Queering Cognitive Behaviour Therapy- A review of Queer Affirmative-CBT, and reflections on adapting it to individual and group therapy in India

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ABSTRACT

There is a need to assess whether standard evidence-based therapeutic modalities can be made queer affirmative (Craig & Austin, 2016). Cognitive Behaviour Therapy is regarded as one of the most effective intervention modalities for a wide range of mental health concerns. This paper explores the potential of combining CBT approaches with queer affirmative practices. In section one, the authors present a content review of forty four articles on affirmative CBT worldwide, to answer three questions- "Can CBT be effectively used with LGBTQIA+ individuals?," "How can CBT be beneficial for LGBTQIA+ individuals?," "How can CBT be modified to make it queer affirmative?" In section two, the authors describe experiences in adapting QA-CBT to the Indian context in individual and group therapy, and present suggestions for making this practice intersectional.

Key words- LGBTQIA+ mental health, CBT, queer affirmative practices

INTRODUCTION

Mental health professionals play a key role in helping LGBTQIA+ individuals to navigate their concerns (Austin et al, 2016). Some researchers have suggested that LGB individuals may be more likely to seek mental health services (McCarrick et al, 2020, Balsam et al, 2006), due to higher mental illness risks, as well as the self-work that is required for self-acceptance and a cultural acceptance of therapy (Balsam et al, 2006). However, there is also research suggesting that LGBTQIA+ individuals do not always access mainstream mental health services; lack of information about available services, negative past experiences with mental health professionals, belief that services will be heterosexist, homonegative or trans-negative, are some LGBTQIA+ specific barriers for the same (Ross et al, 2007). For transgender individuals, clinicians are seen as adversary gatekeepers because of previous experiences of discrimination and laws that put them in positions of power as they can make decisions about eligibility for gender affirming interventions (Austin & Craig, 2015).

In a meta-analysis of 232 studies, it was found that 99.57% of researchers reporting on interventions for mental health conditions do not report on client gender and sexual orientations (Heck et al, 2017, cited Sheinfel et al, 2019). Consequently, there is not much evidence to show that existing evidence-based interventions are useful for LGBT individuals (Haas et al, 2010, cited Sheinfel et al, 2019).

While research in India over the past decade suggests that LGBTQIA+ individuals show higher prevalence rates for mental health conditions, few specific intervention strategies that incorporate queer affirmative practices in evidence-based therapies have been outlined for use with the Indian population (Wandrekar & Nigudkar, 2020).

This paper foregrounds Cognitive Behaviour Therapy (CBT), which has been shown to be as effective as or more effective than other forms of therapy for many conditions (APA, 2017). Opponents of CBT argue that it has a limited scope but is being over prescribed as a 'one size fits all approach'; there is exaggerated evidence of its efficacy; it is 'hyper-rational' and its emphasis on efficiency is derived from neoliberalist and managerialist frameworks; it creates an artificial dichotomy between health and illness without acknowledging the shades in between; it focusses on treating illnesses in a manualized way without acknowledging the socio-political context of these 'illnesses'- this may also lead to framing legitimate responses to socio-political contexts using illness vocabulary (Dalal, 2018).

Within the context of this larger debate, the current paper focusses on examining the potential of use of CBT specifically with LGBTQIA+ individuals based on existing research evidence for and against the same, and describes how CBT can be adapted to the Indian context. The terms LGBTQIA+ and queer are used interchangeably in this paper.

METHODOLOGY

Section 1 of this study is a descriptive content review of existing research on the use of CBT with LGBTQIA+ individuals. Section 2 of this study is an experiential account of adapting QA-CBT to the Indian context.

In Section 1, articles on the use of CBT with LGBTQIA+ individuals were reviewed. The following key questions were considered:

1. "Can CBT be effectively used with LGBTQIA+ individuals?"
2. "How can CBT be beneficial for LGBTQIA+ individuals?"
3. "How can CBT be modified to make it queer affirmative?"

Databases such as ProQuest, Google Scholar, PubMed, SagePub, ResearchGate, and Academia, were searched, using key terms "Cognitive Behaviour Therapy" OR "CBT" AND "LGBT" OR "sexual and gender minorities." Inclusion criteria was any study that foregrounded use of CBT with LGBTQIA+; general articles on CBT efficacy or on LGBTQIA+ mental health were not under the purview of the review, followed by cross-referencing. No specific date or location criteria were used. Journal articles, book chapters, manuals, and published theses were included. Data were abstracted on a standardized data sheet, recording major themes and findings. Data collection was stopped upon saturation i.e. no new articles emerged in search or via cross referencing.

In Section 2, the authors draw on their individual psychotherapy case notes and group therapy session notes for SAAHAS, to inductively generate India-specific suggestions on QA-CBT adaptation.

