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PRISMAS: A Brief Group Intervention Integrating Affirmative and Schema Therapy for LGBTQIA+ Individuals

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Abstract

Schema therapy (ST) has shown promising results. However, there is currently a scarcity of clinical trials for LGBTQIA+ individuals. This study proposes a brief group therapy integrating Affirmative and ST intervention for LGBTQIA+ individuals, addressing sociocultural factors to promote healthy functioning that can counter oppression and internalized prejudice. This study is a first test of the program with LGB individuals and includes (a) experts' evaluation of the protocol and (b) the themes and phases of each session. The content was assessed by four judges with expertise in ST and LGBTQIA+ issues, followed by a pilot study for potential replication in a randomized clinical trial. The judges completed an 84-item questionnaire evaluating the feasibility and acceptability of the protocol. Results showed strong agreement on feasibility, with an average of M = 4.90 (σ = 0.21; CVC = 0.98). The content validity coefficient (CVC) also reflected positive feedback from group facilitators (M = 4.39; CVC = 0.88) and participants (M = 4.65; CVC = 0.93). Acceptability ratings were high, with expert judges scoring a CVC of 0.98 for session adequacy (M = 4.91; σ = 0.08). PRISMAS is a pioneering initiative that contributes to deepening a still underexplored topic in ST.

Keywords: Schema therapy. Affirmative therapy. Sexual and gender minorities. LGBTQIA+. Group therapy.

Resumen

La terapia de esquemas (TE) ha resultados prometedores. Sin embargo, existe una escasez de ensayos clínicos para personas LGBTQIA+. Este estudio propone una terapia grupal breve que integra intervenciones afirmativas y TE para personas LGBTQIA+, abordando aspectos socioculturales para promover un funcionamiento saludable y contrarrestar la opresión y los prejuicios internalizados. Es la primera prueba del programa con personas LGB e incluye (a) la evaluación del protocolo por parte de expertos y (b) los temas y fases de sesión. El contenido fue evaluado por cuatro jueces con experiencia en TE y en temas de LGBTQIA+, seguido de estudio piloto para posible replicación en ensayo clínico aleatorizado. Los jueces completaron un cuestionario de 84 ítems que evaluaba la viabilidad y aceptabilidad del protocolo. Resultados mostraron un fuerte acuerdo en la viabilidad, con un promedio de M = 4.90 (σ = 0.21; CVC = 0.98). El coeficiente de validez de contenido (CVC) también reflejó comentarios positivos de los facilitadores del grupo (M = 4.39; CVC = 0.88) y de los participantes (M = 4.65; CVC = 0.93). Las calificaciones de aceptabilidad fueron altas, con los jueces expertos puntuando un CVC de 0.98 para la adecuación de las sesiones (M = 4.91; σ = 0.08). PRISMAS es pionero a profundizar un tema aún poco explorado en la TE.

Palabras clave: Terapia de esquemas. Terapia afirmativa. Minorías sexuales y de género. LGBTQIA+. Terapia grupal.

Resumo

A terapia do esquema (TE) tem resultados promissores. Contudo, há escassez de ensaios clínicos para pessoas LGBTQIA+. Este estudo propõe uma terapia de grupo breve integrando intervenções afirmativas e TE para indivíduos LGBTQIA+, abordando aspectos socioculturais para promover um funcionamento saudável e combater a opressão e o preconceito internalizado. Trata-se do primeiro teste do programa com pessoas LGB e inclui (a) avaliação do protocolo por especialistas e (b) temas e fases das sessões. O conteúdo foi avaliado por quatro juízes com expertise em TE e intervenções com LGBTQIA+, seguido por estudo piloto para possível replicação em ensaio clínico randomizado. Os juízes completaram um questionário de 84 itens avaliando a viabilidade e aceitabilidade do protocolo. Resultados

mostraram forte concordância para viabilidade, com uma média de M = 4,90 (σ = 0,21; CVC = 0,98). O coeficiente de validade de conteúdo (CVC) também refletiu feedback positivo dos facilitadores do grupo (M = 4,39; CVC = 0,88) e dos participantes (M = 4,65; CVC = 0,93). As classificações de aceitabilidade foram altas, com juízes especialistas atribuindo um CVC de 0,98 para a adequação das sessões (M = 4,91; σ = 0,08). PRISMAS é pioneiro em aprofundar um tema ainda pouco explorado na TE.

