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Can Self-Compassion Be Induced to Reduce Sexual Minority Stigma and Protect
Psychological Functioning?

A thesis
presented to
the faculty of the Department of Psychology
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Masters of Arts in Psychology

by
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August 2013

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Keywords: Stigma, Sexual Stigma, Self-Compassion, Fear of Negative Evaluation

ABSTRACT

Can Self-Compassion Be Induced to Reduce Sexual Minority Stigma and Protect Psychological Functioning?

by

Sheri Lynn LaDuke Chandler

Sexual minorities must deal daily with their stigmatized identities. Specifically, depression and anxiety as well as psychological distress and self-stigma are common among people with stigmatized identities. Self-compassion has been linked to enhanced psychological well-being and less negative feelings toward the self. The aim of this study was to investigate self-compassion as a potential buffer of the effects of sexual minority related rejection experiences on self-perceptions of stigma and psychological symptoms. Participants were randomly assigned to a self-compassion induction group versus 1 of 3 control groups (self-esteem only induction; expressive writing condition; true control) to examine whether self-compassion can be induced to reduce self-stigma, negative mood, and fear of negative evaluation. Results did not support hypotheses; analyses revealed nonsignificant effects for the self-compassion induction. However, results revealed a significant main effect for trait self-compassion predicting outcomes of decreased self-stigma, fear of negative evaluation, and negative mood, and increased positive mood.

TABLE OF CONTENTS

	Page
ABSTRACT.....	2
Chapter	
1.INTRODUCTION	5
Stigma	5
Definitions and types	5
Public and self-sexual stigma.....	7
Psychosocial implications of sexual stigma	9
Fear of Negative Evaluation Among Sexual Minorities.....	12
Self-Compassion as a Buffer Among Sexual Minorities.....	14
Theory and origins	15
Self-compassion and wellbeing	15
The Present Study	18
2. METHOD	21
Participants.....	21
Procedure	21
Self-compassion induction.....	22
Self-esteem induction.....	23
Writing control condition.....	23
True control condition.....	23
Measures	23

Demographics	23
Self-compassion (Part 1).....	23
Self-esteem (Part 1).....	24
Perceived stigma (Part 2).....	24
Fear of negative evaluation (Part 2).....	24
Mood (Part 2).....	25
3. RESULTS	26
Covariate Testing.....	26
Testing Effects of Conditions	27
Examination of the Moderating Role of Trait Self-Compassion	33
4. DISCUSSION.....	34
Study Limitations and Future Directions.....	40
Conclusion.....	41
REFERENCES	43
APPENDICES	51
APPENDIX A: Informed Consent Form	51
APPENDIX B: Demographic Questions	53
APPENDIX C: Table 3.....	55
VITA.....	56

CHAPTER 1

INTRODUCTION

Lesbians, gays, and bisexuals (LGB) belong to a stigmatized group referred to as sexual minorities. The harmful consequences of stigma in general and for sexual minorities have been vastly demonstrated in the literature. Indeed, a decade of research has shown increased depression, anxiety, and even suicidal ideation among those who identify as gay, lesbian, and bisexual largely due to minority stress such as stigma (Meyer, 1995). Additionally, sexual minorities fear negative evaluation that also is linked with negative psychological outcomes. Providing LGB individuals with coping resources to deal with the psychosocial implications of stigma may help to mitigate some negative effects of stigma. Self-compassion may be one coping resource that could limit the internalization of stigma (i.e. self-stigma) and protect psychological and social functioning. Through mindfulness, recognition of a common humanity, and self-kindness, self-compassion has shown positive psychological benefits. The researcher's goal for the present study was to examine this self-compassion resource to LGB individuals through experimental induction. If self-compassion can be induced to mitigate the negative effects of stigma for LGB individuals in an experimental design, the next step should explore how to implement self-compassion exercises into the daily lives of those experiencing this stigma. Thus, results in support of self-compassion's buffering capacity could have clinical implications.

Stigma

Definitions and types. Erving Goffman's definition of stigma is widely cited in the literature. Goffman's (1963) historical definition focuses on an individual's devalued identity or other characteristic that sets him or her apart from the general population. Over time, Link and

Phelan (2001) built on this understanding and conceptualized stigma as existing “when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (p. 377). This addition to the definition retains the basic concepts of what has been traditionally thought of as stigma and recognizes that the loss of power among those with a devalued identity or characteristic is an important component to understanding this concept.

A more social-cognitive approach depicts stigma as a social identity that is devalued (Crocker, Major, & Steele, 1998). Stigma begins with exposure to the negative stereotypes about a group of people that fosters devaluation of that group and those who hold that group identity. Consequently prejudice beliefs are born from these negative stereotypes. Discrimination occurs when behavior is congruent with the prejudices. The culmination of these negative stereotypes, prejudice, discrimination, and loss of resources is a stigmatizing situation, and often this results in a loss of power and resources for the devalued group.

The social-cognitive approach has been built on by others who have further distinguished the self and public components of stigma from the perspective of the stigmatized individual (Corrigan, 2004). Public-stigma is the experience of society’s negative regard toward the stigmatized group. Public stigma can be experienced both directly and indirectly. This can guide and limit the ways in which the stigmatized can interact with the community and interpersonally with others (Corrigan, 2004). This is done through both enacted (direct) and felt (indirect) stigma. Enacted stigma refers to the actual experience of prejudice or discrimination; whereas, felt stigma can be experienced by knowing enacted stigma does or could happen. Enacted or felt stigma can range from actual or anticipated name calling to criminal violence (Herek, 2007). By contrast, self-stigma is the internalization of these negative public attitudes and unfair treatment.

Self-stigma occurs when one applies these negative attitudes toward the self and results in shame (Corrigan, 2004).

Public and self-sexual stigma. Accordingly, Herek (2007) specifies sexual stigma as “the negative regard, inferior status, and relative powerlessness that society collectively accords to any non-heterosexual behavior, identity, relationship, or community” (pp. 906-907). It is also noted that sexual stigma differs from other stigmas in two important ways: 1) it can be concealed, which means anyone can be labeled a sexual minority; 2) in the U.S., sexual prejudice is sometimes accepted and proper. Indeed, it is common for sexual minorities to be denied rights and privileges afforded to heterosexuals as well as face social rejection and ostracism. For instance, with the exception of a handful of states, same-sex couples are not allowed to marry (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). Also, some states have yet to include sexual orientation in discrimination and hate crime laws (Hatzenbuehler, Keyes, & Hasin, 2009). Additionally, sexual minority youth are at an increased risk of bullying and ostracism (Hong & Espelage, 2012). Thus, sexual stigma is the devaluation of those who have a sexual orientation other than heterosexuality in such a way that limits opportunities afforded to those thought to have a heterosexual orientation or behaviors, can take a more aggressive role through verbal or physical harassment, and is often considered acceptable.

