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Original Article

Learnings From SAAHAS—A Queer Affirmative CBT-Based Group Therapy Intervention for LGBTQIA+ Individuals in Mumbai, India

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Abstract

Background: There are few published research studies documenting intervention modalities used with LGBTQIA+ individuals in India. This is a pilot study documenting possibly the first of its kind therapy group named SAAHAS based in Mumbai.

Methodology: SAAHAS was a free, open group for therapy meant for queer individuals. The therapeutic approach used was queer affirmative cognitive behavior therapy. Facilitators were queer psychologists. A survey was conducted to assess the needs of potential participants. Recruitment protocol, group, and session formats and structures are described here. Evaluation was primarily through anonymous participant feedback.

Results: A total of 71 participants completed the intake survey, 28 participants attended at least one group session, and 78% of these were cis-gay men, with low representation of lesbian, bisexual women and transgender and gender nonconforming individuals. Over one year, 12 monthly sessions were conducted. Feedback suggested that the participants liked the group, found it to be a safe space, and reported an improvement in mental health, reduction of distress, reduction of feelings of isolation, and acquisition of knowledge and skills to tackle problems faced by queer people. Peer support, safe space, expert-cum-peer facilitator stance, and queer affirmative cognitive behavior therapy-based therapeutic approach may have contributed to group efficacy.

Conclusion: The SAAHAS therapy group experience provides a useful low-cost therapeutic framework for queer individuals in India.

Keywords

LGBT, queer, group therapy, sexual and gender minorities, affirmative CBT

Introduction

The LGBTQIA+ (lesbian, gay, bisexual, transgender, queer and questioning, intersex, asexual, other identities) community encompasses a multiplicity of sexual and gender minorities, often referred to by the umbrella term "queer," a reclaimed use of what was earlier a derogatory term (used throughout this article to represent all LGBTQIA+ identities). Queer individuals worldwide have had a history of facing stigma (homophobia, transphobia, biphobia), discrimination, violence, erasure from general discourse, marginalization, and invisibility, in a society that is largely heteronormative. Minority stress theory explains how these stressful experiences lead to an increased risk of mental illness and mental health concerns for queer individuals.[1] Queer individuals typically don't access mainstream health and mental health care services, and if they do, they do not receive sensitive and adequate care, and hence, it is clinically relevant to provide them with specialized mental health services

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geared towards their unique needs.[2] While the American Psychological Association has laid down guidelines for working with lesbian, gay, and bisexual individuals[3] and for working with transgender and gender nonconforming (TGNC) individuals,[4] there is relatively limited published research that presents intervention models developed specially for queer individuals.[2]

Indian society following the colonial era has been largely homophobic, and homosexual individuals growing up in India often face unique challenges that are not faced by their heterosexual peers,[5] as do TGNC individuals. Traditionally, psychiatry and the mental health fraternity in India have shown a history of providing mental health services that either focus on conversion therapies,[6] are based on a model of pathologizing these individuals,[7] or represent an approach that is generally ignorant or does not take into account the societal power structures and context in which queer individuals' mental health issues germinate. In the years before the landmark 2018 decision by the Supreme Court about reading down Section 377 of the Indian constitution that criminalized "unnatural sex," a number of senior psychiatrists called for the need for the mental health fraternity to be more sensitive to the needs of queer individuals.[7-12] Some psychiatrists laid out some preliminary guidelines for mental health professionals working with queer individuals.[12,13] Two mental health professionals were instrumental in creating a manual for gay affirmative practice based on guidelines derived from interviews with professionals providing affirmative care in India.[14] However, research on specific intervention modalities adapted to the Indian context is still in its infancy.

One intervention approach that holds a lot of promise when working with queer individuals is group therapy, which has been found to contribute to reduced distress and better mental health outcomes.[1,2,15-18] In India, there are a number of support groups for queer individuals in metropolitan cities. However, most of these are peer-run and focus on discussing common concerns, on advocacy or on socializing. To the best of the authors' knowledge, there is no published data available on a therapy group that is run by mental health professionals and that provides targeted interventions aimed at fostering psychotherapeutic growth and development. The current paper outlines the therapeutic framework, formation, group structures and processes, and preliminary evaluation, of possibly the first such therapeutic group in Mumbai called SAAHAS, and in doing so, aims to provide insights into how this modality can be effectively used to deliver low-cost queer affirmative mental health care.

