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Acceptance and Commitment Therapy for Self-Stigma Around Sexual Orientation: A Multiple Baseline Evaluation

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This study evaluated the effectiveness of 6 to 10 sessions of Acceptance and Commitment Therapy (ACT) for self-stigma around sexual orientation linked to same-sex attraction (what has generally been referred to as internalized homophobia; IH) in a concurrent multiple-baseline across-participants design. Three men and 2 women showed sizeable reductions from baseline to posttreatment and to 4- and 12-week follow-ups in daily reports of the degree to which thoughts about sexual orientation interfered in their lives; distress associated with these thoughts also decreased. Positive changes were observed in self-report measures of IH, depression, anxiety, stress, quality of life, and perceived social support. Consistent with the theory underlying ACT, reductions in daily ratings of the believability of thoughts about same-sex attraction (a process variable) were greater than those observed for frequency of such thoughts. Improvements were also observed in questionnaires measuring ACT processes. Mixed regression analyses confirmed outcome and process effects that were apparent through visual inspection. Implications and the distinctiveness of ACT as an approach are discussed.

Individuals with same-sex attraction experience many negative attitudes from others in contemporary society. For example, 41% of those in the United States endorsed the statement, "Homosexuality is a way of life that should not be accepted by society," while only 49% endorsed the opposite (Pew Research Center, 2007). Marriage inequality, bans on military service, and outright violence is visited upon lesbians, gay men, and bisexual women and men (LGB; While others experience stigma due to their sexual or gender identities, the present study is not focused on sexual or gender identity and thus the more limited acronym will be used.).

Because individuals with same-sex attraction are exposed to these negative attitudes throughout their lives, many believe that they may implicitly or explicitly adopt them and apply them to themselves, at least at some point during development (Forstein, 1988; Gonsiorek, 1988; Loulan, 1984; Malyon, 1982; Pharr, 1997; Sophie, 1988). This process has been referred to as internalized homophobia (IH), which Meyer and Dean (1998) define as "the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161).

While the definition of IH is not itself pathologizing, the term *homophobia* has pathologizing connotations, as it shares its etymological construction with pathological conditions, such as agoraphobia. Indeed, the term was coined by Weinberg (1972) to refer to a condition in heterosexuals characterized by a "dread of being in close quarters with homosexuals" (p. 4), with such dread based on an idea that same-sex attractions, affections, and/or behaviors are both contagious and dangerous. The word *internalized* contributes to this pathologizing connotation by implying that the problem is located within the individual rather than in the attitudes of society. Neither homophobia nor IH are included in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, however (American Psychiatric Association, 2000), and ego-dystonic homosexuality was removed when the third edition was revised (American Psychiatric Association, 1987). A pathological approach also excludes other negative reactions, such as those based on cultural or religious values (Shidlo, 1994). Thus, the term *homonegativism* (Hudson & Ricketts, 1980) has been preferred by some.

In individuals with same-sex attraction, homonegativism can lead to *self-stigma* around sexual orientation. Luoma, Kohlenberg, Hayes, Bunting, and Rye (2008) define *self-stigma* generally as a cluster of "shame, evaluative thoughts, and fear of enacted stigma that results from individuals' identification with a stigmatized group that serves as a barrier to the pursuit of valued life goals"

[1] The hypothetical participant in the videos is played by an actor and is not meant to portray any participant.

Keywords: acceptance and commitment therapy; self-stigma; sexual orientation; internalized homophobia; internalized homonegativity

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(p. 150). In the case of self-stigma around sexual orientation, LGB individuals constitute the stigmatized group. From this perspective, self-stigma (i.e., application of these attitudes to the self) entails a self-categorization process, and therefore those who have not committed to an LGB identity but have thought that such an identity might fit them (e.g., individuals who are consciously questioning their sexual orientation or individuals who have just exhibited same-sex attractions, affections, or behaviors) are among those prone to self-stigma around sexual orientation. Because of the broad use of the term, *internalized homophobia* will be used when discussing research and data from measures based on the concept, but otherwise *self-stigma around sexual orientation* will be used.

Based on decades of scholarship, major mental health associations (e.g., American Psychiatric Association, American Psychological Association) now hold that same-sex attraction, affection, and behavior are not pathological conditions in themselves, nor are they inherently related to any psychopathology, and these organizations have made their nondiscrimination policies clear (American Psychiatric Association, 1974; Conger, 1975). However, self-stigma is psychologically challenging. Evidence suggests that the prevalence of IH is fairly high. For example, Meyer and Dean (1998) surveyed 174 gay and bisexual men and found that about 70% reported some IH. Considering that most participants were public about sexual orientation, this may be an underestimate of the prevalence of IH in LGB populations. While IH is in one sense a normal process (given the prevalence of negative social attitudes), it can also be seen as part of a social stigmatization process that can lead to such problems as depression, suicidality, anxiety, somatic symptoms, distrust, loneliness, self-esteem, and avoidant coping with AIDS. IH has been shown to correlate negatively with social support satisfaction, gay social support, proactive coping with AIDS, and stability of self. Some areas, such as problematic substance use and risky sex behaviors, show more mixed findings (for reviews of correlates, see Shidlo, 1994, and Szymanski, Kashubeck-West, & Meyer, 2008). Meyer and Dean (1998) found that IH correlates negatively with intimacy (e.g., relationship stability and length) and that enacted stigma leads to depression, anxiety, and guilt more in those high in IH than those low in IH. Viewing these results as a matter of social context is supported by the finding that social support mediates the relationship between IH and psychological distress (Szymanski & Kashubeck-West, 2008). Accounting for self-directed homonegativism by appealing to contextual social variables (rather than internal constructs) can also be practically useful because it may lead to social contextual interventions in therapy and elsewhere that may effect positive change.

Despite the applied need, we were able to find only one published treatment evaluation that targeted IH and measured it as a dependent variable. In that study (Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007), a group cognitive behavioral therapy (CBT) intervention for depression in lesbian, gay, bisexual, and transsexual individuals was evaluated in an open trial (N=23). The intervention used was based on a common CBT protocol for depression and incorporated anti-oppression principles as well as sessions on coming-out experiences and IH. While significant improvements in depression were found from pretreatment to posttreatment and 2-month follow-up, no significant differences in IH were found on an LGBT-inclusive version of the Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2001b). However, participants did report that the intervention helped them become more comfortable with their LGB identity, and the objective measures may not have been sensitive enough to detect these changes. Manualized treatments focusing more specifically on IH have also been developed (e.g., Haendiges, 2001; Purvis, 1995) but remain untested.

One possible focus of therapeutic work may be experiential avoidance. In a study of gay male sexual assault survivors, Gold, Marx, and Lexington (2007) found a significant positive correlation between IH and experiential avoidance and that experiential avoidance partially mediated the relationship between IH and depressive and PTSD symptom severity. While findings with this special population may not apply to other LGB subpopulations (e.g., women, those who have not suffered a sexual assault, those who identify as bisexual), they do raise hope that interventions targeting experiential avoidance may be effective in reducing both IH and correlated problems.