Prevalence rates of verbal abuse and violence or property crime against sexual minorities have been reported at 49% and 21% respectively (Herek, 2009). In a national study of 34,653 participants, sexual minorities reported the second highest rates of experiences of discrimination among other stigmatized groups of Black, Hispanic, and woman respondents (McLaughlin, Hatzenbuehler, & Keyes, 2010). Among the discrimination reported, public settings was the most reported followed by offensive name calling. It is not necessary to experience these events

first-hand for them to have an impact on sexual minorities; this is felt stigma (Herek, 2007). Merely being aware of the possibility for enacted stigma, felt stigma can regulate behavior. Thus, public stigma controls how sexual minorities interact with the world through direct discrimination and prejudice and the threat of discrimination and prejudice.

Whereas public stigma is the devaluation of nonheterosexuals by others, self-stigma is the application of that devaluation to the self. This research is concerned with the internalized stigma, or self-stigma, among sexual minorities (sometimes called internalized homophobia; Meyer, 1995). Specifically, gays, lesbians, and bisexuals experience sexual self-stigma when their beliefs are in accord with society's negative judgment of sexual minorities (Herek, Gillis, & Cogen, 2009). Corrigan (2004) describes this attitude as self-prejudice and self-discrimination when it interferes with the way the stigmatized respond to the environment. For instance, sexual minorities may decide not to pursue a long-term relationship because they accept the devaluation of same-sex couples by society; this is self-discrimination. In a sample of 2,259 lesbian, gay, and bisexual adults Herek et al. (2009) found that sexual minorities with stronger cultural ideologies that devalue nonheterosexual characteristics had higher levels of self-stigma. Among the sexual minorities studied Herek and colleagues found that men, political conservatives, and the highly religious had increased levels of self-stigma. Additionally, self-stigma was higher in those who did not believe their sexuality was a choice and routinely passed as heterosexual.

Sexual self-stigma is a multidimensional construct that is related to maladaptive behavior, attitudes, and affect. Early conceptualizations of the construct involved attitudes toward self as a homosexual, attitudes toward other homosexuals, and reactions toward disclosure of sexual identity (Nungesser, 1983). Later conceptualizations included a lack of association with like others and conflict with moral or religious attitudes as a product of self-stigma (Szymanski &

Chung, 2001). That is, sexual self-stigma can include negative attitudes toward the self and other sexual minorities, unwillingness to disclose, distance from like others, and dissonance between moral or religious beliefs and identity.

Psychosocial implications of sexual stigma. Sexual minority stigma has many negative implications including those related to psychological and social well-being. Indeed, sexual minority stigma has been related to negative psychological outcomes such as anxiety and depression. On the extreme end, suicidal ideations are increased for sexual minorities. Bolten and Sareen (2011) reported from a large U.S. sample (N=34,653) that sexual minority adults reported more suicide attempts than their heterosexual counterparts. Specifically, suicide attempt rates were 9.8% and 10% for gay and bisexual men respectively, while their heterosexual counterparts reported 2.1%; rates for lesbian and bisexual women were 10.9% and 24.4% respectively, while their heterosexual counterparts reported 4.2%. It is not merely identifying as a sexual minority that carries these implications; it is the cultural component of devaluing nonheterosexuals. For example, in a sample of gay and bisexual men (1,248) discrimination and physical violence predicted suicidal ideation (Huebner, Rebchook, & Kegeles, 2004).

Devaluation and discrimination often occur at government policy and institutional levels; studies show that even these broad and generalized events can impact the well-being of sexual minorities. These discrepancies in equality can make the stigmatizing characteristic more salient and ultimately are related to poorer mental health outcomes for sexual minorities. Indeed, Hatzenbuehler et al. (2010) reported on a national, longitudinal study of 34,653 participants in which data were collected at an opportune time before and after the time states were voting on limiting marriage to one man and one woman. They found that in states that voted to ban same-sex marriage psychological disorders significantly increased among sexual minorities compared

to sexual minorities in states that did not vote to ban same-sex marriage. Specifically, there was an increase in mood disorders, generalized anxiety disorders, alcohol use disorders, and psychiatric comorbidity among the lesbian, gay, and bisexual participants from the states that banned same-sex marriage. For instance, in these states, generalized anxiety disorder increased 248.2% among sexual minorities. From the same national sample it was found that living in a state that does not include protection for sexual orientation in hate crime laws and discrimination policies predicted a stronger relationship between being a sexual minority and diminished psychological well-being, specifically generalized anxiety disorder, posttraumatic stress disorder, and dysthymia (Hatzenbuehler et al., 2009). Additionally, Riggle, Rostosky, and Horne (2010) reported that a sample of 2,511 sexual minority adults perceived more favorable messages from their environment, had higher levels of outness and social support, and lower sexual self-stigma in areas where sexual orientation was included in the nondiscrimination policies. Thus, systematically neglecting to provide safety to known stigmatized groups, specifically sexual minorities, and denying the stigmatized rights that are afforded to others can have serious psychosocial consequences for sexual minorities.

Experiences with other lifetime or daily discrimination are also related to negative outcomes. Mays and Cochran (2001) found sexual minorities experience significantly more perceived discrimination than heterosexuals. Additionally, this discrimination was associated with more challenges in life such as job loss due to discrimination. Overall, this discrimination was also related to more psychiatric disorders. Other research has linked discrimination with substance use disorders. In a national sample of 577 sexual minorities McCabe, Bostwick, Hughes, West, and Boyd (2010) found increased substance use disorders among those sexual minorities that had experienced higher levels of discrimination. Additionally, Huebner et al.

(2004) found that among male sexual minorities instances of harassment, discrimination, and violence were significantly related to lower self-esteem and suicidal ideation. These more personal experiences of discrimination continue to be associated with poor psychosocial outcomes.

Research consistently reveals negative psychosocial correlates associated with sexual minority stigma. When negative experiences of prejudice and discrimination are turned toward the self, detrimental effects can increase for sexual minorities. Indeed, Meyer (1995) described internalized homophobia as a predictor of feelings of demoralization, guilt, inhibited sexual behaviors, and suicidal ideation. Lewis, Derlega, Griffin, and Krowinski (2003) found that among a sample of 204 sexual minorities, internalized homophobia along with stigma consciousness, openness, and gay-related stress significantly predicted depressive symptoms. These findings have held constant even in meta-analytic methodology. Newcomb and Mustanski (2010) found in an analysis of 31 sources that depressive symptoms had a small to moderate significant correlation with internalized homophobia. Further, Lewis, Derlega, Clark, and Kuang (2006) found that among lesbians internalized self-stigma was significantly correlated with stigma consciousness, negative mood, lesbian-related stress, intrusive thoughts, and even physical symptoms. Additionally, they deal with these negative implications while experiencing diminished resources such as social support. Szymanski and Chung (2001) report that among the 157 lesbian and bisexual women participants, internalized homophobia was significantly and negatively related to overall social support and satisfaction of social support as well as positively related to depression. Finally, self-concept has been diminished as a consequence of accepting the negative societal beliefs about one's group; Herek et al. (2009) found that higher levels of

self-stigma were related to increased psychological distress and well-being mediated by decreased global self-esteem.

