Acceptance and commitment therapy (ACT) for HIV+ gay men: A qualitative analysis

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Acceptance and commitment therapy (ACT) for HIV+ gay men: A qualitative analysis

Abstract

HIV+ gay men experience significant mental health distress related to HIV status, including anxiety and depression (Leiphart, 1998). One major source of this distress is social stigma related to HIV status and sexual orientation, such as more societal blame for gay men contracting HIV than heterosexual men for contracting HIV (Herek, 1999; Herek & Capitanio, 1999). There has been significant evidence to support the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing distress related to social stigma and chronic illness (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010). However, researchers have not explored the utility of ACT in treating distress in HIV+ gay men. The goal of the current study is to explore the potential effectiveness of ACT in treating HIV+ gay men. The participants were five therapists who worked with HIV+ gay men over a year. The participants were asked questions that reflect the six therapeutic processes of ACT: (1) being present, (2) defining valued directions, (3) committed action, (4) self as context, (5) cognitive defusion, and (6) acceptance (Luoma et al., 2007). The researcher defined five categories based on interviews with the participants: (1) social stigma hinders HIV+ gay men, (2) staying in the present, (3) accepting and disconnecting from thoughts and feelings, (4) consider events separate from self, and (5) finding meaning to define committed action. The participants supported the use of ACT for treating distress among HIV+ gay men, such as the importance of HIV+ gay men remaining present focused.

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ACCEPTANCE AND COMMITMENT THERAPY (ACT) FOR HIV+ GAY MEN: A QUALITATIVE ANALYSIS

A THESIS
SUBMITTED TO THE FACULTY OF SCHOOL OF PROFESSIONAL PSYCHOLOGY PACIFIC UNIVERSITY HILSBORO, OREGON

BY
ALAN R. SILVER

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

July 12, 2012

APPROVED:
Michael Christopher, Ph.D.
Abstract

HIV+ gay men experience significant mental health distress related to HIV status, including anxiety and depression (Leiphart, 1998). One major source of this distress is social stigma related to HIV status and sexual orientation, such as more societal blame for gay men contracting HIV than heterosexual men for contracting HIV (Herek, 1999; Herek & Capitanio, 1999). There has been significant evidence to support the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing distress related to social stigma and chronic illness (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010). However, researchers have not explored the utility of ACT in treating distress in HIV+ gay men. The goal of the current study is to explore the potential effectiveness of ACT in treating HIV+ gay men. The participants were five therapists who worked with HIV+ gay men over a year. The participants were asked questions that reflect the six therapeutic processes of ACT: (1) being present, (2) defining valued directions, (3) committed action, (4) self as context, (5) cognitive defusion, and (6) acceptance (Luoma et al., 2007). The researcher defined five categories based on interviews with the participants: (1) social stigma hinders HIV+ gay men, (2) staying in the present, (3) accepting and disconnecting from thoughts and feelings, (4) consider events separate from self, and (5) finding meaning to define committed action. The participants supported the use of ACT for treating distress among HIV+ gay men, such as the importance of HIV+ gay men remaining present focused.

**KEYWORDS:** (1) HIV/AIDS; (2) Gay men; (3) Acceptance and Commitment Therapy; (4) Qualitative Research; and (5) Social Stigma
## Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Literature Review</td>
<td>5</td>
</tr>
<tr>
<td>Method</td>
<td>16</td>
</tr>
<tr>
<td>Results</td>
<td>19</td>
</tr>
<tr>
<td>Discussion</td>
<td>32</td>
</tr>
<tr>
<td>References</td>
<td>37</td>
</tr>
<tr>
<td>Tables</td>
<td>44</td>
</tr>
<tr>
<td>Table 1: Participant Demographics</td>
<td>44</td>
</tr>
<tr>
<td>Table 2: Categories and Subcategories Identified by Participants</td>
<td>45</td>
</tr>
<tr>
<td>Appendices</td>
<td>46</td>
</tr>
<tr>
<td>Appendix A</td>
<td>46</td>
</tr>
<tr>
<td>Appendix B</td>
<td>49</td>
</tr>
</tbody>
</table>
Acceptance and Commitment Therapy (ACT) for HIV+ Gay Men: A Qualitative Analysis

According to the Centers for Disease Control and Prevention (CDC, 2012a), there are roughly one million individuals living with HIV in the United States and 50,000 more Americans become infected with HIV each year. The CDC found that men who have sex with men (MSM) accounted for the most number of new HIV infections in 2009 and that they are the population most impacted by the HIV epidemic. MSM include homosexual men, bisexual men, and other men who have sex with men. Although 2% of the general population is MSM, 61% of individuals infected with HIV each year identify as MSM. In addition, 49% of individuals living with HIV in 2008 identified as MSM. Overall, 286,000 MSM have died due to complications related to HIV/AIDS (CDC, 2011).

Individuals who are diagnosed with HIV experience significant emotional distress, including anxiety and depression (Leiphart, 1998). There are several reasons for this distress, including social stigma against HIV+ individuals (i.e., person diagnosed with HIV) and self-blame for HIV status (CDC, 2011; Cruess et al., 2003; Herek, 1999; Herek & Capitanio, 1999; Lee, Kochman, & Sikkeman, 2002; Leiphart, 1998; Leserman, 2003). Cognitive behavioral therapy (CBT) is a commonly used intervention for treating emotional distress related to HIV status. CBT works by encouraging clients to challenge irrational thoughts and beliefs (Daughters, Magidson, Schuster, & Safren, 2010; Lee, Cohen, Hadley, & Goodwin, 1999). CBT has been shown to be effective in reducing depression and improving medication adherence in HIV patients (Daughters et al., 2010; Lee et al., 1999). Therefore, CBT can be effectively used to treat a number of factors related to HIV distress.

Acceptance and Commitment Therapy (ACT) is an intervention that could prove to be effective in treating HIV related distress in HIV+ gay men. ACT is an intervention designed to
build acceptance of negative thoughts and emotions, as well as encourage individuals to actively seek out activities that match their individualized values (Luoma, Hayes, & Walser, 2007). This intervention has proven to be effective at improving quality of life and reducing distress related to social stigma for clients diagnosed with chronic health conditions such as HIV, epilepsy, and diabetes (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Lundgren, Dahl, & Hayes, 2008; Ruiz, 2010). There has been some evidence of the utility of ACT in treating distress and social stigma in HIV+ individuals, as well as with gay men (Moitra, Herbert, & Forman, 2011; Ruiz, 2010; Yadavia & Hayes, in press). However, there have not been any studies that have explored the utility of ACT in treating distress in HIV+ gay men despite the fact that gay men represent the highest proportion of new HIV cases. The intent of the current study is to understand how ACT could be effective in treating HIV+ gay men by exploring the perspectives of mental health professionals who have experience working with this population.

**Literature Review**

**General Biology and Psychology of HIV**

HIV can be transmitted through four bodily fluids: blood, semen, vaginal fluid, and breast milk (Marr, 1998). For example, a man who has sexual intercourse with an HIV+ woman can become infected with HIV through exposure to the woman’s vaginal fluid. The virus cannot be transmitted through air, saliva, tears, sweat, or skin-to-skin contact (CDC, 2012b). HIV is categorized as an autoimmune disease, which means that HIV infection eventually destroys an individual’s immune system. The body’s immune system protects an individual from many foreign antibodies and infections. Without the immune system, an individual’s body is unable to combat infection, and the individual will die. HIV, when untreated, can lead to a variety of conditions, including cancer, liver disease, and kidney disease. Specifically, HIV primarily
attacks CD4 immune cells (Marr, 1988). When the CD4 cell count drops below 200, an individual is considered to have AIDS. After an individual meets criteria for AIDS, their body is unable to combat infections and often die due to complications from other viruses and infections.

