped that this intervention would help improve the mental health of therapy group members, such as by reducing loneliness, depression, and anxiety.

Method (Aim 2: Group Therapy Intervention)

Approval for this portion of the study procedure was obtained from Colorado State University's Institutional Review Board (IRB). Approval was first obtained for Aim 1; once the materials and procedure for Aim 2 were developed based on the data collected in Aim 1, IRB approval was also obtained for Aim 2.

Group Therapy Intervention

The development of this group therapy intervention was informed by data from the focus groups described above. The process for development of the group therapy intervention protocol, which is provided in Appendix E, was as follows. First, I reviewed the coded focus group data for general themes and topics of interest, drawing initially from the first half of each focus groups, which focused on experiences of connection to and disconnection from the LGBTQ+ community. These themes were used to construct the general session topics, including exploring contributors to connection (Session 2), exploring barriers to connection and considering ways around them (Session 3), navigating unwelcoming spaces (Session 4), and exploring the meaning of community and healthy relationships (Session 5). Some discussion topics and questions were also derived in part from these codes. Other discussion questions added to the protocol mimic questions asked during the focus groups. This decision was made in part due to the rich, meaningful discussions that focus group participants engaged in with prompting from the questions; indeed, participants were observed to connect with one another, expressing resonance, agreement, and acceptance of one another despite lack of explicitly therapeutic facilitation during the focus groups. Because the aim of this intervention was to generate connection, I noted the importance of integrating discussion topics that would allow participants to connect over

shared experiences as well as express their unique experiences around connection and disconnect with an attentive group of community members.

The second half of each focus group allowed for participants to express ideas about logistical considerations, group process, and topics of interest for the proposed intervention specifically; this data was also integrated throughout the protocol, in conjunction with general group best practices. For example, some participants discussed that a scheduled conversation with group facilitators prior to the intervention would be helpful to assess fit for the group and reduce anxiety leading up to the group; this was aligned with general suggestions for group therapy with LGBTQ+ individuals to utilize a screening process to confirm that potential participants are likely to benefit from the intervention (Goodrich & Luke, 2015), in addition to certifying that they meet other eligibility criteria for the criteria. Similarly, Goodrich and Luke advocate for the inclusion of rules or guidelines, including specific discussion of confidentiality and the limits thereof; participants in the focus groups also emphasized the importance of confidentiality and further shared ideas for other group guidelines, many of which are included in the group protocol (Session 1). Other considerations that were derived from the Goodrich and Luke (2015) in addition to emerging in some form as suggestions or themes in the focus groups are as follows: focusing on all aspects of LGBTQ+ identity (i.e., not just sexual orientation, which may exclude trans clients/participants), allowing clients to self-identify, acknowledging the histories and current realities of oppression within and toward the LGBTQ+ community, and ensuring competence of group leaders in working with the LGBTQ+ population. Some ideas for the protocol were taken directly from focus groups; for example, various participants endorsed excitement about the idea of having a shared creative project to contribute to together. Although there are some technology-related barriers that limit the scope of this project, a form of

collaborative collage was integrated in Session 5. Sharing contact information at the end of the intervention was discussed in focus groups as well, with participants tending to agree that they would like the option to continue connecting with other participants after group but that it should not be mandatory.

Additionally, I consulted RCT scholarship and integrated both concepts and specific suggestions for therapy techniques from this literature. These ideas tended to fit well with the focus group data and original intent for the group. For example, providing education on the "central relational paradox" within RCT is part of Session 2, followed by discussion about how the concept applies to participants' own lives. This is consistent with recommendations from Comstock and colleagues (2002), who state that discourse around this concept should occur in RCT group process. RCT psychoeducation provided in Sessions 4 and 5, as well as wrap-up discussion questions in Session 6, reflect suggestions from Comstock and colleagues as well. In addition to psychoeducation from RCT, I considered relevant RCT processes (i.e., mechanisms for change proposed by RCT) to help develop the blueprint for the group. More specifically, one concept from RCT is the notion of mutual empathy (Jordan, 2001). RCT scholars note that empathy is experienced when one person shares their story or emotional experience and another person listens closely, attempting to understand and share in their emotional experience. Mutual empathy, per RCT, involves the second person (e.g., the therapist in a therapeutic context) responding to the first person's disclosure with a reflection of how they were moved or impacted emotionally by their sharing. Co-facilitators of this group agreed to work toward facilitating mutual empathy in two ways. First, they responded to participant disclosures with reflections representing appropriate validation and mutual empathy in an attempt to help participants see that their contributions to the group are important and worthwhile. Second, co-facilitators hoped

to engage participants in communicating mutual empathy to one another by both modeling, as described above, and by directly prompting participants to consider responding to one another's disclosures by sharing the emotional impact on them. Structuring the group largely around open-ended discussion was intended to provide ample opportunities for participants to share and experience mutual empathy in this way. Finally, some direct psychoeducation about mutual empathy was included in the intervention. Mutual empathy, among the other group content and processes, is intended to support the RCT concept of healing negative relational images. As discussed in the introduction, relational images are expectations for relationships that come from prior experiences (Jordan, 2001); negative relational images, for example, may derive from earlier experiences of shame or rejection from individuals, groups, and/or society. RCT posits that negative relational images can be shifted to more helpful and adaptive images when they experience mutually empathic, authentic relationships, showing that there are healthier possibilities than their past patterns. This intervention was structured with this intent in mind; offering a facilitated space for individuals to share their experiences, ideally free from the judgment of non-LGBTQ+ peers, with plentiful opportunities to connect with others on meaningful topics, and with more resources to manage disconnection when it occurs in session.

Finally, some strategies and resources from evidence-based mental health treatments were also briefly included in the intervention to supplement the RCT content and address focus group participants' reported need for specific, implementable tools and skills for attending to their interpersonal concerns. For example, some skills and concepts from dialectical behavior therapy (DBT) and cognitive behavioral therapy (CBT) appear in Session 4.

Participants

As in the focus groups, participants for the group therapy intervention were self-identified LGBTQ+ people in Colorado between the ages of 18 and 29; 29 represented the upper end of the age-related inclusion criteria, though participant ages in the actual group ranged from 18 to 26. Participants were recruited using the same avenues as focus group recruitment, including local LGBTQ+ community centers, mental health non-profits, and college organizations. I initially aimed to conduct one to two therapy groups, consisting of five to eight individuals each. For this project, one iteration of the group therapy intervention was conducted with a total of eight participants. Demographic information about this sample is provided in Table 2.

I determined that those who participated in any of the focus groups for the development of this group therapy intervention ideally would not participate in group therapy interventions themselves; however, focus group participants were permitted to participate in the event of low recruitment of other community members; low recruitment was characterized by four or fewer participants interested in the group therapy intervention prior to the addition of interested focus group participants. This option was not utilized due to adequate initial interest in the group from early recruitment materials.

Procedure

Recruitment materials were distributed via participating community organizations and social media, as described in Aim 1. Recruitment materials consisted of a flyer containing relevant study information as well as a link and quick response (QR) code that directed individuals to the initial screening survey. Individuals who met relevant inclusion criteria for the study based on this survey were immediately redirected to a Calendly page, on which they could

Table 2. Demographic characteristics of the therapy group sample (Aim 2).

		Count
Race	White	7
	Do not wish to respond	1
Ethnicity	Hispanic or Latinx	2
	Not Hispanic or Latinx	5
	Do not wish to respond	1
Gender	Cis Man	1
	Cis Woman	3
	Non-binary	2
	Non-binary/Gender non-conforming/Genderqueer/Genderfluid/"I choose not to label, I use they/them pronouns most of the time"	1
	Trans man/Non-binary/Agender/Demiboy	1
Sexual Orientation	Gay	1
	Gay/Queer	1
	Lesbian/Queer	2
	Pansexual	1
	Queer	1
	Queer/Aromantic/Polysexual/Platoniromantic	1
Age	18	1
	23	2
	24	2
	26	3

schedule a time to participate in a 30-minute Zoom-based screening interview with myself (i.e., primary group therapy facilitator). The content of these interviews is outlined in Appendix E under "Session 0: Pre-group individual interviews". During the interviews, those who indicated interest in participating in these group interventions were screened for active psychosis, suicidal ideation, and homicidal ideation. Screening questions for psychosis were adapted from Phalen and colleagues (2018). We intended that those with any present psychosis, suicidal plans/intent, and/or homicidal ideation/plans/intent would not be eligible to participate in the group and would be referred to a higher level of care as appropriate. However, no participants who engaged in the pre-group screening interview reported or showed any indicators of psychosis, suicidal plans or intent, or homicidal ideation, plan, or intent. All nine participants in these screening interviews met eligibility criteria for the study and were therefore invited to participate in the group therapy intervention portion of the study. Participants were compensated for their participation in the screening interview with a $10 Visa gift card sent to an email address of their choice. All nine participants verbally accepted the offer to participate in the group and consented to being contacted via email for the purpose of ongoing communication about scheduling the group and completing relevant surveys; eight of the nine followed through by completing the pre-group therapy consent form and survey which were sent to interested participants following their screening interviews. Once at least five participants expressed verbal commitment to participate in the group, co-facilitators solidified the group start date and communicated it via email to participants. Participants were provided instructions for joining the group therapy session via email.

The group therapy interventions were conducted virtually using Zoom video call service. Each group therapy session lasted approximately an hour and a half and occurred weekly across

a span of six weeks. One iteration of this intervention was conducted. Participants were not compensated for participating in the intervention itself, as it was expected that the participants would benefit from the intervention; group therapy interventions of a similar length are often valued between $300 and $600. Participants were, however, compensated for their completion of quantitative measures throughout the course of the study, as well as some qualitative questions at the end of their experience. Quantitative measures were administered each week; specific measures are described in the following section. Survey links were emailed to participants following each session and one reminder email was sent prior to the subsequent session. Furthermore, relevant session content, especially worksheets and concrete skills and tools, were also sent to participants when requested after each session. Participants were paid based on estimated total survey completion times at a rate of $15 to $20 per hour. Participants who complete all seven iterations of the relevant measures and complete the final qualitative questions after the intervention received a total of $50 in the form of virtual gift card. Compensation was prorated based on the number of surveys completed; each completed survey will yield a payment of $6.50, with the exception of the final survey which is longer and will therefore yield a payment of $11 because it contained additional items (i.e., opportunities to provide quantitative and qualitative feedback about the group intervention).

As anticipated, each session of the group therapy intervention was adapted from the initial protocol in various ways based on input from group members, clinical judgment of co-facilitators, and limitations related to session length. Appendix F contains a revised protocol that more closely represents the actual content covered in each session; this protocol still includes options for discussion topics and questions that were not specifically used during this

intervention because of the conversations that organically emerged among participants but may still be interesting or helpful prompts in groups with different sets of participants.

Measures

Full versions of each measure, including the demographic information questions and response options, are provided in Appendix D.

Demographic Information. Some demographic information was collected from participants, including age, race, ethnicity, sexual orientation, and gender identity. Although sexual orientation and gender identity were measured using write-in options in Aim 1 to increase inclusivity, we noted issues with the responses in terms of consistency and interpretation of the items. Thus, new items with response options as well as a write-in option were provided for these items instead. See Appendix D for details.

Identity Salience. A measure of identity salience/centrality was drafted for inclusion in this portion of the study. Because this was not a measure of interest for analyses, it was included to help understand participants and their responses in context. It was therefore written with this intent in mind and did not intentionally draw from a particular existing item in the identity salience or identity centrality literature. The item included was as follows: "Which of your personal identities or combinations of identities are most salient or important to you?"

Relational Health Index. The Relational Health Index (RHI) has been used in prior RCT research (Lenz, 2014). It is a 37-item self-report measure intended to assess an individual's level of participation in growth-fostering relationships, which are characterized by authenticity and empowerment with peers, mentors and community (Liang et al., 2002). Items are on a five-point scale ranging from 1 = "Never" to 5 = "Always". Items related to mentorship were not used for the purpose of this study. Examples of items include "After a conversation with my

friend, I feel uplifted", "I feel positively changed by my friend", and "My connections with this community are so inspiring that they motivate me to pursue relationships with other people outside this community". Items using gendered pronoun options such as "I can tell my friend when he/she has hurt my feelings" were changed to "I can tell my friend when they have hurt my feelings" for the purpose of parsimony and gender inclusivity.

Beck Depression Inventory (Second Edition). Symptoms of depression were measured using the Beck Depression Inventory (Second Edition; BDI-II; Beck et al., 1996), a commonly used 21-item self-report measure designed to assess the severity of depressive symptoms in adolescents and adults; one comprehensive review suggests that it has good reliability and validity across over a hundred studies (Wang & Gorenstein, 2013). It asks respondents to complete the measure regarding their symptoms during the two weeks prior to the administration of the measure. This second version of the BDI (BDI-II) was developed to correspond with criteria for depressive disorders in the *DSM-IV* (American Psychiatric Association, 1994). Items are on a 4-point scale ranging from 0 to 3, with 0 being least severe and 3 being most severe. Respondents are asked to indicate which statement "best describes the way [they] have been feeling during the past two weeks, including today". The specific labels for each number depend on the content of the item itself. For example, an item assessing "Self-Criticalness" is as follows: "0 – I don't criticize or blame myself more than usual."; "1 – I am more critical of myself than I used to be."; "2 – I criticize myself for all of my faults."; "3 – I blame myself for everything bad that happens." The total score is obtained by adding the individual scores from each of the items. The following are guidelines for interpreting total scores: minimal range 0-13; mild range 14-19; moderate range 20-28; severe range 29-63.

Beck Anxiety Inventory. Symptoms of anxiety were measured using the Beck Anxiety Inventory (BAI; Beck & Steer, 1990). The BAI is a 21-item self-report measure that assesses severity of anxiety symptoms during the two weeks prior to when the measure is administered. It was designed for use with adolescents and adults. It is considered to have good reliability and validity (Fydrich et al., 1992). Items are on a 4-point scale ranging from 0 = "Not At All" to 3 = "Severely – it bothered me a lot". Respondents are asked to indicate "how much [they] have been bothered by" each symptom, regarding symptoms such as "numbness or tingling", "fear of losing control", and "difficulty breathing". The total score is obtained by adding the individual scores for each of the items. The following are guidelines for interpreting total scores: minimal range 0-7; mild range 8-15; moderate range 16-25; severe range 26-63.

Psychological Sense of LGBT Community Scale. Sense of LGBTQ-specific community was measured using the Psychological Sense of LGBT Community Scale (PSOC-LGBT; Lin & Israel, 2012). It is a self-report measure that assesses various domains of an individual's experience of LGBTQ+ community, including influence, shared emotional connection, and needs fulfillment. Participants will respond to items such as "How much do you feel your opinion matters to other LGBT people?" and "How often do you feel like you belong in the LGBT community?". Items were rated on a Likert scale ranging from 1 = "None" and 5 = "A great deal". Higher overall scores indicated higher levels of sense of community and ability to depend on the broader LGBTQ+ community.

Social Isolation Scale. Social isolation was measured using the Social Isolation Scale (Nicholson et al., 2020). Though initially designed to encompass the experiences of older adults, it has also been used in more recent research with oncology patients aged eighteen years or older (Miaskowski et al., 2020). It is a 6-item self-report measure that assesses a person's perceived

connectedness with members of their social networks, including friends, neighbors, and family members. Participants respond to three items, including "How many of [your family, friends, or neighbors] do you communicate with on a personal level by phone or electronically (e.g., by email, video chat, and/or internet) at least once a month?", on a 5-point scale ranging from 1 = "None" to 5 = "6 or more". They respond to three more items, including "I feel that I spend enough time involved in social activities", on a 5-point scale ranging from 1 = "Strongly disagree" to 5 = "Strongly agree". Total scores are calculated by adding individual item scores, after reverse scoring relevant items. Thus, lower scores are indicative of higher levels of social isolation.

UCLA Loneliness Scale (Version 3). Loneliness was measured using Version 3 of the UCLA Loneliness Scale (Russell, 1996) to bolster data collected on measures assessing similar constructs, such as social isolation. It is a 20-item self-report measure designed to assess loneliness by asking participants to respond to items related to feeling lonely, alone, and socially disconnected (e.g., "How often do you feel that your relationships with others are not meaningful?") as well as reverse-coded items reflecting non-loneliness (e.g., "How often do you feel part of a group of friends?"). Participants responded on a 4-point scale ranging from 1 = "Never" to 4 = "Always". Total scores are calculated by adding individual item scores, after reverse scoring relevant items, such that higher scores are indicative of higher levels of loneliness.

Post-Intervention Questions. Questions designed to assess participants' experiences with the group therapy intervention were administered at the end of each focus group. These questions were developed in part based on the development of the group intervention itself, which in turn depended on the results of the focus groups. However, the general purpose was to

provide participants with an opportunity to discuss details about and feedback on their experience in the group, beyond the quantitative measures meant to assess for symptom changes and changes in other relevant constructs. Items used a scale ranging from "1 = Strongly Disagree" to "5 = Strongly Agree". Examples include "This group provided me with tools to make authentic connections *during* sessions" and "I feel more connected to the LGBTQ+ community after attending this group".

Participants were also offered write-in spaces to respond to four open-ended, qualitative questions meant to ascertain their experiences within, reactions to, and feedback about the group intervention, such as "If the group were to be run again, what changes would you make?".

Analysis Plan

In order to determine whether group members' mean depression, anxiety, relational health, and social isolation scores changed throughout the group intervention, I planned to accumulate evidence from various analyses, a recommendation from Cumming (2013). Cumming advocates for use of effect sizes rather than simply using null hypothesis significance testing (NHST), because NHST involves reporting statistical significance without giving readers a sense of practical or scientific significance; NHST also allows for the risk of Types I or II error, leading to erroneous conclusions. Effect sizes, on the other hand, measure the magnitude and direction of a change or phenomenon and therefore can help researchers draw clearer conclusions about their data. I planned to report Cohen's *d* effect sizes using the following estimates when comparing pre-group and post-group outcomes: 0.2 for a small effect; 0.5 for a moderate effect; 0.8 for a large effect (Cohen, 1988; Cumming, 2013). I planned to conduct a repeated measures ANOVA for each of the aforementioned outcomes across all survey administrations, including before, during, and after the group intervention. Repeated measures

ANOVA is considered appropriate for analysis of data that involves the collection of data using the same measures at multiple points over the course of the study. I further planned to report partial eta squared ($\eta^2_{partial}$) for each measure with comparisons involving more than two groups (i.e., for all timepoints across the study). $\eta^2_{partial}$ is a measure of the amount of variance in a dependent variable explained by a predictor, after accounting for all other predictors in an ANOVA. The following estimates are used for $\eta^2_{partial}$: 0.01 for a small effect; 0.06 for a moderate effect; 0.14 for a large effect (Norouzian & Plonsky, 2018).

The purpose of the qualitative questions provided to group therapy participants after the final session was different from the purpose of focus groups questions; whereas the focus groups were intended to both explore community members' experiences of LGBTQ+ community and isolation as well as provide feedback on the idea for the group intervention, the purpose of the questions following the group therapy intervention was to help assess the impacts of the intervention and modify it for future administrations. Qualitative researchers recommend tailoring analysis to the purpose and questions involved in the data (Rogers & Goodrick, 2010). Thus, for this portion of the study, a less exploratory and more practical analysis was warranted. Specifically, actionable feedback (i.e., specific recommendations that could be implemented toward the development of the final group intervention) can be considered in light of clinical best practices, group best practices, existing research, and the respondent's relevant identities, and a decision can be made on whether and how to integrate the feedback for the following iteration of the group intervention. On the other hand, I anticipated that responses that are considered descriptive but not prescriptive would be coded thematically and reported alongside final results in order to provide more nuance to the quantitative results from the interventions.

Results (Aim 2: Group Therapy Intervention)

Participants

One six-week iteration of the group therapy intervention was conducted. The group contained a total of eight participants, and seven to eight participants attended each session. Demographic characteristics of the sample can be found in Table 2.

Descriptive Statistics

Means and standard deviations of participant scores on each measure administered at each time point are reported in Table 3. All changes between the pre-group therapy survey and the post-group therapy survey were in the expected direction (i.e., in a direction suggesting improvement of helpful outcomes and reduction of distressing symptoms and outcomes).