Fear of Negative Evaluation Among Sexual Minorities

Due to the nature of stigma fear of negative evaluation is common among the stigmatized. Fear of negative evaluation has been defined as “apprehension about others’ evaluations, distress over their negative evaluations, avoidance of evaluative situations, and the expectation that others would evaluate oneself negatively” (Watson & Friend, 1969; p. 449). This fear may further reduce resources such as social support and have negative psychosocial implications. The very nature of holding a stigmatized identity or characteristic ensures a threat of rejection in some form (Crocker et al., 1998). Indeed, prior research consistently shows that various forms of rejection are common in the lives of sexual minority individuals through unfair treatment and discrimination (Herek, 2007, 2009; Katz-Wise & Hyde, 2012; McLaughlin et al., 2010). As part of public stigma it is likely that sexual minorities may anticipate this unfair treatment and fear rejection and negative evaluation (Pachankis & Goldfried, 2006). Such process may even be categorized as felt stigma (Herek, 2007). Some studies have examined fear of negative evaluation related to stigma among sexual minorities. Pachankis and Goldfried (2006) found that gay men fear negative evaluation as measured by social anxiety more than heterosexual men. Specifically, they surveyed 174 men (87 heterosexual; 87 gay) and found that the gay men were significantly higher in social interaction anxiety than heterosexual men. Fear of negative evaluation may be more salient for sexual minorities who are trying to conceal their identity (Schope, 2004). This fear is likely perpetuated through social interactions. Indeed, Oswald (2007) conducted a study with 157 student participants using vignettes either describing a gay man either concealing or not concealing his sexual orientation. Perceivers (participants)

were more likely to interact in the concealed condition. Additionally, perceivers high in sexual prejudice had more negative affect and were less likely to interact in either the concealed or the non-concealed condition. Thus, Oswald found that participants were more likely to interact when a gay sexual identity was concealed, yet they were more likely to associate negative characteristics to the individual concealing.

Instead of fear of negative evaluation per se, some studies have focused more broadly on fear of interpersonal rejection or more specifically on social anxiety among sexual minorities. Hart and Heimburg (2001) point out that coming out may evoke negative reactions. On the other hand, continually passing may lead to psychological distress (see also Miller & Major, 2000). D'Augelli has reported fear of rejection fuels trends in nondisclosure and concealment of sexual minority status among adolescents to their families (1991) and among undergraduates to roommates and other peers (1992). Fear of rejection and lack of social support do not stop with close relationships and acquaintances. Male sexual minorities in particular avoid calling on authority figures in times of victimization for this very reason (D'Augelli, 1992). Previous research has indicated a mediational relationship among gay men between parental rejection and later fear of rejection associated with sexual orientation (Pachankis, Goldfried, & Ramrattan, 2008).

Although research on sexual minorities and fear of negative evaluation is in its infancy, additional evidence for fear of negative evaluation can be drawn from research on other stigmatized groups. For example, George (2000) reported that among the chronically mentally ill, there is a desire to fit-in with society but also a fear of rejection if this is attempted. Moreover, modified labeling theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989) highlights this fear of rejection by explaining responses of the stigmatized to labels and threats of

rejection. Specifically, Link and colleagues identified three strategies mental patients use to avoid rejection: secrecy, withdrawal, and education. It is also noted that while these strategies may reduce the occurrence of rejection, they also limit the individual's opportunities in life. Particularly, this limits opportunities for social support; those with higher levels of stigma have less social support outside their household (Link et al., 1989).

Importantly, fear of rejection carries social and psychological implications. Fear of negative evaluation has been shown to be positively correlated to depression and loneliness in nonclinical and nonstudent populations (Duke, Krishnan, Faith, & Storch, 2006). Specifically, Duke and colleagues used a nonstudent sample of 355 individuals and found that fear of negative evaluation was positively correlated with depression and loneliness. Additionally, in a sample of 174 undergraduates, fear of negative evaluation was found to mediate the relationship between low self-esteem and social anxiety (Kocovski & Endler, 2000). Thus, given that stigma is consistently related to negative psychosocial outcomes and self-conceptions, outcomes of self-stigma, fear of negative evaluation, and both positive and negative mood are included in the current thesis. These negative psychosocial outcomes and self-conceptions underline the importance of finding ways to preserve psychological well-being among LGB individuals experiencing stigma. Presumably a self-compassionate approach including mindfulness, recognition of a common humanity, and self-kindness can mitigate these negative outcomes. Further, understanding the extent to which self-compassion overlaps with current evidence-based treatment that could be used in therapy when these issues are presented should be also considered as an important area of research.

Self-Compassion as a Buffer Among Sexual Minorities

Experiencing stigma presents several challenges including those social in nature and those pertaining to psychological well-being. Sexual minorities are regularly faced with stigmatizing situations, particularly because it is often accepted and seen as appropriate (Herek, 2007). The researcher sought to identify a resource that people can access that will allow them to face these stigmatizing situations while retaining optimal psychological well-being; self-compassion may be such a resource.

Theory and origins. Self-compassion may serve to mitigate the negative psychological effects of stigma. Indeed, Allen and Leary (2010) suggest self-compassion may be an effective and healthy coping strategy. Neff (2003) defines self-compassion as "being open to and moved by one's own suffering, experiencing feelings of caring and kindness towards oneself, taking an understanding, nonjudgmental attitude toward one's inadequacies and failures, and recognizing that one's own experience is part of the common human experience." The construct has been conceptualized as having three subcomponents: self-kindness, recognition of a common humanity, and mindfulness. Self-kindness can be thought of as sympathy or kindness toward the self even in times of suffering or feeling inadequate. A recognition of common humanity is understanding that others have common suffering and recognizing the external factors that contribute to the outcomes of situations. Mindfulness is the act of taking a nonjudgmental and objective view of the situation.

Self-compassion and wellbeing. The conceptualization of self-compassion has been accepted and practiced in Eastern cultures for many years; yet Western research is recently exploring for the first time and finding links between self-compassion and psychological well-being. Previous studies have linked self-compassion to increased well-being and positive

psychological functioning. Specifically, in a sample of 391 undergraduate participants surveyed, those higher in self-compassion are lower in depression and anxiety and have increased life satisfaction (Neff, 2003). Additionally, self-compassion has been linked to higher levels of happiness, optimism, positive affect, wisdom, personal initiative, curiosity, extroversion, agreeableness, and conscientiousness and lower levels of negative affect and neuroticism in a sample of 177 undergraduates surveyed using a correlational design (Neff, Rude, & Kirkpatrick, 2007). Studies indicate that those higher in self-compassion respond more favorably to negative events. For example, Neff, Hsieh, and Dejitterat (2005) found that in a sample of 110 undergraduates taking a difficult course (i.e., engineering), those higher in self-compassion tended to see failure as a learning opportunity, had higher self-confidence, and exhibited a positive coping strategy, positive reinterpretation and acceptance when faced with perceived academic failure following an exam than those lower in self-compassion.

Additionally, Leary, Tate, Allen, Adams, and Hancock (2007) revealed that those higher in self-compassion were less hard on themselves; were more likely to see the negative event more realistically when imagining a hypothetical failure such as an academic, athletic, or performance failure ($n = 123$ undergraduate students); ruminated less; and reported less negative affect when given feedback on a video performance ($n=66$ undergraduate psychology students). Allen and Leary (2010) summarized previous research by noting that when faced with negative circumstances those higher in self-compassion may use more positive coping strategies such as positive cognitive restructuring. Those higher in self-compassion may also avoid more damaging strategies such as avoidance or futile problem-solving approaches. In addition, self-compassion has been negatively correlated to a fear of negative evaluation among a sample of 151 female

high school athletes and explained the variance of fear of negative evaluation beyond that of self-esteem (Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011).

