“Photovoice” in Reducing Public Stigma towards People in Recovery
Background

- Discrimination towards people with lived experience was observed in the workplace (Tsang, Tam, Chan, & Cheung, 2003)
- Public stigma of the general public had impeded the establishment of psychiatric rehabilitation facilities in the communities (Tsang et al, 2003)
Background

- The New Life Psychiatric Rehabilitation Association has conducted many inclusive art programs.
- Participants and facilitators generally perceived the atmosphere in the program as positive.
1. Reduce public stigma through interpersonal contact
2. Evaluate the effectiveness of ‘Photovoice’
What is “photovoice”?

- Interactive photography program
- Flexible: cross-cultural and linguistic
- Communicate in a symbolic and artistic way
- Generate dialogue and discussion
• People with lived experience attended a talk on how to use digital camera
• Students attended a talk on knowledge of mental illness
• Students and People with lived experience came together to take photos
• Sharing session
• Students were invited to write cards and sign a pledge
Method

- 15 People with lived experience recruited from New Life (73.3% male; mean age = 33.50; SD = 15.81) (66.7% Schizophrenia, 20% Depression, 6.7% Bipolar, 6.7% Others)
- 37 students (89.2% male; mean age = 23.84; SD = 2.88)
- Measurement (pre-, post-)


Measures

People with lived experience

• Recovery Assessment Scale (Corrigan, Salzer, Ralph, Sangster & Keck, 2004)
• Well-Being Index (WBI) (Psychiatric Research Unit, 1998)

Students

• Public Stigma Scale (Mak, Chong, & Wong, 2011)
• Social Distance Scale (Chan, Mak & Law, 2009)
• Knowledge about Mental Illness
• Personal Advocacy
## Results

Means and standard deviations of outcomes variables in People with lived experience

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean (SD)</th>
<th>Post-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photovoice (n=15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>3.55 (.46)</td>
<td>3.58 (.43)</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.47 (1.00)</td>
<td>2.61 (1.21)</td>
</tr>
</tbody>
</table>

Well-being ↑
## Results

Means and standard deviations of outcomes variables in student participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-assessment</th>
<th>Post-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public stigma*</td>
<td>2.33 (.54)</td>
<td>2.00 (.55)</td>
</tr>
<tr>
<td>Social distance*</td>
<td>2.51 (.55)</td>
<td>2.35 (.61)</td>
</tr>
<tr>
<td>Scores in knowledge test*</td>
<td>16.6 (4.07)</td>
<td>18.9 (4.12)</td>
</tr>
<tr>
<td>Personal advocacy</td>
<td>2.38 (.57)</td>
<td>2.25 (.51)</td>
</tr>
</tbody>
</table>

- Significant
- Reduction
  - public stigma ($t = 4.74, p < .05$)
  - social distance ($t = 2.19, p < .05$)
- Improvement in mental illness knowledge ($t = -4.52, p < .05$)
- There was no significant change in personal advocacy ($t = 1.62, p = .11$)
Program Satisfaction

People with lived experience
- Feeling respected and understood
- Interaction of group members
- Equal participation between People with lived experience and students
- Atmosphere of the program
- Sharing personal feeling and life experience

Students
- Interaction with group members
- Equal participation between People with lived experience and students
- Atmosphere of the program
- Feeling respected and understood
- Non-verbal interaction with other participants
Limitations

- Small sample size
- No control group
- No follow-up measures
Conclusion

• ‘Photovoice’ is effective in reducing students’ stigma toward people with lived experience at the end of the program
Acknowledgements

Social Welfare Development Fund of Hong Kong SAR Government (SWDF R03)
References

Chan, J. Y., Mak, W. W., & Law, L. S. (2009). Combining education and video-based contact to reduce stigma of mental illness: “The Same or Not the Same” anti-stigma program for secondary schools in Hong Kong. Social Science & Medicine, 68(8), 1521-1526.


thank you

Email: liamanda30@gmail.com
Game-Based Experiential Approach is as Effective as Contact-based Approach in Reducing HIV Stigma

Floria H. N. Chio, Shannon S. Y. Cheng, Winnie W. S. Mak, & Fei Chan
HIV-related stigma

• 10 – 20 % of healthcare professionals reported holding negative attitudes towards PLHIV (Paxton et al., 2005)

