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“Be Open to All Those Ways That People Can Live Their Lives:” LGBTQ+ Client Recommendations for Adapting Emotionally Focused Couple Therapy

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ABSTRACT

Emotionally focused couple therapy (EFCT) is an empirically supported treatment for relationship distress. Yet, despite EFCT's substantial evidence base, to date, there have been no studies that have integrated LGBTQ+ clients' experiences and therapeutic needs into the EFCT process. Thirty-five EFCT clients participated in theater testing focus groups to generate client recommendations for the use of EFCT for LGBTQ+ relationships. Data were analyzed using thematic analysis. Participants drew on their own lived experiences, their experiences receiving EFCT, and EFCT video observation to make recommendations about the use of EFCT for LGBTQ+ relationships.

1 | Introduction

Research documents the positive effects of affirmative psychotherapy for members of the lesbian, gay, bisexual, transgender, queer/questioning plus (LGBTQ+) communities (Burger and Pachankis 2024). However, there is a dearth of relational empirically supported treatments (ESTs) that have been adapted to account for the lived experiences of LGBTQ+ people. Two exceptions are the relationship checkup (RC; Gray et al. 2024) and cognitive behavioral couple therapy (CBCT; Pentel et al. 2021). Recently, Burger and Pachankis (2024) called for additional adaptation of ESTs, such as emotionally focused couple therapy (EFCT; Johnson 2019). Although EFCT has been heavily researched (see Spengler et al. 2024), to date, no empirical studies of EFCT with LGBTQ+ clients have been published. As evidence-based practice calls for the inclusion of client experiences (Aisenberg 2008) and most cultural adaptation models (e.g., ecological validity model [EVM]; Bernal

et al. 2009) include client experiences as part of the adaptation process, it is important to ensure LGBTQ+ client voices are centered when making adaptations to EFCT. Therefore, this article presents the first study of LGBTQ+ clients' experiences of EFCT as well as their recommendations for the adaptation of EFCT to account for their unique lived experiences and therapeutic needs.

2 | Literature Review

This review of the literature provides an overview of EFCT, including EFCT's application across cultures and populations. Additionally, we explore cultural adaptations to ESTs, including frameworks and applications to other romantic relationship models, including CBCT and the RC. We also discuss the unique aspects of LGBTQ+ lives and relationships that necessitate cultural adaptations to existing ESTs. To conclude, we describe the guiding frameworks for this study.

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2.1 | EFCT

EFCT is an empirically supported treatment for distressed couples (Johnson 2019; Spengler et al. 2024). Meta-analyses (e.g., Beasley and Ager 2019; Johnson et al. 1999; Spengler et al. 2024; Wood et al. 2005) confirm its effectiveness in improving relationship satisfaction and reducing distress. Distress is understood as recurring negative interaction patterns that reinforce harmful attributions and relational disconnection, known in EFCT as the negative cycle (Johnson 2019). EFCT targets these patterns by increasing emotional awareness and understanding of attachment-related fears and needs, fostering emotional coherence (Johnson 2019).

EFT involves three stages and nine steps. Stage 1: de-escalation and stabilization, focuses on assessment, building the therapeutic alliance, delineating the core conflict that leads to distress, and externalizing the negative cycle. Stage 2: Restructuring, helps partners identify and integrate disowned emotions and unmet needs, fostering acceptance and creating new interaction patterns. Stage 3: Consolidation, focuses on addressing old problems with new solutions and solidifying healthier interactions. EFT utilizes specific interventions, or “microskills,” to help clients explore and express emotions, build a more responsive and emotionally attuned relationship, and talk to each other via therapist-facilitated enactments. These “microskills,” including empathic reflections, validation, evocative responding, and emotional deepening, are used throughout therapy within the framework of the EFT Tango. This meta-process includes five core moves: focusing on the present process, deepening affect, choreographing engaged encounters, processing these encounters, and integrating and validating new interaction patterns (Johnson 2019).

2.2 | Cultural Adaptations of EFCT

The empirical literature describing EFCT applied to diverse populations is limited. EFCT has been shown to be efficacious at increasing relationship satisfaction (Soleimani et al. 2015) and decreasing relational conflict (Ahmadi et al. 2014) for Iranian couples. Tseng et al. (2024) found Taiwanese avoidant male partners experienced a moderate decrease in depressive symptoms after eight sessions of EFCT, though EFCT wasn't found to improve Taiwanese couples' relationship satisfaction. Following adaptations to account for sociocultural influences on emotional expression, Hattori (2014) found EFT to be effective in reducing conflict for Japanese couples. Furthermore, Guillory (2021) and Nightingale et al. (2019) have both documented adaptations made to EFCT to account for the lived experiences of African American heterosexual couples.

However, to date, the only published literature discussing EFCT with LGBTQ+ clients is conceptual. Drawing on each step of EFCT, Allan and Johnson (2017) and Hardtke et al. (2010) describe an EFCT modified to meet the relational, therapeutic needs of gay male and lesbian relationships. In Stage 1, assessment includes discussing the impacts of minority stress (Frost and Meyer 2023) and how sociopolitical factors relate to the client's presenting problems. Assessment also involves exploring how concepts like fusion (i.e., a lack of separateness or

autonomy stereotypically associated with lesbian relationships [Frost and Eliason 2014]), internalized homophobia (i.e., the proximal stressor of self-stigmatization driven by internalized anti-gay beliefs concerning the gay-identified self [Mohr and Daly 2008]), and how nonmonogamy impacts the negative cycle (Allan and Johnson 2017; Hardtke et al. 2010). Additionally, Hardtke et al. (2010) suggest integrating gender role socialization into the relationship's conceptualization of attachment emotions and needs.

In Stage 2, Hardtke et al. (2010) focus on the importance of emotional response and acceptance for lesbian women. Allan and Johnson (2017) highlight the importance of identity integration related to the view of self and others when working with gay men. Finally, Stage 3 involves helping clients access relevant resources and navigate stressors related to sexual and gender identity discrimination (Allan and Johnson 2017; Hardtke et al. 2010).

