

*Interventions, Internalized Stigma in Mental Disorders*

**Interventions to Reduce Internalized Stigma in individuals with Mental Illness: A  
Systematic Review**

## **Resumen**

**Introducción:** El estigma internalizado tiene una alta prevalencia en personas con problemas de salud mental y se ha asociado con consecuencias negativas en diferentes ámbitos: laboral, social, personal, etc. Por ello, resulta relevante estudiar de forma sistemática las características y eficacia de las diferentes intervenciones psicológicas y psicosociales orientadas a reducirlo.

**Materiales y métodos:** A través de las bases de datos MEDLINE y PsycINFO, entre otras, se buscaron estudios controlados sobre intervenciones específicas para reducir el estigma internalizado en personas con trastornos mentales, publicados entre 2008 y 2018.

**Resultados:** Las intervenciones encontradas pueden agruparse en cuatro bloques: a) intervenciones psicoeducativas acerca del estigma; b) intervenciones cognitivo-conductuales, dirigidas principalmente a modificar las creencias auto-estigmatizadoras; c) intervenciones centradas en la revelación de la enfermedad mental; d) intervenciones multicomponente que combinaban varias de las anteriores. Las intervenciones tenían una duración media de 10 sesiones y se aplicaban predominantemente en formato grupal. En 9 de los 14 estudios revisados se obtenían resultados significativos en la reducción del estigma internalizado, con tamaños del efecto pequeños o moderados. También existían mejoras significativas en otras variables, como recuperación subjetiva o afrontamiento. La principal limitación metodológica de los estudios revisados era la ausencia de información acerca de la tasa de rechazos.

**Conclusiones:** Existen intervenciones eficaces dirigidas a reducir el estigma internalizado, siendo las intervenciones psicoeducativas sobre el estigma y las multicomponente las que muestran mejores resultados. Las intervenciones cognitivo-conductuales y las intervenciones basadas en la revelación se han estudiado en menor medida y sus resultados no son concluyentes.

**PALABRAS CLAVE:** auto-estigma, eficacia, enfermedad mental, estigma internalizado, intervenciones

## **Abstract**

**Introduction:** Internalized stigma has a high prevalence in people with mental health problems and is associated with negative consequences in different areas: work, social, personal, etc. Therefore, it is relevant to systematically study the characteristics and effectiveness of the different psychological and psychosocial interventions aimed at reducing it.

**Materials and methods:** Through the databases MEDLINE and PsycINFO, among others, controlled studies on specific interventions to reduce internalized stigma in people with mental disorders published between 2008 and 2018 were selected,.

Results: The interventions found can be grouped into four blocks: a) psychoeducational interventions about stigma; b) cognitive-behavioral interventions, mainly aimed at modifying self-stigmatizing beliefs; c) interventions focused on the revelation of mental illness; and d) multicomponent interventions that combine several of the above. The interventions had an average of 10 sessions and were predominantly applied in group format. In 9 of the 14 studies reviewed, significant results were obtained in the reduction of internalized stigma with small or moderate effect sizes. There were also significant improvements in other variables, such as subjective recovery or coping.

The main methodological limitation of the studies reviewed was the absence of information on the rejection rate.

Conclusions: There are effective interventions aimed at reducing internalized stigma, with psychoeducational interventions on stigma and multicomponent interventions showing the best results. Cognitive-behavioral interventions and interventions based on disclosure have been studied to a lesser extent and their results are inconclusive.

**KEYWORDS:** efficacy, internalized stigma, interventions, mental illness, self-stigma

The public stigma of mental illness is a construct that encompasses beliefs, emotions and negative behaviors on behalf of society towards people with a mental illness (Michaels, López, Rüsçh, & Corrigan, 2012). Mental disorders are often associated with negative stereotypes such as danger, unpredictability or incompetence, which, in turn, generate emotions of fear, anger, grief, etc. and can lead to behaviors of devaluation, discrimination and social rejection (Rüsçh, Angermeyer, & Corrigan, 2005). The public stigma associated with mental illness is a widely studied phenomenon that has been observed in various sociocultural contexts (Angermeyer & Schomerus, 2017; Mascayano, Lips, Mena, & Manchego, 2015; Parcesepe & Cabassa, 2013), such as our country, Spain (Crespo, Pérez-Santos, Muñoz, & Guillén, 2008; Ruiz et al., 2012).