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999; Twohig, 2012-this issue) is a psychological intervention specifically designed to decrease experiential avoidance and increase psychological flexibility in the presence of difficult private events, such as self–stigmatizing thoughts. An ACT approach to self-stigmatizing thoughts emphasizes willingly allowing these thoughts to occur while defusing from them, and instead focusing on values-based actions. This is an alternative approach to existing methods that have emphasized change in self–stigmatizing cognitive content (e.g., Beckstead & Israel, 2007; Haendiges, 2001; Purvis, 1995; Ross et al., 2007).

ACT has been shown to reduce self-stigma among other populations, such as substance-abusing clients (Luoma et al., 2008) and overweight individuals (Lillis, Hayes, & Bunting, 2009). ACT also has been shown to reduce stigma towards substance-abusing clients by substance abuse counselors (Hayes, Bissett, et al., 2004) and stigma towards racial minorities (Lillis & Hayes, 2007) and people with psychological disorders (Masuda et al., 2007) in a general population.

No studies have yet evaluated ACT as a treatment for self-stigma around sexual orientation. However, Montesinos (2003) reported the successful application of ACT to a 30-year-old male with erectile dysfunction and difficulties accepting same-sex attractions. Over the participant's 7-session course of therapy, experiential avoidance and erectile dysfunction decreased while experiential willingness and behavioral flexibility around same-sex attraction increased. The promising results of this case study, along with the research showing ACT's positive effects on self-stigma in other areas, suggest that more controlled research is now needed to see if ACT may help address self-stigma around sexual orientation. A multiple baseline design is a logical next step, as it provides more experimental control than a case study or an open trial such as that used in the study by Ross et al. (2007), while allowing close examination of change in outcome and process variables over the course of therapy. The present study examines the effects of a 6–10 session ACT intervention on IH and several of its correlates using a multiple baseline design across 3 men and 2 women.

Method

Participants

In order to be enrolled in the study, participants had to report significant distress over issues of sexual orientation, be over 18 years of age, be fluent in spoken and written English, and not meet criteria for a psychotic disorder. Thus, participants did not have to identify as LGB, but they had to experience distress around the possibility of identifying as such. Participants were recruited through 3 avenues: flyers posted around local college campuses and community centers, advertisements placed in local newspapers and online message boards, and referrals from the university counseling center. Recruitment flyers and online posts advertised free therapy and gave details about assessment procedures. Newspaper advertisements were briefer, but all recruitment materials stated that the study was for individuals struggling with sexual orientation or sexual identity issues and that treatment did not aim to change sexual orientation. All materials asked participants to contact the first author for more information. In total, 14 individuals responded. Of these, six were not scheduled for an initial meeting (4 of whom presented primarily with concerns over gender identity rather than sexual orientation, 1 of whom was under 18 years of age, and 1 of whom contacted the first author after recruitment had ended). Of the 8 individuals who were scheduled for the initial meeting, 1 presented primarily with gender identity concerns, and 1 reported sexual orientation concerns that were not sufficiently severe as to make the observation of treatment effects possible. The remaining 6 (4 men and 2 women) were enrolled in the study. One of the male participants withdrew from the study after the first session of treatment, reporting a preference to work on other issues in therapy. Table 1 provides further details about participant characteristics, with some of Participant 4's information omitted according to her preference. (A description of the intervention Participant 4 received and her data are, however, reported in this paper, as they are de-identified.)

Measures

Daily Ratings of Thoughts About Sexual Orientation

The primary dependent variables in the present study (because they were taken frequently enough to be evaluated intensively) were the daily ratings. Participants were asked to make daily ratings on a 0–100 scale of four items: (a) the degree to which negative thoughts about sexual orientation interfered in the participant's life, (b) the distress associated with those thoughts, (c) the believability of the thoughts, and (d) their frequency. Participants were given an 8.5-×−11-inch chart on which to record these ratings and were also asked to report them each day to the experimenter via telephone to a voicemail box. The first author coached participants in the identification of negative thoughts and asked them to focus on ones that were most relevant to themselves and interfered the most in their lives. Examples of such thoughts included, “Being a lesbian is wrong,” and “My

Table 1
Participant Characteristics

Participant	1	2	3	4	5
Sex	M	M	M	F	F
Age	23	24	56	>30	21
Sexual Orientation	Q	G	G		L
Ethnicity	A/AA/C	C	NA		AA/C
Marital Status	S	S	D		S
Occupation	Student	Student, Laboratory Assistant	Artist		Student, Coach
Level of Education	SC	SC	SC		SC

Note. Sexual orientation: G = gay, L = lesbian, Q = questioning; Ethnicity: A = Asian, AA = African American, C = Caucasian, NA = Native American; Marital status: S = single, D = divorced; Education: SC = some college.

gay feelings are a test of my moral virtue." Psychological flexibility theory views interference as a primary outcome, but distress would also be expected to drop gradually over time. Reducing the believability of interfering thoughts is considered to be a primary process variable, while no specific predictions are made regarding the frequency of negative thoughts per se. Together, these items were meant to provide an idiographic measure of self-stigma around sexual orientation.

Self-Report Outcome Variables

Several standardized measures were taken at pretreatment, posttreatment, and at the 4- and 12-week follow-ups.

Short Internalized Homonegativity Scale (SIHS; Currie, Cunningham, & Findlay, 2004). The SIHS is a self-report measure of IH in men consisting of 12 items rated on a 7-point Likert scale ranging from *strongly agree* to *strongly disagree*. The SIHS consists of three subscales (sample items in parentheses): Public Identification as Gay; Sexual Comfort With Gay Men ("Most gay men prefer anonymous sexual encounters"); and Social Comfort with Gay Men ("Making an advance to another gay man is difficult for me"). Each of these subscales constitutes a factor with eigenvalues > 1.0, and the scale as a whole shows acceptable internal consistency (Cronbach's $\alpha = .78$). According to Currie et al. (2005), scores of 47 and higher represent high IH, while scores 25 and below represent low IH. Significant correlations have been found between the SIHS and self-esteem ($r = -.19$), gay social support ($r = -.38$), and several domains of sexual functioning (Currie et al.).

Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2001b). The LIHS is a 52-item self-report measure of IH in women, with items rated on a 7-point Likert scale ranging from *strongly agree* to *strongly disagree*. The LIHS consists of five subscales (sample items in parentheses): Connection With the Lesbian Community; Public Identification as a Lesbian; Personal Feelings about Being a Lesbian ("I feel comfortable being a lesbian"); Moral and Religious Attitudes Toward Lesbians ("Children should be taught that being gay is a normal and healthy way for people to be"); and Attitudes Toward Other Lesbians. The LIHS has high internal consistency (Cronbach's $\alpha = .94$; Szymanski & Chung, 2001b), and its test-retest reliability across 2 weeks is .93 (Szymanski & Chung, 2001a). Its construct validity is supported by significant correlations with self-esteem ($r = -.26$) and loneliness ($r = .41$; Szymanski & Chung, 2001b) as well as with depression ($r = .33$), overall social support ($r = -.28$), overall gay social support ($r = -.36$), and "passing" for heterosexual ($r = .66$; Szymanski, Chung, & Balsam, 2001).