Palavras-chave: Terapia do esquema. Terapia afirmativa. Minorias sexuais e de gênero. LGBTQIA+. Terapia em grupo.

Background

Schema Therapy (ST) is a psychotherapy modality that has gained significant traction in recent years. Originally developed to enhance the cognitive-behavioral understanding of complex cases such as personality disorders (Young et al., 2003), this approach has been applied to various social groups, including LGBTQIA+ individuals (Cardoso et al., 2022; Cardoso & Braga, 2025). However, much remains to be developed, as indicated by a recent study on the consensus of professionals in the field regarding the scientific development needs of this modality (Pilkington et al., 2023). The professionals highlight the need for more methodologically robust experimental studies, focusing on interpersonal outcomes, changes in early maladaptive schemas, schema modes, schema coping responses, and moderators of ST outcomes—essentially, projects centered on interventions and their effectiveness and efficacy (Pilkington et al., 2023). Despite this, there is currently a lack of clinical trials on ST for LGBTQIA+ individuals (Cardoso et al., 2022).

Several international studies have specifically focused on LGBTQIA+ individuals using Group Cognitive-Behavioral Therapy (Ali & Lambie, 2018; Wandrekar & Nigudkar, 2019; Craig et al., 2021b; Smith et al., 2016). While ST falls within the realm of Cognitive-Behavioral Therapies (CBT), it has unique aspects that distinguish it from the classical approach. For this population, the selection of a group format for interventions is particularly relevant. Unlike other historically marginalized groups, such as women or Black individuals, LGBTQIA+ individuals often face challenges in identifying one another due to societal pressure to conceal their sexual orientation. Consequently, they may have fewer connections with other LGBTQIA+ individuals in their daily lives (Cohen & Newman, 2019; Pachankis, 2018; Hatzenbuehler & Pachankis, 2016).

An important aspect of the stigma faced by LGBTQIA+ individuals is the concealment of their sexual sexual orientation and/or gender identity to reduce exposure to risks. As a result, they often have limited support networks and face greater difficulties in finding a sense of belonging within their community during crucial developmental stages, including childhood and adolescence (Cardoso et al., 2024;

Cohen & Newman, 2019). Recognizing others who have gone through similar struggles can be therapeutic, as it provides a sense of connection and engagement in the presence of like-minded individuals—an entirely new experience for many LGBTQIA+ individuals (Cardoso et al., 2022; Cohen & Newman, 2019). Seeking support in safe spaces specifically designed for the LGBTQIA+ community is a common endeavor aimed at fostering meaningful relationships, as this population often reports higher levels of loneliness and lack of social connection compared to their heterosexual peers of the same age (Liu et al., 2019). Having role models for identification and opportunities for meaningful exchanges within a group setting can be particularly empowering for this community, which continues to face daily stigmatization (Cohen & Newman, 2019; Craig et al., 2021a).

The negative outcomes experienced by the LGBTQIA+ population can be understood through the lens of minority stress theory (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 1995; 2003). This theory posits that prejudice and discrimination act as significant stressors, contributing to higher levels of mental distress among LGBTQIA+ individuals compared to their heterosexual counterparts (Meyer, 2003). The stress experienced by LGBTQIA+ individuals encompasses intrapersonal, interpersonal, and structural dimensions. Intrapersonally, it includes internalized prejudice against sexual and gender diversity, which manifests as self-directed criticism and is highly detrimental. Interpersonally, it involves fear of rejection, difficulties in forming strong bonds, and the pressure to conceal one's sexual orientation to gain acceptance. Structurally, it includes prejudice and discriminatory language that foster maladaptive beliefs (Hatzenbuehler & Pachankis, 2016).

Given the multifaceted nature of the stigma faced by this population, therapeutic interventions have been developed considering these specificities. However, studies in this field are still in their early stages globally, and until the implementation of this research, no protocols or programs specifically tailored for the LGBTQIA+ population from the perspective of ST had been reported in Latin America or North America. The only published study proposing a Group ST intervention for LGBTQIA+ was conducted in Iran, focusing on LGB individuals diagnosed with bipolar affective disorder (Hashemi et al., 2021). Although this is an important step for an area neglected by science, the study has limitations, particularly due to its focus on a specific diagnosis within an already niche group. This makes it difficult to generalize the results, especially to non-clinical groups.