2.3 | Cultural Adaptation of Evidence-Based Therapy Models

There is a need to culturally adapt ESTs to account for the therapeutic needs and lived experiences of diverse populations to extend the generalizability of treatments that are often developed with White, heterosexual, cisgender, monogamous, and higher income samples (Wiltsey Stirman et al. 2013). Meta-analyses indicate that culturally adapted therapeutic interventions are more effective than nonadapted treatments (Hall et al. 2016; Soto et al. 2018). Specifically, cultural adaptation is the systematic modification of ESTs to account for a client's culture, meanings, and values, including language, contextual stressors, and therapeutic goals (Bernal et al. 2009; Wiltsey Stirman et al. 2013) and involves deliberately and proactively modifying both surface aspects (e.g., client materials) and structural elements (e.g., integration of cultural factors [Rathod et al. 2018]). Cultural adaptations of ESTs are deliberate, planned, and systematic to ensure fidelity to core components (Bernal et al. 2009; Wiltsey Stirman et al. 2013). Adaptations may occur for a variety of reasons, including to improve outcomes, engagement, and acceptability with a target population (Wiltsey Stirman et al. 2013).

There are several comprehensive models and frameworks that are used to systematically guide the cultural adaptation of interventions. Most cultural adaptation models address specific elements of an EST, including content, context, fidelity, engagement, and cultural competence (Day et al. 2023). While some cultural adaptation models, such as the 4-domain cultural adaptation model (CAM4; Sorenson and Harrell 2021) and the cultural treatment adaptation framework (CTAF; Chu and Leino 2017), integrate theory and application of cultural adaptation, other models (e.g., the EVM, Bernal et al. 1995) more directly address specific elements of an EST that may need to be modified. For example, the EVM identifies eight key elements of interventions that should be considered when making cultural adaptations: (1) the *language* used by the target cultural group, (2) the attributes of the *persons* involved, (3) the incorporation of *metaphors* and other symbols of the cultural group, (4) *content* (i.e., cultural values and traditions), (5) *concepts*

(i.e., intervention conceptualization), (6) the consideration of culturally relevant *goals*, (7) culturally relevant *methods* of intervention, and (8) the sociocultural *context* in which the intervention takes place (Bernal et al. 1995).

2.4 | Cultural Adaptation of Evidence-Based Models for LGBTQ+ Relationships

Members of LGBTQ+ relationships have unique needs and experiences that inform culturally adapted therapy that are distinct from those in cisgender, heterosexual relationships, such as coming out and identity development (Berke et al. 2016; Goldbach and Gibbs 2015; McNamara and Wilson 2020). Several models of therapy, including the RC (Gray et al. 2024) and CBCT (Pentel et al. 2024), have been adapted to account for the unique lived experiences faced by members of LGBTQ+ relationships. For example, the RC manual has been modified to remove heteronormative language and to include potentially relevant topics for lesbian, gay, and bisexual couples (e.g., addressing how societal discrimination impacts the relationship) and therapists implementing CBCT were trained specifically to address minority stress (Pentel et al. 2021). When adapted, both CBCT and the RC have been found to be feasible, acceptable, and effective for addressing the unique circumstances characterizing LGBTQ+ relationships (Gray et al. 2024; Pentel et al. 2021).

Extant research explores affirmative methods for adapting ESTs. For example, in addition to standard assessment procedures, assessment with LGBTQ+ relationships should include an exploration of each partner's identity development (Lytle et al. 2014), intersecting identities (Berke et al. 2016), an ongoing discussion of gender roles, gender identity, and sexual identity (Berke et al. 2016), and the level of support offered by family and friends (Scott et al. 2019). Therapists working with LGBTQ+ relationships should attend to their own experiences of internalized cisheterosexism and homophobia via supervision and ongoing reflection on therapist bias (Lytle et al. 2014). Additionally, therapists should understand the stigma, discrimination, and impacts of minority stress experienced by members of LGBTQ+ communities (Berke et al. 2016; Goldbach and Gibbs 2015; Pentel and Baucom 2022; Scott et al. 2019).

2.5 | Unique Experiences of LGBTQ+ Individuals and Relationships

2.5.1 | Unique Aspects of LGBTQ+ Relationships

While LGBTQ+ relationships are more similar to heterosexual, cisgender relationships than they are different (Gottman et al. 2003; Rostosky and Riggle 2017a, 2017b; Reczek 2020), LGBTQ+ relationships are also unique, often characterized by the impacts of minority stress (Frost and Meyer 2023; Rostosky and Riggle 2017a), identity development (e.g., Cass 1979), and queer joy (Tristano 2022). Studies of lesbian and gay male romantic relationships indicate these relationships are characterized by respect and appreciation of individual differences, positive interactions, effective communication, intimacy,

commitment, egalitarian ideals (Rostosky and Riggle 2017b), affirmation (Pulice-Farrow et al. 2019), and mutual support (Ellis and Davis 2017).

2.5.2 | Coming Out

Coming out is a culturally bound term for the process of disclosing a nonheterosexual and/or a noncisgender identity (Grafsky et al. 2018). Coming out can be both a rite of passage and an ongoing series of events that can involve prejudice, stigma, and rejection (Biswas and Chaudhuri 2019). Unfortunately, at an early age, LGBTQ+ children often internalize the implicit or explicit sociocultural and familial messages that their identity is unacceptable, resulting in experiences of shame, judgment, and rejection (Cass 1979). These experiences are related to attachment experiences for LGBTQ+ individuals (Carnelley et al. 2011) since caregiver acceptance of an LGBTQ+ identity is positively correlated with overall mental and physical wellbeing (Newcomb et al. 2019).

2.5.3 | Identity Development

Identity is especially salient in therapy for individuals possessing marginalized identities (Santisteban et al. 2013). Aspects of identity development for sexual minority individuals may include first same-sex attraction, first same-sex behavior, and first disclosure of identity to a friend (Bishop et al. 2023). Identity development may progress differently depending on age (Bishop et al. 2023), gender (Brown. 2008), and racial identity (Bishop et al. 2023), among others. For transgender and gender non-conforming individuals, identity affirmation, social transition, and gender euphoria may be salient milestones (Doyle 2022).

Most EFCT research has been conducted with individuals possessing dominant cultural identities (i.e., White, cisgender, and heterosexual; Spengler et al. 2020), downplaying the need for identity to be a salient aspect of EFCT. However, as LGBTQ+ individuals experience unique stressors and strengths related to their sexual and gender identities (Horne et al. 2014), which impact their attachment experiences (Cook and Calebs 2016), integrating identity becomes necessary for culturally responsive and effective therapeutic care.

