

Integrating Empowerment Strategies with ACT

to Reduce HIV Stigma and Promote Collective Resilience

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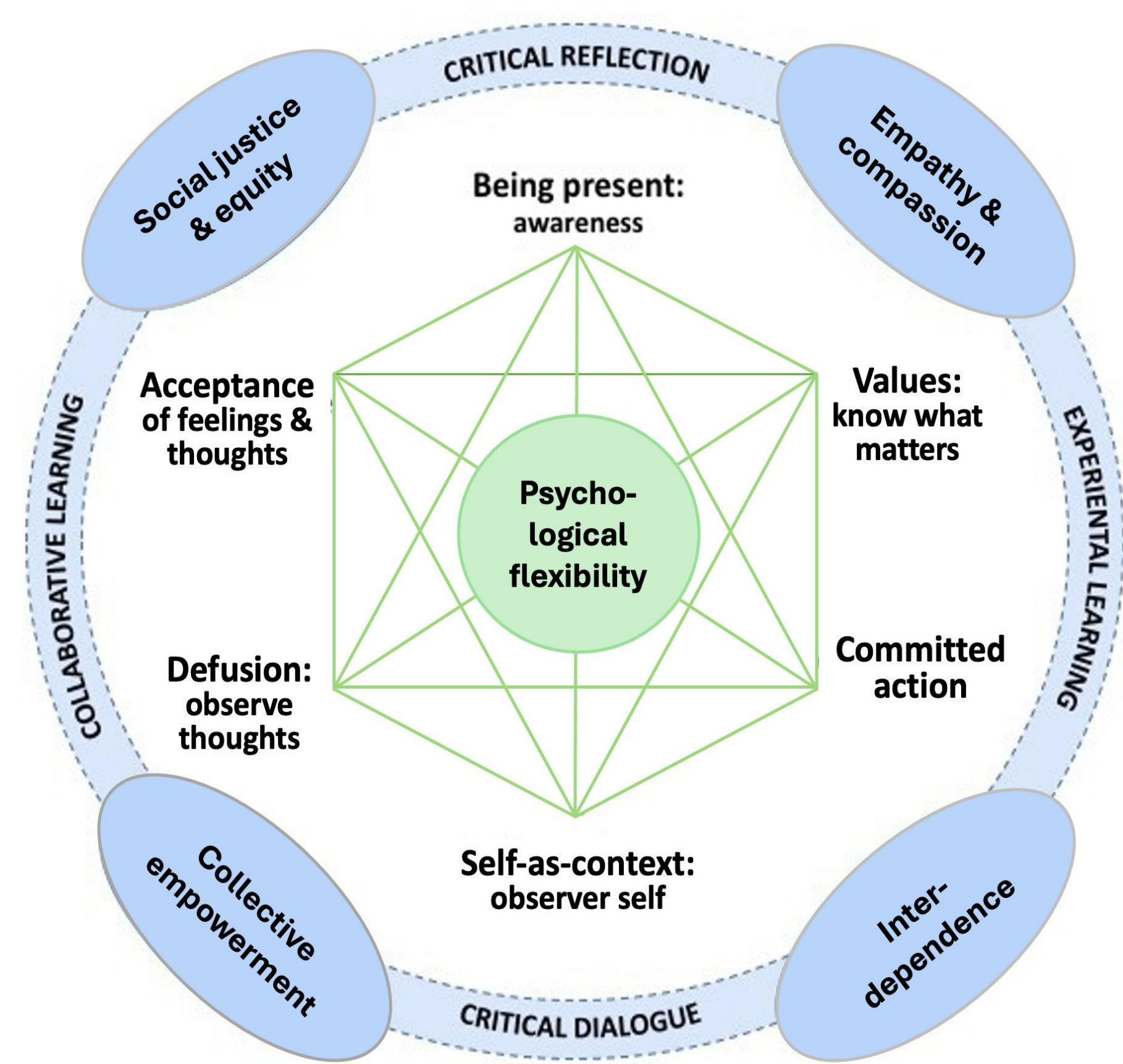
Introduction

Racialized, immigrant, and refugee communities are disproportionately impacted by HIV in Canada, accounting for nearly 70% of first-time diagnoses in 2022 despite representing only 26.6% of the population. The HIV disparities are driven by complex, intersecting structural barriers—including racism, gender inequities, homophobia, migration stress, and poverty—and are severely exacerbated by HIV-related stigma, which deters testing, delays care, and worsens health outcomes. Effective and sustainable stigma-reduction interventions are critically needed.