HIV can be treated by a variety of medications. Protease inhibitors, including atazanavir, reduce the ability of HIV to replicate in an individual’s body (AIDSmeds.com, 2008; LoBuono, 2003; Marr, 1998; Roche Applied Science, 2004). In addition, protease inhibitors can be used to reduce the ability of HIV to take hold in an individual’s body (AIDSmeds.com, 2008; Marr, 1998; Roche Applied Science, 2004). Antiretroviral medications, such as lamivudine, are more focused on deterring the ability of HIV replication in the body (Rathbun, Liedtke, Lockhart, & Greenfield, 2011). Medication regiments involve taking numerous types of medications throughout the day to reduce the effects of HIV and reduce potential side effects of the HIV medications, such as diarrhea and nausea (Montana Office of Public Instruction [MOPI], n.d.). An individual’s HIV regimen can include 12 or more pills a day and must be taken at exactly the right time each day. If an individual does not take medication as prescribed, the person’s body can become resistant to the HIV medication, and thus have to begin a new regimen (AIDSinfo, 2011). In addition, HIV medications can cost an HIV+ individual over $2,100 a month and there is limited government funding to provide access to HIV medications (DeNoon, 2006). Therefore, HIV medications can lead to a number of difficulties for HIV+ individuals, including monetary and physical strains.

HIV+ individuals experience significant anxiety, depression, grief, and anger related to HIV diagnosis (Leiphart, 1998). This symptomology is often a product of fears concerning death, stigma related to having the disease, and a lack of social support (Lee, Kochman, & Sikkeman, 2002; Leiphart, 1998). Social stigma and isolation from social support is linked with the
tendency of individuals to blame HIV+ men and women for their status, especially if they are homosexual (Herek, 1999; Herek & Capitanio, 1999). Also, Lee et al. (2002) found that individuals with high-internalized HIV stigma experienced higher rates of anxiety, depression, and hopelessness compared to individuals with low-internalized HIV stigma. Third, individuals who experience significant life distress reduce the ability of an individual’s immune system to combat infections (Leiphart, 1998; Vanable, Carey, Blair, & Littlewood, 2006). For an individual who is HIV+, further reduction of the immune system’s capability to fight infection can decrease the person’s lifespan. Therefore, treatment of psychological factors related to HIV stigma and social isolation is critical for HIV+ individuals.

**HIV and MSM Distress**

**Factors related to MSM rates of HIV.** Although men and women of any sexual orientation can contract HIV, the most commonly infected group is MSM, which represent only 2% of the general population (CDC, 2012a). Furthermore, MSM represent a majority of new cases of HIV each year. There are several reasons for higher rates of MSM diagnosed with HIV than non-MSM diagnosed with HIV. First, some MSM are seeking sexual partners through the Internet for casual sex and not using condoms, which increases the risk of contracting HIV (Benotsch, Kalichman, & Cage, 2002). Benotsch et al. (2002) found that MSM who used the Internet for casual sex were more likely than MSM who did not use the Internet for casual sex to have unprotected sex. Second, MSM are unlikely to seek out information about preventing HIV due to cultural stigma against MSM (CDC, 2011; Remafedi, 1987). Specifically, MSM youth experience verbal abuse and physical violence due to their sexual orientation because of cultural disapproval of MSM (Remafedi, 1987). Third, MSM are more likely to become homeless and engage in more risky sexual behavior to survive, which increases the risk of contracting HIV.
(Cochran, Stewart, Ginzler, & Cauce, 2002). Fourth, MSM individuals are likely to underestimate the severity of HIV due to the creation of antiretroviral medications, and thus put themselves at elevated risk for contracting HIV (CDC, 2011). These factors elevate the risk of MSM contracting HIV and other sexually transmitted diseases.

In addition to factors related to elevated rates of HIV in MSM, it is necessary to understand how the experiences of MSM contribute to distress, which can be exacerbated by HIV status. Specifically, HIV+ MSM may experience additional stress due to their MSM identity. Therefore, it is important to understand distress related to MSM identity before considering distress related to HIV status.

**Distress related to MSM identity and HIV Status.** There are significant stressors that MSM experience due to their sexual orientation that heterosexual men do not encounter. Lewis, Derlega, Berndt, Morris, and Rose (2002) conducted a study to examine the stressors related to sexual identity that are experienced by MSM and non-heterosexual women, including lesbians and bisexual women. The researchers found that non-heterosexual men and women experience significant distress related to sexual orientation, including concerns about showing affection to a same-sex partner in public and coping with societal discrimination against non-heterosexuals. In addition, the researchers determined that MSM experienced more significant distress related to issues concerning HIV/AIDS and fears associated with physical/verbal aggression than non-heterosexual women. These societal factors that contribute to non-heterosexual distress suggest that MSM are likely to experience more significant mental health issues due to fears related to sexual identity than heterosexuals (Lewis et al., 2002). In fact, MSM, as well as non-heterosexual women, were found to have higher rates of anxiety and depression than heterosexual men and women (Oswalt & Wyatt, 2011).
Anxiety and depression, as well as other forms of distress, appear to be an especially severe problem for MSM compared to heterosexual men and women (Lewis et al., 2002; Oswalt, & Wyatt, 2011). Stressors related to sexual orientation, including experiences of discrimination, significantly reduce the livelihood of this population. In addition, it is important to consider how these stressors may contribute to physical and emotional distress in HIV+ MSM. This analysis is critical considering that stress can significantly reduce the immune functioning of an individual whose immune system is already compromised by HIV (Leiphart, 1998).

For HIV+ MSM, distress related to sexual orientation could enhance the deterioration of the body’s immune system, and thus shorten these individual’s life expectancy (Leiphart, 1998; Leserman, 2003; Leserman, 2008). Cole, Kemeny, Taylor, Visscher, and Fahey (1996) found evidence that gay men who conceal their sexual orientation experience more rapid progression of HIV than gay men who do not conceal their sexual orientation. Specifically, gay men who concealed their sexual orientation had fewer CD4 cells (i.e., immune system cells) than gay men who did not conceal their sexual orientation. These results were found when anxiety, depression, and other demographic factors were held constant to determine if the results were due to psychologically inhibition. In Cole et al.’s study (1996), individuals who did not reveal sexual orientation were considered to be psychologically inhibiting their sexual identity. Therefore, it appears that distress related to sexual identity can reduce an individual’s ability to combat the progression of HIV.

HIV+ MSM experience considerable distress related to social stigma due to sexual orientation and HIV (CDC, 2011; Herek, 1999; Siegel, Lune, & Meyer, 1998). One of the main sources of distress related to sexual orientation is societal stigma. Herek and Capitanio (1999) found that heterosexual Americans continue to equate HIV/AIDS with MSM, which was found
to be associated with negative views towards MSM. Furthermore, Herek and Capitanio reported that participants tended to blame HIV+MSM more than HIV+ heterosexuals for contracting HIV. Social stigma related to HIV can reduce adherence to HIV medication, as well as diminish social support, physical health, and emotional wellbeing (Logie & Gadalla, 2009; Rintamaki, Davis, Skripkauskas, Bennett, & Wolf, 2006). In addition, sexual orientation can increase the detrimental effects of social stigma (Kamen et al., 2011). For example, Kamen et al. (2011) found that HIV+ MSM experienced more symptoms of trauma and dissociation, including depersonalization and numbness, than HIV+ heterosexual men when rates of trauma were equivalent for both groups. As the evidence suggests, emotional distress related to societal stigma due to HIV can be exacerbated by discrimination and fear related to sexual orientation (Herek, 1999; Herek & Capitanio, 1999; Kamen et al., 2011; Logie & Gadalla, 2009; Rintamaki, Davis, Skripkauskas, Bennett, & Wolf, 2006).

