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Examining the Effects of a Well-Being Therapy Protocol on Sexual Minority Individuals' Psychological Well-Being

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EXAMINING THE EFFECTS OF A WELL-BEING THERAPY PROTOCOL ON SEXUAL MINORITY INDIVIDUALS' PSYCHOLOGICAL WELL-BEING

by

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ABSTRACT

Sexual minority individuals are at higher risk of mental health concerns than heterosexual individuals due to the impacts of minority stress. Previous counseling interventions for sexual minority individuals have focused on pathology and reducing negative symptoms. However, there is a need for more empirical counseling interventions that address these disparities from a positive psychology perspective. Utilizing a multiple baseline single case research design, the current study examined the impact of a well-being therapy protocol for improving the psychological well-being and decreasing depressive symptoms for three sexual minority individuals. There was no functional relationship observed for the Well-Being Therapy protocol on psychological well-being or depressive symptoms in the current study. Discussion of the findings and implications for future research are discussed.

Keywords: sexual minority, psychological well-being, well-being therapy, single case research design

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LIST OF ABBREVIATIONS

LGBTQ .....Lesbian, Gay, Bisexual, Transgender, Queer/Questioning

WBT.....Well-Being Therapy

PHQ-9 .....9-item Patient Health Questionnaire

PWBS..... Psychological Well-Being Scales

CHAPTER ONE

INTRODUCTION

Sexual minority (e.g., individuals who identify with a non-heterosexual sexual orientation) individuals are at risk of experiencing more health disparities compared to heterosexual individuals (Centers for Disease Control and Prevention, 2016b; National Advisory Mental Health Council's Workgroup, 2010). For example, lesbian, gay, and bisexual individuals report higher levels of depression, anxiety, suicide attempts, and substance use disorders than heterosexual individuals (Cochran et al, 2003; King et al., 2008; Mayer, 2008). These disparities can be explained through the framework of minority stress theory (Meyer, 2003). According to minority stress theory, in addition to typical life stressors, sexual minority individuals experience additional stressors resulting from prejudice and discrimination from living in a heteronormative culture (Meyer, 2003). Therefore, scholars are calling for more research which examines mental health among both sexual and gender minority individuals from a positive psychology perspective (Harper et al., 2013; Moradi et al., 2009).

Well-Being Therapy, a psychotherapy intervention designed to increase psychological well-being, is one mental health intervention which has been effective in various randomized-controlled trials for improving psychological well-being, and thereby, reducing mental health problems for the general population (Fava, 2016). Though Well-Being Therapy shows promise for improving mental health from a positive psychology perspective, its effectiveness has not been studied in counseling interventions

with sexual minority individuals. The current study examines the impact of a Well-Being Therapy protocol for improving the psychological well-being and reducing mental health problems of sexual minority individuals. In the current study, we focus on sexual minority individuals (e.g., lesbian, gay, bisexual) as opposed to the larger lesbian, gay, bisexual, transgender, queer (LGBTQ) community. This is because previous scholars have determined that the minority stress experiences of gender minority (e.g., transgender, non-binary) individuals are unique and worthy of their own investigation separate from sexual minority individuals (Frost, 2017).

Problem Statement

Sexual minority individuals experience a higher rate of mental health disparities compared to heterosexual individuals (Baker & Garcia, 2012; Hatzenbuehler et al., 2010; King et al., 2008). Though traditional psychotherapy interventions have been utilized with sexual minority individuals, they lack a focus on well-being (Pachankis, 2014), that is, a positive mental state (Ryff, 1989). Specifically, sexual minority mental health is often viewed from a psychopathology perspective (i.e., how can these symptoms be cured?) versus a perspective that facilitates growth and resilience (i.e., how can we encourage improvement in functioning by tapping into inner strengths). Well-Being Therapy provides a novel strengths-based model for working therapeutically with sexual minority individuals (Fava, 2016); however, counselors who are utilizing Well-Being Therapy with their sexual minority clients must also understand how minority stress impacts sexual minority individuals' mental health. Utilizing a multiple baseline single case research design, I examined the effectiveness of a Well-Being Therapy on the psychological well-being of sexual minority individuals.

Professional Significance

Various court cases have occurred involving both practicing counselors (e.g., *Bruff v. North Mississippi Health Services, Inc* (2001), *Walden v. Centers for Disease Control and Prevention* (2010)) and students in counseling training programs (e.g., *Ward v* Wilbanks (2010), *Keeton v. Anderson*-Wiley (2010)) over practitioners' religious freedom being grounds for refusing to work with LGBTQ clients (Herlihy et al., 2014). These court cases were brought on by practitioners who refused to work with LGBTQ clients because doing so would conflict with their religious beliefs (Herlihy et al., 2014). These court cases initiated widespread legal and ethical conversations about nondiscrimination, referral decisions with LGBTQ clients, and gatekeeping in the counseling profession (Herlihy et al., 2014). However, certain states such as Arizona have passed laws prohibiting universities from disciplining students refusing to work with LGBTQ clients if the conflict results from the student's "sincerely held religious beliefs" (AZ Rev. Stat. 15-1862, 2011). Thus, LGBTQ individuals may have additional barriers to receiving appropriate counseling services in a cultural climate where they may be unsure if their counselor may object to seeing them based on their sexual and/or gender identity.

Another legal battle for LGBTQ individuals seeking therapy involves the passage of "conscience clauses", such as HB1840 in Tennessee (Tennessee Code Annotated, 2016), in several states in the United States, which allow counselors to refuse services to LGBTQ clients when they conflict with the counselors' "sincerely held principles," which includes one's religious beliefs (Farmer, 2017). Additionally, many states allow counselors to practice conversion therapy with LGBTQ clients—a method of therapy intended to change one's sexual and/or gender identity (Flores et al., 2020; Movement Advancement Project, 2020). Only 21 states and the District of Columbia explicitly ban counselors from using conversion therapy,

despite evidence that these therapies are not only harmful, but also ineffective for changing sexual and/or gender identity (America Psychological Association, 2013). Of note, the state in which the current study takes place currently allows for the practice of conversion therapy. This is even more significant given evidence that anti-LGBTQ legislation is associated with negative mental health outcomes for LGBTQ individuals (Grzanka et al., 2020).

Social Significance

Sexual minority individuals are classified as being at higher risk of developing serious mental health concerns than heterosexual individuals as a result of minority stressors (e.g., heterosexism, inequitable rights; Baker & Garcia, 2012; Centers for Disease Control and Prevention, 2016b; Lee et al., 2016; National Institutes of Health, 2010). Specifically, sexual minority individuals are at higher risk of suicidality than heterosexual individuals (Baker & Garcia, 2012; Hatzenbuehler et al., 2010). One systematic review demonstrated higher rates of suicide attempts, depression, anxiety, and substance use disorders for lesbian, gay, and bisexual individuals (King et al., 2008; Lee et al., 2016). In line with minority stress theory (Meyer, 2003; 2015), distal stressors such as experiences of discrimination and/or prejudice can contribute to internalized feeling of inadequacy, resulting in the development of mental health problems. This "deficit" framework has been the primary way in which sexual minority mental health has been conceptualized in much of the literature, with less attention to the ways in which sexual minority individuals can flourish (Lytle et al., 2014).

A growing body of researchers are calling for a move away from this traditional deficit view of sexual minority mental health in favor of a more strengths-based lens (Farmer, 2013; Moradi et al., 2009). Moradi et al. (2009) noted the importance of studying the resilience of sexual minority individuals that can develop in the face of minority stress (Meyer, 2015).

Scholars have identified unique strengths that sexual minority individuals possess, such as unique tendencies toward coping and resilience (Meyer, 2015). Additionally, a guiding principle of the American Counseling Association (ACA, 2016) that is distinct from other helping professions is an emphasis on building upon personal strengths and resilience in clients. To the knowledge of the current researcher, no evidence-based mental health treatments exist for sexual minority individuals that not only reduce mental health concerns, but also actively promote well-being in sexual minority clients.

Theoretical Foundation

The current study was built upon Ryff's (1989) model of psychological well-being, and specifically, how this model of psychological well-being influenced the development of an evidence-based mental health intervention (Ryff, 1989). This model of psychological well-being was chosen for the current study because it provides the theoretical foundation for the counseling intervention in the current study, Well-Being Therapy (Fava, 2016).

Psychological Well-Being

Ryff (1989) hypothesized six components of psychological well-being and proceeded to develop a scale, known as the psychological well-being scales for empirically assessing these domains. Ryff's model of psychological well-being is inspired from the Erikson's psychosocial stages model, Buhler's basic life tendencies, Neugarten's descriptions of adult personality, and Jahoda's positive criteria for mental health (Ryff, 1989). Much of the Ryff's model conceptualizes psychological well0being from a eudaimonic perspective (Ryff, 1989), and included six domains to be discussed more in depth below: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relationships, (e) purpose in life, and (f) self-acceptance.

Well-Being Therapy

Fava (2016) developed Well-Being Therapy based on Ryff's (1989) model of psychological well-being as an approach to treating mental health problems from a positive psychology perspective. Ryff's (1989) model of psychological well-being is made up of six dimensions that work to increase one's flexibility under stressful circumstances and provide resilience to reoccurring stressors (Fava, 2016). These six dimensions of psychological well-being are autonomy, environmental mastery, satisfaction with environment and other individuals, personal growth, self-acceptance, and purpose in life (Fava, 2016). Well-being therapy is a manualized, short-term psychotherapy model that emphasizes self-observation with the use of a structured diary to increase a client's awareness of situations that elicit feelings of well-being as conceptualized through the six dimensions of Ryff's model (Fava, 2016).

According to this model, psychological well-being is inversely related to mental health problems, such that as psychological well-being increases, mental health problems decrease. An additional benefit of well-being therapy is in its effectiveness at preventing relapse of mental health symptoms (Fava, 2016). Well-Being Therapy has been examined in the treatment of cyclothymic disorder that involves fluctuation of mood without meeting formal diagnostic criteria for major depressive disorder or mania (Fava, 2017). In a randomized controlled trial, participants were assigned to either a condition where well-being therapy was combined with a more traditional therapeutic approach, cognitive behavioral therapy, or treatment as usual. After treatment, participants in the cognitive behavioral therapy/well-being therapy condition showed improvement in outcome measures and maintained this improvement at one and two-year follow-ups. Additionally, well-being therapy has been found to be a viable alternative to

traditional cognitive therapies in conditions such as panic disorder and obsessive-compulsive disorder (Fava, 2017).

Though Well-Being Therapy has been demonstrated to be efficacious in numerous studies with diverse populations (Gloria et al., 2009; Ryff et al., 2003; Villarosa & Ganotice, 2018) for various mental health problems, its impact has not been examined with sexual minority individuals. Well-Being Therapy has potential to be an effective mental health intervention for sexual minority individuals given it's demonstrated history of effectiveness and its strengths-based focus.

Minority Stress Theory

A growing body of research supports conceptualizing sexual minority mental health disparities through a minority stress lens (Diaz et al., 2001; Meyer 2003). Minority stress theory posits that sexual minority individuals experience unique stressors that contribute to poor mental health resulting from stigma and victimization experiences from identifying as a sexual minority individual (e.g., lesbian, gay, bisexual; Meyer, 2003). Within minority stress theory, stressors are conceptualized as moving along a distal to proximal continuum (Meyer, 2003). For example, external and objective negative events such as prejudice and discrimination occur, which lead to vigilance and expectation of the negative events, ending in feelings of internalization of negative societal attitudes, thus contributing to poor mental health (Meyer, 2003). Conceptualizing sexual minority mental health disparities through a minority stress lens provides counselors with a lens from which to understand the mental health needs of their sexual minority clients.

Study Aims

The current study includes the following primary aim: to improve psychological well-being among a sample of sexual minority individuals attending mental health counseling. This

study utilizes a multiple baseline single case research design to examine the effectiveness of a Well-Being Therapy protocol on sexual minority individuals' psychological well-being. To accomplish these aims, I propose the following research questions:

Research Question One

Does a Well-Being Therapy protocol improve the psychological well-being of sexual minority individuals as measured by the Psychological Well-Being Scales (Ryff, 2014).

Hypothesis

The Well-Being Therapy protocol will improve psychological well-being on the 42-item Psychological Well-Being Scales (Ryff, 2007) for sexual minority participants (Fava, 2016).

Research Question Two

Does a Well-Being Therapy protocol improve mental health for sexual minority participants as measured by the reduction in depressive symptoms from the 9-item Patient Health Questionnaire (PHQ-9)?

Hypothesis

The Well-Being Therapy protocol will reduce depressive symptom scores on the 9-item *Patient Health Questionnaire* (PHQ-9; Kroenke et al., 2001).

Methodology

A multiple baseline single case research design (SCRD) was used to test the effectiveness of the Well-Being Therapy protocol with sexual minority participants. Three criteria make SCRD appropriate for answering research questions: (a) when testing the effectiveness of an intervention, (b) if the population of interest is small or specialized as it may be difficult to find large numbers of participants meeting the criteria; and (c) if the intervention of interest is new or novel to ensure there are no adverse effects from the intervention before using it with larger

groups (Kazdin, 2011). The nature of the current study meets all three of these criteria. Additionally, SCRD can demonstrate causality and generalizability just as other between groups experimental designs, as the individual or group that is being studied acts as its own control (Kratochwill et al., 2010). More specifically, I utilized a multiple baseline design, as it allows for continuous, repeated measurement across participants in a stagger manner, such that, each participant begins receiving the intervention only when the participant before them begins seeing change in their intervention phase. The baseline condition serves to ensure that the independent variable (e.g., psychological well-being) has been adequately isolated to reduce the probability that external factors are the reason for potential participant change. Counselors recruited to administer the intervention received the Well-Being Therapy protocol treatment manual, as well as a one-hour training from the primary investigator (Kratochwill et al., 2010).

Population and Sampling

Treatment Implementers

Counselors (hereafter referred to as "implementers") implementing the Well-Being Therapy protocol in the current study were recruited from a private practice in the Southeastern region of the United States. The counselors were not the participants in the study, but rather, were implementing the Well-Being Therapy protocol. Inclusion criteria for counselors will be: (a) they must be mental health counselors (fully licensed or provisionally licensed and under the direct supervision of a licensed supervisor) and (b) have at least one sexual minority adult client over the age of 18 on their existing caseload. Counselors will receive free training in the Well-Being Therapy protocol, which has been demonstrated as an evidence-based counseling intervention (Fava, 2016), as well as the physical copy of the Well-Being Therapy protocol treatment manual.

Study Participants

Participants for the current study were recruited via convenience sampling at LGBTQ+-affirming venues and social media groups. Inclusion criteria for participating in the current study is: (a) participants must be at least 18 years of age, (b) identify their sexual orientation as something other than heterosexual, and (c) must not endorse any symptoms of serious mental health concerns in the past six months on a study screening form (see Appendix B). Three participants were selected from the study screening form and were each provided informed consent information via a one-hour long call over Zoom. Participants received financial incentives for participating in the Well-Being Therapy protocol in the form of $125 in Amazon gift cards for completing the study. Specifically, participants received $25 Amazon gift cards after completing sessions two, four, and six, and received the remaining $50 after completing session eight. Participants were informed that participation is voluntary and were provided copies of the consent forms detailing expectations for participation as well as their rights as participants. Participant demographic information is described further in chapter three.

Instrumentation

Psychological well-being.

The Well-Being Therapy protocol will serve as the independent variable. Dependent variables will be psychological well-being as measured by Ryff's (1989) 42-item measure of psychological well-being. the 42 item Psychological Well-Being Scales (Ryff, 2014) for sexual minority clients. (Fava, 2016). Each of the subscales of the Psychological Well-Being Scales have demonstrated Cronbach's alpha coefficients that range from .85-.91.