An important aspect of public stigma is that the person him/herself can anticipate the negative consequences he/she will experience when having a mental illness, even when these consequences have not occurred. This anticipation of rejection is called perceived or anticipated stigma, and is differentiated from the experienced stigma, that is, from specific stigmatizing experiences that the person has suffered (Cechnicki & Angermeyer, 2011). In a study conducted among people with schizophrenia, bipolar disorder and depressive disorder (Farrelly et al., 2014), 93% of the participants anticipated discrimination and 87% of the participants had experienced discrimination during the previous year. Gerlinger et al.'s (2013) review, focused on studies of people with schizophrenia spectrum disorders, showed that approximately 65% of participants had perceived stigma and 56% had experienced it.

Sometimes, the person with mental illness accepts and internalizes the stereotypes and prejudices existing in society about their condition, which is known as internalized stigma or self-stigma (Al-Khouja & Corrigan, 2017). The percentage of people reporting moderate or high levels of internalized stigma was 22% in Brohan, Elgie, Sartorius, and Thornicroft's (2010) study and 44% in Picco, Pang, Wen, Jeyagurunathan, and Satghare's (2016) study. A study carried out across fourteen European countries (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012) suggests a direct connection between public and internalized stigma: people with mental illnesses living in countries with less stigmatizing attitudes showed lower levels of internalized stigma.

Another very interesting question in relation to internalized stigma is the "Why try" effect (Corrigan, Bink, Schmidt, Jones, & Rüsçh, 2016). Those people with mental illness who are aware of the existing stereotypes and who agree with them, are more likely to experience low self-esteem and to stop pursuing their personal goals, such as getting a job or having friends, as they believe that they are not valuable enough to achieve these goals. Therefore, internalized stigma would have both emotional and behavioral consequences. In Muñoz, Sanz, Pérez-Santos, and Quiroga's (2011)

study, both the person's recovery expectations and internalized stigma directly influenced their psychosocial performance.

One of the current models proposed to understand internalized stigma is Wood, Byrne and Morrison's (2017) integrative cognitive model, which identifies key processes in the development and maintenance of internalized stigma in psychosis. This model suggests that there is a connection between identification with the group and the awareness of stigma (for example, when receiving a diagnosis) and the triggers of stigma, which activate a series of self-stigmatizing central beliefs. These beliefs are associated, in a bidirectional way, with emotional, physiological, cognitive and behavioral responses that maintain the internalized stigma and that, in turn, are influenced by protective factors (such as having a social support network, peer support or the development of personal goals for recovery). This type of model has clinical implications of great interest and underlines the importance of directing clinical interventions towards those processes and responses that are affected by stigma.

In order to work and reduce the internalized stigma in people with mental illness, various types of psychological and psychosocial interventions have been developed. Although in recent years, different systematic reviews and meta-analyses have been published on interventions to reduce internalized stigma in people with mental illness, their results are inconclusive. Two of these works support its effectiveness, with effect sizes ranging from small to moderate (Tsang et al., 2016; Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015), but other studies have not found sufficient evidence on the effectiveness of these interventions (Büchter & Messer, 2017; Wood, Byrne, Varese, & Morrison, 2016). Of the four existing reviews, only that of Büchter and Messer (2017) had demanding criteria for the inclusion of studies, such as the need to have a control group.