Cohen's *d* Effect Sizes

I calculated Cohen's *d* effect sizes to measure the magnitude of the change in participants' scores on each variable between the pre-group therapy survey and the post-group therapy survey. Data from the surveys administered in the week following Session 1, Session 2, Session 3, Session 4, and Session 5 of the intervention were therefore not considered for these analyses. The following guidelines are suggested for interpretation of Cohen's *d*: 0.2 for a small effect; 0.5 for a moderate effect; 0.8 for a large effect (Cohen, 1988; Cumming, 2013).

For both the "Peer" and "Community" sections of the Relational Health Index (RHI), the effect sizes as measured by Cohen's *d* were large and changes were in the expected direction (i.e., higher relational health; $d = 1.02$ and $d = 0.90$ respectively). Changes in scores on the Beck Depression Inventory (Second Edition; BDI-II) suggested lower symptom severity over time, and the effect size was large ($d = 1.23$). Beck Anxiety Inventory (BAI) scores reflected a medium effect ($d = 0.74$) in the expected direction (i.e., reduced anxious symptom endorsement).

Table 3. Means and standard deviations on each measure administered on every survey.

	M(*SD*)						
Survey	RHI-P*	RHI-C*	BDI-II	BAI	PSOC†	SIS	UCLA
0 (Pre)	**42.8**(10.2)	**41.6**(7.0)	**21.4**(13.6)	**17.8**(13.4)	**56.1**(8.9)	**20.5**(5.3)	**53.8**(11.9)
1	45.0(10.7)	44.0(6.3)	23.7(16.4)	15.7(11.2)	56.8(10.8)	22.0(4.8)	52.8(12.8)
2	43.8(9.5)	44.1(7.3)	16.6(12.7)	13.9(11.2)	59.4(8.7)	19.1(4.6)	53.9(11.9)
3	46.4(7.5)	44.8(7.3)	20.0(17.8)	15.6(18.0)	59.4(9.4)	20.6(5.2)	52.3(10.2)
4	46.0(7.8)	45.8(7.7)	15.0(17.1)	11.8(11.7)	57.7(7.5)	20.3(4.3)	52.2(8.2)
5	46.0(10.2)	46.8(6.5)	19.2(19.9)	14.0(12.5)	60.8(11.3)	20.7(3.3)	48.7(9.2)
6 (Post)	**47.3**(8.8)	**46.8**(8.2)	**13.8**(14.4)	**9.1**(12.3)	**60.8**(8.7)	**22.4**(3.9)	**47.8**(9.2)

*RHI-P and RHI-C denote Peer and Community subscales of the Relational Health Index, respectively.
†PSOC denotes PSOC-LGBT, or the Psychological Sense of LGBT Community Scale.
Bold text is used to identify pre- and post-group survey scores used in the calculation of Cohen's *d* effect sizes.

The change in Psychological Sense of LGBT Community Scale scores represented a medium effect ($d = 0.59$) suggesting stronger sense of community, as did Social Isolation Scale scores ($d = 0.68$), suggesting lower levels of isolation. Finally, the decrease in in UCLA Loneliness scores indicated a large effect of the intervention ($d = 0.99$).

Overall, these effect sizes suggest that the group therapy intervention contributed to meaningful decreases in measures of depressive symptoms, anxious symptoms, loneliness, and social isolation, as well as meaningful increases in relational health (i.e., across peer relationships and community relationships) and sense of LGBTQ+ community.

Repeated Measures ANOVA and Partial Eta Squared

Consistent with the analysis plan, I also conducted repeated measures ANOVA using data on each measure administered across surveys before, during, and after the group therapy intervention (i.e., at seven points in time). Partial eta squared ($\eta^2_{partial}$) is reported alongside the ANOVA results as a measure of effect size. The following guidelines are used to determine size of each effect: 0.01 for a small effect; 0.06 for a moderate effect; 0.14 for a large effect (Norouzian & Plonsky, 2018).

The RHI "Community" subscale score differed across time points during the study, showing a large effect of the intervention ($F(6, 6) = 5.06$, $\eta^2_{partial} = 0.84$) and indicating increased community-related relational health (see Figure 1). The RHI "Peer" subscale score differed across time points during the study, showing a large effect of the intervention ($F(6, 12) = 1.21$, $\eta^2_{partial} = 0.38$) and indicating increased relational health within a peer relationship (see Figure 2). The BDI-II score differed across time points during the study, showing a large effect of the intervention ($F(6, 6) = 0.94$, $\eta^2_{partial} = 0.48$) and suggesting a trend toward reducing depressive symptoms (see Figure 3). The BAI score differed across time points during the study, showing a

large effect of the intervention ($F(6, 6) = 1.43$, $\eta^2_{partial} = 0.59$) suggesting a trend toward reducing anxious symptoms (See Figure 4). The PSOC-LGBT score differed across time points during the study, showing a large effect of the intervention ($F(6, 6) = 1.23$, $\eta^2_{partial} = 0.55$), such that sense of LGBTQ+ community increased over the course of the study (see Figure 5). The SIS score differed across time points during the study, showing a large effect of the intervention ($F(6, 12) = 1.77$, $\eta^2_{partial} = 0.47$) and indicating a reduction in social isolation (see Figure 6). The UCLA Loneliness score differed across time points during the study, showing a large effect of the intervention ($F(6, 6) = 3.72$, $\eta^2_{partial} = 0.79$), such that participants reported less loneliness over the course of the intervention (see Figure 7).

Intervention Feedback

I calculated relevant descriptive statistics for the measures designed specifically to assess participant feedback about the therapy group using a 5-point (i.e., 1 = Strongly Disagree to 5 = Strongly Agree) Likert scale. On the item "This group met my needs", the mean score was 3.25 ($SD = 0.89$). On the item "This group provided me with tools to make authentic connections *during* sessions", the mean score was 3.00 ($SD = 1.51$). On the item "This group provided me with tools to make authentic connections *outside of* sessions", the mean score was 4.00 ($SD = 0.93$). On the item "I feel more connected to the LGBTQ+ community after attending this group", the mean score was 3.25 ($SD = 0.89$). On the item "I did not benefit from attending this group", the mean score was 1.88 ($SD = 0.64$). On the item "I enjoyed attending this group", the mean score was 3.88 ($SD = 0.83$). Finally, on the item "This group increased the quality of relationships in my life", the mean score was 3.63 ($SD = 0.74$).

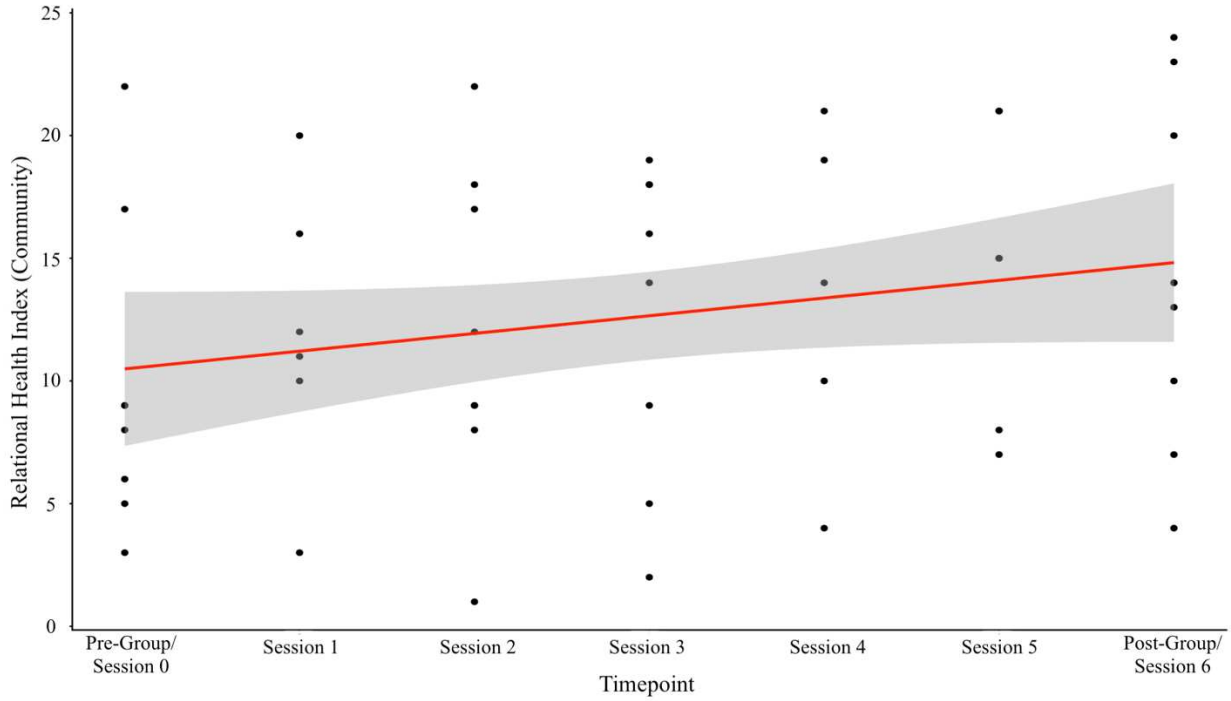

Figure 1. *Relational Health Index (RHI; Community Subscale) Scores Across Timepoints*
Note. The red line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent higher levels of relational health.

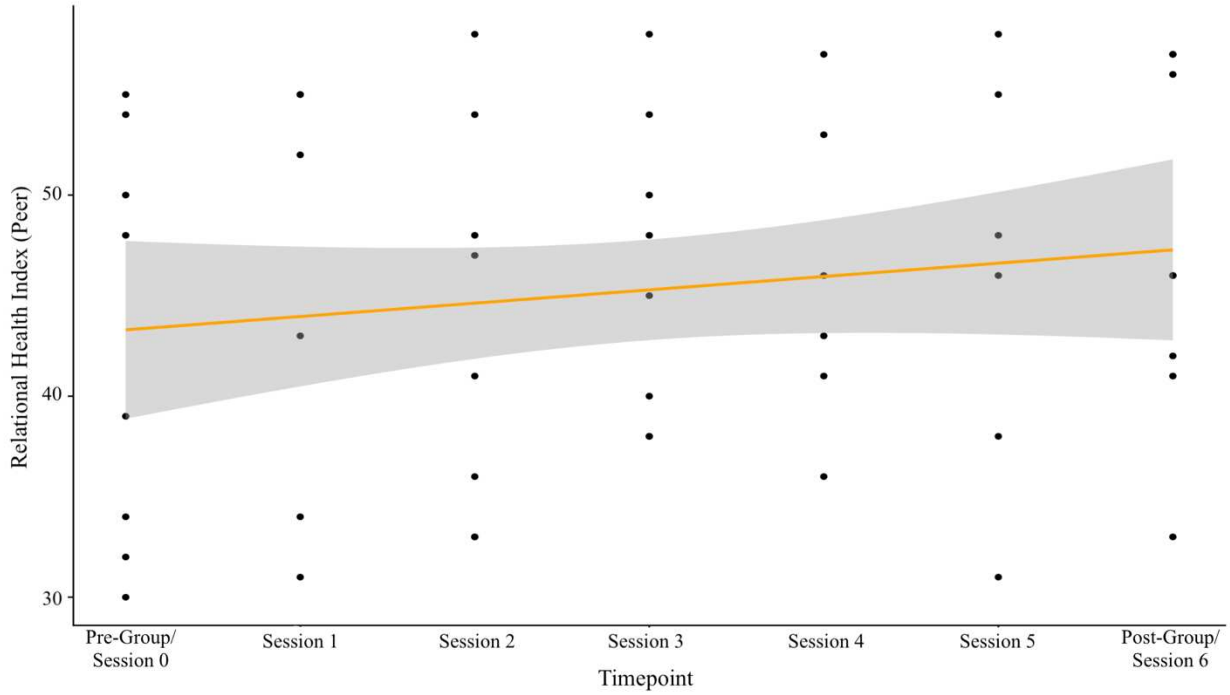

Figure 2. *Relational Health Index (RHI; Peer Subscale) Scores Across Timepoints*
Note. The orange line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent higher levels of relational health.

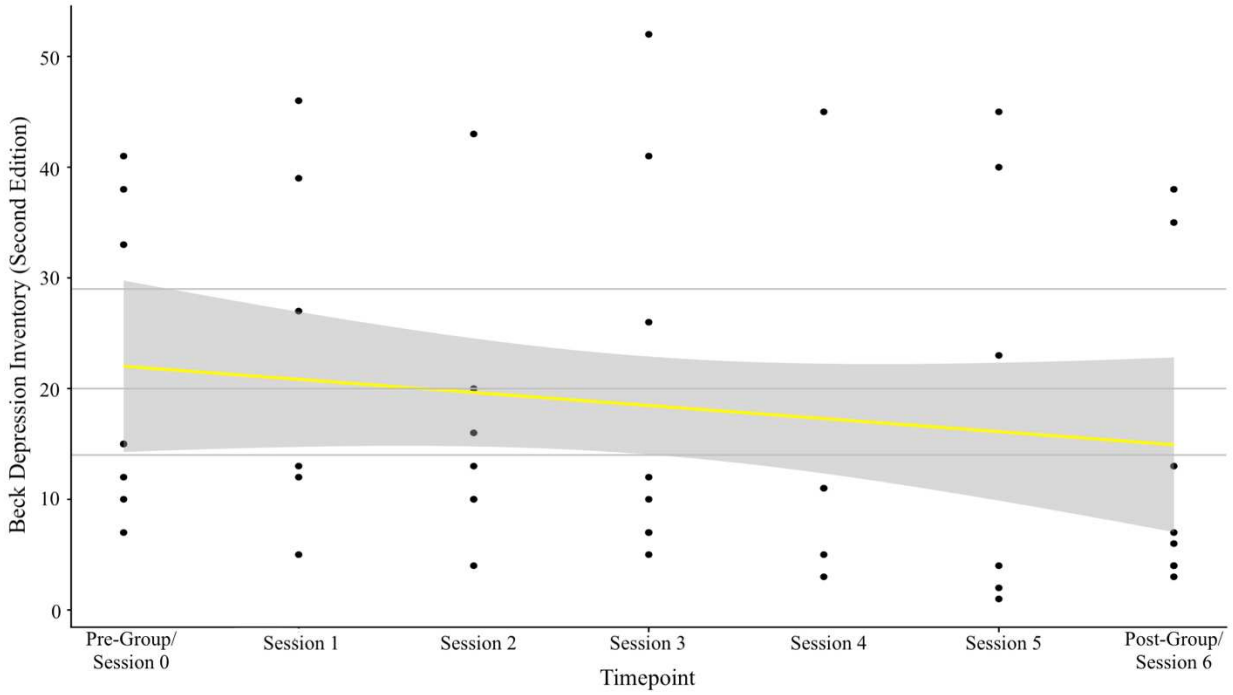

Figure 3. *Beck Depression Inventory (Second Edition; BDI-II) Scores Across Timepoints*
Note. The yellow line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent higher levels of symptom endorsement. The thin horizontal gray lines represent clinical cutoff points for severity ranges of BDI-II scores (0-13 minimal, 14-19 mild, 20-28 moderate, 29-63 severe).

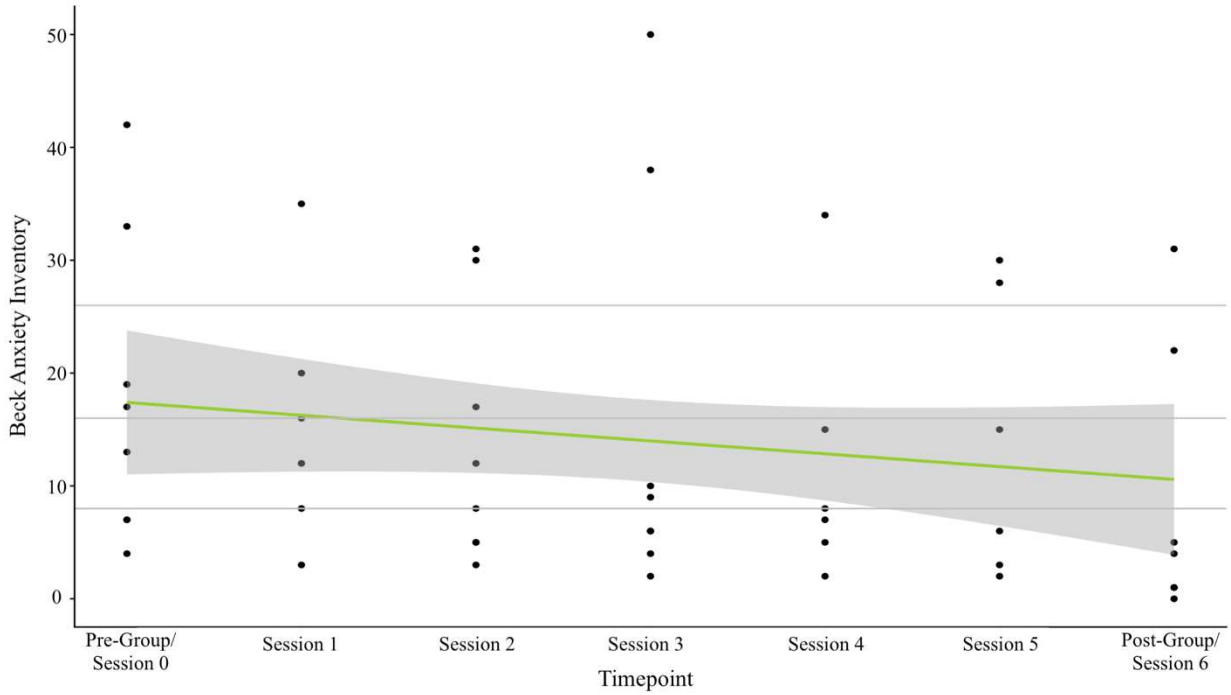

Figure 4. *Beck Anxiety Inventory (BAI) Scores Across Timepoints*
Note. The light green line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent higher levels of symptom endorsement. The thin horizontal gray lines represent clinical cutoff points for severity ranges of BAI scores (0-7 minimal, 8-15 mild, 16-25 moderate, 26-63 severe).

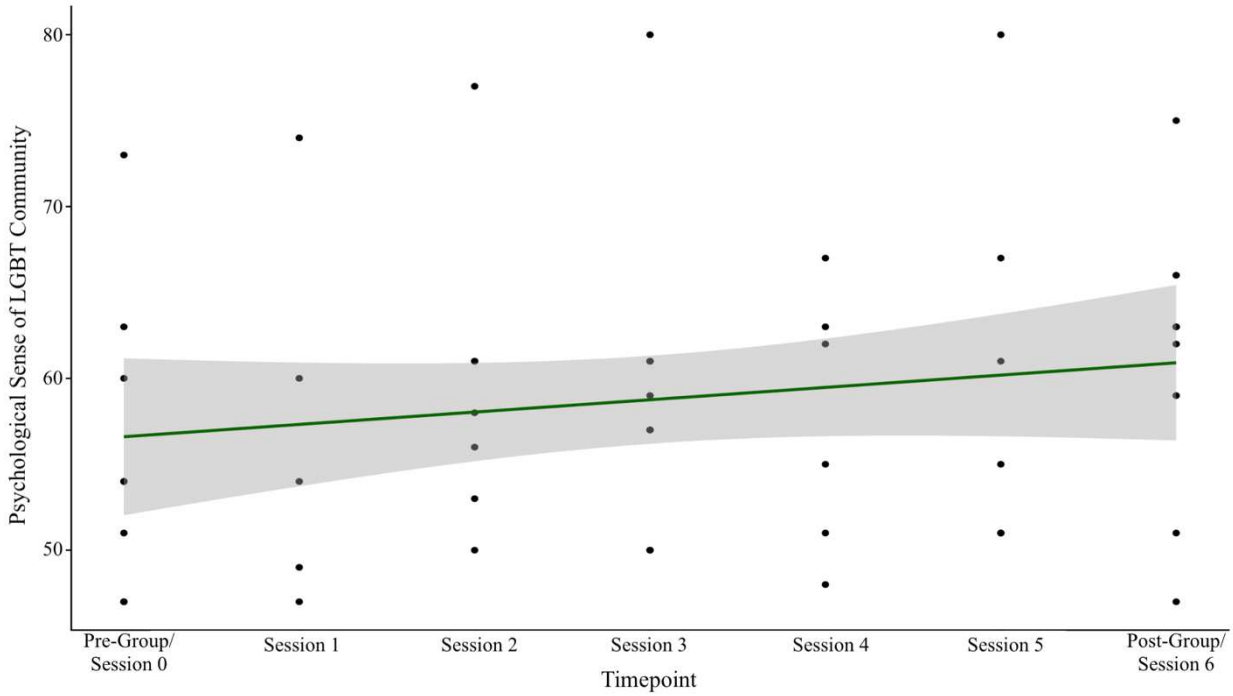

Figure 5. *Psychological Sense of LGBT Community (PSOC-LGBT) Scale Scores Across Timepoints*

Note. The green line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent stronger sense of community.