In contrast to earlier research, Lee, Kochman, and Sikkema (2002) found that HIV+ MSM experienced lower levels of internalized HIV stigma than HIV+ heterosexuals. However, it is plausible that the elevated rate of internalized HIV stigma in heterosexuals may be related to the association of HIV with MSM. Specifically, HIV+ heterosexuals may experience high rates of internalized HIV stigma due to societal associations of HIV with MSM (Herek & Capitanio, 1999; Lee et al., 2002). For example, heterosexuals may fear being associated with HIV due to the perceived societal link between HIV and MSM, including the belief that HIV+ MSM are responsible for their HIV status (Herek & Capitanio). Therefore, it is important to consider societal stigma related to sexual orientation for HIV+ individuals when treating this population.

There is substantial research to suggest that HIV stigma and sexual orientation can lead to negative physical and mental health consequences. However, it is necessary to understand how
specific sexual orientations within the MSM spectrum may influence levels of distress related to HIV. These specific sexual orientations include gay men and bisexual men. The next section will explore how gay men and bisexual men differ due to societal factors and how these factors may influence coping related to HIV.

**Division of MSM Population**

There are several distinctions between the experiences of bisexual men and gay men that could influence these men’s experience with HIV. Although gay men have been associated with HIV by heterosexuals, bisexual men have been viewed as the catalyst for the spread of HIV and other sexually transmitted illnesses (STIs) between homosexual and heterosexual populations (Herek, 2002). Therefore, bisexual men experience discrimination from both homosexual and heterosexual populations. Furthermore, bisexual men experience significantly more suicidal ideation and hopelessness than gay men and lesbian women (Oswalt & Wyatt, 2011). This elevated rate of mental health distress is consistent with the discrimination experienced by bisexual men. There has been little research exploring the factors related to treatment of HIV with bisexual populations only. The majority of statistics and research exploring HIV/AIDS have investigated gay men or MSM, without acknowledging the distinction between gay men and bisexual men, and thus the exploration of issues related to bisexuality are beyond the scope of this study.

**Conclusions of HIV and MSM**

The evidence suggests that MSM experience significant distress due to factors related to HIV and sexual orientation, including discrimination and internalized-homophobia (Cole et al., 1996; Logie & Gadalla, 2009; Rintamaki et al., 2006). For example, HIV+ gay men who conceal their sexual orientation experience more rapid deterioration of their immune system than HIV+
gay men who do not conceal their sexual orientation (Cole et al., 1996). Bisexual men experience differing discrimination due to sexual orientation than gay men and research is lacking on how bisexual men experience mental health symptoms related to HIV. As a result of this lack of research on bisexual men, only gay men will be explored in this study. The following section will explore Acceptance and Commitment Therapy (ACT) to recognize how this modality could be beneficial for treating HIV+ gay men.

Understanding Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) was designed to decrease distress, including anxiety and depression, through increasing an individual’s ability to accept emotional and physical pain as part of the human experience (Hayes, Strosahl, & Wilson, 1999; Luoma et al., 2007). ACT was developed through Relational Frame Theory (RFT). The core of RFT is that language is used to develop associations between stimuli that are often based on the individual’s environment and culture (Blackledge, 2003; Luoma et al., 2007). For example, an individual may develop an association between gay men and HIV based on learning from family members and friends. Therefore, a gay man could learn to associate the construct of “gay” with the construct of “HIV,” and thus believe that as a gay man he is destined to get HIV or is the source of HIV. This thought process could cause significant distress, including depression and anxiety. Therefore, the goal of ACT is to reduce the negative influences of language and assist others in formulating their own desired ways of living through mindfulness and acceptance processes, as well as commitment and behavior change processes (Luoma et al., 2007). These two processes aid people in being more psychologically flexible, which involve adapting to specific situations based on someone’s values.
Mindfulness and acceptance processes. Mindfulness and acceptance processes involve four aspects: acceptance, being present, cognitive defusion, and self as context (Luoma et al., 2007). First, acceptance involves accepting negative thoughts and emotions rather than attempting to alter the frequency of these internal experiences. For example, an individual could learn to accept anxiety-related thoughts and not attempt to reduce the frequency of these thoughts. Specifically, ACT clinicians view the attempt to avoid negative thoughts as the source of suffering. If an individual attempts to not think about negative thoughts, he or she will be more likely to think about those thoughts. Second, being present in the moment is important to ensure that individuals are able to avoid perseverating about the past or future, which can lead to distress. For example, an individual who consistently thinks about past mistakes will be more likely to feel depressed. Third, cognitive defusion involves the concept that thoughts can be viewed simply as thoughts and not as absolute truth to reduce the power of negative thoughts and beliefs. The final mindfulness and acceptance process, self as context, involves separating the self from events. For example, if an individual separates events from himself or herself from a negative event, he or she is less likely to feel depressed or anxious over an undesirable situation. The following section will describe the commitment and behavior change processes that occur after the mindfulness and acceptance processes.

Commitment and behavior change processes. Similar to the mindfulness and acceptance processes, commitment and behavior change processes involve being present and self as context (Luoma et al., 2007). In addition, commitment and behavior change processes involve two other aspects: defined valued directions and committed action. First, an ACT clinician would aid an individual in finding values that match his or her self-defined values (i.e., defined valued directions). For example, a clinician can assist a client in determining that he or she wants more
friends based on his or her values and not values dictated by society. Second, a person can perform committed actions based on his or her self-defined values. For example, if an individual desires to be more social, he or she can do more activities to make more friends, including social support groups. These two aspects, defined valued directions and committed action, in addition, encourage people to act in accordance with his or her own beliefs.

ACT clinicians aid clients in developing psychological flexibility, as well as determining self-defined values (Luoma et al., 2007). Clients can learn to accept negative thoughts as part of the human experience and resist the urge to replace negative thoughts with positive ones. Furthermore, clients can learn to perform actions that are consistent with their self-defined values. There is significant evidence to support the validity of ACT in treating a variety of conditions, including distress related to chronic illness and low-self esteem (Dahl, 2004; Hinton & Gaynor, 2010; Ruiz, 2010). Hayes et al. (2006) found, in a review of the literature, that ACT was more effective, at reducing mental and physical health distress than traditional therapies, including CBT. For example, Hayes et al. (2006) reported, based on outcome results, that ACT was more effective at increasing speaking time for individuals with social phobia than Group CBT. The weighted mean effect size based on the twelve studies that compared ACT to traditional therapy was an average effect size (Cohen’s $d = .48$). Hayes et al.’s (2006) results for the effectiveness of ACT appear promising. The next section will explore the effectiveness of ACT in treating chronic health conditions and mental health distress, including the potential effectiveness of ACT with treating HIV-related distress.