Methodology

Group Aims

SAAHAS is a word in Hindi that means "courage." It is also an acronym for sexuality, acceptance, awareness, health, and support. The acronym symbolizes the major aims of the group:

1. Affirmation of all sexual and gender identities and fostering self-acceptance of the same by queer individuals
2. Increasing awareness about various aspects of gender and sexuality, and mental health, and about the societal structures that influence the two
3. Fostering better overall mental health, reducing symptoms of mental illness and distress, and developing emotional resilience so that queer individuals are better equipped to cope with their stressors
4. Building social support networks of queer individuals and reducing real and subjective isolation

Therapeutic Framework

The group's therapeutic framework is grounded in queer affirmative cognitive behavior therapy (CBT).

Queer affirmative practice, as described by Ranade and Chakravarty,[14] is an approach to counselling that encompasses counsellor self-work, attitudes, knowledge, ethics, and process skills. The fundamental principles of this approach include "understanding and combating heterosexism, recognizing heterosexual privilege where it exists, and understanding and combating homophobia in clients as well as in self." The authors outlined 8 major themes that emerged from their interviews with affirmative therapists and provided the cornerstones of their manuals—inclusive language and terminology, queer-friendly counselling setups, knowledge about diversity and queer resources, emphasis on confidentiality, counsellors' self-awareness of their biases, avoiding assumptions about clients, addressing misinformation and misconceptions of clients, and working on internalized homophobia and self-acceptance. Initially centered on cis-gender homosexual individuals, this approach was later modified to include gender minorities, and currently encompasses all non-"normative" sexual and gender identities. An affirmative approach is one that validates rather than pathologizes queer identities. It is an approach that is rooted in awareness of societal structures and their impact on mental health. At the same time, it honors queer individuals' strengths and resilience. Such an approach can help to interrupt the negative impact of minority stress.

CBT is widely acknowledged to be the most evidence-based efficient intervention for a wide range of mental health concerns. Some researchers and interventionists believe that CBT goes against a "social justice perspective" and is not useful for at-risk individuals; however, a modified form of CBT that is grounded in affirmative practice has been found to be effective in helping queer individuals to identify which of their stressors are internal and which are environmental and linked to societal oppressive structures, helping them to learn adaptive thinking styles and coping strategies to deal with their stressors, and acquiring and maintaining better mental health and emotional resilience.[19] Such a modified

affirmative CBT format has also been successfully adapted to group therapy.[1,16,17]

Reaching Out to Potential Participants

The group was open to all non-"normative" sexual (lesbian, gay, bisexual, asexual, pansexual, etc.) and gender identities (transgender, gender nonbinary, agender, hijra, etc.). Recruitment of participants was done in two phases. In the first stage, an information poster was created by a graphic designer with information in English as well as the local languages predominant to the geographical region (Hindi and Marathi). This poster was circulated through social media channels amongst mental health professionals, organizations that work with queer individuals, and influential queer individuals. Press releases were also sent to local newspapers. In the second stage while the group was already underway, attempts were made to increase group participation through various means. The team organized a community event called "LGBTQIA+ and families—what to do if one's family member is queer." The event was a panel discussion with queer individuals and mental health professionals as panelists, and it was meant for parents of queer individuals to help them understand queer concerns better. Additionally, the group facilitators participated as faculty in a number of queer events held by queer-rights organizations, mental health organizations, and colleges around the city. Social media engagement was increased with an Instagram account and Facebook page outlining learnings from the group. These activities performed the role of advocacy for the queer community at large as well as of increasing group visibility.