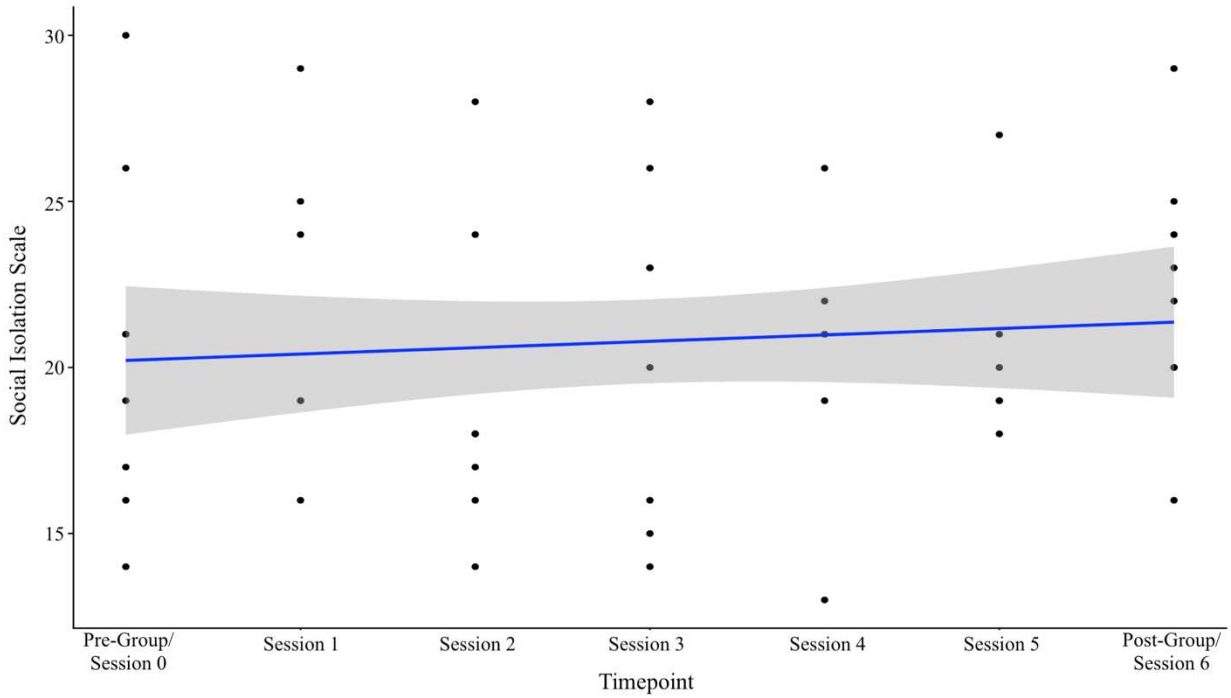

Figure 6. *Social Isolation Scale (SIS) Scores Across Timepoints*
Note. The blue line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent lower levels of social isolation.

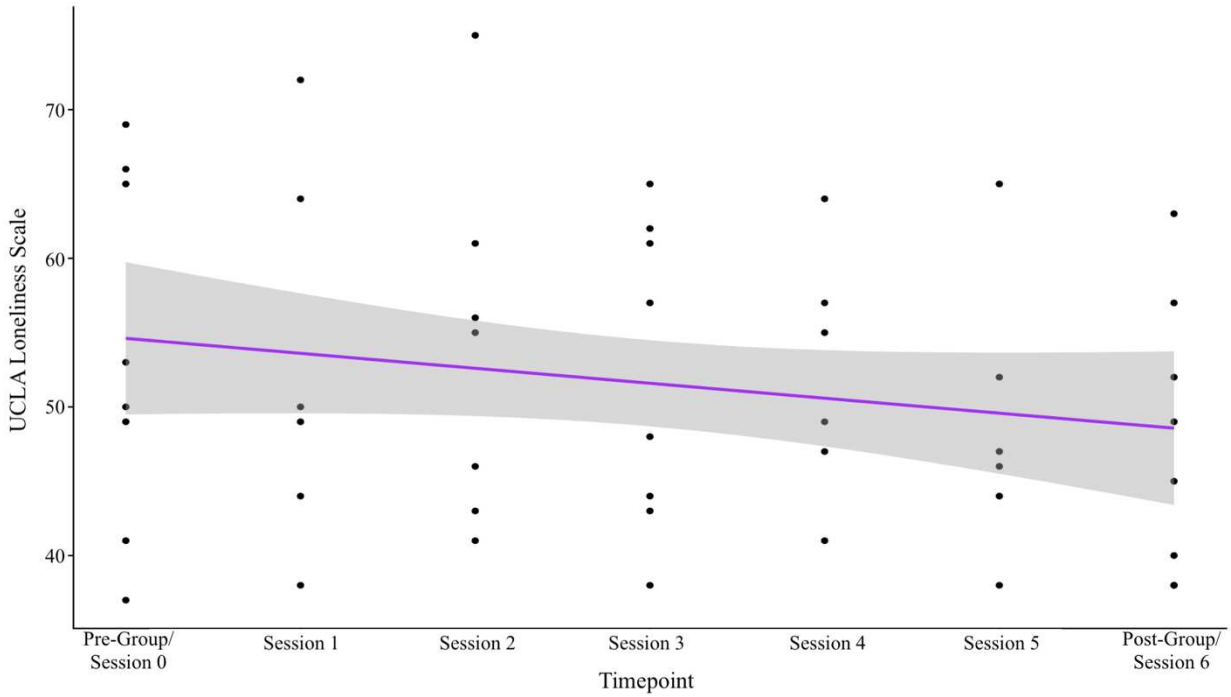

Figure 7. *UCLA Loneliness Scale Scores Across Timepoints*
Note. The purple line represents a trend line fitted to the data, and the gray band represents a 95% confidence interval for predictions from a linear model. Higher scores represent higher levels of loneliness.

Participants were also provided opportunities to offer qualitative feedback on the group. Full responses are listed in Appendix K. A brief summary of the responses suggests the following themes. First, participants largely reported an overall positive experience in the group. Multiple participants noted that it was helpful to hear others' experiences, learn specific skills, receive advice and suggestions, and engage in activities like creating word webs together. Participants reported struggling with the flow of conversations between group members and wishing for interactions to feel more organic. Focus group members made some suggestions for improving the group, including longer sessions, more sessions, longer time (i.e., two weeks) between sessions, more "team building" and fun conversation topics, offering a model of a successful group session at the beginning, and adapting the group for in-person administration.

Discussion

In this study, I first sought to explore the experiences of LGBTQ+ young adults related to connection to and disconnection from queer community. Although prior research has highlighted the importance of social support and LGBTQ+-specific connections for LGBTQ+ mental health, few studies have qualitatively investigated the nuances of these experiences. Given that social support and community connection are understood to support mental wellness, exploring these experiences among LGBTQ+ young adults and helping facilitate such connections may help bridge any remaining mental health disparities between LGBTQ+ individuals and their non-LGBTQ+ peers. Especially considering the role of the field of psychology in historically pathologizing LGBTQ+ identity, it was critical to the project that the development of a group therapy intervention aimed at increasing connection and improving mental health outcomes be responsive to the actual stated needs and experiences of the community it was designed to support. Thus, with the aim of developing and administering a group therapy intervention in mind, I first collected focus group data with LGBTQ+ young adults (age 18 to 29) in Colorado to gain an understanding of their desires and past experiences of connecting with other LGBTQ+ community members, as well as their experiences of disconnection. The results from this portion of the study were intended to be used to directly inform the development of the group therapy intervention in Aim 2. However, the results from Aim 1, especially from the first half of each focus group, also stand alone in representing yet underexplored aspects of LGBTQ+ young adult experiences and hopes for connection.

Results from these groups often coincided with and added depth to findings from existing literature. For example, prior literature has suggested that, while general social support is helpful to mental health for LGBTQ+ individuals, obtaining support from other LGBTQ+ community

members offers additional rewards (Doty et al., 2010). Indeed, participants reflected many rewarding elements of connecting with others who share an LGBTQ+ identity. They discussed the connectedness that comes from sharing identity-related experiences, even discriminatory ones, with people who understand and have similar stories. They noted the reduced burden of explaining their identities to other queer individuals compared to non-LGBTQ+ peers. Some described a "coincidental" and "magnetic" force that draws queer people to one another and allows them to find one another even in unlikely spaces. Because connection with other LGBTQ+ individuals can offer such robust benefits, these findings underscore the importance of interventions that help young adults cultivate the kinds of relationships and communities that offer them.

Focus group results regarding barriers to connection also echo existing literature. Consistent with calls for intersectionality across psychology literature and LGBTQ+-specific research, and consistent with a vast body of literature noting the detrimental effects of "-isms" and phobias within and beyond the LGBTQ+ community (e.g., racism, fatphobia, transphobia; Sadika et al., 2020), participants themselves acknowledged how various forms of discrimination and overall lack of attention on intersectionality in queer spaces were harmful and created exclusion. Focus group participants' reflections on lack of proximity to community, especially as exacerbated by the COVID-19 pandemic, were consistent with recent literature suggesting unique challenges faced by LGBTQ+ young people who had to return to unsupportive home environments early on in the pandemic (e.g., Barrientos et al., 2021; Fish et al., 2020; Salernos et al., 2020). However, focus group findings related to barriers to LGBTQ+ community also offer novel and nuanced information that can be of use to LGBTQ+ individuals, queer-affirming clinicians, and other service providers alike. For example, the codes developed from the focus

groups explored various fears held by LGBTQ+ young adults when approaching relationships, including fear of rejection, fear of harming others, and fear of being perceived as "not queer enough", underscoring the complexity of emotion that underlies lack of engagement with opportunities for connection.

It is important to consider the findings on barriers in tandem with the findings on contributors to connection. The sheer number as well as the nature of the barriers discussed suggest that, even in the presence of various contributors to connection, LGBTQ+ individuals are likely to have experiences that still prevent them from connecting effectively with community. For example, even individuals presented with accessible community spaces and welcoming and affirming individuals with shared identities and experiences may still hold back from authentic connection out of fear of rejection or fearing of harming others, for example. Individuals may have access to safe, robust, celebratory online community but lack the in-person connection they crave – due to lack of accessible spaces, lack of nearby community, or understandable fear of discrimination within local community spaces. Thus, interventions that simultaneously offer considerations for increasing contributors and reducing barriers are likely to be most helpful.

Beyond informing the group therapy intervention developed for this project, I believe the focus group responses suggest numerous opportunities for other forms of understanding, intervention, and support. For example, although it may not be feasible for this therapy group to offer casual, public spaces for connection – especially considering the virtual format of this iteration of the group – various focus group participants expressed a desire for more physically accessible LGBTQ+ spaces for connection that did not center alcohol consumption and other forms of substance use. However, organizations and groups could certainly use this data to support the creation of spaces like this. Furthermore, some participants lamented the high

demand and low supply of existing programs and spaces meant to support LGBTQ+ community members, such as the all-gender housing floor at one university; one participant called for the expansion of such programs, acknowledging that many programs and resources exist and function well to meet some community members' needs but may require growth and additional support to address the needs of even more LGBTQ+ individuals.

I also solicited feedback from focus group participants about ideas for the group therapy intervention; many of these ideas indeed helped inform the actual intervention. Certain suggestions were already aligned with best practices for group therapy and best practices for LGBTQ+-affirming therapy. For example, participants suggested the development of co-created group guidelines and referenced the maintenance of privacy and confidentiality, which are already recommended and even necessary practices for therapy groups (Goodrich & Luke, 2015). Participants also made suggestions for the group that extended beyond existing literature and suggested ways that the intervention could meet their specific needs as LGBTQ+ young adults seeking a space to address connection and disconnection. Suggestions that were feasible and consistent with the intent of the group were adopted; for example, some focus group participants hoped for strategies for seeking affirming spaces and navigating non-affirming spaces, which were integrated as group therapy intervention topics. Others requested that facilitators provide relevant resources to group members at the end of the group; indeed, facilitators used this suggestion to check in with actual therapy group members and offer resources tailored to their requests (see Appendix J). Among the most widely discussed and supported suggestion for the therapy group intervention among focus group participants was the notion of creating optional opportunities for group members to connect with one another after the group ended, which was implemented during the pilot group.

The group therapy intervention protocol represents a novel intervention developed specifically for LGBTQ+ young adults. Because it fills an understudied gap in the literature, because it was developed in response to direct feedback from regional (i.e., in Colorado) community members, and to uphold values of clinical practice based on evidence, it was of the utmost importance to collect various forms of data on the effects of the intervention.

The quantitative data provides preliminary evidence that scores across measures meaningfully changed over the course of the intervention, reflected both in Cohen's *d* effect sizes from pre- and post-group data as well as $\eta^2_{partial}$, reported alongside the repeated measures ANOVA results. All changes were in the expected direction, suggesting that the intervention was effective in reducing symptoms of depression, symptoms of anxiety, social isolation, and loneliness. Similarly, it appears the intervention was effective in increasing relational health across community and peer domains, as well as increasing sense of LGBTQ+ community among participants. Because loneliness, social isolation, and sense of LGBTQ+ were primary targets of this intervention, these effects were of particular importance and help validate that the therapy group was functioning as intended.

Both the BDI-II and BAI are associated with clinically relevant ranges of symptom severity; thus, the changes in mean scores on these measures across the span of the intervention can be interpreted in light of these categories. In both cases, mean scores from before the intervention placed participants on average in the moderate range of symptom severity for both depression (BDI-II; $M = 21.4$; moderate range: 20-28) and anxiety (BAI; $M = 17.8$; moderate range: 16-25) and in the minimal to mild range after the end of the intervention for depression (BDI-II; $M = 13.8$; minimal range: 0-13; mild range: 14-19) and anxiety (BAI; $M = 9.1$; mild range: 8-15). These changes suggest the possibility for the group therapy intervention to reduce

symptoms of diagnoses like Major Depressive Disorder and Generalized Anxiety Disorder. Although the intervention was not designed as a diagnosis-specific group, this finding, if replicated, may suggest that the group is an appropriate form of treatment for certain mood disorders among LGBTQ+ young adults.

As this was a proof of concept study to establish feasibility, it was not within the scope of this study to explicitly test longitudinal effects or mediation/moderation models. However, considering the moderate and large effects noted in this study, future research should explore the processes by which change occurred with a larger sample. The interaction between symptoms of depression and other outcomes like social isolation, sense of community, and loneliness, for example, may dynamically influence one another. For example, a reduction in depression symptoms could be attributed to increased engagement in social relationships, and a reduction in depression symptoms for other reasons may help a person engage socially, making it difficult to note clear directionality of effects. In the context of this study, and using RCT as a theoretical model, I posit that symptoms of depression and anxiety showed reductions in response to the increase in connection with community. In other words, I anticipate that outcomes like relational health (RHI), sense of community (PSOC-LGBT), loneliness (UCLA Loneliness), and social isolation (SIS) may partially mediate the effect of the intervention on depression (BDI-II) and anxiety (BAI) outcomes. However, further research is needed to confirm these conjectures and further explore relationships among variables. Additional research conducting this intervention may also explore session-to-session changes in outcomes, which could serve to supplement qualitative data from participants on the elements of the intervention that they found particularly helpful or unhelpful.

Another finding worth noting is lack of attrition within this study. Seven individuals attended the first group meeting, and an eighth participant expressed interest in joining for the duration of the group but missed the first session due to a scheduling conflict. Various other group members missed one session over the course of the six weeks, and in all but one instance, participants let co-facilitators know in advance of the session and re-joined the group following their scheduling conflicts. Seven participants attended the final session, and the one missing participant informed co-facilitators of the anticipated absence due to a scheduling conflict. While firm conclusions about the intervention cannot be drawn based on this relative lack of attrition, it is worth noting that the rate in this study is substantially lower than attrition rates estimated in group therapy in other contexts, which may range from 20% to 63% (Gulamani et al., 2019).

Overall, results from Aim 2 are promising and suggest a successful proof of concept. As with any novel intervention, further research with a broader range of participants, larger sample sizes, and increased standardization is needed to continue honing and establishing the intervention as based in evidence. First, this project was designed with the understanding that the therapy group would be supervised by Dr. Mark Prince, who is a licensed psychologist in Colorado (PSY.0004925), meaning that all therapy group participants would need to be located in Colorado for each session of the study. Thus, we elected to recruit participants for the focus groups from the same demographic categories, including Colorado residents. It is unclear whether Colorado holds meaningful differences from other states that would suggest that LGBTQ+ young adults there would report distinctly different experiences and needs relative to LGBTQ+ young adults in other geographic locations throughout the U.S. and beyond. It is beyond the scope of this project to name all of the anti-LGBTQ+ legislation recently passed and/or currently being advanced in state legislatures across the country, but it is worth

acknowledging the cultural and political factors that vary by state and may make both the focus group and therapy group data somewhat less generalizable or useful to LGBTQ+ young adults in meaningfully different states or regions.

Because of the nature of this project as a proof of concept, offering only one iteration of the Aim 2 therapy group, the sample size is understandably small, further limiting generalizability of results. As depicted in Table 2, the sample of therapy group members showed meaningful diversity and variation among certain identities; for example, half of participants self-identified with trans and non-binary identities while the other half identified as cisgender. However, other elements of the sample reflected relative homogeneity, with a majority of participants self-identifying as White. Especially considering the focus group results regarding the prevalence of "-isms" and phobias within the queer community, as well as the collective acknowledgment from participants of the importance of intersectionality, it is critical that the therapy group, if expanded, be tested among a sample that is diverse across all intersections of identity. Although the focus group participants showed a broader range of racial identities relative to group therapy participants, it may still be worth collecting intentional focus group data from samples with exclusively non-culturally dominant racial and/or ethnic identities to ensure appropriateness of the intervention for the most marginalized within the LGBTQ+ community.

Future research on this and similar interventions should consider collecting data from participants at various timepoints after the end of the therapy group. Since the group is intended to prompt participants to reflect on their experiences of connection and disconnection and provide them with insights and tools aimed at supporting further connection – both with other group members and with LGBTQ+ community members outside of the group – an especially successful iteration of the intervention may reflect further increases in measures of relational

health and sense of community as well as decreases in loneliness and social isolation, for example. An exploration of the long-term effects of the intervention in shifting participants' levels of and quality of connection by following participants for a set time after the study would also help establish the intervention's potential for spurring sustainable change among group members.

Another interpretive consideration for this study is the lack of control group. Especially for a proof of concept study such as this one, comparison of outcomes between pre- and post-group surveys is appropriate. However, to further investigate the effectiveness of the intervention, future research could compare outcomes to a control group, such as a waitlist control condition, a treatment as usual condition, or an existing, established group therapy intervention.

Furthermore, although the group therapy protocol has since been revised to reflect the changes made between the drafting of the protocol and the actual group content and process, it has not yet been updated to reflect changes suggested by Aim 2 participants in the final session of the group as well as in the anonymous qualitative feedback. Decisions on which elements of participant feedback to integrate should be done with intention and careful consideration of intervention goals, group therapy best practices, and LGBTQ+-affirming therapy practices, just as the initial protocol was developed from focus group responses. Indeed, the qualitative feedback and discussion from the final session of the therapy group is likely to be even more valuable than focus group data in informing the group protocol; whereas focus group participants were asked to provide feedback based on a very brief and general description of the hypothetical and yet-undeveloped group intervention, actual therapy group participants engaged in the group and could speak directly to their experiences within the group. Collectively, they shared various

interesting suggestions for improving the effectiveness of the intervention. For example, group members discussed the idea of extending the duration of the group and hosting sessions that alternated between discussion, presentation of skills, and – a novel component – space to practice implementing the insights, skills, tools, and suggestions presented in prior group sessions, perhaps in smaller subgroups or pairs of therapy group members. Others suggested a week off between sessions so that group members could implement these insights and skills in their existing and new relationships outside of the group.