2.6 | Guiding Frameworks

This study drew on the principles of community based participatory research (CBPR) and queer theory. CBPR methodologically fosters and sustains community-academic partnerships with the aim of developing and disseminating culturally appropriate interventions that engender policy change and aid in the translation of research findings to community implementation (Oetzel et al. 2018). CPBR centers and elevates traditionally marginalized communities and increases collaboration between diverse stakeholder groups (Key et al. 2019). CPBR often exists on a continuum, with the degree of community engagement indicated by how power and control, ownership, decision-making, responsibility, and resources are shared (Key et al. 2019). In addition to these factors, the degree of history between the

community and the researchers, and the level of established trust, respect, and transparency all impact the process and outcomes of CBPR (Key et al. 2019).

Queer theory is a theoretical framework and orientation to pedagogy and scholarship that posits bodies and psyches are not only produced through individual intent, but rather through socio-cultural structures that marginalize nonnormative individuals and relationships (Capobianco 2020). Queer theory is an offshoot of postmodern philosophy and stems from work by, Butler (1990), Sedgwick (1990), and Foucault (1980). These authors, especially Foucault (1980) and Butler (1990), assert that language acts as a measure of social control, solidifying power by making those less powerful fear violating social norms. Furthermore, language functions to create binary systems through which people can be defined as “normal” or “abnormal” and allowed or denied entry based on their ability to perform or adhere to social norms (Butler 1990).

3 | The Current Study

The current study examines how EFCT can be adapted to account for the unique needs, lived experiences, and therapeutic preferences of LGBTQ+ individuals. This study used foundational CBPR principles by fostering long-term community-academic partnerships with both members of the LGBTQ+ communities and EFCT therapists. LGBTQ+ voices were centered throughout the research project by consulting with EFCT therapists who are members of the LGBTQ+ community to develop the research question, interview protocol, and study procedure, as well as by pilot testing the research processes with LGBTQ+ identifying doctoral-level scholars. Additionally, we engaged LGBTQ+ community members as focus group participants and encouraged their engagement throughout the project, including consultation on the publication and distribution of the results, as supported by Dhungel et al. (2019) and Ginwright (2015). All research processes and the rationale were fully explained and explored with LGBTQ+ identifying focus group members to encourage transparency, ownership over the research process, and responsibility for the research results.

3.1 | Research Question

The current study aimed to address the following research question: *What are the recommendations of members of LGBTQ+ relationships for adapting EFCT to account for their unique needs, therapeutic preferences, and lived experiences?*

4 | Methods

This study used a method novel to couple and family therapy (CFT) research called theater testing. Theater testing is a method of data collection that was developed within market research to obtain participants' feedback on products, services, and advertisements (National Cancer Institute 2004). Theater testing involves a small group of targeted participants interacting with and/or discussing audio-visual materials (National Cancer Institute 2004). In market research, theater testing is often combined with focus groups (National Cancer

Institute 2004). Focus groups are a data collection method used when a researcher aims to gather an understanding of participants' attitudes and perceptions of a shared topic (Krueger and Casey 2015). During focus groups, participant interactions can engender a deeper understanding of co-constructed meanings; they are useful when looking to gather both breadth and depth of information (Krueger and Casey 2015). The use of theater testing focus groups allows for gathering a range of opinions and experiences and understanding *why* focus group participants think and feel the way they do about the audiovisual material (Krueger and Casey 2015).

When used in intervention research, theater testing using focus groups involves the intervention's target audience observing and discussing the intervention's impact, feasibility, and the potential for culturally relevant changes (Wingood and DiClemente 2008). Specifically, theater testing can be used to gather the first-person voices and experiences of particular cultural groups to determine how to increase the cultural relevance of an intervention (Wingood and DiClemente 2008). Cultural adaptations that have emerged from the use of theater testing include an increased focus on self-management of HIV symptoms in Thailand (Khumsaen and Stephenson 2017) and the development of an HIV prevention app for men who have sex with men (MSM; Goldenberg et al. 2015).

4.1 | Procedures

4.1.1 | Recruitment

After obtaining IRB approval (IRB #8915), a purposive sample was recruited. Inclusion criteria were: (a) identified as LGBTQ+, (b) had completed at least six EFCT sessions with a partner whom the participant had been dating for a minimum of 1 year, and (c) 18 years or older. Participants were required to be in a relationship for at least a year because research suggests people begin to view their romantic relationship as an attachment relationship after approximately 1–2 years (Hazan and Zeifman 1999; Zeifman and Hazan 2018). Exclusion criteria included: (1) active psychosis, (2) active intimate partner violence (IPV), and (3) suicidal ideation within 1 month of the study. Individuals who displayed suicidal ideation during screening were excluded from the study and provided the 988-crisis line and resources in their area.

The study was advertised on the queer EFCT listserv, ICEEFT listserv, and queer EFCT Facebook groups in April 2023, July 2023, and October 2023. The leaders of EFCT centers and communities were contacted and asked to distribute study information to their local EFCT communities. Additionally, all therapists from English speaking countries listed on the ICEEFT directory were emailed. All study advertisements described the purpose and nature of the study, stated that participation was voluntary, and listed participant compensation (i.e., an Amazon gift card of \$100).

4.1.2 | Data Collection Procedures

One week before the start of each focus group, participants were emailed an overview of the agenda and goals, a copy of the

interview guide, a scheduled Microsoft Teams meeting link, and a link to the consent form and demographic questions. A second reminder email was sent 24 h before each focus group. Demographic information included country of residence, race, ethnicity, age, income, sex assigned at birth, gender identity, sexual identity, length of time in a romantic relationship, and number of EFCT sessions attended. All demographic questions allowed participants to self-identify. See participant demographics in Table 1.

4.1.3 | Data Collection

Eight focus groups, composed of two to six participants, were conducted. A total of 35 LGBTQ+ identifying individuals participated in the study. The goal was to include six participants in each focus group; some participants did not arrive on time and/or dropped out of the study before participation. Focus groups lasted between 105 and 142 min and averaged 122 min. At the start of each focus group, participants were asked about their experience of EFCT, if they had discussed experiences of minority stress with their relationship therapist, and how their therapist created safety in therapy in reference to their identities. Examples of probing questions included: “What was important for you when finding a relationship therapist?” and “How have experiences of discrimination impacted your romantic relationship?”