Depression, Anxiety, and Stress Scales–21 (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 assesses the severity of depression, anxiety, and stress over the past week using 21 self-report items rated on a 0–3 scale. Sums of item responses are doubled to facilitate comparison with the original 42-item DASS. Cutoffs for the Depression Scale are as follows: 0–9, normal; 10–13, mild; 14–20 moderate; 21–27, severe; 28+, extremely severe. For Anxiety, cutoffs are: 0–7, normal; 8–9, mild; 10–14, moderate; 15–19, severe; 20+, extremely severe. Cutoffs for Stress are: 0–14, normal; 15–18, mild; 19–25, moderate; 26–33, severe; 34+ extremely severe. Internal consistencies for the DASS-21 scales are good (Cronbach's αs > .87), and concurrent validity is evidenced by high correlations between the Beck Depression Inventory (BDI) and the DASS-21 Depression Scale ($r = .79$), between the Beck Anxiety Inventory (BAI) and the DASS-21 Anxiety Scale ($r = .85$), and between the BAI and the DASS-21 Stress Scale ($r = .70$; Antony, Bieling, Cox, Enns, & Swinson, 1998). In addition, changes in DASS-21 scores from pre- to posthospitalization correlate with changes in global measures of mental health and functioning, providing evidence for the validity of the DASS-21 as a measure of clinical outcomes (Ng et al., 2007).

World Health Organization Quality of Life—Abbreviated Version (WHOQOL-BREF; WHO, 1996). The WHOQOL-BREF consists of 26 items rated on a 1–5 scale and measures quality of life in domains of Physical and Psychological Health, Social Relationships, and Environment, each domain representing a factor (with eigenvalue > 1.0; Skevington, Lofty, & O'Connell, 2004). In the domains of Physical Health, Psychological Health, and Environment, internal consistency is acceptable (Cronbach's αs at .82, .81, and .80, respectively) but is marginal in social relationships (Cronbach's $\alpha = .68$; Skevington et al., 2004). Test-retest reliability for Physical Health was .66, Psychological Health .72, Social Relationships .76, and Environment .87 (The WHOQOL Group, 1998). Norms from a nonclinical sample for each domain are as follows: Physical Health $M = 73.5$, $SD = 18.1$; Psychological Health $M = 70.6$, $SD = 14.0$; Social Relationships $M = 71.5$, $SD = 18.2$; Environment $M = 75.1$, $SD = 13.0$ (Hawthorne, Herrman, & Murphy, 2006). The WHOQOL-BREF is capable of detecting moderate effect-size changes in quality of life (Hawthorne et al., 2006).

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS is a 12-item self-report measure that subjectively assesses social support from family, friends, and a significant other (each source constituting a factor) using 12 items rated on a 7-point Likert scale. This scale has shown good internal consistency (Cronbach's $\alpha = .88$) and adequate test-retest reliability ($r = .85$). In the original validation sample, the mean score was 69.6 ($SD = 10.3$).

Measures were also taken of drug use, suicidality, and risky sex, but responses were too infrequent to be meaningful.

Self-Report ACT Process Measure

Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011). The AAQ-II is the most recent version of the widely used measure of psychological flexibility, experiential avoidance, and acceptance of private experiences (Hayes, Strosahl, et al., 2004). It consists of 10 self-report items rated on a 7-point Likert scale ranging from *never true* to *always true*. An example item is, “My thoughts and feelings do not get in the way of how I want to live my life.” Higher scores indicate more psychological flexibility and acceptance and less avoidance. The AAQ-II shows good internal consistency (Cronbach's $\alpha > .81$) and correlates negatively with many measures of psychopathology (e.g., BDI-II, $r = -.75$; BAI, $r = -.59$). Scores below the cutoff range of 45–48 are associated with clinically significant distress.

Procedure

Participants who contacted the first author were scheduled for an initial meeting unless it was clear that they did not meet inclusion criteria. During this 1-hour meeting, participants gave informed consent, and demographic and contact information was obtained. In addition, participants were screened for psychotic disorders using the Psychotic Screening Module of the Structured Clinical Interview for the DSM-IV-TR (First, Spitzer, Gibbon, & Williams, 2007), and an unstructured interview regarding participants' struggles with sexual orientation issues was conducted. Lastly, participants were given self-monitoring forms on which to record their daily data regarding their thoughts about their sexual orientation.

A concurrent, multiple-baseline, across-participants design (Hayes, Barlow, & Nelson-Gray, 1999) was employed to evaluate treatment effects. This design consists of several coordinated simple phase changes, in which treatment begins for specific participants at different points in real time and after baseline periods of differing lengths. Ideally, phase changes are staggered so as to occur following a change in the main dependent measure with the participant who most recently underwent a phase change. Varying the times at which phase changes occur controls for the effects of extraneous variables common to participants, and varying the length of baseline phases controls for effects such as maturation and the effects of repeated measures. During the initial meeting, all participants were informed that because of the research design employed in this study, they would be monitoring their thoughts in baseline for a period of 1–8 weeks and would not know exactly when the baseline period would end until they were contacted to schedule the first treatment session.

Following the initial meeting, participants were instructed as to when they were to begin recording daily data. Intervention began no longer than 8 weeks after the initial meeting, and periods in which participants recorded baseline data ranged from 1 to 8 weeks. The intervention consisted of 6–10 weekly 50-minute ACT (Hayes, Strosahl, & Wilson, 1999) sessions. The first author served as the therapist and was trained by the second author, a developer of ACT. All sessions were video recorded, except for those of Participant 2, who requested that his sessions only be audio recorded.

Immediately prior to the first session, participants filled out the standardized outcome and process measures. This same battery of assessments was given immediately following the final session and at 4 and 12 weeks after the final session. Participants were asked to continue daily self-monitoring of thoughts during treatment and were asked to discontinue 1 week after the final session. They were then asked to resume self-monitoring for 1 week at both 4-week and 12-week follow-ups.

Treatment: ACT for Self-Stigma Around Sexual Orientation

A functional protocol was used in this study. The therapist was required to cover each of the six ACT processes (defusion, acceptance, present-moment awareness, self-as-context, values, and committed action) in depth during treatment using ACT-consistent methods drawn from existing major ACT protocols, in particular those of Hayes, Strosahl, and Wilson (1999), Luoma, Hayes, and Walser (2007), and Harris (2007). The flexibility of this functional protocol allowed the therapist to tailor treatment to each participant's unique presentation. For example, length of treatment was allowed to vary from 6 to 10 sessions according to participant's differing needs. Orientation to treatment was conducted in all first sessions, and all final sessions included a discussion of treatment gains. A general description of the processes targeted by ACT will be presented, followed by a more detailed description of the treatment each participant received.