Recruitment Process

Potential participants were asked to fill out an online survey form. This form elicited basic demographic information, information about self-identification, preferred mode of contact for further interaction, information about why they wished to be a part of the group, topics they wished to discuss, and any queries about the group that they had. This survey performed the dual purpose of helping facilitators to understand the overall needs and expectations from group therapy held by queer individuals, and preliminary screening and understanding of specific participants' needs. Upon receipt of each potential participant's responses, the facilitators sent a mail to them with information about the group and the measures that would be taken for their safety and answering their specific queries. Each potential participant was invited for a face-to-face or video interview with the facilitators. The purpose of the interview was for safety considerations and to screen participants for their fit with the group, and also to help reassure the individuals about the group processes and clarify their doubts. Following a successful conclusion of this meeting, if the group goals and participant goals aligned, they were eligible to join the group.

Informed Consent and Mental Health Screening

Each participant attending their first session was given an informed consent form that outlined the group purpose and group rules. Written and signed consent was taken for attending the group, for undergoing periodic assessments, and for the use of anonymized data for research. Signing the form also implied agreement to follow the group rules. Participants were also informed about the potential risks of participation and that they were free to leave the group at any time.

The Patient Health Questionnaire 9 (PHQ 9) is a 9-item self-report screening inventory of depression.[20] The Generalized Anxiety Disorder 7 (GAD 7) scale is a 7-item self-report inventory of anxiety.[21] These two tools were administered to all participants attending the group in order to gain further insights into their current clinical status and plan more comprehensive intervention, and to increase their self-awareness about their mental health status. They were provided feedback about their scores. If scores were very high, they were additionally referred for individual psychotherapy and/or psychiatric intervention.

Group Structure and Logistical Considerations

Facilitators

Previous research has suggested that most queer individuals prefer queer therapists.[2,15] They may find that the approach of a queer therapist may be less top-down, and may believe that these therapists can actually relate to their experiences as they also face the same oppressive societal structures. The two facilitators for the group were from the queer community and self-identified as cis-gender lesbian women. They were trained psychologists with a background in clinical work, and were experienced in individual therapy with queer clients, clients facing trauma, clients with mental illness, and with group therapy for other populations. The approach used by them was a combination of expert-cum-peer facilitation, where they were experts in mental health intervention and peers with respect to queer experiences. A senior mental health professional was invited for the first two sessions to serve as a supervisor and mentor for the facilitators.

Venue

A lot of queer events are held in the southern and western part of the metropolitan city of Mumbai in Maharashtra. They have often been accused of being "elitist" for this reason, and queer individuals staying in the suburbs and the surrounding Thane district may find these resources inaccessible, thus making them feel more marginalized and isolated, as reported by clients of the facilitators in some individual therapy sessions. The facilitators decided to hold the group sessions in Thane with the aim of reaching out to this group of people. A prominent mental health organization in Thane, where the

facilitators consult, offered the use of a private community space as the venue.

Format

An open-group format was followed, where participants could start attending any session and could attend any number of sessions. This was chosen as a modality based on participants' feedback in the surveys about the need for flexibility, and also because of the ever-increasing need for therapy services for queer individuals which made increasing access to more people an ethical responsibility. Sessions were held once a month for a duration of two hours, on a weekend.

Group Rules

Keeping in mind the very real safety risks that queer individuals may face in Indian society, confidentiality was emphasized as a key group rule. Facilitators and all group participants were expected to maintain confidentiality with respect to what was discussed and also crucially with respect to other members' identities. "Outing" other group members, that is, disclosing that they are queer to individuals outside the group without their consent, was forbidden. Other group rules involved respecting and using others' preferred pronouns, and respecting the group space and others' experiences. Solicitation or cruising, and consumption and dealing of substances, were forbidden.

Session Themes and Structures

Topics for each session were selected based on group discussion and facilitator analysis of the group needs. Each session began with a check-in—introduction of the facilitators and laying down of group rules, as well as setting the agenda for the day. All participants introduced themselves with names and with their preferred pronouns. Then the theme was discussed, with participants sharing their experiences and challenges. Facilitators helped the participants to emotionally process these challenges and provided information and inputs. Each session ended with the facilitators summarizing the key points discussed and with setting the agenda for the next session. Each session was grounded in the affirmative CBT approach, with maximum emphasis on validating participant identities and experiences, exploring and acknowledging the impact of societal structures and the context, while simultaneously discussing the CBT thought-feeling-action model and teaching participants to recognize unhelpful cognitions that may add to their distress, cognitive reframing, and teaching and practicing coping skills.

