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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”

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

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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.

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