Title

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Authors

Sunder, Gowri

Bosley, Hannah

Ceja, Alexis

et al.

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Gowri Sunder, MDes[a], Hannah Bosley, PhD[b,c], Alexis Ceja[a] , Briana McGeough, PhD[d], Annesa Flentje, PhD[a,e]

[a]Community Health Systems, School of Nursing, University of California, San Francisco
[b]Berkeley Therapy Institute, 1749 Martin Luther King Jr Way, Berkeley, CA 94709
[c]Department of Psychiatry and Behavioral Sciences, University of California, San Francisco, 401 Parnassus Ave, San Francisco, CA 94143
[d]School of Social Welfare, The University of Kansas, 1545 Lilac Lane Room 302 Lawrence, KS 66045
[e]Alliance Health Project, Department of Psychiatry and Behavioral Sciences, School of Medicine, University of California, San Francisco, 1930 Market St, San Francisco, CA 94102

Gowri Sunder https://orcid.org/0000-0002-6476-0696
Hannah Bosley https://orcid.org/0000-0003-4587-314X
Alexis Ceja https://orcid.org/0000-0002-6359-5377
Briana McGeough https://orcid.org/0000-0002-9903-7828
Annesa Flentje https://orcid.org/0000-0002-1964-4151

Correspondence regarding this article should be addressed to Gowri Sunder, gowri.sunder@ucsf.edu

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Abstract

Sexual and gender minority (SGM) people experience health disparities due to minority stress. We investigated the applicability of AWARENESS, a 10-session cognitive-behavioral intervention, to intersectional minority stress. We assessed the impact of the intervention format (group *vs*. individual sessions) and modality (in-person *vs*. telehealth). AWARENESS was piloted among SGM women in individual sessions and SGM people in a group format. Session progress notes, feedback surveys, and semi-structured feedback interviews were analyzed. Twelve participants began the intervention. Eight participants provided feedback (n=5 in the women's pilot, n=3 in the group pilot). Participants reported learning new skills and applying the intervention in their daily lives. In both pilots, participants applied the intervention psychoeducation and skills to multiple identities and characteristics. Feedback emphasized the importance of integrating an intersectional perspective consistently and directly throughout the intervention. Although the group and telehealth formats provided useful opportunities for connection and support, future iterations of AWARENESS may need to approach enrollment of participants with a personalized approach to determine which format or modality will be most beneficial. This study suggests that AWARENESS is feasible for intersectional minority stress. We outline future intervention modifications to improve participant engagement and address intersectional minority stressors.

Keywords: LGBTQ, minority stress, intervention, cognitive-behavioral therapy

Introduction

Sexual minority people (SM; *i.e.,* those with a sexual orientation other than heterosexual) and gender minority people (GM; *i.e.,* those with a gender that differs from societal expectations based on their sex assigned at birth), face greater health problems compared to heterosexual or cisgender individuals. These include increased risk for substance use (Cochran et al., 2004; Green & Feinstein, 2012; McCabe et al., 2009), mental health disorders (Bockting et al., 2013; Cochran et al., 2003; King et al., 2008; Lipson et al., 2019), and co-occurring mental health and substance use disorders (Lipsky et al., 2012; Ruppert et al., 2020). The minority stress model has been one of the most prominent frameworks used to explain the prevalence of health disparities among sexual and gender minority people (SGM) people. According to the minority stress model, SGM people encounter daily experiences of stigma, discrimination, and other unique stressors that contribute to poor health outcomes (Meyer, 2003).

The minority stress model has been expanded to include the distinct experiences of people who are multiply oppressed and marginalized due to their intersecting identities (Bowleg et al., 2003). The intersectionality framework posits that social identities and characteristics (*e.g.,* gender identity, race/ethnicity, and sexual orientation) are interdependent and interconnected (Collins, 1990; Crenshaw, 1989). Intersectional experiences cannot be accurately understood by treating an individual's identities and characteristics as separate and independent from one another (Crenshaw, 1991). Research that does not consider the intersecting identities and characteristics of a population cannot fully understand the multiple ways in which they are marginalized and subsequently experience health disparities (Bowleg, 2012; Crenshaw, 1989). An SGM person with overlapping minority characteristics may be multiply oppressed and marginalized. For instance, according to the US Transgender Survey (USTS) Black transgender

individuals reported greater rates of victimization, economic hardships, and health disparities than other transgender respondents (James et al., 2017), which may be related to distinct experiences of stigma at intersection of race and gender identity or expression. Thus, interventions to address minority stress should holistically consider the impact of the person's unique, individual set of intersecting minority stressors.

Intervention studies tend to focus on specific subgroups of a minoritized population, which often results in understudied populations and interventions that may not be applicable in real-world contexts where patient populations are comprised of a diversity of intersections of experiences and identities. In contrast, an intersectional framework offers opportunities for improved generalizability and inclusivity. Although existing literature has often examined intersectionality using a deficit-focused approach (*i.e.,* focusing on the negative impacts of multiple oppressed and marginalized identities and characteristics), strengths-based approaches to intersectionality have been described (Ungar, 2013). The strengths-based approach to intersectionality examines the individual's or community's resilience (*i.e.,* ability to adapt, and thrive when faced with adversity) and can be used to identify individual or community attributes that promote health (Ungar, 2013).

In the present study, our approach is both intersectional and strengths-based. Each person's set of identities may expose them to an array of minority stressors and these same identities can also increase a person's access to sources of community and resilience. An individual may belong to communities comprised of others with shared intersecting identities who help navigate intersectional stigma, identify resources, and provide social support. Further, intersectional SGM communities (*e.g.,* SGM communities of color, SGM people with disabilities) may also mine diverse cultural histories, traditions, and creative modes of expression

to cultivate joy, community, and pride. For instance, in response to exclusion from broader SGM or Black communities, people have formed organizations for Black SGM individuals that host meet-ups and cultural events, create opportunities for economic support, and places to share health and educational information. Such organizations and communities are uniquely equipped to buffer the person-specific, intersectional minority stressors Black SGM individuals may face, so interventions to address intersectional minority stress would be remiss to not encourage clients to connect with these resources.

It is therefore important to tailor the intervention to an individual's unique experiences, highlighting how intersectional identities can mitigate or amplify the impact of minority stress. Further, SM and GM communities are heavily overlapping. For example, recent studies of GM experience based on large samples (>2,000) have found that less than 5% identified as straight or heterosexual (Clark et al., 2022), suggesting that intersecting minoritized identities among GM people are extremely common, even before accounting for race/ethnicity and other individual characteristics.

