Cultural Arts for Reducing Depressive Symptoms and Age-related Self-stigma in Older People: A Randomised Waitlist Controlled Trial

Tianyin Liu, Ph.D

Department of Applied Social Sciences

The Hong Kong Polytechnic University

Document date: June 1st, 2024

Background

Depression is a common chronic condition in old age; however, it is, to a large extent, under-recognized and under-treated. In Hong Kong, it is estimated that approximately 1 in 10 older people has clinically significant depression (Sun et al., 2012), and it is associated with suffering, functional impairment, and diminished health-related quality of life in older adults (Unützer et al., 2000). Research shows that stigmatizing belief is an important barrier to seeking help from mental health services (Barney et al., 2006), and some study suggests that self-stigma may be more strongly linked to the perception of barriers to mental health care than perceived public stigma (Arnaez et al., 2019). Self-stigma obstructs help seeking and recovery from mental illness, and has been widely researched in severe mental illness, adult and adolescent population. However, self-stigma has rarely been studied in older persons living with depression in Chinese community, who may face tripled the harm from internalized ageism, stigma about depression, and Chinese culture about *face*; and intervention aimed at reducing self-stigma is very scarce.

Self-Stigma: Depression, Ageism, and Lose "Face"

Stigma, according to Goffman (Goffman, 2009), is predominately a social construct that associates an tribute with a stereotype. Self-stigma comprises mainly three steps: awareness of the stereotype, agreement with it, and applying it to one self. Once self-stigma is formed, the person may embody the negative stereotype, often unconsciously, in his/her behaviour and functioning, leading to more social isolation and hopelessness (Levy, 2009).

It is common for older people with depression to develop self-stigma. For instance, in Europe, self-stigma occurs among approximately 1 in 5 people with bipolar or depression (Brohan et al, 2011). Some common self-stigmatising beliefs about depression include that the person is *responsible for his/her own situation*, he/she is *weak, unable to recover,* and *undesirable to be around* (Barney et al., 2009). The most common coping strategies with the stigma include avoidance, withdrawal, and secrecy. It was reported that among mental health patients in Hong Kong, regardless of age, the most frequently reported coping method was maintaining secrecy about the illness (Chung & Wong, 2004). Depressed older adults may also suffer from ageist beliefs. Ageism centres around the stereotypes of older people as *burdensome* and *useless* (Ayalon & Tesch-Römer, 2018), and older persons are discriminated against in employment, health care, and

other domains. When older persons internalize ageist beliefs, they can begin to believe and behave as though they are no longer independent, healthy, and vibrant human beings (Levy, 2009).

In addition, depressed older adults in Hong Kong may face unique moral experiences tied to stigma. Yang et al. proposed a dimension of *moral experience,* or *what is most at stake for people in a local social world,* to stigma (Yang et al., 2007). In Chinese culture that values "face", there are moral-somatic (where values are linked to physical experience) and moral-emotional (values are linked to emotional states) dimensions to stigma. To elaborate, "face" represents one's moral status in the local community, an individual may "have" and "receive" face for individual achievement, "give" face to respected others, or "lose" face for socially undesirable conditions associated with them, and the physical sensation of "losing face" is inseparable from the emotion of humiliation. Seeking professional mental health is often times associated with "losing face" (Yang, 2007). The interplay between these three types of plausible self-stigma in older adults with depression in Hong Kong may add extra barriers to their help seeking behaviours, and have pervasive negative impact on recovery.

Effectiveness of Previous Intervention Programmes

With growing awareness of the impact of mental illness self-stigma, there is arisen interest in interventions aiming to combat self-stigma. However, the results so far are inconclusive. A critical review reported that eight out of the 14 studies that met their inclusion criteria revealed significant improvement in self-stigma outcome (Mittal et al., 2012). It also summarized two main approaches of intervention: one, interventions that attempt to alter the stigmatizing beliefs; and two, interventions that enhance skills for coping with self-stigma through improvements in self-esteem, empowerment (Mittal et al., 2012). The latter coincides with the "why try" model, suggesting empowerment as the mediator, and it is also gaining traction among experts than the former. A more recent study systematically reviewed five randomized controlled trials, despite the heterogeneity of these interventions, they had some elements in common: all of them included elements of psychoeducation and either Cognitive Behavioural Therapy (CBT) techniques or methods aimed at helping participants to develop a personally helpful identity (Büchter & Messer, 2017). However, despite that individual studies reported some effectiveness, the systematic review concluded the effectiveness of the interventions for self-stigma uncertain because previous studies lacked statistical power, used questionable outcome measures, and had a high risk of bias (Büchter