In sum, previous research has found that self-compassion is linked with more positive psychological outcomes. Thus, such beliefs may serve to buffer individuals from the harmful effects of negative life events. Recently, an experimental research design has permitted the induction of a self-compassionate state. In such a study (Leary et al., 2007), 115 undergraduate student participants were asked to write about their experiences with a negative event (i.e., one in which they felt rejected) and then to console themselves in writing as if they were talking with a friend who had experienced the negative event. Specifically, they were to write about ways in which other people also experience similar events (recognition of common humanity), describe the event without emotion (mindfulness), and write expressing self-kindness towards themselves the same as they would a friend in that situation (self-kindness). Results indicate that self-compassion can indeed be induced thereby providing a resource beyond that of self-esteem or positive self-beliefs. Specifically, those in the self-compassion condition reported significantly lower negative affect than the other conditions of self-esteem, writing control, and true control. They also indicated that the event was more likely to be caused by the kind of person they were than participants in the other conditions. However, they also reported that they were significantly more similar to other people than the other groups, suggesting a combination of mindfulness and recognition of a common humanity. According to this cutting edge work it is the impact of self-kindness and understanding along with nonjudgment that contributes to self-compassion's positive impact.

It is important to note that although self-compassion and self-esteem overlap conceptually, self-compassion has unique characteristics not offered by the concept of self-

esteem. Neff (2011) reviewed the literature comparing and contrasting the differences between these two constructs. Self-esteem has been thought to be a key resource in dealing with poor self-concept. The disadvantage of self-esteem is that it relies on social ranking for feelings of self-regard. Thus, if outperformed by another, self-esteem could drop making the individual vulnerable to poor self-concept. Self-esteem can be domain specific, can result in ego inflation, and can provide a skewed conception of the situation or event. By contrast, self-compassion addresses these deficiencies in self-esteem by avoiding a social ranking system and taking the perspective of similar human experiences and objectively viewing the situation in the context of a common humanity. Additionally, self-kindness replaces the feelings of failure or inadequacy that may accompany unfavorable outcomes when only relying on self-esteem.

The Present Study

Prior research on self-compassion has been related to positive mental health in nonstigmatized samples. This has been examined in the context of a negative event and continued to be related to positive mental health outcomes. Additionally, the concepts involved in self-compassion have been compared to positive coping mechanisms such as cognitive restructuring as opposed to avoidance. This study is an attempt to expand the literature and knowledge of self-compassion in the context of a stigmatizing identity. Specifically, this study explored a self-compassion induction using a sample of participants that self-identified as sexual minority. Experiencing stigma may lead to thoughts of differentness, perceiving the situation as personal, and sometimes feelings of inadequacy due to the stigmatizing characteristic (Corrigan, 2004). That is, when the negative experiences or perceived beliefs of others toward the stigmatized identity are internalized, self-stigma develops. Self-compassion addresses elements that may lead to negative psychological consequences by focusing on a common humanity

instead of differentness by focusing on a mindful and objective view instead of perceiving the situation as personal and by focusing on self-kindness instead of feelings of inadequacy due to a stigmatizing characteristic.

Induced self-compassion has the potential to serve in a buffering capacity to promote well-being in the face of negative life events such as stigma. An important extension of this work is in the lives of sexual minorities. Those who hold stigmatized identities or conditions are more likely to experience rejection and harmful negative psychological effects of their stigma. Further, they may fear social rejection and negative perceptions of others. Although self-compassion is increasingly gaining attention in the literature, no prior work (to our knowledge) has enlisted self-compassion as a possible buffer in the face of sexual minority-related stigma. Presumably, the rejection that sexual minorities experience due to their identity would be a context in which to examine the possible benefits of being kind to oneself, believing in a common humanity and being in a mindful state.

The researcher's aim for the present thesis was to examine whether self-compassion could buffer stigmatized individuals from the negative psychological impact of rejection related to sexual minority identification by analyzing existing data from a project in which a self-compassionate state was induced among sexual minorities. Current mood state, self-perceptions of stigma, and worry about others' evaluations were examined after participants completed a self-compassion induction, a self-esteem induction, an expressive writing induction (in which sexual minorities merely wrote about their negative social interaction), or a control task (in which participants did not elaborate in writing on their experiences).

The first hypothesis of the present study was that sexual minorities in the self-compassion induction would report less self-stigma as compared with sexual minorities in the three control

groups (self-esteem induction, writing control, and true control) (H1). The second hypothesis was that sexual minorities in the self-compassion condition would report less fear of negative evaluation as compared with sexual minorities in the three control groups (self-esteem induction, writing control, and true control) (H2). Hypothesis 3 was that sexual minorities in the self-compassion induction would report less negative mood including anger, hurt feelings, anxiety, sadness, and self-conscious emotions (e.g. shame and embarrassment) as compared with sexual minorities in the three control groups (self-esteem induction, writing control, and true control; H3). Hypothesis 4 was that sexual minorities in the self-compassion induction would report greater positive mood including happiness and belonging as compared with sexual minorities in the three control groups (self-esteem induction, writing control, and true control; H4). Additionally, baseline self-compassion was explored to determine whether trait self-compassion plays a role in the effects of the self-compassion induction on reports of stigma, fear of negative evaluation, and mood.

CHAPTER 2

METHOD

Participants

Participants were individuals who self-identified as a sexual minority either through a pool of undergraduate psychology students at a southeastern university ($n = 68$) or recruited to participate online via a broad advertisement strategy ($n = 30$; described below). A total of 408 individuals participated in Part 1 of the study; however, 310 did not identify as a sexual minority, completed the questionnaires more than once, or did not respond to Part 2 of the study. The sample included a total of 98 participants that self-identified as a sexual minority (44.9% homosexual, 49% bisexual, 6.1% other). On average participants were 28 years of age ($SD=13.24$; range=18-76), with the majority female (70.4% female versus 28.6% male and 1% other) and White (88.9% white, 2% African American, 2% Hispanic, 2% Alaskan or Native American, 4% Other).

Procedure

Due to the stigmatizing nature of minority sexual orientation, this research study was conducted online to encourage participation by those who perceive stigma. The online study required participants to sign up via an online survey system (SONA or Limesurvey) that automatically notified the investigators of the participants' request to participate. Potential undergraduate student participants self-selected into the current study from a list of available studies on SONA. These participants were identified by only an ID number that allowed them to receive course credit for their participation. Potential participants outside of the psychology participant pool self-selected into the study by directing their web browser to the study website via Limesurvey.