**ACT and Chronic Illness**

There has been significant evidence to support the efficacy of ACT in treating psychological distress related to chronic illnesses, including epilepsy and diabetes (Dahl et al.,
2004; Gregg, Callaghan, Hayes, & Glen-Lawson, 2007; Hayes et al., 2006; Lundgren et al., 2008; Ruiz, 2010). Ruiz (2010), in a review of ACT, found evidence that experiential avoidance is a major source of distress related to chronic illness. Specifically, experiential avoidance is the attempt to avoid undesirable thoughts, emotions, and physical symptoms, including pain. This avoidance leads patients with chronic illnesses to feel more distress from physical and emotional pain because they are unable to accept their distress. However, researchers utilizing ACT have shown that ACT significantly improves distress related to mental and physical distress by encouraging clients to accept that they will experience negative thoughts and physiological experiences, and thus avoid expending energy to avoid negative experiences. Dahl et al. (2004) found that ACT significantly reduced the frequency that individuals needed medical care and the number of missed work days due to chronic pain and stress compared to participants in the medical treatment as usual condition. The researchers proposed that these participants were able to accept that they will feel pain and not attempt to avoid physical distress (Dahl et al., 2004). In addition, Gregg, Callaghan, Hayes, and Glen-Lawson (2007) found that participants in the ACT and diabetes education condition were more likely to use coping strategies, report diabetes-self care, and blood glucose within normal range compared to individuals with diabetes who received education only. Gregg et al. (2007) also found that acceptance of pain and distress mediated the improvements in individuals with diabetes. (Based on the evidence, ACT appears to be effective at reducing mental health distress and chronic pain in individual’s suffering from chronic health conditions. Therefore, it is necessary to explore the potential effectiveness of ACT in reducing distress related to HIV+ gay men.

**Potential Utility of ACT in Treating HIV+ Gay Men**
There is potential for treating HIV+ gay men using ACT. In addition to the evidence supporting effectiveness of ACT in treating psychological pain and physiological suffering in chronic illnesses, including HIV medication adherence, ACT has been shown to effectively reduce distress related to social stigma (Gregg et al., 2007; Dahl et al., 2004; Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; Moitra et al., 2011; Yadavia & Hayes, in press). Moitra et al. (2011) found that an acceptance-based treatment was effective for HIV+ individuals in improving medication adherence to HIV medication. As previously described, one of the main sources of distress for HIV+ gay men is social stigma due to sexual orientation and HIV status (CDC, 2011; Herek, 1999; Kamen et al., 2011; Siegel, Lune, & Meyer, 1998). ACT has been found to be effective in reducing distress related to social-stigma experienced by gay men and women due to sexual orientation (Yadavia & Hayes, in press). Although Yadavia and Hayes did not find a reduction in thoughts related to social stigma in gay men and women, the authors did find that participants reported less distress related to these thoughts. The reduction of distress related to sexual orientation is necessary to ensure physical vigor in HIV+ gay men, including immune system health (Cole et al., 1996). Therefore, it appears that ACT could be an effective method for treating HIV+ gay men.

**Present Study**

There is consistent evidence to support the effectiveness of ACT in treating chronic health issues, social stigma problems, and sexual orientation concerns. Regrettably, no researchers have explored the utility of ACT in treating distress related to HIV+ in gay men. It was hypothesized that gay men would benefit from reducing the tendency to suppress negative thoughts and emotions, as well as find self-defined values of living. The following thesis
explored the potential utility of ACT by interviewing therapists who have experience working with HIV+ gay men.

**Method**

**Participants**

The participants were five therapists: two female and three male. The mean age of the participants was 36.8 years old, and the age range was 27-43 years old. All participants identified as Caucasian, and practiced therapy in the general Portland area (e.g., Portland, Beaverton, and Hillsboro). Three participants identified as gay, one identified as lesbian, and one identified as heterosexual. The participants obtained several different types of degrees: one obtained a Masters of Science in Clinical Psychology, and is working towards a Doctorate in Clinical Psychology (i.e., Psy.D.); one obtained a Masters of Science in Psychology, and is working towards a Psy.D.; one obtained a Psy.D.; one obtained a Doctorate in Psychology (i.e., Ph.D.); and one obtained a Masters in Social Work (i.e., MSW). The range of time that the clinicians conducted therapy was 2.5-11 years. The clinicians conducted therapy with HIV+ gay men from 1.5-11 years. The clinicians adhered to various theoretical orientations: one identified as an integrationist, and had formal training in dialectical behavioral therapy (DBT) and cognitive behavioral therapy (CBT); one clinician used theories related to Adlerian individual psychotherapy and eye movement desensitization and reprocessing (EMDR) therapy; one clinician identified as a gestalt therapist; one clinician identified as an eclectic, and incorporates CBT and ACT into treatment; and one clinician identified as eclectic and humanistic (See Table 1).

**Procedure and Materials**
The participants were identified through an Internet search for clinicians who practice therapy with HIV+ gay men. The participants were contacted by phone or email to participate in the study. Participants who conducted therapy with HIV+ men for over a year and practiced therapy in the general Portland area were included in the study. If participants did not meet these exclusionary criteria, they were not interviewed. The interview times ranged from 27-35 minutes, depending on how much information the clinician presented. The researcher conducted the interviews in person at each participant’s place of business, and each interview was recorded with an audio recorder.

Each participant was provided with a consent form to read and sign before the interview (Appendix A). The researcher acquired information from the participants through a semi-structured interview (see Appendix B). First, the participants were asked open-ended questions to acquire demographic information, including age and sexual orientation. Following the demographic questions, the participants were asked open-ended interview questions. Each question consisted of two or more probing questions to clarify the information. Furthermore, additional questions were asked to gather more detail and clarify a participant’s response. These questions were created to reflect the six therapeutic processes of ACT: (1) being present, (2) defining valued directions, (3) committed action, (4) self as context, (5) cognitive defusion, and (6) acceptance (Luoma et al., 2007). Specifically, the fourth interview question reflects being present; the fifth interview question reflects acceptance; the sixth interview question reflects cognitive defusion; the seventh interview question reflects self as context; the eighth interview question reflects defining valued directions; and the ninth interview question reflects committed action. In addition, the third interview question was designed to assess how participants
conceptualize distress experienced by HIV+ gay men based on each participant’s theoretical orientation.

The interviews were later transcribed into Microsoft Word. The researcher maintained the audio recordings and transcriptions on a password-protected computer. These transcriptions and audio recordings were safeguarded at all times by the researcher. Each participant was assigned a code by the researcher, which included numbers and letters, to keep each participant’s identity separate from his or her responses. A master list was created to display which participant was linked to which code. The researcher kept the master list in a locked drawer.

**Qualitative Research**

The researcher used qualitative methods to explore the themes exhibited by the participants. Specifically, the researcher chose this method because it is useful for understanding phenomenon that has not been previously explored (Camic, Rhodes, & Yardley, 2003). In addition, qualitative research can be beneficial in understanding how cultural factors can affect a person’s response. For example, in this study, a participant who practices Gestalt therapy may conceptualize a case differently than a participant who practices CBT. Camic et al. reported that semi-structured interviews are often explored by qualitative analyses to generate theories, and thus this format was used in this study. Qualitative research was used in this study to aid the researcher in understanding how the participants conceptualize treatment for HIV+ gay men in relation to ACT.

**Transcription Analysis**

Following the transcription of the interviews, the researcher printed out the transcribed interviews to develop themes between the participants’ responses. Specifically, the researcher read the transcriptions thoroughly to find relationships. The researcher utilized grounded theory
to develop relevant theoretical models from the transcriptions (Camic et al., 2003; Saldaña, 2009). The researcher did not utilize statistical software because of the qualitative nature of the research, as well as the small sample size and short interviews.

The next stage of analysis involved coding the transcribed interviews. The researcher utilized axial coding to organize the participants’ responses into categories and subcategories (Saldaña, 2009). In addition, Saldaña noted that axial coding is commonly used for grounded theory research. First, the researcher highlighted relevant statements made by the participants in the Microsoft Word document. Second, the researcher created tables within the same Word document to take notes on the highlighted statements. Third, the Word document was printed, and the researcher separated each interview into separate packets. Fourth, the researcher used color-coding to label the subcategories and categories. Fifth, the categories and subcategories were developed and typed out using the highlighted statements and typed notes.