& Messer, 2017). Furthermore, these programmes are all targeted at severe mental illness, and few stem from a theoretical background to examine the effect of empowerment on self-stigma in depressed older adults.

Community-based Cultural Art Programmes

Community-based cultural arts differ from Art Therapy; while the latter often uses art as a tool for expression and to build up a psychotherapeutic relationship between clients and certified therapists in one-on-one or small-scale formats (American Art Therapy Association, 2012), the former uses art as a platform to provide a social and creative outlets or activity schemes for promoting wellness (Castora-Binkley et al., 2010). Artwork consists of a process and a product, and the beneficial effects of creating art are not dependent on a person's skill or talents; some argue it is reliant on the creative process (Patterson et al., 2011), some think that the product has more importance because of its interpretive value (Ahmed & Siddiqi, 2006). However, in the field of non-pharmacological interventions utilizing arts, rigorously designed and evaluated intervention studies are scarce.

Empowerment through Arts: Process & Product

Wreford defined empowerment as the development of self-efficacy (Bandura, 2000), the belief that an individual has about his or her capacity to execute behaviours necessary to produce specific performance attainments. Community-based art programmes have the potential to empower the participants, which is supported by empirical data. A UK study evaluating the impact of participatory art projects for people with mental health needs found that arts participation increased levels of empowerment and had the potential to impact mental health and social inclusion (Hacking et al., 2008). However, the mechanism of empowerment was not discussed in detail.

We hypothesize that for older adults living with depression who might internalize ageist beliefs such as being useless and worthless, or stereotypes of depression as weak and undesirable to be around, both the creative process of art making and the final art product may act as empowering agencies. In the process of appreciating and creating art, the participants will be exposed to new things and acquire new skills. One unique feature of community-based cultural arts is its relative ease of creating a "no fail" environment since there is no right or wrong in art, and participants can feel safer to try and gain confidence in the creative process. The final product, as a tangible manifestation of the creative process, can be perceived by not only the participants

themselves but also the friends and families of the participants and also the general public. Therefore, for older adults who may have lost their productive roles, self-efficacy in learning and creating new things and social recognition of their creation may empower them to have reduced self-stigma.

Preliminary findings

We co-developed a cultural art programme with older adults and professionals and tested its feasibility and preliminary effects (Liu et al., 2023). The findings revealed that culturally appropriate participatory arts groups can effectively promote empowerment in older people, and a definitive trial is needed to reveal its effectiveness.

Research plan and methodology

Design

This study is a two-arm randomized waitlist controlled trial. The trial will compare older adults at risk for depression joining the cultural arts programme (experimental), versus those who receive treatment as usual (waitlist control) in local NGOs. A statistician who is not involved in any part of the study will independently randomise participants by using a predetermined random table generated by Microsoft Excel. Those numbers will not be decoded until the intervention group is assigned. The allocation is known to the interventionists, and concealed to the participants. Data will be collected at two-time points: baseline (T0) and completion of the 9-session intervention (T1).

Study Sample

Fifty participants will be recruited through community outreach and open referrals from local NGOs. The inclusion criteria are: (a) aged 60 years or above; (b) at risk for depression, i.e., Patient Health Questionnaire (PHQ-9) score under 10 (Kroenke et al., 2001); (c) having at least one risk factor of depression, including frequent loneliness, lack of social interaction, lack of meaningful/enjoyable activities, chronic pain, more than four chronic diseases, or bereavement. The exclusion criteria were: (a) known history of autism, intellectual disability, schizophrenia-spectrum disorder, bipolar disorder, Parkinson's disease, or dementia; (b) illiterate; (c) physically frail; or (d) significant suicidal risk.