In Part 1 of the study, participants completed an informed consent form (see Appendix A), demographic questions (including sexual orientation; see Appendix B), Self-Compassion Scale (Neff, 2003), Perceived Stigma Scale, and the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Following completion of Part 1, the investigator sent an email to participants to inform them of how to complete the remainder of the study (the online survey system permits investigators to send emails to participants while retaining their anonymity). Prior to the email, each participant was randomly assigned to one of four experimental conditions (self-compassion induction, self-esteem induction, writing control, and a true control) and sent a corresponding survey link to complete Part 2 of the study.

Part 2 of the study followed the methods used by Leary et al. (2007). All participants were asked to “Think and write about a negative event that you experienced related to your sexual orientation (e.g., lesbian, gay, bisexual) that made you feel badly about yourself—something that may have involved humiliation or rejection by others. Please describe the event and then provide details regarding what led up to the event, who was present, precisely what happened, and how you felt and behaved at the time.” Further instructions were based on the corresponding experimental condition.

Self-compassion induction. Participants ($n = 24$) assigned to the self-compassion induction were asked to think and write about the event in a compassionate manner. The next three writing prompts correspond to Neff’s (2003) conceptualization of self-compassion and its three components. Recognition of a common humanity was prompted by having the participant list ways in which other people also experience similar events. The second prompt, self-kindness, instructed participants to write expressing self-kindness toward themselves the same as

they would a friend in that situation. The third prompt encouraged mindfulness by instructing the participant to describe the event without emotion.

Self-esteem induction. Participants (n = 20) in the self-esteem condition were given three prompts to promote positive feelings toward the self. The first prompt asked them to list their positive characteristics. Next, they were instructed to describe how the event was not their fault and interpret the event in a way that made them feel better about themselves. Finally, they were asked to explain how the event was not a reflection of who they are.

Writing control condition. Participants (n = 27) in the writing control received only one additional prompt. They were instructed to write freely about the event and explore all emotions related to what happened in order to ensure any change in feelings among the participants was not due to simply writing about their negative event.

True control condition. Participants (n = 27) in the true control condition were not given any additional writing prompts.

At the completion of the writing exercises all participants completed a set of dependent measures: perceived stigma, fear of negative evaluation, and mood.

Measures

Demographics. Multiple socio-demographic factors were assessed (e.g., age, race, gender) including sexual orientation (lesbian, gay, and bisexual).

Self-compassion (Part 1). The Self-Compassion Scale (SCS; Neff, 2003) was used to assess self-compassion in this study. Overall, self-compassion is the extent that an individual exhibits self-kindness, a recognition of a common humanity, and mindfulness. The scale consists of twenty-six items on a 5-point Likert scale (1 = almost never; 5 = almost always) divided into six subscales: self-kindness (e.g., "I'm kind to myself when I'm experiencing

suffering"; $\alpha = .79$); self-judgment (e.g., "I'm intolerant and impatient towards those aspects of my personality I don't like"; $\alpha = .84$); common humanity (e.g., " I try to see my failings as part of the human condition" $\alpha = .70$); isolation (e.g., "When I'm really struggling, I tend to feel like other people must be having an easier time of it"; $\alpha = .81$); mindfulness (e.g., " When something painful happens I try to take a balanced view of the situation"; $\alpha = .77$); and over-identified (e.g., "When I fail at something important to me I become consumed by feelings of inadequacy"; $\alpha = .77$). Subscales were calculated by taking the mean of each subscale. Total self-compassion scores were calculated by reverse-scoring the self-judgment, isolation, and over-identification subscales and calculating the mean. Analysis revealed a strong internal consistency ($\alpha = .94$) for the total scale.

Self-esteem (Part 1). The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) is commonly used for a global assessment of self-esteem. The RSE consists of ten items (e.g. "On the whole, I am satisfied with myself") on a 4-point Likert scale (1 = strongly agree; 4 = strongly disagree). Analysis revealed a strong internal consistency ($\alpha = .91$).

Perceived stigma (Part 2). The Perceived Stigma Scale (adapted from Mickelson, 2001) is designed to measure both public and self-stigma. The scale consists of eight items with responses on a 5-point Likert scale (1 = definitely disagree; 5 = definitely agree). For the purpose of this study four items regarding self-stigma (e.g. "I have felt odd/abnormal because of my sexual orientation.") were used. A mean score was calculated for self-stigma. Analysis revealed moderate internal consistency ($\alpha = .73$).

Fear of negative evaluation (Part 2). The Brief Fear of Negative Evaluation Scale (FNE; Leary, 1983) was constructed to measure how much concern people have of being negatively evaluated by others. The scale consists of twelve items (e.g. "I am afraid others will

not approve of me”) with responses on a 5-point Likert scale. Sum scores were calculated with higher scores indicating more fear of negative evaluation. Analysis revealed a moderate internal consistency ($\alpha = .93$).

Mood (Part 2). The mood scale is a list of twenty-eight adjectives intended to measure the present mood of the participant. For each item the participant indicated the extent he or she felt the adjective on a 7-point Likert scale (“not at all” to “extremely”). The scale consists of seven subscales: anger (e.g., “irritated”), sadness (e.g., “depressed”), anxiety (e.g., “nervous”), hurt feelings (e.g., “pained”), happiness (e.g., “cheerful”), accepted (e.g., valued”), and ashamed(e.g., embarrassed) (Buckley, Winkel, & Leary, 2004).

CHAPTER 3

RESULTS

Covariate Testing

Prior to testing main study hypotheses, a preliminary analysis explored six demographics as possible covariates Age, sexual orientation (two categories), gender (two categories), and race (minority versus majority). A power analysis using G*power (Faul, Erdfelder, Buchner, & Lang, 2009) based on six potential predictors, alpha of .05 and a medium effect size indicated adequate sample size was met (98 participants were needed for adequate statistical power (.80). Results of covariate testing revealed that demographic variables were not significantly related to the main study variables; thus, no demographic variables were entered in the main regressions.

In order to determine whether self-esteem should be used as a covariate in the main analyses of hypotheses 1-9, an ANOVA was conducted to check for significant differences in self-esteem between the conditions. A one-way ANOVA for a between groups design revealed no significant differences in trait self-esteem among the conditions $F(3, 94) = .66, p=.58$ (see Table 1). Thus, self-esteem was not controlled for in subsequent analyses testing main study hypotheses.

Table 1. ANOVA Difference in Self-Esteem across Groups at Baseline

	Groups								N	df	F	p
	SC		SE		WC		TC					
	N	M(SD)	N	M(SD)	N	M(SD)	N	M(SD)				
Self-Esteem	24	30.58(5.48)	20	28.35(5.88)	27	30.48(6.45)	27	30.15(5.77)	97	94	.66	.58

Note. SC = self-compassion, SE = self-esteem, WC = writing control, TC = true control

Testing Effects of Conditions

In order to examine both the main effects of condition and the moderating role of trait self-compassion in the effects of condition, a hierarchical, moderated multiple regression analysis was conducted for each of the nine dependent variables: self-stigma, fear of negative evaluation, anger, happiness, hurt feelings, anxiety, sadness, accepted, and ashamed. For all regressions experimental condition (three dummy variables) was entered in the first step as the independent variables. It was anticipated that there would be a significant effect of condition such that those in the self-compassion condition would have decreased self-stigma (H1), fear of negative evaluation (H2), anger, hurt feelings, anxiety, sadness, and ashamed mood (H3) and increased happiness and accepted mood (H4) than those in the three control conditions. In order to test the interaction of trait self-compassion and condition, trait self-compassion (centered variable) and the interaction with self-compassion induction condition were entered sequentially to the model. The interaction between condition and Part 1 self-compassion was examined to determine whether the effect of the self-compassion induction depended on trait self-compassion.