Defusion work involves building the skill of noticing thoughts (e.g., self-stigmatizing ones) simply as ongoing cognitive events rather than allowing them to be treated as facts that must either be believed or proven wrong. Acceptance is deliberately experiencing one's experiences (e.g., thoughts, emotions, memories, sensations) willingly, and without needless defense, and is viewed as an alternative to habitual patterns of experiential avoidance. Creative hopelessness work readies individuals for acceptance by bringing them into contact with the costs of avoidance and is typically executed by discussing

with them the different methods they use to control their thoughts, feelings, memories, emotions, sensations, and exploring how well these methods have worked. Video 1 provides an example of creative hopelessness as applied to self-stigmatizing thoughts. Acceptance and defusion both support present-moment awareness, which can be described as "being in the now" in a way that allows attention to be focused, flexible, and voluntary.

Self-as-context is a sense of self as the observer of one's experiences and is distinguished from the content of self-conceptualizations (i.e., "stories" about the self). While we do view sexual orientation labels themselves as self-conceptualizations, we regard fusion with overly elaborated and self-stigmatizing stereotypical conceptualizations of these labels to be much more problematic than simple fusion with the labels. However, viewing sexual orientation labels as "stories" (i.e., defusing from them) can be powerful in promoting defusion from stigmatizing, rigid, and/or limiting stereotypes and in empowering the flexible use of sexual orientation labels in the service of living a full, meaningful life. Video 2 demonstrates how this may be done clinically and points out the two-dimensional, objectified nature of stereotypes based on labels. Later in session, self-as-context may be presented as an experienced (rather than conceptualized and objectified) sense of self that may empower flexibility around self-conceptualizations, as it is stable no matter what conceptualization is adopted. It is important to note that viewing sexual orientation as a self-conceptualization is *not* used here to encourage participants to conceptualize themselves differently (e.g., as heterosexual). There are two reasons for this: (a) encouraging participants to do so would perpetuate the repressive societal messages from which we are trying to help them defuse, and (b) it would be theoretically inconsistent in that ACT seeks to promote *flexibility* around cognitive content rather than to change it.

Values are chosen directions for action that establish meaning in the present; committed actions are the behavioral manifestations of those values and the creation of larger patterns of meaningful behavior. The mindfulness processes of ACT (acceptance, defusion, present-moment awareness, and self-as-context) are practiced to empower committed action in the service of values. Present-moment awareness of the process of values-based committed action (and not just its outcome) helps individuals to find meaning in action, even when external outcomes are undesired. For example, an individual who

Video 1. The first author applying creative hopelessness to attempts to eliminate self-stigmatizing thoughts around sexual orientation.

Video 2. The first author using the Documentary of Africa metaphor (Harris, 2007) to instigate defusion from self-as-content.

makes a disclosure of sexual orientation to a family member may still find meaning and value in this action, even if the family member reacts negatively. Mindfulness processes also aid in values construction, which involves the individual choosing the properties of her or his actions that are meaningful to *her* or *him* rather than merely complying with others, attempting to avoid guilt or anxiety, or valuing something because one has to do so. Video 3 demonstrates therapeutic work around these features of valued action.

The sense of choice inherent in values can be especially important for LGB populations because the term "values" has often been used to stigmatize LGB individuals (e.g., "family values"). ACT takes a truly idiographic approach that respects each individual's values. Often this means working through a variety of values. For example, individuals with same-sex attraction may wish to find ways that "family values" can still be a great source of meaning for them, regardless of their sexual orientation.

Participant 1. This participant presented with distress over uncertainty about his sexual orientation and was in treatment for 7 sessions. Creative hopelessness was conducted in Session 1, and willingness to have uncertainty (i.e., acceptance of uncertainty) was presented as an alternative. In Session 2, acceptance work continued, and the committed action of contacting a queer organization was chosen as homework. Session 3 focused on acceptance of the participant's discomfort in discussing his sexual orientation with a family member. Values clarification around the participant's relationship with this family member was conducted to highlight the purpose of accepting distress. Session 4 focused on defusion from the participant's worries about discussing his sexual orientation with others. In Session 5, the Documentary of Africa metaphor (Harris, 2007, p. 155) was introduced to cultivate defusion around self-as-content and to introduce self-as-context. In this metaphor, self-as-content (e.g., gay, straight) is likened to different documentaries of Africa, all of which present coherent stories based on facts, but none of which actually constitute the experience of Africa. Self-as-context is then introduced as the viewer or director of these documentaries. Video 2 demonstrates the use of this metaphor to instigate defusion from self-as-content with a hypothetical participant. Values, especially around family, were discussed in depth in Session 6, and barriers to valued action were discussed in Session 7. Present-moment awareness and other mindfulness processes were practiced at the beginning of Sessions 3–6 using brief mindfulness exercises.

Participant 2. This participant's presenting problem was distress and awkwardness around his sexual orientation, especially in social situations. He was in therapy for 10 sessions. Session 1 included creative hopelessness around attempts to avoid awkwardness over his sexual orientation, and acceptance was presented as an alternative. In addition, defusion was introduced around negative self-judgments. In Session 2, present-moment awareness and acceptance of awkwardness was practiced in session, and defusion from troublesome thoughts continued. Self-as-context was introduced in Session 3 using the Documentary of Africa metaphor, and in Session 4 values (e.g., in relationships) were discussed in depth. In Session 5, the distinction between pleasing others and pursuing one's values was emphasized. Defusion from the idea that gay people must fit themselves into gay stereotypes was practiced in Session 6. Session 7 focused on acceptance of and defusion from private events around awkward social situations. In Sessions 8 and 9, the participant's values were discussed, and Session 10 focused on the idea that acceptance of pain and regret is necessary for holding values as important. Present-moment awareness and other mindfulness processes were practiced during brief exercises (e.g., body scans, walking mindfulness) at the beginning of Sessions 2–10. Homework commitments were chosen

Video 3. The first author guiding a hypothetical participant in values work to clarify what was important for her in a homework commitment she made.

based on session content in Sessions 1–5 and 8 and were reviewed during the following sessions.

Participant 3. This participant presented with issues of worthlessness, stigma, and insecurity around his sexual orientation, and was in therapy for 10 sessions. Session 1 included creative hopelessness work, and acceptance and defusion were presented as an alternative. In Sessions 2 and 3, defusion was discussed further (e.g., by likening thoughts of worthlessness to billboards on a freeway, which may pass by without action being taken with respect to them). In addition, a shift in life focus from the pursuit of feeling states to the pursuit of valued action was stressed. In Sessions 4 and 5, mindfulness processes were revisited, and values were discussed in depth (e.g., around safer sex). In Session 6, material from Sessions 2 and 3 was reviewed, and the participant made a behavioral commitment to valued action. In Sessions 7 and 8, self-as-context was discussed, and variants of the observer exercise (Hayes, Strosahl, & Wilson, 1999, pp. 192–196) were used to practice this process. In sessions 9 and 10, creative hopelessness and mindfulness processes were revisited. Mindfulness processes were practiced during brief exercises at the beginnings of Sessions 4–8 and 10. Homework commitments related to session content were made at the end of Sessions 1–4, 6, and 8.