AWARENESS (Approach the World with Acceptance, Respect, and Equity with New and Explicit Strategies for Self-Awareness) is a 9-session cognitive-behavioral intervention aimed at addressing intersectional minority stress among SGM people by teaching participants skills to cope adaptively with identity-related stressors such as discrimination, microaggressions, and internalized stigma (Flentje, 2020). Cognitive-behavioral therapy (CBT) has been supported as an effective treatment for improving the impact of minority stress on SGM people (Martell et al., 2004; Pachankis et al., 2015; Smith et al., 2016). CBT provides SGM people with the opportunity to learn coping skills to manage experiences with discrimination and other minority stressors (Balsam et al., 2019). Since minority stress has been robustly associated with greater

rates of co-occurring mental health and substance use disorders, reducing minority stress may help participants achieve adaptive change in both mental health and substance use outcomes. A cognitive-behavioral model can be applied to help individuals learn ways of responding to minority stressors by reflecting on core beliefs about themselves, challenging their automatic responses or assumptions, and learning ways to interrupt unhelpful patterns while taking account of the sociopolitical circumstances responsible for these stressors. In pilot studies, AWARENESS was tested among SM men living with HIV who used substances. Results indicated that participants in AWARENESS gained skills to cope with intersectional minority stress, and experienced greater integration of their identities. Primary outcomes such as substance use and mental health symptoms signaled decreases (though null hypotheses were not rejected on these variables, likely due to low statistical given power pilot sample size) among AWARENESS participants. Yet, the AWARENESS intervention has not been tested among SM women or GM participants.

There is a precedent for using cognitive-behavioral therapy to address minority stress. For example, EQuIP (Empowering Queer Identities in Psychotherapy), was developed to reduce sexual minority stress, alcohol use problems, and symptoms of depression and anxiety among sexual minority women (Pachankis et al., 2020), and interventions have been developed to support transgender women (Sevelius et al., 2020) and adapted for SM men of color (Jackson et al., 2022), though no known intervention has been developed to address intersectional minority stress among SGM people. This highlights a need to expand interventions for minority stress for a broader, more diverse set of SGM subgroups. Further, there is a need to increase many of these interventions' applicability to intersectional minority stress (that is, identity-based stressors that overlap with SGM identities, such as race, socioeconomic status (SES), or ability status) given

evidence that a person's overlapping identities can either exacerbate or increase resilience to minority stress. The AWARENESS intervention addresses distal (*e.g.*, discrimination) and proximal (*e.g.,* internalized stigma) minority stressors. The AWARENESS intervention encourages participants to apply the intervention principles to all identity characteristics salient to them, in addition to their SGM identities. A key clinical strategy of the present intervention is to seek a more nuanced understanding of the lived experiences of SGM people by examining the myriad ways they are affected by their overlapping identities.

The present study aimed to develop an intervention for intersectional minority stress among SM women and GM people that can be applied to decrease minority stress across individuals' broad range of identity experiences. We expanded the 9-session AWARENESS intervention content (described above) to a 10-session intervention by adding a new session on the topic of intersectional identities as the initial session of the intervention and expanding the examples of coping skills to include broader SGM identity examples. We sought to test the new, intersectional 10-week AWARENESS intervention among SM women and GM people.

While the AWARENESS pilot study offered only an individual, in-person intervention, the present study examined both group and telehealth delivery. Empirically, CBT has mounting evidence for equivalent effectiveness in both group and individual settings (Söchting, 2014), though there have been some mixed findings in the literature (Tucker & Oei, 2007). A group-based intervention format offers potential benefits not possible in individual-only conditions, such as group members acting as co-therapists and fostering a sense of community among group members (Morrison, 2001; Söchting, 2014). This may be particularly important for the AWARENESS intervention, given that minority stress is a key target mechanism; for example, group dynamics may potentiate certain types of in-vivo exposures directly related to the

intervention (*e.g.,* if a microaggression occurs between participants) offering the opportunity for members to practice new responses.

Research has found that CBT delivered over the internet, using video-conferencing and text-based chat platforms, is comparable in effectiveness to face-to-face CBT (Andersson et al., 2014; Andrews et al., 2018; Carlbring et al., 2018). Telehealth is a promising tool to increase accessibility to CBT interventions as many SGM people have limited access to culturally competent treatment services for substance use and mental health concerns (Williams & Fish, 2020). The COVID-19 pandemic and the limitations it placed on in-person services further highlight the importance of translating CBT for telehealth among SGM communities.

The present study takes a qualitative approach to assess participant feedback to understand the impact of these key extensions of the AWARENESS intervention to improve future iterations of the manual. With this goal in mind, we examine feedback on the applicability of AWARENESS content among a diverse population of SGM people who may experience intersectional minority stressors and identify potential barriers or pathways for improvement. We will further examine the impact of intervention format (*i.e.,* individual *vs.* group delivery) and delivery modality (*i.e.,* in-person *vs*. telehealth) on participant experience.

Methods

Participants

Recruitment was conducted through flyers in community settings (*e.g.,* coffee shops), health clinics, and online (*e.g.,* Craigslist, Reddit). The study also recruited through snowball sampling through the recommendation of study participants. Participants were told that the goal of the study was to determine if a brief intervention can help people manage stressors related to experiences of SGM people, such as stigma or discrimination.

Potential participants were required to complete a screening interview over the phone. Participants were recruited to represent two populations in two arms of a pilot: SM women with substance use (who received the intervention through weekly individual sessions), and SGM people (who received the intervention in a group format). Recruitment materials outlined each pilot's respective format (individual *vs.* group) and inclusion criteria. Inclusion criteria for both the SM women's individual pilot and the SGM group pilot required that participants be 18 years or older, be fluent in English, have moderate to severe levels of minority stress as measured by CARS (Chu et al., 2013), identify as a sexual or gender minority person, and reside in California. Exclusion criteria for both studies included the presence of a severe substance use disorder (six or more symptoms within the past 12 months as defined by the DSM (American Psychiatric Association, 2013) and current symptoms of schizophrenia or bipolar disorder (MINI, (Lecrubier et al., 1997)). For the telehealth format, exclusion criteria also included active risk of suicidality, recent hospitalization for a mental health concern, or recent self-harm. For the women's intervention pilot, inclusion criteria also required participants to identify as SM women and report at least one occasion of drinking four or more drinks or of using an illicit substance in the previous three months, but not meet the criteria for a severe substance use disorder.