Depressive Symptoms

I will use the 9-item Patient Health Questionnaire to measure levels of depressive symptoms (Kroenke et al., 2001). Participants will be asked to report how often they have had various depressive symptoms over the last two weeks on a 4-item Likert scale ranging from 0 (not at all) to 3 (nearly every day). I will calculate the total scores at each point for an overall depressive symptom score. The PHQ-9 has been shown across two large studies to have a reliability score of .86 and .89 (Kroenke et al., 2001).

Demographic Survey

The demographics surveys for both implementers and participants will be created by the researcher and will collect various demographics (e.g., gender identity, age, highest level of education completed, sexual identity). The implementer demographics form will include additional items assessing experience as a counselor, such as number of years as a counselor, preferred theoretical orientation, and current setting in which they are practicing, accounting for external validity (Kratochwill et al., 2014).

Social Validity

Social validity was assessed using the standardized Client Satisfaction with Services Questionnaire (CSQ-8; Ledford & Gast, 2018; Nguyen et al., 1983). This measure has demonstrated cronbach's alphas ranging from .83 to .93 across numerous studies (Attkisson & Greenfield, 2004). The CSQ-8 consists of eight closed-ended questions with response values ranging from 1-4 and is scored by adding up the scores of each item for a total sum. The questionnaire was sent to participants after completing the Well-Being Therapy protocol.

Data Analyses

Visual analysis was used to analyze the research questions. For SCRD, visual analysis includes six components (Kratochwill et al., 2010): (a) level, or the line indicating presence of the data points in both baseline and intervention phases; (b) data trend or slope; (c) data variability, or the stability of data over time; (d) consistency of patterns across similar phases; (e) immediacy of effect, or time and magnitude of an effect after the intervention was implemented; and (f) data overlap. Vertical analyses was also utilized to determine that the participants still in the baseline phase do not change once the intervention is administered to another participant. Additionally, three basic effects, at three different points in time, are needed to determine the effectiveness of the intervention. Data analysis was conducted each week. The researcher received, scored, and plotted data from the psychological well-being scales and patient health questionnaire each week to determine when participants should move from the baseline to intervention condition.

Definition of Terms

For the current study, I explore the effects of a Well-Being Therapy protocol on the psychological well-being and depressive symptoms of sexual minority participants. As there are myriad operational definitions for psychological well-being and depressive symptoms, this section describes how they will be defined in the current study.

Psychological Well-Being

Ryff (1989) hypothesized six components of psychological well-being and proceeded to develop a scale, known as the psychological well-being scales for empirically assessing these domains. Ryff's model of psychological well-being is theoretically derived from several frameworks, including Erikson's psychosocial stages model, Buhler's basic life tendencies,

Neugarten's descriptions of adult personality, and Jahoda's positive criteria for mental health (Ryff, 1989). Much of the Ryff's model conceptualizes psychological well-being from a eudaimonic perspective (Ryff, 1989), and included six domains to be discussed more in depth below: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relationships, (e) purpose in life, and (f) self-acceptance.

Autonomy

Autonomy refers to the extent to which individuals view themselves to be consistent with their own convictions. Autonomy can also be thought of as self-determination, self-regulation, and an overall sense of independence (Ryff, 1989). As Ryff (1989) notes, having an internal locus of control is something that is prevalent throughout the literature when describing individuals with healthy psychological functioning. Ultimately, individuals high in autonomy do not rely on approval for others as it relates to their psychological well-being; rather, these individuals evaluate themselves based on their own standards and values (Ryff, 1989).

Environmental mastery

This dimension describes how well individuals manage their situations. In other words, it is the individual's ability to choose or create environments consistent with their own standards or values (Ryff, 1989). Overall, environmental mastery can be described as a sense of control over one's own environment.

Personal growth

Personal growth refers to the extent to which individuals make use of their personal potential. Furthermore, this dimension of psychological well-being refers to an individual's ability to continue to develop their potential and ultimately, grow as a person (Ryff, 1989). Life span theorists posit that continued growth in the face of new life challenges is essential to overall

psychological well-being (Ryff, 1989). It may also be the one dimension of this model of psychological well-being that relates most closely to the eudaimonic view of well-being.

Positive relationships

Positive relationships refers to the depth of ties with significant others. It is well-documented throughout the literature that the presence of warm, trusting interpersonal relationships is a major component of psychological well-being (Ryff, 1989). Ryff (1989) goes further to note that the ability to love and to receive love is vital to overall mental health. Developmental theorists also speak to the importance of fostering lasting relationships as pivotal to well-being (Ryff, 1989).

Purpose in life

This dimension describes the extent to which respondents felt their lives had meaning and direction. Having a clear sense of directedness and intentionality is viewed as a core component of psychological well-being (Ryff, 1989). Ryff (1989) goes further to note that individuals who are functioning positively have goals, intentions, and an overall sense of direction, which all ultimately contribute to meaning in life.

Self-acceptance

Self-acceptance is the knowledge and acceptance individuals have of themselves. Self-acceptance is overall, a positive sense of oneself. Ryff (1989) note that this is an essential feature to mental health and is a key component to optimal functioning.

The psychometric properties have been tested with the psychological well-being scales on various populations, including individuals from lower socioeconomic status (Ryff & Keyes, 1995; Curhan et al., 2014), Latinx college students (Gloria, Castellanos, Scull, & Villegas, 2009), and African Americans living in New York, and Mexican Americans living in Chicago

(Ryff, Keyes, & Hughes, 2003). The researcher will utilize the 42-item scale because it has stronger psychometric properties than the short version. Additionally, the 42-item scale has seven questions for each of the six constructs to portray client experiences of each domain of the psychological well-being scales more reliably.

Depressive Symptoms

Depressive symptoms will be assessed via the 9-Item Patient Health Questionnaire (PHQ-9). The PHQ-9 score can range from 0 to 27, and each of the items are scored on a scale from 0 (not at all) to 3 (nearly every day). Additionally, levels of depressive symptom severity can be minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), severe (20-27).

Limitations

Perhaps the biggest limitation of the current study is in collecting self-report data on the Psychological Well-Being Scale and the 9-question Patient Health Questionnaire. Single-case research design has traditionally been utilized in the field of special education to measure observable externalized behavior changes in participants. However, the strengths of single-case research, including its efficacy in terms of only needing a small sample size and for work with heterogenous populations, such as sexual minority individuals, outweigh this limitation regarding its appropriateness for the current design.

Summary

Chapter one introduced the constructs of interest investigated in the current study. The research design was explained, including limitations and ethical considerations. Chapter two further discusses the philosophical and theoretical tenets of Ryff's (1989) model of psychological well-being and Well-Being Therapy. Chapter three discusses the methodological procedures of the multiple baseline single case research design on using well-being therapy to improve the

psychological well-being and reduce depressive symptoms of sexual minority individuals. Chapter four discusses the results of the study. Chapter five presents the implications, conclusions, and future research based on the results.

CHAPTER TWO

LITERATURE REVIEW

Chapter one provided a general understanding and introduction of the issue under investigation, while chapter two examines the constructs being evaluated for the current study more in-depth: minority stress theory and psychological well-being. After establishing the philosophical tenets underlying these constructs, I go into further detail about different models of well-being therapy, which ultimately inform the intervention being used in the current study: Well-Being Therapy. I then provide a review of the literature on well-being therapy and discuss the need for its application with sexual minority individuals.

Philosophical Tenets

Minority Stress Theory

Minority stress theory posits that stigma, prejudice, and discrimination produce additional layers of stress beyond daily life stressors, which, in turn, leads to adverse health outcomes (Meyer, 2003). Minority stress processes move on a distal to proximal continuum (Meyer, 2003). Distal stressors, or objective external stressful events, include violence and discrimination related to one's perceived sexual identity. Additionally, Meyer described proximal stressors, or more subjective experiences, which operate through the internalization of social stigma by sexual minority individuals, including internalized homophobia, concealment of sexual identity or sexual orientation, and

expectations of rejection and discrimination. Some of the consequences of stigma involve feelings of devaluation and a sense of isolation, fear, insecurity, and exclusion from the target group and its members (Meyer, 2003).

However, scholars are trying to move the study of sexual minority health away from the traditional deficit perspective housed in a medical model, in favor of a strengths-based view housed in a holistic model (Gahagan & Colpitts, 2017). Within this, Gahagan & Colpitts (2017) note that examining sexual minority health from a strengths-based viewpoint enhances understanding of how sexual minority individuals can rebound from, resolve, and prevent relapse of psychological distress (Carver, 1998; Gahagan & Colpitts, 2017, Meyer, 2015). This strengths-based perspective can be viewed as a "health promotion" perspective, in that it focuses on helping sexual minority individuals increase control over and improve their health (Gahagan & Colpitts, 2017). This health promotion conceptualization of sexual minority mental health lends itself well to interventions housed in the field of positive psychology.

Positive Psychology

Traditional approaches to mental health and psychological distress focus on the disease process, where optimal functioning was defined as the absence of illness (Parker & Peterson, 2008). Positive psychology has been defined as the empirical examination of what makes life worth living (Park & Peterson, 2008; Seligman & Csikszentmihalyi, 2000). Additionally, it is the study of the optimal human experience. However, positive psychology does not ignore the challenges that humans experience, such as psychological distress. Rather, the importance of positive psychology lies in its argument that goodness is as important to examine in individuals as pathology (Park & Peterson, 2008; Seligman

& Csikszentmihalyi, 2000). Positive psychology as a field of inquiry attempts to understand positive subjective experiences such as life satisfaction and psychological well-being (Parker & Peterson, 2008), the latter of which will be the focus of the current study.

Psychological Well-Being

The psychological well-being tradition grew out of a positive psychology movement to emphasize personal feelings of well-being in the face of distress (Ryff, 1989; Seligman, 2011). Positive psychology approaches to mental health have conceptualized well-being as comprising two dimensions: hedonia and eudaimonia (Forgeard et al., 2011). Hedonia has been described as a way of feeling, whereas euadimonia is typically described as a way of being (Huta & Waterman, 2014). Though both hedonia and eudaimonia may are sometimes considered separate constructs, they have influenced each other throughout the development of the field of positive psychology.

Hedonic View of Well-Being. The hedonic view of well-being is considered similar to subjective well-being, which refers to one's own perceived experience of happiness (Umucu et al., 2019). Additional hedonic well-being constructs include life satisfaction, contentment, and positive emotions (Ryff & Singer, 2008). Therefore, hedonic well-being is often considered a short-term and more a more fleeting way of viewing feelings of well-being, in contrast to its counterpart of eudaimonic well-being.

Eudaimonic View of Well-Being. In contrast to the more fleeting nature of hedonic well-being, the eudaimonic view of well-being refers to the fulfillment of one's true nature or potential (Ryan & Deci, 2001; Umucu et al., 2019). As such, scholars

consider eudaimonia to make up longer-lasting aspects of well-being, such as meaning, purpose, and having goals in life (Ryff, 1989; Seligman, 2011). Scholars state that achieving eudaimonic well-being involves a state of self-realization, where one is aware of one's own convictions and can proceed to act on those convictions. Though several models of psychological well-being have been described in the literature (Seligman, 2018), the current study focuses on Ryff's (1989) model of psychological well-being, the psychological well-being scales.

Ryff's Psychological Well-Being Scales

Ryff (1989) hypothesized six components of psychological well-being and proceeded to develop a scale, known as the psychological well-being scales for empirically assessing these domains. Ryff's model of psychological well-being is inspired from the Erikson's psychosocial stages model, Buhler's basic life tendencies, Neugarten's descriptions of adult personality, and Jahoda's positive criteria for mental health (Ryff, 1989). Much of the Ryff's model conceptualizes psychological well0being from a eudaimonic perspective (Ryff, 1989), and included six domains to be discussed more in depth below: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relationships, (e) purpose in life, and (f) self-acceptance.

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functioning. Ultimately, individuals high in autonomy do not rely on approval for others as it relates to their psychological well-being; rather, these individuals evaluate themselves based on their own standards and values (Ryff, 1989).

Environmental mastery

This dimension describes how well individuals manage their situations. In other words, it is the individual's ability to choose or create environments consistent with their own standards or values (Ryff, 1989). Overall, environmental mastery can be described as a sense of control over one's own environment.

Personal growth

Personal growth refers to the extent to which individuals make use of their personal potential. Furthermore, this dimension of psychological well-being refers to an individual's ability to continue to develop their potential and ultimately, grow as a person (Ryff, 1989). Life span theorists posit that continued growth in the face of new life challenges is essential to overall psychological well-being (Ryff, 1989). It may also be the one dimension of this model of psychological well-being that relates most closely to the eudaimonic view of well-being.

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Positive relationships refers to the depth of ties with significant others. It is well-documented throughout the literature that the presence of warm, trusting interpersonal relationships is a major component of psychological well-being (Ryff, 1989). Ryff (1989) goes further to note that the ability to love and to receive love is vital to overall mental health. Developmental theorists also speak to the importance of fostering lasting relationships as pivotal to well-being (Ryff, 1989).

Purpose in life

This dimension describes the extent to which respondents felt their lives had meaning and direction. Having a clear sense of directedness and intentionality is viewed as a core component of psychological well-being (Ryff, 1989). Ryff (1989) goes further to note that individuals who are functioning positively have goals, intentions, and an overall sense of direction, which all ultimately contribute to meaning in life.

Self-acceptance

Self-acceptance is the knowledge and acceptance individuals have of themselves. Self-acceptance is overall, a positive sense of oneself. Ryff (1989) note that this is an essential feature to mental health and is a key component to optimal functioning.

Ryff's Psychological Well-Being Scales with Sexual Minority Individuals

Though Ryff (1989) utilized an integrated model of philosophical and psychological theories related to eudaimonia to create a multidimensional model of psychological well-being, it is important to understand how this model of psychological well-being has been examined in relationship to mental health among sexual minority individuals.

Riggle et al., (2009) examined associations between LGB self-identification, perceived daily discrimination, and eudaimonic well-being using the National Survey of Midlife Development in the United States (MIDUS). The MIDUS measured eudaimonic well-being with a short form of Ryff's psychological well-being scales. Eudaimonic well-being was lower on all subscales except for personal growth for sexual minority individuals than heterosexual individuals, as well as lower for total psychological well-being scores. However, the only statistically significant differences were in the domains

of environmental mastery, positive relations with others, and self-acceptance, as well as total psychological well-being scores. Furthermore, identifying as a sexual minority was a significant predictor of lower eudaimonic psychological well-being.

Rostosky et al., (2018) examined the associations between lesbian, gay, and bisexual positive identity and eudaimonic well-being using the six domains of Ryff's (1989) psychological well-being scales in a sample of 332 lesbian, gay, and bisexual adults. In a structural equation model, LGB authenticity accounted for unique variance in all six domains of the psychological well-being scales, and belonging to LGB community account for unique variance in four domains—positive relations with others, self-acceptance, purpose in life, and environmental mastery. Ultimately, the five LGB positive identity factors accounted for between 15% and 27% of the variance in the six domains of psychological well-being. These findings support the notion that emphasizing positive qualities of being a sexual minority may be beneficial to improving their psychological well-being.

Kertzner et al., (2009) examined relationships between social and psychological well-being, as well as depression, in a sample of 396 lesbian, gay, and bisexual respondents. The researchers used the 18-item short form of the psychological well-being scales (Ryff & Keyes, 1995). In this sample, sexual identity valence and connectedness to the LGB community independently predicted psychological well-being, such that individuals who had a more positive sense of their sexual identity and who were more connected to the LGB community had greater psychological well-being. This supports the notion that psychological well-being is an an idiosyncratic and individual process,

and for sexual minority individuals, is strongly related to identification with an LGB identity.