In short, the review of the literature shows that internalized stigma has an important presence in people with a mental illness and usually leads to different negative consequences in the lives of these people. Although there are several reviews about the effectiveness of interventions to reduce internalized stigma, no clear results have been obtained, thus it seems relevant to continue investigating this issue. The objective of the present study is to perform a systematic and updated review on the characteristics and effectiveness of interventions aimed at reducing internalized stigma in people with mental illness, using restrictive inclusion criteria that ensure methodological rigor.

## Methodology

To carry out this review study, the recommendations of the PRISMA statement (Urrútia &

Bonfill, 2010) have been taken into consideration. The bibliographic search was carried out in the MEDLINE, PsycARTICLES, Psychology Database, PsycINFO, Public Health Database y Social Science Databases. The combination of the following descriptors was used as search criteria: (mental illness OR mental health OR psychiatric OR schizophre\* OR psychosis OR psychotic OR delusional OR depressi\* OR bipolar OR schizoaffective OR personality disorder) AND (stigma OR self-stigma\* OR self-perception OR internalized stigma OR internalised stigma OR shame OR devaluation) AND (intervention OR program OR therapy OR psychotherapy OR treatment OR trial OR cbt). The bibliography of articles related to the topic was also revised to expand access to more research, as well as previous reviews and meta-analyses.

The inclusion criteria for the studies were the following:

- a) Applying a specific intervention to reduce internalized stigma in people with mental disorders.
- b) Having a control group.
- c) Having at least two moments of measurement (pre and post treatment).
- d) Being published between 2008 and 2018.
- e) Being published in scientific journals indexed in JCR, in English or Spanish.

The search strategy is summarized in Figure 2. In each of the screenings, the inclusion criteria discussed above were followed. There were certain articles that passed the first screening (based on the abstract and/or title) because they apparently fulfilled the inclusion criteria. However, the subsequent detailed reading of the entire article revealed that this was not the case and these articles were excluded in the next step of the process. Finally, 14 articles were included that met the inclusion criteria, which are summarized, in alphabetical order, in Table 1.

<Please Insert Figure 1 about here>

<Please Insert Table 1 about here>

## **Results**

### ***Participants***

The *samples* of the studies had been obtained through mental health institutions and with the help of pamphlets and similar materials. In 2 of the 14 studies (Çuhadar & Çam, 2014; Hansson, Lexén, & Holmén, 2017) there was no reference made as to how the sample was obtained. The *number of participants* was equal to or greater than 30 people in most articles. The smallest sample

consisted of 29 participants (Michaels et al., 2014) and the largest sample had 268 participants (Lucksted et al., 2017). The average age was 42 years. In 7 studies, the sample was mainly composed of women (Corrigan et al., 2015; Çuhadar & Çam, 2014; Ivezić, Sesar, & Mužinić, 2017; Michaels et al., 2014; Rüşch et al., 2014; Yanos, Roe, West, Smith, & Lysaker, 2012).

In 11 of the 14 articles, the diagnosis of the participants was specified. In seven of them (Hansson et al., 2017; Lucksted et al., 2017; Morrison et al., 2016; Rüşch et al., 2014; Uchino, Maeda, & Uchimura, 2012; Wood, Byrne, Enache, & Morrison, 2018; Yanos et al., 2012), the numbers of participants with different disorders were specified. In five articles (Hansson et al., 2017; Lucksted et al., 2017; Roe et al., 2014; Uchino et al., 2012; Wood et al., 2018), most of the sample had a diagnosis of schizophrenia. In another article (Morrison et al., 2016), most of the sample had suffered a psychotic episode. In other cases, the sample was composed mostly of people with depressive disorder (Rüşch et al., 2014) or by people with schizoaffective disorder (Yanos et al., 2012). In another article (Çuhadar & Çam, 2014), the sample was composed only of people with bipolar disorder and in another two studies, the sample was composed exclusively by people with schizophrenia (Fung, Tsang, & Cheung, 2011; Ivezić et al., 2017).