Results

Two analyses were performed: First Cycling and Second Cycle methods. The First Cycling method was initial coding, which involved coding each transcript line-by-line (Saldaña, 2009). The coded lines were explored within each participant’s interview and between interviews to find repeated themes. Second, axial coding, a Second Cycle method, was utilized to reduce the number of codes created from initial coding, and label statements or ideas that occurred in most of the interviews as subcategories. Third, the subcategories were grouped into overarching categories to provide more meaningfulness and structure to the data (see Table 2). The categories and subcategories were created to assess the potential utility of ACT theoretical concepts for treating HIV+ gay men. The researcher found 6 main categories based on the analysis: (1) social stigma hinders HIV+ gay men, (2) staying in the present, (3) accepting and disconnecting from
thoughts and feelings, (4) consider events separate from self, and (5) finding meaning to define committed action. The following section will discuss each category and subcategory in depth.

Social Stigma

All five of the participants indicated that HIV+ gay men experience distress related to social stigma. The participants reported several social factors that contribute to distress among this population, including societal blame for HIV status and lack of social support from family. One participant described the negative affects of social stigma.

There is tremendous amount of negative stigma around HIV. Societal stigma. There is an assumption that you know people were doing drugs and having unsafe sex and living a party lifestyle and so when people become infected there is a feeling of "oh I've been a really dirty slut." So they internalize all these negative internal characteristics.

Societal blame for HIV status. All of the participants indicated that HIV+ gay men are consistently blamed by society for their HIV status. Specifically, the participants indicated that society condemns HIV+ gay men for their status because homosexuality is still not fully accepted by the society at large. One participant described how society views people who contract HIV as responsible for their HIV status.

I work with folks who have cancer and I work with folks, who have HIV, and definitely people feel sorry for the person with cancer and there is a lot of societal blame on the person with HIV. Like “you did this to your self,” and so I think people really internalize that, it really eats them up. Let's see, what other kind of societal factors can I think of, even in this day and age, there is tremendous amount of negative stigma around HIV. Societal stigma. There is an assumption that you know people were doing drugs and having unsafe sex and living a party lifestyle and so when people become infected there
is a feeling of "oh I've been a really dirty slut, I've been..." etc. So they internalize all these negative internal characteristics.

Another participant indicated that HIV has been considered a “gay disease,” and HIV+ gay men experience discrimination from the gay community and the heterosexual community.

I guess the overall stigma of what it means to be HIV+ is the first piece of it, particularly due to the history of AIDS/HIV in this country and how it was traditionally perceived to be a gay disease. I think that's one of the biggest factors. Also the factor of within the gay community there is a lot of stigma towards gay men who have HIV. The commonly used term of how people describe their status: "are you clean, drug and disease free" like those kinds of statements builds an even larger stigma to something that is already difficult to deal with.

Furthermore, all of the participants indicated that HIV+ gay men experience more societal blame for their HIV status than HIV+ straight men.

**Lack of social support.** A second factor related to social stigma is the lack of social support that is available to HIV+ gay men. Three of the five participants reported that HIV+ gay men are unable to obtain social support due to social stigma. One participant reported:

The stigma of "I don't want my family to know, I don't want my friends to know, I don't want the community at large to know," prevents them from even reaching out to engage in therapy, to engage in group support, or even get free services, like there is an HIV day center here in Portland that offers free meals to people who are positive.

A second participant reported that HIV+ gay men have difficulty accessing health care services. In addition, another participant reported that individuals lose friends and family due to their status.
They feel like their friends dropped them when they were diagnosed. I was really surprised that their gay male friends would not be more understanding about it with all the education and experiences through the 80s and 90s. I was shocked to hear people say that “half my friends don’t talk to me anymore.” I had no idea that could be possible.

**Staying in the Present**

After being asked about their views about HIV+ gay men remaining in the present, all of the participants indicated that it was essential for HIV+ gay men to remain in the present. Over half the participants indicated that being present focused assists clients in being more psychologically flexible to reduce distress. In addition, all five participants indicated that HIV+ gay men should avoid ruminating about the past and present. However, four participants reported that it is necessary for HIV+ gay men to consider past experiences to comprehend the present. One participant indicated that understanding the client’s past encounters is essential for understanding the client’s present experiences.

There is a lot of stigma attached with that. So they are coming and talking about the shame and stigma of this disease and the question I have is, what are times you have had shame and stigma? And it might relate to their experiences growing up as a gay male. So then I would argue that the shame and stigma that they feel today is likely higher than if they hadn't had their shame and stigma experiences and so that's what I mean. I need to understand other experiences they've had that contribute to their reaction today.

**Flexibility in the present.** Three of the participants indicated that HIV+ gay men who stay in the present moment could react more flexibly to psychological distress. One participant reported that “by being present with and being aware of what is true here and now allows for a
greater deal of flexibility for moving forward and allows for whatever changes that want to be manifested.” Another participant reported:

The notion of wanting to control things that you don't have control over. You can't be chronically sick in this country without becoming very poor. A lot of the people I see are HIV+ and there are always worries and stresses about finances and what is going to happen next and again that keeps them from being able to cope with what's right in front of them. Overall, these three participants reported that HIV+ gay men who remain in the present are able to deal more effectively with distress and make desired changes than HIV+ gay men who are stuck in the past or future.

Avoid over-identification with past/future. All of the participants indicated that it was detrimental for HIV+ gay men to focus on the past or future. Several participants indicated that over-identification with the past or future can lead to anxiety or depression, respectively. One participant reported:

Lot of self-blame, lots of opportunities for self-blame and that's the realm of depression there. Rehashing old events, old traumas, and coming from a trauma model, a person got to the place where they are HIV+ is a whole series of traumas lined up in a way that many of those conditions resulted in them not taking good care of themselves and so then staying focused on the past keeps a person focused on those traumas and keeps them stuck and some way of not being able to deal or cope with their situation. Worrying about the future is the realm of anxiety, which is the notion of wanting to control things that you don't have control over.

The participants also indicated that ruminating about the past or future detracts from HIV+ gay men’s ability to deal effectively with the present. For example, one participant reported, “I can
Imagine if somebody just started feeling, "things were so much better before the diagnosis," and you could get stuck there. There is a danger of being stuck, if you are thinking too much about the past.” These participants appear to view over-identification with the past or future can reduce an individual’s ability to remain in the present.

**Understand past to comprehend the present.** Three of the five participants indicated that it is critical to explore the past of HIV+ gay men understand their present circumstances. One participant reported that it is important for HIV+ gay men to deal with their past as long as they do not dwell on it.

So many of them who come to me have a lot of traumatic experience or a lot of rejection for being gay already, or other traumatic history. I think it's good to deal with it, but I think it's not good to dwell on it or spend a lot of time just like telling and retelling stories from the past.

Another participant reported, “To say [about the past], given that [individual’s past], "how are you moving or given that, how are you functioning now?” Yes potentially detrimental but certainly necessary as well.”

**Accepting and Disconnecting from Thoughts and Feelings**

Although in varying degrees, all five participants indicated that it was necessary to accept thoughts and feelings that can cause distress. Specifically, all of the participants indicated that suppression of negative thoughts can lead to negative outcomes; acceptance improves an individual’s ability to react flexibly to distress; and over-identification with negative thoughts increases distress. However, one participant reported that it was necessary to challenge thoughts related to a person’s worth.

When we are talking about negative thoughts I would distinguish between, "I am a bad
person, I deserve this. This is God's retribution because I'm gay." Those thoughts I would challenge. To me those thoughts are different then "I have this diagnosis and I'm not happy about it and I don't like it." I would certainly challenge the first ones that "I'm a horrible person," and I would do like the CBT challenge of negative thoughts. The other part I would accept. Even challenging the negative thoughts, I think again, sometimes you can just mind watch with them. That's a balance too. I'm not just going to let somebody mind watch the idea that this is God's retribution for them because they are gay. I'm going to challenge that a little bit.