Participant 4. This participant's presenting issue was general discomfort regarding her sexual orientation, and her course of therapy lasted 10 sessions. The first session began with an introduction of self-as-context (using the Documentary of Africa metaphor). In addition, creative hopelessness was conducted, and acceptance and defusion were presented as alternatives. Homework was based on in-session creative hopelessness work and consisted of tracking the workability of attempts at controlling thoughts and feelings. Sessions 2–4 focused on defusion from and acceptance of stigmatizing thoughts. This work included the use of word repetition (Hayes, Strosahl, & Wilson, 1999, pp. 154–156), a technique involving repeating a word over and over for 1–2 minutes until it temporarily loses its meaning. An abbreviated version was chosen as Session 3's homework. Valued committed action was highlighted in both sessions as the reason for this work, and Session 2 homework consisted of "taking a small risk in the name of something important." Session 5 focused on acceptance of feelings associated with talking about sexual orientation. In Sessions 4 and 5, the participant committed to attending LGBT events of interest to her in the community as homework. Values induction was conducted in Session 6 by discussing with the participant what she would want loved ones to say about how she had lived her life after she had died. In Session 7, the Documentary of Africa metaphor was presented again. Session 8 focused on defusion from self-as-content and other thoughts. In Session 9, values around discretion versus openness about sexual orientation were discussed, and defusion was revisited in Session 10. Mindfulness processes, especially present-moment awareness and self-as-context, were practiced at the beginning of Sessions 7–9.

Participant 5. This participant reported concerns around adopting a lesbian identity and was in therapy for 6 sessions. In Session 1 the Documentary of Africa metaphor was presented to engender defusion from self-as-content and to build a sense of self-as-context with the purpose of making the adoption of a lesbian identity less threatening. In Session 2, defusion from worries about exploring her sexual orientation was instigated, and an appeal to a felt sense of valued action in this area was made. In Sessions 3 and 4, defusion from worries continued, and acceptance work was conducted around negative thoughts and outcomes. The point was made that negative experiences can serve as reminders of personal values. Session 5 focused on values clarification around sexual orientation, family, and friends, and committed action was chosen as homework. In Session 6, acceptance of fear was emphasized as a way to overcome barriers to the valued action of disclosure of sexual orientation. Mindfulness processes were practiced with brief exercises at the beginning of Sessions 2–6, and homework relevant to session content was chosen in Sessions 3–5.

Treatment Integrity

Other ACT therapists trained by the second author used the Acceptance and Commitment Therapy Rating Scale (Walser & Karlin, 2009) to rate a random selection of 25% of treatment sessions. Ratings of general therapeutic stance could range from 1 (indicating that the therapist did not use the ACT approach and/or used processes incompatible with ACT) to 5 (indicating an expert use of ACT with great frequency and depth). The same scale was used with the addition of 0, which indicated that the item was not covered in this session, for the use of metaphors, exercises, and homework and for the depth of coverage on the six specific ACT processes (defusion, acceptance, present-moment awareness, self-as-context, values, and committed action). This change was made because the therapist was not required to address each ACT process or use metaphors or exercises in each session. Overall integrity scores were computed by averaging all non-zero ratings for each session. These ratings indicated that ACT was delivered skillfully and in depth. The mean of the overall integrity scores across the 10 sessions rated approached the ceiling of the scale: 4.4 out of 5 (SD=.5). The six specific ACT processes were each rated in at least

four sessions; average ratings for each ranged from 4.2 to 4.8; and peak scores in every area reached 5.

Results

Daily Ratings of Thoughts

Weekly averages on interference and distress from negative thoughts about sexual orientation are presented in Figure 1; believability and frequency of such thoughts are presented in Figure 2. Means and standard deviations of pretreatment, posttreatment, and 4- and 12-week follow-up data from self-monitoring of thoughts are presented in Table 2. All data pertaining to the baseline period were considered pretreatment data, and data pertaining to the days following the final session were considered posttreatment. Although only 1 baseline data point is displayed in each of Participant 1's graphs, these points represent an average of 10 daily responses, making it possible to determine level and variability (see Table 2) as well as trend (increases in interference, believability, and frequency and a decrease in distress).