Alongside the understandable limitations and need for replication with the aforementioned considerations in mind, the results from this study represent a meaningful extension of prior literature on queer-affirming therapy, relational-cultural theory, and the importance of connection to community. Considering that mental health disparities remain between LGBTQ+ individuals and their non-LGBTQ+ counterparts in terms of common concerns such as depression and anxiety (Bostwick et al., 2010), an intervention demonstrating some symptom reduction in these domains is one way to continue reducing disparities and bolstering options for LGBTQ+-affirming group therapy. Prior literature has demonstrated ways in which outcomes like depression and anxiety may occur together with disconnection from others (Noguchi et al., 2021; Saris et al., 2017; Sherry et al., 2008); similarly, this study showed depression and anxiety symptoms decreasing in response to an intervention aimed at deepening connection to others both within and outside of the study. This is also consistent with LGBTQ+-specific research outlining ways in which queer individuals are uniquely prone to disconnection from self and others due, in part, to understandable and sometimes adaptive interpersonal responses to lack of acceptance from others (Asakura & Craig, 2014). The mere interest in participation in an intervention aimed at increasing connection and reducing isolation among

LGBTQ+ young adults suggests how the desire for safe and healthy connection persists among members of this community.

On a positive note, existing psychological literature has demonstrated the helpful effects of connection to community in supporting mental health among LGBTQ+ people (Asakura & Craig, 2014; Doty et al., 2010; Poteat et al., 2012). This literature was somewhat limited, exploring just a few ways in which LGBTQ+ individuals successfully seek and find helpful connection (e.g., GSAs, peer networks, informal connections). The focus group data expanded this literature by allowing participants to discuss numerous forms of and contributors to connection as well as relevant barriers, adding depth to our understanding of how successful connections are formed among LGBTQ+ young adults and what needs are yet unmet within the community on this topic. The group therapy intervention was developed in response to community members' stated needs, interests, and experiences and represents an integration of these needs alongside a growing body of literature operationalizing relational-cultural therapy (RCT) practices. Although the intervention was not purely based in RCT principles and practices, as it integrated ideas from focus groups as well as concrete tools and skills from other theoretical frameworks, the themes addressed in the group protocol reflect many of the crucial components of RCT. Furthermore, results suggest that the intervention indeed may change the strength of outcomes relevant to RCT's goals, such as increasing sense of LGBTQ+ community and decreasing loneliness and social isolation. Currently, research on applying RCT to the LGBTQ+ community is limited, with some articles discussing RCT principles in relation to clinical work with LGBTQ+ individuals (Flores & Sheely-Moore, 2019; Singh & Moss, 2016) but not developing concrete, implementable intervention protocols to be tested. This study is therefore a unique contribution to the field, extending theory into practice.

In addition to interpretations of concrete data and observations on attendance reflected in results and discussion, I am also including here my own personal reflections on the group as a researcher and co-facilitator of the group. Indeed, the data confirmed my sense of the group as a place where participants were able to develop insights and meaningful progress toward goals related to connecting with others both inside and out of the group. Overall, participants appeared to connect well with each other and consistently adhered group rules related to inclusive, respectful language and communication. Many expressed resonance with one another's stated experiences, and even when specific experiences differed, co-facilitators and participants alike helped validate all experiences make connections between stories. At times, communication between participants was slower and appeared awkward; this was reflected in some of the feedback suggesting more time and prompts for getting to know one another at the beginning and throughout the intervention, to increase comfort and familiarity when discussing the group topics around connection and disconnection. I suspect that this was also related to the virtual format of the groups. Although we requested that participants leave their cameras on as much as possible to approximate an in-person group therapy experience more closely, co-facilitators were flexible with enforcement of this guideline, erring on the side of respecting participants' boundaries around participation and visibility. However, this may have contributed in some ways to the moments where participants may have struggled to connect or communicate more freely. When participants did appear more closely connected with one another, it was often during times of reflecting on shared experiences and acknowledging the positive impact of another participant on them (i.e., mutual empathy). Earlier on in the intervention, co-facilitators made more of an effort to offer validation, reflections, and connections between topics; over the course of the group, participants appeared better able to make these connections and reflections on their own.

Participants also shared their own tips and suggestions for making connections and addressing barriers to connection, which appeared helpful to bolster suggestions and psychoeducation directly from facilitators. Co-facilitators noted that, at times, certain older participants (age 26) appeared to take on a mentorship-adjacent role, especially toward the youngest member of the group (age 18), offering more solutions, suggestions, and support as opposed to using the space for their own processing.

Generally, most elements of the intervention were well-received by participants. The co-created word web about contributors to connection in Session 2 went especially well, with participants reflecting that it helped them feel hopeful early in the intervention, which seemed important to effectively navigating later conversations that focused more on barriers to connection and prior difficult experiences. One intervention in particular did not work out well – namely, the attempted collaborative creative project introduced in Session 5; see Appendix E for details on the intended intervention and Appendix F for a description of how the final sessions were modified in response to this. This activity represented an attempt to integrate Aim 1 focus group data recommending that group therapy participants engage in a collaborative creative project together at the end of the intervention; however, the virtual format of the group was not conducive to this activity and the attempted adaptation did not seem to be of interest to group members. Despite these limitations of the virtual format, I imagine that it supported attendance because of the flexibility it offers. Participants in the group lived in various cities and towns within Colorado, and it was exciting that the virtual format allowed for group members to connect across distance. Results affirmed that a virtual format for this therapy group is feasible and can be effective at facilitating helpful outcomes, even despite limitations.

Based on participant feedback and my own clinical perspective, the following recommendations are for future facilitators of this group protocol. First, I recommend providing consistent opportunities for group members to connect and get to know one another holistically throughout the intervention, especially at the beginning of the group. Open-ended, unstructured time to get to know one another may be facilitative of more open, engaged, and authentic conversations later on in group (Yalom & Crouch, 1990). Second, I recommend that co-facilitators engage in validation, modeling, and facilitation of conversation and mutual empathy among participants; however, I also recommend co-facilitators do this intentionally and sparingly, allowing space for participants to naturally engage with each other in these ways, which may be especially impactful for group members. Similarly, I recommend that facilitators allow space for a combination of participant-provided and facilitator-led suggestions for navigating disconnection and increasing connection. Facilitator-led suggestions can also be derived from group-specific needs. I recommend checking in with group members about their specific needs and hopes and tailoring the specific tools, skills, and resources to these stated hopes and needs. Should the group be facilitated virtually in the future, I recommend adapting or not using the collaborative creative project activity. In either a virtual or in-person format, it may be helpful to check in with group members about feasible and interesting ideas for a collaborative project to engage in together, which may be more meaningful than responding to instructions from facilitators.

Next, I suggest careful consideration around facilitator selection. Of course, any facilitator or co-facilitator of this group must be adequately trained in counseling and familiar with LGBTQ+ experiences, terminology, and affirming mental health practices. It is highly recommended that facilitators hold LGBTQ+ identities; this was requested by many focus group

participants and allowed for the creation of a space completely free from the possibility of harm from non-LGBTQ+ individuals. For non-LGBTQ+ individuals interested in facilitating this group, I suggest first ensuring that your participation in this group would not be taking opportunities away from LGBTQ+ clinicians. Furthermore, I suggest deep reflection around reasons for facilitating the group as well as around your actual knowledge and comfort directly addressing LGBTQ+ issues and topics. In this group, participants and facilitators discussed many nuances of the LGBTQ+ experience that may not be understandable or accessible to non-LGBTQ+ individuals, as they are not well-researched or presented in the literature on culturally competent care. Non-LGBTQ+ facilitators should seek supervision and consultation with LGBTQ+ clinicians as appropriate throughout the course of the group.

Finally, I recommend that facilitators decide with intention whether they will run the intervention virtually or in-person. I believe that the virtual Zoom format of this study offered many benefits, including flexibility, accessibility, comfort, and agency around participation (i.e., allowing for the possibility of entering a break-out room without explanation to connect or debrief with a facilitator). On the other hand, the virtual format also had limitation, including difficulty connecting organically (i.e., due to lack of body language, difficulty reading social cues, and general disconnection from attempting to interface through a screen) and lack of feasibility for engagement in a collaborative creative project to end the group. The virtual group allowed for participation from individuals across various locations within the state, which could be seen as both a benefit (i.e., connecting with others that participants would not normally have the opportunity to meet) and a limitation, considering that many group members were interested in maintaining connection with one another after the group and would encounter more barriers to doing so with individuals who lived far from them. Similarly, an in-person iteration of this group

may have benefits and limitations. Benefits would likely involve more organic and natural connection with group members and facilitators due to lack of screens and increased ability to perceive body language and social cues. However, in-person groups may also pose barriers to accessible therapy, as considerations for scheduling, transportation, and physically accessible gathering space must be made. Even well-intentioned decisions about space and scheduling may inadvertently exclude potential group members, especially financially marginalized members of the LGBTQ+ community. Facilitators should consider these advantages and disadvantages carefully and attempt to minimize disadvantages as much as possible with either choice.

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Appendix A

An example of a letter of support, which I attempted to solicit from all collaborating organizations but received from only some of the organizations who agreed to share flyers related to recruitment for this study.

June 23, 2021

Shelby D. Tuthill, M.S.
Graduate Student
Counseling Psychology
1876 Campus Delivery
Fort Collins, CO 80523

Dear Shelby,

It is our pleasure to sign this letter in support of your doctoral dissertation project, "Building connection and reducing isolation: A group therapy intervention for LGBTQ+ young adults", which will be conducted by you, Shelby Tuthill, M.S. and supervised by your academic advisor, Dr. Mark Prince (License PSY.0004925). This project will contribute to the development of a culturally sensitive group therapy intervention aimed at building a sense of community and support among LGBTQ+ young adults. We support this project as we believe this is important to the mental health and wellbeing of LGBTQ+ people, including the LGBTQ+ people that our organization serves.

We are committed to supporting this project by distributing flyers and other material (e.g., digital recruitment ads) for the recruitment of participants. We intend to distribute these materials to relevant groups and individuals served by our organization. We will distribute two separate sets of materials to support recruitment for focus groups, as well as recruitment for the group therapy intervention itself.

We understand that participants will be compensated for their participation in either part of this study and will be informed of the potential risks and benefits of the study before they decide to participate. In sum, we look forward to supporting this important project, by aiding in recruitment of participants for focus groups and therapy intervention groups.

Sincerely,

Everett Gonzales, Jr.

Everett Gonzales, Jr.
President - Northern Colorado Equality
970-396-0851
northerncoequality@gmail.com

Appendix B

Script for co-facilitators to follow when introducing and facilitating focus groups, reflecting most recently updated script (i.e., reflecting changes made in response to feedback from co-facilitators and focus group participants).

Introduction: Hello, everyone! Thank you for being here today, we really appreciate you taking time out of your busy schedules to be a part of this project. Each of you has been asked to participate in this group because we believe you have unique and important contributions to make, and we are eager to learn from you all today. My name is [insert name of co-facilitator] and my pronouns are [insert co-facilitator's pronouns if comfortable sharing]. [switch facilitators] My name is Shelby and my pronouns are she/her. I am a graduate student at Colorado State University and I do research focused on LGBTQ+ mental health. [switch back to co-facilitator]

Introductions: Let's start by introducing ourselves – then in a moment I'll go over the ground rules of this group. As you may remember, you are not required to disclose your actual name to the other participants during this focus group to maintain your own privacy and confidentiality. However, as we get to talking, other group members may want to reference something you said. Please provide a name – yours, or a fake name chosen for this study – and, if you want, please also share the pronouns you would like us to use to refer to you during this study. You can also share a fun fact about yourself if you want!

[complete introductions]

Purpose: The purpose of this time together is to explore the experiences you all have had in terms of being connected or disconnected to the broader LGBTQ+ community. We will also ask for some feedback and input about an idea for a group therapy intervention for LGBTQ+ young adults.

Timeframe and Confidentiality: This group should last approximately an hour and a half. Our discussion today will be audio recorded for transcription purposes, and all of your names will be kept confidential by the researchers. We ask that you help maintain the confidentiality of other participants by not discussing what we talk about today with other people, or who the other participants were.

Ground Rules: Before we start, I'll talk a bit about the structure of the group. One of us will ask a question to the entire group, and then you all will have a conversation with each other answering the question. There are approximately 15 questions we want to address, so I will let you all know when it is time to wrap up one conversation and move on to a new question. However, you are welcome to talk back and forth more than once on a given question. We will also be posting the questions in the Zoom chat. If I interject at other points to move the conversation in a specific direction, please know that it is in the interest of time or making sure all participants have the chance to contribute. There are no right or wrong answers here, and your experiences, beliefs, and opinions are all valid. You might find that you resonate with much of what other group members share, or your experience might be quite different. We want to get a

sense of both shared and not shared experiences and opinions. It might feel uncomfortable at first to share a thought that does not match with what others have shared, but those types of contributions are incredibly important, and we encourage you to give voice to them. That said, please share within the bounds of what feels safe to you – you are never required to contribute. Our hope is that this group can be a space of respectful and honest conversation, so we ask that you do your best to engage with other participants respectfully. On a practical note, it's best for discussion and transcription if all members of the group are allowed to participate equally with *one* person speaking at any given time. Does anyone have questions about what I've said so far?

Great! Thanks everyone. Now we can get started on our questions.

- In a sentence or two, how connected do you feel to the broader LGBTQ+ community? (7 minutes)
    - If you do feel connected in any capacity, tell us about what that community looks like for you – about how many people? What are their relationships to you?
    - How satisfied are you with your current level of connectedness to the community/to what extent are you seeking more connection?
- What have your experiences been like connecting with other LGBTQ+ community members?
    - What has been difficult about it? – what made it difficult? (3 minutes)
    - What has been rewarding about it? – what made it rewarding? (3 minutes)
- What parts of your identity, personality, or experiences have you felt unsafe or uncomfortable bringing into relationships with other LGBTQ+ people (if any)? (6 minutes)
- What tools, skills, or spaces do you use that help you build authentic connection with other LGBTQ+ community members?
    - What additional tools/skills/spaces do you feel like you would need to have more authentic connections like this? (6 minutes)
- Tell me about a time when you felt most connected to the LGBTQ+ community. (6 minutes)
- When do you feel most isolated from the broader LGBTQ+ community? What contributes to that isolation? (5 minutes)

[pause the group and let them know we are switching topics – should be about 50ish minutes into the meeting time]

Part of this research project may also involve the development of a 6-week therapy group for LGBTQ+ young adults, aimed at reducing isolation and increasing healthy connections among LGBTQ+ community members. The hope would be that this group would also reduce things like depression and anxiety. The group itself may involve talking through experiences of connection and disconnection, developing strategies for successful and fulfilling connection with other LGBTQ+ community members, and building strong connections with the group members themselves. This group will likely take place via Zoom to start out with.

- To what extent would a group like this meet your needs or the needs of other LGBTQ+ young adults that you know? (4 minutes)

- What would you want to make sure was included in this group? What would you *not* want this group to include? (5 minutes)
- What would you most want the facilitators of this group to know? (6 minutes)
- Any other reactions to or ideas for this group? (5 minutes)

[wrap up/give space for final reflections]

Thank you all for your time and contributions today! We really appreciate your input on this. As a reminder, you will be sent one follow-up survey which will be similar to the one you completed before attending today's focus group. We ask that you complete it as soon as you can. Once you get to the end of that survey, you'll be asked to provide an email address where we can send you a virtual gift card in exchange for your participation in this research study. Do you have any questions?

Possible phrases to use when facilitating:

- I appreciate your contributions, and I wonder if others in the group have thoughts about this topic as well.
- In the interest of time, let's move to the next question.
- I appreciate the rich discussion here but want to remind everyone of the question (in the Zoom chat): [restate question/topic]
- Before we move on to the next question, I want to make sure everyone who wants to talk has had a chance to contribute.

Appendix C

Demographic measures administered in Aim 1.

Demographic Questions

What is your date of birth? (mm/dd/yyyy)

How do you define your race? Choose all that apply.
□ Native American, Indigenous American, American Indian and/or Alaska Native
□ Asian
□ Black of African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Another _____
□ Do not wish to respond

How do you define your ethnicity?
□ Hispanic or Latinx
□ Not Hispanic or Latinx
□ Another _____
□ Do not wish to respond

Do you identify as part of the LGBTQ+ Community?
□ Yes
□ No
□ Do not wish to respond

How do you define your sexual orientation/preference?
Write in: _____

How do you define your gender identity?
Write in: _____

Appendix D

All measures administered in Aim 2.

Demographic Questions

What is your date of birth? (mm/dd/yyyy)

How do you define your race? Choose all that apply.
□ Native American, Indigenous American, American Indian and/or Alaska Native
□ Asian
□ Black of African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Another _____
□ Do not wish to respond

How do you define your ethnicity?
□ Hispanic or Latinx
□ Not Hispanic or Latinx
□ Another _____
□ Do not wish to respond

How do you describe your sexual orientation? Choose all that apply and feel free to self-identify in the text box.
□ Lesbian
□ Gay
□ Bisexual
□ Pansexual
□ Queer
□ Asexual
□ Demisexual
□ Aromantic
□ Demiromantic
□ Heterosexual
□ Other: _____

How do you describe gender identity? Choose all that apply and feel free to self-identify in the text box.
□ Trans woman
□ Trans man
□ Two-Spirit
□ Non-binary
□ Gender non-conforming
□ Agender
□ Bigender
□ Genderqueer

□ Genderfluid
□ Demigirl
□ Demiboy
□ Intersex
□ Cis woman
□ Cis man
□ Other: _____

Which of your personal identities or combinations of identities are most salient or important to you? _____

What is your current age (in years)?
□ 18
□ 19
□ 20
□ 21
□ 22
□ 23
□ 24
□ 25
□ 26
□ 27
□ 28
□ 29

Relational Health Index (RHI)

Liang, B., Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., & Miller, J. B. (2002). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly, 26*(1), 25-35.

(R) indicates that this item should be reverse scored prior to calculation of a mean score.

PEER (RHI-P)

Next to each statement below, please indicate the number that best applies to your relationship with a close friend.

1 = Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always

1. Even when I have difficult things to share, I can be honest and real with my friend.
2. After a conversation with my friend, I feel uplifted.
3. The more time I spend with my friend, the closer I feel to them.
4. I feel understood by my friend.
5. It is important to us to make our friendship grow.
6. I can talk to my friend about our disagreements without feeling judged.
7. My friendship inspires me to seek other friendships like this one.
8. I am uncomfortable sharing my deepest feelings with my friend. (R)
9. I have a greater sense of self-worth through my relationship with my friend.
10. I feel positively changed by my friend.
11. I can tell my friend when they have hurt my feelings.
12. My friendship causes me to grow in important ways.

COMMUNITY (RHI-C)

Next to each statement below, please indicate the number that best applies to your relationship with or involvement in this community.

1 = Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always

1. I feel a sense of belonging to this community.
2. I feel better about myself after my interactions with this community.
3. If members of this community know something is bothering me, they ask me about it.
4. Members of this community are not free to just be themselves. (R)
5. I feel understood by members of this community.
6. I feel mobilized to personal action after meetings with this community.
7. There are parts of myself I feel I must hide from this community. (R)
8. It seems as if people in this community really like me as a person.
9. There is a lot of backbiting and gossiping in this community. (R)
10. Members of this community are very competitive with each other. (R)
11. I have a greater sense of self-worth through my connection with this community.
12. My connections with this community are so inspiring that they motivate me to pursue relationships with other people outside this community.
13. This community has shaped my identity in many ways.
14. This community provides me with emotional support.

Beck Depression Inventory, Second Edition (BDI-II)

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory–II.* San Antonio, TX: Psychological Corporation.

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully. And then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
    - 0 - I do not feel sad.
    - 1 - I feel sad much of the time
    - 2 - I am sad all the time.
    - 3 - I am so sad or unhappy that I can't stand it.
2. Pessimism
    - 0 - I am not discouraged about my future.
    - 1 - I feel more discouraged about my future than I used to.
    - 2 - I do not expect things to work out for me.
    - 3 - I feel my future is hopeless and will only get worse.
3. Past Failure
    - 0 - I do not feel like a failure.
    - 1 - I have failed more than I should have.
    - 2 - As I look back, I see a lot of failures.
    - 3 - I feel I am a total failure as a person.
4. Loss of Pleasure
    - 0 - I get as much pleasure as I ever did from the things I enjoy.
    - 1 - I don't enjoy things as much as I used to.
    - 2 - I get very little pleasure from the things I used to enjoy.
    - 3 - I can't get any pleasure from the things I used to enjoy.
5. Guilty Feelings
    - 0 - I don't feel particularly guilty.
    - 1 - I feel guilty over many things I have done or should have done.
    - 2 - I feel quite guilty most of the time.
    - 3 - I feel guilty all of the time.
6. Punishment Feelings
    - 0 - I don't feel I am being punished.
    - 1 - I feel I may be punished.
    - 2 - I expect to be punished.
    - 3 - I feel I am being punished.