Evaluation

After one year (12 sessions) of the group, a feedback form was created, that elicited information regarding participants' comfort and safety within the group, whether and how exactly they felt the group had helped them, their perception of the facilitators' attitudes and skills, and overall impressions and suggestions, using both close-ended Likert-format questions and open-ended questions. To encourage honest feedback and reduce social desirability, the feedback form was sent to the participants through an online group with instructions emphasizing that constructive criticism was welcome, and responses were completely anonymous.

Results

Findings of the Intake Survey

Over the course of the year from May 2018 to April 2019, 71 individuals filled in the initial intake survey. This data represents individuals interested in joining the group. Demographic data of these respondents is presented in Table 1. A total of 21 (21.12%) had heard about SAAHAS from their friends, 12 (16.9%) had heard about it from existing group members, 26 (36.61%) learnt about it from social media, 6 (8.45%) were existing individual therapy clients of the facilitators, 8 (11.26%) were referred by other mental health professionals, 2 (2.81%) found out about the group after attending the community event by SAAHAS, and 2 (2.81%) found out through other events where SAAHAS was featured.

Table 1. Intake Survey—Demographic Details of Respondents (N = 71)

Gender Identity	**N (%)**	**Ages**	**N (%)**
Cis-man	45 (63.38)	17-20 years	10 (14.08)
Cis-woman	12 (16.9)	21-30 years	30 (42.25)
Transgender/ gender queer	10 (14.08)	31-40 years	24 (33.8)
Sexual orientation		41-50 years	7 (9.86)
Gay	38 (53.52)	**Locations**	
Lesbian	9 (12.67)	Thane	11 (15.49)
Gay/bisexual (unsure)	3 (4.22)	Central suburbs/ off Thane	21 (29.58)
Bisexual and pansexual	9 (12.67)	Mumbai western suburbs	26 (36.62)
Questioning	2 (2.81)	Other cities	12 (16.91)
Heterosexual (trans-identifying)	4 (5.63)	Other countries	1 (1.4)
Panromantic asexual	2 (2.81)		
Allies (cis-gender heterosexual)	4 (5.63)		

Table 2. Intake Survey—Reasons for Joining the Group and Topics of Interest (N = 71)

Reasons for Joining	N (%)	Topics of Interest	N (%)
Discussing concerns with like-minded peers	25 (35.21)	Queer-specific experiences of stigma	39 (54.93)
Helping others	18 (25.35)	Love and relationships	16 (22.54)
Learning to cope with mental health issues	15 (21.13)	Mental health and illness, addictions	15 (21.13)
Learning to deal with queer-specific problems	11 (15.49)	General awareness and "life guidance"	10 (14.08)
Obtaining support	7 (9.86)	How to deal with family members, coming out	7 (9.86)
Obtaining information	4 (5.63)	How to deal with loneliness	4 (5.63)
Allyship	4 (5.63)	Other relevant topics (education, occupation, finances, etc.)	4 (5.63)
Building connections with other queer initiatives	2 (2.82)	How to stay safe	3 (4.23)
Being a part of a safe space	2 (2.82)	Safe sex and HIV	2 (2.82)
Curiosity	1 (1.41)	Unsure about topic	5 (7.04)
Understanding self	1 (1.41)		

Reasons for attending the group and preferred topics for discussion are presented in Table 2. Respondents asked questions related to the size and profile of the group, qualifications and experience of the facilitators, goals of the group, location, timings and payments, whether it was an online or in-person group, and guidelines and steps taken to ensure safety. One respondent asked whether the group's intention was affirmative or conversion-based, while others asked whether the group would help with their specific issues. Some cis-gender heterosexual respondents asked if the group was open to allies.

Group Participants

The outstation participants were given references for queer resources in their areas. The 58 local participants (81.6%) were asked to come in for a face-to-face or video interview. Out of these, 39 (67.2%) came for the interview (including existing clients in individual therapy). Finally, 28 participants (48.28%) attended at least one SAAHAS session.