Creating a therapeutic group based on ST—a well-supported model that has accumulated evidence over the years through its profound intervention strategies—holds the potential to help individuals within the LGBTQIA+ community strengthen their healthier aspects and counter the internalization of stigmatizing structures (Cardoso et al., 2022). ST originated from the need to develop tools capable of exploring

deeply ingrained cognitive structures or accommodating patients who lack a specific diagnosis or clear complaints (Young et al., 2003). As such, the LGBTQIA+ population — vulnerable to minority stress throughout their lives — stands to benefit from techniques that address past experiences and help them face the stigma and prejudice against sexual and gender diversity through affirmative care.

Cardoso et al. (2022) explore how LGBTQIA+ individuals can be impacted by a specific schema mode called the inner critic (oppressive sociocultural) mode. Individuals within this population often endure a continuous barrage of negative messages from their sociocultural environment, leading to feelings of inadequacy, self-judgment, and heightened levels of self-criticism. These internalizations reflect the psychological consequences of the sociocultural oppression they encounter daily. This theory aligns with existing research on stigma and minority stress, which underscores how external structures can inflict psychological harm at an individual level (Hatzenbuehler & Pachankis, 2016).

It is important to note that ST has established effective protocols for group settings (Farrell & Shaw, 2013), although there is currently a lack of research specifically focused on the LGBTQIA+ population. Both heightened self-criticism and dysfunctional coping strategies, along with challenges related to personal identity, can be considered relevant transdiagnostic processes in the mental health issues of the LGBTQIA+ population. These processes are intertwined with minority stress, as they stem from both micro and macro cultural influences—from family dynamics to societal prejudices against sexual and gender diversity (Craig et al., 2021a). Based on this, the main goal of this study is to propose a brief group therapy integrating Affirmative and ST intervention for LGBTQIA+ individuals, addressing sociocultural aspects to promote healthy functioning that can counter oppression and internalized prejudice. This study is a first step toward that goal. It was conducted with sexual minoritized (LGB) individuals to obtain preliminary data on acceptability and feasibility, prior to applying the program with LGBTQIA+ individuals in a future randomized controlled trial. Pilot data from this sample were essential because they allow refinement of intervention content, delivery, and measurement strategies in a population with unique minority-stress experiences before investing resources in a full randomized controlled trial. Demonstrating acceptability and feasibility can identify cultural or structural adaptations needed to ensure engagement, reduce attrition, and improve ecological validity; it also strengthens the ethical and methodological justification for scaling the program to a broader and more diverse LGBTQIA+ sample. To achieve this, we will present (a) the experts' initial evaluation of the protocol, (b) the participants' and facilitators' adequacy evaluations after the pilot version of the protocol was completed, and (c) the themes of the sessions and each phase of the intervention present in the second and final version.

Method

This study was conducted according to the guidelines of the National Health Council and in compliance with the ethical standards for research involving human subjects (Resolution 466/2012 and Resolution 512/2016). It was approved by the Ethics Committee of the Federal University of Minas Gerais (CAAE Protocol: 69265523.7.0000.5149 and Opinion no. 6.136.046. All participants were volunteers and signed an Informed Consent Form.

Participants

To evaluate the intervention, four expert judges (two women and two men) were selected. The criteria for selection were: (a) training or postgraduate education in ST, and (b) proven experience or training in working with LGBT+ individuals. All the judges were Brazilian, cisgender, and had a degree in Psychology, with ages ranging from 29 to 41 years old (M = 34). Half of them belonged to a a sexual minoritized group, while the other half identified as heterosexual. Two of the expert judges had a master's degree, one had a doctorate, and one was a specialist in the subject. The average proven experience in ST and working with LGBTQIA+ individuals was 11 years. Among the four participants, three were members of the Brazilian Association of Schema Therapy (ABTE).

After the experts' evaluation, based on the feedback provided, an intervention manual was developed consisting of 10 sessions. Using this manual, a pilot group was conducted with a total of nine LGB participants (Braga & Cardoso, n.d.). The study used a convenience sample, randomly composed according to the following inclusion and exclusion criteria: Inclusion: (a) self-identify as lesbian, gay or bisexual; (b) be aged 18–35 years — this age range was chosen considering the higher rates of mental distress compared with the general population (Pachankis, 2018). Exclusion: (a) patients with psychotic disorders; (b) concurrent diagnostic conditions with depressive disorders (e.g., bipolar affective disorder, personality disorders); (c) individuals with neurocognitive disorders. In total, 78% of the participants were women, most of whom identified as Black or Brown (55%). All participants had completed high school, with three having completed higher education and two holding a master's degree (for results of the pilot study, see Braga and Cardoso, n.d.).