In a sample of 373 lesbian, gay, and bisexual participants, Riggle et al., (2017) explored the associations of outness, identity concealment, and LGB authenticity with psychological well-being. Outness was not a significant predictor of psychological well-being, but LGB identity concealment and authenticity were significant predictors of psychological well-being. Specifically, more LGB identity concealment was significantly associated with lower psychological well-being, and more depressive symptoms. Higher levels of LGB authenticity were significantly associated with higher psychological well-being and fewer depressive symptoms. These findings contribute to the argument that helping sexual minority individuals live authentically may improve their psychological well-being.

The previous literature examining Ryff's model of psychological well-being with sexual minority individuals has been correlational in design. However, Ryff's conceptualization of the Psychological Well-Being Scales was developed into a clinical intervention, Well-Being Therapy (Fava, 2016), which may be a credible mental health intervention for improving sexual minority psychological well-being and mental health given previous correlational studies (Riggle et al., 2017; Rostosky et al., 2018). Well-being therapy utilizes specific techniques and processes designed to increase overall psychological well-being according to Ryff's model. Since its development, well-being therapy has been examined in several studies to establish it as an evidence-based treatment (Fava, 2016). The current study examines the impact of well-being therapy with a population in which it has not been previously studied: sexual minority

individuals. As such, Ryff's (1989) model of psychological well-being is utilized as the leading framework. Well-Being Therapy will be discussed in the following section, in addition to studies examining its overall validity as an evidence-based treatment for improving psychological well-being.

Well-Being Therapy

Well-Being Therapy is a short-term psychotherapy intervention designed to increase psychological well-being through self-observation using a structured diary (Fava, 2016). Well-being therapy is typically designed as an eight-session treatment, though depending on the nature of the problem, it can range from eight to 16-20 sessions (Fava, 2016). Well-being therapy has been examined as a stand-alone intervention, as well as in combination with cognitive behavioral therapy.

Well-being therapy is derived from cognitive behavioral therapy, which conceptualizes mental health issues as stemming from one's negative automatic thought processes in response to particular situations (Williams & Garland, 2002). Those thoughts then elicit feelings, which result in behavior that is maladaptive and reinforces the negative thoughts. Well-being therapy takes a strengths-based approach by encouraging clients to remember feelings of well-being in response to situations as the point of intervention (Fava, 2016; cycle of pathology can be seen in figure 1). Clients log their feelings of well-being through a structured diary and discuss their reflections each session with the therapist. By helping clients develop awareness of their feelings of well-being, they can then develop more positive thoughts, which lead to less distress, ultimately disrupting the cycle that is leading to mental health problems.

The overall course of well-being therapy is divided into phases. The initial phase is concerned with developing self-observation of psychological well-being. In this phase, clients are introduced to Ryff's (1989) model of psychological well-being and are encouraged to begin thinking about the things that bring them a sense of well-being. Clients are asked to report in a structured journal the circumstances surrounding their view of well-being, rated on a scale of 0-100, with 0 being the absence of well-being and 100 being the most intense well-being that could be experienced.

Next, clients are encouraged to identify thoughts, beliefs, and behaviors leading to the instances that are disrupting feelings of well-being. Once instances of well-being are properly recognized, the client is encouraged to identify thoughts and beliefs leading to the interruption of well-being, similar to automatic thoughts in cognitive behavioral therapy. The difference between identifying automatic thoughts in well-being therapy versus cognitive behavioral therapy is a focus on well-being instead of thoughts and beliefs contributing to distress. Additionally, the therapist may reinforce and encourage activities that elicit well-being. For example, assigning a task of completing a pleasurable activity for a certain time each day.

Once clients understand the things that encourage their well-being, and the things that interfere with them achieving a sense of well-being, the final part of well-being therapy focuses on cognitive restructuring of the thoughts and beliefs that are inhibiting psychological well-being and working to restructure client cognitions in a way of allowing for more psychological well-being (Fava, 2016).

Empirical Studies of Well-Being Therapy. Well-being therapy has been utilized in a variety of clinical trials with a multiple different mental health presentations. In

many cases, well-being therapy has been utilized in combination with cognitive behavioral therapy and compared against "treatment as usual" or "clinical management" conditions (Fava et al., 2011; 2005; 1998). One study randomized participants between either a cognitive behavioral therapy or a well-being therapy condition to assess the differential effects of well-being therapy on mental health and psychological well-being (Moeenizadeh & Salagame, 2010). However, whether as a standalone treatment or a combination treatment with cognitive behavioral therapy, well-being therapy has been demonstrated to have positive effects on depression, affective disorders, and anxiety (Fava et al., 2011; 2005; 1998; Moeenizadeh & Salagame, 2010). What follows is a review of clinical trials examining the effectiveness of well-being therapy.

The first study to look at well-being therapy's effectiveness (Fava et al., 1998) examined the impact of well-being therapy on the treatment of residual mental health symptoms after treatment for various affective disorders (e.g., major depressive disorder, panic disorder, generalized anxiety disorder). Twenty patients, after treatment, were randomized into either a well-being therapy or cognitive behavioral therapy treatment condition to manage residual symptoms, as residual symptoms have potential to result in relapse of severe mental health episodes. Both conditions led to reduction in residual symptoms, but the well-being therapy condition resulted in great reduction of symptoms and more improvement in overall psychological well-being (Fava et al., 1998).

Another study examined the impact of a cognitive behavioral therapy - well-being therapy combination therapy in the treatment of generalized anxiety disorder (Fava et al., 2005). Twenty participants with generalized anxiety disorder were randomly assigned to either eight sessions of pure cognitive behavioral therapy, or four sessions of cognitive

behavioral therapy with four subsequent well-being therapy sessions. Though, as expected, both treatment conditions resulted in reduction of anxiety, the cognitive behavioral therapy - well-being therapy combination therapy resulted in further reduction of anxiety and more improvement in psychological well-being.

Fava et al., (2011) examined the impact of well-being therapy in a sample of patients with cyclothymic disorder. 62 participants with DSM-IV cyclothymic disorder were randomly assigned to either a cognitive behavioral therapy - well-being therapy combination therapy or clinical management. The clinical management condition was described as providing support and resources for patients, and utilizing clinical techniques such as exposure strategies, journaling, and cognitive restructuring, simply not in a structured format like the cognitive behavioral therapy - well-being therapy treatment. Patients in the cognitive behavioral therapy - well-being therapy condition demonstrated greater improvements after treatment compared to the clinical management group, and these improvements were maintained at one- and two-year follow-up (Fava et al., 2011).

One study examined the impact of well-being therapy as a standalone treatment compared with cognitive behavioral therapy (Moeenizadeh & Salagame, 2010). In a sample of 40 participants with major depressive disorder, two groups were randomized into either a cognitive behavioral therapy group, or a well-being therapy group. Pre and post assessment measure depression with the two-item Beck Depression Inventory (BDI-II) and psychological well-being with the psychological well-being scales (Ryff, 1989). Both groups demonstrated reduction in depression scores after treatment, with the well-

being therapy group demonstrated lower depression scores than the cognitive behavioral therapy condition, and with a larger effect size (Moeenizadeh & Salagame, 2010).

Overall, well-being therapy's effectiveness in improving negative mental health symptoms and psychological well-being have been demonstrated in several clinical samples. In line with previous literature (Fava, 2016), it is hypothesized that the improvement in psychological well-being has the largest impact on maintenance of recovery from psychological distress. Furthermore, self-monitoring of episodes of well-being (as prescribed in well-being therapy; Fava, 2016) may lead to easier identification of automatic thoughts inhibiting psychological well-being, versus traditional cognitive behavioral therapy which focuses on monitoring episodes of psychological distress. Though well-being therapy has been examined in previous samples, as the current study is an examination of a Well-Being Therapy protocol for sexual minority individuals, it is important to examine how well-being therapy has been examined in other studies with diverse populations.

Empirical Studies of Well-being therapy with Diverse Populations

To date, only one study has examined the benefits of well-being therapy with a diverse group outside of the general population (Moeenizadeh & Zarif, 2017). In one study, the authors examined the impacts of well-being therapy for reducing depression in women experiencing infertility (Moeenizadeh & Zarif, 2017). This study contained 22 total participants. Eleven participants were assigned to a well-being therapy treatment condition, and the other eleven were waitlisted for well-being therapy, and participants were assessed via a 21-item depression, anxiety, and stress scale (DASS-21) and the psychological well-being. Participants in the well-being therapy group experienced

drastically higher scores on the psychological well-being than the waitlist-control group. Though this study demonstrates the effectiveness of well-being therapy with a specific group outside of the general population, there is an overall lack of studies examining well-being therapy's impact on other diverse groups.

Though the empirical literature on the application of well-being therapy with diverse groups is limited, scholars have hypothesized that well-being therapy could be beneficial to different groups (Nierenberg et al., 2016), namely, individuals with disability and chronic illness. Though, this was only hypothesized by Nierenberg et al., 2016, and not examined empirically. Though well-being therapy shows promise for improving psychological well-being, and relatedly, decreasing psychological distress, there needs to be more examination of well-being therapy in diverse populations. The focus of the current study is to examine the impact of a Well-Being Therapy protocol with a sample of sexual minority individuals using a multiple-probe single-case research design.

Conclusion

Chapter two discussed the philosophical and theoretical tenets of psychological well-being and a subsequent psychotherapy intervention (well-being therapy) developed out of a dominant theory of psychological well-being. There are a few large group studies examining the impact of well-being therapy on psychological well-being and mental health for individuals with various DSM mental health diagnoses. However, none of these have examined well-being therapy with sexual minority individuals. Chapter three discusses the methodological procedures of the multiple baseline single case research design on using well-being therapy to improve the psychological well-being and reduce

depression, anxiety, and stress of sexual minority individuals. Chapter four discusses the results of the study. Chapter five presents the implications, conclusions, and future research based on the results.

CHAPTER THREE

METHODOLOGY

Chapter one provided a general understanding and introduction of the issue under investigation, while chapter two examined the constructs being evaluated for the current study more in-depth. The current chapter discusses the methods for examining the proposed constructs. The major sections of the chapter include information on the research design, the setting and participants of the study, the intervention and implementation procedures, and the various measures used for data collection and analysis. The research questions for the current study were investigated quantitatively to test the effectiveness of an existing Well-Being Therapy protocol for sexual minority participants (Ledford & Gast, 2018).

Research Questions and Hypotheses

The current study utilized a multiple baseline single case research design to examine the effectiveness of a Well-Being Therapy protocol with a sample of sexual minority participants. The specific research objectives and procedures will be explained in more detail below. This following research questions guide the current study:

Research Question One

Does a Well-Being Therapy protocol improve the psychological well-being of sexual minority individuals as measured by the Psychological Well-Being Scales (Ryff, 2014). The Well-Being Therapy protocol will improve psychological well-being on the 42-item Psychological Well-Being Scales (Ryff, 2014) for sexual minority participants.

Research Question Two

Hypothesis

Does a Well-Being Therapy protocol improve mental health for sexual minority individuals as measured by the reduction in depressive symptoms from the 9-item Patient Health Questionnaire (PHQ-9)?

Hypothesis

The Well-Being Therapy protocol will improve mental health for sexual minority individuals as measured by a reduction in depressive symptom scores on the 9-item Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001).

Research Design

This study utilized a multiple baseline single case research design (SCRD) to test the effectiveness of the Well-Being Therapy protocol with sexual minority participants. Single case research designs are more often used in education research, but have started to make a strong emergence into the counseling field. Due to the rigor of the research design, single case research can demonstrate causality and generalizability just as other between groups experimental designs, as the individual or group that is involved in the study acts as its own control (Kratochwill et al., 2010). Three criteria make SCRD appropriate for answering research questions: (a) when testing the effectiveness of an intervention; (b) if the population of interest is small or specialized as it may be difficult to find large numbers of participants meeting that criteria; and (c) if the intervention of interest is new or novel to ensure there are no adverse effects from the intervention before using it with larger groups (Kratochwill et al., 2010). The nature of the current study meets all three of these criteria.

Additionally, SCRD can demonstrate causality and generalizability just as other between group experimental designs, as the individual or group that is being studied acts as its own control (Kratochwill et al., 2010). More specifically, I will utilize a multiple baseline design, as it allows for continuous, repeated measurement across participants, but does so intermittently to reduce threats to validity (e.g., testing fatigue, diffusion of treatment, extended time in baseline). SCRD discusses interventions in terms of baseline condition and intervention condition with each individual participant (Kratochwill et al., 2010). The baseline condition serves to ensure that the independent variable (e.g., psychological well-being) has been adequately isolated to reduce the probability that external factors were the reason for potential change in the participant. For the current study, the baseline condition was a waitlist period in which participants lived their lives normally without any other mental health counseling services and the intervention condition was the eight-week Well-Being Therapy protocol.

Sampling Procedure

The population for this study were adults over the age of 18 years of age who identify with a non-heterosexual sexual orientation and did not meet screening criteria for serious mental health concerns. Participants for the current study were recruited throughout South Carolina due to the research design being implemented. Participants in the current study are individuals from the community who are seeking out counseling services, not to be confused with the implementers in the study who are the treatment implementers. The research design requires consistent data collected over a long period of time, and the Well-Being Therapy protocol was being implemented at a private practice in South Carolina. Thus, recruitment near the location of the private practice was

necessary to increase accessibility to the treatment location. After two weeks of recruiting via emails to various LGBTQ- affirming venues in South Carolina, three participants were identified. Upon completion of a brief demographics form and a symptom checklist for serious mental health concerns, all three participants met the inclusion criteria. Therefore, the sample for the current study comprised four (N=3) sexual minority adults over the age of 18 who did not meet criteria for serious mental health concerns and were in South Carolina.

Data collection consisted of 20 consecutive weeks beginning the first full week of December 2021 and ending in the middle of April 2022. The primary investigator and a graduate research assistant collected data from participants weekly via a text message Qualtrics survey. Due to data collection beginning in December, when many participants and counselors were taking a holiday break, participant one remained in the baseline phase for five weeks where consistent level and trend were established, and she could move into the intervention phase of the study. There was a total of 8 counseling sessions per participant/implementer, 24 sessions total, scheduled during the study. Sessions were conducted in person or online via Google Meets (based on participant/implementer schedules) within a private practice owned by the treatment implementers in the study. If participants or implementers had to cancel or reschedule a session, they would simply continue the Well-Being Therapy protocol where they left off upon their next meeting, thus ensuring each participant received the full eight session Well-Being Therapy protocol.

Treatment Implementers

Three implementers of the Well-Being Therapy protocol were recruited from a private practice in the Southeastern region of the United States. The counselors were not the participants in the study, but rather, implemented the Well-Being Therapy protocol. Inclusion criteria for implementers were: (a) they must be mental health counselors (fully licensed or provisionally licensed and under the direct supervision of a licensed supervisor) and (b) have at least one sexual minority adult client over the age of 18 on their existing caseload. If counselors were not fully licensed, they needed to provide proof that they are currently being supervised by a licensed professional counselor supervisor and informed consent needed to be signed by the supervisor. Implementers received free training in the Well-Being Therapy protocol, which has been demonstrated as an evidence-based counseling intervention (Fava, 2016), as well as the physical copy of the Well-Being Therapy protocol treatment manual. All three implementers volunteering in the current study were fully licensed professional counselors, thus alleviating the concerns about supervision requirements.