FINDINGS AND DISCUSSION

Section 1: A review of the use of CBT with LGBTQIA+ individuals

We found 40 journal articles, 1 book chapter, 1 manual, 2 theses relevant to the topic, dated 1996 to 2021. There were 2 reviews of papers, 23 sources conducted empirical studies testing varied interventions and their response, 8 case study papers, 9 manuals or proposed guidelines and programs, and 2 trial proposals. Many of the articles were from Canada, USA and Australia, and were published after 2013.

A. Can CBT be effectively used with LGBTQIA+ individuals?

In the past Behaviour Therapy has been used as part of Sexual Orientation Change Efforts to promote a heterosexist agenda, hence, some LGBTQIA+ individuals may approach anything associated with BT with some scepticism (Balsam et al, 2006). CBT has been criticized for disempowering clients from marginalized groups, by focussing on their problems rather than strengths, and relying on expert control (Eamon, 2008, cited Craig et al, 2013). Others criticize CBT for being incompatible with the social justice perspective, because it and ignores structural roots of depressive symptoms (Pollack, 2004, cited Ross et al, 2007), and uses a deficit-focused perspective that may 'force' individuals to adapt to their oppressive environments (Van Der Bergh, 2002, cited Craig et al, 2013),

However, advocates of CBT have stated that on the contrary, CBT may help clients to recognize which aspects of their concerns are environmental and which are internal or cognitive, to move towards changing certain aspects of their environment as a step towards solving their problems; it may focus on client identified sources of distress but also simultaneously reinforce client strengths to deal with distress (Craig et al, 2013).

It is important to recognize that while CBT is regarded as the gold standard for many concerns, the benefits of CBT are still being empirically tested with LGBTQIA+ individuals (Craig et al, 2013). In a review by Busa et al (2018), the authors did not find any studies that provided evidence that CBT can be effectively used for specific concerns that transgender individuals may face. Lucassen et al (2021) found that 2.3% of the users of their Computerized CBT form of treatment called SPARX, were transgender, however, completion rates for transgender people were low and they did not show a significant improvement in their depression scores. This suggests that mainstream CBT may not be adequate to serve the needs of transgender individuals unless adapted for the same (Lucassen et al, 2021). Some clinicians have emphasized how CBT protocols have been developed keeping disorders on the DSM in mind, and as such, may not be effective for problems that don't fit into a DSM category, or for multiple chronic concerns, and that conducting it with a culturally diverse population may require some adaptation (Safren & Rogers, 2001).

However, when modified incorporating queer affirmative practices, CBT has demonstrated significant utility with LGBTQIA+ individuals (Austin & Craig, 2015). Jaffe et al in 2007 assigned methamphetamine-dependent gay and bisexual men to one of four treatment conditions- CBT (control, N=33), Contingency Management (CM, N=38), CM+ CBT (N=36), and a gay-specific version of CBT (a culturally tailored approach that incorporated references that were fitting with experiences of gay men, N=38), and found through latent growth curve models that those who received gay-specific CBT showed the steepest positive

change, with a decrease in depression, self-reported sexual risk behaviours, and methamphetamine use, and those in the standard CBT control group showed the least change.

A study examined preferred therapeutic modalities for lesbian, gay and bisexual individuals by presenting written descriptions of three therapeutic approaches- psychodynamic therapy, CBT and humanistic therapy (McCarrick, 2020). Therapy naive LGB individuals were similar to their heterosexual counterparts with respect to preferred therapeutic modalities, preferring CBT and HT more than psychodynamic therapy. Furthermore, LGB individuals expressed preference for CBT over LGB affirmative therapy; the researchers speculated that the latter in isolation may be perceived as patronizing or compartmentalizing their individual experiences; the authors suggested that traditional LGB-AT approaches should be modified to better address the needs of LGBTQIA+ individuals in the 21st century. However, not recruiting participants that were specifically seeking treatment could have affected results.

B. How can CBT be beneficial for LGBTQIA+ individuals?

Balsam et al (2006) suggested reasons why CBT may be useful for LGBTQIA+ individuals. There is evidence supporting the effective treatment of many of the disorders showing high prevalence in LGBTQIA+ populations using CBT; the collaborative problem-solving approach to therapy adopted by CBT practitioners may give LGBTQIA+ clients a sense of agency, and the CBT approach of seeing behaviours as functional and not functional, rather than good or bad, may be perceived by them as being non-judgmental.

Researchers have proposed the Minority Stress Theory (Mayer, 1996 and 2003), which postulates that LGBTQIA+ individuals face distal stressors (discrimination, victimization, harassment) and proximal stressors (internalized stigma, concealment, expectations of rejection), and these stressors contribute to higher risk for mental health conditions, with coping and social support as protective factors. According to Pachankis (2014), CBT is and uses techniques that are pertinent to addressing the cognitive, affective and interpersonal pathways that underlie the impact of minority stress on mental health.

