Back to the Drawing Board:

The epic (AND ONGOING) tale of developing an ACT-based stigma reduction curriculum for the classroom.

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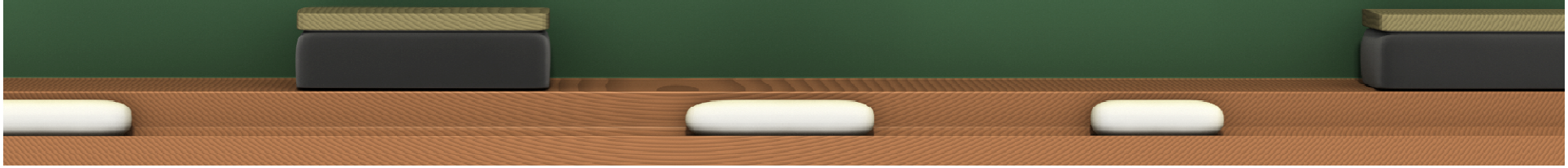

PREFACE

Why Abnormal Psychology?

- Undergraduate abnormal psychology is often the first, and frequently only, in depth exposure students have to this subject matter

- Many healthcare and criminal justice students are strongly encouraged or required to take Abnormal Psychology

- Reducing stigma among future healthcare and criminal justice professionals has a large potential public health impact

CHAPTER 1

The Usual Lineup

Three typical strategies for reducing enacted stigma

- Educational/informational interventions
  - (e.g. “You shouldn’t stigmatize people because look at all these examples of how that stereotype is inaccurate”)
- Contact-based interventions
  - (e.g. “Why don’t you two hang out for a while and then you won’t stigmatize each other”)
- Verbal confrontation of negative attitudes
  - (e.g. “You’re a bad person for stigmatizing others so quit it!”)

CHAPTER 2

A new sheriff in town…?

It's a bird, it's a plane, it's psychological flexibility man!!!

Why an Act-based intervention?

- Interventions based on acceptance-based models provide a new avenue toward stigma reduction (Hayes, et. al., 2004) that may be well-suited for the classroom setting (Masuda et. al., 2007).

- ACT targets several potential processes of change that appear to be related to stigmatizing attitudes or behavior including:
  - Mindfulness
  - Experiential Avoidance/Acceptance
  - Defusion
  - Perspective Taking
  - Values-based Committed Action

Processes of change: Mindfulness/automaticity

- Stigma-related bias emerges very early in the behavior stream
- Awareness of these biases is poor and the influence of these early responses on subsequent behavior tends to go unnoticed (Greenwald, Poehlman, Uhlmann, & Banaji, 2009)
- A few studies suggest that mindful awareness may mitigate some of the influence of these early and rapid biases (Djikic, Langer, & Stapleton, 2008, Ostafin and Marlatt, 2008)

Processes of change: EA/Acceptance

- Suppression and avoidance of stereotype-related thinking and feelings can lead to negative effects among both in and out-group members (Inzlicht & Kang, 2010, Macrae et al. 1994).

- Direct attempts to reduce or suppress stigmatizing thoughts are known to produce paradoxical effects including increases in those very thoughts (e.g., Smart & Wegner, 1999, 2000).

Processes of change: Defusion

- Creating a verbal "us" and "them“ is an inextricable feature of social interactions and yet can lead to rigid and inflexible behavior that is tied to and controlled by our conception of self and other.
- In cognitive defusion, people are taught to notice this process of constructing social so that behavior more likely to come under other sources of influence, such as direct experience with the other or personal values.
- At least one study has shown that ratings of believability (a measure of defusion) of stigmatizing attitudes mediated improvements in burnout and stigma (Hayes, Bissett, et al., 2004)

Processes of change: Perspective Taking

- In and out-group effects may be reduced through fostering identification with an over-arching category that places both individuals in the same in-group.
- Compassion-focused interventions that foster a sense of commonality in suffering have been shown to increase feelings of connectedness with others (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).
- Perspective taking exercises such as mimicking the movements of another appear to reduce prejudice toward a perceived outgroup (Inzlicht, Gutsell, & Legault, 2012).

Processes of change: Values-based committed action

- From an ACT perspective, values are "freely chosen" and the reinforcement in moving toward an action is intrinsic in the valued action itself.
- Interventions aimed at helping people to contact their own motivations to reduce prejudice tend to result in lower levels of prejudice (Phills et al, 2011, Legault et al., 2011).
- ACT's emphasis on overt behavior change and values-based action is consistent with findings that indicate that direct positive actions toward out-groups may have direct effects on reducing prejudice (Corrigan et al., 2001).