• Some health professionals also admitted treating PLHIV in a less than professional manner (Campbell, Nair, Maimane, & Nicholson, 2007)
HIV-related stigma reduction

- **Contact-based Approach**
  - Initiating contact with stigmatized persons or groups
  - Significant across different settings, age groups, ethnicities, and countries in reducing prejudice (Pettigrew & Tropp, 2006)
Drawbacks of contact-based approach

• Generalization of the effectiveness of face-to-face contact to the natural setting remains in question (Couture & Penn, 2003)
• The effect is short-lived
• Relies on the availability of PLHIV who are willing to share their experience with others (Cahill, 1995)
Alternative means of HIV stigma reduction

• **Promotion of perspective-taking**
  - Improve intergroup attitudes (Todd & Galinsky, 2014)
  - More positive attitudes towards PLHIV
  - Less avoidance for health care workers in treating PLHIV

• **Game-based experiential workshop**
  - Imagine issues and stressors that PLHIV might face on a day-to-day basis
  - Experience the feelings, belief and situations of PLHIV
  - Talk openly about HIV/AIDS
Aim of the present study

- Compared the effectiveness between two conditions:
  1) game-based experiential approach
  2) in-vivo contact-based approach
Participants

- 88 students (57 females, 64.8%)
- Mean age 22.6 (SD = 4.89)
- Response rates were 98.9% at post-training and 85.3% at 1-month follow-up
Participants (n = 88)

<table>
<thead>
<tr>
<th>Variables</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (Age)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>31 (35.2%; $M = 23.0, SD = 3.69$)</td>
</tr>
<tr>
<td>Female</td>
<td>57 (64.8%; $M = 22.6, SD = 4.89$)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>79 (90.8%)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>4 (4.6%)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>4 (4.6%)</td>
</tr>
<tr>
<td>Type of professional program</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>29 (39.7%)</td>
</tr>
<tr>
<td>Medicine</td>
<td>1 (1.4%)</td>
</tr>
<tr>
<td>Clinical psychology</td>
<td>21 (28.8%)</td>
</tr>
<tr>
<td>Social work</td>
<td>13 (17.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (12.3%)</td>
</tr>
</tbody>
</table>
Program content

**Game-based experiential approach**

“I can, I can’t”
- Randomly divided into PLHIV vs non-PLHIV
- Blindfolds and stood shoulder to shoulder
- Announced a variety of daily activities
- Took one step forward/back if they thought they could/could not perform
- Take off their blindfolds

“Difficult to say…”
- Role-played different scenarios in pairs for around five minutes

**In-vivo contact-based approach**

90-minute sharing session hosted by two trained PLHIV:
- Story telling
- Interaction with healthcare professionals
- Issues of disclosure
- Attitudes
- Antiretroviral treatment
- Policy issues
Activities announced in “I can, I can’t”

- Kissing
- Dating
- Getting married
- Giving birth
- Donating blood
- Hot spring
- Hotpot
- Swimming
- Sauna
- Sexual activities
<table>
<thead>
<tr>
<th>Measures</th>
<th>No of items</th>
<th>Range</th>
<th>Cronbach's alpha</th>
<th>References</th>
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</thead>
<tbody>
<tr>
<td>HIV/AIDS-related knowledge</td>
<td>23</td>
<td>0% - 100%</td>
<td></td>
<td>Lau et al., 2007a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lau, Tsui, &amp; Ho, 2007b</td>
</tr>
<tr>
<td>Stigmatizing attitudes towards PLHIV</td>
<td>14</td>
<td>14-84</td>
<td>Pre: .86</td>
<td>Galinsky et al., 2005</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Post: .86</td>
<td>Herek, Capitanio, &amp; Widaman, 2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follow-up: .86</td>
<td>Li et al., 2007</td>
</tr>
<tr>
<td>Discrimination</td>
<td>7</td>
<td>7-54</td>
<td>Pre: .70</td>
<td>Abell, Rutledge, Mccann, &amp; Padmore, 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Post: .79</td>
<td>Herek &amp; Capitanio, 1993</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follow-up: .83</td>
<td>Herek, Capitanio, &amp; Widaman, 2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Li et al., 2007; Pisal et al., 2007; Yiu, Mak, Ho, &amp; Chui, 2010</td>
</tr>
<tr>
<td>Fear of infection</td>
<td>5</td>
<td>5-30</td>
<td>Pre: .80</td>
<td>Carter et al., 1996</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Post: .80</td>
<td>Yiu et al., 2010</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Follow-up: .80</td>
<td></td>
</tr>
<tr>
<td>Support for coercive policies</td>
<td>6</td>
<td>6-36</td>
<td>Pre: .61</td>
<td>Lau et al., 2007a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Post: .69</td>
<td>Lau et al., 2007b</td>
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<td></td>
<td></td>
<td></td>
<td>Follow-up: .78</td>
<td></td>
</tr>
<tr>
<td>Willingness to treat</td>
<td>10</td>
<td>10-60</td>
<td>Pre: .82</td>
<td>Carter et al., 1996</td>
</tr>
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<td></td>
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<td>Post: .86</td>
<td>Herek et al., 2002</td>
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<td></td>
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<td></td>
<td>Follow-up: .91</td>
<td>Li et al., 2007</td>
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Results
### Means and standard deviations of outcome variables by group membership