The ACE Intervention

The **Acceptance and Commitment to Empowerment (ACE)** intervention integrates 2 evidence-based models to reduce stigma at the individual and collective levels: (i) *Acceptance and Commitment Therapy (ACT)* that promotes psychological flexibility through mindful, experiential activities grounded in six processes of being present, defusion, acceptance, self-as-context, values, and committed action; and (ii) *Freirean-informed Collective Empowerment (FCE)* that honours the lived experiences and strengths of affected communities, promotes critical dialogue on self-compassion, praxis (reflection and action), interconnections/interdependence, and stigma in the context of power relations in society. ACE consists of six weekly online self-guided learning modules paired with six online group sessions.

Figure 1. ACE Model



Methodology

Project ACE consisted of three phases: **(1) assessment of local contexts** of stigma to inform ACE adaptation; **(2) community capacity building** through a train-the-trainer program with service providers and community leaders; and **(3) community implementation of ACE training** across six project sites (Calgary, Edmonton, London, Niagara, Ottawa, and the Greater Toronto Area). **Data collection:** (i) sociodemographic questionnaire; (ii) pre, immediate post-, 3-month post- intervention survey with validated scales; (iii) 3-month post-intervention focus groups; and (iv) monthly post-intervention activity logs.

Participants

The team engaged 141 participants; 126 completed the intervention: Phase 2 (n=38); and Phase 3 (n=88). This poster focuses on Phase 3 results.

Sociodemographic characteristics: Majority self-identified as new immigrants with **<5 years in Canada** (n=52; 59%); **female** (n=56; 64%); median age was **35-39** and mean age bracket was **38.5**. Participant **sexual orientation** included: heterosexual (n=62; 70%); bisexual (n=9; 10%); gay (n=5; 6%); lesbian (n=2; 2%); option not listed (n=9; 10%).

NOTE: Validated scales included: (i) the 12-item HIV Stigma Scale with 4 subscales on personalized stigma, disclosure concerns, concerns with public attitudes and negative self-image; (ii) the 4-item Perceived Discrimination from Service Providers Scale; (iii) the 12-item Cognitive and Affective Mindfulness Scale (CAMS-R) that assesses mindfulness; (iv) the 7-item Acceptance and Action Questionnaire Version II (AAQ-II) that measures experiential psychological inflexibility and cognitive fusion; (v) the 28-item BRIEF COPE that measures 14 different coping strategies; and (vi) the 12-item Self-Compassion Scale Short (SCS-S) that measures self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification.

Results

The **ACE intervention** offers a powerful model to reduce stigma at multiple levels, moving psychological flexibility beyond an individual psychological trait into **collective empowerment** and social change.

Table 1: Descriptive Statistics and Repeated Measures ANOVA Results - Psychometric Outcomes Across Intervention Time Points							
Psychometric-Scaled Variables	Pre-Intervention	Immediate post-int.	3-Months post-int.	Pairwise Comparison of Repeated Measures ANOVA			RM-ANOVA (M_1, M_2, M_3)
	N=88	N=86	N=73	Mean Diff (M_2-M_1)	Mean Diff (M_3-M_2)	Mean Diff (M_3-M_1)	^a F-Statistics
	M_1 (SD)	M_2 (SD)	M_3 (SD)				
Stigma towards PLHIV (Scale=104, $\alpha=0.93$)	44.3 (12.83)	41 (10.73)	42.75 (14.44)	-3.3*	1.75**	-1.55	^b13.33***
Confidence to Fight Stigma (Scale=50, $\alpha=0.94$)	38.84 (9.51)	41.77 (7.38)	41.73 (6.26)	2.93	-0.04	2.89	4.28*
Self-Compassion (Scale =60, $\alpha=0.83$)	40.86 (7.76)	41.41 (7.28)	42.82 (7.46)	0.55	1.41*	1.96	4.78*
Empowerment Readiness (Scale=36, $\alpha=0.85$)	29.49 (6.5)	31.8 (5.34)	32.69 (4.6)	2.31**	0.89	3.2***	12.42***
Mindfulness (Scale =48, $\alpha=0.81$)	34.3 (6.22)	34.81 (6.31)	35.19 (5.42)	0.51	0.38	0.89	1.55
Acceptance and Action (Scale =49, $\alpha=0.91$)	20.31 (10.46)	20.52 (8.92)	18.45 (7.76)	0.21	-2.07**	-1.86	4.71*
Use of Emotional Support, BRIEFCOPE 5, 15 (subscale=8, $r=0.61$)	5.53 (1.78)	6.05 (1.6)	6.06 (1.48)	0.52	0.01	0.53	4.96*
Venting, BRIEFCOPE 9, 21 (subscale=8, $r=0.28$)	4.5 (1.69)	5.24 (1.41)	5.38 (1.4)	0.74*	0.14	0.88**	11.18**
Planning, BRIEFCOPE 14, 25 (subscale=8, $r=0.52$)	6.15 (1.64)	6.63 (1.38)	6.73 (1.35)	0.48*	0.1	0.58*	7.3**
Self-Blame, BRIEFCOPE 13, 26 (subscale=8, $r=0.49$)	4.46 (1.74)	4.38 (1.5)	3.95 (1.41)	-0.08	-0.43*	-0.51*	6.73*