As shown in Table 2, results of the first step of the regression testing main effects of condition revealed no significant differences between the self-compassion group and the other three conditions for the outcome variables of Self-Stigma, Fear of Negative Evaluation, Anger, Sadness, Ashamed, Happiness, and Accepted moods. Step 1 also revealed a nonsignificant difference in Hurt Feelings between the self-compassion condition and the self-esteem condition, although there was a marginally significant difference with the writing control ($b = 3.19, se = 1.67, p = .06$) and true control ($b = 2.96, se = 1.67, p = .08$) conditions as compared to the self-compassion condition such that the self-compassion condition revealed less hurt feelings. Finally, Step 1 revealed a nonsignificant difference in Anxiety between the self-compassion

condition and the self-esteem condition and the True control conditions, although there was a marginally significant difference with the writing control ($b = 3.44, se = 1.84, p = .06$) condition.

Table 2. Hierarchical Regression Analysis Summary for Condition and Self-Compassion Predicting Outcome Variables

Variable	Self-stigma				Fear of Negative Evaluation				Anger			
	B	se	β	ΔR^2	B	se	β	ΔR^2	B	se	β	ΔR^2
Step 1				.01				.01				.02
SE Dummy	-.25	.34	-.09		-.17	3.35	-.01		-1.56	1.75	-.11	
WC Dummy	.07	.31	.03		2.57	3.11	.11		.75	1.62	.06	
TC Dummy	.05	.31	.02		1.97	3.11	.08		-.11	1.62	-.01	
Step 2				.08				.25				.01
SC centered	-.45	.15	-.29**		-7.85	1.39	-.51**		-.79	.83	-.10	
Step 3				.00				.01				.00
SC*condition	.19	.37	.06		2.96	3.30	.09		.22	1.99	.01	

Note. SC = self-compassion, SE = self-esteem, WC = writing control, TC = true control

* $p < .05$, ** $p < .01$, † $p < .1$

Table 2. (continued)

Variable	Hurt Feelings				Anxiety				Sadness			
	B	se	β	ΔR^2	B	se	β	ΔR^2	B	se	β	ΔR^2
Step 1				.06				.04				.03
SE Dummy	.50	1.81	.03		1.60	1.98	.10		.83	2.13	.05	
WC Dummy	3.19	1.67	.24†		3.44	1.84	.23†		2.93	1.97	.19	
TC Dummy	2.96	1.67	.22†		2.92	1.84	.20		2.89	1.97	.18	
Step 2				.06				.06				.10
SC centered	-2.04	.84	-.24*		-2.23	.92	-.24*		-3.17	.96	-.32**	
Step 3				.00				.00				.00
SC*condition	.866	2.00	.05		1.11	2.20	.06		1.18	2.30	.06	

Note. SC = self-compassion, SE = self-esteem, WC = writing control, TC = true control

* $p < .05$, ** $p < .01$, † $p < .1$

Table 2. (continued)

Variable	Ashamed				Happiness				Accepted			
	B	se	β	ΔR^2	B	se	β	ΔR^2	B	se	β	ΔR^2
Step 1				.04				.02				.04
SE Dummy	-.82	1.52	-.07		.72	2.07	.04		.73	1.61	.06	
WC Dummy	.60	1.41	.05		-1.69	1.92	-.11		-2.20	1.49	-.19	
TC Dummy	1.94	1.41	.17		-.17	1.92	-.01		-.91	1.49	-.08	
Step 2				.05				.13				.06
SC centered	-1.66	.71	-.24*		3.44	.92	.36**		1.78	.75	.24*	
Step 3				.00				.00				.00
SC*condition	.59	1.69	.04		-.43	2.21	-.02		.39	1.77	.02	

Note. SC = self-compassion, SE = self-esteem, WC = writing control, TC = true control

* $p < .05$, ** $p < .01$, † $p < .1$

Exploratory Analysis of the Moderating Role of Trait Self-Compassion

In order to test the moderating role of trait self-compassion, the centered self-compassion variable was entered sequentially in Step 2 followed by the interaction with self-compassion induction in Step 3. Although not directly hypothesized, results of the second step of the hierarchical regression did reveal a significant main effect for trait self-compassion for outcome variables, such that those individuals who scored higher in self-compassion also reported less self-stigma ($b = -.45, se = .15, p = .01$), fear of negative evaluation ($b = -7.85, se = 1.39, p < .01$) hurt feelings ($b = -2.04, se = .84, p = .02$), anxiety ($b = -2.23, se = .92, p = .02$), sadness ($b = -3.17, se = .96, p < .01$), and ashamed ($b = -1.66, se = .71, p = .02$) moods across conditions. By contrast, those individuals who scored higher in self-compassion also reported more happiness ($b = 3.44, se = .92, p < .01$) and more acceptance ($b = 1.78, se = .75, p = .02$).

When the self-compassion and self-compassion induction interaction variable was entered sequentially into the third step, analyses revealed a nonsignificant interaction for both self-stigma and fear of negative evaluation ($p = .61; p = .37$, respectively). Similarly nonsignificant interactions were found for negative mood variables of Anger ($p = .91$), Hurt Feelings ($p = .67$), Anxiety ($p = .62$), Sadness ($p = .61$), and Ashamed ($p = .73$), and positive mood variables of Happiness ($p = .85$) and Accepted ($p = .83$). Thus, trait-self-compassion did not moderate the effect of the self-compassion induction.

CHAPTER 4

DISCUSSION

Sexual minorities often have to deal with the experience and perceptions of stigma daily. Exposure to these negative attitudes and beliefs about their identity can erode personal resources such as self-esteem and social support and is related to increased depression and anxiety. Further, a fear of negative evaluation and self-stigma are common among the stigmatized and have also been linked with negative psychosocial outcomes. Providing LGB individuals with coping resources to deal with the psychosocial implications of stigma may help to mitigate some negative effects of stigma. The researcher's aim was to investigate self-compassion as a potential buffer of these effects of sexual minority-related rejection experiences on self-perceptions of stigma and psychological symptoms through experimental induction. Specifically, participants were randomly assigned to a self-compassion induction group versus one of three control groups (self-esteem only induction; expressive writing condition; true control) to assess the buffering nature of self-compassion on self-stigma, negative mood, and fear of negative evaluation.

Overall, hypotheses 1-4 were not supported. That is, individuals in the control conditions of self-esteem induction, writing control, and true control did not differ from those in the self-compassion induction on the nine outcome variables of self-stigma, fear of negative evaluation, anger, hurt feelings, anxiety, sadness, ashamed, happiness, and accepted. However, there was a marginally significant difference between the self-compassion induction and writing and true control groups for *hurt feelings* (with less hurt feelings among those who completed the self-compassion induction). Additionally, there was a marginally significant difference between the self-compassion and the writing and true control conditions for *anxiety* (with less anxiety among those who completed the self-compassion induction).