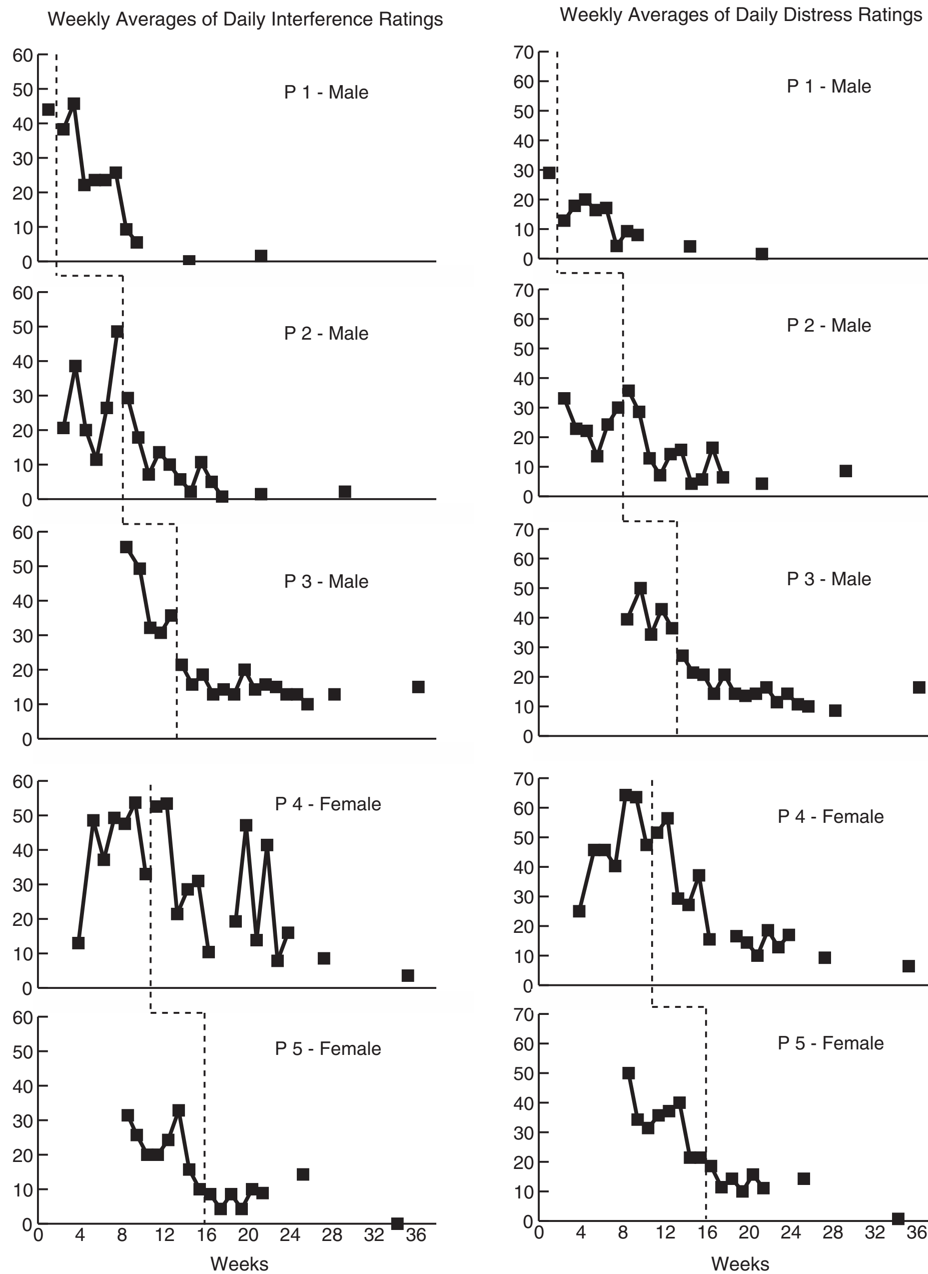

Figure 1. Weekly averages of daily ratings of interference and distress associated with thoughts about sexual orientation.

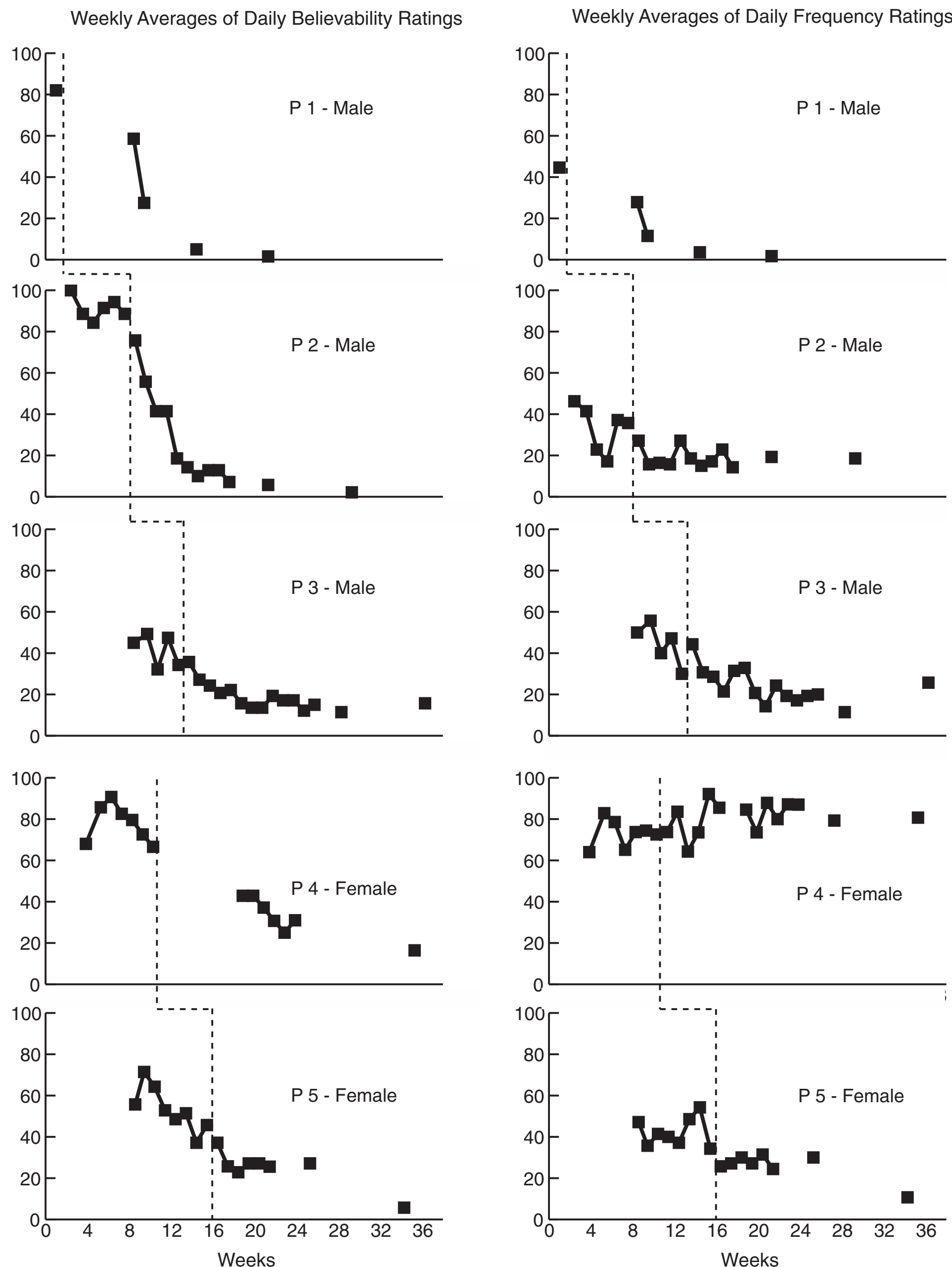

Figure 2. Weekly averages of daily ratings of believability and frequency of thoughts about sexual orientation.

Some believability and frequency data from Participants 1 and 4 are not shown because participants changed the thoughts they were rating without informing the investigators. After this problem was detected, investigators clarified the thoughts being rated each session. For Participant 1, the means of the omitted believability and frequency ratings were 86.6 (SD=7.3) and 53.4 (SD=15.2), respectively. During this period of time, Participant 1's frequency ratings were decreasing, and his believability ratings were fairly level. The mean of Participant 4's omitted believability ratings was 87.3 (SD=22.0), and there was an upward trend in these data. Participant 4's data from Week 17 are missing due to illness.

Sizeable improvements in interference and distress from baseline to the later time points were observed in all participants. Some participants showed decreases during baseline in interference (Participants 3 and 5) or distress (Participant 5) but the pattern of decrease during treatment was unrelated to these baseline differences. A

similar pattern was shown for believability ratings. For frequency ratings, changes were both inconsistent and smaller.

In order to add to a visual inspection approach, the actual daily ratings during baseline and treatment were analyzed using Hierarchical Linear Modeling (HLM; Hedeker & Gibbons, 2006). HLM takes advantage of the large amount of longitudinal data and can readily address missing data provided a linear model applies to the obtained data. HLM analyses were conducted using the number of days within the phase as a linear covariate (the first day of each phase was set to zero) and assessing whether there was a significant slope in the baseline and in the treatment phases. Analyses were first conducted assuming a random intercept and slope and allowing them to be correlated, followed by an analysis that assumed they were not correlated. The simpler model was used if it was determined not to differ significantly in modeling the covariance matrix as determined by the restricted log likelihood. Denominator degrees of freedom for fixed effects test statistics were based on the Sattherthwaite approximation. Effect sizes for significant slopes were examined as suggested by Raudenbush and Liu (2001) and were discussed using Cohen's (1988) cutoffs: small $\geq .2$; medium $\geq .5$; large $\geq .8$. In view of the small N, alpha values of .1 or less were interpreted.