In order to bolster internal consistency and replication of the current study, information and professional credentials of the treatment implementer are important to describe (Kazdin, 2011). Demographic information of the counselors were assessed via a demographic form administered through Qualtrics and will be described further. Additionally, which clients were seen by which treatment implementer is noted in Table 3.1. Though I did not collect data on the quality of the therapeutic alliance, I believe this information is important to document for external validity purposes as scholars have

spoken extensively about the importance of the therapeutic alliance for predicting counseling outcomes (Prochaska & Norcross, 2018).

Implementer one identifies as a 31-year-old White/Caucasian, heterosexual, cisgender female. She is a fully licensed professional counselor currently working in a private practice setting. She has practiced as a counselor for six years. She describes her counseling theoretical orientation as an integration of gestalt therapies, emotion-focused therapies, and person-centered counseling.

Implementer two identifies as a 37-year-old Black/African American heterosexual, cisgender female. She is a fully licensed professional counselor currently working in a private practice setting. She has practiced as a counselor for seven years. She describes her counseling theoretical orientation as stemming largely from cognitive behavioral therapy.

Implementer three identifies as a 39-year-old Black/African American, heterosexual, cisgender female. She is a fully licensed professional counselor currently working in a private practice setting. She has practiced as a counselor for four years. She describes her counseling theoretical orientation as an eclectic approach, with a foundation rooted in cognitive behavioral therapy, solution-focused therapy, and reality therapy.

Study Participants

Participants for the current study were recruited from the local community of the primary investigator in the Southeastern United States. The primary investigator emailed various LGBTQ+ affirming venues and social media pages (e.g., Facebook, Instagram), and also reached out to his university's LGBTQ+ resource center. Individuals interested in participating in the study filled out a screening form via Qualtrics asking about history

of various serious mental health concerns (e.g., suicidal ideation, hallucinations/delusions, experienced traumatic events) in the past six months (See Appendix B), as the nature of the current Well-Being Therapy protocol were not meant to address such serious mental health concerns. If participants did not endorse any of the serious mental health concerns, they were then asked to fill out a brief demographics form including age, sexual orientation, and gender identity, and were asked to provide their contact information. The primary investigator then contacted the first three eligible individuals that met screening criteria.

The primary investigator contacted the first three eligible individuals and arranged a meeting to discuss the informed consent process and what participation in the study would entail. Participants were informed that they would begin the study by not attending any therapy sessions (baseline phase) for a set period of time (kratochwill et al., 2010). Participants were informed that they would receive a total of $125 in Amazon giftcards for completing the 8-session Well-Being Therapy protocol ($25 after sessions 2, 4, 6, and $50 after the eight session). Participants were informed that participation is voluntary and were given informed consent documents to keep for their records. In the baseline phase, participants received weekly text messages from the primary investigator with the Qualtrics link to the Psychological Well Being Scales and the 9-item Patient Health Questionnaire.

After receiving the informed consent, participants were officially enrolled in the baseline phase of the study and began receiving weekly text messages with the Qualtrics survey. The primary investigator and a graduate research assistant plotted the data each week in Microsoft excel to determine when stability was established in the baseline

phase. Once stability was established and participants were ready to begin the Well-Being Therapy Protocol, the primary investigator contacted the three implementers, and they decided who amongst them (based on their current availability) would contact the participants to begin the intervention. For the current study, the implementers informed the primary investigator that they preferred to contact participants directly, given the nature of their private practice schedules. The demographics of the participants selected for the study are described below. All participants' names have been de-identified and have been replaced with pseudonyms/aliases that are different from the unique identifiers provided during data collection to ensure confidentiality and to illustrate respect for the participants and not minimizing their importance in this study by referring to them as just a number-letter combination.

Participant one, Casey, identifies as a 21-year-old, White/Caucasian, lesbian, cisgender female. Casey has had some college education, but no degree, and reports her current yearly household income as being in the $0-$9,999 range. She described her reasons for seeking counseling were to improve her general mental wellness and shift to a more positive outlook. She has had previous counseling as a young child in her elementary school but does not remember the reasons for receiving those services.

Participant two, Mary, identifies as a 20-year-old, White/Caucasian, lesbian, cisgender female. Mary has had some college education, but no degree, and reports her yearly household income as being between $150,000 to $174,999. She described her reasons for seeking counseling as wanting help with generalized anxiety and to acquire some better coping mechanisms. She reports previous experience seeing a counselor for seven months for familial issues and a major depressive episode.

Participant three, Kyle, identifies as a 30-year-old, Black/African American, gay, cisgender male. He holds a graduate degree and reports his yearly household income as being between $25,000 and $49,999. He reported his reasons for seeking counseling were to help develop better relationships. His previous experiences with counseling involved ten sessions over the course of a year as an adult.

Instruments

Demographic Survey

The demographics surveys for both counselors (See Appendix E) and clients (See Appendix D) were created by the researcher and collected various demographics (e.g., gender identity, age, highest level of education completed, sexual identity, reasons for seeking therapy, any previous therapy received and previous time spent in therapy). The counselor demographics form included additional items assessing experience as a counselor, such as number of years as a counselor, preferred theoretical orientation, and current setting in which they are practicing.

Psychological Well-Being Scales

Psychological well-being was measured using the 42-item Psychological Wellbeing Scales (Ryff et al., 2007) once weekly. In line with multiple baseline design, participants two and three received the measure intermittently in baseline, and once weekly in intervention. The Psychological Wellbeing Scale is comprised of six subscales (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance), and each item is rated on a 7-point likert scale (1 = strongly agree; 7 = strongly disagree). Example items include “In general, I feel I am in charge of the situation in which I live,” and “I enjoy making plans for the future and

working to make them a reality." 21 items on the measure are reverse-coded; thus, after reverse coding, total scores are gathered by adding the total scores on each item for each subscale. Total scores on each subscale then add up, with higher scores meaning more psychological well-being. Each of the subscales of the *Psychological Well-Being Scale* have demonstrated Cronbach's alpha coefficients that range from .85-.91.

Patient Health Questionnaire

I used the 9-item Patient Health Questionnaire to measure levels of depressive symptoms (Kroenke et al., 2001) intermittently in baseline, and once weekly during intervention. Clients were asked to report how often they have had various depressive symptoms over the last two weeks (e.g., little interest or pleasure in doing things, feeling down, depressed, or hopeless) on a 4-item Likert scale ranging from 0 (not at all) to 3 (nearly every day). The scale has cutpoints of 5, 10, and 15, representing mild, moderate, and severe levels of depressive symptoms. I will calculate the total scores at each point for an overall depressive symptom score, with higher scores indicating more depressive symptoms. The PHQ-9 has been shown across two large studies to have a good construct and criterion validity and reliability scores of .86 and .89 (Kroenke et al., 2001).

Social Validity

The questionnaire administered to clients will be the standardized Client Satisfaction with Services Questionnaire (CSQ-8; Nguyen et al., 1983) in order to assess the social validity of the intervention (Ledford & Gast, 2018). This measure has demonstrated cronbach's alphas ranging from .83 to .93 across numerous studies (Attkisson & Greenfield, 2004). The CSQ-8 consists of eight closed-ended questions with

response values ranging from 1-4, and is scored by adding up the scores of each item for a total sum.

Procedure

In line with multiple baseline single case research design protocol, treatment comprised of both a baseline condition and an intervention condition. It is recommended that the researcher collects data for at least three consecutive data points prior to entering the intervention condition. The first participant received at least three sessions in baseline before moving into the intervention condition. The second client remained in baseline until a change in level or trend is observed for the first client on their intervention condition, then the second client will move into the intervention condition. This process was repeated for the third participant.

Baseline Condition

A benefit of SCRD is that participants serve as their own controls (Kratochwill et al., 2010). This control happens in the baseline condition, defined as the condition in which participants do not receive the independent variable of the Well-Being Therapy protocol. For the current study, baseline was a waitlist period in which participants were not receiving any mental health counseling. Every week, the primary investigator would send a text message with the psychological well-being scales and the PHQ-9 to participants via a Qualtrics survey link. Participants would complete it on their own time. The primary investigator scored and plotted both total psychological well-being scale scores and PHQ-9 scores each week (unless not doing a probe) in order to make assessments about when participants can move into the intervention phase of the study. It has been documented that there should be at least three data points in baseline before

proceeding to the experimental condition (Kratochwill et al., 2010; Horner et al., 2005). Within these three data points, there should be a consistent pattern in level and/or trend of data points.

Intervention Condition

Well-being therapy is a structured, time-limited therapy intervention that lasts for eight weekly sessions (Fava, 2016), with each session lasting between 45-60 minutes. In accordance with the multiple baseline design, clients two and three did not begin receiving the Well-Being Therapy intervention until a change in level or trend was observed in the intervention condition for the client before them.

Well-being therapy is a derivative of cognitive-behavioral therapy, which posits that psychological distress is caused by negative automatic thought patterns, which influence one's feelings, then influencing one's behavior in a negative cycle that perpetuates itself. Typical cognitive-behavioral therapy involves training clients to challenge and reframe automatic negative thoughts.

Well-being therapy also intervenes at the negative automatic thoughts, but instead, challenges clients to think about things that bring them feelings of well-being (Fava, 2016). Using a structured diary, the purpose of well-being therapy is to train clients to challenge negative cognitions that lead to psychological distress by tapping into their inner well-being resources. Implementers in the current study received a copy of the Well-Being Therapy protocol manual (Fava, 2016) and received a one-hour training on the treatment protocol from the primary investigator.

For the current study, the primary investigator used a random number generator to decide who would be eligible to begin the intervention phase of the study first. Once

stability was established in baseline, the primary investigator contacted the treatment implementers, and they discussed among themselves who had the most current availability to see the participant. Once decided, the designated implementer would contact the participant and schedule their first counseling session utilizing the Well-Being Therapy protocol. Implementers met with the participants once a week (unless a scheduling conflict arose) for a one-hour counseling session. After each session, the implementers would send the primary investigator a recording of the session so he and another outside observer could conduct fidelity checks to ensure the Well-Being Therapy protocol was being implemented as intended.

Data Collection

Multiple baseline design does not require every participant to engage in continuous measurement every session (Ledford & Gast, 2018). For this study, all clients completed both the psychological well-being scales (Fava, 2016) and PHQ-9 after every session until baseline stability was established. Standard protocol is to have consistency in at least three to five data points in baseline (Kratochwill et al., 2011). Prior to the beginning of the study, both implementers and participants completed demographic forms. At the end of the study, participants completed the satisfaction with services questionnaire (Nguyen et al., 1983) for social validity purposes.

Interobserver Agreement (IOA)

The current study did not use IOA during data collection but did use IOA to enhance the rigor of treatment fidelity procedures. Two outside observers on the research team, outside of the implementers, observed recorded counseling sessions and utilized a treatment fidelity checklist to determine accurate implementation of the intervention. The

Well-Being Therapy manual has specific objectives to be met in each of the eight sessions. The primary investigator created a fidelity checklist based on these objectives in the manual (See Appendix H). The two observers used the checklists to ensure a level of agreement and ensure strong treatment fidelity.

Treatment Fidelity

Treatment fidelity in SCRD refers to the strategies used to evaluate the extent in which the intervention was implemented as it was intended or planned (Ledford & Gast, 2018). The treatment fidelity procedures in the current study included audiotaping counseling sessions between implementers and participants in the study, and assessment by two outside observers (the primary investigator and a master's level counselor education student). The assessment of the counseling sessions occurred at all counseling sessions. According to SCRD guidelines, collection of IOA of at least 20% of sessions across each condition (both baseline and intervention) is considered appropriate (Kratochwill et al., 2010). The Well-Being Therapy protocol is eight sessions in length, and treatment fidelity checks were conducted at every session. Upon completion of the checklists, the observers will engage in point-by-point interobserver agreement, indicating whether a component of the intervention occurred or not based on the markers indicated in the Well-Being Therapy manual (Fava, 2016). The scores were then divided but the total number of areas/components of the checklist and multiplied by 100 to get a percentage. It is ideal to get 100% IOA from the outside observers; however, 80% IOA is acceptable for data collection (Kratochwill et al., 2010).

Data Analyses

Data analytic procedures will be described below. First, I discuss more in-depth the independent and dependent variables in the current study. Then I discuss the primary analytic plan.

Threats to Validity

Internal Validity

In single case research, like all research designs, there are several threats to validity that could impact the results of the investigation. The most common threats to internal validity are (a) history effects, an event occurring at the time or during the experiment/study that could influence the results or outcomes; (b) maturation, any change or growth for the participant that occurs naturally over time; (c) instrumentation, any change in measurements or the way an instrument is used or the validity and relatability of the measure that influences the results of measurement of the construct under inquiry; (d) testing, any change that may be attributed to repeated testing or testing fatigue; and (e) diffusion of treatment, this occurs if the treatment intervention inadvertently enters the baseline stage or during times of the study when it is not supposed to, thus, influencing results of the study (Kazdin, 2011).

I took several initiatives to control for internal validity threats. First, the multiple baseline design is an attempt at controlling for testing threats, insofar as participants will be less likely to anticipate what I am assessing through the measures. By assessing at varying points in the study, rather than every time point, participants will be more likely to respond to each assessment truthfully. Additionally, there is the possibility of maturation threats to internal validity, as it has been documented that a strong therapeutic

alliance can contribute to positive therapeutic outcomes (Prochaska & Norcross, 2014). Although there are limitations and threats to internal validity, these threats were accounted for and safeguarded against as best as possible without reducing the external validity of the investigation. Though I did not collect data assessing the quality of the therapeutic alliance in the current study, I do note the implementer/participant pairings for external validity purposes in Table 3.1.

Table 3.1 Treatment Implementer and participant pairings.

Implementer	Participant
Implementer 1	Casey
Implementer 2	Kyle
Implementer 3	Mary

External Validity

The therapists recruited for the study all practiced in the same private practice setting. To account for this and increase the replicability of the current study, I collected information about the therapist's setting in the demographics form. Additionally, collecting other information on the demographics form, such as the theoretical orientation of the therapists, will help to increase replicability of the study.

Independent Variable

The independent variable for the study will be the Well-Being Therapy protocol. The well-being therapy is an 8-session manualized treatment to increase psychological well-being (Fava, 2016). I will provide a one-hour training for implementers participating

in the study on the Well-Being Therapy protocol using the treatment manual. Each implementer will also receive a physical copy of the treatment manual. Specific procedures for implementing the independent variable to participants are described below. Specific procedures for ensuring treatment rigor were discussed in the treatment fidelity section above.

Dependent Variables

The dependent variables for the current study are self-reported scores on the total scores of the Psychological Well-Being Scales (Ryff, 2014) and total depressive symptom scores on the PHQ-9. I will discuss the assessment scales used in the current study below.

Primary Analytic Plan

Visual analysis was used to analyze the research question. Visual analysis assesses six components of graphed data across phases and participants to identify a causal relationship between constructs as well as the magnitude and strength of that causal relationship. The six components of visual analysis include: (a) level, the mean or line indicating presence of the data points in both phases; (b) data trend or slope, the direction or degree of the data path over time; (c) data variability, the stability of the data; (d) consistency of patterns across similar phases, stability or pattern of data in each phase; (e) immediacy of effect, time and magnitude of an effect after the intervention was implemented; and (f) data overlap, how many data points in one phase overlap or are the same as data points in another phase (Kratochwill et al., 2010). Additionally, three basic effects, at three different points in time, were needed to determine the effectiveness of the intervention (Ledford & Gast, 2018; Kazdin, 2011).