Given that CBT helps with restructuring thinking, CBT can help to challenge internalized homonegativity, chronic expectations of rejection, and contingent self-worth, and hopelessness and helplessness about the future (that arise from unsupportive environments) in a safe space, which in turn positively affects one's beliefs about oneself and one's interactions with others, and leads to healthier behaviours (Austin & Craig, 2015, Balsam et al, 2006, Craig et al, 2013, Pachankis, 2014).

Safren et al (2001) stated that since most of the mental health concerns faced by LGBTQIA+ individuals stem from social stressors, CBT interventions aimed at coping with chronic stress would be useful with this group. CBT can empower clients from marginalized groups by teaching them concrete strategies to deal with minority stress (Balsam et al, 2006), and can reduce their feelings of powerlessness by helping them to decrease negative outcomes like social exclusion, depression and anxiety (Craig et al, 2013).

CBT can help sexual minority individuals to achieve good physical, mental and social health and to protect it, to cope with their sexual identity and the coming out process better, and to

establish positive social support networks (Eamon, 2008, cited Craig et al, 2013). It helps LGBTQIA+ clients to draw on their personal resilience (Herrick et al, 2013, cited Pachankis, 2014).

C. How can CBT be modified to make it queer affirmative?

General guidelines

Purcell et al (1996) suggested that "to sensitively work with gay and lesbian clients, CBT therapists must have basic information about their multi-faceted culture, their client's involvement and understanding of those cultures, as well as knowledge of techniques of behaviour change and assessment." This cultural-sensitivity approach was also endorsed by other researchers (Balsam et al, 2006, Safren & Rogers, 2001, Safren et al, 2001), who stated that there is no evidence suggesting that LGBTQIA+ individuals benefit differently from CBT; they proposed that the general principles of CBT are the same for cis-heterosexual and LGBTQIA+ individuals, but because the latter may have "unique political, social, interpersonal, and personal qualities that define their culture" (Purcell et al, 1996), therapists need to creatively adapt treatment strategies to suit them (Balsam et al, 2006). Therapists need to explore the extent to which social norms and oppression that may contribute to their clients' presenting concerns, and be sensitive to cultural community norms (Balsam et al, 2006).

Ross et al (2007) wrote about how anti-oppression approaches can be integrated with CBT; these approaches would involve understanding the structural context of depression for LGBTQIA+ individuals while retaining beneficial elements of CBT. Alessi (2014) proposed a two-ponged assessment framework, the first stemming from minority stress theory, and the second examining a client's general internal psychological processes such as maladaptive self-schemas and coping strategies, which may also be affected by minority stressors, in keeping with the psychological mediation model described by Hatzenbuehler; they believed that both these processes need to be considered together to develop a more accurate account of the concerns faced by LGBTQIA+ individuals (Hatzenbuehler, 2009, cited Alessi, 2014).

LGBTQIA+ affirmative practices have been regarded as being best practice for LGBTQIA+ individuals, and it involves affirming clients' gender and sexual identities, and recognizes the impact of societal forces such as heterosexism, homo-negativity, bi-negativity and trans-negativity, on clients' well-being, and actively helps clients to overcome these (Craig & Austin, 2016); in doing so, they honour the APA guidelines for working with sexual and gender minorities (APA, 2012, 2015). LGBTQIA+ affirmative practice is not an independent treatment modality but can be incorporated into existing models of intervention for individual, relationship, family and group therapy (Craig & Austin, 2016). Integrating CBT with LGBTQIA+ affirmative practice may help to maintain the evidence- base of CBT while ensuring affirmative values and content throughout the therapeutic process (Craig & Austin, 2016).

Research based guidelines in adapting CBT to LGBTQIA+ clients that have been summarized in Table 1.

Some researchers (Austin & Craig, 2015, Austin et al, 2016) also developed a Trans-Affirmative CBT framework. This approach involves the following principles (Austin et al, 2016)-

1. Adopting an affirmative stance towards gender diversity
2. Recognizing transgender specific sources of stress such as gender dysphoria, trans-negativity and systemic oppression
3. Delivering CBT content within an affirming and trauma-informed framework

Therapists focus on creating a safe-trans-affirmative environment within which clients learn to recognize the links between their experiences of trans-negativity and their distress through the lens of Minority Stress Theory, so that "they can move from seeing themselves as being 'disordered' to understanding that they are 'doing their best to cope with complex and often hostile circumstances" (Austin & Craig, 2015).

Many intervention studies have been developed after consultation with members of the LGBTQIA+ community or by mental health professionals who identified as queer (Craig et al, 2015, Hall et al, 2019, Lucassen et al, 2015, Pachankis, 2014, Wandrekar & Nigudkar, 2019). Involving queer individuals in designing interventions may contribute greatly to efficacy as well as client comfort. Many of the groups studied were conducted by LGBTQIA+ facilitators (Hall et al, 2019, Llyod et al, 2021, Smith et al, 2017, Wandrekar & Nigudkar, 2019) and clients expressed a preference for the same. Disclosing therapist's gender and sexual identity is recommended; cis-het therapists may need to acknowledge their relative positions of privilege when working with queer clients.