### ***Characteristics of the interventions***

Regarding the type of intervention in the experimental groups, the most frequent were psychoeducational interventions on stigma (Çuhadar & Çam, 2014; Ivezić et al., 2017; Lucksted et al., 2017; Michaels et al., 2014; Uchino et al., 2012). All of them focused on psychoeducation about mental health and mental disorders, about the different forms of stigma and about the strategies to deal with it, although they differed in the number and duration of sessions. For example, the shortest intervention was the so-called "Anti-Stigma Project" workshop (Michaels et al., 2014), which consists of a single 3-hour session. In this workshop, participants were informed about the impact of stigma on the lives of people with mental illness and their families. In contrast, the longest intervention was the "Psychoeducation group program" by Ivezić et al. (2017), which consisted of 12 group sessions over 3 months. Through a psychoeducational approach based on the principles of recovery and empowerment, a better knowledge of the disease, prevention of relapse, reduction of internalized stigma and coping with social stigma and discrimination were favored.

The second most frequent type of intervention were the studies that applied the so-called "Narrative Enhancement/Cognitive Therapy" (NECT) (Hansson et al., 2017; Roe et al., 2014; Yanos et al., 2012). It consisted of a multi-component group intervention, whose objective was to help people with mental disorders to recognize the effects of stigma on themselves, to identify and reconsider self-stigmatizing beliefs, and to build a richer personal narrative. Its duration was 8

weeks and it included psychoeducational sessions on stigma, sessions aimed at cognitive restructuring, and sessions in which narrative techniques were used.

In two of the studies, the multicomponent program "Coming Out Proud" (COP) was applied (Corrigan et al., 2015; Rüscher et al., 2014). It was a group intervention based on disclosure, which consisted of 3 sessions of two hours each. Its objective was to support the participants in their personal decision process with respect to revealing (or not) the mental disorder in the different contexts of their life.

In one of the studies, the multicomponent program "Photo-Voice" (Ruscinova et al., 2014) was applied. This intervention was led by peers that, starting from an artistic activity, defied stigma and worked to empower people with mental illnesses. It combined psychoeducational components, experiential exercises and activities of community participation and integration.

In addition, another study applied the "Self-stigma Reduction Program" (SRP) (Fung et al., 2011), which is a multicomponent intervention that combines psychoeducation, cognitive-behavioral therapy, motivational interview, social skills training and training to achieve objectives.

The remaining studies evaluated cognitive therapy together with the usual treatment (Morrison et al., 2016) and cognitive-behavioral therapy (CBT) (Wood et al., 2018). In both cases, self-stigmatizing stereotypes and beliefs were approached using cognitive-behavioral strategies, such as guided discovery, cognitive restructuring techniques, behavioral experiments, assessment of advantages and disadvantages of various ways of dealing with stigma, and training in skills.

The *development* of the therapies were explained in a more detailed way or by referring to the manuals used in all the articles, except in one of studies (Uchino et al., 2012), in which the objectives of the therapy were explained but its development was not indicated.

The average *number* of sessions of the studies was approximately 10 sessions, with the minimum being one session (Michaels et al., 2014; Wood et al., 2018) and the maximum being 20 sessions (Hansson et al., 2017; Roe et al., 2014; Yanos et al., 2012). One study did not specify the number of sessions performed (Ruscinova et al., 2014). Regarding the *format of the interventions*, the sessions were carried out in groups in 11 of the studies. In two interventions (Morrison et al., 2016; Wood et al., 2018), the sessions were carried out individually, while in another study, the two modalities were combined (Fung et al., 2011). The average *duration* of the interventions was around 10 weeks, with a minimum of 3 hours (Michaels et al., 2014) and a maximum of 20 weeks (Yanos et al., 2012).