The facilitators were a professional psychologist and a final-year psychology student, both trained or specialized in ST. They were trained by the two developers of the intervention, but the authors of the protocol did not have direct access to its implementation, and the facilitators did not participate in the writing of the PRISMAS protocol.

Instruments

The Intervention Judges Evaluation Form (IJEF) was formulated by the research team at the Laboratory of Studies and Interventions in Cognitive and Contextual Therapies at the Federal University of Minas Gerais. The instrument collects general sociodemographic information of respondents and includes 84 questions to assess the feasibility and acceptability of the protocol. To measure feasibility, the IJEF includes 25 questions, 18 of which are on a Likert scale from 1 to 5 (rated from "poorly adequate" to "very adequate") and 7 open-ended questions for suggestions from the expert judges. The questions assess aspects such as the duration of the sessions, frequency of meetings, format of the intervention (online or in-person), instruments used in the evaluation phase, location of the sessions, the structure of the intervention manual, and the supervision format between researchers and therapists during each meeting. Acceptability is assessed through 59 questions (6 for each of the first 9 meetings and 5 for the tenth meeting), with 49 of these questions on a Likert scale from 1 to 5, and 10 open-ended questions for qualitative suggestions for change.

The *Intervention Facilitator or Participant Evaluation Form* (IFPEF) was created to evaluate the feasibility and acceptability of the intervention among participants and facilitators, using two versions of the same questionnaire. Both versions contained a total of 50 questions, with the same 5 questions repeated throughout the sessions. The questions, such as "2) How do you assess the duration of the activities in this session (were they too fast, too slow, etc.)?; 3) How do you assess your perception of the therapeutic bond between you and the group? Did the session facilitate connection?; 4) How do you assess the adequacy of the session to its proposal (was what was proposed for the session actually addressed)?; 5) How do you assess the structure of the sessions (location, your own posture as a schema therapist, materials, etc.)?" were used to evaluate feasibility, focusing on factors such as structure, duration, session flow, and perceived therapeutic bond. The question "1) How do you assess the content of this session (in terms of its adequacy to ST and the clarity of the subjects presented)?" was used to evaluate the acceptability of the session's content.

Procedures

Initially, the two authors of this study, who have prior training and experience in ST and working with LGBTQIA+ individuals, developed the basic structure of the protocol based on a review of the relevant literature. After discussing the topic with other laboratory members, conducting preliminary literature research (both in ST and Cognitive-Behavioral Therapy), and receiving input, the intervention was structured into 10 sessions, with at least three interventions per meeting. Aspects such as the duration, number of meetings, and therapist training were defined based on other programs for different groups (e.g., Craig et al., 2021b).

After this phase, the protocol was systematized into a form to assess feasibility and acceptability, which are the first two criteria for creating an evidence-based therapeutic program (Craig et al., 2021b). Feasibility was defined as the adequacy of structural aspects of the intervention, such as the duration of the meetings, location of application, group size, and therapist training. Acceptability was understood as the adequacy of the content addressed in the group—whether the protocol and session topics met their intended objectives based on the scientific literature on ST and psychotherapy with LGBTQIA+ individuals.

The expert judges were selected based on their previous experience in ST and with LGBTQIA+ individuals, requiring an intersection of knowledge in both areas. The research team contacted professionals via email, inviting them to evaluate the intervention. The experts received the evaluation form, hosted on the Google Forms platform, which included an informed consent form for participation in the research. After agreeing to the consent form, the experts completed the questionnaire and returned it to the Laboratory's database.

After the judges' evaluation phase, based on the results obtained, the protocol developers created a pilot intervention manual. This manual consisted of a 120-page guide that included the main concepts covered in each session, the objectives of the sessions, and a step-by-step guide on how to apply each of the proposed interventions, based on the literature in the field of Affirmative and ST. Each facilitator received a copy of the manual, as well as one week of training, which included an explanation of each activity and active role-playing of the interventions. Additionally, they were supervised weekly by one of the developers, with one-hour meetings to address questions, report perceived difficulties, and received instructions for the application of the intervention.