* $p < .05$, ** $p < .01$, *** $p < .001$; ^a F-Statistics measured the significance of within person change across the three intervention times.
^b The quadratic trend, rather than the linear trend, of the Repeated Measures ANOVA was statistically significant for this variable.

Data Convergence and Divergence: Key Themes

THEME 1. PERSONAL TRANSFORMATION

Although the *mindfulness* scores did not reach statistical significance, participants' narratives diverged sharply. Many shared their use of **mindfulness** and **present-moment grounding** to connect to self-compassion and actively disrupt internalized oppression and stigma.

Tee: "I learned to stop judging myself so harshly for things I couldn't control. Mindfulness was a truly transformative practice for me; when the anxiety or the stigma gets overwhelming, I use those grounding tools to bring myself back to the present moment." (FG A)

Mama K: "For me, I like the fact that, the ACE, or what we learned, was, how to be mindful in everyday activities for the little things, even for, like, having a cup of tea. So, like, how to be mindful in all you do." (FG A)

Curry: "I think mindfulness was the best. [...] There are many times we do things... in the subconscious. But this time, being mindful really helped bring them into my consciousness that, I'm actually doing this. I'm walking, and I want to listen to my steps... (FG C)

THEME 2. INCREASED PSYCHOLOGICAL FLEXIBILITY

Survey scores showed a statistically significant increase in **psychological flexibility** and **self-compassion** among participants. Qualitative data converged, whereby participants reported a profound shift away from experiential avoidance toward defusion, emotional acceptance, self-compassion, and a broader sense of self-as-context.

Amina: "I used to think that venting or showing I was overwhelmed meant I was failing. But learning to just name the anxiety, to say 'I'm feeling completely stuck right now' out loud to someone else, stopped it from turning into that heavy self-blame. It's like I gave the feeling permission to just be there instead of trying to bury it." (Amina, FG A)

Tee: "ACE helped me understand that disappointment is a normal emotion, not a failure... I learned how to sit with disappointment instead of fighting it, or blaming myself, or others." (FG A)

Elena: "Before the program, I kept everything locked inside and blamed myself. Learning to let it out—to vent, to lean on my support systems, and to actively plan for my future without shame—was like a weight being lifted off my shoulders." (FG B)

THEME 3. STIGMA TRAJECTORY & PRAXIS

Data show an immediate reduction in stigma post-intervention ($M_2-M_1=-3.30^*$), followed by partial attenuation at 3 months ($M_3-M_2 = 1.75^{**}$), with stigma remaining below baseline overall. While this suggests a need for booster sessions or reflects scale limitations rather than individual failure, it is powerfully countered by a highly significant, continuous increase in **Empowerment Readiness** across the study ($M_3-M_1=3.20^{***}$). Supported by this psychological readiness, participants (n=73) entered active Freirean *praxis*, conducted **994 community activities, reaching >16,000 people**. Despite a hostile environment fluctuating their perceived stigma, their values-driven **Committed Action** remained uncompromised, as reflected in these entries in the Post-Intervention Activity Logs:

- "Have gotten involved in a project to share my story on print media about stigma and how to overcome it."
- "During our 2SLGBTQIA+ get-together and games night, we created space for people to share their stories and experiences with stigma. Hearing each other's voices and strategies for coping was powerful; it reminded everyone that we are not alone and that stigma can be challenged through community and connection."
- "I challenged HIV misinformation gently and promoted inclusive, non-judgmental language in a group attended by 14 people"
- "I organized an online seminar with 10 students on HIV stigma and prevention, fostering empathy and informed discussions."

Conclusion

This study demonstrates the powerful synergy achieved when expanding Acceptance and Commitment Therapy (ACT) beyond individual-level interventions into macro-level community health. While ACT promotes the essential psychological flexibility needed to navigate systemic stigma, pairing it with Freirean-informed Collective Empowerment (FCE) helps steer internal resilience toward collective action. By anchoring ACT processes in a structural framework like FCE, participants did not merely adapt to a stigmatizing environment—they actively mobilized to transform it. Ultimately, this integration encourages the ACT community to explore how intentional pairing of ACT core processes with macro-structural models can promote collective, values-driven committed action capable of transforming systemic health inequities.

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