Most studies used the usual treatment as a comparison group (Lucksted et al., 2017; Roe et al., 2014; Rüscher et al., 2014; Uchino et al., 2012; Wood et al., 2018; Yanos et al., 2012). In 3 of studies, it was not clear what the usual treatment consisted of (Roe et al., 2014; Rüscher et al., 2014;

Uchino et al., 2012), while in the remaining 3, it was generally indicated that the usual treatment involved psychiatric and psychosocial rehabilitation in the community setting (Lucksted et al., 2017; Wood et al., 2018; Yanos et al., 2012). The waiting list was used as a control in 4 studies (Corrigan et al., 2015; Hansson et al., 2017; Ivezić et al., 2017; Russinova et al., 2014). In the rest, psychoeducation (Wood et al., 2018), no treatment (Çuhadar & Çam, 2014), or another type of activity, such as reading a newspaper (Fung et al., 2011), or watching a video (Michaels et al., 2014) were used as control.

### ***Results of the interventions***

The evaluation of results was carried out in all cases through standardized scales on internalized stigma and other variables of interest, such as self-esteem, quality of life, empowerment, depression or coping strategies. The most widely used instrument to assess internalized stigma was the Internalized Stigma of Mental Illness Scale (ISMI), which was used in nine studies (Çuhadar & Çam, 2014; Ivezić et al., 2017; Lucksted et al., 2017; Morrison et al., 2016; Roe et al., 2014; Rüşch et al., 2014; Russinova et al., 2014; Wood et al., 2018; Yanos et al., 2012).

Regarding the effectiveness of interventions to reduce internalized stigma (see Table 2), significant results were obtained in 9 of the 14 studies. More specifically, "Coming Out Proud" obtained a significant reduction compared to the waiting list (Corrigan et al., 2015). Interventions based on psychoeducation obtained a significant reduction compared to the waiting list (Ivezić et al., 2017), the usual treatment (Lucksted et al., 2017; Uchino et al., 2012) and no treatment (Fung et al., 2011). The "Narrative Enhancement/Cognitive Therapy" program obtained a significant reduction when compared with the waiting list (Hansson et al., 2017) and with the usual treatment (Roe et al., 2014). The "Photo-voice" program obtained a significant reduction compared to the waiting list (Russinova et al., 2014). The "Self-stigma Reduction Program" obtained a significant reduction compared to the performance of another activity in the post-treatment, although there were no differences in the follow-ups (Fung et al., 2011).

**<Please Insert Table 2 about here>**

Regarding the effect size, there was considerable variability among the 11 articles that provided this data (Corrigan et al., 2015; Fung et al., 2011; Hansson et al., 2017; Ivezić et al., 2017; Lucksted et al., 2017; Morrison et al., 2016; Roe et al., 2014; Rüşch et al., 2014; Russinova et al., 2014; Wood et al., 2018; Yanos et al., 2012) but, apart from the measure used, values that indicated a small or moderate effect size predominated.

With regard to the effects on other *variables*, Table 3 synthesizes the results in the main variables that have been studied. Subjective recovery improved in all cases in which it was evaluated, regardless of the type of intervention performed (Lucksted et al., 2017; Michaels et al., 2014; Morrison et al., 2016; Russinova et al., 2014), as well as coping strategies (Rüsch et al., 2014; Russinova et al., 2014). Self-esteem improved significantly in two of the studies where "Narrative Enhancement/Cognitive Therapy" was used (Hansson et al., 2017; Roe et al., 2014). However, it did not improve in Yanos et al.'s (2012) study where the same intervention was used or when cognitive therapy was performed along with the usual treatment (Morrison et al., 2016). The results in the rest of the variables are heterogeneous. For example, stress related to stigma improved significantly in the two cases in which "Coming Out Proud" was performed (Corrigan et al., 2015; Rüsch et al., 2014), whereas it did not improve when CBT was used (Wood et al., 2018). Empowerment only improved when "Photo-voice" was carried out (Russinova et al., 2014), but not with other interventions (Ivezić et al., 2017; Rüsch et al., 2014). Depression decreased significantly with cognitive therapy along with the usual treatment during the post-treatment (Morrison et al., 2016), but not with "Photo-voice" (Russinova et al., 2014) or with CBT (Wood et al., 2014).