During baseline no significant time effects were seen for time for any of the rated dimensions (that is, none of the slopes differed significantly from zero): the frequency of negative thoughts about sexual orientation [slope estimate assuming uncorrelated slope and intercept $= -.103$, SE $= .182$, $t(2.17) = -.57$, $p = .62$, 95% CI: -.82, .61], their believability [slope estimate assuming uncorrelated slope and intercept $= -.29$, SE $= .121$, $t(3.57) = -2.05$, $p = .12$, 95% CI: -.60, .10], the distress they produced [slope estimate allowing correlated slope and intercept $= -.014$, SE $= .221$, $t(3.55) = -.065$, $p = .95$, 95% CI: -.66, .63], or their life interference [slope estimate allowing correlated slope and intercept $= -.118$, SE $= .279$, $t(3.85) = -.42$, $p = .70$, 95% CI: -.91, .67].

During treatment these patterns changed. The frequency of thoughts about sexual orientation still did not change [slope estimate assuming uncorrelated slope and intercept $= -.146$, SE $= .098$, $t(3.99) = -1.48$, $p = .21$, 95% CI: -.42, .13], but their believability declined significantly [slope estimate allowing correlated slope and intercept $= -.383$, SE $= .122$, $t(3.97) = -3.13$, $p = .036$, 95% CI: -.72, -.04, effect size $= 1.43$, a large effect], as did the distress they produced [slope estimate allowing correlated slope and intercept $= -.138$, SE $= .034$, $t(4.35) = -4.06$, $p = .013$, 95% CI: -.23, -.05, effect size $= 1.99$, a large effect], and the self-reported life interference related to them [slope estimate allowing correlated slope and intercept $= -.148$, SE $= .055$, $t(3.93) = -2.68$, $p = .056$, 95% CI: -.30, .01, effect size $= 1.26$, a large effect].

Self-Report Measures

Average scores for self-report questionnaires given at pretreatment, posttreatment, and 4- and 12-week follow-up are presented in Table 3. It was not possible to analyze IH parametrically because the scales differed for male and female participants. Descriptively, across the two measures participants improved from pretreatment 23% by posttreatment, 32% by the 4-week follow-up, and 40% by the 12-week follow-up. SIHS scores, averaged over the male participants (1–3) improved 31% from pre- to posttreatment, 34% pretreatment to 4-week follow-up, and 34% pretreatment to 12-week follow-up. In female participants (4–5), posttreatment and 4-week follow-up scores on the LIHS changed less than 1% from pretreatment to posttreatment and 4-week follow-up but improved 20% from pretreatment to 12-week follow-up.

The other scales were analyzed using Mixed Model Repeated Measures (MMRM) across four assessment periods: pretreatment, posttreatment, and at 4-week and 12-week follow-ups. MMRM is similar to HLM but treats time as categorical rather than as a continuous covariate. In addition to an omnibus test of differences across time, contrasts were then calculated between pre-treatment and each of the later assessment phases. All analyses were conducted using an unstructured covariance matrix. The significance of contrast estimates from pretreatment to the other assessment periods are shown in Table 3 for each measure.

It is a mistake to overemphasize statistical inference in these data because the N is too low, but the pattern of improvement is worth noting. Participants were in the normal range on anxiety and did not change significantly; participants were moderately depressed (above 14; Lovibond & Lovibond, 1995) and mildly stressed (> 18) at pretreatment and both were significantly reduced by follow-up. Social support showed significant gains throughout; quality of life and psychological flexibility showed improvements at 4-week follow-up.

Discussion

The present study is the first published controlled evaluation of any treatment targeting self-stigma around sexual orientation as its main outcome. Using a concurrent, multiple baseline, across-participants design to examine the effectiveness of a brief, time-limited protocol with 3 men and 2 women, the data provided preliminary support for the effectiveness of ACT for this problem. Consistent and large improvement was seen during treatment (but not baseline) for daily ratings of the interference and distress caused by thoughts about sexual orientation. Similarly to other ACT research (e.g., Varra, Hayes, Roget, & Fisher, 2008), changes in the frequency of difficult thoughts was limited (visual inspection suggested limited change; statistical analyses showed no

Table 2
Means and Standard Deviations for Daily Thought Monitoring Data at Pretreatment, Posttreatment, 4-Week Follow-up, and 12-Week Follow-up

	P1				P2				P3				P4				P5			
	Pre	Post	4-wk.	12-wk.	Pre	Post	4-wk.	12-wk.	Pre	Post	4-wk.	12-wk.	Pre	Post	4-wk.	12-wk.	Pre	Post	4-wk.	12-wk.
Interference	44.0	2.1	0.0	1.6	27.4	0.8	1.4	2.1	41.5	11.4	12.9	15.0	38.8	12.9	8.6	3.6	22.5	8.9	14.3	0.0
	(12.4)	(3.9)	(0.0)	(2.1)	(20.4)	(2.0)	(2.4)	(3.9)	(19.9)	(2.4)	(2.7)	(6.5)	(20.5)	(9.5)	(7.5)	(7.5)	(16.1)	(9.2)	(5.3)	(0.0)
Distress	29.0	7.1	4.1	1.6	24.5	6.7	4.3	8.6	40.5	10.7	8.6	16.4	46.1	17.1	9.3	6.4	33.6	11.1	14.3	0.7
	(12.6)	(3.9)	(1.4)	(2.1)	(18.7)	(5.1)	(4.5)	(7.4)	(17.9)	(1.9)	(3.8)	(5.6)	(18.9)	(2.7)	(7.3)	(11.1)	(17.1)	(10.5)	(5.3)	(1.9)
Believability	82.0	26.4	5.0	1.6	91.4	7.5	5.7	2.1	41.8	12.9	11.4	15.7	77.4	28.6		16.4	53.5	25.6	27.1	5.7
	(5.9)	(3.8)	(2.5)	(2.1)	(10.4)	(7.6)	(5.3)	(2.7)	(13.1)	(2.7)	(2.4)	(4.5)	(14.6)	(11.1)		(26.4)	(17.3)	(17.4)	(7.6)	(5.3)
Frequency	44.6	8.6	3.6	1.7	33.7	13.3	19.3	18.6	44.9	16.4	11.4	25.7	72.5	86.4	79.3	80.7	42.4	24.4	30.0	10.7
	(20.9)	(3.8)	(1.4)	(2.2)	(18.6)	(8.2)	(8.4)	(9.0)	(15.2)	(4.8)	(3.8)	(8.4)	(15.3)	(6.9)	(5.3)	(6.7)	(13.6)	(8.8)	(8.16)	(6.1)

significant change), suggesting that it was a change in the function of thoughts more so than their frequency that was responsible for the strong effects seen on interference and distress. Anecdotally, all participants reported high satisfaction with the intervention at termination.