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>Game-based experiential group</th>
<th>In-vivo contact-based group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>HIV/AIDS-related knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65.41</td>
<td>78.36</td>
</tr>
<tr>
<td></td>
<td>(11.56)</td>
<td>(8.33)</td>
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<tr>
<td>Stigmatizing attitudes</td>
<td></td>
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<tr>
<td></td>
<td>33.87</td>
<td>30.11</td>
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<tr>
<td></td>
<td>(8.09)</td>
<td>(7.13)</td>
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<tr>
<td>Discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14.61</td>
<td>12.83</td>
</tr>
<tr>
<td></td>
<td>(4.00)</td>
<td>(3.07)</td>
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<tr>
<td>Fear of infection</td>
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<td></td>
<td>15.33</td>
<td>13.24</td>
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<td></td>
<td>(4.09)</td>
<td>(3.69)</td>
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<tr>
<td>Support for coercive policies</td>
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<tr>
<td></td>
<td>17.63</td>
<td>15.63</td>
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<tr>
<td></td>
<td>(3.09)</td>
<td>(3.55)</td>
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<tr>
<td>Willingness to treat</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>41.04</td>
<td>44.87</td>
</tr>
<tr>
<td></td>
<td>(5.53)</td>
<td>(5.61)</td>
</tr>
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</table>
## Effect sizes of outcome variables by group membership

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>Game-based experiential group</th>
<th>In-vivo contact-based group</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test vs. Post-test</td>
<td>Pre-test vs. Follow-up</td>
<td>Post-test vs. Follow-up</td>
<td>Pre-test vs. Post-test</td>
<td>Pre-test vs. Follow-up</td>
<td>Post-test vs. Follow-up</td>
</tr>
<tr>
<td>HIV/AIDS-related knowledge</td>
<td>.590**</td>
<td>.616**</td>
<td>.005</td>
<td>.431**</td>
<td>.319**</td>
<td>.010</td>
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<tr>
<td>Stigmatizing attitudes</td>
<td>.379**</td>
<td>.219**</td>
<td>.053</td>
<td>.405**</td>
<td>.140*</td>
<td>.167**</td>
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<tr>
<td>Discrimination</td>
<td>.230**</td>
<td>.083*</td>
<td>.050</td>
<td>.346**</td>
<td>.184**</td>
<td>.071</td>
</tr>
<tr>
<td>Fear of infection</td>
<td>.280**</td>
<td>.211**</td>
<td>.019</td>
<td>.457**</td>
<td>.264**</td>
<td>.110*</td>
</tr>
<tr>
<td>Support of coercive policies</td>
<td>.462**</td>
<td>.146**</td>
<td>.075</td>
<td>.329**</td>
<td>.266**</td>
<td>.000</td>
</tr>
<tr>
<td>Willingness to treat</td>
<td>.535**</td>
<td>.311**</td>
<td>.035</td>
<td>.516**</td>
<td>.395**</td>
<td>.100*</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01
Discussion
Effectiveness of the game-based experiential approach

- The game-based experiential approach was as effective as the in-vivo contact-based approach in reducing HIV-related stigma.
- This is an equivalence study.
  - Contact-based approach is effective in reducing HIV-related stigma in Hong Kong (Yiu, Mak, Ho, & Chui, 2010)
Effectiveness of the game-based experiential approach