These questions were followed by showing two segments of the EFCT training videos *The EFT Path to Secure Connection: Working Successfully with Same-Sex Couples* (Reel Concepts for Susan Johnson Inc. 2011). The first video involves Stage 1 work (e.g., negative cycle tracking) with a gay male couple; the second video involves Stage 2 work (e.g., withdrawer re-engagement) with a lesbian couple. The sessions in the EFCT videos were conducted by the founder of the EFCT model, Dr. Sue Johnson. The videos demonstrate how to practice EFCT with fidelity. The EFCT demonstration did not include common sociocultural approaches to working with populations that experience marginalization, such as therapists broaching their identities with clients and a collaborative approach to exploring the impact of marginalization. As such, the EFCT videos are intended to represent a strong demonstration of EFCT; they do not speak to work with LGBTQ+ relationships more specifically. Participants observed 20 min of the Stage 1 video and 20 min of the Stage 2 video; these segments were chosen based on consultation with two EFCT trainers, as they represented key interventions in EFCT (e.g., negative cycle tracking). After viewing each video, the focus group members discussed their general impressions, including what the EFCT therapist did well and/or what EFCT therapists could do better when working with members of LGBTQ+ communities. Due to challenges with technology, the first two focus groups were only able to hear the audio and not see the videos.

A doctoral-level scholar assisted with the facilitation of focus groups 1, 3, 4, and 6. Co-facilitation of focus groups allows for multiple tasks to be completed simultaneously and strengthens data collection (Krueger and Casey 2015). The first author, as the moderator of the focus groups, directed the discussion, while the co-facilitator took detailed notes to enhance the focus

group discussion (Krueger and Casey 2015). The first author engaged in memoing (i.e., a recommended practice in qualitative research that aids in the development of codes and themes during data analysis and involves note-taking during and after an interview or focus group [Creswell and Poth 2018]) at the conclusion of each focus group. To support triangulation of the research findings, the first author compared the notes taken by the research scholar to the first author’s memos and participant statements. The transcripts automatically generated by Microsoft Teams were used for data analysis. To ensure the accuracy of the transcripts, the first author re-listened to the audio recording of each focus group and corrected any transcription errors.

4.2 | Data Analysis

Thematic analysis, a six-stage qualitative methodology that allows a researcher to elucidate complex and often latent understandings of participant experiences (TA; Braun and Clarke 2006 2019), was used to analyze the data. TA involves six steps as outlined in Braun and Clarke (2019): (1) Familiarizing oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. To familiarize themselves with the data, the first author re-listened to each recorded focus group and memoed throughout before rereading each transcription four times, as recommended by Saldana (2021). A coding framework was developed based on semantic codes; this framework clustered participant feedback within three distinct areas from which participants drew on to provide their feedback: their lived experiences, their experiences in therapy, and their observation of the EFCT videos. Inductive coding (i.e., codes developed during analysis [Saldana 2021]) was used due to the wealth of data from which to draw; the first author developed these codes by reading through the data and identifying codes, categories, and patterns. Latent coding (i.e., coding that involves interpreting underlying meaning, themes, and/or concepts based on context [Saldana 2021]) subsequently was used to interpret participants’ responses and categorize them into the coding framework. The coding framework was applied by indexing each transcript using the latent codes developed by the first author. Themes were developed after the first author completed coding in consultation with the second and third authors; the subthemes were specifically developed using latent coding in the context of the coding framework.

Once the first author generated themes within the context of the coding framework, they then reviewed each candidate theme by reading the coded data extracts, considering the relationship between themes and whether they developed a coherent pattern to unite ideas (Braun and Clarke 2019). Once the coded data reflected a coherent pattern, the first author determined whether the themes accurately reflected the meaning of the data by reviewing each theme in relation to the data and research question. These steps were repeated iteratively until all themes appeared coherent. The first author then defined and named the themes by identifying the aspect of the data each theme captured. Finally, the first author concisely named each theme before producing the report with the second and third authors.

TABLE 1 | Participant demographics.

Participant number	Age	Self-reported gender identity	Self-reported sexual identity	Race	Ethnicity
P1	52	Cisgender man	Gay	White Australian Tongan	Not Hispanic/Latinx
P2	41	Cisgender man	Gay	White	Not Hispanic/Latinx
P3	63	Cisgender woman	Lesbian	White	NR
P4	66	Queer	Queer	Prefer not to answer	Prefer not to answer
P5	63	Queer	Gay	White	Not Hispanic/Latinx
P6	NR	Queer	Gay	White	Not Hispanic/Latinx
P7	62	Prefer not to say	Lesbian	White	Not Hispanic/Latinx
P8	53	Cisgender woman	Lesbian	White	Not Hispanic/Latinx
P9	32	Cisgender woman	Bisexual	Multiracial	Not Hispanic/Latinx
P10	38	Cisgender woman	Gay	White	Not Hispanic/Latinx
P11	56	Cisgender woman	Lesbian	White	Not Hispanic/Latinx
P12	43	Queer	Lesbian	Black	Not Hispanic/Latinx
P13	32	Queer	Lesbian	White	Not Hispanic/Latinx
P14	38	Queer man	Gay/Queer	White	Not Hispanic/Latinx
P15	50	Cisgender woman	Pansexual	White	Not Hispanic/Latinx
P16	39	Prefer not to answer	Lesbian	Asian	Not Hispanic/Latinx
P17	39	Cisgender woman	Lesbian	Multiracial	Not Hispanic/Latinx
P18	32	Questioning/unsure	Questioning/unsure	White	Not Hispanic/Latinx
P19	31	Cisgender woman	Lesbian	White	Mexican American
P20	72	Cisgender woman	Lesbian	White	Not Hispanic/Latinx
P21	71	Cisgender man	Gay	White	Not Hispanic, Latinx
P22	73	Cisgender man	Gay	White	Not Hispanic/Latinx
P23	32	Cisgender woman	Bisexual	Asian	Not Hispanic/Latinx
P24	32	Cisgender woman	Demisexual	White	Mexican American, Mexican, and/or Chicax
P25	64	Queer	Queer	White	Not Hispanic/Latinx
P26	54	Queer	Gay	White	Not Hispanic/Latinx
P27	31	Transgender man	Queer	White	Not Hispanic/Latinx
P28	33	Genderqueer	Queer	White	Not Hispanic/Latinx
P29	29	Cisgender woman	Bisexual	White	Brazilian
P30	40	Queer woman	Pansexual	South Asian	Not Hispanic/Latinx
P31	41	Transgender man	Straight	White	Not Hispanic/Latinx
P32	36	Femme-by	Queer	Asian	Not Hispanic/Latinx
P33	50	Cisgender woman	Queer	White	Not Hispanic/Latinx
P34	41	Genderqueer	Queer	Black	Not Hispanic/Latinx
P35	35	Genderfluid	Pansexual	White	Not Hispanic/Latinx

Abbreviation: NR, not reported.