Intervention

AWARENESS (Flentje, 2020) was originally developed as a nine-session cognitive-behavioral intervention, designed to address all components of minority stress as defined by the minority stress model (Meyer, 2003), as a pathway to decreasing substance use. Minority stressors targeted in the intervention include the experience of discrimination and microaggressions, anticipation of discrimination, concealment, and the internalization of stigma.

The AWARENESS intervention protocol under investigation in this study adopted one additional session at the start of the intervention to teach participants about the concept of intersectionality (see Figure 1), with the following nine sessions focusing on the same topics as the original manual (Flentje, 2020). Each session of the individual AWARENESS pilot was 60 minutes, while each group session lasted 90 minutes. The first AWARENESS session asked participants to reflect on how their different characteristics (*e.g.*, sexual orientation, gender identity, ability status, SES, race or ethnicity, cultural background, and other traits) shape their experiences. Participants briefly discussed the history of their identities and were introduced to the cognitive-behavioral model (*i.e.,* links between thoughts, feelings, and behaviors and how these change in response to triggering events). Participants were also asked to track how they believed that people respond to their many intersecting identities and characteristics and how their communities protect or expose them to stress, in addition to tracking their mood, substance use, and any other behavior or experience (*e.g.,* anxiety, diet) that they wished to track. Next, each of the four minority stress concepts were addressed in paired weekly sessions (see Figure 1). The first session within each pair involved psychoeducation on minority stress concepts (*e.g.*, learning about microaggressions and observing one's thoughts, feelings, and behaviors when they occur). The second of the pair covered coping skills related to the minority stress concept that was introduced in the prior session (*e.g.*, practicing new values-aligned ways to respond when one experiences a microaggression) detailed in greater length in (Flentje, 2020).

At-home exercises allowed participants to observe and track their experiences of each component of minority stress, as well as practice related coping skills. Participants were introduced to several key skills in the intervention, such as making conscious choices related to the concealment of identity, challenging automatic thoughts related to internalized stigma,

evaluating threat assessment in anticipation of discrimination, increasing mindfulness regarding automatic coping behaviors, and practicing new response options. In sessions, participants shared experiences with coping skills, intervention concepts, and at-home exercises with the study clinician and, if in the group format, with other participants in a discussion moderated by the study clinician. The final session concluded the intervention with a reflection on all the skills and tools participants learned in the intervention.

Procedure

The procedures were the same for participants in both the individually- and group-delivered interventions. Study staff administered informed consent. Prior to the first intervention visit, participants completed baseline behavioral and biological assessments. Then, participants proceeded to complete the first of the ten weekly intervention sessions with the study clinician. Participants completed intervention visits weekly for the next nine weeks and were asked to complete at-home exercises each week to practice and track skills discussed in the session. The study clinician also conducted an individual check-in with the group at the midpoint of the intervention, and as needed. After the tenth and final session, participants completed outcome assessments, feedback questionnaires, and a feedback interview.

Assessment and intervention sessions were initially completed in person with the study clinician and research staff at a community health clinic. However, due to state and local guidelines during COVID-19, the study assessments and activities were transitioned to telehealth in March 2020. The intervention sessions were then conducted through Zoom. Study handouts, exercises, and questionnaires were distributed to participants electronically. Study staff also provided participants a guide to using telehealth before the first internet-based session. Participant check-ins and questions were addressed over phone calls with the study team.

Measures

Participant characteristics. Participant characteristics were surveyed including age, gender identity, sexual orientation, sex assigned at birth (SAAB), relationship status, race/ethnicity, education, household income, and education. Participant characteristics were tabulated from the assessment measure responses.

Feedback Questionnaire Likert scale questionnaires and semi-structured interviews were used to collect feedback on the intervention from participants following the 10th session of the intervention. Feedback questions asked participants to reflect on the intervention in relation to participants' sexual and/or gender minority identities.

The feedback questionnaires asked participants to report: the novelty of the intervention (*e.g.,* "To what degree did you discuss the subject matter in the intervention sessions that you hadn't talked about before?", "Did this intervention provide you with any new coping skills?"), the value of the intervention (*e.g.,* "Do you feel you got something of lasting value or importance from the sessions?" with 5-item responses from "Definitely not" to "Definitely yes"), and whether they would recommend the intervention (*e.g.,* "How likely is it that you would recommend this intervention to a friend?"). The feedback questionnaire responses were tabulated.

Study Clinician's Session Progress Notes and Intersectionality. For this pilot assessment of AWARENESS' applicability to intersectional minority stressors, we also examined the specific types of minority statuses discussed in each intervention session, as noted by the study clinician in session progress notes. The identities and personal characteristics that the study clinician noted were discussed by participants in relation to intervention content were extracted for analysis by each session. For individually delivered sessions, these results were analyzed by

each participant. Those noted in the group sessions were discussed in the presence of group members and thus could not be enumerated by individual. So, the identities and personal characteristics recorded in the study clinician's session progress notes were collectively analyzed across each session.

Semi-structured Feedback Interviews. Participants who participated in the semi-structured feedback interviews provided feedback on their experience in the intervention. They were asked about their experiences with intervention concepts and coping skills, challenges in completing the intervention, experience with the telehealth modality, and if they would recommend the intervention to others.

Feedback interviews were analyzed using thematic analysis (Braun & Clarke, 2006) focused on the research questions: 1) what components of the intervention content on psychoeducation and coping skills were useful or not applicable for application to intersectional minority stress, 2) which components of the intervention format (group vs. individual) were helpful or unhelpful, and 3) which components of the intervention modality (in-persons vs. telehealth) were helpful or unhelpful. Two members of the research team (a doctoral student in clinical psychology and a research assistant) reviewed the transcripts and generated codes, convening to create a coding structure. Through a process of iteratively discussing the code structure and reviewing the transcripts, researchers organized the codes that emerged from the text into themes. Consistency across coders was evaluated to ensure the rigor of analysis and the coders resolved discrepancies through discussion.

Results

Participant characteristics are reported in Table 1.

Intervention completion

SM Women, Individual Intervention. Eight participants enrolled and consented in the women's individual-session pilot of AWARENESS. Of these, seven completed at least one intervention session, and five completed the intervention. Of the two participants who dropped out before completing the intervention, one completed five sessions and discontinued due to schedule conflicts, and another participant completed two sessions and discontinued for unknown reasons. Two participants completed the intervention in person (before the COVID-19 pandemic), one participant completed half of the sessions in-person and the second half online, and two participants completed all sessions online.