**Negative outcomes with suppression.** All five participants indicated that HIV+ gay men experience negative outcomes when they attempt to suppress harmful thoughts and emotions. One participant reported that individuals decrease their ability to manage their emotions by attempting to suppress them.

We know that avoidance increases anxiety. So you have a stressor here, in this case the stressor is the HIV disease. It’s uncomfortable to think about it, to talk about it. So we put energy into avoiding it because we think that it’s going to help us feel better. But then we just keep avoiding it, and it grows when we just really need to address it. I always tell people if we avoid our emotions they build and they explode.

Several participants indicated that suppression of negative thoughts and emotions is linked to negative health outcomes, including reduced immune functioning. One of the participants reported:

Both anxiety and depression are normal phenomenon. Then the depressed person wants to control it, wants an immediate end to that and through that thrashing around makes the depression worse. The same way with anxiety, and so on that level, on the basic human
level not accepting the immediate situation makes it worse. Add into that the dimension of HIV, in that struggle, in that emotional struggle creating a lot of physiological conflict in our bodies, cortisone levels increase and changes digestion. So the person who is constantly trapped in worrying or constantly trapped in depression there literally changing their physiology and then add to that HIV, which is already an uphill battle, and is changing physiology, there is some pretty good evidence that they are hastening their health decline with that emotional struggle.

Several participants indicated that they educate clients, in their work, about the negative effects related to suppression and the benefits of acceptance (e.g., avoid angry outbursts).

**Increase flexibility and decrease energy use with acceptance.** All five of the participants indicated that accepting negative thoughts and emotions could improve an HIV+ gay man’s ability to be psychologically flexible and reduce an HIV+ gay man’s energy expenditure. Several participants described how acceptance can reduce the energy they expend. One participant indicated that acceptance of negative thoughts assists HIV+ gay men cope with negative views expressed by others about HIV.

People should not treat you badly because of this. But some people will and at some level you have to accept that because you don't hurt anyone but yourself by becoming upset about it. They don't care, I mean they are going to say bad things about you if they want to, and whether or not you get upset that’s usually the farthest thing from their mind. And so that the acceptance of those thoughts and those feelings can actually help them to not give so much power to the other person and to empower themselves.

Participants indicated acceptance aids HIV+ gay men in reacting more flexibly to distress and avoid getting stuck in their thoughts. One participant described how clients often do not consider
where there distress comes from.

I think that the more that a person can connect with what is true, the greater the flexibility, the greater the affirmation, the greater the self-awareness that they have to move forward on their own terms. I think that's a general principle in the way that I work, that accepting what is and then moving forward. Sometimes that has to be broken down for people because, let's say, "accepting what is, that I am very angry at myself for being HIV+." But in between being HIV+ and "being angry with myself [example client]," are a whole number of factors around stigma … about gay men that the client may be skipping over, and just going from HIV+ to, "I hate myself," and then breaking that all down in between, sort of processing what is, not just acknowledging yes you are angry at yourself for being HIV+, for example. But really processing every little piece that makes up that experience for him can only help him to be more aware of his experience and be able to move forward or get the support, whatever it may be.

**Avoid over-identification with thoughts.** When the participants were asked about over-identification with thoughts, all the participants reported that it is essential for HIV+ gay men to avoid over-identification with negative feelings and beliefs. Several participants indicated that HIV+ gay men often consider their thoughts and feelings as an objective reality. In addition, numerous participants described how some clients react to negative thoughts and emotions, as well as what actions could improve the situation, with one participant reporting:

I've been asked to intervene more than once with clients who got really angry with their doctors, and said threatening things to their doctors. They can't go around threatening your doctor all the time. But from a place of anger and then believing, “I have to do something with this anger” and then having an action is regrettable. I think if people could learn this
skill, first of all observing their mental actions and observing how mental actions watching
how things arise how long actions sustain themselves and then watching how they drop off.
I think people would have a different understanding. Anger is fleeting, depression is
fleeting, and anxiety is fleeting.
Furthermore, several therapists indicated that the goal of therapy is often to reduce the emphasis
on negative thoughts and emotions.
The point of therapy would be to look at that adjustment, that way to understand things,
and really tear it apart and process in a way that might allow a person to see that there are
other ways of thinking, other ways of feeling about, other ways of experiencing those
events. That actually happens a lot where clients will come in and they describe over
identifying the way they have explained how things happened in their life.

Consider Events Separate from Self

The participants were asked about their viewpoints related to understanding events outside
the self. All of the participants believed that it was crucial for HIV+ gay men to view events as
being outside themselves, especially HIV status. However, several participants indicated that
HIV+ gay men should avoid completely separating themselves from life events.

Understand self outside of context of HIV. All five participants suggested that HIV+ gay
men should consider themselves outside the context of HIV. Specifically, the participants
reported that HIV+ gay men should not only describe their identity their HIV status. One
participant reported, “I think that’s very helpful [separating self from events] and I think that’s
what balances. Recognizing the thoughts, feelings, and emotions are a part of us, but that it’s not
all of us.” In addition, another participant described how HIV+ gay men often include HIV as
their entire identity, and that they can have separation from their HIV status.
But I also think that people should not pigeon hole themselves, everyone is already going to do that enough to them. "An HIV+ gay man, I know all about you" kind of thing, and for them to remember that they have a whole world of interests and thoughts and feelings that are totally unrelated to those things or that are painful for them.

**Limit separation of self from events.** Four of the participants indicated that it is necessary for HIV+ gay men to avoid separating themselves fully from events. Specifically, these participants indicated that HIV+ gay men should avoid concluding that all events or situations are outside themselves. For example, one participant reported:

> Like all things, you can take that to an extreme that is not healthy and if you projected everything as an external cause or an external source, you would never take responsibility for anything. Back to acceptance and commitment model, accepting some conditions that are way beyond our control but then taking committed response to manage the things that are in our control.

Furthermore, most of these participants indicated that it is important to determine how all of the individual’s life experiences contribute to distress, with one participant reporting:

> Yah. I think that all parts of their identity are important for sure. Its very important and that’s why sometimes that's not the main topic of conversation because that's not what is on top, there might be something on top that's totally unrelated, some kind of work interaction that I think still helps them. Whatever we are working on helps them with the whole situation. Building skills and an interaction at work, and tolerating an emotion that comes up at work will help them to tolerate an emotion later on that comes around.

**Finding Meaning to Define Committed Action**

The final category, which all of the participants endorsed, is finding meaning to define
committed action. Specifically, this section will focus on how the participants assist HIV+ gay male clients find meaning in their lives, as well as engage in activities that match their valued meaning. One participant indicated, “I think that reassessing values and belief systems that they've had for most of their lives can be very beneficial in terms of helping them not go through life thinking some how broken or defective.”

**Guide individuals to find meaning.** All of the participants indicated that it is essential to assist HIV+ gay men define features that give their life meaning. Several participants indicated that it is important to discuss with HIV+ gay men what values they have. One participant reported:

So it starts with the conversation of this disease, as one part of you and there is more to it than that. But then just looking for experiences, relationships, things in their life that are meaningful to them and recognizing that the disease was one part of their life. But there is still a husband and a son and a brother and maybe a father, they have other roles. Whatever there profession is.

Other participants described the importance of finding valued meaning due to the uncertainty of the progression of HIV. For example, one participant reported:

I think some people come in and say that's what getting diagnosed did for them almost, then suddenly they felt like life had meaning; or they realize that, "oh time is limited and I need to do something important with my life or need to appreciate my life." To me that often ends up being the hook that helps somebody to turn around and feel better with almost any situation is this feeling that there is meaning and that there life is meaningful in someway.