- Provides an alternative way
- Game-based experiential approach
  - Does not risk PLHIV for unintended disclosure
- Contact-based approach
  - Empowerment
  - Reach large number of audience


References


Yiu, J. W., Mak, W. W., Ho, W. S., & Chui, Y. Y. (2010). Effectiveness of a knowledge-contact program in improving nursing students’ attitudes and emotional competence in serving people living with HIV/AIDS. Social Science & Medicine, 71(1), 38-44.
thank you

Diversity &
Well-being
Laboratory

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Meta-analysis on the Effectiveness of HIV Stigma Reduction Programs

Winnie W. S. Mak
Phoenix K. H. Mo
Gloria Y. K. Ma
Maggie Y. Y. Lam

Diversity and Well-being Lab
Department of Psychology
The Chinese University of Hong Kong
• Global and local initiatives to reduce HIV stigma

• No statistical consolidation on the effectiveness of HIV stigma reduction efforts

• Identification of active ingredients that enhance HIV stigma reduction effects
HIV stigma

- strong and significant impediment to public health across the globe
- a key obstacle to HIV treatment, prevention, care and support (Mahajan, Sayles, Patel et al., 2008; Valdiserri, 2002)
Programs aimed at reducing stigma and discrimination against PLHIV or people at risk of HIV infection should address the modifiable causes of stigma and discrimination including:

- ignorance about the harm of stigma
- continuing irrational fears of infection
- moral judgment
• Key intervention approach
  – increasing acceptance of PLHIV (Brown, Macintyre, Trujillo, 2003)
  – education about HIV/AIDS (Mahajan, Sayles, Patel et al., 2008)

• Stigma reduction efforts focus on misconception towards HIV/AIDS (Herek & Capitanio, 1999; Liu, Hu, Stanton, Sylvie, & Yang, 2006)

• Critics argue that knowledge alone does not necessarily lead to decrease in levels of stigma (UNAIDS, 2012)

• Effective stigma programs should also aim at improving participants’ attitudes and changing behaviors toward PLHIV
• Only systematic reviews have been conducted on HIV stigma reduction programs (Brown et al., 2003; Sengupta et al., 2011)

• Solid evidence-based conclusions beyond anecdotal reviews and observations are needed
Aims of the study

• Synthesize effectiveness of HIV stigma reduction programs
  – Increase in HIV knowledge
  – Reduction in negative attitudes towards PLHIV

• Identify potential moderators in HIV stigma reduction programs
Methods
Inclusion Criteria

- intervention design
- involved a stigma reduction component
- focused on HIV stigma
- at least one stigma-related outcome

Exclusion Criteria

- irrelevant to HIV
- irrelevant to stigma
- non-intervention-based (e.g. qualitative studies, commentary, and literature reviews)
- not written in English

no restrictions on sample size, sample type, use of control group, duration of follow-up, or publication source
Identification of Studies

• Journal articles, book chapters, and dissertations from 4 major online databases:
  – PsycInfo (1967-2012)
  – Sociological Abstracts (earliest-2012)
  – Medline (1950-2012)
  – Education Resources Information Center (ERIC; earliest-2012)

• Key terms: “HIV”, “stigma”, and “reduction”
Data Extraction

- 6 coders; inter-reliability: .82 (Fleiss’ Kappa) and Pearson’s r reached 1.00
- Coding scheme developed by the authors
  - sample characteristics, measurements, intervention characteristics, participants demographics
- Quality assessment
  - randomized assignment
  - concealment method
  - intent-to-treat analysis
  - blinded study
4192 citations identified for screening

143 articles met the inclusion criteria

50 articles were coded

15 studies entered in meta-analysis
Studies’ Characteristics

• Participants
  – ~29,000; 96% studies involved fe/male genders; 42% professionals; 32% students; 20% community samples

• Interventions
  – lectures and talks with interactive activities (e.g. group work, experiential activities, Q&A, counseling, contact with PLHIV)
  – 34% single session in 1-2 days; 52% multiple sessions in 2-4 days

• Methodological quality
  – 58% has control group
  – 22% has random assignment
  – no intent-to-treat nor allocation concealment
  – non-standardized measures
Results
Effect sizes of the Interventions