CHAPTER 3

Take One:
The Adventure Begins

Our first take at an ACT-based stigma reduction curriculum

- We designed a single-module, 3 hour intervention based on Masuda et al. (2007) and piloted it across several semesters
- Measured outcomes at pre and post intervention
- Both anecdotal reports and measures indicated it wasn't working

CHAPTER 4

Take two:
Back to the Drawing Board

What we thought was needed

- Identify the core principles around which to organize the intervention
- Have lots of qualitative feedback to aid further refinements
- Incorporate homework so that students could practice outside of classroom
- Add in a more intensive focus on self-processes and perspective taking
- Ultimately wanted to produce a detailed curriculum that would be easy to implement and disseminate

8 organizing principles targeting stigma reduction

1. Notice the process of objectification of others and build awareness of biases and the automatic process of stereotyping.
2. Normalize the occurrence of prejudiced thinking, so that it need not be suppressed or avoided and can be accepted.
3. Differentiate between prejudiced thoughts and prejudiced behavior.
4. Accept and defuse from prejudiced thinking.
5. Facilitate a hierarchical frame of a “common humanity” in suffering that competes with the tendency toward “us vs. them” framing that is part of objectification and stigma.
6. Open up to difficult emotion rather than attempting to suppress difficult thoughts and emotions related to themselves and others.
7. Develop a positive sense of connection and empathy in relation to the target group (i.e. those identified as “mentally ill”).
8. Articulate values and set intentions for how they would want to be toward people in the stigmatized group.

Revised curriculum

Five 30-45 minute modules:

- **Module 1:** Introduction to the curriculum and building awareness of social classification. (Contact with Present Moment)
- **Module 2:** Normalizing the occurrence of prejudice thinking and acceptance as an alternative strategy. (Acceptance)
- **Module 3:** Building a sense of common humanity and common suffering in relation to psychological suffering. (Flexible Perspective Taking)
- **Module 4:** Differentiating between prejudiced thoughts and prejudiced behavior. Defusing from stereotype-based thinking while developing a positive sense of connection and empathy in relation to the stigmatized group. (Defusion & Perspective Taking)
- **Module 5:** Perspective taking practice and setting intentions for how students would want to behave toward people in the stigmatized group. (Perspective taking and Values-based Committed Action)

Structure of each module:

- Debrief homework from previous week (except the first module)
- In-class experiential exercises and discussion (voluntary)
- Assignment of Out-of-class homework
  - Experiential exercises (voluntary)
  - Written assignments (required)
- Feedback questionnaires (voluntary)

CHAPTER 5

Let's Take This Baby For a Test Drive

Testing the revised curriculum

Participants:

- 58 students enrolled in an undergraduate Abnormal Psychology course at a community college (3 terms)
- 30 female, 27 male, 1 transgender
- Programs of study
  - Criminal Justice 26%
  - Drug and Alcohol Counseling 22%
  - Healthcare Profession Graduate Programs 16%
    (Occupational Therapy, Physical Therapy, Psychology)
  - General studies/other 36%

Study Design

11-week Abnormal Psychology Course
Met once a week for 4 hours

Week 1-5	Pre-Assessment	Week 6-10	Week 11
Standard abnormal psychology lecture focused on etiology, diagnosis, and treatment of Axis I and II disorders		First 3 hours class: standard abnormal psychology lecture Last 45 min. of class: **Stigma Intervention**	**Post assessment** & Final Exam

Measure	Expected results
AAQ-Stigma – with subscales:	
•Stigma mindfulness	Increases in stigma awareness
•Stigma experiential avoidance	Reduced experiential avoidance
•Stigma fusion	Reduced fusion
Similarity measure	Increased self-other overlap
Social Discounting	Increased valuing of people with SMI
Social Distancing	Decreased desire for social distance
Acceptance and Action Questionnaire – II (AAQ-II)	Potential moderator
Interpersonal Reactivity Index (IRI)	Potential moderator
Implicit Association Test for Mental Illness Stigma	Potential moderator

Similarity Measure

Instructions: In the numbered spaces below, please list the following people in order of who you feel is most similar to you with #1 being the MOST similar to you and #7 being the LEAST similar to you. For example, if you felt that your closest friend was the person on this list that was most similar to you, you would write "Closest friend" in the line marked #1. **Please make sure you put everyone on this list in only one spot and rank everyone on the list.**

- **Your closest friend**
- **Your kindergarten teacher**
- **A person diagnosed with cancer**
- **A person living in London right now**
- **The family member you're closest to**
- **A person diagnosed with schizophrenia**
- **Your favorite musician**

Most similar to you

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Least similar to you

7. _____

Social Discounting Measure 1

1.	**A.** $110 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
2.	**A.** $125 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
3.	**A.** $140for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
4.	**A.** $155 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
5.	**A.** $170 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
6.	**A.** $185 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
7.	**A.** $200 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
8.	**A.** $215 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
9.	**A.** $230 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society
10.	**A.** $245 for you	*OR*	**B.** $75 for you and $75 for Mental Illness Advocacy Society