Although marginal significance does not equate to support for study hypotheses, the trends of the marginal effects suggest the self-compassion induction had a marginal influence on hurt feelings and anxiety. These are highlighted given that Richman and Leary (2009), in their systematical review of the literature on rejection, found that hurt feelings and anxiety are the most common outcomes in the experience of rejection. Thus, our findings for hurt feelings and anxiety – albeit marginally significant – are aligned with the results of this review. If self-compassion has mitigating properties at all in the context of sexual stigma, it would be most appropriate and relevant if it could mitigate hurt feelings and anxiety.

That Leary et al. (2007) found strong evidence for the success of a self-compassion induction leads to the question of why the present study did not show similar support. One possible explanation for the lack of significant findings could be that participating in a laboratory-based induction may be more effective than an online induction. Another possible explanation is that the self-compassion induction is inadequate to deal with the ingrained experiences of living with a stigmatizing characteristic. As suggested by Link in relation to stigma in general (1987), sexual minorities often grow-up in an atmosphere that is not accepting of nonheterosexuals. While developing an identity that is inconsistent with the ideals that society expects, sexual minorities may become sensitive to the negative attitudes and behaviors of others toward sexual minorities and may even adopt these negative attitudes and behaviors themselves (self-stigma). Thus, a short induction of only a few minutes may not allow the stigmatized participant to counter the negative attitudes accumulated over a lifetime. In addition, this particular induction that targeted *a negative event* related to sexual orientation may not have as adequately represented the sexual stigma experienced by the participants in their lives as a whole

as would targeting the worst event encountered or the overall experience with the stigmatized identity.

Additionally, because trait-like self-compassion was significantly related to outcome variables, future inductions aimed at consistent practice of self-compassion may result in better outcomes for the sexually stigmatized. For instance, a Mindful Self-Compassion (MSC) intervention has shown success in increasing self-compassion and psychological well-being in pilot studies (Neff & Germer, 2012). This intervention spans a time period of 8 weeks. Participants meet once a week during this time for 2 hours to learn and practice mindfulness and self-compassion. In addition, an intervention of mindfulness-based stress reduction (MBSR) may also increase self-compassion (Birnie, Speca, & Carlson, 2010). The MBSR intervention consists of 8 weekly meetings lasting 90 minutes. The main focus of this intervention is experiential mindfulness practice as well as a self-kindness perspective. Although these interventions may be lengthy for study inductions, briefer versions may be beneficial.

Another potential explanation for the limited effects found for the self-compassion induction includes that this study did not differentiate the level of how “out” the sexual minority participants were to others. The extent to which an individual who identifies as a sexual minority is “out” may influence the perspective he or she takes on stigmatizing situations and the amount of rejection the individual has experienced (Waldo, 1999). The literature suggests that being open about and not concealing sexual identity is related to positive psychological and social well-being (e.g., Herek, Cogan, Gillis, & Glunt, 1998; Morris, Waldo, & Rothblum, 2001; Reeves & Horne, 2009). Due to the nature of recruitment, this study may have had a disproportionately large number of participants who were out (i.e., perhaps those who are not out are reluctant to participate in a study for gays, lesbians, and bisexuals). Because outness was not

assessed in the study, analyses could not control for this potentially important confound. Future research should assess level of outness in self-compassion inductions as well as consider using more nuanced sampling strategies to obtain a diverse or representative sample. For example, community-based participatory research and respondent-driven sampling, which is comparable to a snowballing strategy where additional participants are identified through the contacts of existing participants, may provide greater reach into this more hidden population (Gile & Handcock, 2010; Roosa, Knight, & Umana-Taylor, 2012).

A final possible explanation for the lack of significant findings could be due to the study being conducted online and, therefore, being dependent upon participant integrity to fully participate and respond to the writing prompts as the instructions directed for the four conditions. For example, if participants in the self-compassion induction were not actually demonstrating an objective view of the situation, or writing about the concern as if talking to a friend, or explaining the event unemotionally, then they did not fully engage in the self-compassion induction, which could explain why the self-compassion condition did not emerge as significantly different from the other three conditions. Future studies should examine additional self-compassion induction methods and manipulation checks on aspects of these inductions.

In addition to the main hypotheses, this study explored whether a trait-like dimension of self-compassion might play a role in the effect of a self-compassion induction on reports of self-stigma, fear of negative evaluation, and mood. That is, it may be the case that those low in trait self-compassion experience greater benefit from the induction of self-compassion than those already high in self-compassion because the induction would provide a resource they ordinarily do not have. Conversely, it is possible that those higher in trait self-compassion benefit more from an induction because it reminds them to tap into their resource they already have.

However, these analyses revealed no significant interactions. Rather, the strongest findings were between overall trait self-compassion and more positive outcomes. That is, the greater general tendency toward self-compassion individuals indicated being, the less they reported self-stigma, fear of negative evaluation, hurt feelings, anxiety, sadness, ashamed, and the more they reported happiness and (marginally) accepted, across all conditions. While these findings do not identify a causal link between self-compassion and the outcomes of stigma and do not assess the contribution of a third possible variable, they do suggest self-compassion might play a role in outcomes of stigma, but rather at the dispositional level rather than a situation or induction level. It may be that more transient self-compassion is not as impactful as the continuity of self-kindness that a trait would assume. Further research is needed to identify whether there are other ways to induce self-compassion on a consistent basis in order to become more trait-like.

Although the present study found limited evidence for the effectiveness of a self-compassion induction, given this study was the first one of its kind – to induce self-compassion among sexual minorities – it may be too soon to dismiss self-compassion as a coping resource that can be enhanced. *If* self-compassion can be successfully induced in a sexual minority sample, it could serve as a viable strategy for coping with sexual stigma. Future, and presumably more successful, inductions of self-compassion at a basic research level could lead to translational science on the daily lives of sexual minorities and their coping with stigma via self-compassion exercises.

Moreover, clinical work may incorporate self-compassion via methods and techniques that overlap with the concepts of self-compassion such as Acceptance and Commitment Therapy (ACT) when assisting a stigmatized client. Like self-compassion, ACT has multiple components that culminate in an optimal coping strategy for the individual. Some of these components

overlap with self-compassion, while others are contradictory between the two. Specifically, ACT is contradictory to self-compassion in terms of acceptance of feelings or private events that occur in response to a negative situation. The acceptance component in ACT instructs the individual not to resist or avoid these private events but to accept them (Luoma, Hayes, & Walser, 2007). Acceptance conveys the importance of letting yourself feel and experience things and recognizing that these feeling are part of the experience. By contrast, self-compassion advocates for separating emotion and the experience to avoid rumination (Neff, 2003). It is also important to note that while self-compassion does not violate the ACT concept of being in the moment, the particular induction method used in this study does by asking the participant to recall a negative event.