Broadly consistent with daily data, self-report measures also improved in depression and stress, social support, and quality of life. ACT processes improved as well. Questionnaires assessing IH improved but could not be statistically examined. It should be noted that these traditional IH questionnaires do not target interference by difficult thoughts, but rather whether certain thoughts are agreed to, which does not line up perfectly with an ACT approach. ACT de-emphasizes cognitive content (e.g., changing the form of self-stigmatizing thoughts or stereotypes) and instead targets the person's relationship to thought. The goal is workability linked to values, not the form of thought per se.

Likewise, while some items in our self-report IH measures assessed cognitive content around identity, we did not directly target the importance of developing an identity around sexual orientation. Issues of identity have been a major theme in the literature on IH (e.g., Cass, 1979). In contrast with many approaches, which emphasize formation of a positive LBG identity (e.g., Beckstead & Israel, 2007; Haendiges, 2001; Purvis, 1995), ACT views identity formation itself as in part a cognitive act. In ACT, steps are taken to defuse from the conceptualized self even when its content is positive; instead, a deeper sense of self that is based on the continuity of consciousness itself is fostered. For example, instead of attempting to promote positive beliefs about sexual orientation while eliminating negative ones, ACT focuses on being aware of one's perspective and that of others, and taking the steps needed to move in a values-based direction. This is thought to allow thoughts and feelings to assume their natural level based on experience and workability. This does not mean that identity formation is negative: it depends on the function and context of this process. Adoption and use of labels such as lesbian, gay, or bisexual, for example, can represent action based on values of self-respect (i.e., not hiding one's attractions or affections in shame) or openness to romantic love. The use of identity in a values-based way is likely supported by defusion from negative societal attitudes and acceptance of feelings of attraction and/or affection as well as others, such as anxiety about others' reactions. However, a focus on fusion with a positive LGB identity may lead to futile attempts to suppress negative thoughts that are culturally established, and fusion with labels may engender a sense of essential differentness, which could undermine values of, for example, connection with others belonging to different categories. Of course, a sense of differentness or otherness need not be experienced as negative, and a focus on differentness could represent a process of acceptance of

one's unique experiences and values as important, in part because of their differentness. Again, context and function are key. Even fusion with a heterosexual identity may limit valued action. For example, a heterosexual man may avoid expressing affection for a close male friend in an effort to keep his behavior consistent with his heterosexual identity. Thus, ACT encourages a more open and flexible approach to all thoughts, positive and negative, and about events, others, or oneself, with labels being considered more as possible tools for valued action than as facts that need to be believed or disproven. In session, most participants reported finding this approach to labels (i.e., identity) quite different and also quite freeing. Given the importance of identity issues, further research should explore this approach to sexual identity in ACT.

The present study is notable in that it is the first published evaluation of ACT for self-stigma around sexual orientation and provides evidence for the effectiveness of ACT for this problem. IH is not a disorder and is not recognized in the DSM-IV-TR (American Psychiatric Association, 2000), but LGB individuals have been found to seek treatment from mental health care providers at a rate over three times that of heterosexuals and are significantly more likely than heterosexual individuals to meet criteria for two or more disorders (Cochran, Sullivan, & Mays, 2003). This pattern is true of other stigmatized groups, and there is a growing body of evidence that self-stigma and shame are in part responsible for the pervasiveness of behavioral health problems among those who are the recipients of enacted stigma (e.g., Corrigan, Watson, & Barr, 2006; Ritsher & Phelan, 2004).

Table 3
Means and Standard Deviations of Self-Report Measures at Pretreatment, Posttreatment, 4-Week Follow-up, and 12-Week Follow-up

	Pre	Post	4-wk.	12-wk.
Internalized Homophobia –	50.3	34.7	29.3	32.7
Male (SIHS)	(4.0)	(12.6)	(11.9)	(15.9)
Internalized Homophobia –	147.5	148.5	147	118.5
Female (LIHS)	(33.2)	(29.0)	(12.7)	(30.4)
Depression (DASS-D)	14.4	7.2*	7.2**	4.8**
	(8.2)	(3.6)	(4.1)	(2.3)
Anxiety (DASS-A)	5.2	4.8	3.2	4.0
	(3.9)	(4.1)	(3.6)	(4.0)
Stress (DASS-S)	16.0	15.6	10.2**	8.0**
	(4.7)	(7.1)	(4.9)	(5.8)
Quality of Life (WHOQOL)	220.6	252.6	244.2**	254.0
	(62.4)	(51.6)	(64.6)	(47.2)
Perceived Social Support	44.8	63.4**	53.0**	57.0***
(MSPSS)	(14.4)	(10.8)	(14.4)	(10.0)
Overall Psychological	44.2	51.2	51.2*	49.8
Flexibility (AAQ-II)	(2.4)	(8.5)	(7.3)	(6.8)

Note. Probability levels from MMRM contrast analyses from pretreatment to the phase indicated: * <= .10, ** <= .05, *** <= .01 (two-tailed; It should be noted that these probability values are based on the consistency of within subject changes in a mixed model analysis and cannot be directly derived from the means and standard deviations in the table). Internalized homophobia was not evaluated parametrically because two different measures were used.

Although statistical analyses and visual inspection of the data suggest a treatment effect for ACT in this study, the question of clinical significance remains and additional research will be needed to address it. There are other weaknesses. The self-monitoring questions used were developed specifically for this study, and thus their meaning with respect to other standards of functioning is difficult to determine. In addition, it is worth noting that the multiple baseline design used does not control for nonspecific effects of treatment. For example, Participant 1 emphasized how helpful it was simply to talk about his issues of sexual orientation. In addition, placebo effects and demand effects cannot be ruled out as a cause of changes in outcome variables. Contact with the therapist was partially controlled for in this design, as such contact occurred at the initial meeting and during baseline data reporting. However, contact became more intense once treatment began and other controls might have usefully been included (e.g., deliberately including nonjudgmental conversations in baseline so that the impact of "having someone to talk to" might be better assessed before examining the impact of ACT. Although no statistically significant changes in daily ratings were observed during the baseline period, visual inspection of the data of Participants 3 and 5 does reveal some trend towards improvement during baseline, which may call into question the attribution of the source of later improvements to treatment. Thus, the present data should be viewed as suggestive but not conclusive.

That needs to be juxtaposed against the paucity of available treatment evidence for self-stigma regarding sexual orientation. Clinical researchers need to begin to address the needs of stigmatized groups and to help change the social and cultural context that leads to self-stigma. ACT has now been shown to be useful in this area for several specific populations. When combined with the evidence reviewed earlier that ACT can be helpful with self-stigma, the present study suggests that a larger trial is now warranted examining the impact of ACT for self-stigma around sexual orientation on the health and well-being of affected populations, for example individuals who are HIV-positive.

Appendix A. Supplementary data

Supplementary data to this article can be found online at doi:10.1016/j.cbpra.2011.09.002.

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