At the beginning of the first session, participants and facilitators received the informed consent form and the first evaluation sheet (with five questions). At the end of each of the following nine sessions, all participants answered questions related to that session, five questions at a time, totaling 50 questions. The form was provided in printed format and later organized in Microsoft Excel.

Data analysis

Data analysis was performed using JASP (version 0.17.1.0) and Excel. Descriptive statistics were used to calculate frequencies, means, and standard deviations. The level of agreement among judges, participants, and facilitators was also assessed to determine the acceptability and feasibility of the intervention, based on scores from both parts of the form, as well as the total agreement using scores from all questions on a scale from 0 to 5, where higher scores indicate greater agreement with the evaluated item. Qualitative data were also considered, according to the suggestions from judges,

participants, and facilitators, highlighting aspects of the intervention's structure (e.g., duration, instruments used).

Results

Feasibility Analysis

The feasibility analysis of the sessions showed that the experts rated the structure of the intervention with an average of $M = 4.90$ ($\sigma = 0.21$). The aspects "Training and supervision of therapists, roles of each therapist" and "Creation of the intervention manual and appendix" were the highest-rated items ($M = 5$). The "Number of sessions and duration of the intervention" received the lower ratings ($M = 4.5$). In the qualitative analysis, the expert judges pointed out the need for more sessions or longer meeting times. This aspect was adjusted for the pilot group by increasing each meeting time by 30 minutes (totaling 2 hours per session).

The agreement among the judges was evaluated by calculating the Content Validity Coefficient (CVC), a technique used to measure the clarity of language and the practical relevance of instruments or protocols (Hernández-Nieto, 2002). The CVC was calculated based on the formulations proposed by Hernández-Nieto (2002), assessing the acceptability of each session, as well as the overall acceptability and feasibility. The analysis by experts resulted in a CVC of 0.98 for feasibility, indicating a high level of agreement among the judges. Values above 0.80 were considered adequate, which was the adopted cutoff point.

For participants and facilitators, since evaluations were conducted at each meeting, the CVC and the mean acceptability and feasibility per session were calculated. Table 1 summarizes each measured aspect, including their respective means and CVC. All feasibility CVCs were considered adequate, except for session 6, which was rated as inadequate by the facilitators. This session also received the lowest ratings from both facilitators and participants in terms of the average score ($M = 3.88$ and $M = 4.56$, respectively).

Table 1. Feasibility Data of the Sessions

	Facilitators		**Participants**	
Session	**Mean Feasibility**	**CVC**	**Mean Feasibility**	**CVC**
1	4,38	0,875	4,53	0,906
2	4,13	0,825	4,56	0,912
3	4,38	0,875	4,77	0,944
4	4,13	0,825	4,62	0,925
5	4,13	0,825	4,6	0,921
6	3,88	0,775*	4,56	0,912

	Facilitators		Participants	
Session	**Mean Feasibility**	**CVC**	**Mean Feasibility**	**CVC**
7	4,38	0,875	4,58	0,917
8	4,75	0,955	4,71	0,943
9	4,88	0,975	4,77	0,956
10	4,88	0,975	4,81	0,962
Total	4,39	0,880	4,65	0,930

* *Note:* value below the adequacy cutoff point.

Acceptability Analysis

Regarding the acceptability of the intervention, the expert judges reported a CVC = 0.98 on the adequacy of the proposed sessions, with an average of *M* = 4.91 (σ = 0.08). Session 6, by expert evaluation, had the lowest average (*M* = 4.8) and CVC = 0.96, although it was still considered very adequate. Acceptability and agreement were also high for both participants and facilitators (*M* = 4.94, CVC = 0.99; *M* = 4.90, CVC = 0.98). The averages and CVC values for acceptability were higher than for feasibility among all evaluated groups (judges, participants, and facilitators), indicating that the intervention was more adequate in terms of content and themes addressed than in its structure (although the structure was also within the proposed parameters). Session 2 had the lowest average by participants (*M* = 4.63, CVC = 0.925), and Session 3 by the facilitators (*M* = 4.5, CVC = 0.90), but both still met the cutoff. Table 2 summarizes the means and CVC levels regarding the acceptability of each session.