However, ACT and self-compassion overlap in three ways. First, cognitive defusion within ACT (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) is in part similar to the mindfulness component in self-compassion in that it promotes an objective view of the situation. Cognitive defusion urges the individual to separate meaning from words (Hayes et al., 2006), thereby, minimizing the private events that occur as a result of thinking about a particular instance. Second, the element of ACT labeled "being present" partially aligns with the self-compassion concept of minimal self-judgment. While self-judgment is kept at a minimum for all contexts in self-compassion (Neff, 2003), the ACT concept of being present focuses on reducing self-judgment in the moment (Hayes, Strosahl, & Wilson, 1999). Third, self as context in ACT corresponds to the mindfulness component of self-compassion. Self as context encourages the individual to separate himself or herself from the event and become an observer. This concept of self in context addresses over-identifying with a particular ideal self. When individuals are psychologically inflexible in a way that they are unable to view their self-concept objectively in

the context of the situation, negative psychological outcomes may result. ACT would encourage the client to separate thoughts of the situation from self-views or ideals (Luoma et al., 2007). Similarly, mindfulness in self-compassion encourages the individual to take an objective view of the situation and minimizing over-identifying with the situation (Neff, 2003).

Thus, it may be that ACT that overlaps with self-compassion could be explored as a means to reduce the psychosocial consequences of experiencing stigma. To date, only one study has directly measured the effects of ACT on self-compassion. Stafford-Brown and Pakenham (2012) tested an Acceptance and Commitment Therapy intervention on 56 clinical psychology interns who were assigned to either the treatment or a control group. Self-compassion was assessed at baseline, postintervention and a 10-week follow-up. There was a significant interaction between the subscale of over-identification and treatment condition such that over-identification decreased after the ACT treatment condition and at a 10-week follow-up compared to the control condition. Thus, more research is needed to investigate self-compassion and inducing self-compassion states among stigmatized sample, including sexual minorities.

Study Limitations and Future Directions

Future research should continue to examine self-compassion among sexual minorities, given the potential benefits to coping with stigma. Limitations of the present study should be considered when interpreting the results of this research as well as when designing future research. First, recruitment of sexual minority samples poses likely sampling bias due to the stigmatizing nature of identifying as a sexual minority. That is, those that are out may be more likely to respond and are likely to experience stigma differently than those who are keeping their sexual identity a secret (Waldo, 1999). Future research should assess level of outness. As well, additional sampling strategies might be employed, such as community based participatory

research or respondent-driven sampling, to try to have greater reach into this more hidden population (Gile & Handcock, 2010; Roosa et al., 2012).

Additionally, the nature of writing about a negative event related to sexual orientation could have limited the effects of the induction. For example, the induction was designed to target one particular negative event related to sexual orientation. Perhaps when studying a stigmatizing identity the induction might try targeting the worst event encountered, or by contrast, the overall experience with that identity. Future researchers might also try induction via in-person studies rather than online studies to determine if integrity and results of the study vary.

Finally, future inductions aimed at consistent practice of self-compassion could result in better outcomes for the sexually stigmatized. For instance, a Mindful Self-Compassion (MSC) intervention has shown success in increasing self-compassion and psychological wellbeing in pilot studies (Neff & Gerner, 2012). This intervention spans over a time period of 8 weeks. Participants met once a week during this time for 2 hours to learn and practice mindfulness and self-compassion. In addition, an intervention of mindfulness based stress reduction (MBSR) can also increase self-compassion (Birnie et al., 2010). The MBSR intervention consisted of 8 weekly meetings lasting 90 minutes. The main focus of this intervention is experiential mindfulness practice as well as a self-kindness perspective. While these interventions may be too lengthy for study inductions, it may be beneficial to create a shorter induction using components from interventions such as these.

Conclusion

Providing LGB individuals with coping resources to deal with the psychosocial implications of stigma may help to mitigate some negative effects of stigma. While the self-compassion induction used in this study has previously yielded results of improved

psychological states, it was not successful with this sample. However, this study does provide further evidence that higher levels of baseline self-compassion predict more favorable outcomes. In addition, there were marginal differences between the self-compassion induction and control conditions for some variables. Thus, more research is needed to investigate other self-compassion inductions that are more effective in among stigmatized sample, including sexual minorities.

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APPENDICES

Appendix A

Informed Consent Form

The research study you have signed up to participate in is entitled “The Study of Self among Sexual Minorities.” The purpose of this study is to examine the feelings people who identify themselves as a sexual minority (e.g., gay, lesbian, bisexual) experience when asked to recall and write about a past negative event. In this two-part online survey, you will first be asked to complete a few brief questionnaires. Once you have completed those questionnaires, you will be sent a link via email to complete the second portion of the study, in which you will be asked to recall and write about a past negative event and to complete a few more questionnaires. You may experience some minor distress by participating in this study. This survey is completely anonymous and confidential. In other words, there will be no way to connect your name (or other personally identifying information) with your responses. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the ETSU IRB, and the personnel associated with this research project have access to the study records. Participation in this research experiment is voluntary, and you may refuse to participate. Once you begin the study, if, at any time, you decide that you do not wish to continue with the study, you may quit at any time without penalty. If you quit or refuse to participate, the benefits to which you are otherwise entitled will not be affected. There are no alternative procedures except to choose not to participate in the study. If you have any research-related questions or problems, you may contact Dr. Stacey Williams at williasl@etsu.edu or 423-439-4615 or Dr. Ginni Blackhart at blackhar@etsu.edu or 423-439-4613. You may also contact the chairperson of the Institutional Review Board at East Tennessee State University at 423-439-6055 if you have

questions about your rights as a research participant. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you cannot reach the study staff, you may call an IRB Coordinator at 423-439-6055 or 423-439-6002. By clicking on the “Next” button below (which will take you to the survey portion of part 1 of this study), you confirm that you have carefully read and understand the above information about the study, that you identify as a sexual minority (e.g., gay, lesbian, bisexual), and that you are 18 years of age or older.

Appendix B

Demographic Questions

Sexual orientation:

- Heterosexual
- Bisexual
- Homosexual
- Other, Please Specify: _____

Gender:

- Male
- Female
- Other (please specify) _____

Age: _____

Race: Alaskan/Native American

African American

Asian

Caucasian/White

Hispanic

Other

Are you currently a college student? Y/N

What level are you currently? Undergraduate
 Graduate

Relationship Status:

- Single
- Committed Relationship
- Cohabiting
- Married
- Separated
- Divorced
- Widowed

Appendix C

Table 3

Table 3. Descriptive Statistics for Study Variables

Variable	M (SD)	Min.	Max.
Self-Compassion	3.05 (.71)	1.50	4.96
Self-Esteem	29.98 (5.89)	17	40
Fear of Negative Evaluation	37.13 (10.97)	16	60
Anger	9.82 (5.74)	4	26
Hurt Feelings	9.80 (6.05)	4	28
Anxiety	11.83 (6.59)	4	28
Sadness	11.44 (7.04)	4	28
Ashamed	7.45 (5.05)	4	27
Happiness	16.47 (6.78)	4	28
Accepted	20.46 (5.34)	5	28

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(Under Review). Examining a paradox of perceived stigma,
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Taylor, D., Williams, S. L., & **LaDuke, S. L.** (in preparation).
Perceived stigma and relationship satisfaction among sexual
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