- Random effect analyses

<table>
<thead>
<tr>
<th></th>
<th>Knowledge</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At post-intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with control</td>
<td>1.10 (.49 - 1.71)</td>
<td>.49 (.28-69)</td>
</tr>
<tr>
<td>without control</td>
<td>1.13 (.68-1.59)</td>
<td>.34 (.17-.51)</td>
</tr>
<tr>
<td><strong>At follow-up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with control</td>
<td>.72 (.13-1.3)</td>
<td>.25 (.11-.40)</td>
</tr>
<tr>
<td>without control</td>
<td>.64 (.17-1.12)</td>
<td>.14 (.35-.9)</td>
</tr>
</tbody>
</table>

Note: Cohen’s d (95% confidence interval in parentheses)
Publication Bias Analyses

- Rosenthal’s fail-safe N, how many missing studies with mean zero effect sizes are required to make the effect sizes non-significant:
  - For stigmatizing attitudes at follow-up, the fail-safe number was low among studies with control groups (Rosenthal's N =10)
  - For the rest of the outcome variables (both at post-intervention and follow-up and among studies with or without control groups), Rosenthal's N ranged between 101 and 1067
Publication Bias Analyses

• Funnel plots
uneven distribution in lower part of the funnel, esp.
collection on the right side of the funnel,
indicates that studies with favorable results tend to be
published and included in meta-analyses

  – asymmetry in lower part of the funnel was observed in analyses of
    attitudes at post-intervention and attitudes at follow-up among
    studies with control groups

  – our review might be biased toward positive results
Publication Bias Analyses

• Duval and Tweedie’s trim and fill method determines how many studies are missing for funnel plots to be symmetrical and computes the estimated effect size after adjusting the bias.

  – For attitudes at post-intervention among studies with control groups, three studies were missing and the imputed effect size was .39 (95% CI = .19–.59).

  – For attitudes at follow-up among studies with control groups, two studies were missing and the imputed effect size was .20 (95% CI = .07–.34).

  – No studies were missing in the remaining outcome variables (both at post-intervention and follow-up and among studies with or without control groups).
• Percentage of male
  – moderated the effect of the interventions on knowledge among studies with control group
  – smaller effect size among studies with more men
Participant Moderators

- Educational level
  - moderated the effect of the interventions on attitudes among studies without control group
  - larger effect size among studies with participants having more years of education
Intervention Moderators

- Interactive components
- Number of sessions
- Intervention duration

- Moderated the effect on attitudes among studies with control groups

- Larger effect size among studies
  - With interactive components
  - With two or more sessions
  - Lasted longer than 1 week
Stigma reduction programs were generally effective in reducing HIV stigma

- Significant, large effect in increasing participant’s knowledge,
- Significant, medium effect in improving attitudes toward PLHIV
- Positive results were also observed at follow-up, but the strength of the effects was weaker
Women generally reported greater acceptance of health messages and greater improvements from health interventions, compared to men (Sikkema, Hansen, Meade, Kochman, & Lee, 2005).

People with more education may have fewer misconceptions about HIV and less fear towards PLHIV

- more responsive to anti-stigma programs and more likely to report positive attitudinal changes
Limitations

- Publication bias
  - biased toward positive results
- With a dearth of studies reporting non-significant results
  - unclear what components do not work in reducing stigma and in which population
Limitations

- Many stigma reduction programs were multi-faceted, making it difficult to delineate what were the effective components in reducing stigma.

- Other indicators, such as stigmatizing behaviors, were not included as one of the outcome measures in the present study as very few studies used stigmatizing behaviors as outcomes.
Implications

Interventions should involve interactive components in multiple sessions of longer duration

• more intensive
• allow participants to reflect on the skills and concepts learned in the previous sessions, and to apply them in later sessions
• involve exercises that allow participants to practice and apply the learned skills or concepts; perspective taking and empathy
• facilitate message retention and attitudinal change (Stice & Shaw, 2004; Tobler, Roona, Ochshom, Marshall, Streke, & Stackpole, 2000)
Implications

• Future studies should seek to include other indicators of stigma and conduct a wider review with studies not formally published in the literature.

