

Acceptance and Compassion-Based Group Therapy to Reduce HIV Stigma

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Interventions that target the burden of HIV-related stigma among gay and bisexual men with HIV could yield a broad array of benefits to HIV-positive individuals. In particular, recent research suggests that reducing HIV-related stigma might increase contact with medical professionals, adherence to medication, disclosure to sexual partners, and enhance the ability of persons with HIV to build necessary support networks. In this clinical pilot, we examined the feasibility, acceptability, and usefulness of delivering an HIV-related stigma-reducing group intervention in a community mental health setting to gay and bisexual men living with HIV who are currently connected with care but reporting ongoing difficulties due to HIV-related stigma. The basis of this intervention, acceptance and commitment therapy (ACT), has been found to be effective in reducing the experience of self-stigma among persons with substance abuse histories, and a recent pilot suggests it is helpful for gay and lesbian persons experiencing internalized homophobia. Along with ACT, we have incorporated ideas and exercises from compassion-focused therapy (CFT), an intervention designed to increase compassion while decreasing shame, an affective state close to self-stigma. We hypothesized that this integrated approach would be effective for those experiencing HIV-related stigma. Eight clients currently receiving mental health treatment at the UCSF Alliance Health Project (AHP) Services Center were recruited via clinician referral for an eight-session group, and five completed the group. Follow-up measures of psychological flexibility and HIV-related stigma were completed by three participants, whose data is presented here.

HIV-RELATED stigma is associated with a cascade of harmful outcomes for persons living with HIV/AIDS. HIV-related stigma has been found to markedly reduce the well-being of persons living with HIV/AIDS through its association with reduced medication adherence and reduced contact with medical providers (Sayles, Wong, Kinsler, Martins, & Cunningham, 2009). It can also lead to reduced disclosure of HIV status, resulting in a greater likelihood of serodiscordant sexual partners (Poindexter & Shippy, 2010) and a restricted social support network (Kalichman, DiMarco, Austin, Luke, & DiFonzo, 2003) of persons knowledgeable of their serostatus. Further, recent research has largely focused on international and cross-cultural examples of stigma (Genberg et al., 2009, 2008; Maman et al., 2009). Though associated with HIV-related stigma, many of the interventions for issues like reduced adherence actually target specific mental disorders (e.g., depression; Safren et al., 2009). Further, the majority of interventions associated with HIV-related stigma are uncontrolled, nonrandomized, and are primarily focused on HIV-related stigma among HIV-negative samples (Sengupta, Banks, Jonas,

Miles, & Smith, 2011). As minority stress theory illustrates, constant exposure to societal stigma results in psychological vulnerabilities that may in turn result in both psychological distress and poor adherence behaviors. Thus, future research may reveal that, in some cases, these interventions are targeting effects of HIV-related stigma (e.g., depression, medical noncompliance, poor adherence) while neglecting to address stigma itself.

Sexual minority stress (SMS) is a term used to describe the psychological stress experienced by sexual minorities (gay, lesbian, and bisexual people) who live in a predominantly heterosexual world. SMS was an outgrowth of Meyer's (1995) original conceptualization of minority stress theory, which posited that any model that did not account for the full array of proximal and distal stressors is unlikely to capture the full impact of a stigmatized identity on the well-being of a given minority group. SMS is the additive effect of four components: internalized homophobia (internalized negative attitudes and beliefs toward homosexuality), expectation of stigma, concealment of one's sexual identity, and discriminatory events (e.g., violence, bullying, and rejection; Meyer, 2003; Meyer, Schwartz, & Frost, 2008). For many gay and bisexual men, SMS stressors are present prior to an individual's awareness of his sexuality, since many adult gay and bisexual men report memories of being bullied or stigmatizing experiences in early childhood due to perceived gender atypicality

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(Plöderl & Fartacek, 2009). Although many studies have focused only on the role of internalized homophobia, the relative weight of each factor and the pattern of psychological deficits or dysfunction to which severe elevations of any particular component might lead are not known. One study suggests that discriminatory events and the expectation of stigmatizing treatment are the most salient (Kuyper & Fokkema, 2010).