7. Self-Dislike
    0 - I feel the same about myself as ever.
    1 - I have lost confidence in myself.
    2 - I am disappointed in myself.
    3 - I dislike myself.
8. Self-Criticalness
    0 - I don't criticize or blame myself more than usual.
    1 - I am more critical of myself than I used to be.
    2 - I criticize myself for all of my faults.
    3 - I blame myself for everything bad that happens.
9. Suicidal Thoughts or Wishes
    0 - I don't have any thoughts of killing myself.
    1 - I have thoughts of killing myself, but I would not carry them out.
    2 - I would like to kill myself.
    3 - I would kill myself if I had the chance.
10. Crying
    0 - I don't cry any more than I used to.
    1 - I cry more than I used to.
    2 - I cry over every little thing.
    3 - I feel like crying, but I can't.
11. Agitation
    0 - I am no more restless or wound up than usual.
    1 - I feel more restless or wound up than usual.
    2 - I am so restless or agitated, it's hard to stay still.
    3 - I am so restless or agitated that I have to keep moving or doing something.
12. Loss of Interest
    0 - I have not lost interest in other people or activities.
    1 - I am less interested in other people or things than before.
    2 - I have lost most of my interest in other people or things.
    3 - It's hard to get interested in anything.
13. Indecisiveness
    0 - I make decisions about as well as ever.
    1 - I find it more difficult to make decisions than usual.
    2 - I have much greater difficulty in making decisions than I used to.
    3 - I have trouble making any decisions.
14. Worthlessness
    0 - I do not feel I am worthless.
    1 - I don't consider myself as worthwhile and useful as I used to.
    2 - I feel more worthless as compared to others.
    3 - I feel utterly worthless.
15. Loss of Energy
    0 - I have as much energy as ever.
    1 - I have less energy than I used to have.
    2 - I don't have enough energy to do very much.
    3 - I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
    0 - I have not experienced any change in my sleeping.
    1a - I sleep somewhat more than usual.
    1b - I sleep somewhat less than usual.
    2a - I sleep a lot more than usual.
    2b - I sleep a lot less than usual.
    3a - I sleep most of the day.
    3b - I wake up 1-2 hours early and can't get back to sleep.
17. Irritability
    - I am not more irritable than usual.
    - I am more irritable than usual.
    - I am much more irritable than usual.
    - I am irritable all the time.
18. Changes in Appetite
    0 - I have not experienced any change in my appetite.
    1a - My appetite is somewhat less than usual.
    1b - My appetite is somewhat greater than usual.
    2a - My appetite is much less than before.
    2b - My appetite is much greater than usual.
    3a - I have no appetite at all.
    3b - I crave food all the time.
19. Concentration Difficulty
    0 - I can concentrate as well as ever.
    1 - I can't concentrate as well as usual.
    2 - It's hard to keep my mind on anything for very long.
    3 - I find I can't concentrate on anything.
20. Tiredness or Fatigue
    0 - I am no more tired or fatigued than usual.
    1 - I get more tired or fatigued more easily than usual.
    2 - I am too tired or fatigued to do a lot of the things I used to do.
    3 - I am too tired or fatigued to do most of the things I used to do.
21. Loss of Interest in Sex
    0 - I have not noticed any recent change in my interest in sex.
    1 - I am less interested in sex than I used to be.
    2 - I am much less interested in sex now.
    3 - I have lost interest in sex completely.

Beck Anxiety Inventory (BAI)

Beck, A. T., & Steer, R. A. (1990). *Manual for the Beck Anxiety Inventory*. San Antonio, TX: Psychological Corporation.

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

0 = Not at all; 1 = Mildly, but it didn't bother me much; 2 = Moderately – it wasn't pleasant at times; 4 = Severely – it bothered me a lot

1. Numbness or tingling
2. Feeling hot
3. Wobbliness in legs
4. Unable to relax
5. Fear of worst happening
6. Dizzy or light-headed
7. Heart pounding/racing
8. Unsteady
9. Terrified or afraid
10. Nervous
11. Feeling of choking
12. Hands trembling
13. Shaky/unsteady
14. Fear of losing control
15. Difficulty in breathing
16. Fear of dying
17. Scared
18. Indigestion
19. Faint/lightheaded
20. Face flushed
21. Hot/cold sweats

Psychological Sense of LGBT Community Scale

Lin, Y., & Israel, T. (2012). Development and validation of a Psychological Sense of LGBT Community Scale. *Journal of Community Psychology, 40,* 573-587.

All items were assessed on the following scale:
1 = "None"
2 = "A little"
3 = "Some"
4 = "A fair amount"
5 = "A great deal"

1. How much do you feel able to influence the actions, thoughts, and feelings of other LGBTQ+ people?
2. How much do you feel other LGBTQ+ people influence your thoughts and actions?
3. How much do you feel your opinion matters to other LGBTQ+ people?
4. How much do you feel you can influence what the LGBTQ+ community is like?
5. How much do you care what LGBTQ+ people think of your actions?
6. How much do the opinions of other LGBTQ+ people matter to you?
7. In general, how friendly do LGBTQ+ people feel toward each other?
8. In general, how thoughtful are LGBTQ+ people toward each other?
9. In general, how well do LGBTQ+ people get along?
10. In general, how warm do LGBTQ+ people feel toward each other?
11. In general, how much of a sense of camaraderie do LGBTQ+ people feel with each other?
12. How often do you feel that you are a member of the LGBTQ+ community?
13. How often do you feel like you belong in the LGBTQ+ community?
14. How often do you feel a part of the LGBTQ+ community?
15. How much do you feel that you help other LGBTQ+ people when they need help?
16. How much do you feel that your needs are met by the LGBTQ+ community?
17. How much do you feel that you can get help from the LGBTQ+ community if you need it?

Social Isolation Scale (SIS)

Nicholson Jr, N. R., Feinn, R., Casey, E. A., & Dixon, J. (2020). Psychometric evaluation of the social isolation scale in older adults. *The Gerontologist, 60*(7), e491-e501.

Please answer the questions below about your interaction with others.

1) Thinking about your family, friends, or neighbors…

   a. How many of them do you see face-to-face at least once a month? Check one answer.
      □1: None
      □2: 1
      □3: 2-3
      □4: 4-5
      □5: 6 or more

   b. How many of them do you communicate with on a personal level by phone or electronically (e.g. by email, video chat, and/or internet) at least once a month? Check one answer.
      □1: None
      □2: 1
      □3: 2-3
      □4: 4-5
      □5: 6 or more

   c. How many of them do you feel close to on a personal level (e.g., could confide in or share personal feelings with)? Check one answer.
      □1: None
      □2: 1
      □3: 2-3
      □4: 4-5
      □5: 6 or more

2) Thinking about the relationships you have with individuals or groups you are a part of, please rate how much you agree or disagree with the following statements.

   a. Overall, I feel that my relationships are fulfilling.
      □1: Strongly disagree
      □2: Somewhat disagree
      □3: Neither agree nor disagree
      □4: Somewhat agree
      □5: Strongly agree

   *b. I feel like I just don't belong.
      □1: Strongly disagree

□2: Somewhat disagree
□3: Neither agree nor disagree
□4: Somewhat agree
□5: Strongly agree

c. I feel that I spend enough time involved in social activities.
□1: Strongly disagree
□2: Somewhat disagree
□3: Neither agree nor disagree
□4: Somewhat agree
□5: Strongly agree

*Reverse Score item 2b
Lower Scores of SIS = Higher levels of social isolation

UCLA Loneliness Scale (Version 3)

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, *66*(1), 20-40.

Instructions: The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by writing a number in the space provided. Here is an example:

How often do you feel happy?

If you never felt happy, you would respond "never"; if you always feel happy, you would respond "always."

NEVER	RARELY	SOMETIMES	ALWAYS
1	2	3	4

1. How often do you feel that you are "in tune" with the people around you?*
2. How often do you feel that you lack companionship?
3. How often do you feel that there is no one you can turn to?
4. How often do you feel alone?
5. How often do you feel part of a group of friends?*
6. How often do you feel that you have a lot in common with the people around you?*
7. How often do you feel that you are no longer close to anyone?
8. How often do you feel that your interests and ideas are not shared by those around you?
9. How often do you feel outgoing and friendly?*
10. How often do you feel close to people?*
11. How often do you feel left out?
12. How often do you feel that your relationships with others are not meaningful?
13. How often do you feel that no one really knows you well?
14. How often do you feel isolated from others?
15. How often do you feel you can find companionship when you want it?*
16. How often do you feel that there are people who really understand you?*
17. How often do you feel shy?
18. How often do you feel that people are around you but not with you?
19. How often do you feel that there are people you can talk to?*
20. How often do you feel that there are people you can turn to?*

Scoring: Items that are asterisked should be reversed (i.e., 1 = 4, 2 = 3, 3 = 2, 4 = 1), and the scores for each item then summed together. Higher scores indicate greater degrees of loneliness.

Post-Group Intervention Items

Items were developed by the author for the purpose of assessing group outcomes quantitatively and qualitatively. These items were only administered at the end of the final survey.

Please rate your experience with this group therapy intervention using a scale ranging from "1 = Strongly Disagree" to "5 = Strongly Agree".

This group met my needs.
This group provided me with tools to make authentic connections *during* sessions.
This group provided me with tools to make authentic connections *outside of* sessions.
I feel more connected to the LGBTQ+ community after attending this group.
I did not benefit from attending this group.
I enjoyed attending this group.
This group increased the quality of relationships in my life.

How would you describe your experience in this group?

What, if anything, was helpful about this group?

What, if anything, was unhelpful about this group?

If the group were to be run again, what changes would you make?

Appendix E

Aim 2 group therapy intervention protocol, including pre-group screening procedures (Session 0), general structure for intervention sessions (1-6), and notes on therapy process throughout.

SESSION 0: PRE-GROUP INDIVIDUAL INTERVIEWS

Purpose: Determine fit for group (30 mins)

1 – co-facilitators introduce selves and briefly review purpose of group (1 min)

Name, pronouns, relevant qualifications/training
Remind participants the interview is being recorded
Purpose: The aim of this group is to support LGBTQ+ young adults in making and maintaining healthy, growth-fostering connections and friendships with other LGBTQ+ community members all across Colorado. While we certainly hope you will find those kinds of connections among group members, we will also be discussing ways of seeking connections with community members outside of this group as well. This will be a space where you can discuss part experiences of connection and disconnection, and where we can work together to figure out how to seek affirming queer spaces and how to navigate non-affirming ones.

2 – ask potential group member about interest in the group and themselves (3 mins)

Gather participant name, pronouns, age, confirm CO residency
Tell us a little bit about what drew you to this group.
Where did you hear about the group?
What would you be hoping to get from this group if you participated in it?
Are you comfortable with being video and audio recorded for the purpose of the study?
What is important for us (facilitators) to know about you?

3 – screen for risk (3 mins)

Sometimes when people seek out therapy, they are dealing with difficult emotions and thoughts. It's important to us that we make sure that our group will match up with your needs and experiences, so we have a few questions we are asking everyone who is interested in the group. First, are you currently experiencing thoughts about killing yourself?
What about in the past/have you ever had thoughts about this?
If yes to either: Assess plan, intent, frequency, duration, triggers/risk factors, access, protective factors, etc.
Are you currently experiencing thoughts about harming or killing others?
What about in the past/have you ever had thoughts about this?
If yes to either: Assess plan, intent, frequency, duration, triggers/risk factors, access, protective factors, etc.

4 – screen for psychosis (2 mins)

Do you see or hear things that other people can't or don't see or hear?

If yes: tell me more about that (distinguish between possible psychosis and people feel they are more observant than others, have sensory processing differences/ASD/tinnitus etc.)

5 – determine eligibility (2 mins)

If the participant has no evidence of risk and no evidence of psychosis based on screening questions, proceed with remainder of interview (below). If they appear to have more risk than we are comfortable with (i.e., ideation and plan/intent, ideation and recent attempts) or signs of psychosis: "Unfortunately, based on some of our screening questions, you do not meet criteria for the group. Our priority is to make sure you get the level of care that you need, and because of your _____ [suicidal thoughts/thoughts of hurting others/atypical sensory experiences], our group will not be a good fit as we are not able to address these kinds of experiences. What we can do is provide you with some referrals based on what might fit your needs better at this time."

Therapy referrals: Psychology Today (since clients could be coming from anywhere in CO it may not be reasonable to have local referrals ready for all possible regions)
Hotlines: https://one-colorado.org/support/local-national-suicide-prevention-hotlines/
Trevor Project: 866-488-7386 (24/7) or Live Chat with the Trevor Project (Daily 3pm-9pm EST)
Trans Lifeline: 877-565-8860
GLBT National Youth Talk: 1-800-246-7743 (Monday-Friday, 4pm-12 am EST/Saturday, 12pm-5pm EST) or email the GLBT National Youth Talk
National Suicide Hotline: 800-273-8255
Text an anonymous crisis counselor: 741741
Colorado Crisis and Support Line: 1-844-493-TALK (8255) (has mental health professionals available 24 hours a day, 365 days a year)

6 – answer questions about group/process/study (5 mins)

Answer questions the participant has, add any information it sounds like they might need to make their decision

7 – ask group member about preferences for group process (7 mins)

When we were conducting early research to develop this group, we found that people had different ideas about what they were hoping for from this group. For example, some people felt that they would want this group to be free from discussions of trauma whereas others wanted this to be a space where they could openly discuss trauma. What would you prefer? How would you want us as facilitators handle it if another group member mentioned something triggering in group? What about if one group member said something harmful to you or another group member? Other things you would like us to know?

8 – discuss fit for group/timeline for decision (3 mins)

If it is clear the participant is not a good fit, check in with them about it and see how they are feeling. Suggest other resources if appropriate and be clear why group would not meet their stated needs. If client is a good fit but reports being uninterested in group,

consider opening discussion about why (to deepen our understanding of who might be a good fit) but do not attempt to convince them to attend. If extra time and discussion with supervisor/co-facilitator is needed to determine fit, let participant know a clear timeline to be informed about the decision. If the participant needs time to decide, establish a clear timeline for you to hold their spot.

SESSION 1: GETTING STARTED

Purpose: Introduce group purpose and guidelines, get to know each other (90 mins)

1 – co-facilitators introduce selves (1 min)

Name, pronouns, relevant qualifications/training

2 – review confidentiality/informed consent/recording (3 mins)

Remind participants of the surveys, and that survey participant informs how much they are compensated for their participation. Remind participants that they can use whatever name they want for this group, it doesn't have to be their usual name if they want extra measures to protect privacy. Also be clear that facilitators and researchers will maintain confidentiality, but we cannot make guarantees about other group members, though we will set it as a group rule (later).

3 – review purpose of group and acknowledgment of intersectionality (3 mins)

Statement of purpose: The aim of this group is to support LGBTQ+ young adults in making and maintaining healthy, growth-fostering connections and friendships with other LGBTQ+ community members. While we certainly hope you will find those kinds of connections among group members, we will also be discussing ways of seeking connections with community members outside of this group as well. This is a space where you can discuss part experiences of connection and disconnection, and where we can work together to figure out how to seek affirming queer spaces and how to navigate non-affirming ones.

Statement on intersectionality: It is important to us that this group is guided by the concept of intersectionality; this is a group related to connection and disconnection within the LGBTQ+ community, and we acknowledge that the ways that people connect and are treated within relationships and queer spaces are informed by all the identities they hold, including but not limited to race, ethnicity, gender identity, gender expression, sexual orientation, romantic orientation, socioeconomic status, religious affiliation, body size, ability/disability status, and so much more. We hope that this can be a space where group members are free to share these unique experiences; we also hope that this can be a space where dynamics of privilege and oppression can be addressed to minimize harm to the most marginalized within our community.

Statement of excitement and gratitude: We are really grateful to have each of you here as part of this group. We want to take a moment to highlight how special it is to have a space that is comprised only of people who are part of the LGBTQ+ community. Thank you for being here! We are looking forward to getting to know you all better.

4 – mini introduction (1 min)

We will do more formal introductions in a moment, but for now we would love if everyone could share the name and pronouns you would like us to use for you in this group.

5 – review basic ground rules and solicit new ones from group (20-30 mins)

Rule 1: Respect confidentiality and privacy of other group members by ensuring you are joining group from a private location, not discussing group content with people outside the group, not identifying group members to people outside the group, not recording video or audio of sessions.
Rule 2: Do not engage in outside friendships or romantic/sexual relationships with other group members during the course of the 6-week group. There will be an optional opportunity to share contact information with one another at the end of the group.
Rule 3: Maintain respectful language use, including respecting group members' names/pronouns/identities and not using offensive or derogatory language toward others.
Rule 4: There is never any pressure to share in group. You are welcome to do so but never required, and your amount of verbal participation in the group will not affect your compensation for this study.
Other rules to develop with group members: How to navigate repairing harm in the group; how to navigate discussions of trauma/triggers; cameras and mics on/off; anything else the group feels is important

6 – icebreaker/group introductions (5 mins)

Name, pronouns (to remind everyone, if they don't already have name and pronouns in bio), fun fact or favorite queer character in media, set an intention for your participation in this group, anything you want us to know about you?

7 – discussion: what do you want to get out of this group? (20 mins)

Possible follow-up/discussion questions:
What parts of the group's purpose statement align most with what you are looking for?
How satisfied are you with your current level of connection with other LGBTQ+ people?
What do you think you would need to be able to make the kids of connections you want?
What helps you feel connected to the LGBTQ+ community?

8 – discussion: getting to know each other (20 mins)

Now that we've created some ground rules and talked a bit about what we are each looking to get out of this group, we figured you all might want to get to know each other a bit beyond just fun facts. We have the rest of the time reserved to share a little more about yourself – whatever you'd like us to know!
Ideas if needed: work, hobbies, favorite shows/movies/books, favorite artists/songs

9 – wrap up (5 mins)

Answer group member questions about group, etc.
Reminder about post-group survey

Notes on process/intervention: Getting the group to agree on how to handle harm and trauma/triggers may be difficult – even in focus groups, participants did not agree. For harm, some wanted a zero-tolerance policy where members would be kicked out if they compromised the emotional safety of another group member; others wanted facilitators to educate the person creating harm without "attacking" them. Regarding trauma, some group members wanted this to be a space that was lighthearted and did not rely on using trauma to bond with each other. Others were craving a safe and understanding space to share their traumatic experiences with other

queer people. Ultimately, it will be difficult to balance these needs without alienating one or more group members in some way, but it is important to the group mission that this is a space where important conversations are had and not avoided. Some ideas on compromise, if necessary: for navigating harm, consider providing options for "calling people in", where either a facilitator or the harmed person can name the harm and make space for discussion of how to repair it, which may involve offering some space to process after; for navigating trauma, one possible compromise is to have breakout rooms in Zoom where one group is welcoming of trauma and the other will not discuss trauma or will avoid discussion of decided-upon triggering content – this would work well if the group cannot come to consensus on whether this group should be more lighthearted or allow space for emotional heaviness; for navigating triggers, it may be helpful to allow group members to self-advocate and self-soothe on their own terms, but the group can be intentional about checking in with group members when they return to the space and offering support (e.g., if someone needs to briefly leave the virtual space when triggered or to avoid triggering content). It's important to note that one of the central pieces of RCT is the idea that conflict and disagreement can be effectively handled in a way that ends up strengthening the relationship and ensuring that all parties are heard. The facilitator should therefore support the group in finding "solutions" to potential conflict that allow for at least an initial opportunity to repair the relationship.

Another major note on facilitation: facilitators should be attuned to ways of facilitating mutual empathy based on the RCT definition – not just listening closely to others' experiences but also sharing how their stories/experiences have moved/affected/changed us. Facilitators can model this behavior as well as facilitate it by saying things like, "thank you for sharing that. How did hearing _____'s experience affect you?" or "what was it like to hear _____'s experience?" or other ways of getting group members to reflect and share the impact.