4.3 | Author Positionality

All acquired knowledge is inescapably constrained by the author's own culture, perspectives, motivations, and languages. Trustworthy qualitative research, therefore, involves a discussion of researcher reflexivity. The first author identifies as a

White, pansexual, polyamorous, agender, femme presenting person from a lower-middle class background; as part of this project, the first author continuously journaled about the impact of their identities on the generation and interpretation of knowledge, as well as the identities of participants. As the first author organized and conducted all focus groups, it can be

assumed their identities significantly impacted the research. Indeed, as the first author's identities matched most of the participants' identities (i.e., White, member of the LGBTQ+ communities), it is likely that participants were more open to sharing and that the first author was able to gather a more complete picture of their experiences than if they did not share these identities. The second author identifies as a white, cis, female from a working-class background, and she has been practicing and/or studying EFT since 2002. The third author identifies as white, gay/queer, cis male, from a working-class background, and has engaged in queer and harm reduction community work for 20 years and now explores the impact of minority stress on relationships and how to work with it in therapy.

4.3.1 | Trustworthiness

The trustworthiness of qualitative research is determined by the degree to which the data and research procedures have been made transparent (Hadi and José Closs 2016). To amplify transparency, the exact procedures of the study have been described and evidence of triangulation has been provided (i.e., the use of multiple sources to develop a comprehensive understanding of a phenomenon, such as member checking [Hadi and José Closs 2016]). To further ensure accurate transcription, participants were each emailed a copy of their responses for member checking, which is a method for the researcher to ensure accurate portrayal of participant voices and experiences by empowering participants to confirm or deny the accuracy of the ideas conveyed (Creswell and Poth 2018). Three participants returned their transcripts and agreed that their thoughts were actively conveyed. Two participants emailed the first author notes they had taken during the focus groups. Additionally, previous research and theory have been used to justify the choice of theories and methods, and thick, rich descriptions of participant statements have been provided.

5 | Results

5.1 | Participants

A total of 35 LGBTQ+ identifying individuals participated in the focus groups. Age, race, ethnicity, gender identity, and sexual identity related demographic information are provided in Table 1. Most of the sample identified as White (71%) and from the United States (89%). The remaining participants lived in Belgium (3.67%), Canada (3.67%), and Australia (3.67%). Two participants identified as multiracial, two identified as Asian, two identified as Black, and two participants preferred not to specify. Only three participants identified as Hispanic, Latino/a/x, or Spanish origin; two participants identified as Mexican, Mexican American, and/or Chicana/o/x, and one participant identified as Brazilian. Participants' ages ranged from 29 to 73, with a median age of 34. Most participants reported being employed full time (60%), while 20% reported being employed part-time, and 20% reported being unemployed. Household income (in US dollars) ranged from \$30,000 to \$400,000, with a median income of \$260,000.

The length of participants' most recent romantic relationship ranged from 20 months to 33 years, with a median of 7.38 years. Fifty-seven percent of participants reported being married, 17% in a committed partnership, 17% having an unmarried partner, 9% reported being single, and one reported being engaged and cohabitating. Of the participants who identified as single, two participants reported recently terminating relationships, and one participant reported identifying as single within a consensually nonmonogamous relationship structure. Seventy-one percent of participants had no children, while 20% had 1–2 children, and 9% had 3–4 children. Most participants were highly educated, with 18% having a doctoral degree, 38% a master's degree, 14% a bachelor's degree, and 6% having earned an associate degree. Nine percent reported having attended some college or university, and 15% reported having some post-graduate schooling.

More than half the participants (57%) reported receiving a mental health diagnosis in their lifetime. Of the 19 participants who chose to disclose this diagnosis, 47.36% reported being diagnosed with a depressive disorder, 26.32% with an anxiety disorder, 5.26% with attention deficit hyperactivity disorder (ADHD), 10.53% with an adjustment disorder, and one participant reported they had been diagnosed with bipolar disorder. Several participants (37%) were also taking medication for their mental health, and the types of medication included Escitalopram, Zoloft, and Prozac, among others. Overall, most participants reported being satisfied with their EFCT experience: 79.5% reported being extremely satisfied, 15.9% reported feeling somewhat satisfied, 2.3% reported feeling neither satisfied nor dissatisfied, and 2.3% reported feeling somewhat dissatisfied.

5.2 | Themes

Three themes were generated from the data through inductive coding: talking about LGBTQ+ identity in relationship therapy, avoiding assumptions through honoring individual experiences, and understanding what it means to be a member of LGBTQ+ communities. Through latent coding, participants' responses were identified as stemming from their lived experiences, experiences in EFCT, or observing EFCT as delivered in the EFCT videos. Therefore, the results are presented using this categorization.

5.2.1 | Talking about LGBTQ+ Identity in Relationship Therapy

5.2.1.1 | Lived Experiences. Participants drew on their lived experience outside of both the study and therapy to discuss how sexual and/or gender identity should be integrated into EFCT. The latter three focus group members noted identity may be foreign and uncomfortable for some EFCT therapists, leading participant 28 (P28) to suggest using listening, empathy, and affirmation. Several focus group members also noted the importance of therapist humility when discussing identity, such as P33's suggestion to "be humble...move slow...you don't need to be an expert."

5.2.1.2 | Own Experiences in Therapy. Most participants reported that their EFCT therapist had not discussed their

sexual and/or gender identities in therapy. However, the concept of an open discussion of sexual and/or gender identities was perceived as positive. Many participants reported that the discussion of how identities impacted their relationship indicated that the EFCT therapist was ready to have a deeper, richer relationship and make room for experiences of marginalization, identity-related trauma, and oppression. For example, for P30, this looked like their therapist asking, “What does queer mean to you?” which meant the therapist recognized “that queer identity is this huge span of things.” In this vein, some participants recommended specific questions therapists could ask; P19 suggested asking, “How [identity] has affected you and how you communicate with one another? How has your sexual orientation shaped the way you relate...in this relationship?”

Several participants indicated that their therapist discussed gender, sexual, and racial identity broadly to allow their clients to find what was relevant for them. P14, one of the participants whose therapist had deliberately integrated their sociocultural context into therapy, described how their therapist explained common couple experiences to ensure it felt inclusive:

So [our therapist will] say things like, it's common for couples who are in interracial relationships or for queer couples to experience some of this. I wonder, does any of that resonate with either of you? I always think she's hearing something that is kind of facilitating this question, but instead of just saying, hey, I wonder if this is true for you...she's kind of making some distance. That, for me, is helpful.