• High quality stigma reduction programs with psychometrically sound outcome measures are warranted.
Acknowledgements

Research helpers in abstract screening, study coding, and coordination

- Gladys Chan
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- Alison Lee
- Ingrid Pang
- Cliff Siu
- Vinca Tang
- Amy Wong
- Samson Wong


Joint United Nations Programme on HIV/AIDS. (2012). Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.


thank you

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How self-compassion and mindfulness differentially affect self-stigmatizing thought content and process

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Winnie W. S. Mak

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The Chinese University of Hong Kong
Self-stigmatizing thought content

• Definition
  – Endorsed negative stereotypes and evaluations toward the self (i.e., cognitive dimension)
  – Well documented
  – Being a burden, having a tainted life, and having inconvenience (Corrigan et al., 2012; Mak & Cheung, 2010)

• Impacts on mental well-being
  – Self-worth, self-esteem, self-efficacy, life satisfaction
  – Depression, distress
Self-stigmatizing thought process

• Definition
  – Repetition and automaticity of self-stigmatizing thinking as a mental habit
  1. the repeated occurrence of negative thoughts about the spoiled identity
  2. the fact that such thoughts come automatically, unconsciously, and unintentionally
  – High levels of experiential avoidance and lack of mindfulness (Chan, 2013)

• Impacts on mental well-being
  – Supression, rumination, constant mental negotiation
  – Chronic distress
Mindfulness

• Definition
  – Being aware of the present moment experience in a non-judgmental manner (Brown & Ryan, 2003)
  – Keeping a stance of equanimity v.s. suppression, excessive fixation

• Impacts on mental well-being
  – Immediate impact: adding vividness to experience and orientation toward the present moment with curiosity, openness, and acceptance
  – Chronic impact: self-regulation of attention and emotion
Self-compassion

Definition
- Sensitivity to own experience of suffering and positive self-perceptions (Neff, 2003a,b)
- Self-kindness: understanding and warmth (v.s. self-judgment)
- Common humanity: common human experience, interconnected, equal (v.s. isolation)
- Mindfulness (v.s. overidentification)

Impacts on mental well-being
- Increasing personal growth, life satisfaction, and happiness
- Reducing maladaptive perfectionism, depression, and anxiety
Different emphases

Mindfulness & process
• Metacognition, the ability to direct and sustain attention nonjudgmentally
• In contrast to the mindless, less “awake” states of habitual or automatic functioning
• Disengaging individuals from automatic thoughts and thus buffering the negative effect of rumination on well-being

Self-compassion & content
• A positive attitude and state of mind for suffering
• To be less self-critical and keep positive self-perception, when the painful experience involves self-stigmatizing judgments and thoughts of inadequacy
• No external standards to criticize selves
Aims & Hypotheses

Mindfulness
- negatively related to the process of self-stigmatizing thoughts;
- can moderate its effect on mental well-being

Self-compassion
- negatively related to the content of self-stigmatizing thoughts;
- can moderate its effect on mental well-being;
- it is also negatively related to the process
Methods

• Participants
  – 169 people with lived experience (52.7% men; mean age = 42.7 years, SD = 10.2) from four NGOs in Hong Kong that provide psychiatric rehabilitation services in the community
  – 291 people living with HIV (95% men; mean age = 41.8 years, SD = 11.1) in a community outpatient clinic specialized in treating HIV-related illnesses

• Measures
  – Five Facet Mindfulness Questionnaire (FFMQ; Bohlmeijer et al., 2011)
  – Self-Compassion Scale (SCS; Raes et al., 2010)
  – The Cognitive Subscale of Self-Stigma Scale (SSC; Mak & Cheung, 2010)
  – Self-stigmatizing Thinking’s Automaticity and Repetition Scale (STAR; Chan, 2013)
  – Satisfaction with Life Scale (SWLS; Diener et al., 1985)
Testing the model in people with lived experience with standardized coefficients

χ²(14) = 28.41, p = .01, CFI = .97, NNFI = .92, RMSEA = .05
Testing the model in people living with HIV with standardized coefficients

Self-compassion

Mindfulness

Self-stigma content

Self-stigma process

Life satisfaction

Mindfulness * self-stigma process

Self-compassion * self-stigma content

Beta = .33
Total effect

Beta = .19

low: t = -4.22, p < .05
high: t = 1.13, p > .05
Discussion

Self-compassion as a relatively stronger predictor of self-stigma and life satisfaction

- Consistent with previous findings (e.g., Baer, Lykins & Peters, 2012)

- Multi-faceted nature & well-being outcomes are more strongly influenced by self-kindness and common humanity (Pauley & McPherson, 2010)