SGM People, Group Intervention. In the other pilot arm, four SGM participants consented and participated in a group-based delivery of AWARENESS with an online format. Of these, two participants dropped out of the intervention, one after six sessions and one after seven sessions. Three out of the four provided feedback on the intervention format, including one participant who did not complete the intervention.

Feedback Questionnaire

Participants in both formats reported the intervention provided *some* to *many* new coping skills (*n*=5 in the SM women's pilot, *n*=1 in the group pilot) and that they probably or definitely received something of lasting importance or value from the intervention (*n*=5 in the SM women's pilot, *n*=2 in the group pilot). Among those who participated in the SM women's pilot with individual sessions, all five participants reported they were either moderately (*n*=1) or extremely likely (*n*=4) to recommend the intervention to a friend. The three individuals in the group had a mixed response, noting they were slightly unlikely (*n*=1), moderately likely (*n*=1), and extremely likely (*n*=1) to recommend this intervention to a friend.

Study Clinician's Session Progress Notes and Intersectionality

The coping skills and minority stress concepts were applied to diverse minority statuses and individual characteristics throughout the intervention. Twenty different intersecting identities were noted in the study clinician session progress notes across the seven participants who participated in the individual intervention format for SM women (Table 2, Figure 2). The study clinician's notes revealed that participants in this intervention format related each minority stress concept to sexual orientation, gender identity, and race and ethnicity. These notes indicate that some identities were only related to specific minority stress concepts. In the sessions on discrimination, the study clinician also noted that age, parent status, disability status, SES, identity as a bullying survivor, identity as a sexual assault survivor, and membership in a social community were discussed. In the sessions covering anticipation of discrimination, participants discussed SES, education or employment status, gender confirmation surgical patient experience, and spirituality or religion. In the sessions covering concealment, participants discussed polyamory, spirituality or religion, immigrant status, education or employment status, gender confirmation surgical patient experience, and membership in a social community. In the sessions on internalized stigma, participants discussed mental health status, polyamory, immigrant status, gender expression, gender confirmation surgical patient experience, and disability status. On average, the study clinician's notes indicated that participants in the individual intervention discussed 8.3 different intersecting identities (median 7, range 6-11).

Fifteen different intersecting identities were collectively discussed in the group intervention (Table 3). Participants related each minority stress concept to gender identity, sexual orientation, and race/ethnicity. Additional identities that were applied to the sessions on discrimination were SES, education status, age, bilingualism, immigrant status, and spirituality.

In the sessions covering anticipation of discrimination, participants discussed immigrant status, education status, mental health status, race and ethnicity, and age. In the sessions covering concealment, participants discussed gender expression, mental health status, HIV status, immigrant status, and role as a "top" *versus* "bottom". In the sessions covering internalized stigma, participants discussed substance use, immigrant status, mental health status, and religion. On average, participants in the group intervention discussed 5.4 different intersecting identities per session (median 5, range 1-9).

Semi-Structured Feedback Interviews

Intervention Content

Participants' feedback generally indicated that the intervention content was relevant and helpful for learning about minority stress concepts as well as coping with minority stress by understanding and changing patterns of behavior. Participants identified several aspects of the intervention content that were helpful including 1) *applying the content to different identities,* 2) *daily self-monitoring and home practice exercises,* 3) *learning the language for minority stress concepts,* 4) *contextualizing minority stress experiences in history/community,* and 5) *learning to integrate coping skills*.

Applying Content to Different Identities. Several participants specifically highlighted the intersectional component of the intervention as being helpful and discussed broadly applying the intervention content to their own minoritized identities. A participant discussed the importance of the "integration" of their identities in their experience of the intervention.

> *When I developed as a young man and immigrant in this country, a sense of identity based on being gay because that was the reason I believed I lost everything. You know, family, country, language, religion, friends, everybody, job, etc. So, it was like...so that's what you don't like, that's what it's going to be in your face. So that reactivity kind of*

> *formed many of the decision of my life. So, at this point in my life I'm coming to a place of not only transitioning from a profession that I have been exercising for almost three decades. I'm reclaiming parts of my life that I would not...that I didn't have the space to be before.*

Another participant noted that the attention to intersectionality was something they had not been able to find in prior counseling but may have found useful, particularly in working with therapists whose identities are different from their own.

> *… a lot of therapies … haven't been very helpful for me in terms of getting into the … nitty gritty of the things I deal with as a result of … various intersectional [identities]… it's hard for both neurotypical therapists, …… [and] straight people to help in a lot of ways.*

Daily self-monitoring and home practice exercises. Participants also noted that the daily self-monitoring and consistent formatting of home practice exercises helped with integrating the intervention content into their lives. For example, one participant reflected,

> *…to me, it's a perfect way of bringing attention organically to the things were being highlighted in the intervention both in terms of the difficult aspects and in terms of the coping skills.*

Learning the language for minority stress concepts. Several participants reported that they found it useful to learn how to define and identify minority stress. Participants reported having language for minority stress concepts helped them manage stress. One participant noted, "Really naming these issues is very powerful and you can't combat something without knowing what it is."

When asked which sessions they found useful, participants highlighted different sessions around each minority stress concept. This may relate to their unique experiences or overlapping identities. For instance, one participant reported internalized stigma and anticipation of discrimination were the most useful concepts because

…it's actually been a huge impediment to me dating because I'm like I'm not hypervisible on my own but my illness and my disability are both invisible and my orientation… like I'm sure it showed on the surveys, most people assume I'm straight unless otherwise indicated.

In contrast, another participant noted that while the information about hypervigilance and the biological response to stress was useful, "…the sessions on internalized stigma were less helpful for me at this stage in my life just because I feel like I had done a lot of that work for myself in previous years."

Conceptualizing minority stress experiences in history/community. Several participants felt it was useful to understand their experiences within the context of SGM community and history. They reflected on the influence of geographical location, social changes, or their various communities on their exposure to minority stress across their life. Participants reported it was useful to understand shared experiences of adversity and examples of resilience. One participant said,

And I think I have more respect for myself with certain experiences because I can see them on a larger scale than just myself. And I can recognize the things I'm going through as things that people who are sexual minorities go through.

Learning to integrate coping skills. Finally, participants reported that the intervention provided the tools to apply coping skills in their daily life when they experienced minority stressors. One participant highlighted the utility *of "…thinking about matching the coping to the stressor…"*

Specific helpful skills that were reported included mindfulness and observing without judgment, grounding and breathing skills, making conscious choices about the concealment of identities, noticing positive emotions, assessing threat, and reducing hypervigilance.