CBT adaptations in individual therapy

1. ESTEEM

In the US, a trans-diagnostic CBT approach for Men having Sex with Men that would help across different mental health conditions that MSM individuals (aged 18 to 35) often face, has been developed (Pachankis, 2014, Pachankis et al, 2015, Pachankis et al, 2019), by adapting the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders by Barlow et al in 2011. In a randomized control trial (Pachankis et al, 2015), it was found that MSM who participated in ESTEEM, showed significant reductions in depression, substance use, sexual compulsivity, condom-less sex with casual partners, and improved condom use self-efficacy. In 2019, Pachankis et al proposed a Project ESTEEM randomized control trial protocol. In 2020, Pachankis et al published findings about EQUIP (Empowering Queer Identities in Psychotherapy)- an adaptation of ESTEEM for sexual minority adult women with depression and alcohol use. McCormick (2018) proposed a telehealth ESTEEM adaptation for use in rural America.

2. RAINBOW SPARX

Lucassen et al (2015) from New Zealand suggested that computerized CBT programs may be particularly useful for LGBT individuals, because they offer privacy without fear of disclosure, and may be used by youth who are geographically isolated from urban centres that typically offer mental health services; however, they may also be impersonal and may not

allow for detection of clients' worsening clinical states. They adapted SPARX for use with LGBQ individuals and termed it RAINBOW SPARX, with appearance changes (eg. more gender-neutral avatars) and script-related changes that accounted for 5.9% of the overall program's script. This CCBT program uses mini-games based on specific CBT skills and the themes adapted to address specific issues for sexual minorities. Twenty one 13- to 19-year-old sexual minority youth welcomed the intervention and showed a reduction in symptoms of depression, anxiety and hopelessness maintained at a three-month follow-up (Lucassen, Merry, et al, and Lucassen, Hatcher, et al, 2015).

3. Other approaches

Several case studies demonstrate the efficacy of modified versions of CBT for a range of mental health concerns for LGBT individuals (Balsam et al, 2006, Safren & Rogers, 2001, Safren et al, 2001). Walsh and Hope (2010) presented a case study demonstrating how to identity-focused treatment using CBT principles, addressing the link between gay identity and social anxiety for a gay man, led to steeper decline in symptoms compared to traditional CBT. Satterfield and Crabb (2010) described the use of CBT in a case study of a 61-year-old gay man with depression. Perry et al (2017) presented a case study of a 22-year-old genderqueer client, and suggested that minority stress related factors may have interfered with the successful use of CBT, and called for culturally competent modifications in CBT to address these difficulties.

Kaysen et al (2005) outlined a case study successfully using Cognitive Processing Therapy, a form of CBT introduced as a treatment for Post Traumatic Stress Disorder with a gay victim of a hate crime. Cohen et al (2018) and Perales (2017) described how Trauma Focused CBT can be adapted for use with LGBTQIA+ youth and their parents.

CBT adaptations in Group Therapy

1. AFFIRM

AFFIRM is an LGBT affirmative CBT-based group therapy intervention developed by researchers in Canada (Craig & Austin, 2016). In an open pilot feasibility study by Craig and Austin (2016) and subsequent wait-list control study (Craig et al, 2021), it was found that participants perceived benefits from the intervention, and depression scores reduced post the intervention and remained low post three months; improvement was better than wait-list controls. Exploring the mechanisms that led to this change (Craig & Austin, 2016, Craig et al, 2018, Craig et al, 2021), the researchers found that participants showed reductions in threat appraisals (positively related to depression) and increases in challenge appraisals (negatively related to depression), and increases in the use of engagement coping strategies rather than disengagement coping strategies. Austin et al (2018) found that transgender participants showed positive responses to AFFIRM. Craig et al (2019) designed an implementation protocol for a clinical trial for Project Youth AFFIRM, and outlined a protocol to train community practitioners to deliver AFFIRM (Craig, 2020). A digital adaptation called AFFIRM Online was found useful (Craig, Iacano, et al, and Craig, Leung, et al, 2021).

2. Other group therapy modules

Ross et al (2007) adapted the Mind over Mood model developed by Greenberger and Padesky in 1995 designed for individuals with depression, and facilitators used an anti-oppression framework to contextualize issues. Hall et al (2019) developed BOWS- Being Out With Strength, and Lloyd et al (2021) developed a CBT-based queer well-being group. Project PRIDE (Promoting Resilience In Discriminatory Environments), developed by Smith et al (2016 and 2017), was designed as a group therapy program meant to be delivered by community-facilitators and focused on HIV prevention. Heck in 2015 piloted a minority-stress informed resilience promotion module for LGBTQ youth conducted within a high school Gay Straight Alliance. Target groups and session themes for all these group interventions are described in Table 2.