Furthermore, several participants indicated that finding meaning could improve mental and
physical health of HIV+ gay men, with one participant indicating:

One of the big factors was people who had hobbies, people who had interests. People who took responsibility for their health on one hand and also created a lifestyle where there whole life wasn't about being HIV+ on the other hand. Encouraging someone to develop some interests outside of their own selves and their illness, something that keeps them engaged keeps the person proactively involved. There are a lot of wellness benefits to that.

**Engage in activities that match meaning.** All five participants indicated that they guide HIV+ gay men to engage in actions that match their valued meaning. Several participants indicated that there were activities that some HIV+ gay men could not pursue, including being employed. One participant reported:

> It helps them find leisure activities they didn't know they had or other ways that they can engage with other people either through community services or volunteer work. It makes them not feel like, "I'm this disabled person." and I don't use the term in the context of being physically disabled. I mean the societal view of what it means to be disabled, this idea that "I'm not productive." I find that values exercises and meaning exercises and guidance can help people figure out that "ok, maybe I can't work anymore because of my medication regiment or because maybe they have diarrhea all the time, but what can I do so that my life is fulfilling to me and I get joy out of it?"

Furthermore, some participants reported that HIV+ gay men should come up with activities on their own, with one participant reporting:

> It certainly has to be stuff that is directed by them. You can't be making suggestions, "have you thought about a cooking class or an art class, or something like that." It’s really exploring with them the whole idea of meaning and value and satisfaction with life.
Therefore, it appears to encourage HIV+ individuals to find values that relate to their valued meaning to provide confidence and support.

**Discussion**

The goal of this thesis was to assess the potential utility of ACT in treating mental health distress among HIV+ gay men. Previous research suggests that ACT is effective in treating individuals experiencing distress related to chronic illnesses, as well as treating distress related to being a sexual minority. In addition, evidence suggests that ACT is effective in treating distress related to social stigma. Contrary to previous research, this thesis explored the utility of ACT qualitatively. The study explored how therapists who work with HIV+ gay men conceptualize the utility of ACT. Specifically, the therapists were asked questions related to using the six therapeutic processes of ACT with HIV+ gay men. The following sections will explore the findings and limitations of the thesis.

The five participants were interviewed to explore the potential utility of ACT for treating HIV+ gay men. Five major themes or categories were found: (1) social stigma hinders HIV+ gay men; (2) staying in the present; (3) accepting and disconnecting from thoughts and feelings; (4) consider events separate from the self; and (5) finding meaning to define committed action. First, participants reported that HIV+ gay men experience distress related to social stigma, including experiencing blame for HIV status and lacking social support due to stigma. Second, the participants indicated that HIV+ gay men should remain present focused to react more flexibly to distress by avoiding over-identification with the past and the future. However, several participants indicated that HIV+ gay men should consider the past to understand the present. Third, the participants described how accepting and avoiding over-identification of negative thoughts could improve flexibility to distress and reduce energy spent on rumination. In addition,
the participants reported that HIV+ gay men should avoid over-identification and suppression of negative thoughts to avoid distress. Fourth, the participants suggested that HIV+ gay men should consider events outside of themselves. Specifically, the participants suggest that HIV+ gay men should consider themselves outside of their HIV status. However, several participants indicated that HIV+ gay men should avoid considering all events outside themselves to evade responsibility. A final finding, based on participant responses, is that HIV+ gay men should be encouraged to find meaning in their lives, as well as engage in activities related to their valued meaning.

The findings from this thesis support the evidence of past research based on the utility of ACT for individuals with chronic illnesses, as well as individuals who experience distress related to sexual orientation. The participants’ interviews supported evidence that HIV+ gay men are blamed for their HIV status and are isolated due to social stigma (Herek, 1999; Herek & Capitanio, 1999). Participants endorsed the importance of all six of the ACT therapeutic processes in the interviews: (1) being present, (2) defining valued directions, (3) committed action, (4) self as context, (5) cognitive defusion, and (6) acceptance (Luoma et al., 2007). For example, the participants reported that it was important for HIV+ gay men to accept negative thoughts and emotions related to distress, including the knowledge that people will discriminate against them due to their HIV status (i.e., acceptance). In addition, participants reported that HIV+ gay men should consider themselves outside their HIV status (i.e., self as context). However, inconsistent with previous studies, several participants described how limitations should be placed on some of the six therapeutic processes, including remaining in the present and self as context. For example, several participants reported that it was important to consider the past to understand the present. Overall, the participants appear to support the utility of ACT.
There are several limitations to this thesis. First, there was a small sample size, and thus it is inappropriate to generalize the results to therapists who work with HIV+ gay men in general. In addition, the sample size does not generalize to the population in general because the participants were only recruited in Portland, OR. Third, the qualitative analysis was used to explore the potential utility of ACT, and cannot be used to determine causal relationships (Camic et al., 2003). Specifically, the study cannot be used to demonstrate that all therapists who treat HIV+ gay men should utilize ACT treatment. Therefore, these results should be interpreted with caution.

Although this thesis has provided exploratory information about treatment for HIV+ gay men, there are several directions for future research. Future researchers could test the effectiveness of ACT through single case designs, which involve repeatedly measuring change among a small sample of participants. For example, researchers could assess whether HIV+ gay male participants experience changes in behavior, such as reduced suppression, after initiating an ACT treatment protocol. In addition, clients could compare ACT with other therapeutic interventions. For example, future researchers could determine if ACT is more effective at treating distress among HIV+ gay men than other forms of treatment, including CBT. Furthermore, researchers could consider the utility of ACT in treating HIV+ bisexual men, through quantitative or qualitative means. For example, researchers could use qualitative methods to understand how clinicians view the utility of ACT for treating HIV+ bisexual men. This thesis has opened the door for future research of the potential effectiveness of ACT for treating sexual minorities.

The thesis has provided a number of preliminary insights from mental health professionals for using ACT to treat distress in HIV+ gay men, including how reducing the impact of
rumination of negative thoughts and feelings can lead to improved quality of life. In addition, the participants clarified the extent to which HIV+ gay men can benefit from ACT concepts, such as not completely ignoring past experiences. Although this design is not comprehensive, the thesis has presented the opportunity for future research. This research will hopefully lead to more effective treatment options for HIV+ gay men who experience distress due to their sexual identity and HIV status.
References


Table 1

**Participant Demographic Information**

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Sexual Orientation</th>
<th>Years Practicing Therapy</th>
<th>Years Practicing Therapy with HIV+ Gay Men</th>
<th>Participant Theoretical Orientation(s)</th>
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*Note.* EMDR = eye movement desensitization and reprocessing; DBT = dialectical and behavioral therapy; ACT = acceptance and commitment therapy; CBT = cognitive behavioral therapy.
### Table 2

**Categories and Subcategories Identified by Participants**

<table>
<thead>
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<th>Categories</th>
<th>Subcategories</th>
<th>Number of Participants Who Supported Category or Subcategory</th>
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<tr>
<td>1. Social stigma hinders</td>
<td>1. Societal blame for HIV status</td>
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<td>HIV+ gay men</td>
<td>2. Lack of social support</td>
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<td>2. Staying in the present</td>
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<td></td>
<td>3. Understand past to comprehend the present</td>
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<tr>
<td>3. Accepting and</td>
<td>1. Negative outcomes with suppression</td>
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<tr>
<td>disconnecting from thoughts</td>
<td>2. Increase flexibility and decrease energy use with acceptance</td>
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<tr>
<td>and feelings</td>
<td>3. Avoid over-identification with thoughts</td>
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<tr>
<td>4. Consider events separate</td>
<td>1. Understand self outside context of HIV</td>
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<td>from self</td>
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<td>5. Finding meaning to define</td>
<td>1. Guide individuals to find meaning</td>
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<tr>
<td>committed action</td>
<td>2. Engage in activities that match meaning</td>
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Appendix A