Unhelpful Areas of Intervention Content

Participants also identified areas of content as being less helpful when it was *difficult to apply the concepts to identity* or *current experiences*. For instance, one participant noted that the intervention materials did not always seem to relate to their identity or personal characteristics.

> *…one thing I noticed even in the beginning when I was looking at the homework and writing assignments was that a lot of it was written with … the experience of being visible or being discriminated against for the experience of being sexual minority or perhaps not being gender conforming or cis. Which I understand especially because this is an intervention focused on LGBTQ people. But then for me, I felt like it was hard to apply sometimes to my experiences because even on top of the pandemic and my daily life being different than usual, I feel like a lot of the ways people treat me are not really related … to my orientation or gender identity. A lot of it has more to do with how I'm being racialized or at times being misgendered*

While a different participant had noted that the material on internalized stigma was helpful while considering less "visible" identities, this participant elaborated on the challenge of having to decipher which of their identities another person might be responding to with prejudice. One participant noted that, because of their location and community, they found it difficult to apply intervention content to their lives when they were not going out as much or did not experience stressors, particularly relevant due to limited social contacts during COVID pandemic shut-downs. Overall, participants expressed a general desire for more discussion of intersectionality throughout the intervention.

Delivery Format

Participants' feedback concerning the intervention format highlighted several helpful and unhelpful aspects of delivering the intervention in a group, as opposed to in one-on-one individual sessions consistent with the established AWARENESS format.

Helpful Aspects of Group Delivery Format. Participants identified several areas in which the group-based delivery of the intervention was helpful. These helpful aspects included: 1) that participants felt a sense of *community* in the group, 2) the *group's diversity* in identities, experiences, and perspectives, 3) *sharing experiences and resources* with the group, 4) opportunities for *social interaction* during a global pandemic, 5) feeling *validated* by the group, 6) *working through conflict* within the group, and 7) group *logistics* such as setting guidelines, checking-in at both the individual and group level, and the group's small size ($n = 4$). Participants' feedback within these areas generally suggested that these aspects of the group expanded the benefits that they received from the intervention, above and beyond the intervention content itself.

Community. Community was mentioned in each feedback interview as a helpful aspect of the group delivery format. The sense of community created in the group was perceived as helpful because the communal feeling enhanced participants' comfort with vulnerability and sharing painful experiences. As one participant described,

> *There was a level of openness and vulnerability and … it was not just an intellectual discussion, ...in reality we were sort of weaving in between the emotional and the intellectual and even ... that essence of who we are as humans. So it was vulnerable.*

Perhaps the sense of community and vulnerability identified within the group enabled participants to apply the concepts associated with minority stress more deeply to their emotional lives. Rather than intellectualizing the intervention content and avoiding the emotional impact, the sense of community may have enabled individuals to engage with challenging, painful, identity-related emotions. For example, the participant stated that by engaging with the group

discussion topics related to minority stress, "*the concepts became more about lived experience rather than just the concept.*"

The group's sense of community was also helpful because it reminded participants that they are not alone in coping with minority stress and that other group members shared similar challenges in their own lives. This may have increased individuals' perceptions of their ability to cope with ongoing social and political stressors.

Group diversity. Participants in this group were united by their shared experience of having a SGM identity, but they varied along the lines of gender identity, age, SES, racial and ethnic identity, and cultural background. Participants indicated the group helped them to broaden their understanding of how the intervention content can be applied beyond just their own experience of their own identities, as participants shared experiences of minority stress and coping based on their overlapping minority identities. A common theme among the group participants' feedback interviews was that the group's sense of community was made more meaningful by its diversity, allowing participants to observe the impact of a broader range of minority stress experiences, including ones they might not have faced in their own lives.

This expanded sense of awareness of how individuals in different SGM sub-groups respond to minority stress may have also given participants new ideas for coping mechanisms they could apply to their own experiences of stigma. One participant shared:

> *... even if there's a generational divide or different race or sexuality or gender identity, learning from their experiences and connecting and having very close, similar experiences even though we are not very similar people has been beneficial… I could adopt some of those coping mechanisms.*

Sharing with the group. This theme fell into two categories: *sharing experiences* (*e.g.,* discussing experiences of trauma with the group) and *sharing resources* (*e.g.,* discussing the

community resources and strategies that participants used to cope with these experiences). Two of the three group participants indicated that sharing their experiences and resources was helpful because it enabled participants to learn from examples of how other participants applied the intervention content to their varying identities and lived experiences and gain new ideas for strategies to cope, even beyond the content explicitly within the intervention. For example, one participant stated,

> "*we talked specifically about different strategies we use personally. Or we shared something other people use... it was very powerful in talking through strategies about how to deal with anticipating discrimination and how we respond or can respond ...*"

An additional benefit of sharing with the group was the experience of validation, by having difficult emotions and memories acknowledged and feeling supported by the group. One participant reflected,

> *...one of the problems with trauma is isolation. So there's no more isolation there, there's no more silence because I don't know what to feel. But to create a space where all of that was invited. So that was number one. The fact that it was not pathologized right away. [...]we don't have the resources that are sometimes even just the feedback of someone saying "yeah that happened to you and it was horrible". Actually, we have – because of society's fear of quote-unquote difficult emotions – the typical thing of, "Oh it wasn't so bad". Or, "nothing really happened"[...] So, minimizing and suppressing all of that, of course, it does a number on our awareness [...] I love the fact all these difficult things came up, but they were held in a way where there was compassion, validation, and respect.*

Of note, this participant shared experiences of discrimination and victimization related to identities other than their SM identity, which were not in common with other group members. Nonetheless, the shared framework of minority stress allowed other group members to relate to these experiences through validation and empathic responding.

Other helpful aspects. Other helpful elements of the group included aspects of the group process such as *opening the sessions with a check-in, individual check-ins with the therapist,*

small group size, and *working through conflict.* While these elements were mentioned less frequently, participants generally found that it was useful to check in with each other at the beginning of the group sessions to understand how the group might respond to intervention content. Participants indicated that they enjoyed having a balance in group content between discussion of past experiences (e.g., sharing experiences with minority stress they had encountered in the previous week) and working with new skills.

Some group members indicated that *check-ins with the therapist* as well as *working through conflict within the group* helped navigate conflicts that occurred within the group. Participants also shared that disagreements or conflicts within the group were not necessarily experienced as negative. By working through conflict within the group, some found that they were able to gain another perspective on the concepts taught in the intervention.