Out of the 28 actual SAAHAS members, 18 (64.29%) identified as cis-gay men, 4 (10.71%) identified as cis-bisexual men, 4 (14.29%) identified as cis-lesbian women, 1 (3.57%) identified as transmasculine queer, and 1 (3.57%) identified as genderqueer pansexual. A total of 18 (64.29%) were aged 21 to 30 years, 8 (28.57%) were aged 31 to 40 years, and 2 (7.14%) were aged 41 to 49 years.

Findings of the screening inventories suggested that 10 (35.71%) showed no symptoms of anxiety, and 5 (17.86%), 6 (21.43%), and 3 (10.71%) showed mild, moderate, and severe anxiety, respectively; 5 (17.86%) showed no symptoms of depression, while 10 (35.71%), 3 (10.71%), and 6 (21.43%) showed mild, moderate, and moderately severe or severe depression, respectively. All participants with scores higher than the cutoffs of 10 and 15 on the GAD 7 and PHQ 9, respectively, were referred for individual psychotherapy as an adjunct to group therapy. Consequently 12 (42.85%) of group participants were also undergoing simultaneous individual psychotherapy and/or psychiatric consults. Of the participants, 4 (14.29%) did not complete the screening protocols.

With respect to attendance, 8 (28.57%) of the participants attended a single session, 10 (35.71%) attended 2 to 3 sessions, 4 (14.29%) attended 4 to 6 sessions, and 3 (10.71%) each attended between 7 and 8 to between 9 and 12 sessions; however, given the open-group format, these numbers also differ based on when the participants joined the group.

Group size varied from 5 to 17 participants with an average of 8 participants per session.

Table 3. Session Themes and Topics of Discussion

Session	Theme	Topics of Discussion/Strategies Used
1	General LGBTQIA+ concerns	Group-building processes Group sharing Psycho-education and myth-busting about gender, sexuality, mental health issues, minority stress model
2	Anxiety	Psycho-education about state, trait, and clinical anxiety Sources of anxiety for queer individuals Unhelpful cognitions that exacerbate anxiety Healthy coping strategies

(Table 3 Continued)

(Table 3 Continued)

Session	Theme	Topics of Discussion/Strategies Used
3	Musts/shoulds and cognitive distortions Gender and sexuality	Psycho-education about cognitive distortions, specifically shoulds/musts Link between these thoughts and coping in relation to specific queer concerns Cognitive reframing Gender-bread person—psycho-education about sex, gender expression, gender identity, sexual orientation, romantic orientation, sexual behavior
4	Romantic relationships	Challenges in dating and long-term relationships for queer individuals Components of healthy relationships Maladaptive/unrealistic expectations about relationships Concepts of consent and recognizing abuse, dealing with being single, unrequited love, and breakups
5	Coming out—to self and others	Identity exploration Cass model of identity development Theory about coming out to others Sharing coming-out stories Emotional and practical considerations while coming out and safety planning
6	Body image	Exploring family, media, and societal sources of body image issues for queer individuals Cognitive distortions that negatively impact appearance self-esteem Ways to challenge these messages and develop healthier ways to perceive and think about the body
7	Sex	Challenges in sex-education for queer individuals within a sex-negative culture Psycho-education and myth-busting about safe sex practices, consent, polyamory, BDSM, asexuality, and varied sexual preferences Concepts of sexual self-esteem and maladaptive beliefs about sex Healthy sexual communication and negotiating boundaries in sexual relationships
8	Pride	Discussion on the good things about being queer, celebration of personal strengths, meaning derived from experiences as a queer individual in India The concept of queer pride
9	Relationships with family of origin	Challenges in family acceptance of queer individuals Unhelpful demands from oneself and from other family members in family interactions and reframing of these distortions Healthy communication in the family
10	Loneliness and isolation	Objective and subjective isolation for queer individuals and its roots in discrimination and heteronormativity Unhelpful thoughts that promote behaviors that keep one isolated Healthy coping strategies to deal with these feelings
11	Media	The role of queer representation in mainstream media and queer media in identity development and fostering resilience Creating a group-sourced list of helpful queer media
12	Self-esteem	Psycho-education about self-esteem, gender self-esteem and self-efficacy The impact of societal and religious stigma, discrimination, internalized homophobia/biphobia/transphobia on self-esteem Unhelpful cognitions that impact self-esteem and cognitive reframing of internal and societally learnt messages

Session Themes

The first session was held in June 2018, and 12 sessions have been held at monthly frequency till May 2019. Table 3 provides a detailed description of themes and points of discussion for all 12 sessions.