In India, a queer affirmative based therapy group SAAHAS (Sexuality, Awareness, Acceptance, Health and Support) was found to show promise in helping LGBTQIA+ individuals with mental health concerns (Wandrekar & Nigudkar, 2019), and digital adaptations using video conferencing and chat platforms of the same have been presented (Wandrekar & Nigudkar, 2021).

Cultural adaptations and intersectionality

Research suggests that minority stress experiences are similar worldwide and may only vary in degree rather than kind, and therefore, existing CBT modules developed in some countries can be successfully adapted cross-culturally (Pan et al, 2021). Pan et al in 2021 adapted the ESTEEM model to the Chinese context. Recognizing that Chinese culture is collectivistic and emphasizes interpersonal harmony and conformity to norms, adaptations had to be made to the original Assertiveness module of ESTEEM- emphasizing a gradual relationship-building approach to help men to function effectively in their families while affirming their sexual orientation. Duarte-Valez et al (2010) provided a case study adapting a CBT module to fit the needs of a gay Puerto Rican adolescent client with depression, for whom, sexuality, family and spirituality emerged as major sources of distress.

A limitation of the studies reported is the lack of detail about how minority stress related with sexual and gender identity may interact with that associated with socio-economic status, racial identity, religious affiliation, and other psycho-social variables to lead to mental health outcomes (Sheinfel et al, 2019) In feasibility studies, participants reported that lack of intersectionality-focus was a limitation of the groups (Hall, 2019, Llyod, 2021).

Section 2: Experiences adapting QA-CBT to the Indian context

Individual therapy

The two authors have professional training in applied psychology with a clinical focus and ten years of experience each, and are researchers and practitioners trained in CBT. Here, we present an account of 80 case notes of LGBTQIA+ clients seen over the past 3 years. Between the two authors practicing as mental health professionals, we've conducted psychotherapy with clients across the LGBTQIA+ spectrum, with gender identities of cis-men, cis-women, transmen, transwomen, genderqueer, genderfluid, gender-nonbinary,

intersecting with sexual orientation identities of gay, lesbian, bisexual, pansexual, asexual, demisexual, along with those using the labels queer and questioning.

We strive to create an affirmative framework as per APA guidelines (2012, 2015) and as conceptualized in India by Ranade & Chakravarty (2013). This involves affirmative settings, inclusive language, affirmation of client's identity and acknowledging the reality of stigma in their lives. We follow the CBT-guidelines mentioned in Table 1. Our approach seeks to primarily separate concerns related to their queer identity, from those that aren't, and also to recognize how the queer identity may play a role in their presenting concerns. Queer specific concerns that our clients bring to therapy include figuring out their identity, dealing with internalized homo-negativity, bi-negativity, ace-negativity and trans-negativity, gender dysphoria, support during the transitioning process, fear of rejection and stigma, histories of trauma related to harassment and abuse stemming from stigma, support for coming out, dealing with family of origin reactions to trauma, isolation and loneliness. Concerns related to work performance, relationship difficulties revolving around personality and belief related incompatibilities, anxiety about health, losing loved ones, are some examples of concerns unrelated to being queer. Concerns such as body image and self-worth related difficulties, relationship difficulties, may be mitigated by queerness; for instance, ideas of masculinity and femininity and depictions of the same in queer culture may shape body image concerns, internalized stigma may affect self-worth, and difficulties in navigating relationships as a queer person in a heterosexist homo-negative society, may add specific variables to relationship difficulties. We often disclose our own queer identity in the intake, which we have found to build comfort and safety. A trauma-informed practice is integral to our work given queer histories of complex trauma. The strategies that we have found to be the most effective have been psychoeducation about the minority stress theory, psycho-education about trauma and mental health conditions, psychoeducation about gender identity and sexuality where necessary, understanding the cognitive triad and exploring the role of minority stress in contributing to thoughts, feelings and actions, cognitive restructuring, trauma narrative processing, behavioural activation recognizing the resources and constraints for queer individuals, training in assertiveness and boundary setting, emotion regulation strategies, relaxation training and grounding, and problem-solving skills.

As is true of any therapeutic modality, QA-CBT alone may not be effective or adequate and may need to be combined with techniques from other approaches and/or medications for certain clients, for instance, those with very severe clinical concerns.