Unhelpful Aspects of Group Delivery Format. While participants' feedback pointed to several ways in which the group delivery of AWARENESS was helpful, they also indicated several drawbacks or barriers within the group format that should be addressed by future iterations of this study. Specifically, the unhelpful aspects of the group intervention delivery included 1) *group diversity challenges,* 2) *conflict and microaggressions within the group,* and 3) *outside-of session-contact.* Further examination of these points of feedback may provide areas for improvement and modification in future iterations of AWARENESS.

Group diversity challenges. Although the group's heterogeneity in identities along the lines of gender, age, race, and culture was identified as a strength, this was also an area of difficulty as noted by some participants. There were occasional tensions within the group when some individuals with marginalized characteristics perceived that others in the group (who did

not share their identities) did not understand their experiences of minority stress — or even unintentionally perpetuated stigma within the group, as in the case of one participant unknowingly using a slur. Another participant noted they felt they had to educate other group members who did not share the same characteristics or identity. The experience of having to speak on behalf of marginalized groups that were not well represented in the group may have reduced the intervention's ability to buffer against minority stress. Thus, a suggestion made by one participant was that

> *...in future iterations if there's opportunities to select they want to be in a group only with people who share a certain identity with them that might be helpful. Like say having a group with only people of color or maybe a group with only trans and gender non-conforming people.*

Conflict and microaggressions in the group. Relatedly, tension that arose from the group members' non-shared identities sometimes manifested in microaggressions. While this may have provided some opportunities for *in vivo* exposure (*i.e.*, giving participants opportunities to practice the skills taught in this intervention for values-aligned, direct responses to microaggressions), we learned from the group process that this needed to be handled directly to be optimally effective. For example, when one group member (likely unintentionally, as they were unfamiliar with the group they were referring to) used a slur within the group, the facilitator handled it by redirecting the group discussion to group agreements and conducting check-ins with each participant outside of the session, rather than discussing the specifics of the term with all participants in the group session. One participant advised that they would have preferred that the facilitator immediately addressed the comment directly, but also felt "*wary of… confrontation*" within the setting.

Outside-of-session contact. It was noted that the group process was complicated by some group members engaging in contact with one another outside of session through email and text messages. One participant reported that it created tensions within the group.

Delivery Modality

Participants also discussed the impact of the telehealth delivery of the intervention through Zoom and the electronic distribution of study materials. All but two participants who provided feedback completed at least one session of the AWARENESS intervention via telehealth, given the onset of the COVID-19 pandemic in the middle of intervention deployment in March 2020. Qualitative feedback from participants in the group and the women's pilots were combined to assess participants' feedback on the delivery modality of the intervention (*i.e.,* telehealth compared to in-person sessions).

Helpful Aspects of Telehealth Modality. Two primary themes emerged from participant feedback regarding the helpfulness of a telehealth intervention: 1) *engagement*, how the telehealth format enhanced participants' enjoyment or completion of the program, and 2) *convenience*, the ease of completing the intervention.

Increased Engagement. Participants described experiencing increased engagement due to being a part of the intervention in a telehealth format. Participants reflected that this online format reduced their isolation (including but not limited to social isolation during the COVID-19 pandemic), helped with social anxiety or fear of seeing a therapist or group, and facilitated access to a therapist. The opportunities that telehealth created for connection were an essential component of engagement, including having a meaningful social experience or helping with fears around connecting with a clinician or group. One participant observed that it was "*helpful*

in this time where there's very little access to the outside world to have this [intervention program] and to remain sane."

Convenience. Participants identified that the telehealth format offered them convenience and reduced some of the logistic barriers of attending in-person sessions. Participants identified that telehealth offered them the flexibility of location, a reduced need for transportation and its associated monetary and time costs, and ease of accessing the intervention through an online videoconferencing platform.

Unhelpful Aspects of Telehealth Modality. Participants discussed three primary challenges of a telehealth-delivered intervention: 1) *social interactions over telehealth,* 2) *technology accessibility and issues*, and 3) *privacy.*

Social Interaction Over Telehealth. Participants discussed several challenges of the social interactions of group and individual sessions over telehealth. One participant expressed initial concerns about connecting with the study clinician and feeling comfortable sharing over a telehealth session. However, as the intervention progressed, the participant also noted it felt easier than they expected. Another participant discussed the difficulty of nonverbal communication online during the group session:

> *...the ways that people might perceive or not perceive body language or things like that can change…So maybe at times, unless someone decides to speak up, it may be hard to tell if someone relates to your experience or is being affirming unless they say something*

Two participants also reported that turn-taking in a group over telehealth was challenging, which led group members to interrupt others or not speak during sessions.

Privacy. A few participants discussed the challenges of finding a private space to discuss sensitive topics during the telehealth sessions. For instance, one participant reported, *"...I live*

with four other people and sound travels, even though I try to speak as softly as possible during meetings. But it's not private, for sure, 100%." Another participant who had not yet come out to their parents discussed the need to find private spaces in their home to participate in the telehealth intervention sessions.

In addition, the online format allowed for contact between the group participants that was not visible to the study clinician (*i.e*., private or "direct messages" in chat between participants, text message, email). The multiple forms of communication may have provided opportunity for different forms of expression (*e.g., "…if people felt more comfortable participating in writing…"),* but at the cost of easily monitored interactions by the study clinician during and outside of the intervention sessions.

Technology Accessibility and Issues. The study clinician noted that it was difficult to sustain individual sessions when there was inconsistent Wi-Fi access. "Freezing" on a video call could inconveniently impact the discussion of emotional content, but this was an infrequent occurrence. No participants reported technology access issues being a personal challenge during the sessions, but one participant felt that the design of the intervention and study materials should be more accessible for people who use screen readers, for instance.

Discussion

This study analyzed feedback on the extension of the AWARENESS intervention to address intersectional minority stress among SGM people, in a group format, and through a telehealth modality. Participant feedback from the SM women's pilot and SGM group pilot supported the feasibility of applying AWARENESS intervention content to a variety of intersectional identities and characteristics. Participants further indicated that the intervention format and modality had an impact on their engagement with the intervention content.