1. **Study title**

   Acceptance and Commitment Therapy for HIV+ Gay Men: A Qualitative Analysis

2. **Study personnel**

<table>
<thead>
<tr>
<th>Name</th>
<th>Alan Silver (Master’s Candidate)</th>
<th>Michael Christopher, PhD</th>
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<tr>
<td>Role</td>
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<td>Faculty Advisor</td>
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<tr>
<td>Program</td>
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</tr>
<tr>
<td>Email</td>
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<td><a href="mailto:mchristopher@pacificu.edu">mchristopher@pacificu.edu</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>(253) 318-9983</td>
<td>(503) 352-2498</td>
</tr>
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</table>

3. **Study invitation, purpose, location, and dates**

   You are invited to participate in a research study exploring factors that may prove beneficial to treating HIV+ gay men in the therapeutic setting. You were invited to join this study because you are a therapist with extensive experience working with this population. The study will begin in January 2012 and end July 2012. This study will be conducted in Portland, OR.

4. **Participant characteristics and exclusionary criteria**

   Only therapists who have had at least one year of experience working with HIV+ gay men and practice in the Portland metro area will be allowed to participate in the study. Participants who do not meet this criterion will be excluded from the study.

5. **Study materials and procedures**

   If you agree to be in this study, the researcher will conduct a face-to-face interview with you. The interview will take 45-60 minutes to complete. All interviews will be audio-recorded using an audio recorder. All recordings will be stored on a password-protected computer. Each interview will be transcribed and paper copies of the transcriptions will be kept in a locked filing cabinet in the office of the Thesis Advisor. Once interviews are transcribed, the audio-recordings will be deleted. The transcribed interviews will be de-identified using coded participant numbers in place of participant names. There will be a master list that identifies which participant is linked to which number so that the information can be destroyed if you wish to withdraw from the study. The master list will be kept on a password-protected computer.
6. Risks, risk reduction steps and clinical alternatives
   a. Unknown risks
      Not applicable
   b. Anticipated risks and strategies to minimize/avoid
      Therapists may feel discomfort reporting their views on HIV+ gay men. If you feel
      uncomfortable at any time during the interview you may choose not to answer any of the
      questions and you may also withdraw from the study at any time. There is also a risk to breach of
      confidentiality. Therapists will not be required to disclose personal information nor that of their
      clients. If a therapist discloses identifying information about the client, the audio recording will
      be immediately stopped and then the disclosed information will be deleted. Further, if any
      identifying information does get recorded and is not caught at the time of the interview this
      information will not be transcribed. Keeping the audio recordings on a password-protected
      computer will reduce the risk of breach of confidentiality. Once the recordings or transcribed,
      they will be deleted. Each participant will be assigned a code in place of his/her name. Therapists
      will have the opportunity to dropout of the study at anytime.
   c. Advantageous clinical alternatives
      Not applicable

7. Adverse event handling and reporting plan
   In the event of a minor adverse event (e.g., disclosure of client information), the IRB at Pacific
   University will be contacted by the next business day. Further, if identifying information is
   accidentally disclosed about a participant or a client, that portion of the recording will be deleted.
   Additionally, if any identifying information does get recorded and is not caught at the time of the
   interview this information will not be transcribed. In the event of a major adverse event (e.g., severe
   discomfort on the part of the therapist or breach of confidentiality), the IRB at Pacific University will
   be notified within 24 hours. Further, the faculty advisor will be contacted immediately to address any
   concerns conveyed by the therapist. In the event of a breach of confidentiality, all participants known
   to have been affected will be contacted and given the opportunity to withdraw from the study.

8. Direct benefits and/or payment to participants
   a. Benefit(s)
      There are no direct benefits to participating in this study.
   b. Payment(s) or reward(s)
      Participants will not be paid for their participation.

9. Promise of privacy
   The records will be kept private and your information will be kept confidential. The transcribed
   interview will be de-identified using coded participant numbers in place of your name. The consent
   form you filled out will be kept separate from your responses. The consent forms and responses will
   be kept separately in locked file cabinets. The paper transcripts, electronic transcripts, and master list
   will be destroyed following the completion of the study (i.e., July 2012). Informed consent will be
   retained for no more than 3 years, and then destroyed. If this study is presented for publication, no
   information will be included that would reveal the identity of a participant.
10. Medical care and compensation in the event of accidental injury

During your participation in this project it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving complete medical care as a result of your participation in this study. If you are injured during your participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

11. Voluntary nature of the study

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. If you choose to withdraw after beginning the study your data will be discarded and there will be no penalty or compensation.

12. Contacts and questions

The researcher(s) will be happy to answer any questions you may have at any time during the course of the study. Michael Christopher can be reached at (503) 352-2498 and Alan Silver can be reached at (253) 318-9983. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. If you become injured in some way and feel it is related to your participation in this study, please contact the investigators and/or the IRB office. All concerns and questions will be kept in confidence.

13. Statement of consent

Yes  No

☐  ☐  I am 18 years of age or over.
☐  ☐  All my questions have been answered.
☐  ☐  I have read and understand the description of my participation duties.
☐  ☐  I have been offered a copy of this form to keep for my records.
☐  ☐  I agree to participate in this study and understand that I may withdraw at any time without consequence.
☐  ☐  I give permission for the researcher(s) to gather audio data for analysis, understanding that any published reports will not use my audio data in any form.

Participant’s signature

Date

Principal investigator’s signature

Date
Appendix B

Participant Code: _____________

Demographic Information

1. Age: _____
2. Gender: ______
3. Race/ethnicity: _____________
4. Sexual-orientation: _________________
5. Degree(s) obtained: _________________
6. Length of time practicing therapy: _________________

Thesis Interview Questions

1. How long have you been working with HIV+ gay men?

2. What societal factors do you believe hinder HIV+ gay men’s ability to cope with HIV?
   a. Probe: Do you feel that social stigma affects HIV+ gay men’s ability to cope? How so?
   b. Probe: Do you feel that HIV+ gay men experience social stigma that would differ from HIV+ heterosexual men?

3. What theoretical orientation/s do you identify with?
   a. Probe: How would you conceptualize distress related to HIV+ status based on theoretical orientation(s)?
   b. Probe: Are you familiar with ACT and mindfulness-based treatments? What do you know about them?

4. Do you feel that it would be more effective for this population to focus on the present? How so?
   a. Probe: Why would it be harmful for these individuals to focus on past events? Future events?
5. In what way do you feel that accepting thoughts and emotions related to distress about HIV is important for this population? For example, accepting thoughts that others will have biases against individuals who are HIV+.
   a. Probe: If you do not feel this way, why not?

6. In what way do you feel that over identifying with (or being fused with) thoughts may negatively contribute to distress among this population?
   a. Probe: How could attempts to suppress negative thoughts be related to distress among this population?
   b. Probe: Would it be beneficial to accept negative thoughts related to being an HIV+ gay male? How so?

7. Would it be beneficial to encourage these individuals to focus on events as being outside themselves?
   a. Probe: How would it be helpful for an HIV+ gay man to view himself outside the content of his thoughts and feelings?

8. How do you feel that guiding these individuals to find aspects that give their life meaning (i.e., in terms of meaning for the client) would be beneficial?

9. Would you guide these individuals to actively seek ways to make their lives match their valued meaning of what they want their life to look like? How so?

10. What ideas other ideas do you have for psychotherapy with HIV+ gay men?