SESSION 2: CONNECTION MATTERS

Purpose: Explore contributors to connection and introduce central relational paradox (90 mins)

1 – brief review of ground rules (see session 1) (2 mins)

Put them in the Zoom chat for reference. Because people may begin discussing trauma, it may also help to review limits to confidentiality around child abuse in particular.

2 – overview of purpose of this session (1 min)

You all signed up to participate in this group in part because you were seeking more connection with other LGBTQ+ community members. Today we're going to spend some time talking about what contributes to feeling connected. Next week, we'll talk about what gets in the way of making the kinds of connections you are hoping for.

3 – activity: word web for connection/community (20 mins)

We want to know what kinds of things help you feel connected to other LGBTQ+ community members. During our discussion, we (facilitators) will be adding your ideas into a word web so that we can keep track of your ideas and reference them later.

Discussion questions:

What makes you feel safe and comfortable enough to make connections?

Tell us about the times you felt most connected to the LGBTQ+ community – what made those experiences good or memorable?

Per focus groups: safety, validation/affirmation of identities, shared experiences, shared identities, shared interests, nonjudgment, mutual support (relying on one another/uplifting one another), humor, creative self-expression, authenticity, not needing to explain oneself or prove one's identities/queerness

Note: One topic that often came up in focus groups was Pride – if this does not come up in discussion, you can mention it and see if people resonate. Have them try to identify what it is about Pride that contributes to that feeling of connection and add that to the word web.

4 – reflection on activity (20 mins)

What was this activity like for you?

Have you had experiences that reflect these forms of connection and community?

How did they make you feel?

5 – relational-cultural psychoeducation: central relational paradox (2 mins)

Statement on RCT: We live in a society that values independence and self-sufficiency; these things can be adaptive at times, but ultimately our brains are wired to be in connection with other people. Isolation can be a source of pain, and the right relationships can be a source of healing! Our expectation for relationships are influenced by past experiences. Many of us may have experienced rejection or judgment because of our LGBTQ+ identities, and others have even faced judgment from within the broader LGBTQ+ community. These experiences can give us the sense that something is wrong with us or that it is never safe to bring our full, authentic selves into connection with other people. It might feel like this keeps us safe, but it may also be the thing that keep us

isolated. In relational cultural therapy, this is called the "central relational paradox" – the idea that, in order to be accepted and connected to others, we actually tend to disconnect from important parts of ourselves, bringing only some pieces of ourselves into our relationships. We develop strategies for this, like withdrawing from others, not sharing our true feelings, criticizing others, and more.

6 – relational-cultural discussion (20 mins)

Reactions to that idea? How does it fit or not fit with your experiences?
How can we as a group work to make this space a safer place to be yourself?
What experiences have you had that have shaped how much of your true self you bring into your relationships?
What strategies have you developed to be more accepted by others?
What parts of you do you tend to hold back? What parts do you want other people to see and validate?
What is the cost of holding parts of yourself? What do you miss out on because of it?

7 – wrap-up (5 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: Per RCT, therapist role is to respond with empathy and be responsive to group members' needs. RCT is clear that being authentic (as a therapist) is *not* about spontaneous, honest reactions but rather intentional responding based on empathy, caring, and what would be most helpful based on what you know about the group member. In this group, we will not be working with robust client histories like we would in individual therapy. This is where we can lean on our understanding of LGBTQ+ issues and focus group data to understand the kinds of experiences LGBTQ+ young adults have had (while also being careful not to make overgeneralizations/assumptions). For example, many group members' early relationships may have been characterized by withdrawal, rejection, judgment, even abuse; facilitators should be careful not to replicate these dynamics. In a group setting, there is an added layer of needing to also attend to how group members are responding to one another (and monitoring/adjusting those interactions based on the same principles). So for example, if facilitators notice that a group members is judging or invalidating the experience of another group member, a facilitator could make a comment on process, inviting the invalidated person to share their emotional reaction and starting a dialogue between the group members (offering support on how to handle the conversation e.g., I statements, taking turns, summarizing, etc. as needed). Another theme in terms of the experience of LGBTQ+ people is erasure and being silenced, which can be multiplied by belonging to certain other categories of marginalization. Thus, the group should aim to ensure that individual group members are not silenced or skipped over, especially if they are among the more marginalized group members. Facilitators should closely monitor group members to ensure that they have the opportunity to share when it seems like they have something to say, gently (no pressure) checking in with people who have not shared their perspective, coming back to important topics/emotions when the subject is changed, etc. The important piece is sticking with each other and remaining connected while also helping to ensure that the connections being forged are healthy.

SESSION 3: BARRIERS TO CONNECTION

Purpose: Explore barriers to connection and ways around them (90 mins)

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (1 min)

Last week we talked about why connection to others is so important, and we talked about some of the ways that this group can be a safer space to be our authentic selves. We also began talking about how our past experiences shape how we connect or disconnect from others. This week, building on those ideas, we will spend some time talking about what tends to get in the way of connection. Next week, we'll talk about how we might go about determining whether a certain space, person, or group has what you need to feel connected.

3 – activity: roadblocks to connection/community (8 mins)

Have group members take 6 minutes or so to write down their personal roadblocks to connection and community.

Roadblocks can be…

Thoughts (e.g., I'm not cool enough, I'm not queer enough, I will be rejected, no one will like me)

Physical barriers (e.g., living in a rural area with no community spaces, lack of sober gathering spaces, physical inaccessibility)

Emotional barriers (e.g., anxiety, depression/low energy)

Community barriers (e.g., racism, transphobia, biphobia, etc. within community)

Specific experiences when you tried to connect but did not succeed

Strategies for disconnection (per yesterday's discussion on the central relational paradox, what things do you do to keep yourself from connecting authentically with others?)

4 – discussion: what seems to get in the way of making the kinds of connections you want to make with other LGBTQ+ people? (20 mins)

Encourage group members to share from the lists of roadblocks they just generated. Share screen with the list so people can collaborate on it. Follow-up questions:

What kinds of thoughts do you have that convince you not to reach out to others?

What fears do you have about initiating connections?

What physical barriers get in the way of community? Emotional barriers? Etc.

Have others in the group experienced similar barriers?

What does it feel like when you come up against these barriers?

Have you noticed any of these barriers coming up in this group? If so, how should we handle them as a group moving forward?

5 – discussion/activity: ways around barriers (30 mins)

For the next part of our group today, we wanted to talk about some ways to deal with, remove, or move around some of the barriers you all came up with. We want to start by

acknowledging that some barriers you have identified are structural or deeply engrained in society and therefore difficult to change or overcome, and that it may not make sense to talk about simply overcoming them as an individual – these are barriers that will require collective action toward dismantling the systems themselves. This time is open for discussion of any of the barriers you all named, but we recognize that certain ideas may only apply to certain types of barriers, or that certain ideas might be safer to implement for some community members than others.
With all that in mind, what are some thoughts you have on working around a certain barrier?
Format: have one group member identify a possible solution/way around and have them clarify which barrier(s) it would apply to; ask group their thoughts on the idea and what they would need to use it successfully; have group brainstorm other possible ways around that barrier; then move to a new idea/barrier
If the barrier is a thought: have group members "talk back" to the thought and/or come up with a more helpful one
Seeing barriers in context: What are some of the ways that oppression, privilege, and uneven power dynamics affect these barriers? (Note: seeing barriers in the sociocultural context can help people see that the barriers are not their fault, removing some of the shame)

6 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: One of the helpful things about RCT as a framework is that, in my experience, it layers well and is not at odds with other orientations. Although RCT pushes back against the individualist focus of CBT, I think the idea of challenging unhelpful thoughts can apply well to reducing barriers to connection. RCT may argue that the best and primary way to change people's connection-interfering behaviors and thoughts would be by showing them over time that relationships can be mutually empathic and growth-fostering, including the therapeutic relationship, so that clients can learn in real time that a different outcome (i.e., than rejection/invalidation/etc.) is possible. However, in this group we only have 6 sessions to get to know the group and work to make real changes in their lives. Thus, there may be utility to directly identifying and challenging the unhelpful/maladaptive patterns of thought that seem to interfere with or outright prevent connection-seeking behavior. Of course this thought challenging (if used) should be done relationally, and with facilitators being mindful of the idea that making thoughts the "main problem" or primary barrier can wrongly imply that there are not other very real barriers such as actual experiences of rejection, abuse, racism/other forms of discrimination, etc. that we LGBTQ+ people must attend to when deciding whether to enter into a given space. With RCT as a primary orientation, a priority is to validate the depth of group members' experiences with these difficult, sometimes systemic barriers – not to talk them out of it or provide "solutions" that push them to engage in unsafe spaces, but rather to listen to their experience, allow space for them to process it, offer a space where those same dynamics of oppression are not replicated, etc.

SESSION 4: NAVIGATING NON-AFFIRMING SPACES & PEOPLE

Purpose: Brainstorm & learn new ways of navigating spaces that do not feel welcoming (90 mins)

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (2 min)

In the past few weeks, we've focused on what kinds of things help you feel connected, and what tends to get in the way. Last time, we even started talking about ways around some barriers to connection. When we conducted focus groups to develop this therapy group, we found that some wanted time set aside specifically to discuss how to go about dealing with spaces that aren't welcoming. This week, I was thinking that we could spend some time talking about how to navigate spaces or relationships that are not affirming or that don't help you feel connected.

3 – discussion: your past experiences (20 mins)

To start things off, would anyone like to share any past experiences of relationships, events, or spaces where you felt like you couldn't be yourself or weren't safe or affirmed?

Follow-up questions:

How could you tell it was non-affirming? (e.g., using emotions, behaviors, environmental/social cues, etc.)

How did you handle this situation, and how do you wish you could have handled it looking back?

4 – brainstorm and psychoeducation: how to navigate these spaces (30 mins)

Invite group members to generate ideas about how to navigate these spaces. If they are struggling to come up with ideas or if there is extra time, consider introducing ideas from other therapeutic orientations (starting with RCT).

Ideas from therapy:

RCT: Disconnections occur in all relationships, including healthy ones. It is important, then, to find ways of reconnecting and navigating conflict that do *not* involve keeping parts of your authentic self out of the conflict. (Note: there are other times that it is best not to stay in harmful relationships or community spaces – this concept does not apply to those situations)

DBT: DEARMAN provides a framework for having conversations with others during which you need to express a boundary or make a request. Is that something you all would be interested in going over together?

If yes, have a group member come up with an example of a boundary they feel they need to set/request they need to make, or one that they tried to communicate in the past ineffectively. Use this to guide the conversation: https://www.edencounseling.com/resources/Eden-DBT/DBT-Interpersonal-Effectiveness/dbt-interpersonal-effectiveness-grp-4-handouts.pdf

CBT: (if needed/if time allows) Introduce CBT triangle and idea of intervening on the level of thoughts and behaviors

5 – discussion: reflection on brainstorming (15 minutes)

We have come up with a list of strategies and ideas for dealing with difficult relationships or spaces where we don't feel like we can be our full selves.
Which of these strategies resonated the most with you?
Which didn't resonate?
What might prevent you from using these strategies?
Are there any that you want to use moving forward? If so, in what situation? What support do you need from the group around this?

6 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: Intersectionality/identity is crucial to keep in mind here in addition to the explicit statement about it in last week's schedule. There are very real reasons why people may feel unsafe setting certain boundaries, engaging in conflict in certain spaces, getting up and leaving certain spaces, ranging from financial need to physical danger and more. Facilitators should be attuned to these realities when facilitating these discussions and avoid making one-size-fits-all assertions about what strategies and skills may work for a given person or situation.

SESSION 5: SEEKING AFFIRMING SPACES/PEOPLE

Purpose: Explore ideas around what growth-fostering relationships and community look and feel like and how to seek them out (90 mins)

1 – brief review of ground rules (see session 1) (2 mins)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (1 min)

Last week we talked about ways to navigate spaces and relationships that are not affirming and don't allow us to be our full selves. This week, we wanted to talk about finding and maintaining the kinds of relationships where we can be authentic, and where we feel like the relationship inspires us to grow, be creative, and connect even more deeply.

3 – psychoeducation: RCT principles (30 mins)

Since we have been using relational-cultural therapy as a framework, we wanted to share a few concepts from that model. These are some of the things that, according to RCT, are important pieces of growth-fostering relationships.

Authenticity: Authenticity means representing ourselves honestly and fully in our relationships. Per RCT, this can be a challenge when we have been shamed, oppressed, marginalized, and when we have received messages that we are not worthy as we are. Growth-fostering relationships are ones in which we can start moving toward being authentic and not being shamed for it.

Mutual empathy: We think of empathy as one person listening to another person's experience and being emotionally affected by it. Mutual empathy works like this: let's imagine two people, Person A and Person B. Person A shares a difficult experience with Person B, and Person B listens closely, feeling affected by their story. Person B expresses the effect that hearing about this experience has had on them, showing that they were moved by the story. The idea here is that it can be connecting to empathize with someone else, but it strengthens the connection even further when another person believes that their experiences can genuinely move or impact others.

"Five good things": When people are well-connected, they may feel the following 5 things. 1) greater sense of energy, zest, or vitality; 2) more able to act; 3) more accurate picture of self; 4) greater sense of worth; and 5) more motivation to connect with others

Note: after each term, allow space for discussion of each one.

4 – activity: connection/community collage (20 mins)

A few weeks ago, you all generated a word web of things that help you feel connected and supported in your relationships with other LGBTQ+ people. As we talk about seeking out spaces and relationships that are safe and help us feel connected, we wanted to create something tangible and visible to help us visualize what these kinds of relationships might look and feel like. The plan is to co-create a collage together that represents the kinds of things we would look for in these relationships – literally or conceptually.

Logistics: pull up Canva or similar site capable of searching and putting together words and images. Have group members shout out terms or things they think would characterize a safe, connected, community-oriented space or relationship. It can be physical things (e.g., blankets, tea, pride flags), concepts (e.g., authenticity, inclusivity, acceptance), feelings (e.g., joy, coziness, love), or anything else that group members can think of.

5 – optional "homework" activity: make your own collage

6 – discussion: seeking community (20 mins)

Now that we have talked through some ideas from RCT about what we can look for in growth-fostering relationships and spent some time imagining what healthy community would look like, we can spend some time talking about how we might go about finding relationships or community like this. What ideas do you all have on this?
What have you tried in the past that worked well?
What have you tried in the past that didn't work well, and how would you do it differently this time?

7 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

SESSION 6: WRAPPING UP

Purpose: End the group by sharing final reflections, discussing take-aways from the group, and optionally sharing contact information (90 mins)

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – optional: collage/art sharing (2-10 minutes)

Last week, we made a collaborative collage and invited you all to spend some time this week making your own collages or other forms of art or writing based on the ideas we have been talking about in group. We want to give anyone who did this the opportunity to share with the group if you'd like! Did anyone have a piece they wanted to share?
Follow-up questions:
What was it like to make this?
What are others' reactions to this piece?

3 – overview of purpose of this session (2 minutes)

Over the past few weeks, we have been talking about all sorts of topics related to connection and disconnection within the queer/LGBTQ+ community. This week is our final session together, so we wanted to make sure we made time to tie up any loose ends, talk about what we are each taking away from the group, and sharing what our experiences were like in this group. When we were initially developing the idea for this group, the people we talked to about it expressed that they were interested in the idea of having the option to share contact information with other group members so that you can potentially continue the connections you made here after the group ends. So, at the end of our session today, we will have an option to share whatever contact info you are comfortable with among the group members. There is absolutely no pressure to share any of your contact info, and you can have complete control over which forms of information you share if you decide to.

4 – discussion: reflections on group (10-40 mins)

First, we wanted to see if there were any remaining topics that you all wanted to make space for today – either things we haven't touched on yet, or things that we discussed in previous weeks that you wanted to revisit or that you have new thoughts about.
[allow space for discussion]

We also want to make space for anyone wants to share their thoughts on what this group was like for them and what they are taking from it moving forward. As a reminder, your final survey will also ask you for feedback about the group, so there is no pressure to share here.
[allow space for discussion]

5 – optional: discussion questions (30 mins)

Adapted from *The relational cultural model: A framework for group process,* possible discussion questions for the group if time allows:

When we first started this group, what were your expectations for how relationships with other LGBTQ+ people would go? And have those expectations changed?
Which strategies for disconnection are you hoping to leave behind?
Which strategies for authentic connection are you hoping to use moving forward?
What part(s) of yourself did you share with this group that you normally hide from others?
How has inauthentic relating affected your sense of self-worth and relational confidence?
What are some sociocultural influences that have affected your ability to develop/maintain relationships? In response to such sociocultural influences, what types of strategies have you used for survival?
What relational strengths did you bring to the group? Were there strengths that you developed over the course of the group?
What strengths did you notice in other group members?
How have other group members impacted or moved you?

6 – statement of gratitude (2 minutes)

[insert statement here – to increase authenticity, it will likely be important for final remarks of gratitude for the group to be shared spontaneously by facilitators or to be written just before the final session rather than having a scripted statement prepared in advance of the group]

7 – optional: sharing contact information (5 minutes)

As we discussed at the beginning of the session today, we want to take a minute to talk about sharing contact information with other group members. We know that the ability to connect with others after the group was important to some of you, so this is a moment where you can share if you feel comfortable. Before we start, here are some general guidelines. First, we as facilitators will not be sharing our information and cannot take your contact information either. Second, there is no pressure to share your information, this is completely optional and will not affect your compensation in any way. Third, feel free to only share whatever information you are comfortable with – phone number, email, social media, or any other options are fine!

Note: each group may have different preferences around whether sharing contact information means sharing with everyone (pros: no one feels left out; cons: people may feel less comfortable sharing their information if there were people in the group that they would not want to be in contact with after the group) or choosing who they want to share information with (pros: increased comfort and empowerment to choose where their information goes; cons: if certain people do not receive any information or requests for their information, they may feel left out and this could impede progress made toward increasing relational competence and sense of community – also unclear logistically how this would work if Person A wants to share with Person B, but Person B does not want to share with Person A)

8 – closing remarks on surveys and compensation (5 minutes)

Thank you all again for your participation in this group, and for filling out the surveys throughout. We have one final survey for you to complete – it will look like all of the

other surveys, except at the end we will also provide some space for you to leave feedback on what the overall group experience was like for you. You will be compensated based on the number of surveys you completed.
[put csu.lgbtq@gmail.com in chat in case people have questions or issues with compensation]

Appendix F

Aim 2 group therapy intervention protocol (Sessions 1-6), revised in accordance with actual group content.

SESSION 1: GETTING STARTED

Purpose: Introduce group purpose and guidelines, get to know each other (90 mins)
Note: Few changes were made to this session from the initial protocol. Namely, we made space for full introductions before introducing group rules rather than completing brief introductions then continuing them in-depth after rules were established. This section also includes the co-created group rules/guidelines from this group of participants.

1 – co-facilitators introduce selves (1 min)

Name, pronouns, relevant qualifications/training

2 – review confidentiality/informed consent/recording (3 mins)

Remind participants of the surveys, and that survey participant informs how much they are compensated for their participation. Remind participants that they can use whatever name they want for this group, it doesn't have to be their usual name if they want extra measures to protect privacy. Also be clear that facilitators and researchers will maintain confidentiality, but we cannot make guarantees about other group members, though we will set it as a group rule (later).

3 – review purpose of group and acknowledgment of intersectionality (3 mins)

Statement of purpose: The aim of this group is to support LGBTQ+ young adults in making and maintaining healthy, growth-fostering connections and friendships with other LGBTQ+ community members. While we certainly hope you will find those kinds of connections among group members, we will also be discussing ways of seeking connections with community members outside of this group as well. This is a space where you can discuss part experiences of connection and disconnection, and where we can work together to figure out how to seek affirming queer spaces and how to navigate non-affirming ones.

Statement on intersectionality: It is important to us that this group is guided by the concept of intersectionality; this is a group related to connection and disconnection within the LGBTQ+ community, and we acknowledge that the ways that people connect and are treated within relationships and queer spaces are informed by all the identities they hold, including but not limited to race, ethnicity, gender identity, gender expression, sexual orientation, romantic orientation, socioeconomic status, religious affiliation, body size, ability/disability status, and so much more. We hope that this can be a space where group members are free to share these unique experiences; we also hope that this can be a space where dynamics of privilege and oppression can be addressed to minimize harm to the most marginalized within our community.