- Address not only rumination but also self-criticism and positive perception
• Their different functions: self-compassion & mindfulness on content and process
  – Self-compassion could buffer self-stigma content
  – Mindfulness could buffer self-stigma process
Limitations

Cross-sectional data

Hypotheses were supported either by PLHIV or people with lived experience

Experimental and longitudinal research for causal relationships

What factors induce this difference and whether the patterns can be replicated need further exploration
Implications

• Filled the research gap in the unique functions of self-compassion and mindfulness on self-stigma content and process
• Interventions need to particularly address and mitigate both content and process of self-stigmatizing thoughts
• Cultivating both mindfulness and self-compassion as they can address different mental processes of self-stigmatization
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References

thank you

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Exploring the moderating effect of personal narratives on stigma endorsement and life satisfaction among people with lived experience
Mental health recovery is a journey of healing & transformation enabling a person with a mental health issue to live a meaningful life in a community of his/her choice while striving to achieve his or her full potential.”

(SAMHSA, 2003)
Personal Recovery

- Person-Driven
- Many Pathways
- Holistic
- Peer
- Relational
- Culture
- Addresses Trauma
- Strengths/Responsibility
- Respect
- Hope

(SAMHSA, 2012)
For people with lived experience, their mental health challenges can have profound impact, above and beyond symptoms, including:

- experiences of stigma
- change in self-identity
- impact on quality of life

(Bellack, 2006)
Self-stigma

- Internalization of the public stigma directed toward their mental health status
  (Corrigan & Watson, 2002; Mak & Cheung, 2010)
  - endorse and concur with negative stereotypes and prejudice and prescribed to their identity
  - perceive themselves as devalued
Self-stigma

- hinder work participation
- disrupt social relationships
- cause negative appraisals toward self
- diminish life satisfaction and well-being

(Markowitz, 1998; Rosenfield, 1997; Wright, Gronfein, & Owens, 2000)
Recovery is not just the absence of symptoms

- Some people with lived experience considered “recovered” in the medical sense may still experience self-stigma, feel distressed by negative self-perceptions and frustrated by a perceived inability to participate in important life activities and relationships.

- Subjective recovery experience of people with lived experience is critical to their ways of coping with self-stigma and life satisfaction (in addition to structural enabling factors).
Recovery-oriented narratives

- Making sense of who they are and their illness through personal narratives
  - reconstruct their self-perception
  - redefine their mental health challenges
  - boost meaningfulness and well-being
Aims of the Study

- To identify the protective role of personal narratives on self-stigmatization
- To examine how the richness of personal narratives can potentially moderate the negative impact of self-stigma on life satisfaction, after controlling for the positive and negative symptoms of psychosis
Hypothesized relationships

Positive symptoms of psychosis

Negative symptoms of psychosis

Self-stigma

Life satisfaction

Personal narratives
Methods
Study Participants

INCLUSION CRITERIA:
1. Aged between 18 and 55 years
2. A ICD-10 diagnosis of schizophrenia, persistent delusional disorder, schizoaffective disorder, other nonorganic psychotic disorders, or unspecified nonorganic psychosis
3. A duration of illness, defined as the length of time since first presentation to the hospital, less than 60 months
4. Ethnic Chinese
5. Speak Cantonese
6. Sufficient understanding and expressive capacity

EXCLUSION CRITERIA:
1. Have organic brain disorder
2. Have a known history of intellectual disability
3. Diagnosed with drug-induced psychosis
110 people in recovery of schizophrenia spectrum disorders (53.6% male) were recruited from different psychiatric outpatient clinics and community mental health centers across various districts in Hong Kong.

- Mean age = 31.30 years old (SD = 11.14)
- Mean illness duration = 2.38 years (SD = 2.06)
- Majority of the participants were single (79.1%, n = 87) and unemployed (38.9%, n = 42), and had secondary education as the highest level of education (36.4%, n = 40)
1. Positive and negative symptoms of psychosis
   - Assessed by trained research staff using:
     - Scale for the Assessment of Positive Symptoms (SAPS; Andreasen, 1984; Cronbach’s $\alpha = .85$)
     - Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1984; Cronbach’s $\alpha = .89$)
2. **Self-stigma**