Interventions

Participants in the experimental group will receive a nine-session (including an introductory and orientation session) cultural arts programme; the details of the programme are described in the protocol development paper (Liu et al., 2023). Participants in the control group will receive treatment as usual, which is their normal daily activities and usual mental health and health care available in NGO centers.

Measurements

The primary outcome measures are:

1) Self-stigma:
    a. Stigma about Depression is accessed by the 16-item Self-Stigma of Depression Scale (SSDS) (Barney, Griffiths, Christensen, & Jorm, 2010), which comprises subscales of Shame, Self-Blame, Social Inadequacy, and Help-Seeking Inhibition. Questions begin with the stem "If I were depressed, I would …" and include items such as "feel inferior to others" (Shame), "think I should be able to cope with things" (Self-Blame), and "feel I couldn't contribute much socially" (Social Inadequacy). Participants respond using a 5-point Likert scale of 1 (strongly disagree) to 5 (strongly agree).
    b. Ageism beliefs are accessed by four questions modified from the Perceptions of Age Discrimination (PAD) (Sabik, 2015) to address internalized ageism. Items are rated on a scale of 1 (strongly disagree) to 5 (strongly agree) and included the statements "I consider myself a person who has been deprived of the opportunities that are available to others because of my age," "I am excluded from many sectors of public life because of my age," "After ending my working life, I am/will be considered to be worthless," and "My achievements are not appreciated in our society because of my age."
2) Depression is assessed by the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001). It is a 9-itme instrument that incorporates depression diagnostic criteria with other leading major depressive symptoms, and rates the frequency of the symptoms which factors into the scoring severity index. PHQ-9 scores of 5-9, 10-14, 15-19, 20 and above represent mild, moderate, moderately severe, and severe depression.

The secondary outcome measures are:

1) Empowerment is measured by the self-empowerment subscale (4 items) from the Mental Health Recovery Measure (MHRM) (Young & Bullock, 2003). The MHRM scale has been validated in Hong Kong population (Ye et al., 2013). Items are rated on a 5-point scale ranging from 1, strongly disagree, to 5, strongly agree; higher scores indicate higher self-reported level of self-empowerment. The four items are: "I believe in myself", "I have control over my mental health problems", "I am in control of my life", and "I socialize and make friends".
2) Cognitive fusion is measured by the self-report Cognitive Fusion Questionnaire (CFQ) (Gillanders et al., 2014). It is a 7-item Likert-type scale ranging from 1 (never true) to 7 (always true). Example items include: "My thoughts cause me distress or emotional pain" and "I tend to get very entangled in my thoughts." Higher scores indicated higher levels of cognitive fusion in participants, ranging from 7 to 49. The scale was validated in Chinese, with good internal consistency ($\alpha = 0.92$) and test-retest reliability ($r = 0.67$) (Zhang et al., 2014).

The control variables are basic demographics: age, gender, marital status, education (years and highest attainment), work years, and number of chronic diseases.

Data analysis

We will generate descriptive statistics of the demographic and outcome variables at the baseline (T0). The independent sample t-test will be used to compare the means of continuous variables in the intervention and control groups; the chi-square test will be used to compare categorical variables; and Fisher exact test will be used for variables with low cell counts ($n < 5$). As observations at two time points are nested within individuals, changes in outcome measures will be assessed by a two-level linear mixed model. R will be used for data analysis. Results will be reported according to the CONSORT statement for trials of non-pharmacological treatments. All results will be reported with the appropriate effect sizes, along with statistical significance and confidence intervals.

References

Ahmed, S. H., & Siddiqi, M. N. (2006). Essay: Healing through art therapy in disaster settings. *The Lancet, 368*, S28-S29.

Arnaez, J. M., Krendl, A. C., McCormick, B. P., Chen, Z., & Chomistek, A. K. (2019). The association of depression stigma with barriers to seeking mental health care: a cross-sectional analysis. *Journal of Mental Health*, 1-9.

Ayalon, L., & Tesch-Römer, C. (2018). *Contemporary perspectives on ageism*: Springer International Publishing.

Bandura, A. (2000). Cultivate self-efficacy for personal and organizational effectiveness. *Handbook of principles of organization behavior, 2*, 0011-0021.

Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health, 9*(1), 61.

Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2010). The Self-Stigma of Depression Scale (SSDS): development and psychometric evaluation of a new instrument. *International Journal of Methods in Psychiatric Research, 19*(4), 243-254.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian & New Zealand Journal of Psychiatry, 40*(1), 51-54.

Brohan, E., Gauci, D., Sartorius, N., Thornicroft, G., & Group, G. E. S. (2011). Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study. *Journal of affective disorders, 129*(1-3), 56-63.

Büchter, R. B., & Messer, M. (2017). Interventions for reducing self-stigma in people with mental illnesses: a systematic review of randomized controlled trials. *GMS German Medical Science, 15*.

Castora-Binkley, M., Noelker, L., Prohaska, T., & Satariano, W. (2010). Impact of arts participation on health outcomes for older adults. *Journal of Aging, Humanities, and the Arts, 4*(4), 352-367.

Chung, K., & Wong, M. (2004). Experience of stigma among Chinese mental health patients in Hong Kong. *Psychiatric Bulletin, 28*(12), 451-454.

Clift, S. (2012). Creative arts as a public health resource: moving from practice-based research to evidence-based practice. *Perspectives in Public Health, 132*(3), 120-127.

Corrigan, P. W., Larson, J. E., & Ruesch, N. (2009). Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World psychiatry, 8*(2), 75-81.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*: Simon and Schuster.

Hacking, S., Secker, J., Spandler, H., Kent, L., & Shenton, J. (2008). Evaluating the impact of participatory art projects for people with mental health needs. *Health & Social Care in the Community, 16*(6), 638-648.

Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys results from two population-based studies. *Research on aging, 26*(6), 655-672.

Johnson, V., & Stanley, J. (2007). Capturing the contribution of community arts to health and well-being. *International Journal of Mental Health Promotion, 9*(2), 28-35.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine, 16*(9), 606-613.

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current directions in psychological science, 18*(6), 332-336.

Liu, T., Chan, R., Yeung, C., Lee, L. C. B., Chan, T. N. C., Welton, K., ... & Wong, G. H. Y. (2023). "Participation Is Fun and Empowering": A Participatory Approach to Co-Design a Cultural Art Program for Older Chinese at Risk of Depression in Hong Kong. *Innovation in aging*, *7*(5), igad041.

Mak, W. W., Chan, R. C., & Yau, S. S. (2016). Validation of the Recovery Assessment Scale for Chinese in recovery of mental illness in Hong Kong. *Quality of Life Research, 25*(5), 1303-1311.

Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: a critical review of the literature. *Psychiatric services, 63*(10), 974-981.

Sabik, N. J. (2015). Ageism and body esteem: Associations with psychological well-being among late middle-aged African American and European American women. *The Journals of Gerontology: Series B, 70*(2), 189-199.

Sun, W. J., Xu, L., Chan, W. M., Lam, T. H., & Schooling, C. M. (2012). Depressive symptoms and suicide in 56,000 older Chinese: a Hong Kong cohort study. *Social Psychiatry and Psychiatric Epidemiology, 47*(4), 505-514.

Unützer, J., Patrick, D. L., Diehr, P., Simon, G., Grembowski, D., & Katon, W. (2000). Quality adjusted life years in older adults with depressive symptoms and chronic medical disorders. *International Psychogeriatrics, 12*(1), 15-33.

Wreford, G. (2015). Arts and health in Australia. *Oxford Textbook of Creative Arts, Health, and Wellbeing: International perspectives on practice, policy and research*, 135.

Yang, L. H. (2007). Application of mental illness stigma theory to Chinese societies: synthesis and new direction. *Singapore medical journal, 48*(11), 977.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social science & medicine, 64*(7), 1524-1535.

Ye, S., Pan, J.-Y., Wong, D. F. K., & Bola, J. R. (2013). Cross-validation of mental health recovery measures in a Hong Kong Chinese sample. *Research on Social Work Practice, 23*(3), 311-325.

Young, S., & Bullock, W. (2003). The mental health recovery measure. *Toledo: University of Toledo, Department of Psychology*.