Statement of excitement and gratitude: We are really grateful to have each of you here as part of this group. We want to take a moment to highlight how special it is to have a space that is comprised only of people who are part of the LGBTQ+ community. Thank you for being here! We are looking forward to getting to know you all better.

4 – brief introduction (3 mins)

Name, pronouns (to remind everyone, if they don't already have name and pronouns in bio), fun fact or favorite queer character in media, set an intention for your participation in this group, anything you want us to know about you?

5 – review basic ground rules and solicit new ones from group (20-30 mins)

Rule 1: Respect confidentiality and privacy of other group members by ensuring you are joining group from a private location, not discussing group content with people outside the group, not identifying group members to people outside the group, not recording video or audio of sessions.
Rule 2: Do not engage in outside friendships or romantic/sexual relationships with other group members during the course of the 6-week group. There will be an optional opportunity to share contact information with one another at the end of the group.
Rule 3: Maintain respectful language use, including respecting group members' names/pronouns/identities and not using offensive or derogatory language toward others.
Rule 4: There is never any pressure to share in group. You are welcome to do so but never required, and your amount of verbal participation in the group will not affect your compensation for this study.
Other rules to consider developing with group members: How to navigate repairing harm in the group; how to navigate discussions of trauma/triggers; cameras and mics on/off; anything else the group feels is important

Other guidelines (developed by actual group during this study):
Use the hand-raising feature as needed – you don't have to raise your hand first to contribute, but you can use it whenever you want to jump in and facilitators will call on you.
It's okay to discuss difficult topics in the group! One suggestion for discussing traumatic or triggering events is to name the impact of the situation rather than disclosing the details, to avoid triggering other group members. However, we acknowledge that we cannot predict the effect of what each group member says. Therefore, you are always welcome to privately message facilitators (Shelby or Brenna) and we can move you into a breakout room with Brenna to talk separately. This can be done at any time for any reason!
If conflict emerges between group members, we can open it up to be addressed in session but can also do it outside of the group after group meetings with just facilitators and the individuals involved.
Group members identified a desire to be explicitly invited into the conversation if they are not talking much. This can be done by facilitators or other group members (but as per Rule 4, there is never pressure to share!).

7 – discussion: what do you want to get out of this group? (20 mins)

Possible follow-up/discussion questions:
What parts of the group's purpose statement align most with what you are looking for?
How satisfied are you with your current level of connection with other LGBTQ+ people?
What do you think you would need to be able to make the kids of connections you want?

What helps you feel connected to the LGBTQ+ community?

8 – discussion: getting to know each other (20 mins)

Now that we've created some ground rules and talked a bit about what we are each looking to get out of this group, we figured you all might want to get to know each other a bit beyond just fun facts. We have the rest of the time reserved to share a little more about yourself – whatever you'd like us to know!
Ideas if needed: work, hobbies, favorite shows/movies/books, favorite artists/songs

9 – wrap up (5 mins)

Answer group member questions about group, etc.
Reminder about post-group survey

Notes on process/intervention: Getting the group to agree on how to handle harm and trauma/triggers may be difficult – even in focus groups, participants did not agree. For harm, some wanted a zero-tolerance policy where members would be kicked out if they compromised the emotional safety of another group member; others wanted facilitators to educate the person creating harm without "attacking" them. Regarding trauma, some group members wanted this to be a space that was lighthearted and did not rely on using trauma to bond with each other. Others were craving a safe and understanding space to share their traumatic experiences with other queer people. Ultimately, it will be difficult to balance these needs without alienating one or more group members in some way, but it is important to the group mission that this is a space where important conversations are had and not avoided. Some ideas on compromise, if necessary: for navigating harm, consider providing options for "calling people in", where either a facilitator or the harmed person can name the harm and make space for discussion of how to repair it, which may involve offering some space to process after; for navigating trauma, one possible compromise is to have breakout rooms in Zoom where one group is welcoming of trauma and the other will not discuss trauma or will avoid discussion of decided-upon triggering content – this would work well if the group cannot come to consensus on whether this group should be more lighthearted or allow space for emotional heaviness; for navigating triggers, it may be helpful to allow group members to self-advocate and self-soothe on their own terms, but the group can be intentional about checking in with group members when they return to the space and offering support (e.g., if someone needs to briefly leave the virtual space when triggered or to avoid triggering content). It's important to note that one of the central pieces of RCT is the idea that conflict and disagreement can be effectively handled in a way that ends up strengthening the relationship and ensuring that all parties are heard. The facilitator should therefore support the group in finding "solutions" to potential conflict that allow for at least an initial opportunity to repair the relationship.

Another major note on facilitation: facilitators should be attuned to ways of facilitating mutual empathy based on the RCT definition – not just listening closely to others' experiences but also sharing how their stories/experiences have moved/affected/changed us. Facilitators can model this behavior as well as facilitate it by saying things like, "thank you for sharing that. How did hearing _____'s experience affect you?" or "what was it like to hear _____'s experience?" or other ways of getting group members to reflect and share the impact.

SESSION 2: CONNECTION MATTERS

Purpose: Explore contributors to connection and introduce central relational paradox (90 mins)
Note: No major changes were made to this session of the protocol. See Appendix G for the word web generated by group participants in this study during this session.

1 – brief review of ground rules (see session 1) (2 mins)

Put them in the Zoom chat for reference. Because people may begin discussing trauma, it may also help to review limits to confidentiality around child abuse in particular.

2 – overview of purpose of this session (1 min)

You all signed up to participate in this group in part because you were seeking more connection with other LGBTQ+ community members. Today we're going to spend some time talking about what contributes to feeling connected. Next week, we'll talk about what gets in the way of making the kinds of connections you are hoping for.

3 – activity: word web for connection/community (20 mins)

We want to know what kinds of things help you feel connected to other LGBTQ+ community members. During our discussion, we (facilitators) will be adding your ideas into a word web so that we can keep track of your ideas and reference them later.
Discussion questions:
What makes you feel safe and comfortable enough to make connections?
Tell us about the times you felt most connected to the LGBTQ+ community – what made those experiences good or memorable?
Per focus groups: safety, validation/affirmation of identities, shared experiences, shared identities, shared interests, nonjudgment, mutual support (relying on one another/uplifting one another), humor, creative self-expression, authenticity, not needing to explain oneself or prove one's identities/queerness
Note: One topic that often came up in focus groups was Pride – if this does not come up in discussion, you can mention it and see if people resonate. Have them try to identify what it is about Pride that contributes to that feeling of connection and add that to the word web.

4 – reflection on activity (20 mins)

What was this activity like for you?
Have you had experiences that reflect these forms of connection and community?
How did they make you feel?

5 – relational-cultural psychoeducation: central relational paradox (2 mins)

Statement on RCT: We live in a society that values independence and self-sufficiency; these things can be adaptive at times, but ultimately our brains are wired to be in connection with other people. Isolation can be a source of pain, and the right relationships can be a source of healing! Our expectation for relationships are influenced by past experiences. Many of us may have experienced rejection or judgment because of our LGBTQ+ identities, and others have even faced judgment from within the broader LGBTQ+ community. These experiences can give us the sense that something is wrong

with us or that it is never safe to bring our full, authentic selves into connection with other people. It might feel like this keeps us safe, but it may also be the thing that keep us isolated. In relational cultural therapy, this is called the "central relational paradox" – the idea that, in order to be accepted and connected to others, we actually tend to disconnect from important parts of ourselves, bringing only some pieces of ourselves into our relationships. We develop strategies for this, like withdrawing from others, not sharing our true feelings, criticizing others, and more.

6 – relational-cultural discussion (20 mins)

Reactions to that idea? How does it fit or not fit with your experiences?
How can we as a group work to make this space a safer place to be yourself?
What experiences have you had that have shaped how much of your true self you bring into your relationships?
What strategies have you developed to be more accepted by others?
What parts of you do you tend to hold back? What parts do you want other people to see and validate?
What is the cost of holding parts of yourself? What do you miss out on because of it?

7 – wrap-up (5 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: Per RCT, therapist role is to respond with empathy and be responsive to group members' needs. RCT is clear that being authentic (as a therapist) is *not* about spontaneous, honest reactions but rather intentional responding based on empathy, caring, and what would be most helpful based on what you know about the group member. In this group, we will not be working with robust client histories like we would in individual therapy. This is where we can lean on our understanding of LGBTQ+ issues and focus group data to understand the kinds of experiences LGBTQ+ young adults have had (while also being careful not to make overgeneralizations/assumptions). For example, many group members' early relationships may have been characterized by withdrawal, rejection, judgment, even abuse; facilitators should be careful not to replicate these dynamics. In a group setting, there is an added layer of needing to also attend to how group members are responding to one another (and monitoring/adjusting those interactions based on the same principles). So for example, if facilitators notice that a group members is judging or invalidating the experience of another group member, a facilitator could make a comment on process, inviting the invalidated person to share their emotional reaction and starting a dialogue between the group members (offering support on how to handle the conversation e.g., I statements, taking turns, summarizing, etc. as needed). Another theme in terms of the experience of LGBTQ+ people is erasure and being silenced, which can be multiplied by belonging to certain other categories of marginalization. Thus, the group should aim to ensure that individual group members are not silenced or skipped over, especially if they are among the more marginalized group members. Facilitators should closely monitor group members to ensure that they have the opportunity to share when it seems like they have something to say, gently (no pressure) checking in with people who have not shared their perspective, coming back to important topics/emotions when the subject is changed, etc. The

important piece is sticking with each other and remaining connected while also helping to ensure that the connections being forged are healthy.

SESSION 3: BARRIERS TO CONNECTION

Purpose: Explore barriers to connection and ways around them (90 mins)
Note: Some changes were made to this section of the protocol. First, rather than having participants write down their roadblocks to community (Section 3), facilitators opted to have participants discuss them aloud. For this portion, as well as for discussion of "solutions", it was helpful to have facilitators share the screen so participants could follow along more closely with the discussion. Appendix H contains the list of roadblocks and solutions/ideas suggested by the participants in this study. Furthermore, the end of this session was adapted to offer an opportunity for participants to share what kinds of tools and skills they wanted from facilitators, which allowed facilitators to adapt the specific ideas and resources presented in the subsequent session to meet participants' needs.

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (1 min)

Last week we talked about why connection to others is so important, and we talked about some of the ways that this group can be a safer space to be our authentic selves. We also began talking about how our past experiences shape how we connect or disconnect from others. This week, building on those ideas, we will spend some time talking about what tends to get in the way of connection. Next week, we'll talk about how we might go about determining whether a certain space, person, or group has what you need to feel connected.

3 – activity: roadblocks to connection/community (8 mins)

Have group members take 6 minutes or so to discuss their personal roadblocks to connection and community. Facilitators should write them down (with screen shared if appropriate) to document them as they go.

Roadblocks can be…

Thoughts (e.g., I'm not cool enough, I'm not queer enough, I will be rejected, no one will like me)

Physical barriers (e.g., living in a rural area with no community spaces, lack of sober gathering spaces, physical inaccessibility)

Emotional barriers (e.g., anxiety, depression/low energy)

Community barriers (e.g., racism, transphobia, biphobia, etc. within community)

Specific experiences when you tried to connect but did not succeed

Strategies for disconnection (per yesterday's discussion on the central relational paradox, what things do you do to keep yourself from connecting authentically with others?)

4 – discussion: what seems to get in the way of making the kinds of connections you want to make with other LGBTQ+ people? (20 mins)

Follow-up questions to generate discussion for the roadblock activity, or discussion after completing it:

What kinds of thoughts do you have that convince you not to reach out to others?

What fears do you have about initiating connections?
What physical barriers get in the way of community? Emotional barriers? Etc.
Have others in the group experienced similar barriers?
What does it feel like when you come up against these barriers?
Have you noticed any of these barriers coming up in this group? If so, how should we handle them as a group moving forward?

5 – discussion/activity: ways around barriers (30 mins)

For the next part of our group today, we wanted to talk about some ways to deal with, remove, or move around some of the barriers you all came up with. We want to start by acknowledging that some barriers you have identified are structural or deeply engrained in society and therefore difficult to change or overcome, and that it may not make sense to talk about simply overcoming them as an individual – these are barriers that will require collective action toward dismantling the systems themselves. This time is open for discussion of any of the barriers you all named, but we recognize that certain ideas may only apply to certain types of barriers, or that certain ideas might be safer to implement for some community members than others.
With all that in mind, what are some thoughts you have on working around a certain barrier?
Format: have one group member identify a possible solution/way around and have them clarify which barrier(s) it would apply to; ask group their thoughts on the idea and what they would need to use it successfully; have group brainstorm other possible ways around that barrier; then move to a new idea/barrier
If the barrier is a thought: have group members "talk back" to the thought and/or come up with a more helpful one
Seeing barriers in context: What are some of the ways that oppression, privilege, and uneven power dynamics affect these barriers? (Note: seeing barriers in the sociocultural context can help people see that the barriers are not their fault, removing some of the shame)
Note: Write down a list of solutions/tips alongside the barriers mentioned, and keep screen shared. Also, this part of the session turned out to be a helpful time to explicitly check in with the group and ask them specifically what kinds of tools and skills they would like to learn from/discuss with facilitators and each other, so that we could adapt the content of the subsequent session to best meet their needs. For example, participants from this study expressed interest in learning how to be present while connecting with others, strategies for maintaining connection after establishing a new relationship, ways to manage self-critical thoughts, and how to be more self-compassionate.

6 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: One of the helpful things about RCT as a framework is that, in my experience, it layers well and is not at odds with other orientations. Although RCT pushes back against the individualist focus of CBT, I think the idea of challenging unhelpful thoughts

can apply well to reducing barriers to connection. RCT may argue that the best and primary way to change people's connection-interfering behaviors and thoughts would be by showing them over time that relationships can be mutually empathic and growth-fostering, including the therapeutic relationship, so that clients can learn in real time that a different outcome (i.e., than rejection/invalidation/etc.) is possible. However, in this group we only have 6 sessions to get to know the group and work to make real changes in their lives. Thus, there may be utility to directly identifying and challenging the unhelpful/maladaptive patterns of thought that seem to interfere with or outright prevent connection-seeking behavior. Of course this thought challenging (if used) should be done relationally, and with facilitators being mindful of the idea that making thoughts the "main problem" or primary barrier can wrongly imply that there are not other very real barriers such as actual experiences of rejection, abuse, racism/other forms of discrimination, etc. that we LGBTQ+ people must attend to when deciding whether to enter into a given space. With RCT as a primary orientation, a priority is to validate the depth of group members' experiences with these difficult, sometimes systemic barriers – not to talk them out of it or provide "solutions" that push them to engage in unsafe spaces, but rather to listen to their experience, allow space for them to process it, offer a space where those same dynamics of oppression are not replicated, etc.

SESSION 4: TOOLS FOR MANAGING DISCONNECTION AND NON-AFFIRMING SPACES

Purpose: Brainstorm & learn new ways of navigating spaces that do not feel welcoming (90 mins)
Note: A few notable changes were made to this session. First, per the adaptation made to session 3, participants had requested that facilitators offer various forms of skills/tools/ideas for managing common barriers to connection. Thus, co-facilitators adapted the tools presented and prepared others (though there was some overlap with the initial protocol), which are now listed here. Through supervision, co-facilitators consulted regarding the anticipated time to review and discuss each skill. They also consulted regarding the shift in tone of the group when discussing roadblocks in the prior session; co-facilitators determined that another discussion focused on disconnection, as initially outlined for this section, may be likely to be redundant and reduce sense of hope. Based on these considerations, facilitators opted to begin the session with the concrete tools and skills. The name of the session has been changed to reflect this shift. Reviewing and providing examples of how to use each skill took the entire session, so some prompts for discussion at the end of the session were removed.

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (2 min)

In the past few weeks, we've focused on what kinds of things help you feel connected, and what tends to get in the way. Last time, we gathered suggestions from all of you about how you have navigated these barriers or ideas for new things to try, which is so helpful! We also wanted to bring in some other ideas we had, based in ideas from various therapy perspectives, based on what you all stated might be helpful during session last week.

3 – psychoeducation: managing disconnection (30 mins)

Tools presented here can be developed based on group members' needs, as expressed at the end of Session 3. For example, in the pilot group, participants indicated wanting tools for being present during connection with others, strategies for maintaining connection once established, ways to deal with self-critical thoughts, and ways to increase self-compassion. Thus, the following tools were presented:
CBT: Introduce CBT triangle and idea of intervening on the level of thoughts and behaviors – this can set up a discussion around why we might challenge thoughts using something like putting thoughts on trial; by intervening on thoughts, emotions will shift too: https://www.therapistaid.com/worksheets/cbt-triangle
Consider coming up with an example of a common self-critical thought to use/go through with the group to "put on trial": https://www.therapistaid.com/worksheets/putting-thoughts-on-trial
Self-compassion: For this section, I used an adapted self-compassion exercise from a workbook, but anything that prompts participants to engage in more self-compassionate self-talk will be helpful here. In particular, participants in the pilot group appeared to

resonate with the idea of speaking to/treating yourself like you would speak to/treat a friend.
If/then model of boundaries: https://ninaamir.com/boundaries-if-this-than-that-rules/
In the discussion of boundaries, consider bringing in RCT discussion of "boundaries as a meeting place" and a way to continue a relationship (i.e., I am willing to continue our relationship on these terms), not (necessarily) a way to cut off a relationship.

Other ideas that could be presented based on group member needs/preferences:
RCT: Disconnections occur in all relationships, including healthy ones. It is important, then, to find ways of reconnecting and navigating conflict that do *not* involve keeping parts of your authentic self out of the conflict. (Note: there are other times that it is best not to stay in harmful relationships or community spaces – this concept does not apply to those situations)
DBT: DEARMAN provides a framework for having conversations with others during which you need to express a boundary or make a request. Is that something you all would be interested in going over together?

If yes, have a group member come up with an example of a boundary they feel they need to set/request they need to make, or one that they tried to communicate in the past ineffectively. Use this to guide the conversation: https://www.edencounseling.com/resources/Eden-DBT/DBT-Interpersonal-Effectiveness/dbt-interpersonal-effectiveness-grp-4-handouts.pdf

5 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

Notes on process/intervention: Intersectionality/identity is crucial to keep in mind here in addition to the explicit statement about it in last week's schedule. There are very real reasons why people may feel unsafe setting certain boundaries, engaging in conflict in certain spaces, getting up and leaving certain spaces, ranging from financial need to physical danger and more. Facilitators should be attuned to these realities when facilitating these discussions and avoid making one-size-fits-all assertions about what strategies and skills may work for a given person or situation.

SESSION 5: SEEKING AFFIRMING SPACES/PEOPLE

Purpose: Explore ideas around what growth-fostering relationships and community look and feel like and how to seek them out (90 mins)
Note: In session 4, we did not finish reviewing concrete tools for managing disconnection and increasing connection that participants wanted, so we opted to open this session by following up with the remaining tools here. This shifted the whole session, such that we did not have time for some of the final discussion (now listed here as optional). We intended for the collage activity (in the initial protocol) to be moved to the final session because of lack of time. This is discussed further in Session 6 note.

1 – brief review of ground rules (see session 1) (2 mins)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (1 min)

Last week we talked about concrete skills and tools you can use that can help you feel more connected in different ways. There were a few of those we didn't get around to discussing last time, so we will start there today.

We also wanted to talk about finding and maintaining the kinds of relationships where we can be authentic, and where we feel like the relationship inspires us to grow, be creative, and connect even more deeply.

3 – review of remaining tools/skills

This section should be adapted (if needed – no need if facilitators finish reviewing everything in Session 4) to whatever participants feel they are still needing.
Mindfulness: It can be easy to get caught up in our heads when we are trying to be present and connect with other people. We can find ourselves overthinking, being self-critical, getting caught up in strong emotions, or feeling distracted. Mindfulness offers a way to stay in touch with the present moment. See worksheet for more details: https://www.therapistaid.com/worksheets/what-is-mindfulness
Maintaining connection: One participant described being unsure what to do once they establish a new connection in terms of how to maintain and grow it. Co-facilitators generated some ideas together between sessions (e.g., scheduling time together/scheduling reminders to reach out to friends in one's calendar) and invited feedback from the group as well.