Other participants also found this intervention to be effective. For example, P5 stated:

...sometimes [our therapist] will bring up the fact that men are wired certain ways and women tend to be wired in certain ways. And when you have a couple who are both wired similarly or were raised in a similar [socio-cultural] environment... It can be a really good thing, and it can sometimes not be such a good thing.

P31 explained the reason they thought this intervention was effective: “The subtext is I’m not assuming what’s going on with you. I’m leaving it to you to define that and I’m...putting it out there that I do have some vague clue of things that could be going on with you.”

However, a few participants noted that discussing gender and sexuality did not “belong” in therapy. For most of these participants, the absence of an open discussion of identity felt “like total acceptance,” (P8), especially when participants presented in relationship therapy with what they deemed to be ordinary relationship struggles. Several of these participants indicated that therapy would feel less safe if their therapist was to directly ask and/or discuss their sexual and/or gender identities.

5.2.1.3 | Video Observations. Much of the discussion about LGBTQ+ identity was in direct relation to viewing the EFCT videos. For example, after watching the stage one EFCT

video, several participants concluded that the therapist should broach their identities at the start of therapy to make it safe for clients to integrate their own identities as they deem relevant. Additionally, participants noted that broaching identities with all partners present may engender conversation about each partner’s experience of marginalization and may help each partner understand the other’s experience. Many participants recommended the use of engaged encounters (i.e., enactments) when talking about identities, such as “How does that (e.g., experiences of homophobia) play out between the two of you?” (P14).

When marginalized identities are discussed in therapy, participants indicated that the therapist should focus on listening to clients, rather than mechanically applying a model of therapy. P24 stated it was necessary to:

...really [take] the time to listen to the story that may not be the norm...for hetero couple relationship therapy. And saying okay, what can I learn from my two clients who are in this relationship that I may be not so exposed to? What can I take from this so that I can mirror that back to them? Rather than I’m going to apply everything I have in my toolkit that I’ve applied to all my heteronormative cisgender couples and assume it’s going to work for [LGBT]Q+ people.

Many of the focus group members discussed the need for additional silence, curiosity, and attunement when asking about marginalized identities, as this indicated the therapist and topics were safe.

Focus group members also discussed the importance of the therapist showing they have knowledge and experience working with LGBTQ+ communities. After watching the EFCT videos, participants noted they observed the clients needing to educate the therapist about the experience of being a gay man, which felt as though they were being asked to “teach the teacher” (P11). Participants indicated that needing to educate the therapist about experiences of marginalization would make therapy feel less safe.

Additionally, when talking about identity, several participants noted they would prefer a separate session to fully explore how their LGBTQ+ identities inform their relationships. Many participants noted that this was not something they had thought about before and would, therefore, need time to process. P11 specifically recommended asking about this identity-related trauma, such as, “Is there any part of this fear that’s related to your identity as a queer person?” She explained, “As a queer person.... I would be so happy to receive that question. It would really make me feel like they wanted to know about my experience.”

5.2.2 | Avoiding Assumptions Through Honoring Individual Experiences

5.2.2.1 | Lived Experiences. Almost all participants discussed the importance of asking about individual experiences to avoid making assumptions and ensuring clients’ lived experiences were truly honored. This included using gender neutral language,

using a strengths-based perspective, and framing the problem as common among all couples, not specifically LGBTQ+ relationships. When drawing on their lived experiences, participants noted that they felt safe discussing their identities and experiences of marginalization when people were curious, interested, and did not make assumptions. P32 noted they felt safe discussing identity when therapists “treated me like I was normal and I was like, that’s just such a low fucking bar.” (P32). Being treated as “normal” also meant holding the complexity of intersecting identities. For example, P33 stated, “They...say I want to know your experience versus tell me about...all gay people or Black people.”

5.2.2.2 | Own Experiences in Therapy. Drawing on their own experiences in therapy, participants emphasized focusing on individual experiences as a way to avoid assumptions and/or LGBTQ+ stereotypes. Part of avoiding assumptions involved ensuring that the therapist was working to truly see the people in front of them, as P35 explained, “...it is the sense of attunement...that element of like really being in this moment right here right now with this person or these people who are in front of you....” Several participants noted that one way their therapist helped them to feel safe was by treating them as individuals and as a couple, rather than a stereotype or representation of LGBTQ+ communities. P15 explained, “Many people who identify as members of the LGBTQ+ community have this thing with normal. Like what is normal and what is not normal. To normalize what’s happening in your same-sex relationship is validating.”

In addition to normalizing common relationship dynamics, which included providing psychoeducation on how withdrawer and pursuer dynamics appear in relationships (P28), participants noted that integrating the differences, challenges, and/or uniqueness of being in an LGBTQ+ relationship in both positive and negative cycles was important. P13 noted, “I think it’s important to acknowledge the differences...not a whole lot, but just occasionally...especially when you’re bringing up those feelings and those emotions and those blocks especially and how it might relate to...to what’s going on.” Participants whose therapists were able to do this successfully struck a balance between indicating that they had knowledge of LGBTQ+ communities while also focusing on the individuals and relationship dynamics in front of them.

5.2.2.3 | Video Observations. The majority of focus group members noted that the language used in the videos indicated that the therapist was “making assumptions” about what it meant to be a gay man and a lesbian couple. P24 explained:

...the use of the word cliché. It didn’t click. It sounded almost presumptuous to me personally...I don’t identify as a gay man, but if the session was with two lesbians or even... I would have felt a bit [in]validated or maybe dismissed a bit because of the word choice.

In addition to ensuring that the therapist’s language did not reflect stereotypes or assumptions about LGBTQ+ clients, P21 said, “...it seems to me that one of the keys for a therapist...is to really be open to all those ways that people can live their lives

and want to live their lives and encourage and support as well as help them towards whatever goals they may have.”

5.2.3 | Understanding What It Means to be LGBTQ+

5.2.3.1 | Lived Experiences. One of the most common subthemes participants discussed was that the therapist should have a thorough understanding of what it means to be a member of LGBTQ+ communities and the impacts of oppression, marginalization, and queer joy. This meant understanding bi-erasure, common gay male experiences, common experiences in lesbian relationships, current events and news related to LGBTQ+ communities, the impacts of identity-based trauma, and the beauty of living outside of the norm, among others.