Vertical analysis was also utilized to determine that the participants still in the baseline phase do not change once the intervention is administered to another participant. Additionally, three basic effects, at three different points in time, are needed to determine the effectiveness of the intervention. A basic effect was determined after the introduction of the independent variable at one contrast between phases (i.e., if the slope, level, or variability is different from predicted in the baseline condition). Data analysis was conducted each week. The researcher received, scored, and plotted data from both the psychological well-being scales and the PHQ-9 measures each week to determine when participants move from the baseline to intervention condition. Decisions to move participants into the intervention conditions were based on the scores of the psychological well-being scales, as this was the main research question.

Ethical Considerations

It is the researchers' responsibility to inform the participants of potential risks and benefits of participating in the current study and to obtain informed consent of the participants. I followed the human subjects protocol that was approved by the university's institutional review board (IRB) in order to ensure the confidentiality of participants and identified risks and benefits of participating in this study. Other than the potential for discomfort caused by increased awareness, there are no known risks associated with participating in this research, except for slight risk of breach of confidentiality, which steps will be taken to protect. Though the results of the study will be disseminated, participant identities will not be revealed. Participation in this study was completely voluntary and participants were informed that they were free to withdraw from the study at any time, without negative consequences. To ensure the study is

conducted with integrity, fidelity, and in line with ethical standards, the following measures will be taken:

1. The study did not begin until approved by the dissertation chair and committee members, as well as the Institutional Review Board at the University of South Carolina.
2. Participation in this study was voluntary with the opportunity to withdraw participation at any point, and all participants were informed of this in their informed consent document.
3. Both implementers and participants were deidentified and provided a pseudonym to ensure confidentiality of participation.
4. All data were stored in a double-locked cabinet and all electronic data will be stored on a password protected Qualtrics account.
5. Consent forms were provided to all participants.
6. Permission to use measures/instruments were obtained before use.

Chapter Summary

Chapter three discussed the plan for investigating the proposed Well-Being Therapy protocol with sexual minority individuals. The methodology described in this chapter included: (a) research questions and hypothesis, (b) research design, (c) population and sampling procedures, (d) instrumentation, (e) data collection methods, (f) intervention procedure, and (g) data analysis. In chapters four and five, I will discuss the results of this inquiry and the implications of the current study.

CHAPTER FOUR

RESULTS

Chapter Four presents the results of the investigation, addressing each research question and construct measured individually. The purpose of the current research study was to examine the effectiveness of Fava's (2016) Well-Being Therapy protocol with a sample of sexual minority adults. This investigation utilized a multiple baseline single case research design, across four participants, to examine the effectiveness of the Well-Being Therapy protocol on sexual minority individuals' psychological well-being. In the current study, psychological well-being was measured by Ryff's (1989) Psychological Well-Being Scales. As this measure has not been systematically utilized in the concurrent, weekly measurement schedule of single case research designs, we also measured depressive symptoms with a brief 9-item Patient Health Questionnaire (Kroenke et al., 2001), as the relationship between psychological well-being and depressive symptoms has been documented in previous studies (Rostosky et al., 2018).

Population and Sample

The population for this study were adults over the age of 18 years of age who identify with a non-heterosexual sexual orientation and did not meet screening criteria for serious mental health concerns. Participants for the current study were recruited throughout South Carolina due to the research design being implemented. Participants in the current study are individuals from the community who are seeking out counseling services, not to be confused with the counselors in the study who are the treatment

implementers. The research design required consistent data collected over a long period of time, and the Well-Being Therapy protocol was being implemented at a private practice in South Carolina. Thus, recruitment near the location of the private practice was necessary to increase accessibility to the treatment location. After two weeks of recruiting via emails to various LGBTQ- affirming venues in South Carolina, three participants were identified. Upon completion of a brief demographics form and a symptom checklist for serious mental health concerns, all three participants met the inclusion criteria. Therefore, the sample for the current study comprised four (N=3) sexual minority adults over the age of 18 who did not meet criteria for serious mental health concerns and were in South Carolina.

Data collection consisted of 20 consecutive weeks beginning the first full week of December 2021 and ending in the middle of April 2022. The primary investigator and a graduate research assistant collected data from participants weekly via a text message Qualtrics survey. Due to data collection beginning in December, when many participants and counselors were taking a holiday break, participant one remained in the baseline phase for five weeks where consistent level and trend were established, and she could move into the intervention phase of the study. There was a total of 8 counseling sessions per participant/implementer, 24 sessions total, scheduled during the study. Sessions were conducted in person within a private practice owned by the counselors in the study. If participants or implementers had to cancel or reschedule a session, they would simply continue the Well-Being Therapy protocol where they left off upon their next meeting, thus ensuring each participant received the full eight session Well-Being Therapy protocol.

Participants

Participants for the current study were recruited from the local community of the primary investigator in the Southeastern United States. The primary investigator emailed various LGBTQ+ affirming venues and social media pages (e.g., Facebook, Instagram), and also reached out to his university's LGBTQ+ resource center. Individuals interested in participating in the study filled out a screening form via Qualtrics asking about history of various serious mental health concerns (e.g., suicidal ideation, hallucinations/delusions, experienced traumatic events) in the past six months, as the nature of the current Well-Being Therapy protocol were not meant to address such serious mental health concerns. If participants did not endorse any of the serious mental health concerns, they were then asked to fill out a brief demographics form including age, sexual orientation, and gender identity, and were asked to provide their contact information. The primary investigator then contacted the first three eligible individuals that met screening criteria.

The primary investigator contacted the first three eligible individuals and arranged a meeting to discuss the informed consent process and what participation in the study would entail. Participants were informed that they would begin the study by not attending any therapy sessions (baseline phase) for a set period. Participants were informed that they would receive a total of $125 in Amazon giftcards for completing the 8-session Well-Being Therapy protocol ($25 after sessions 2, 4, 6, and $50 after the eight session). Participants were informed that participation is voluntary and were given informed consent documents to keep for their records. In the baseline phase, participants received

weekly text messages from the primary investigator with the Qualtrics link to the Psychological Well Being Scales and the 9-item Patient Health Questionnaire.

After receiving the informed consent, participants were officially enrolled in the baseline phase of the study and began receiving weekly text messages with the Qualtrics survey. The primary investigator and a graduate research assistant plotted the data each week in Microsoft excel to determine when stability was established in the baseline phase. Once stability was established and participants were ready to being the Well-Being Therapy Protocol, the primary investigator contacted the three counselors participating as the treatment implementers, and they decided who amongst them (based on their current availability) would contact the participants to begin the intervention. For the current study, the counselors informed the primary investigator that they preferred to contact participants directly, given the nature of their private practice schedules.

Research Question Results

The order in which the three participants would be ranked to receive the intervention was decided using a random number generator. Each week in the intervention phase of the study, counselors implementing the Well-Being Therapy protocol informed the primary investigator of their anticipated session times with participants, allowing the primary investigator to know what day and time to send the survey to participants via Qualtrics. Immediately following the sessions, participants completed the Qualtrics survey that included both the Psychological Well-Being Scales and the 9-item Patient Health Questionnaire. All participants' names have been de-identified and have been replaced with pseudonyms/aliases that are different from the unique identifiers provided during data collection to ensure confidentiality and to

illustrate respect for the participants and not minimizing their importance in this study by referring to them as just a number-letter combination.

Research Question One

The first research question examining a causal relationship in this study was, "Does an 8-session Well-Being Therapy protocol improve the overall psychological well-being of sexual minority individuals?". Participants levels of psychological well-being were measured using Ryff's (1989) Psychological Well-Being Scales. The visual analysis of participants' psychological well-being scores can be seen in Figure 4.1.

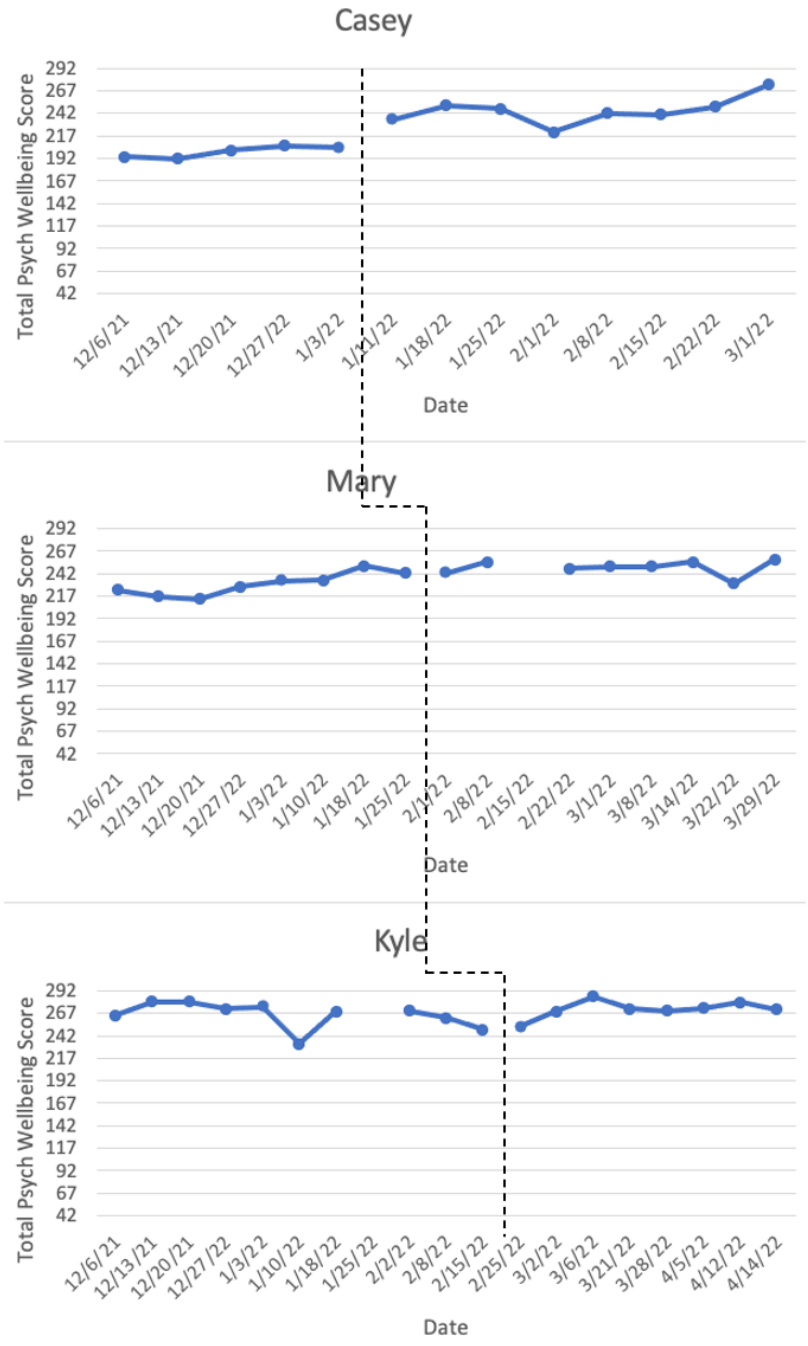

Figure 4.1 Visual Analysis of Psychological Well-Being Scores Among Participants

Casey's baseline phase was the shortest (five sessions) among all participants, as she was the first participant chosen to receive the Well-Being Therapy protocol via a

random number generator. Due to the counselors and participants being on leave for the holiday break, Casey was set to be in the baseline phase for a minimum of five sessions until both she and her assigned counselor returned from the holiday break. Casey's data were slowly moving upward throughout the baseline phase, ranging from 192 to 206 with a mean of 199.6. Though Casey's scores had a slight upward trend, there was variability in the trend such that overall, the level remained relatively stable. Thus, after the fifth week of baseline, Casey was ready to move into the intervention phase of treatment.

Casey moved into the intervention phase after five sessions of the baseline phase of not attending any therapy. Using the last three data points in baseline for comparison, there was an immediate change in level and slope after Casey began receiving the Well-Being Therapy protocol. After the first session of the intervention phase, Casey's total score on the Psychological Well-Being Scales was 235, an increase from 205 the week prior in baseline. Overall, Casey's data remained stable in level throughout the intervention phase, except for a downward slope after the fourth session. However, that drop in slope leveled back out the following week and increased until treatment ended. Of note, Casey's highest score on the Psychological Well-Being Scales was after her final session in the intervention phase. During the intervention phase, Casey's scores ranged from 221 to 274, with a mean of 245. Additionally, there were no overlapping data points between intervention and baseline for Casey, supporting a basic effect of the Well-Being Therapy protocol on Casey's psychological well-being.

After a basic effect was confirmed after session four of Casey's intervention phase, Mary moved into the intervention phase of the study. Throughout baseline, Mary already had an upward trend in her psychological well-being scores. At session two of the

intervention phase, there was another upward trend in her data. However, Mary had to reschedule her third session for the following week. Upon resuming with the Well-Being Therapy protocol, her scores dropped back down to the same level as her first data point in intervention and the final three data points of baseline. There was a slight decrease in psychological well-being scores in session seven, which increased after session eight to the highest psychological well-being score Mary reported throughout the entire study. Despite being the highest psychological well-being score reported by Mary, it was not significantly higher than Mary's other data points. Furthermore, the level of Mary's data throughout intervention remained similar to the level of her baseline phase. Additionally, the percentage of nonoverlapping data between Mary's baseline and intervention phases was 37.5%, supporting the finding that there was no basic effect of the Well-Being Therapy protocol on Mary's psychological well-being.

Kyle began the intervention phase of the study after Mary's second session in intervention. Kyle began the study with high psychological well-being scores, and this did not change much in the intervention phase. After session three, there was a clear upward trend in Kyle's psychological well-being scores. However, his scores leveled back out after session four and remained at the same level overall as his scores in baseline. Kyle's scores on the psychological well-being scales in the intervention phase ranged from 252 to 286, where the max score on this measure is 292. Additionally, only 12.5% of Kyle's data were nonoverlapping between baseline and intervention phases, supporting the finding that there was no basic effect of the Well-Being Therapy protocol on Kyle's psychological well-being.

Research Question Two

The second research question in the current study was, "Does an 8-session Well-Being Therapy protocol improve mental health for sexual minority individuals by reducing depressive symptoms, as measured by the 9-item Patient Health Questionnaire?". The visual analysis of participants' PHQ-9 scores can be seen in Figure 4.2.