Group therapy

Our experiences of setting the queer affirmative CBT-based therapy group are described elsewhere (Wandrekar & Nigudkar, 2019, 2021). The group is a queer only group with open format allowing for members to join in at any time, and queer specific themes for each session are decided collaboratively by facilitators and participants. Queer psychologists adopt a peer-cum-expert facilitator stance. Our focus is on resilience building rather than a deficit-focused approach, and we frequently discuss queer-specific strengths. Due to the dynamic participation, CBT-strategies are built into every session rather than taught in a graded fashion. For instance, in the session on queer intimate partner relationships, we discuss and

affirm queer specific challenges in building and maintaining relationships and the lack of systemic support for the same, provide psycho-education about multiple different kinds of relationship styles possible and psycho-education about intimate partner abuse, identify maladaptive beliefs about queer relationships and gender roles in the same and locate these in heterosexist conditioning and queerphobia, explore how these beliefs may affect emotions and relationship behaviours, work on restructuring these beliefs through group knowledge and experiences and generate more expansive notions of what healthy queer monogamous and non-monogamous relationships can look like beyond the marriage centric Indian notions, and practice boundary setting and healthy communication and interpersonal skills.

Specific adaptations to the Indian context

1. Addressing the role of the family

One of our major observations in working with queer individuals in India has been the crucial role of the family of origin in their lives. Indian society is collectivistic, and family and kinship norms are seen as very important. Individual identities incorporate the roles and responsibilities one has to perform in the context of your family. In the cis-hetero-patriarchal set-up, gender norms are rigidly enforced, and heterosexual marriage (following class, caste and religious rules) is seen as compulsory forms the only acceptable script for individual life. Mishra (2020) explored how queer individuals learn to feel guilt due to the anticipation of future parental unhappiness due to their identity and failure to live up to reciprocal family expectations.

In terms of the cognitive triad, given how the sense of self is dependent on one's identity as a good child to parents, queer identity may come into conflict with the same, and this combined with the negative way in which parents and society view queer identities, may fundamentally affect core beliefs about self-worth in the direction of worthlessness; the frequent rejection, abuse, victimization within families due to one's identity may heighten perceptions of the world as an unsafe place where they will never be accepted; and knowing that they will not be able to live up to the only acceptable heterosexual and gender roles scripts may contribute to beliefs about the future as hopeless. In addressing these beliefs, we have had to help clients understand how their beliefs have been shaped by the context of Indian societal structures and views of queer identities, help them to form self-worth schemas that are not completely dependent on meeting family obligations (eg. "I may be queer and may not meet all my family's expectations from me, but that does not make me a bad child or person"), and separate family perceptions of their own identities from their own pleasure and satisfaction in the same. Connecting queer individuals to queer resources in India, helping them to build families of choice, and showing positive media representation, challenging homo-negative and trans-negative beliefs, and presenting alternative models of healthy and happy queer relationships, may foster hope about the future and modify beliefs about the world (egs. "It is possible to lead a happy life even if you cannot follow the conventional marriage script by subverting or rewriting scripts," "While some in my family may reject me, I can reach out to others who may accept me for who I am.")

It is important to recognize that coming out to parents as the final ideal may be a Eurocentric notion (LABIA, 2013) and for queer individuals in India, coming out may be a complex decision with many psychological, social, economic ramifications; selectively disclosing identities based on assessments of risk, contexts and relationships may be a helpful stigma management strategy (Ranade, 2019); as therapists, we have to respect this and help individuals to take disclosure related decisions that fit in with their lived realities. Families are often sites of violence after coming out, with increased surveillance, mobility restrictions, forcible separations from partners, forced marriages, frequent emotional blackmail, as some of many potentially traumatic consequences for individuals (Chakrapani et al, 2017, Fernandes & Gomathy, 2003, LABIA, 2013, Ranade, 2019). Processing this trauma and learning to see it as violence stemming from prejudice, rather than internalizing it as a natural and fair consequence of one's identity, is crucial trauma work. In addition, we have noticed that clients wish to work with rather than without or against families; teaching assertive communication and boundary setting strategies within the context of family relationship building practices (similar to Pan et al, 2021) is important. We adapt queer affirmative frameworks to acknowledge the importance of family and the reality and emotional and practical impact of family-centred minority stress on queer individual lives, and teach CBT strategies of decision making, problem solving, boundary setting, restructuring cognitions, and healthy emotion regulation and coping, to help clients navigate these concerns. The following case vignette provides an example of how this can be done in a group therapy context.

In group therapy sessions on "family', participants shared their experiences dealing with family members, for those who had come out and those who hadn't. We explored and validated feelings in response to these experiences, which included guilt, shame, hurt, anger, resentment, betrayal, frustration, anxiety, grief and sadness. Some common beliefs underlying some of the distressing feelings were elicited- "'I must never disappoint my parents," "My queer identity means that I will never be able to give my parents happiness," "Failing to keep my family happy makes me a terrible child and makes me worthless." We explored the origins of these beliefs and linked these to cultural notions about families in a collectivistic country like India that encourage compliance to family norms as an indicator of worth. We helped participants to challenge shame-generating beliefs about their queer identities by locating these beliefs in the context of cis-heteronormativity, and homo and trans-negativity, and by encouraging them to list out evidence against these beliefs, based on feedback from their chosen families and affirmative resources. We explored the impact of family non-acceptance, erasure, pressure for heterosexual marriages, and abuse, and discussed personal ways of negotiating identities as a family member and queer person. Participants were at different stages in their relationships with their families, and participants who had come out or chosen not to some years ago and had learnt to find ways to deal with varied degrees of acceptance, helped to de-catastrophize and provide hope to those participants who reported beliefs similar to "My family members will never accept me and I cannot stand it." The sessions incorporated strategies such as boundary setting and healthy communication. Resources to deal with family violence were shared. Transformative

ideas that challenged beliefs about what 'a family' can mean, were discussed, with emphasis on building families of choice.