Generally, participant feedback suggested that the content of the intervention was helpful and provided key skills to cope with minority stressors. Most participants endorsed learning at least “a few” new skills from the intervention, gaining “something of lasting value or importance” from participating in the intervention, and that they would recommend the intervention to others. Participants identified some of the strengths of the intervention as the pairing of minority stress concepts with pertinent coping skills and its intersectional considerations of stigma. Participants found self-monitoring activities useful in learning minority stress concepts, with a few participants noting that this was the first time they had named the stress they experienced. In pairing minority stress concepts with specific coping skills, participants were able to identify which minority stress concepts were most salient in their life and therefore which coping skills would be the most useful. Participants reported they were able to apply a variety of coping skills taught in the intervention in their daily life. Participants also responded positively to the addition of a first intervention session on intersectionality to the original intervention manual (as described in (Flentje, 2020)). Several participants reflected that the context of the socio-political environment and the diversity of their communities was particularly helpful in the discussions on minority stress concepts and coping skills. For instance, participants talked about the impact of race or immigration history on their encounters with SGM-specific minority stressors and the importance of integrating their identities.

Prior research indicated that psychoeducation and coping skills in AWARENESS were applied to an average of six different identities in a randomized control trial among SM men living with HIV (Flentje et al., 2022). In this study, all participants reported applying the intervention content to minority stress experiences related to non-SGM-specific identities, including ability status, immigration status, SES, and relationship orientation (see Figure 2).

Participants in the individual intervention discussed an average of eight different identities, and those in the group intervention discussed an average of five. This disparity between the group and individual intervention may be because each person in the individual intervention had more opportunities to talk, and therefore more opportunities to report the applications to other identities or characteristics. Even within the group intervention, participant feedback suggested that it was useful to observe how others applied the minority stress concepts and coping skills to their unique intersecting identities.

Minority stressors may not be experienced by every SGM person in the same way, nor are they necessarily experienced continuously over time. Our goal was to make AWARENESS applicable to the real-world needs of clinicians. As SGM patients hold overlapping identities and experiences, a treatment that could be adapted to various intersecting minority stress experiences may be more practical to adopt. We aimed to balance the flexibility of the intervention to be applicable to people with a diversity of backgrounds and experiences of minority stress, while also ensuring the content was specific to shared SGM experiences of stigma. Participant feedback suggests how future iterations can do so more effectively. Attention should be paid to adding more intersectional discussion of minority stress throughout the intervention manual, specifically discussing the impact of both visible and less- or non-visible (*e.g.,* ability status, SES, religion) characteristics. Feedback indicated that the future iterations of the AWARENESS manual, particularly the psychoeducation components, should include more representative examples of the different ways that SGM communities can experience and cope with intersectional minority stressors (*e.g.,* examples of people coping with racial- or disability-specific stigma as well as SGM-specific stigma). Further, it would be beneficial to increase opportunities to directly discuss and report how participants are applying the concepts to other

marginalized characteristics that intersect with SGM identities. This could be integrated into the at-home and in-session exercises throughout the intervention to help participants visualize how they might extend minority stress concepts and coping skills to their own life. A person-specific service delivery, which relies on ecological momentary assessment to map symptoms and behaviors for tailored treatment plans (von Klipstein et al., 2020), may also increase the benefit that each participant can glean as AWARENESS is tested among a larger, more representative sample.

The participant feedback also revealed that the different intervention formats (group *vs.* individual) had different strengths and challenges. The strengths of the group format included opportunities to learn from other participants, to have community and validation, and to have in-vivo exposure to minority stressors. Exposure to minority stress within the group, and the resulting group tensions, were the primary challenges of the group format and points to considerations for future iterations of AWARENESS. Future interventions should consider specific responses to minority stress events that occur within the group, including a specific procedure that group leaders can follow when these events occur. In this case, the group leader referred to the group rules and norms to redirect the group. However, given the focus of the intervention on coping with minority stress, more could have been done to create opportunity for learning and generalizing the AWARENESS coping skills. Any method for addressing minority stress within the context of a group format must equally prioritize and balance multiple considerations: (1) the need to address the minority stressor to reduce the impact on the individual(s) in the group, (2) the need to address the stressor in such a way that it does not demonize or alienate the individual within the group who made the misstep (*e.g.,* "calling in" (Ross, 2019)) and instead integrate the resolution process as the goal, and (3) the opportunity to

use the stressor as a valuable opportunity to nonjudgmentally work on minority stress coping skills. Feedback highlighted the importance of ensuring participants are not afraid to express disagreement or hurt to resolve conflict while ensuring minoritized participants do not feel responsible for educating the group. Further, AWARENESS may benefit from personalization to an individual's desired delivery methods, as not everyone may benefit from the group format or may find greater benefit from a group of people with shared minoritized identities (*e.g.,* a group for SGM people of color) or from participants in similar generational cohorts.

The telehealth modality was generally perceived as acceptable to the participants. The advantages of this modality were primarily improved access to support and counseling, especially with the increased isolation and reduced access to community support during the COVID-19 lockdowns. Barriers included difficulty accessing private space and moderating the group. Telehealth provided opportunities for multiple options of communication, but different channels of digital communications made it more difficult for the clinician to monitor group boundaries and communications. In the future, a group telehealth intervention must set clear norms of digital contact during and outside of the intervention sessions. With adequate attention to these barriers, AWARENESS can be feasibly adapted to telehealth.

Limitations

This qualitative study has a small sample size which may limit generalizability, particularly in terms of the application of the intervention material to intersectional minority stressors. Future research should test AWARENESS in a more comprehensively heterogeneous sample. Relatedly, all participants who enrolled in the telehealth intervention were able to do so because they had access to the technology, digital literacy, and other resources required to participate. Prior research suggests that intersectional characteristics like SES, race and ethnicity,

and age are important considerations for designing efficacious engagement with telehealth and digital intervention (Ng et al., 2022; Western et al., 2021). Therefore, the present study has limited generalizability for the barriers and needs of SGM communities in telehealth interventions. Despite precautions in the study protocol, such as informing participants that their responses would not be associated with identifying information, participants may have felt less willing to critique the intervention due to the self-report feedback interview format. Generalizability may also be limited by the effects of the COVID-19 pandemic onset and related shifts in SGM mental health (Flentje et al., 2020) during the intervention period, which included both a drastic increase in isolation and other pandemic stressors. For instance, the pandemic may have altered everyday minority stress exposures and created new challenges in accessing community support. Future examination of AWARENESS will be required to confirm feasibility as measured by enrollment. Although enrollment in both the individual and the group pilots was relatively low, most of the study enrollment occurred during the height of the COVID-19 pandemic in the spring of 2020. Given the disruption to health, employment, housing, and access to private space for counseling during this time, we believe the enrollment numbers are encouraging.