Social Discounting Measure 2

1.	**A.** $100 for Cancer Help Society	*OR*	**B.** $10 for Mental Illness Advocacy Society
2.	**A.** $90 for Cancer Help Society	*OR*	**B.** $20 for Mental Illness Advocacy Society
3.	**A.** $80 for Cancer Help Society	*OR*	**B.** $30 for Mental Illness Advocacy Society
4.	**A.** $70 for Cancer Help Society	*OR*	**B.** $40 for Mental Illness Advocacy Society
5.	**A.** $60 for Cancer Help Society	*OR*	**B.** $50 for Mental Illness Advocacy Society
6.	**A.** $50 for Cancer Help Society	*OR*	**B.** $60 for Mental Illness Advocacy Society
7.	**A.** $40 for Cancer Help Society	*OR*	**B.** $70 for Mental Illness Advocacy Society
8.	**A.** $30 for Cancer Help Society	*OR*	**B.** $80 for Mental Illness Advocacy Society
9.	**A.** $20 for Cancer Help Society	*OR*	**B.** $90 for Mental Illness Advocacy Society
10	**A.** $10 for Cancer Help Society	*OR*	**B.** $100 for Mental Illness Advocacy Society

Social Distancing Measure

1-paragraph fictional narrative about “Jim Johnson” who had been in a mental hospital 2 years ago because of “problems”. Students then answered the following questions:

A	B	C	D
Definitely willing	**Probably willing**	**Probably unwilling**	**Definitely unwilling**
			Willing ⟶ Unwilling
How would you feel about renting a room in your home to someone like Jim Johnson?			A B C D
How about being a worker on the same job as someone like Jim Johnson?			A B C D
How would you feel having someone like Jim Johnson as a neighbor?			A B C D
How about as the caretaker of your children for a couple of hours?			A B C D
How about having your children marry someone like Jim Johnson?			A B C D
How would you feel about introducing Jim Johnson to a young woman you are friendly with?			A B C D
How would you feel about recommending someone like Jim Johnson for a job working for a friend of yours?			A B C D

CHAPTER 6

Survey Says...

Sort of

Results: Qualitative data

- Students were overwhelmingly positive in their evaluation of the stigma intervention (n=56).

Looking back over the past 5 weeks please rate how you feel about the things we were doing at the end of those classes overall.	Strongly Disagree				Strongly Agree	*M (SD)*
I felt what we did was meaningful.	2 (3%)	2 (3%)	4 (7%)	9 (16%)	39 (70%)	4.45 (1.0)
I learned something important that will impact my life outside of class.	3 (5%)	2 (3%)	4 (6%)	12 (18%)	35 (52%)	4.32 (1.1)

Results: Qualitative data

- Anonymous written feedback included:
  - “I have gotten more out of and learned more from [the stigma intervention] than I have in the rest of my whole higher education experience combined.”
  - The last 5 weeks have been extremely meaningful to me.”
  - “The ideas lasted and stayed in my mind.”
  - “I felt this was a fantastic learning experience.”
  - “It was a pleasure and a blessing.”
  - “It opened my heart a bit more and usually I feel I’m bad with empathy.”

Results: Increased similarity

- Students rated the person diagnosed with schizophrenia as being more similar to themselves after the stigma intervention. There was no change in perceived similarity for the person with cancer.

Measure	**Pre *M(SD)***	**Post *M(SD)***	**P value**	**Effect size (d)**
Similarity to person with schizophrenia (n=50)	5.56 (1.5)	4.92 (1.7)	.004	.42
Similarity to person with cancer (n=49)	5.18 (.13)	5.10 (1.3)	.62	.07

Results: What we didn't impact

Measure	Pre *M(SD)*	Post *M(SD)*	P value	Effect size (d)
AAQ-stigma mindfulness (n=33)	29.67 (6.8)	31.09 (7.9)	.28	.19
AAQ-stigma cognitive fusion (n=50)	26.46 (9.0)	26.92 (8.92)	.65	.06
AAQ-stigma experiential avoidance (n=32)	33.31 (9.5)	32.59 (9.9)	.51	.12
Social discounting (me vs MI) (n=47)	6.63 (3.3)	6.30 (3.6)	.30	.19
Social discounting (cancer vs MI) (n=30)	4.21 (1.9)	4.04 (1.7)	.45	.11
Social distance (n=53)	.80 (.59)	.87 (.55)	.20	.17

Interpretation

- It appears we were successful in increasing the sense of similarity with people seen as having schizophrenia.
- Suggests we were successful with principle 5: *Facilitate a hierarchical frame of a "common humanity" in suffering that competes with the tendency toward "us vs. them" framing that is part of objectification and stigma.*
- It also appears that we still have a lot more work to do!

Limitations

- No control group
- We didn't have a self-report measure of stigmatizing attitudes (e.g. CAMI)
- We did not measure fidelity to the curriculum
- Two of the measures we used were new and their sensitivity to intervention is unknown:
  - Social discounting
  - AAQ-Stigma
- Did not include a measure of believability (the SAB) that was shown to be impacted in previous ACT research.

EPILOGUE

Next Steps

- Conduct additional analyses to understand what happened
  - Review qualitative data
  - Look for predictors of response
  - Preliminary analyses suggest that people reporting low levels of stigma-related experiential avoidance didn't like the curriculum and didn't respond to it
- Include a control group
- Include a measure of attitudes and believability
- Have measures more narrowly focus on "psychological disorders"
- Dismantle and study individual processes more intensively
- Any ideas from the audience?

Tune in Next Time for The Next Installment of…

Back to the Drawing Board