Participants explained that, when learning about experiences of oppression and marginalization from clients, it is essential for the therapist to be aware of potential blind spots and be cautious when asking about identity and the experiences of marginalization. Therapists need to know that LGBTQ+ people “routinely experience external stressors and traumas that the typical cis, straight (particularly White) couple might not” (P30). Thus, it was important for the therapist to lead with curiosity to signal nonjudgment and to ensure that therapists validated clients’ experiences without centering therapist learning.

The participants in the eight focus groups specifically highlighted an important consideration when working with LGBTQ+ individuals and relationships, especially when individuals hold multiple intersecting identities. A critical aspect of feeling safe with a therapist involves not feeling ‘othered’ and knowing that the therapist believes the client. P30 noted:

...I think that people who are marginalized...either hide ourselves... or we walk through the world with such a deeper understanding of the systems around us. And so... when I look at the world, I see 1000 threads of what it means to be and to be in systems and to be as a human in relationship with other humans. I do not make assumptions of relationship structure or life, what life looks like to be happy, and I have found so often that therapists have not done enough of a deep dive and have certainly not been exposed to thinking that leaves them anywhere but at the surface. And I think if you’re going to engage with... the queer community, where what we are doing constantly [is trying to] liberate us from all the ties that bind us, then you cannot show up in that space with your unliberated thinking and try to guide us because we’re fucking smarter. And we are being more reflective and thoughtful every day.

5.2.3.2 | Own Experiences in Therapy. Younger participants, participants in interracial relationships, as well as (most) participants with LGBTQ+ identifying therapists, noted that they appreciate their therapist adapting EFCT to account for their sociocultural context:

...how do these societal pressures and norms and policies really influence the day-to-day interactions as a queer couple? For example, we're walking down the street. Is it safe to hold hands or is it going to become this thing where we're feeling physically unsafe? How do we navigate that? And how does that build up for us relationally? And really, diving into how that may impact the relationship, because I feel sometimes, we just internalize it. (P23)

Interestingly, participants noted they had different recommendations for cisgender, straight therapists. For example, P24 stated:

...really taking the time to listen to the story that may not be the norm...for hetero couple relationship therapy. And saying okay, what can I learn from my two clients who are in this relationship that I may be not so exposed to? What can I take from this so that I can mirror that back to them [and] so I can help them feel supported and they can help other clients. Rather than I'm going to apply everything I have in my toolkit that I've applied to all my heteronormative cisgender couples and assume it's going to work for [LGBT]Q+ people.

It was important for participants that therapists who identify as straight and cisgender do not make statements that imply assumptions that they understand the lived experiences of being a member of LGBTQ+ communities. This was highlighted for P11 when watching the stage one EFCT video: "... [The therapist] didn't even say [it's like] you're a stranger in a strange land. She said, 'You're a stranger in a strange land.' And it was very matter of fact, and I thought [that] you can't really speak to a queer person's experience if you're not queer..."

5.2.3.3 | Video Observations. Participants also noted that it is essential for therapists to convey their understanding of LGBTQ+ communities by staying in context before moving into the process. For example, P34 (who was trained in EFCT) stated:

...the limiting piece of EFT...what I have been told... [is] identity doesn't matter. Sex doesn't matter. Gender doesn't matter. And I'm aware in this moment that that's what [the therapist] did. It's like we don't have to talk about sex. Let's talk about what's underneath that.... For marginalized groups, that's the thing that we need to feel seen. It doesn't mean that there's not anything underneath. But when you skip that, it's dismissed.

Indeed, participants noted that watching the training videos felt like observing an expert apply a formula that may not fully apply to LGBTQ+ clients. Therefore, they thought that adapting EFCT to account for the unique lived experiences of LGBTQ+ individuals and relationships was essential.

6 | Discussion

The aim of this qualitative study was to explore and document the recommendations of members of LGBTQ+ communities for modifying EFCT to account for their therapeutic preferences,

needs, and lived experiences. Existing literature provides practice guidelines for working with LGBTQ+ individuals and relationships. However, to date, there are no studies of how to adapt EFCT for LGBTQ+ relationships. Furthermore, as the integration of client identities has not been explicitly included in EFCT manuals (Johnson 2004, 2019). Therefore, while several of the findings align with previous research indicating cultural adaptation of ESTs for LGBTQ+ relationships, including the discussion of minority stress (see Gray et al. 2024; Pentel et al. 2021), these findings are unique to EFCT due to their emphasis on identity-related attachment experiences.

Participants in this study voiced a desire during assessment for therapists to both ask about and listen to their experiences of identity in a way that indicated therapists were aware of the complexities and impacts of marginalization and minority stress (Frost and Meyer 2023). While assessment in EFCT explicitly invites clients to share their attachment and relationship histories, to date, there has been no explicit integration of identity-related experiences into the EFCT manual (Johnson 2004, 2019). This finding reflects Nightingale et al.'s (2019) discussion of taking time to listen to each client's cultural narrative when using EFCT with individuals from marginalized communities and Guillory's (2021) discussion of therapist knowledge of common dynamics in African American heterosexual relationships. Furthermore, clients' desires for open, authentic, and genuine relationships with their therapists align with previous research on the therapeutic preferences of LGBTQ+ clients as well as with the principles of a multicultural orientation framework (Davis et al. 2018). While Johnson (2019) provides a thorough discussion of creating a therapeutic relationship in EFCT, this discussion has centered on the therapist acting as an attachment figure for clients, rather than openly and authentically discussing how identity-related experiences impact the therapeutic relationship (Davis et al. 2018).

Participants provided specific recommendations for EFCT therapists. For example, participants expressed the need for additional sessions exploring identity development, the impact of identity development on attachment experiences, and using specific interventions and engaged encounters (i.e., enactments) to deepen understanding about identity in the context of relationships. These recommendations appear similar to the modification of the parent-management training oregon model (PMTTO) made by Parra-Cardona et al. (2017) when working with undocumented Latinx parents, as they added sessions and components to discuss the cultural context of the intervention recipients. Yet, the emphasis on attachment is unique to the EFCT model, thereby emphasizing the importance of identity-related attachment experiences for members of the LGBTQ+ communities and highlighting the necessity of exploring these experiences for EFCT therapists.