### ***Methodological quality of the studies***

Finally, we have analyzed the methodological quality of the studies included in this review using a scale that assesses the following aspects: existence of a control group, existence of randomization, information on the randomization method, on the rejection rate, on the rate of dropouts and on the effect size. Table 3 reveals that six of the studies reached levels of maximum methodological quality, between 5 and 6 points. However, six articles presented a limited methodological quality, with scores equal to or less than 3 points.

Overall, the main limitation is the lack of information about the rejection rate to participate in the study, which was only indicated in 5 of the articles. It should be borne in mind that all the selected studies had a control group, as it was one of the inclusion criteria of this review. Random assignment was performed in all studies, except for one, but only 9 of them specified the procedure used to carry this randomization out. With regard to drop-outs during the study, the rate of drop-outs in post-treatment was indicated in 10 of the 14 articles, and in 7 of the 9 articles that include the follow-up period, the drop-out rate is indicated during said period.

<Please Insert Table 3 about here>

## **Discussion**

In this review, a variety of psychological and psychosocial interventions aimed at reducing internalized stigma in people with severe mental disorder have been found. The present review is not limited to specific diagnoses but has adopted the definition of severe mental disorder proposed by the National Institute of Mental Health (USA), which includes three dimensions to consider: diagnosis, duration and disability (see Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). Thus, the term severe mental disorder encompasses various types of alterations of prolonged duration, which entail a variable degree of disability and social dysfunction, and which must be addressed in various healthcare resources of the psychiatric and social care network (Comunidad de Madrid, 2003; Conejo et al., 2014; Guinea, 2007). That is, those with schizophrenia spectrum disorders, but also those with other mental disorders such as bipolar disorder, major depression or personality disorders, would be considered as being included in the group of people with severe and lasting mental disorders and who, as a consequence of their illness, have persistent disabilities.

The interventions found could be grouped into several blocks: a) psychoeducational interventions on stigma (Çuhadar & Çam, 2014; Ivezić et al., 2017; Lucksted et al., 2017; Michaels et al., 2014; Uchino et al., 2012); b) cognitive-behavioral interventions, mainly aimed at modifying self-stigmatizing beliefs (Morrison et al., 2016; Wood et al., 2018); c) interventions focused on the disclosure of mental illness (Corrigan et al., 2015; Rüşch et al., 2014); d) multicomponent interventions that combine several of the above (Fung et al., 2011; Hansson et al., 2017; Roe et al., 2014; Russinova et al., 2014; Yanos et al., 2012). Most studies have obtained a reduction of internalized stigma (at least in some aspects of it), in post-treatment and/or follow-up, with small to moderate effect sizes. These results coincide with those found in the reviews by Tsang et al. (2016) and Yanos et al. (2015). However, different results have been found depending on the characteristics of the intervention and the group with which it was compared. Interventions aimed at reducing internalized stigma have also been proven to be effective in significantly improving other aspects, especially those of subjective recovery and coping strategies when facing stigma. In this case, there was also great variability depending on the variable and the type of intervention performed.

The present review shows that the most common interventions are those based on psychoeducation on stigma or those that include some psychoeducational component of this type. With respect to the effectiveness of interventions whose main element is psychoeducation on stigma, the results show its positive effects in reducing internalized stigma. However, these results should be considered with caution, as half of these studies have a poor methodological quality (Ivezić et al., 2017; Michaels et al., 2014; Uchino et al., 2012). The common aspects of interventions based on psychoeducation are the provision of information about mental disorders,

internalized stigma and strategies to cope with it. In this regard, Yanos et al. (2015) stated that obtaining information about the myths of the disease serves as a tool to think critically and not internalize stigmatizing feelings and behaviors present in society.