Outcomes and Feedback

Six months after the first date of attendance, 9 regular participants completed the GAD 7 and PHQ 9. Out of these, 7 (77.7%) showed a reduction in their scores on both measures, while 2 (22.22%) showed no change. The two who showed no change had low baselines levels of symptoms.

Table 4. Feedback by Group Participants (N = 15)

Area of Feedback	Participant Responses
Overall experience of the group	Excellent 40%, very good 40%, good 40%, fair/not good/poor 0%
Feelings of safety in the group	Very safe 73.3%, somewhat safe 26.7%, can't comment/ somewhat unsafe/very unsafe 0%
If cis-LB woman or if T, feelings of being welcome in the group	Yes 100%, can't say/no 0%
Whether SAAHAS meetings have helped in	
Reduction of feelings of isolation and loneliness	Yes to a great extent 73.3%, yes to some extent 26.7%, can't say/no 0%
Identity exploration	Yes to a great extent 33.3%, yes to some extent 60%, can't say 6.7%, no 0%
Increase in comfort in queer identity and self-acceptance	Yes to a great extent 60%, yes to some extent 40%, can't say/ no 0%
Better understanding of queer issues	Yes to a great extent 66.7%, yes to some extent 33.3%, can't say/no 0%
Better understanding of mental health issues	Yes to a great extent 53.3%, yes to some extent 46.7%, can't say/no 0%
Increase in confidence to deal with stigma and discrimination	Yes to a great extent 53.3%, yes to some extent 46.7%, can't say/no 0%
Increase in skills to deal with stigma and discrimination	Yes to a great extent 26.7%, yes to some extent 73.3%, can't say/no 0%
Reduction of anxiety, depression, and distress	Yes to a great extent 13.3%, yes to some extent 73.3%, can't say 13.3%, no 0%
Improvement in overall mental health and well-being	Yes to a great extent 26.7%, yes to some extent 73.3%, can't say/no 0%
Whether facilitators	
Affirm and respect identities and experiences	Yes 100%, can't say/no 0%
Are knowledgeable about queer issues	Yes 100%, can't say/no 0%
Provide each individual space to express opinions	Yes 100%, can't say/no 0%
Manage group dynamics well	Yes 100%, can't say/no 0%

Feedback from the 15 participants who completed the feedback form is summarized in Table 4. Responses to the open-ended questions suggest that participants believed that attending SAAHAS provided them with a safe space in which to express their concerns without judgment, helped to increase self-acceptance of their queer identity and their self-esteem, helped them to manage their anxiety better and increased understanding of mental health issues, taught them healthier ways of thinking, developed their skills to more effectively deal with family conflict, reduced feelings of isolation and loneliness, and helped them to find supportive people and friends. The sessions on dealing with family members, relationships, self-esteem, loneliness, coming out, body image, queer media, and queer pride were reported to have been the most helpful.

Participants' feedback about improving the group was focused on topics (discussing more LBT concerns and biphobia), intervention strategies within the group (personalized assessment of strengths and weaknesses for participants; incorporating exercises, role plays, and activities; promoting more sharing and retention of information through outlining points to discuss prior to the group; and providing resources to acquire more information on the topic), group rules (ensuring punctuality of group members and not allowing participants to stray off topic), and logistics (having bimonthly meets to better accommodate increased members, making the venue more friendly for people staying on the western suburbs, and increasing the outreach to make it accessible to more individuals who require the services).

Discussion

Experiences while running SAAHAS for a year, information about group expectations from the initial survey, and evaluative group feedback yield certain insights that can prove useful to better understand and utilize this intervention modality.