4 – psychoeducation: RCT principles (30 mins)

Since we have been using relational-cultural therapy as a framework, we wanted to share a few concepts from that model. These are some of the things that, according to RCT, are important pieces of growth-fostering relationships.
Authenticity: Authenticity means representing ourselves honestly and fully in our relationships. Per RCT, this can be a challenge when we have been shamed, oppressed, marginalized, and when we have received messages that we are not worthy as we are. Growth-fostering relationships are ones in which we can start moving toward being authentic and not being shamed for it.

Mutual empathy: We think of empathy as one person listening to another person's experience and being emotionally affected by it. Mutual empathy works like this: let's imagine two people, Person A and Person B. Person A shares a difficult experience with Person B, and Person B listens closely, feeling affected by their story. Person B expresses the effect that hearing about this experience has had on them, showing that they were moved by the story. The idea here is that it can be connecting to empathize with someone else, but it strengthens the connection even further when another person believes that their experiences can genuinely move or impact others.
"Five good things": When people are well-connected, they may feel the following 5 things. 1) greater sense of energy, zest, or vitality; 2) more able to act; 3) more accurate picture of self; 4) greater sense of worth; and 5) more motivation to connect with others

Note: After each term, allow space for discussion of each one.
Note: In the pilot group, we did not get to "five good things" and ended the group after discussion of mutual empathy.

5 – optional discussion: seeking community (20 mins)

Now that we have talked through some ideas from RCT about what we can look for in growth-fostering relationships and spent some time imagining what healthy community would look like, we can spend some time talking about how we might go about finding relationships or community like this. What ideas do you all have on this?
What have you tried in the past that worked well?
What have you tried in the past that didn't work well, and how would you do it differently this time?
Note: We did not have time for this in the pilot group, but such discussion may be worthwhile in other groups with enough time.

6 – wrap-up (5-10 mins)

What ideas are sticking with you from our time together today?
Reminder about post-group survey

SESSION 6: WRAPPING UP

Purpose: End the group by sharing final reflections, discussing take-aways from the group, and optionally sharing contact information (90 mins)
Note: In the initial protocol, Session 5 included a sort of virtual collage activity. In the pilot group, there was no time in Session 5 and this activity was offered as an option during the final session. However, participants declined; they did not seem to fully grasp how the activity would work and it would have been fairly difficult in the virtual setting; it was initially designed to attempt to meet focus group participants' stated interest in having a collaborative creative project together with other participants. Thus, in an in-person version of this group, it may be ideal to check in with participants leading up to the final few sessions about what kind of creative project, if any, would be of interest to them (e.g., collage, painting, friendship jewelry-making, sharing playlists, etc.) to organize as a group for Session 5 or 6. In the virtual format, we opted to take a suggestion from a group member to make another word web focusing on intentions and take-aways from the group (see Appendix I). Furthermore, we opted to use Discord as a platform for participants to optionally share their contact information with one another. Facilitators shared resources with participants after the group ended, which can be seen in Appendix J.

1 – brief review of ground rules (see session 1) (1 min)

Put them in the Zoom chat for reference.

2 – overview of purpose of this session (2 minutes)

Over the past few weeks, we have been talking about all sorts of topics related to connection and disconnection within the queer/LGBTQ+ community. This week is our final session together, so we wanted to make sure we made time to tie up any loose ends, talk about what we are each taking away from the group, and sharing what our experiences were like in this group. When we were initially developing the idea for this group, the people we talked to about it expressed that they were interested in the idea of having the option to share contact information with other group members so that you can potentially continue the connections you made here after the group ends. So, at the end of our session today, we will have an option to share whatever contact info you are comfortable with among the group members. There is absolutely no pressure to share any of your contact info, and you can have complete control over which forms of information you share if you decide to.

3 – discussion: reflections on group (10-40 mins)

First, we wanted to see if there were any remaining topics that you all wanted to make space for today – either things we haven't touched on yet, or things that we discussed in previous weeks that you wanted to revisit or that you have new thoughts about.
[allow space for discussion]

We also want to make space for anyone wants to share their thoughts on what this group was like for them and what they are taking from it moving forward. As a reminder, your final survey will also ask you for feedback about the group, so there is no pressure to share here.
[allow space for discussion]

Note: In the pilot group, based on suggestions from a group member, we created another word web for group members to share what they are taking away from the group and what their new intentions and hopes for connection are upon leaving the group.

4 – optional: discussion questions (30 mins)

Adapted from *The relational cultural model: A framework for group process,* possible discussion questions for the group if time allows:

When we first started this group, what were your expectations for how relationships with other LGBTQ+ people would go? And have those expectations changed?

Which strategies for disconnection are you hoping to leave behind?

Which strategies for authentic connection are you hoping to use moving forward?

What part(s) of yourself did you share with this group that you normally hide from others?

How has inauthentic relating affected your sense of self-worth and relational confidence?

What are some sociocultural influences that have affected your ability to develop/maintain relationships? In response to such sociocultural influences, what types of strategies have you used for survival?

What relational strengths did you bring to the group? Were there strengths that you developed over the course of the group?

What strengths did you notice in other group members?

How have other group members impacted or moved you?

5 – statement of gratitude (2 minutes)

[insert statement here – to increase authenticity, it will likely be important for final remarks of gratitude for the group to be shared spontaneously by facilitators or to be written just before the final session rather than having a scripted statement prepared in advance of the group]

6 – optional: sharing contact information (5 minutes)

As we discussed at the beginning of the session today, we want to take a minute to talk about sharing contact information with other group members. We know that the ability to connect with others after the group was important to some of you, so this is a moment where you can share if you feel comfortable. Before we start, here are some general guidelines. First, we as facilitators will not be sharing our information and cannot take your contact information either. Second, there is no pressure to share your information, this is completely optional and will not affect your compensation in any way. Third, feel free to only share whatever information you are comfortable with – phone number, email, social media, or any other options are fine!

In this group, co-facilitators created a Discord server for participants to join and let them know that it would be deleted in a few weeks, so they would need to either create their own server or share alternate contact information with each other ahead of the 2-week deadline. Participants were all familiar with Discord, but facilitators can model what it looks like to make an account if needed.

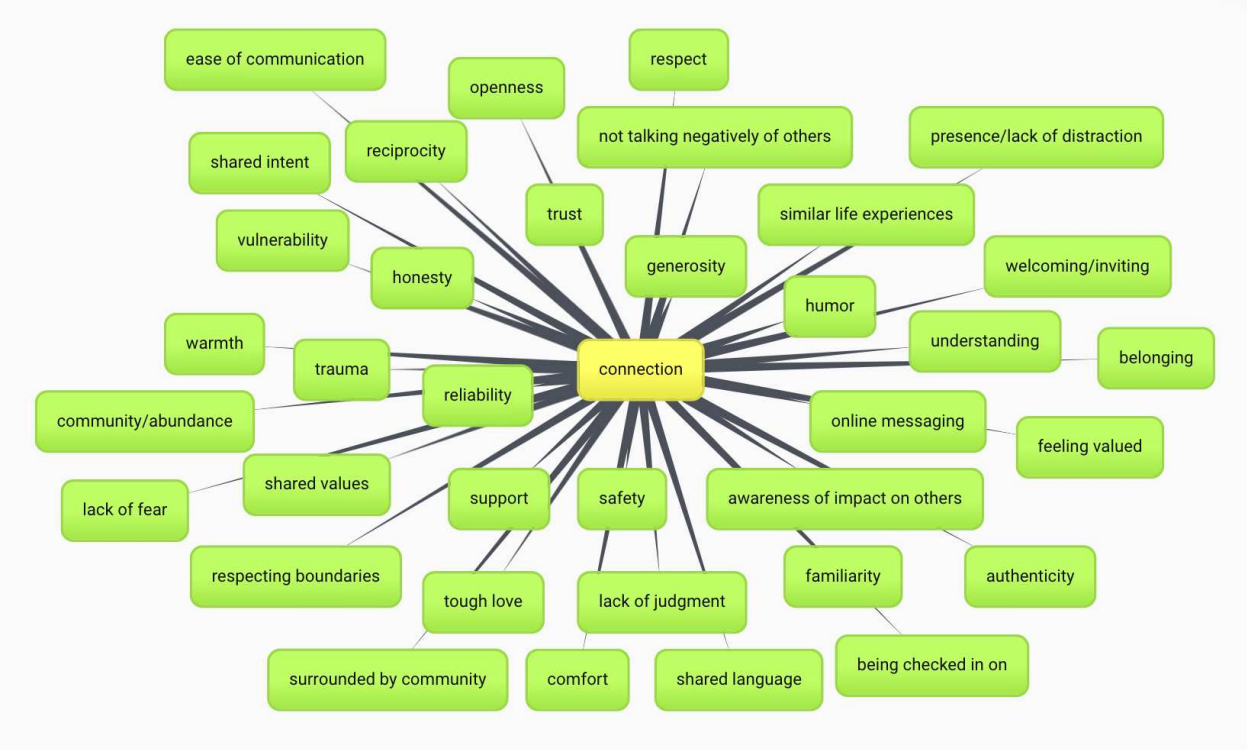
Note: each group may have different preferences around whether sharing contact information means sharing with everyone (pros: no one feels left out; cons: people may feel less comfortable sharing their information if there were people in the group that they would not want to be in contact with after the group) or choosing who they want to share information with (pros: increased comfort and empowerment to choose where their information goes; cons: if certain people do not receive any information or requests for their information, they may feel left out and this could impede progress made toward increasing relational competence and sense of community – also unclear logistically how this would work if Person A wants to share with Person B, but Person B does not want to share with Person A)

7 – closing remarks on surveys and compensation (5 minutes)

Thank you all again for your participation in this group, and for filling out the surveys throughout. We have one final survey for you to complete – it will look like all of the other surveys, except at the end we will also provide some space for you to leave feedback on what the overall group experience was like for you. You will be compensated based on the number of surveys you completed.
[put csu.lgbtq@gmail.com in chat in case people have questions or issues with compensation]

Appendix G

Word web generated by therapy group members (Aim 2) in Session 2 of the intervention using https://bubbl.us/.



Appendix H

List of "roadblocks" to connection and suggestions/solutions generated by therapy group members (Aim 2) in Session 3 of the intervention.

Thoughts: self-doubting thoughts; overanalyzing; fortune-telling (leading to disappointment); second-guessing self; am I queer enough/the right kind of queer?/do I look queer enough?; wondering/guessing what the other person is looking for from the connection; it's been too long so I can't reach out

Emotional barriers: fear of not being accepted fully (for all intersecting identities); stress/rumination; exhaustion; embarrassment; fear of vulnerability; fear of over/under-sharing; insecurity/lack of confidence; lack of knowledge/capacity for maintaining relationships

Physical barriers: preferring in-person connection/lack of nearby community; lack of events for young adults

Strategies for disconnection (behavioral/interpersonal barriers): putting on a "mask" to meet other's expectations; being on the phone/watching movies/staying surface-level in conversations

Community barriers: different communication styles (depth, straightforwardness, frequency, format, ghosting); internalized homophobia (shame); drinking culture; differing life stages/experiences

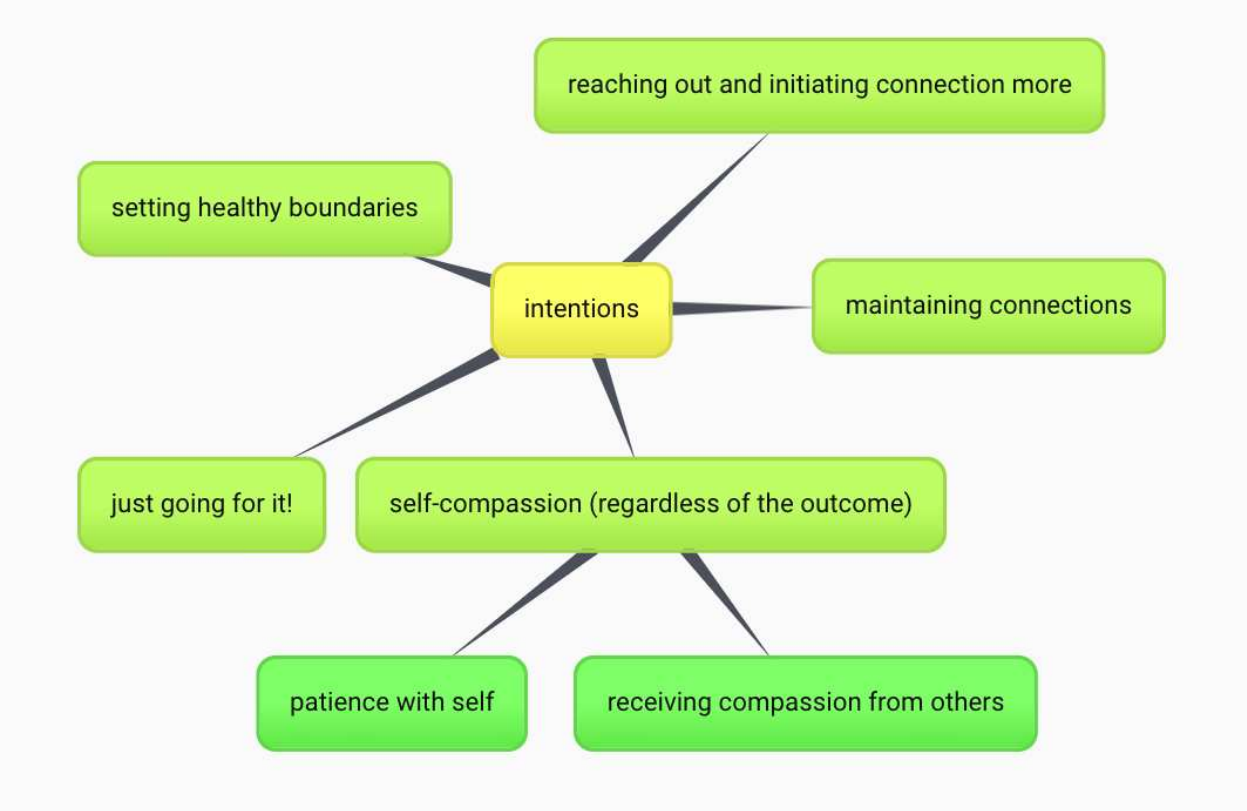
Other barriers: disconnect between intention/expectation and reality; feeling excluded; not fitting in with norms/scripts; perceiving that other friend groups are already well-established and not knowing how to introduce yourself; past experiences; society (lack of time/energy with other life responsibilities)

Ideas:
Being willing to feel awkward enough to introduce self to new people; remembering it can be worth it and that worst-case scenario isn't inevitable
Inviting people along to events
Reaching out as soon as someone crosses your mind (rather than second-guessing) – "this made me think of you"
Reminder that some connection is better than none, giving self grace about time between texts/connection
Offer apologies when appropriate, share authentic feelings
Reframing risk of reaching out: if I reach out and it goes well, I get the relationship I want; if it doesn't go well, I get the same thing as if I never reached out (or I get closure)
When thinking about reconnecting with former connections, remembering that no one is the same person twice, it is normal to change over time
Responding to cues in friendships that suggest vulnerability is okay
Not everything I think about myself is true – "that's just the self-doubt talking"
"Let them think that – I'm actually [self-affirmation]" – it's more helpful to believe what a friend would say than what an enemy would

Affirmations (even if they feel weird at first)
Reminding yourself of what a friend would say to you
Cultivating self-forgiveness (“it’s okay that this happened, I can do it differently next time”)
Gratitude
Don’t always plan out ways of connecting, do them before you have the chance to overthink
Reminder to start with the first step

Appendix I

Word web generated by therapy group members (Aim 2) in Session 6 of the intervention using https://bubbl.us/.



Appendix J

Resources shared with therapy group (Aim 2) participants following the final session of the intervention.

THERAPY:

- https://www.psychologytoday.com/us/therapists (search via location, specialty, insurance, and more)
- https://queerasterisk.com/services/counseling-services/ (currently full but may accept clients in the future)
- https://lgbtqcolorado.org/resources/wpbdp_category/mental-health/ (list of CO LGBTQ+-affirming counseling services)

COMMUNITY ORGANIZATIONS:

- https://lgbtqcolorado.org/about/
- https://queerasterisk.com/
- https://www.nocoequality.org/
- https://one-colorado.org/
- https://pflag.org/

FACEBOOK GROUPS:

- https://www.facebook.com/groups/LGBTQDenver/
- https://www.facebook.com/groups/lgbtoutdoorsco/
- https://www.facebook.com/groups/168107770258072/

EVENTS:

PRIDE:

- Fort Collins: June 1, 2023
  - https://nocosafespace.com/pride-march/
- Loveland: June 10, 2023
  - https://allevents.in/loveland/loveland-pride-celebration/200024524797843
- Longmont: June 30, 2023
  - https://www.outboulder.org/events/longmont-pride-2023
- Denver: June 24-25, 2023
  - https://denverpride.org/
- Colorado Springs: June 10-11, 2023
  - https://allevents.in/colorado%20springs/pikes-peak-pride-2023-the-power-of-pride/200023891328913

Appendix K

Qualitative data from the survey administered after the final group therapy session (Aim 2).

Item: How would you describe your experience in this group?
Responses:

1. "Authentic"
2. "This group helped give me some perspective and tools to try out. I don't feel as alone now in my struggles to connect with other LGBTQ+ people, but I am disappointed that I didn't feel/was unable to co-create a connection with any of the group members."
3. "I didn't come in with a goal. But i had enjoyable moments, and learned a few new skills!"
4. "It was overall positive."
5. "My experience was overall very positive. This group was helpful, but could be improved to make it even better."
6. "My experience in this group was a really good one. Being able to have discussions with other LGBTQ+ people from across the state and know we have similar struggles made me feel less alone and more hopeful. Shelby and Brenna did a great job facilitating the group and knew when to let group members speak their mind and when they could pitch in some tools we could use."
7. "This group was a positive experience and helped me put effort in intention."
8. "A new experience"

Item: What, if anything, was helpful about this group?
Responses:

1. "I enjoyed hearing from others"
2. "Hearing other group members' concerns. Facilitators and members alike sharing what has worked for them."
3. "Working together on something (like a web) to get the ball rolling. Then sharing things and getting advice."
4. "The skills we were taught."
5. "Being a part of this group was helpful towards giving me skills to make connections, allowing opportunities to talk about friendships and were I have struggled. I enjoyed how it reframed connections for me in thinking about what I need."
6. "It was really helpful to discuss struggles and have other suggest ways to overcome them. It was very helpful to have the handout with different tools to reference back to. I also really enjoyed the word webs we made. Having time to self-reflect and learn reframing skills. I learned that self-criticism, feeling alone, and having self-doubt is something a lot of people go through, and self-compassion is very important. There is a spectrum to everything and it is okay to make progress little by little. A lot of the time self-improvement is seen very black and white and I learned it's okay to make mistakes and take it day by day."
7. "Getting to speak with other people that are also having a similar experience building community."
8. "Hearing others experiences"

Item: What, if anything, was unhelpful about this group?
Responses:

1. “Lack of group participation and responding directly to one another. Lack of interaction that might resemble how to foster connection outside of the group.”
2. “No indovidual time already alloted. It would be nice to have every other week of group and individual sessions in between.”
3. “No complaints”
4. “Nothing was unhelpful, but I wish there was more time for discussion about relationship building over learning skills. Sometimes the word webs helped with conversations, but I also think they hindered some of the organic flow of them.”
5. “It was difficult to be conversational so sometimes it felt a bit anxiety inducing.”
6. “N/A”

Item: If the group were to be run again, what changes would you make?
Responses:

1. “I would prefer the facilitators give an example in the beginning of what a successful group therapy session might look like. There’s one in Platonic by Marisa Franco which makes it clear that participants will benefit most from interacting with each other instead of always waiting on the facilitators to say things like it’s a Zoom class. I think I would’ve liked if each session was opened with the opportunity to share something we struggled with or made progress on since last session. Two weeks between sessions maybe.”
2. “As stated above, every other week. Also team building and fun stuff so we were more comfortable sharing and making friends. It would be nice if it was in person too. But i know thag wasn't possible this time. And double the ammount of weeks, so we have more time to process.”
3. “Longer sessions”
4. “I would want the group to be longer to give more time for processing, I also would have appreciated talking through where everyone was at in terms of making connections.”
5. “Add more exercises to allow a better flow of communication.”
6. “N/A - everything we talked about in the group today”