2. Intersectional lens

Given the diversity in Indian society, adopting an intersectional framework in therapy is imperative. Intersectionality- a paradigm that emerged from the works of Kimberle Crenshaw in 2008 and other Black scholars, has been over the past few years been used in the mental health context (eg. Cairney et al, 2013, Seng et al, 2012). An intersectional lens in CBT therapy requires us to acknowledge and explore how the multiple social identities (along the lines of class, religion, caste, gender, sexual orientation, ability/disability, etc) of an individual intersect in forming their concept of the self and self-worth. We also need to recognize that client locations along multiple identities may create complex power, privilege and oppression dynamics, that affect their mobility and ability to access resources and vulnerability to trauma and marginalization, among other factors; these in turn, may shape their beliefs about personal control and agency, perception of the future as hopeful or hopeless, and perception of the world as supportive or hostile. In addition, clients' complex social realities may encompass varied cultural contexts that may encompass different conceptual understandings of and degrees of acceptance for queer identities. It is important to acknowledge that besides bi-negativity, trans-negativity, ace-erasure, stigma about polyamorous relationships, that may exist within the LGBTQIA+ community and spaces, there may also be sexism, communalism, casteism, ableism and classism, and to explore how this may affect clients' experiences of community and access to these spaces.

Intersectional QA-CBT involves affirming the challenges specific to clients' lived realities, helping clients understand how different identity locations and experiences of multiple layers of discrimination affect thoughts, actions and feelings, helping them restructure cognitions and learn coping strategies to regain a sense of control. Therapists have to be mindful of cultural norms, culture specific resources and limitations in access and mobility when suggesting behavioural exercises. Engaging in critical reflexivity- understanding and acknowledging therapist-client differences along social locations of privilege, power and oppression and asking yourself 'What do I recognize or not recognize due to the positions I occupy?' (Hunting, 2014) may be important self-work for a therapist. QA-CBT therapists with an intersectional lens may have to work towards building a practice that is access friendly, affordable, culturally informed and sensitive, feminist, and caste-aware and Dalit, Bahujan, Adivasi (DBA) affirmative. This case vignette describes how this can be done in individual therapy-

B.R. was a 21-year old autistic Dalit trans woman. She reported a history of bullying in school and abuse at home. She struggled with gender dysphoria, low self-worth, loneliness, anxiety, and trauma triggers. The therapist affirmed her identity, validated her distress and the reality and impact of violence based on prejudice, and helped her access resources to navigate gender dysphoria. Over many sessions, she was able to see how her sense of self as worthless was strongly shaped by messages that were rooted in ableism, casteism and trans-negativity. The therapist explored her trauma narratives and helped her to reframe her experiences in the light of traumatic incidents that were rooted in prejudice, rather than her fault or something that she deserved. In therapy sessions, she learnt boundary setting,

assertive communication and skills to navigate social situations, emotion regulation and grounding skills, and built safety plans for potentially violent situations. Psychoeducation about autism and neurodivergence, about trauma and how it shapes experiences, and about transformative ways of looking at gender identity and expression, helped her to reconceptualize what she previously saw as her weaknesses. She benefited from accessing suggested resources, such as support groups and social media platforms that centered marginalized voices of queer, DBA and neurodivergent individuals. She was able to challenge automatic thoughts, recognize and validate her strengths, effectively deal with trauma triggers, build strong connections with affirming peers, and work actively towards her goals. Her advocacy work and building a strong political and collective identity helped to build her sense of self-worth.

CONCLUSION

This paper outlines the use of CBT modified using queer affirmative frameworks for working with LGBTQIA+ individuals. It makes a case for focussing on the impact of families and incorporating an intersectional lens when adapting it to the Indian context.

We have intentionally limited the scope of the paper to existing research papers on CBT with LGBTQIA+ individuals. In doing so, we have not enumerated on the history of CBT and the larger debate for and against the use of CBT in general across disciplines. We encourage readers to supplement this paper with existing theory and contemporary discourse on the same, to provide a richer understanding of the larger context and critique of CBT that made this specific QA-CBT adaptation imperative.