Table 2. Acceptability Data of the Sessions

	Experts		Facilitators		Participants	
Session	**Mean Acceptability**	**CVC**	**Mean Acceptability**	**CVC**	**Mean Acceptability**	**CVC**
1	4,85	0,97	5,00	1,00	5,00	1,00
2	4,85	0,97	5,00	1,00	4,63	0,92
3	4,95	0,99	4,50	0,90	5,00	1,00
4	5,00	1,00	5,00	1,00	4,88	0,97
5	5,00	1,00	5,00	1,00	5,00	1,00
6	4,73	0,96	5,00	1,00	4,88	0,97
7	4,88	0,97	5,00	1,00	5,00	1,00
8	5,00	1,00	5,00	1,00	5,00	1,00
9	5,00	1,00	4,50	0,90	5,00	1,00
10	4,90	0,98	5,00	1,00	5,00	1,00
Total	4,91	0,98	4,90	0,98	4,94	0,99

Pilot Group Adjustments

Based on the judges' initial analysis, the intervention protocol was constructed and tested in a pilot group consisting of 10 sessions, each lasting 2 hours (Braga & Cardoso, n.d.). Three evaluation sessions (pre- and post-test) were conducted by the research team, each lasting an average of 40 minutes. Table 3 describes the characteristics of the intervention, following the Template for Intervention Description and Replication (TIDieR), designed prior to the pilot group and restructured according to the adequacy results obtained through the participants' and facilitators' analyses.

Table 3. Template for Intervention Description and Replication (TIDieR)

N°	Item
1.	NAME PRISMAS: A Brief Group Therapy Integrating Affirmative and Schema Therapy for LGBTQIA+ People
2.	WHY The creation of intervention programs for LGBTQIA+ individuals remains scarce. The limited existing literature focuses on classical Cognitive Behavioral Therapy, generally addressing specific symptoms or diagnoses. Affirmative and ST offers resources for addressing diffuse complaints and allows for a focus on life history, encompassing important aspects of minority stress. It shows promise as an intervention to address the suffering of these individuals, even without a specific diagnosis. "PRISMAS: A Brief Group Therapy Integrating Affirmative and Schema Therapy for LGBTQIA+ People" aims to reduce excessive self-criticism (inner critic oppressive sociocultural schema mode) and teach life skills (strengthening the affirmative healthy adult mode) in individuals with diverse gender identities and sexual orientations. This aims to reduce symptoms of anxiety, depression, and stress, dysfunctional schema activations, and the internalization of minority stress, as well as to promote well-being.
3.	WHAT What (materials): The program is a brief group therapy integrating Affirmative and Schema Therapy, initially tested with LGB individuals. It allows for psychoeducation on the approach, as well as on schemas and modes, with a particular focus on the inner critic (oppressive sociocultural) mode and the affirmative healthy adult mode. During the PRISMAS program sessions, participants are exposed to various cognitive, experiential, and behavioral interventions based on the theoretical framework of ST. Additionally, specific aspects related to the experiences of LGBTQIA+ individuals, such as minority stress and internalized prejudice against sexual and gender diversity, are explored, focusing on the intersection of these concepts with participants' life histories, schemas, and modes.
4.	What (procedures): Details of the sessions and procedures can be accessed in Cardoso and Braga (2025), and in Table 4.

N°	Item
5.	WHO PROVIDED The program was developed by the authors of the manual (Bruno Luiz Avelino Cardoso and Ana Clara Gomes Braga), who are trained in ST and Human Sexuality, with expertise in studies and interventions with LGBTQIA+ populations. The program was conducted by a psychologist trained in ST with expertise in working with LGBTQIA+ individuals, who was the group therapist, and a psychology intern in their final year of undergraduate studies with clinical internship experience in LGBTQIA+ populations and ST.
6.	HOW (mode of delivery; individual or group) The program was delivered through ten intervention sessions plus two evaluation sessions (pre-test and post-test). PRISMAS sessions were held weekly in a group setting with up to 10 participants, each lasting 2 hours. The total process time was 20 hours.
7.	WHERE The pilot intervention took place in person in a group therapy room at the Federal University of Minas Gerais, Brazil.
8.	WHEN AND HOW MUCH Each session lasted an average of 2 hours. The group met on Tuesdays from 10:00 AM to 12:00 PM. Before starting the intervention, each participant underwent an evaluative session lasting about 40 minutes, where they completed the pre-test. After the intervention, a new session was held for the post-test evaluation. The intervention was offered free of charge.
9.	TAILORING The intervention was not customized during the pilot group. However, a version of the group for transgender and gender diverse people is being developed by Dr Bruno Cardoso's laboratory. This new version of PRISMAS will include adaptations to address the specific needs of this population.
10.	MODIFICATION The intervention was not modified during its execution. After conducting the pilot group and considering feedback from facilitators and participants, the following modifications were made: (a) increasing the number of sessions to 12, with the two new sessions comprising interventions that were previously part of the early meetings, spacing out the content, and (b) expanding facilitator training to include more experiential training.
11.	HOW WELL How well (planned): Participation fidelity in the program was assessed based on participant attendance, process evaluations conducted at the end of each pilot group session, and responses to action plans, which consisted of small tasks to generalize what was learned during the training sessions.
12.	How well (actual): Participants attended the program consistently, with no dropouts. The acceptability and feasibility data, evaluated by participants and implementers, were positive and consistent.