Efficacy of SAAHAS

The primary source of evaluating group efficacy was participant feedback. The quantitative feedback was overwhelmingly positive (in spite of attempts to reduce social desirability). Participants reported positive experiences with the group, and experiences were more positive for those who had engaged with the group for longer. They reported that attending SAAHAS had significantly helped with reducing feelings of isolation, understanding queer issues and mental health concerns better, increasing self-acceptance, and increasing confidence in coping with stigma and discrimination; and had moderately helped with identity exploration, reducing anxiety, increasing overall mental health and well-being, and in developing skills to cope with stigma and discrimination. This was also supported by the qualitative information yielded through their expressed responses to open-ended questions. To quote one participant, "Thanks to SAAHAS, my anxieties have been much more in control. And every session, I do find a solution to any problems I've been facing regardless of the topic."

Comparing baseline and endline scores on various inventories was difficult due to the open dynamic nature of the group, and due to the lack of a control group and lack of control of other factors such as also engaging in individual psychotherapy. However, reduction in symptoms was seen for the regular participants assessed after 6 months. More robust research protocol needs to be used to test for actual rather than perceived benefits of the group, and quantitative and qualitative paradigms for the same by independent researchers are being considered for evaluating the next phase of SAAHAS.

Utility of Specific Group Processes

Although the feedback did not directly explore what aspects of the group format and processes helped group participants, facilitator observations and qualitative data from the feedback received suggest that various factors may have played a role.

1. Peer support

The primary reasons for joining expressed by queer respondents in the intake survey seemed to be the desire to discuss concerns with other like-minded queer individuals and the desire to help other queer individuals. One of the biggest benefits of group intervention may be its potential to reduce feelings of isolation. This may operate through two mechanisms. Group therapy may help to connect queer individuals to others with whom they share concerns and hence provide a sense of "universality."[1] To quote a group participant, "Attending SAAHAS helped me deal with the feeling of isolation. In the group we all are somewhat in the same boat and somehow it feels better to know that you are not the only one struggling and fighting every day." Given the rejection and lack of support experienced by queer individuals from their families of origin and friends, groups may increase social support networks of queer individuals and may provide them with a new family of choice. In the words of another group member:

> The whole experience of being with SAAHAS has been very moving and loving. It has allowed me to hang out with queer people without any haste. I've made new friends and we have become more of a family where everyone kind of takes care of everyone else (which I really have experienced).

2. Safe space

Queer individuals often feel unsafe in public spaces due to the reality of discrimination, and there is an additional burden of the stigma of mental illness faced by those with mental health issues that may make individuals feel vulnerable. SAAHAS facilitators used strict screening protocol and strict enforcement of group confidentiality, to enhance feelings of safety with respect to attending the group. A non-judgmental affirmative stance was used to enhance feelings of psychological comfort in the setting. All the participants reported in their feedback that they felt safe in the group. To quote one participant, "With SAAHAS, I have had a great experience. It feels better to know that there's a safe space where I can talk out some of my issues without being ridiculed or being scared of judgement."

3. Peer-cum-expert facilitator stance

Having queer facilitators was integral to the idea of making the group a "queer-only" safe space. Participants in the initial interview were found to be much keener about participating in the group when they learnt that the facilitators were also queer, and reported that they may not have been as comfortable had the facilitators not been from the queer community. Additionally, given that the facilitators were also mental health professionals made the group "more reliable, approachable, and trustworthy" (as noted by one participant). Participants appreciated that the facilitators were in a position to empathize better with queer concerns and at the same time provide useful inputs to help with mental health concerns. All participants agreed that the facilitators were knowledgeable, skilled, and affirming.