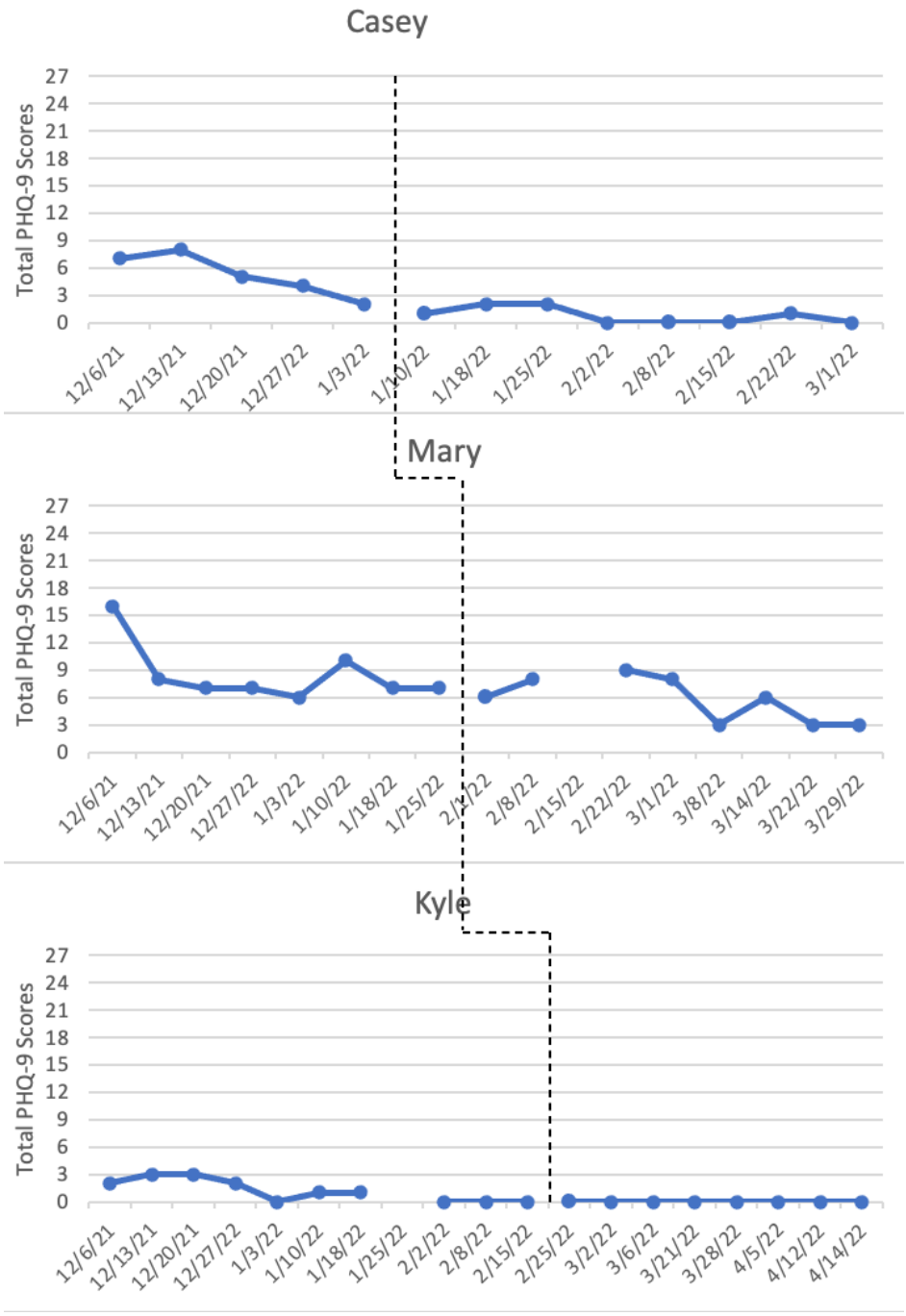

Figure 4.2 Visual Analysis of PHQ-9 Scores Among Participants

Casey's score on the 9-item Patient Health Questionnaire started out at a 7, and slightly increased to an 8 the following week. However, throughout baseline, her

depressive symptoms score projected a downward slope until the end of baseline. Her scores ranged from 2 to 8 with a mean of 5.2.

In the intervention phase, there was an immediate drop down to a score of 1 for Casey. Furthermore, Casey's scores on the PHQ-9 remained stable in level and trend with very little variability throughout the intervention phase. Her data in the intervention phase ranged from 0-2, with a mean of 0.75. Additionally, there was 25% overlap in data points between intervention and baseline phases for Casey. However, these data should be cautiously interpreted, as Casey's scores on the PHQ-9 was already decreasing in baseline and could have potentially reached 0 without even entering the intervention condition. As such, given the already downward trend of Casey's PHQ-9 scores in the baseline phase, there is not sufficient evidence to conclude a basic effect of the Well-Being Therapy protocol on Casey's depressive symptoms.

Mary's depressive symptoms started off in baseline in the "moderately severe" range with a score of 16 on the PHQ-9, but dropped down into the "mild" range in the next session. Apart from the score of 10 in week six of the baseline phase, Mary's scores on the PHQ-9 remained in the mild range throughout the duration of baseline. Upon beginning the Well-Being Therapy protocol, Mary's self-reported depressive symptoms remained consistent in level and trend with her baseline self-reported depressive symptoms scores for the first four sessions of the intervention phase. However, beginning in session five, Mary's scores dropped down to the "minimal" range with a score of 3 on the PHQ-9. In session six of the intervention, her score increased back into the mild range with a 6, and then decreased back down into the minimal range for the final two sessions of the Well-Being Therapy Protocol.

Though there was slight variability in Mary's PHQ-9 scores throughout intervention, ultimately there is a downward trend in her scores from the beginning of intervention to the end. Furthermore, there was a 37.5% overlap in data points between baseline and intervention phases for Mary's PHQ-9 scores. Overall, the effects of the Well-Being Therapy protocol on Mary's self-reported depressive symptoms were much harder to discern than Casey's; however, I conclude that due to the downward trend in her PHQ-9 scores throughout the intervention phase, there was a basic effect of the Well-Being Therapy protocol on Mary's self-reported depressive symptoms.

Kyle's PHQ-9 scores were variable throughout the first half of the baseline phase, though all remaining between 0 and 4. By the end of baseline, Kyle's scores had gone completely down to 0, indicating an absence of depressive symptoms. His scores remained at 0 throughout the entire intervention phase. This would not be considered a basic effect, as Kyle's last three data points in baseline were at 0, thus indicating no change in level or trend in intervention.

Vertical analysis was also conducted for this construct throughout the study for all participants in all phases. Through vertical analysis, the data was analyzed as new data points were plotted to ensure that the participants in baseline were not responding in ways similar to the participants in intervention. Through consistent vertical analysis, there were no changes among the three participants in this study during baseline or intervention that proved questionable or appeared to influence the data other than the intervention training. Therefore, through vertical and visual analysis, one participant illustrated a small basic effect for psychological well-being, and two participants demonstrated basic effects for reduction in depressive symptoms.

Treatment Fidelity

Treatment fidelity, also known as treatment integrity, is used in single case research when data are collected during the intervention phase only and can be described as the degree of adherence between the planned intervention procedures to the actual implemented intervention procedures (Ledford & Gast, 2018). Variability in intervention implementation across participants may result in variability of outcomes and a reduction in reliability of the study's results (Kazdin, 2011). To establish strong treatment fidelity, the intervention training was video recorded and saved to a shared Google Drive folder between the primary investigator and treatment implementers. The two outside observers were provided a Treatment Fidelity Checklist or rating sheet with the procedures of the intervention to complete after reviewing the audio recording of each session (Appendix H). Upon completion of the checklist the observers independently calculated their own treatment fidelity percentage by dividing the number of observed procedures completed by implementer by the number of planned procedures and then multiplying by 100.

To ensure rigor and high adherence to intervention implementation, interobserver agreement (IOA) was utilized between observers. Interobserver agreement is not required for treatment fidelity processes; however, IOA is typically used to assess the accuracy of observational measurement of the variable under investigation (Kazdin, 2011). Typically, IOA is completed on 20-33% of observations per phase and requires a minimum of 80% IOA to ensure valid results (Ledford & Gast, 2018; Kazdin, 2011). However, since this study did not utilize observational measurement of the primary dependent variable, IOA was not used in this way. Instead, IOA was used to ensure rigor during the assessment of treatment fidelity. Therefore, IOA was collected on 100% of all intervention sessions.

The IOA process between the two outside observers demonstrated 97.8% adherence to the intervention protocols in two of the participants' interventions, which resulted in 98.5% overall treatment fidelity across all intervention implementations.

Social Validity

Social validity is a key component of single case research as applied research strives to investigate socially important goals, interventions/treatments, and outcomes for the participants of interest (Kazdin, 2011). Additionally, if the interventions/treatments are more acceptable and easily implemented, they will be more likely to be used by others in the future (Kazdin, 2011). The social validity of the current study was assessed using the 8-item Client Satisfaction with Services Questionnaire (CSQ-8; Nguyen et al., 1983). The primary investigator also added an open-ended question asking participants if they would like to share anything else about their experience with the Well-Being Therapy protocol. The scores of the CSQ-8 ranges from 8 to 32, with higher scores indicating greater satisfaction with the intervention. For the current study, Casey reported a satisfaction score of 29, Mary reported a satisfaction score of 27, and Kyle reported a satisfaction score of 32. Casey and Mary did not provide responses to the open-ended question, but Kyle indicated the following:

> "This was a great experience. My therapist was amazing and we just clicked, it was an experience that I will take with me throughout my journey".

Chapter Summary

Chapter Four presented the results of the data analyses utilized in this investigation. Areas of analysis included: (a) visual analysis of the data, (b) treatment fidelity, and (c) social validity of the intervention training. Chapter Five includes a

discussion of the results, areas and recommendations of future research, implications for counselor preparation, counselor educators, counselors, and supervisors and limitations of the study.

CHAPTER FIVE

DISCUSSION

Chapter five includes a summary of the investigation, including the purpose of the study, research methodology, and results. Conclusions drawn from this investigation are based on the results and hypotheses and will be presented and discussed in this chapter. The chapter concludes with a discussion of: (a) study limitations, (b) implications for counselor education and professional counselors, and (c) areas of future research.

Summary of the Study

The current study also carries with it specific professional and social significance. Various court cases have occurred involving both practicing counselors and students in counseling training programs that offer grounds for refusing services to LGBTQ clients based on one's personal and/or religious beliefs (*Cash v. Hofherr*; *Keeton v. Anderson-Wiley*; *Ward v. Polite*). These court cases were initiated by practitioners who wanted to refuse services due to them conflicting with their own personally held beliefs about LGBTQ individuals. Thus, LGBTQ individuals, and in the case of the current study, sexual minority individuals, experience very specific barriers to receiving high-quality mental health counseling services.

Due to experiences of minority stress, sexual minority individuals are at higher risk of experiencing mental health and well-being concerns than heterosexual individuals (Cochran et al., 2003; Meyer, 2003). Many previous studies discussing mental health and well-being disparities among sexual minority individuals do so from a deficit

perspective—that is, focusing only on reduction of negative symptoms (Harper et al., 2013; Moradi et al., 2009). Recent scholars have begun calling for more research examining sexual minority mental health from a positive psychology perspective (i.e., how can we not only reduce negative mental health symptoms, but also promote longer-lasting well-being for sexual minority individuals; Harper et al., 2013; Moradi et al., 2009).

Meyer (2015) discusses the other side of minority stress, that is, developing and nurturing the resilience and positive mental health changes that can occur from living in a culture of minority stress. The current study sought to develop psychological well-being among sexual minority clients through a manualized Well-Being Therapy protocol. Well-Being Therapy aims to enhance psychological well-being through emphasizing various aspects of well-being, such as: autonomy, personal relationships, purpose in life, personal growth, environmental mastery, and self-acceptance. However, the effectiveness of a Well-Being Therapy treatment protocol has not yet been examined for sexual minority clients, despite potential for improving overall psychological well-being. Thus, the current study examined the effectiveness of a Well-Being Therapy protocol in a sample of sexual minority individuals using a multiple baseline single case research design.

Discussion of Results

The results and finds of this study are contextualized to other research on psychological well-being, positive psychology, and sexual minority mental health presented in chapter two. In order to determine a causal relationship between the intervention's effects on the dependent variables in single case research, at least three basic effects need to occur among the data. This means, through visual analysis, each

participant in the study (N=3) needs to illustrate a change in slope, level, or a change in both slop and level across phases over time in their data. Finally, inferences and conclusions from the results of each research question are made.

Research Question One

The first research question examined if there was a causal relationship between the Well-Being Therapy protocol and psychological well-being among sexual minority individuals by asking the question "Does a Well-Being Therapy protocol improve psychological well-being for sexual minority individuals?". Psychological well-being was assessed via the Psychological Well-Being Scales (Ryff, 1989). As stated in Chapter Four, only one basic effect can be ascertained from the vertical analysis, which was for Casey's psychological well-being scores.

Casey had the lowest psychological well-being score of the three participants in the current study, thus having room to improve from the beginning. Casey's two lowest domains of psychological well-being were in the autonomy and environmental mastery domains. That is, Casey began the study with very little sense of herself as an independent person with agency and felt as though she had little control over her life circumstances. Throughout the Well-Being Therapy protocol, Casey discussed noticing things in her life that she was unhappy with, and learned to live without them (e.g., she dropped a dreaded French class she was taking in college after the second session of intervention). Her environmental mastery score improved by 20 points from the beginning of her baseline phase to the end of the intervention phase, thus indicating that Casey was learning how to take control of her life situations after participating in the Well-Being Therapy protocol.

Mary did not demonstrate a basic effect from the Well-Being Therapy protocol in her psychological well-being scores. After session two of the intervention phase, it appeared as if Mary's psychological well-being scores were moving in an upward slope. However, she had to reschedule her third session due to conflicts with her college schedule, and upon resuming session three two weeks after session two, her scores had flattened back out to what they were previously, and then remained consistent in level. Mary's data were particularly unique, as, upon conducting fidelity checks, the outside observers learned that she had other outside life circumstances that could be interfering with her ability to work through her well-being in the study. For example, Mary had a very sick family member in the hospital during her time in the study, and thus, was possibly grieving, or anticipating grieving. Additionally, she had been to her primary care provider throughout her time in the study and changed her psychotropic medication in the middle of the study, which she shared with her treatment implementer. It is fortunate that her psychological well-being did not decrease throughout the study with all these outside circumstances in Mary's life, however, this may explain why he psychological well-being never improved drastically from the Well-Being Therapy protocol.

Kyle began the study with high psychological well-being scores, almost presenting with a ceiling effect in his scores. Overall, there was no basic effect observed for Kyle's psychological well-being scores. After session three of the intervention phase, it appeared as if Kyle's data were moving in an upward slope and were almost at the highest point offered by the psychological well-being scales. However, his data leveled back out to what they were previously and remained relatively consistent throughout the remained of the intervention. Kyle scored high on all subscales of the psychological well-

being scales from the beginning of the study, except for in the self-acceptance domain. Of note, by the end of the study, his scores in the five other subscales remained consistent, but his self-acceptance score improved by five points by the end of intervention. Though Kyle did not demonstrate a basic effect in total psychological well-being, he did not have much room to improve in the first place, and where he did (in the self-acceptance domain), he did improve slightly, suggesting the Well-Being Therapy protocol was helpful in the domain in which Kyle needed.

Research Question Two

The second research question examined if there was a causal relationship between the Well-Being Therapy protocol and psychological distress among sexual minority individuals by asking the question "Does a Well-Being Therapy protocol improve mental health for sexual minority individuals. Mental health was assessed via the 9-item Patient Health Questionnaire (Kroenke et al., 2001).

Casey began with the study with a PHQ-9 score in the "mild" range for depressive symptoms, which steadily decreased in slope until her last week in the baseline phase. Upon starting the intervention phase, her PHQ-9 score decreased slightly, and remained a consistent level overall, even getting to 0 for three weeks in the middle of her intervention phase. Casey's scores decreasing on the PHQ-9 make sense in relationship to her psychological well-being scores, such that as her psychological well-being scores increased, her depressive symptoms decreased, in line with previous literature (Rostosky et al., 2018).

Mary's PHQ-9 scores were the highest of all three study participants at the beginning of the baseline phase, being in the "moderately severe" range of depressive

symptoms. However, this score decreased dramatically the following week to the "mild" range of depressive symptoms and remained steady for the remainder of the baseline phase. Upon entering the intervention phase of the study, Mary's PHQ-9 scores remained in the mild range until session five, in which they decreased below a score of 5 and remained steadily until the end of the intervention phase. One possible explanation for this is that she did change her psychotropic medication midway through the intervention phase, which specifically targeted alleviating depressive symptoms. Another explanation is that even though her psychological well-being scores did not improve drastically enough to consider it a basic effect, her scores did remain steady and continue in a very slight upward trend. Perhaps with more time in treatment, her psychological well-being and depressive symptoms would continue to improve.