After analysis by the intervention therapists, group participants, and the research team, the protocol was expanded to 12 sessions, each lasting 2 hours (see details in Cardoso & Braga, 2025). This is the current version of the program. The pilot study data and initial efficacy evidence will be available in Braga e Cardoso (n.d.).

PRISMAS Group Therapy

PRISMAS is the Brief Group Therapy Integrating Affirmative and Schema Therapy for LGBTQIA+ individuals that resulted from this study, following the suggested changes presented in the quantitative and qualitative analyses on the acceptability and feasibility of the intervention. The program's objective is to combat and disempower the inner critic (oppressive sociocultural) mode and to strengthen the affirmative healthy adult mode, thereby alleviating symptoms of anxiety, depression, and stress stemming from minority stress.

The name PRISMAS was chosen by the research laboratory to represent the image of a raw crystal before the formation of a rainbow, symbolizing self-refinement through affirmation and acceptance of one's identity. The intervention is a brief group therapy, initially applied to LGB individuals, and is currently being expanded to include transgender and gender diverse individuals. During the sessions, participants are exposed to cognitive, experiential, and behavioral interventions, exploring specific aspects of LGBTQIA+ experiences, such as minority stress and internalized prejudice against sexual and gender diversity. The intervention is divided into three parts, totaling 12 sessions, as outlined in Table 4, which contains the name and main theme of each session (Cardoso & Braga, 2025).

Table 4. PRISMAS Intervention Structure

Initial Sessions: Understanding Schema Therapy and My Internal Way of Functioning
Sesson 1. "Connecting with my network and understanding my way of functioning": Bond creation and self-monitoring.
Session 2. "Getting to know my different sides": Presentation of modes.
Session 3. "How society influenced the criticisms that I internalized about myself": Inner critic modes, minority stress, and prejudice against sexual and gender diversity.
Session 4. "Knowing and highlighting my strengths": Strengthening the affirmative healthy adult mode.
Session 5. "Connecting with my history": Deepening self-knowledge about how what I went through influenced who I am
Intermediate Sessions: Changing My Way of Thinking, Acting, and Feeling Through the Integration of Schema Therapy and Affirmative Therapy

Session 6. "I think, therefore I (do not) criticize myself": Cognitive strategies for coping with the inner critic (oppressive sociocultural) mode. Session 7. "The child who lives in me": Welcoming the child modes. Session 8. "Where does this internal storm come from? Understanding my emotions": Emotion-focused strategies for understanding and regulating various modes. Session 9. "Allowing myself a new way of feeling": Experiential strategies for coping with the inner critic (oppressive sociocultural) mode. Session 10. "Acting as the person I aspire to be": Behavioral strategies for coping with the inner critic (oppressive sociocultural) mode.
Final Sessions: Consolidating and Strengthening My Affirmative Healthy Adult and Having Fun with My Happy Child
Session 11. "Connecting our individual strengths with health and affirmation": Building the healthy adult connected to the social group. Session 12. "Releasing the happy child": Allowing the expression of creativity and fun for the group's closure.

Discussion

The main objective of this study was to propose a brief group therapy integrating Affirmative and ST intervention for LGBTQIA+ individuals, addressing sociocultural aspects to promote healthy functioning that can counter oppression and internalized prejudice. To achieve this, we presented (a) the experts' initial evaluation of the protocol, (b) the participants' and facilitators' adequacy evaluations after the pilot version of the protocol was completed, and (c) the themes of the sessions and each phase of the intervention present in the second and final version.