4. Queer affirmative CBT-based intervention approach

Facilitator observations and participant report both suggest that the combined affirmative CBT approach was integral to the success of the group. In the initial intake survey, most respondents had reported that they wished to discuss queer-specific experiences of stigma as well as the challenges of getting into relationships and dealing with family members that were unique to queer individuals living in a heteronormative society. The affirmative approach fits in perfectly with this need. The emphasis on preferred pronouns

and validation of all identities, and discussion of the societal context of queer struggles in every session, furthered the affirmative stance. Facilitators also strove to make the group approach "intersectional," trying to address the simultaneous impact of the religious, caste, and class identities of the participants (similar to Nerses, Kleinplatz, and Moser).[17]

Facilitators also took into account recommendations for making CBT more relevant that were made by Craig, Austin, and Alessi,[16] such as helping individuals to distinguish between problems that are environmental and those that stem from dysfunctional thoughts (or in the words of one participant, "the group helped me to segregate my issues into queer identity related and queer identity unrelated"), validating queer individuals' self-reported experiences of discrimination, emphasizing "unhelpfulness" rather than "invalidity" of thoughts during cognitive restructuring, building participants' skills for interacting with their difficult social environments, and emphasizing their strengths and resilience (as was specifically done in the session on "pride").

The open structure of SAAHAS was different from that in other documented group therapy models.[1,16,17] This approach made it necessary to incorporate the psycho-educational and skill training components of CBT in each session rather than in the typical session-after-session structured format. The open group provided space for new members to join in and contribute new perspectives to the group whilst learning from older members. SAAHAS had its first session a few months before the Supreme Court read down section 377, and this historic moment was followed by an increase in queer individuals seeking help and coming out. The open format was conducive to encouraging new participation in this somewhat changed social climate.

Inclusivity and Access

The information about referral sources suggests that the most effective ways to reach out to potential participants for such groups are social media and word of mouth. Furthermore, most of the individuals who actually attended the group did so because existing members recommended it to them.

The group was open to all non-normative gender and sexual identities. However, similar to experiences of other groups worldwide,[15] the group was largely attended by cis-gender gay and bisexual men (78.57%). The facilitators made many attempts to encourage more lesbian and bisexual women, and TGNC individuals to participate, such as explicitly declaring measures taken to foster safety of lesbian and bisexual women and transgender individuals (LBT) in the informational email, and attending events meant specifically for LBT individuals as a part of outreach. LBT individuals may be less likely to be a part of spaces facilitated by cis-gay men[15]; however, in this case, the facilitators themselves identified as a part of LBT. Notwithstanding these attempts, only 14.29% participants were lesbian and bisexual women and only 7.14% identified as TGNC. This may be linked to the "politics of access."[15] In a patriarchal society like India, cis-gay men may often present at the forefront of accessing health care services while LBT individuals are often hesitant to come out and seek help. In the specific question addressed to LB women and TGNC members, they all reported that they felt welcomed in the group. However, a few reported that they would like more discussion on LBT issues. Similarly, TGNC individuals often have unique concerns that are not shared by cis-gender queer individuals, for instance, dysphoria, transphobia, information about surgery, etc.[18] Thus, although most of the topics discussed may be relevant to those belonging to all queer identities, it may be beneficial to have some SAAHAS sessions that are dedicated towards addressing the specific concerns of these particularly marginalized subgroups of queer individuals to make sessions more meaningful for them. Furthermore, inviting transgender or gender nonconforming co-facilitators for the sessions for them may help to compensate for the possible barriers created by the cis-gender identification of the facilitators.

The group venue was specially chosen to facilitate attendance of queer individuals who find it more difficult to access other queer resources due to their place of residence. Sessions were held in English, Hindi, and/or Marathi, and information about the group was also disseminated in these 3 languages. SAAHAS sessions were completely free of cost, to make the group accessible for more individuals. A future goal of the SAAHAS team is to start branches of the group in more parts of the city to reach more queer individuals who may benefit from this intervention. In the meantime, social media forums were used to share some of the key themes discussed during the group sessions with a larger audience of those who may not be able to attend the group.

Conclusion

SAAHAS is possibly the first of its kind queer affirmative CBT-based group therapy intervention model adopted in India. Preliminary research suggests that queer individuals welcome this approach and it may also be efficacious in fostering better mental health outcomes for queer individuals. Learnings from the SAAHAS experience can provide a useful, low-cost framework for therapeutic intervention that needs to be further replicated in different parts of the country.

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