For reasons not clearly identified, SMS consistently exerts a greater impact on the mental health and well-being of HIV-positive gay and bisexual men than HIV-negative men (Cochran & Mays, 2009). This may be due, in part, to the synergistic effects of managing both SMS and HIV-related stigma. HIV-related stigma places an additional psychosocial stressor on gay and bisexual men, and results in worsened medical and psychosocial outcomes. This may be even more pronounced among older adults with HIV, who now comprise approximately half of the HIV-positive men in San Francisco (San Francisco Department of Public Health, 2010). Older HIV-positive men often report lower quality of life and higher psychological distress than their younger counterparts (Avis & Smith, 1998; Heckman et al., 2000; Kalichman, Heckman, Kochman, Sikkema, & Bergholte, 2000), and the changing meaning of HIV infection among younger individuals is poorly understood.

The experience of SMS may also have a particularly strong association with psychological well-being and disease status. Among HIV-positive gay men, social isolation, lack of condom use, and poor medication adherence have been associated with high minority stress (Cochran & Mays, 2006, 2009). A large body of research suggests that increased stress and a lack of social support are associated with faster HIV-disease progression (Leserman, 2000). It is also possible that the links between SMS and psychological well-being are partially explained through emotion regulation strategies such as experiential avoidance (Hatzenbuehler, 2009).

Acceptance and Commitment Therapy for Stigma

There are few interventions for the experience of stigma and even fewer that have been empirically based and assessed. It is also important to consider the context of interventions working with urban, sexual-minority men. Recent well-designed studies working with women of color (e.g., Rao et al., 2012) have drawn from the broader stigma literature, which suggests that education, contact with affected persons, skills training, and counseling approaches are necessary components of stigma-reduction programs (Brown, Macintyre, & Trujillo, 2003). This literature may present increasingly disparate recommendations for men who have been exposed to multiple campaigns intended to increase education regarding the virus and are unlikely to have avoided contact with affected persons, such as

sexual-minority men in large North American, European, and Australian cities. One promising direction has been the so-called third-wave behavioral therapies, which include functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), dialectic behavioral therapy (DBT; Linehan, 1993), acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2001), and others. While the theories behind these therapies are staunchly within the behavioral tradition, they are unique in their focus on the function of private events (thoughts, feelings, etc.) in the present moment, acceptance of adverse internal states, and a perspective that thoughts related to the self are subject to learning histories, rehearsal, and internal reinforcement. This is in contrast to more traditional cognitive and behavioral approaches that seek instead to alter the form or frequency of private events (e.g., automatic thoughts). It should be noted that not all theorists view this as a break with the tradition of cognitive-behavioral therapy, but rather a continuation of long-standing approaches and stances with a particular emphasis (Hofmann & Asmundson, 2008; Hofmann, Sawyer, & Fang, 2010; Mennin, Ellard, Fresco, & Gross, 2013). There is a distinction in technique between those cognitive-behavioral therapies labeled “ACT” and those focused on cognitive reappraisal; this specific intervention is firmly aligned with the former.

ACT specifically focuses on the verbal processes that underlie experiential avoidance and cognitive fusion. Experiential avoidance refers to avoidant behaviors that occur in response to internal stimuli—in accordance with the philosophy of ACT, it is important to note that “avoidant behaviors” include internal behaviors such as mental distraction, rumination, or reappraisal when it serves to reduce emotional experiences of shame or the awareness of stigma. For example, a man with HIV might have frequent thoughts such as “I will be rejected if people know of my HIV status.” These thoughts have the ability to occur in the absence of actual experience with such an event, but might lead him to engage in denial or rationalizations that reduce the experience of shame, such as assuming that he is not statistically likely to pass on the virus or avoiding romantic intimacy to reduce the likelihood of having thoughts about his HIV-positive status. These thoughts may also lead to behavioral avoidance that functions to reduce affective and experiential contact with infection, such as avoiding disclosure to his parents, reducing his ability to utilize them as valued caretakers. He might also choose not to disclose his status to sexual partners or suggest the use of condoms, putting others at risk of contracting HIV and himself at risk of contracting additional sexually transmitted infections.

As noted above, ACT is one of a few theory-based approaches that has yielded effective antistigma interventions

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