Much like his psychological well-being scores, Kyle did not have much room to improve regarding his PHQ-9 scores. He consistently reported scores below the "mild" range of depressive symptoms for the first half of baseline, which eventually decreased to 0 and remained at 0 until the end of the intervention phase of the study. This is consistent with his psychological well-being scores, which were almost experiencing a ceiling effect from the beginning of the study. Kyle's PHQ-9 scores and psychological well-being scores being consistent with one another suggests there may be a relationship between psychological well-being and depressive symptoms, consistent with previous literature (Riggle et al., 2017).

Social Validity

Social validity of the current study was assessed via the Client Satisfaction with Services Questionnaire (CSQ-8; Nguyen et al., 1983). The CSQ-8 ranges in scoring from

8-32, with higher scores indicating more satisfaction with services. All three participants reported being very satisfied with services, even the participants who did not demonstrate basic effects in their ratings of their own psychological well-being, such as Mary and Kyle. Casey demonstrated basic effects in both her psychological well-being scores and her depressive symptom scores, so it was not surprising to see that she reported a high satisfaction score. A basic effect was also observed among Mary's PHQ-9 scores, despite not appearing for Mary's psychological well-being scores, thus indicating improvement in at least one of the areas under investigation in the current study. This finding, paired with Mary's high satisfaction with services is indicative that the Well-Being Therapy protocol was well-liked by Mary. Kyle's endorsement of a maximum satisfaction score of 32 was understandable, though, as his psychological well-being scores were already almost experiencing a ceiling effect when he began the study. Additionally, his depressive symptoms on the PHQ-9 were in the below the "mild" range when they were at their highest at the beginning of his baseline phase, thus indicating that he already had high psychological well-being.

Limitations

Though this study provided a novel approach to intervening to improve the psychological well-being of sexual minority participants using a single case research design, there were clear limitations. One limitation is that the assessments in the current study were not used as inclusion criteria, thus allowing a participant like Kyle, who already had high psychological well-being, into the study which made achieving a basic effect unlikely. Additionally, several limitations exist with the psychological well-being measure used in the current study. For one, the six-factor structure of the psychological

well-being scales has not been confirmed with sexual minority samples, thus it is not clear if this measure even accurately captures the experience of psychological well-being for sexual minority participants.

The psychological well-being scales are also limited in that there is no sensitivity to change data for their use. Thus, it is unclear if this measure is appropriate for the concurrent measurement required by single case research design. Though the current study tried to make up for this by also assessing well-being using the PHQ-9, there is no way of being certain until more research is conducted on the sensitivity of the psychological well-being scales.

Another major limitation of the current study is that the quality of the therapeutic alliance was not assessed. Previous scholars have spoken to the importance of the therapeutic alliance for predicting positive counseling outcomes (Prochaska & Norcross, 2014). Upon completing fidelity checks, it was clear that some participant/implementer relationships were stronger than others, but there was no way to accurately measure this in the current study. Another concern with measuring therapeutic alliance for the current study was concern around the already long 42-item psychological well-being scales. Additionally, Kyle spoke to the positive qualities of his implementer in his satisfaction survey, suggesting that this may have played an important role in the outcomes of the study.

Furthermore, the current study used a broad Well-Being Therapy protocol with sexual minority individuals, rather than adapting it culturally to the specific minority stress-related mental health concerns of the sample. Pachankis (2014) notes that

interventions used with sexual minority individuals should be adapted through a minority stress lens and provides concrete steps on how to do so.

Implications

Despite the current study's limitations, there are several positive implications for counselor education, practice, and research. Previous scholars have noted that many counselors often graduate from their counselor training programs feeling unprepared to work with sexual and gender minority clients (Miller et al., 2007; Troutman & Packer-Williams, 2014). The current study is one attempt at examining effective counseling interventions with sexual minority clients (i.e., what really works or not). Counselor educators can use these findings in various classes in the counselor education curricula, such as diagnosis, counseling skills, multicultural counseling, and counseling practicum to help counselors-in-training evaluate the quality of effective counseling interventions for sexual minority individuals. For well-intentioned counselors who do not feel competent working with sexual minority clients, having manualized treatment protocols that have demonstrated effectiveness with sexual minority clients may be a viable entry point into working with sexual minority clients.

As mentioned in chapter two, there is a call for counselors to conceptualize sexual minority mental health through a positive psychology lens; rather than focusing solely on existing mental health disparities, counselors should also explore ways in which to help their sexual minority clients flourish. Despite not demonstrating a functional relationship on improving psychological well-being, the Well-Being Therapy protocol was evaluated very positively by the participants in the study. Additionally, though the Well-Being Therapy protocol only demonstrated a basic effect for Casey, both Mary and Kyle's

psychological well-being remained stable, with variable improvements throughout the intervention phase of the study. These findings, paired with the positive client satisfaction ratings, suggest that intervening in sexual minority mental health from a psychological well-being framework may still be appropriate. While counselors may feel pressure from outside entities to diagnose mental health concerns in their sexual minority clients, they can also have frank conversations with their sexual minority clients about how developing and improving psychological well-being may also be effective at relieving psychological distress.

Another implication of the current study is in its contribution to the positive psychology intervention literature with sexual minority individuals. Intervention studies from a positive psychology philosophy are needed (Harper et al., 2013; Moradi et al., 2009). Sexual minority individuals already experience barriers to accessing quality mental health (Walsh & Goldberg, 2020), and many counselors report being unfamiliar with how to help sexual minority clients effectively (Farmer, 2017). Counselor educators should discuss sexual minority mental health disparities with their students, and specifically, how to evaluate the quality of existing mental health interventions for sexual minority clients. Additionally, counselor educators should emphasize the importance of conceptualizing sexual minority mental health disparities through a minority stress framework—thereby taking the blame off the sexual minority clients for experiencing the side effects of living in a heterosexist culture (Meyer, 2003).

The current study was the first application of a Well-Being Therapy protocol with a sample of sexual minority individuals. Though the satisfaction survey suggested participants were happy with the services they received, the visual analyses suggest that

Well-Being Therapy cannot yet be considered a viable treatment option for all sexual minority individuals. Counselors deciding to utilize Well-Being Therapy with their sexual minority clients should discuss this modality with their clients to gauge if it might be a good fit for treatment. For example, counselors can use the Psychological Well-Being Scales to assess potential clients' current levels of psychological well-being. If the potential client already scores high on levels of psychological well-being, then they might not benefit directly from well-being therapy.

Future Research

Though the findings of the current study shed light on one specific intervention for sexual minority psychological well-being, there are many avenues by which future studies could continue to contribute to this line of research. One study could conduct a confirmatory factor analysis of Ryff's (1989) psychological well-being scales with a sample of sexual minority individuals to ensure that this measure is even appropriate to the population being studied. Additionally, another single-case research design study could be conducted that adapts the Well-Being Therapy protocol in line with Pachankis' (2014) suggestions when working with sexual minority individuals.

Another interesting study would be to also collect data on the competencies of the counselors when working with sexual minority individuals. Perhaps researchers could use the sexual orientation counselor competencies scale (SOCCS; Bidell, 2005) and utilizing a single-case research design, analyze how these competencies change over the course of working with sexual minority clients.

As mentioned previously, more single-case research is needed utilizing the psychological well-being scales in order to establish the measure as being appropriate for

the concurrent measurement necessary for single-case research. Studies could even go further than the current, so as to visually analyze specific subscales that may be more disparate among sexual minority individuals, such as self-acceptance. The self-acceptance domain of the psychological well-being scales may allude to proximal minority stress and internalized heterosexism, and thus may be an area of intervention with many sexual minority individuals. Additionally, future examinations of the effectiveness of a Well-Being Therapy protocol with sexual minority clients may be examined through large scale, randomized controlled trials. The Psychological Well-Being Scales' current psychometric properties may lend themselves well to measuring psychological well-being in this way than the concurrent measurement system required by single-case research design. Future intervention studies could also administer the psychological well-being scales at several follow-up periods (e.g., 3 months, 6 months) following the Well-Being Therapy protocol as well, since Ryff's (1989) theory of psychological well-being is aimed at improving long-term, or eudaimonic, well-being.

Conclusion

The current study was the first to utilize a multiple baseline, single-case research design to examine the effectiveness of a Well-Being Therapy protocol. Additionally, it did so with sexual minority individuals, who often already experience many mental health disparities compared to heterosexual individuals as a result of minority stressors. The results of this study did not illustrate functional relations on psychological well-being or depressive symptoms for sexual minority participants. However, there were slight improvements observed in the individual subscales of the psychological well-being scales, and noticeable decreases in depressive symptoms, though not significant enough

to conclude basic effects. The results of the current study suggest that Well-Being Therapy may not improve the psychological well-being for all sexual minority individuals, but considering the improvements in Casey's data, there may be a specific demographic of sexual minority individuals that do benefit from the treatment protocol. Additionally, the satisfaction survey results suggest that the Well-Being Therapy protocol was well-liked by all of the participants, despite two out of three participants not demonstrating visually significant improvements in psychological well-being. While this study does have its limitation, there are many future studies that could build off of these findings to improve the state of intervention research with sexual minority individuals specifically targeting psychological well-being.

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APPENDIX A

PARTICIPANT RECRUITMENT FLYER

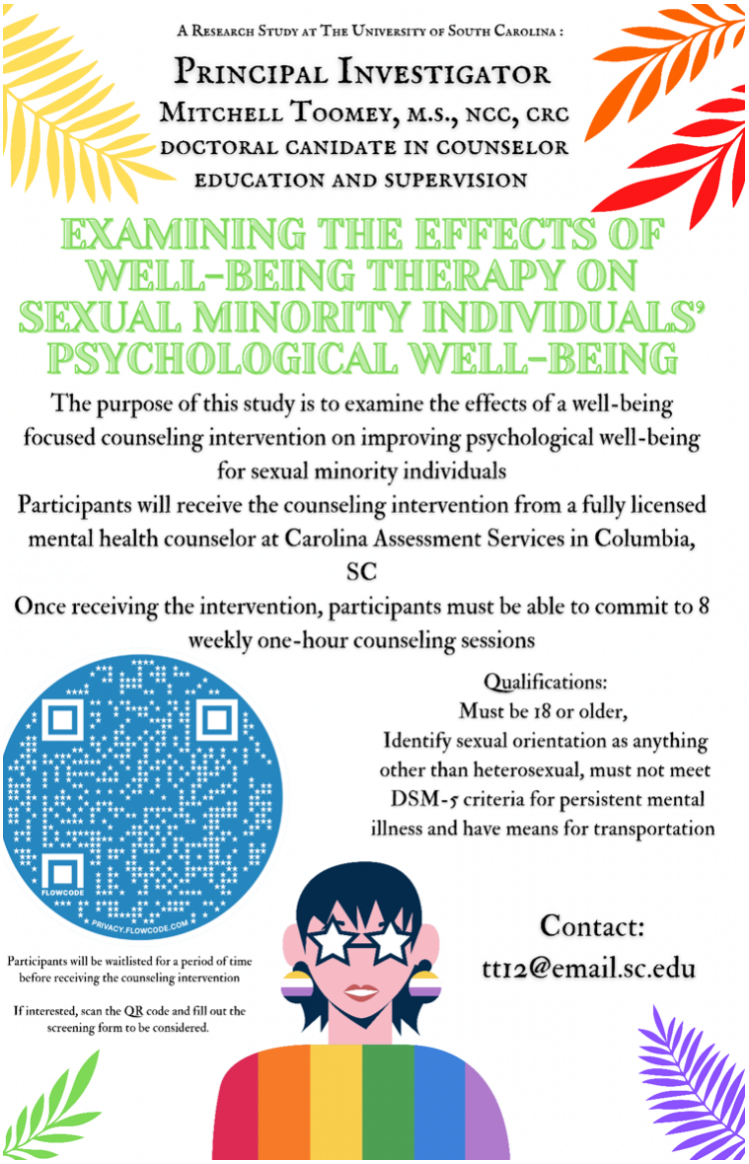

Figure A.1 Participant Recruitment Flyer

APPENDIX B

PARTICIPANT SCREENING FORM

The specific study for which you are being screened is a counseling intervention designed to improve psychological well-being. Psychological well-being can be defined as one's overall mental health functioning. Over the duration of treatment, you will be asked to consider and build upon instances in your life that make you feel well. If you are selected to be a client in the study, you will receive an informed consent document detailing your rights as a participant in the research study. You will also be financially compensated for attending and completing the intervention.

If you are interested in being considered for the study, please complete the screening form below. If you have any questions, please contact the principal investigator of the study, Thomas Toomey at tt12@email.sc.edu. If you do not meet eligibility criteria for the study, you will be redirected to the end of the form. If you do, we will ask for contact information to provide more details about the study.

Have you previously received counseling services before?

- Yes
- No

If so, for what?

Are you currently experiencing, or have you experienced within the past 6 months:

□ Alcohol or drug abuse involvement

□ Arrest/law enforcement

□ Delusions/Paranoia

□ Self-harm

□ Hallucinations

□ A traumatic event

□ Suicidal ideation/attempt

Please give a brief description of the concerns client is hoping to address with counseling:

Sexual Orientation:_____

Gender Identity:_____

Client name: _____

Last First MI

Client phone number: _____

(xxx) xxx-xxxx

DOB:_____ mm/dd/yyyy

APPENDIX C

PARTICIPANT INFORMED CONSENT DOCUMENT

UNIVERSITY OF SOUTH CAROLINA
CONSENT TO BE A RESEARCH SUBJECT
Examining the Effects of a Well-Being Therapy Protocol on Sexual Minority Individuals' Psychological Well-Being

KEY INFORMATION ABOUT THIS RESEARCH STUDY:

You are invited to volunteer for a research study conducted by Thomas Mitchell Toomey. I am a doctoral candidate in the Department of Educational Studies, at the University of South Carolina. The University of South Carolina office of the Vice President for Research is sponsoring this research study. The purpose of this study is to examine the effects of a well-being-focused counseling intervention on psychological well-being among sexual minority individuals. You are being asked to participate in this study because you are over the age of 18 and identify your sexual orientation as something other than heterosexual. This study is being done at Carolina Assessment Services, LLC and will involve approximately four subjects.

The following is a short summary of this study to help you decide whether to be a part of this study. More detailed information is listed later in this form.

- You will be one of four participants in the current study. You will each start on the waitlist the same week. The order in which the first participant begins receiving the counseling intervention will be randomized.
- You will be on a waitlist for at least three weeks prior to receiving the counseling intervention, where you will not receive any other counseling
- While waitlisted, you will receive weekly text messages from the PI (Thomas Toomey) with a confidential survey link via Qualtrics that you can complete on your phone
- When it is time for you to begin the counseling intervention, you will attend weekly, one-hour long counseling sessions at Carolina Assessment Services, LLC. You will be assigned a fully licensed counselor based on your best weekly availability.

PROCEDURES:

If you agree to participate in this study, you will do the following:

1. You will be one of four participants in the current study. There will be a waitlist period for all participants which will be a period that you will be enrolled in the study, but not receiving any counseling. You will each start on the waitlist the same week.
2. Complete weekly assessments of psychological well-being and depressive symptoms via a Qualtrics survey sent to you by text message from the researcher
3. Begin the counseling intervention after the participant receiving the intervention in the order before see improvements in their psychological well-being.
4. Complete a survey about your psychological well-being and depressive symptoms weekly.
5. Complete weekly homework in the form of reflective journaling about instances that promote well-being

6. Have your counseling sessions audio recorded in order to ensure the details that you provide are accurately captured.

DURATION:
Participation in the study involves one weekly visit over a period of eight weeks. Each counseling session will last about 60 minutes.