Several focus group members indicated that therapist broaching (i.e., a consistent openness and commitment to exploring issues of diversity, culture, identity, power, privilege, and oppression with clients [Day-Vines et al. 2020]) was helpful. Research indicates the open discussion of therapist identity supports LGBTQ+ clients openly exploring their own identities (Berke et al. 2016; Goldbach and Gibbs 2015), supporting the use of broaching in EFCT. Broaching in therapy increases credibility

and decreases client dropout (e.g., Choi et al. 2015; Thompson and Jenal 1994; Zhang and Burkard 2008). However, broaching has not been explicitly incorporated into the EFCT manual (Johnson 2004, 2019), emphasizing the importance of integrating broaching into EFCT when working with LGBTQ+ clients.

Additional recommendations included increasing transparency, providing more psychoeducation about EFCT and relationships, and normalizing the struggles of LGBTQ+ relationships. Therapeutic transparency has been shown to increase task alliance (Turns et al. 2019), and psychoeducation shows a medium to small effect size when used as part of couple therapy (Park et al. 2020). Previous research also indicates normalizing the challenges of LGBTQ+ relationships may foster hope (Edwards et al. 2024). As EFCT is an experiential model, there has been little emphasis on psychoeducation and transparency about the processes of therapy (Johnson 2019). Therefore, these recommendations would change how EFCT is practiced and what information is conveyed to clients.

The theme avoiding assumptions and focusing on individual experiences describes how participants recommend EFCT therapists attend to individual experiences to avoid making assumptions and ensure each client's experience is honored. Nightingale et al. (2019) discuss asking about each client's individual experiences and narrative when working with African American heterosexual couples using EFCT, and Wasil et al. (2022) recommend open-ended assessments to integrate culturally salient presenting concerns. This theme also depicts participants' strong beliefs that EFCT therapists, especially straight, cisgender EFCT therapists, should avoid using stereotypes and preconceived notions of LGBTQ+ communities when working with LGBTQ+ individuals and relationships. Broadly, this reflects extant research—although not EFCT research—indicating that culturally responsive practice involves awareness of the common experiences of cultural groups while simultaneously tailoring treatment to each individual and/or relationship (Davis et al. 2018). This recommendation also echoes Mosher et al.'s (2017) cultural humility framework, which emphasizes *being with* clients and, thus, focuses on the process, values, and interactions between the therapist and client. Historically, EFCT de-emphasizes culture in favor of understanding attachment as a universal phenomenon (Johnson 2004, 2019).

The final theme, understanding what it means to be LGBTQ+, illustrates the necessity for EFCT therapists working with LGBTQ+ relationships to have a basic understanding of the common experiences of sexual and/or gender minorities. For participants, this included an awareness of the systems and impacts of oppression, the ways that LGBTQ+ individuals experience the world that is different from cisgender, heterosexual people, and the ways that LGBTQ+ individuals, relationships, and communities engage in resilience and world-making. Participants discussed the necessity of therapists working with members of LGBTQ+ communities to have a strong understanding of the common experiences shared by sexual and/or gender minorities. For example, one part of this shared experience was the way in which LGBTQ+ individuals disowned parts of themselves to cope with a hostile sociocultural context. Research documents the impacts of this aspect of minority stress (see Frost and Meyer 2023, for a review). The latter stages

of EFCT focus on integrating disowned parts of self, supporting EFCT as an important model for use with LGBTQ+ relationships (Burger and Pachankis 2024). Both culturally responsive practice and cultural humility may be central to implementing this recommendation (Mosher et al. 2017). Furthermore, noticing, nurturing, and celebrating joy is vital to engaging in socioculturally attuned therapy with LGBTQ+ relationships (see Westbrook and Shuster 2023) and understanding that revising traditional and normative ways of being is inherently part of what it means to be queer (Berlant and Warner 1998). EFCT's historical de-emphasis of client sociocultural experience in favor of relational and attachment experiences has heretofore rendered this knowledge and way of practicing as gratuitous. The need for members of the LGBTQ+ community to be seen and known in their identities significantly shifts how EFCT is understood and practiced.

7 | Implications

This study project aimed to function as an anti-oppressive work, shifting traditional research power relations by forming long-term relationships with members of LGBTQ+ communities, ensuring that interview questions are culturally relevant, centering LGBTQ+ voices, and ensuring that LGBTQ+ voices are instrumental in their own relational healing. Like Sullivan (2020), Dhungel et al. (2019), and Ginwright (2015), this study aims to give members of LGBTQ+ communities the opportunity to develop their own critical consciousness and, consequently, move toward liberation and healing. Indeed, participants' emphasis on therapist acceptance of "all those ways people can live their lives" moves toward a social constructivist conceptualization of identities and experiences within the context of relationships. There is the opportunity to reimagine and expand what is considered "normal," "healthy," and "desirable" within relationships and create relationships that navigate—but do not incorporate—oppression and marginalization and can serve as a source of resilience.

7.1 | EFCT Therapist Training and Practice

The findings from this study inform EFCT therapist training and practice. Primarily, EFCT therapists working with members of LGBTQ+ communities should receive additional training to ensure they understand the impacts of minority stress as well as common dynamics in LGBTQ+ relationships. Moreover, it is essential that EFCT therapists are trained to broach their identities and integrate their clients' experiences of identity into tracking negative cycles and reconstructing each partner's view of self and view of the other. Finally, the EFCT manual should be modified to include the integration of a multicultural orientation (Davis et al. 2018) and an emphasis on actively incorporating clients' identities.

8 | Limitations

While this study provides important insights into the therapeutic needs, preferences, and lived experiences of LGBTQ+

individuals in relationships who have experienced EFCT, this study cannot possibly describe all the unique experiences and therapeutic needs of LGBTQ+ individuals. This may be especially true for participants navigating other marginalized identities, such as race, ethnicity, class, and ability status, among others. Indeed, the majority of this sample identified as White and over the age of 30, limiting generalizability to members of LGBTQ+ communities who are younger and are people of color. A further limitation of this study was that the first two focus groups were unable to see the videos due to technology challenges. While they could hear the audio, it is possible that they may have missed information that could only be received by viewing the tape and/or their attention may have wavered more. Participants also made several assumptive statements about what would fit best for certain groups under the LGBTQ+ umbrella (e.g., gay men, lesbian women). Therefore, it should be noted that participants can only speak to their own lived experiences despite their more encompassing statements. Finally, although we aimed to have six attendees in each focus group, three participants dropped out of the study, and four participants miscalculated the time zones, thereby arriving late to the focus group. This resulted in half of the focus groups having less than six participants. It is possible that the consensus may have been clearer with a consistent number of participants (i.e., six) in each group.

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