There are few applied studies of ST for LGBTQIA+ individuals, with only one clinical trial conducted so far (Hashemi et al., 2021). The study of Hashemi et al. (2021) consisted of eight sessions and involved a clinical group of gay men diagnosed with bipolar affective disorder. The sessions followed the cognitive conceptualization of ST but applied techniques typically associated with classical CBT, such as cognitive restructuring, and did not include key interventions of this approach, such as chairwork or imagery rescripting. Furthermore, the concept of modes was not introduced. Despite these limitations, as well as other issues related to how the results were assessed, this initial study was promising and demonstrated a reduction in mental distress in this group.

Given this, it is possible to hypothesize that groups using more experiential techniques and having a greater theoretical focus on ST would yield even more significant results. Fidelity to the model is essential for the proper replication of results previously found in the literature, as in the case of group ST for individuals with borderline personality disorder (Farrell & Shaw, 2013). The PRISMAS program,

as evaluated by experts, proved to be quite consistent in terms of its adherence to the theoretical and epistemological foundations of ST. This acceptability was also evident in the structure of the sessions and the organization of each activity, which were well-rated with high agreement among judges, participants, and facilitators alike.

The same was true regarding the feasibility of the protocol—the group structure, therapist training, methods of pre- and post-test evaluation, and the type of material used with participants were equally well evaluated, with high rates of agreement among expert judges. Although some concerns were raised about the duration of the group, considering that ST is typically a long-term therapy (Young et al., 2003).

The only specific session whose feasibility CVC fell below the cutoff point was Session 6, although this occurred only in the facilitators' evaluations, not in those of the participants or judges. This may be due to the low number of evaluators, as only two therapists rated the intervention. This session also received the lowest acceptability ratings from the expert judges, although it was still considered adequate. Considering all this, Session 6 was reformulated and refined in the final version of the intervention, featuring a clearer flow of activities, better time allocation, and more elements of Affirmative and ST in its proposals.

Another aspect adjusted based on the feasibility analysis was the addition of two sessions. These were integrated into the initial part of the protocol, following qualitative feedback from participants and facilitators who felt that the psychoeducation phase was somewhat rushed. The pilot group reported that the initial activities were motivating and engaging, but there was not enough time to delve into them. Thus, the final protocol was adjusted to allow more time to deepen the concepts and build connections more calmly before initiating deeper interventions.

However, there is no intention to excessively increase the number of sessions, considering participants' adherence. Group CBT protocols for LGBTQIA+ individuals typically consist of 8 to 10 sessions (Ali & Lambie, 2018; Craig et al., 2021b; Skinta et al., 2015). To replicate the success rates regarding participant involvement, the final number of 12 sessions was established for PRISMAS, aligning with existing literature while seeking therapeutic depth using experiential techniques and a greater focus on the therapeutic relationship—two aspects cited as positive points in the qualitative evaluation by judges.

The results of this study should be interpreted in light of its limitations. Although a larger sample was not the study's objective, a larger sample would have strengthened the evaluation of the intervention. Involving more experts to evaluate the intervention could have improved the structure of the sessions and provided additional input for the final version. This limitation was mitigated by selecting experts with extensive experience in ST and LGBTQIA+ populations. Additionally, focusing on LGB individuals at this stage is an important limitation, as transgender and gender-diverse individuals remain underrepresented in research. To mitigate this limitation, future

studies should address this gap and examine specific considerations for working with these populations.

Conclusion

In summary, the PRISMAS program presents promising and well-evaluated data from expert judges in the fields of ST and therapy for LGBTQIA+ individuals. This group model proposes to be innovative as the first group therapy integrating Affirmative and ST for LGBTQIA+ individuals, encompassing a variety of transdiagnostic aspects linked to the distress of being part of a minority without the limitation of specific clinical groups. Furthermore, it is a proposal entirely based on Affirmative and ST, utilizing its theoretical model and core interventions.

The PRISMAS program was tested in a pilot study (Braga & Cardoso, n.d.) and is being tailored to meet the needs of transgender and gender-diverse populations. Some customizations aim to address the needs of this audience, which may differ in certain respects from those of sexual-minoritized groups despite shared intersectional concerns. It is crucial that the proposal be evaluated in a randomized controlled trial with a control group and a sufficiently large sample to assess the protocol's effectiveness. Further evidence on PRISMAS should be collected across diverse contexts, including varied cultural settings and online delivery.

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