RISKS/DISCOMFORTS:

Loss of Confidentiality:
There is the risk of a breach of confidentiality, despite the steps that will be taken to protect your identity. Specific safeguards to protect confidentiality are described in a separate section of this document.

BENEFITS:

You may benefit from participating in this study by becoming more self-aware about your psychological well-being, and how to tap into inner resources for improving well-being.

COSTS:
There will be no costs to you for participating in this study other than possible costs related to transportation to and from the research site.

PAYMENT TO PARTICIPANTS:
You will receive a total of $125 in Visa gift cards for participating in the study. The counseling intervention is 8 weekly sessions. You will receive $25 after sessions two, four, and six, and $50 after final session.

CONFIDENTIALITY OF RECORDS:
Information obtained about you during this research may be published, but you will not be identified. Information that is obtained concerning this research that can be identified with you will remain confidential to the extent possible within State and Federal law. The investigators associated with this study, the sponsor, and the Institutional Review Board will have access to identifying information. All records in South Carolina are subject to subpoena by a court of law. Study information will be securely stored in locked files and on password-protected computers.

VOLUNTARY PARTICIPATION:

Participation in this research study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. If you do withdraw from this study, the information you have already provided will be kept in a confidential manner. If you wish to withdraw from the study, please call or email the principal investigator listed on this form.

Concerns about your rights as a research subject are to be directed to, Lisa Johnson, Assistant Director, Office of Research Compliance, University of South Carolina, 1600 Hampton Street, Suite 414D, Columbia, SC 29208, phone: (803) 777-6670 or email: LisaJ@mailbox.sc.edu.

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. **If I have any more questions about my participation in this study, or a study related injury, I am to contact Mitchell Toomey at 706-399-8615 or email tt12@email.sc.edu.**

I agree to participate in this study. I have been given a copy of this form for my own records.

If you wish to participate, you should sign below.

Signature of Subject / Participant	Date
Signature of Qualified Person Obtaining Consent	Date

APPENDIX D

PARTICIPANT DEMOGRAPHICS FORM

<u>Directions:</u> Please complete the following general demographics survey (all responses are <u>confidential</u>). Please type in your answers. Feel free to change the formatting or use more space if needed.

---

1. **Name (First and Last) _____**
2. **Current Age ___**
3. **Which best describes your sexual orientation (Check all that apply)**
   - o Heterosexual
   - o Gay
   - o Lesbian
   - o Bisexual
   - o Asexual
   - o Pansexual
   - o Self-Identify (Please specify) ___
4. **Income**

How much combined money did all of members of your household earn last year?

   - o $0 to $9,999
   - o $10,000 to $24,999
   - o $25,000 to $49,999
   - o $50,000 to $74,999
   - o $75,000 to $99,999
   - o $100,000 to $124,999
   - o $125,000 to $149,999
   - o $150,000 to $174,999
   - o $175,000 to $199,999
   - o $200,000 and up

5. **What is the highest level of school you have completed or the highest degree you have earned?**
   - o Less than high school degree
   - o High school degree or equivalent (e.g., GED)
   - o Some college but no degree
   - o Associate degree
   - o Bachelor's degree
   - o Graduate degree

6. **Which of the following categories best describes your TYPICAL employment status?**
   - o Employed, working 40 or more hours per week
   - o Employed, working 1-39 hours per week
   - o Not employed, looking for work
   - o Not employed, NOT looking for work
   - o Retired
   - o Disabled, not able to work
7. **Which best describes your gender identity (Check all that apply)**
   - o Cisgender Male
   - o Cisgender Female
   - o Transgender Male
   - o Transgender Female
   - o Genderqueer, gender non-conforming
   - o Non-binary
   - o Self-Identify (please specify) ___
   - o *For gender identity:*

   "Transgender" is a term used to describe people whose gender identity differs from the sex the doctor marked on their birth certificate.
   "Cisgender" refers to people whose sex at birth and current gender identity are aligned.
   "Genderqueer" and "non-binary" can refer to those who have sex-gender incongruence, or may not experience gender as either woman or man.
   "Gender nonconforming" refers to gender expression that does not match the gender norms of the gender they are perceived to be by society.
   "Questioning" is the process of exploring and discovering one's own gender identity or gender expression.

8. **Which best describes you race/ ethnicity? (Check all that apply)**:
   - o Black/African American
   - o Asian American/Asian
   - o Caucasian/White (Non-Hispanic)
   - o Hispanic/Latinx
   - o Native-American
   - o Native Hawaiian or other Pacific Islander
   - o Self-Identify (Please specify) ___
9. **Please describe your reasons for seeking counseling**

10. **If applicable, please list any previous experiences with counseling. (e.g., duration of counseling, for what reasons were you seeking counseling)**

APPENDIX E

TREATMENT IMPLEMENTER DEMOGRAPHICS FORM

<u>Directions:</u> Please complete the following general demographics survey (all responses are <u>confidential</u>). Please type in your answers. Feel free to change the formatting or use more space if needed.

---

1. **Name (First and Last) _____**
2. **Current Age ___**
3. **Which best describes your sexual orientation (Check all that apply)**
   - o Heterosexual
   - o Gay
   - o Lesbian
   - o Bisexual
   - o Asexual
   - o Pansexual
   - o Self-Identify (Please specify) ___
4. **Which best describes your gender identity (Check all that apply)**
   - o Cisgender Male
   - o Cisgender Female
   - o Transgender Male
   - o Transgender Female
   - o Genderqueer, gender non-conforming
   - o Non-binary
   - o Self-Identify (please specify) ___
   - o *For gender identity:*

   "Transgender" is a term used to describe people whose gender identity differs from the sex the doctor marked on their birth certificate.
   "Cisgender" refers to people whose sex at birth and current gender identity are aligned.
   "Genderqueer" and "non-binary" can refer to those who have sex-gender incongruence, or may not experience gender as either woman or man.
   "Gender nonconforming" refers to gender expression that does not match the gender norms of the gender they are perceived to be by society.
   "Questioning" is the process of exploring and discovering one's own gender identity or gender expression.

5. **Which best describes you race/ ethnicity? (Check all that apply)**:

- Black/African American
- Asian American/Asian
- Caucasian/White (Non-Hispanic)
- Hispanic/Latinx
- Native-American
- Native Hawaiian or other Pacific Islander
- Self-Identify (Please specify) ___

6. **How long have you been practicing as a counselor?**

7. **What is your professional designation as a counselor? (e.g., LPC, LPC-A, NCC, CRC)**

8. **Describe your preferred counseling theoretical orientation?**

9. **What setting do you currently practice in?**

APPENDIX F

PSYCHOLOGICAL WELL-BEING SCALES

Instructions: Circle one response below each statement to indicate how much you agree or disagree.

1. "I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

2. "For me, life has been a continuous process of learning, changing, and growth."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

3. "In general, I feel I am in charge of the situation in which I live."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

4. "People would describe me as a giving person, willing to share my time with others."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

5. "I am not interested in activities that will expand my horizons."

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

6. “I enjoy making plans for the future and working to make them a reality.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

7. “Most people see me as loving and affectionate.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

8. “In many ways I feel disappointed about my achievements in life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

9. “I live life one day at a time and don't really think about the future.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

10. “I tend to worry about what other people think of me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

11. “When I look at the story of my life, I am pleased with how things have turned out.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

12. “I have difficulty arranging my life in a way that is satisfying to me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

13. “My decisions are not usually influenced by what everyone else is doing.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

14. “I gave up trying to make big improvements or changes in my life a long time ago.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

15. “The demands of everyday life often get me down.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

16. “I have not experienced many warm and trusting relationships with others.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

17. “I think it is important to have new experiences that challenge how you think about yourself and the world.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

18. “Maintaining close relationships has been difficult and frustrating for me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

19. “My attitude about myself is probably not as positive as most people feel about themselves.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

20. “I have a sense of direction and purpose in life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

21. “I judge myself by what I think is important, not by the values of what others think is important.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

22. “In general, I feel confident and positive about myself.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

23. “I have been able to build a living environment and a lifestyle for myself that is much to my liking.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

24. “I tend to be influenced by people with strong opinions.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

25. “I do not enjoy being in new situations that require me to change my old familiar ways of doing things.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

26. “I do not fit very well with the people and the community around me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

27. “I know that I can trust my friends, and they know they can trust me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

28. “When I think about it, I haven’t really improved much as a person over the years.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

29. “Some people wander aimlessly through life, but I am not one of them.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

30. “I often feel lonely because I have few close friends with whom to share my concerns.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

31. “When I compare myself to friends and acquaintances, it makes me feel good about who I am.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

32. “I don’t have a good sense of what it is I’m trying to accomplish in life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

33. “I sometimes feel as if I've done all there is to do in life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

34. “I feel like many of the people I know have gotten more out of life than I have.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

35. “I have confidence in my opinions, even if they are contrary to the general consensus.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

36. “I am quite good at managing the many responsibilities of my daily life.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

37. “I have the sense that I have developed a lot as a person over time.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

38. “I enjoy personal and mutual conversations with family members and friends.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

39. “My daily activities often seem trivial and unimportant to me.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

40. “I like most parts of my personality.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

41. “It’s difficult for me to voice my own opinions on controversial matters.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

42. “I often feel overwhelmed by my responsibilities.”

Strongly agree	Somewhat agree	A little agree	Neither agree nor disagree	A little disagree	Somewhat disagree	Strongly disagree

APPENDIX G

9-ITEM PATIENT HEALTH QUESTIONNAIRE

Patient Health Questionnaire
How often have they been bothered by the following over the past 2 weeks?

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Little interest or pleasure in doing things?
Feeling down, depressed, or hopeless?
Trouble falling or staying asleep, or sleeping too much?
Feeling tired or having little energy?
Poor appetite or overeating?
Feeling bad about yourself—or that you are a failure or have let yourself or your family down?
Trouble concentrating on things, such as reading the newspaper or watching television?

Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?

Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?

APPENDIX H

TREATMENT FIDELITY CHECKLIST

Session One

1. Get client's account of how they feel, current and past distress, and treatment history
2. Provide information to client about the structure and modalities of WBT, including estimated number of sessions, their duration and interval, and expected homework
3. Establish a first communication channel and build the basis of a therapeutic alliance
4. Introduce the concept of self-therapy
5. Give the first homework assignment (well-being diary)

Session Two

1. Check how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Attempts to understand which feelings and experiences make the client feel better
4. Introduce the concept of optimal experiences
5. Introduce monitoring of thoughts and behaviors that interrupt well-being
6. Continue with homework assignments (well-being diary)

Session Three

1. Check how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Enhance understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Begin to understand which thoughts and/or behaviors lead to premature interruption of well-being
5. Introduce the observer's column in the well-being diary
6. Continue with homework assignments (well-being diary, activities encouragement and scheduling)

Session Four

1. Check how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Enhance understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Begin the cognitive restructuring of the thoughts and/or behaviors that led to a premature interruption of well-being, as evidenced by notes written in the observer's column

5. Introduce one or two psychological dimensions of well-being according to the material that is presented
6. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Five

1. Check how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Enhance understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Continue the cognitive restructuring of the thoughts and/or behaviors that led to a premature interruption of well-being, as evidenced by notes written in the observer's column
5. Introduce one or two additional psychological dimensions of well-being according to the material that is presented
6. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Six

1. Check how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Review of cognitive restructuring and in vivo contrast of automatic thoughts
4. Introduce and/or improve dysfunctional dimensions of psychological well-being according to the material that is presented
5. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Seven

1. Check how the past week went for the client in general and feelings about ending therapy soon
2. Review the well-being diary and the difficulties related to its completion
3. Review of cognitive restructuring and in vivo contrast of automatic thoughts
4. Reinforce strategies for improving psychological well-being
5. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)
6. Reinforce willingness to keep working (self-therapy) after therapy has ended

Session Eight

1. Checking the client's feelings about ending therapy
2. Review of well-being diary
3. Pointing out improvements that have occurred in the various areas of well-being and in the amount of distress
4. Discuss difficulties that limited the self-therapy with WBT
5. Emphasizing the importance to keep on working (self-therapy) afterwards

APPENDIX I

WELL-BEING THERAPY TRAINING SCRIPT FOR IMPLEMENTERS

Beginning

1. Discuss Mental Health Disparities among sexual minority individuals
2. Overview of Minority Stress and its impact on mental health among sexual minority individuals
3. Discuss the state of mental health practice for addressing minority stress-related mental health concerns among sexual minority individuals
4. Discuss Ryff (1989) theory of psychological well-being
    a. Personal growth
    b. Self-acceptance
    c. Autonomy
    d. Environmental mastery
    e. Positive relations
    f. Purpose in life
5. Provide overview of Well-Being Therapy
6. Go into detail about each session of well-being therapy:

Session One

1. How to get client's account of how they feel, current and past distress, and treatment history
2. How to provide information to client about the structure and modalities of WBT, including estimated number of sessions, their duration and interval, and expected homework
3. How to establish a first communication channel and build the basis of a therapeutic alliance
4. Introduce the concept of self-therapy
5. How to give the first homework assignment (well-being diary)

Session Two

1. How to check how the past week went for the client in general
2. How to review the well-being diary and the difficulties related to its completion
3. How to attempts to understand which feelings and experiences make the client feel better
4. Introduce the concept of optimal experiences
5. Introduce monitoring of thoughts and behaviors that interrupt well-being
6. Continue with homework assignments (well-being diary)

Session Three

1. How to check how the past week went for the client in general
2. How to review the well-being diary and the difficulties related to its completion

3. How to enhance understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Beginning to understand which thoughts and/or behaviors lead to premature interruption of well-being
5. Discuss the introduction the observer's column in the well-being diary
6. Discuss importance of continuing the homework of the well-being diary

Session Four

1. Discuss checking how the past week went for the client in general
2. Emphasize reviewing the well-being diary and the difficulties related to its completion
3. Emphasize enhancing understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Learn how to begin the cognitive restructuring of the thoughts and/or behaviors that led to a premature interruption of well-being, as evidenced by notes written in the observer's column
5. Discuss introducing one or two psychological dimensions of well-being according to the material that is presented
6. Discuss continuing with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Five

1. Emphasize checking how the past week went for the client in general
2. Emphasize reviewing the well-being diary and the difficulties related to its completion
3. Enhance understanding of which feelings and experiences make the client feel better, including optimal experiences
4. Continuing the cognitive restructuring of the thoughts and/or behaviors that led to a premature interruption of well-being, as evidenced by notes written in the observer's column
5. Discuss introducing one or two additional psychological dimensions of well-being according to the material that is presented
6. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Six

1. Emphasize checking how the past week went for the client in general
2. Review the well-being diary and the difficulties related to its completion
3. Review of cognitive restructuring and in vivo contrast of automatic thoughts
4. Discuss introducing and/or improve dysfunctional dimensions of psychological well-being according to the material that is presented
5. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)

Session Seven

1. Emphasize checking how the past week went for the client in general and feelings about ending therapy soon
2. Review the well-being diary and the difficulties related to its completion
3. Review of cognitive restructuring and in vivo contrast of automatic thoughts
4. Reinforce strategies for improving psychological well-being

5. Continue with the homework assignments (well-being diary, activity encouragement and scheduling, graded task assignment)
6. Reinforcing willingness to keep working (self-therapy) after therapy has ended

Session Eight

1. Checking the client's feelings about ending therapy
2. Emphasize reviewing of well-being diary
3. Importance of pointing out improvements that have occurred in the various areas of well-being and in the amount of distress
4. Discussing difficulties that limited the self-therapy with WBT
5. Emphasizing the importance to keep on working (self-therapy) afterwards