- Stigma Resistance subscale of Internalized Stigma of Mental Illness Scale (ISMI; Boyd Ritsher, Otilingam, & Grajales, 2003)
  - Sample item: “I can have a good, fulfilling life, despite my mental illness.”
  - 5 items were rated on a 4-point scale from 1 (strongly disagree) to 4 (strongly agree)
  - The items were reversely coded to represent self-stigma endorsement
  - Cronbach’s alpha = .71
3. Personal narratives

- Indiana Psychiatry Illness Interview (IPII; Lysaker et al., 2002)
  - narrate their life story and describe their perceptions about the illness as well as their personhood as it relates to the illness

- Scale To Assess Narrative Development (STAND; Lysaker et al., 2003) was used to code the extent to which people possess a rich or impoverished narrative based on the data elicited in the IPII
4. Life satisfaction

- Test’s Life Satisfaction Scale (TLLS; Test, Greenberg, Long, Brekke, & Burke, 2005)
  - 4 domains: living situation, social relationships, work, evaluation of self and present life
  - Sample item: “How satisfied are you with the kind of work that you do?”
  - 18 items were rated on a 4-point scale from 1 (strongly unsatisfied) to 5 (strongly satisfied)
  - Cronbach’s alpha = .93
Results
Relationships between symptoms, self-stigma, personal narratives and life satisfaction

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<td>2. Negative symptoms of psychosis</td>
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<td>3. Self-stigma</td>
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<td>4. Personal narratives</td>
<td>.12</td>
<td>- .37***</td>
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<td>5. Life satisfaction</td>
<td>-.14</td>
<td>-.33**</td>
<td>-.57***</td>
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Range of scale
- Positive symptoms of psychosis: 0-175
- Negative symptoms of psychosis: 0-120
- Self-stigma: 1-4
- Personal narratives: 4-20
- Life satisfaction: 1-5

Mean
- Positive symptoms of psychosis: 11.90
- Negative symptoms of psychosis: 30.72
- Self-stigma: 2.13
- Personal narratives: 11.25
- Life satisfaction: 3.35

Standard deviation
- Positive symptoms of psychosis: 13.08
- Negative symptoms of psychosis: 19.08
- Self-stigma: .46
- Personal narratives: 2.82
- Life satisfaction: .64

Note: * p < 0.05, ** p < 0.01, *** p < 0.001; N = 105
## Moderation analysis

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<td>1. Positive symptoms of psychosis</td>
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<td>2. Negative symptoms of psychosis</td>
<td>(-.31^{**})</td>
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<td>3. Self-stigma</td>
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<td>(-.52^{***})</td>
<td>(-.52^{***})</td>
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<td>4. Personal narratives</td>
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<td>5. Self-stigma X Personal narratives</td>
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<td>Adj. ( R^2 )</td>
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<td>6.49^{**}</td>
<td>23.53^{***}</td>
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*Note: * \( p < 0.05 \), ** \( p < 0.01 \), *** \( p < 0.001 \); N = 105*
Moderation analysis

Positive symptoms of psychosis → Negative symptoms of psychosis

Self-stigma

Life satisfaction

Adjusted $R^2$: 44%

Note: ** $p < 0.01$, *** $p < 0.001$; N = 105
Moderation analysis
Discussion & Implications
Discussion

- Consistent with the previous findings (Markowitz, 1998; Rosenfield, 1997), self-stigma was negatively associated to life satisfaction among people with lived experience.

- People with higher level of self-stigma tended to report dissatisfaction in their living situation, social relationships and work, and have negative evaluation of self and present life, above and beyond their clinical symptoms.
Discussion

- People’s personal narratives about their identity and their illness can mitigate the negative impacts of self-stigma on life satisfaction.

- Subjective experience and perception of personal recovery cannot be neglected and should be a core focus in the recovery process.
Limitations

- Small sample
  - recruited 212 people with lived experience and are actively transcribing and coding the personal narrative data
- Cross-sectional data
  - following up the sample at 6-month (n=130 as of Jan 2015) and 12-month (n=44 as of Jan 2015)
  - temporal relationships of self-stigma, personal narratives, and well-being
Implications

- Importance of personal narratives in mitigating the negative effect of stigma on life satisfaction
- Enable people with lived experience ample opportunities to tell their personal stories and reconstruct a positive self-experience
- Transform their stigmatized self-identity to diversified and meaningful ones and to facilitate their well-being in the recovery journey
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