Conclusion

This study indicates that AWARENESS is feasible in addressing intersectional minority stress among SGM participants but may benefit from minor modifications prior to additional testing in these expanded formats and populations. Participants reported the intervention psychoeducation and coping skills were useful in daily life, particularly that they could apply the intervention to a variety of intersectional identities and experiences. Future iterations should more explicitly outline how coping skills and minority stress can be applied to other

intersectional identities given the differences in the ways that subgroups of SGM communities may experience minority stress (*e.g.*, invisible *vs.* visible characteristics). Further, the intervention may benefit from the personalized assessments of desired intervention formats (group *vs*. individual) and modalities (in-person *vs*. telehealth). Future research is also needed to test in-person or hybrid (*i.e.,* a mix of online and in-person sessions) group sessions of AWARENESS. Personalization based on needs related to certain identities or experiences (*e.g.,* groups for SGM individuals who identify as gender minority or racial minority or of a specific age range) may also need to be considered in future iterations of AWARENESS.

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Data Availability Statement: The participants of this study did not give written consent for their data to be shared publicly so, due to the sensitive nature of this research, supporting data is not available.

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Table 1. Baseline demographic information of those who completed at least one session of AWARENESS (*n*=11)

Demographic	*n*
Gender identity	
Transgender woman	1
Cisgender woman	6
Man	3
Another gender identity	1
Sex assigned at birth	
Female	7
Male	4
Age: mean, median	31.6, 25
Race/ethnicity[1]	
American Indian	1
Asian	3
Hispanic/Latinx	2
White	8
Another race or ethnicity	2
Sexual Orientation[1]	
Asexual	1
Bisexual	4
Gay	6
Another sexual orientation	1
Education	
Nursery school to high school, no diploma	1
Some college	1
2-year college degree	1
4-year college degree	3
Graduate or professional degree	5
Income	
< $10,000	3
$10,000-$20,000	1
$20,000-$30,000	1
$30,000-$40,000	1
$40,000-$50,000	1
$50,000 - $75,000	4

[1] Participants could select multiple responses, so frequency exceeds sample size.

Table 2. Identity statuses and individual characteristics discussed among 7 SGM women who participated in the AWARENESS individual intervention.

Identity status and individual characteristics	Number of participants *n* (%)
Gender identity	7 (100%)
Sexual orientation	7 (100%)
Education status	5 (71%)
Race/ethnicity	5 (71%)
Employment status	4 (57%)
Gender expression	4 (57%)
Socioeconomic status	4 (57%)
Age	3 (43%)
Immigrant status	3 (43%)
Spirituality or religion	3 (43%)
Body size	2 (29%)
Member of social community	2 (29%)
Disability status	1 (14%)
Gender confirmation surgical patient	1 (14%)
Mental health status	1 (14%)
Parent status	1 (14%)
Physical health status	1 (14%)
Polyamory	1 (14%)
Survivor of bullying	1 (14%)
Survivor of sexual assault	1 (14%)

Table 3. Identity statuses and individual characteristics discussed in each AWARENESS group intervention session.

Identity status and individual characteristics	Number of sessions *n* (%)
Sexual orientation	8 (80%)
Race/ethnicity	8 (80%)
Gender identity	7 (70%)
Immigrant status	6 (60%)
Age	5 (50%)
Mental health status	4 (40%)
Education status	3 (30%)
Spirituality or religion	3 (30%)
Socioeconomic status	2 (20%)
HIV status	2 (20%)
Gender expression	1 (10%)
Introversion/extraversion	1 (10%)
Bilingualism	1 (10%)
Role as top versus bottom	1 (10%)
Substance use	1 (10%)

Figure 1. AWARENESS Intervention Sessions

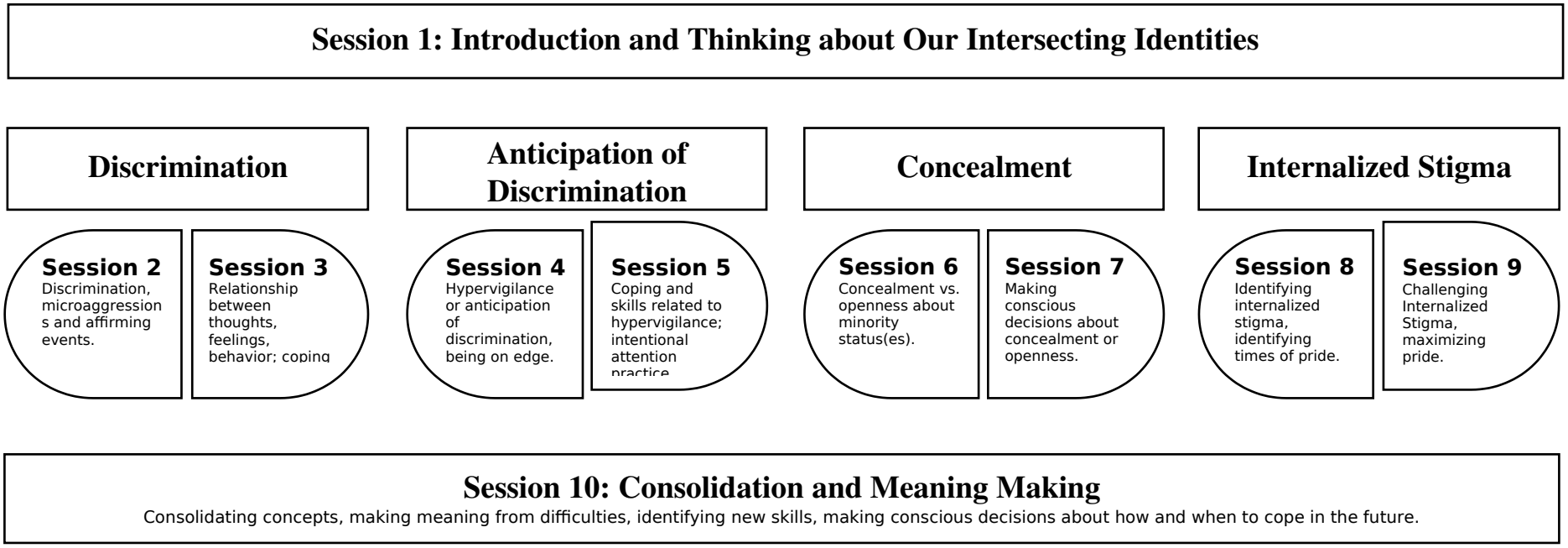

Figure 2. Word cloud of the frequency of identity statuses and individual characteristics discussed in the AWARENESS sessions of the individual intervention sessions on each minority stress component.