We believe that this paper can be useful for mental health and allied professionals that work with LGBTQIA+ individuals who are exploring ‘best practice’ therapeutic frameworks for use with their clients, as well as CBT practitioners looking t adapt their existing practices to better serve the needs of LGBTQIA+ clientele. Adding QA-CBT models as a part of the teaching and supervision curriculum for mental health and allied professionals may strengthen the skills and sensitivities of professionals to respond to needs of sexual and gender minorities. QA-CBT based training models can also be useful as a part of capacity building of LGBTQIA+ community workers and peer support networks, providing them with concrete tools to help community members.

There is great potential for further research on QA-CBT specific to the Indian context. This could include more practitioner experiences but could also foreground LGBTQIA+ client experiences as recipients of QA-CBT. We need robust local clinical research comparing QA-CBT with other intervention models as well as its efficacy for different subgroups of LGBTQIA+ clients. We need research on the QA-CBT that goes beyond a deficit-focus approach and explores its utility for community mental health and resilience building.

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Table 1: Summary of guidelines for QA-CBT

Guidelines to make CBT queer affirmative (Craig et al, 2013, Pachankis, 2014, Safren & Rogers, 2001).
1. Identify and work on therapist's personal assumptions about LGBT and reduce bias 2. Affirm identities of LGBTQIA+ individuals 3. Validate client's reported experiences of discrimination without automatically universalizing or minimizing these; acknowledge the reality and impact of heterosexism and homonegativity on clients' lives and acknowledge the mental health consequences of minority stress 4. Assess how client's sexual orientation may fit into conceptualization of a presenting problem (to see whether the major problems brought to therapy are related or unrelated to identity-specific factors) 5. Emphasize collaboration over confrontation with attention to client- therapist differences 6. Identify and affirm clients' unique personal strengths and resilience 7. Distinguish between environmental problems and problems that are due to dysfunctional thoughts, to acknowledge what is within and outside an individual's control 8. For problems that are environmental, help clients make positive changes, increase their strengths and supports, and build their skills in coping and interacting with these problems 9. Acknowledge the impact of minority stress in development and maintenance of negative beliefs about their identities 10. An affirmative approach to cognitive restructuring that involves questioning helpfulness and utility of holding on to certain thoughts, rather than validity or rationality of these thoughts 11. Use client identified strengths and their support networks to generate lists of helpful thoughts 12. Ensure that homework or behavioral assignments that are given to queer clients are congruent with queer culture and are realistic keeping in mind their degree of outness. 13. Affirm healthy and rewarding experiences of sexuality 14. Pay attention to relative presence and absence of affirmative social support networks and focus on building the same, and facilitate healthy relationships 15. Empower LGBTQIA+ individuals to communicate openly and assertively across contexts 16. Do not utilize CBT for any sexual orientation change efforts.

Table 2: Target groups and themes of CBT groups for LGBTQIA+

AFFIRM (Craig et al, 2015, 2016, 2018, 2021)	**BOWS (Hall et al, 2019)**	**LGBQ well-being group (Llyod et al, 2021)**
14 to 29 years old LGBTQ	18 to 29 years LGBTQ with depression	LGBQ adults with common mental health concerns
• introduction to CBT and Minority Stress • the impact of homo-negative and trans-negative attitudes and behaviours on stress • understanding how thoughts affect feelings • using thoughts to change feelings • exploring how activities affect feelings • planning to overcome counterproductive thoughts and negative feelings • the impact of minority stress and prejudice on social relationships • developing safe, supportive and identity affirming social networks	• group building • coming out stories and introduction to helpful and unhelpful thinking • LGBTQ related internalized oppression • identifying core-self-beliefs • identifying origins of core beliefs rooted in oppression and links to emotional states • cognitive strategies to change thoughts • importance of self-love • developing individualized self-affirmations to combat internalized oppression	• introduction to CBT and the group • overcoming avoidance • overcoming negative & unhelpful thinking • working on over-thinking and worry • coping with distressing feelings • negative beliefs about ourselves &self-criticism • developing body acceptance and confidence • loneliness and making connections, developing LGBQ confidence and resilience • relapse prevention.
Group by Ross et al, 2007	**Project PRIDE (Smith et al, 2016, 2017)**	**GSA-based group (Heck, 2015)**
LGBTQ adults with depression	18- to 25-year-old MSM	Members of a high school GSA
• 14 sessions each examining the thought-action-feeling link and using CBT exercises. • module on coming out • module on internalized homonegativity, bi-negativity and trans-negativity and their	• 2 sessions-introduction, group building and minority stress theory • 2 sessions-understanding specific sexual minority stressors, developing goals using SMART,	• understanding minority stress and identifying coping skills for minority and general stress • affect regulation skills • cognitive skills using the CBT framework

impact on depression on LGBT individuals.	understanding Lazarus' 2000 stress and coping model • 1 session- Links between stress, coping and sexual behavior such as condom less sex • 1 session- safe sex practices and sexual communication skills • 1 session- review	• a problem-solving framework to make coming out decisions.