Regarding multicomponent interventions, these combine psychoeducational, cognitive-behavioral, narrative, and motivational elements as well as elements based on mutual support and empowerment. This type of intervention offers very positive results, not only about the internalized stigma but about other variables related to it. Along this line, a study on the effectiveness of an intervention program on internalized stigma (PAREI) has recently been developed, which combines psychoeducational, cognitive-behavioral, motivational and peer support strategies (Díaz-Mandado, 2015). The results have shown significant improvements in the emotional dimension of internalized stigma, the perceived legitimacy of discrimination, the subjective recovery and social functioning in the experimental group compared to the usual treatment control group.

In relation to the cognitive-behavioral interventions, they have focused on cognitive aspects, especially on the cognitive restructuring of beliefs and self-stigmatizing schemes and on the assessment of advantages and disadvantages of various forms of coping with stigma. The two interventions found did not show differences in the internalized stigma compared to the usual treatment (which, in turn, included very varied options among which cognitive therapy was included) nor a differential effectiveness with respect to receiving psychoeducation on stigma. With regard to the programs based on disclosure, the results are not consistent with respect to the reduction of internalized stigma, as significant results were obtained in the study compared with the waiting list but not with the usual treatment.

If the characteristics of the five studies without meaningful results on internalized stigma are studied in depth, it is observed that three of them present the shortest duration of the set of reviewed interventions, specifically between one and three sessions (Michaels et al., 2014; Rüscher et al., 2014; Wood et al., 2018). It is noteworthy that stereotypes and prejudices, in general, are particularly resistant to change, so that longer interventions may be required to produce changes in the internalized stigma. The other two studies (Morrison et al., 2016; Yanos et al., 2012) presented longer interventions, but had the smallest sample sizes together with Wood's (2018) study, which may have influenced the absence of significant results due to the low statistical power. Another interesting issue is that the two interventions that followed an individual format did not obtain significant results on internalized stigma (Morrison et al., 2016; Wood et al., 2018). A study on the opinions of users of mental health services who participated in a course in clinical psychology found that they perceived positively having a space to talk and feel respected, as well as providing learning opportunities, as this provided different opinions and points of view (Campbell & Wilson,

2017). In this regard, it has been found that peer education reduced internalized stigma in older people with depression (Conner, Ward, Iii, & Brown, 2015). It seems therefore advisable to provide a group format when working on internalized stigma.

An interesting finding is the fact that different intervention modalities had different effects on variables directly or indirectly related to internalized stigma. In this sense, knowing in depth the characteristics and objectives of each person will enable planning the intervention (or combination of interventions) that is most effective for them. For example, if the person has a high degree of stress associated with the stigma of mental illness, an intervention approach based on disclosure will be especially useful. However, if the intention is to promote empowerment and community participation, an intervention based on the "Photo-voice" methodology will be the option of choice. The information provided by this review is therefore valuable when it comes to designing and applying evidence-based interventions tailored to the needs of the person.

## **Conclusions**

Based on the above, we can conclude that: a) Most of the interventions reviewed are effective in reducing internalized stigma, although with small to moderate effect sizes; b) Many of the interventions aimed at reducing internalized stigma produce improvements in other aspects such as subjective recovery, coping strategies, or self-esteem; c) Psychoeducation on aspects related to the stigma of mental illness is a common element in most interventions; d) Psychoeducational interventions on stigma and multicomponent interventions are the most used and are effective in reducing internalized stigma; e) Cognitive-behavioral interventions and interventions based on disclosure are applied to a lesser extent and their results are inconclusive.

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Table 1.

*Summary of articles on interventions to reduce internalized stigma in people with severe mental disorder (2008-2018)*

| <b>Authors and year. Country</b>     | <b>N</b>                                | <b>Groups</b>  | <b>Duration. N° of sessions and format. Moments of measurement</b>   | <b>Measures</b>  | <b>Main results</b>  |
|--------------------------------------|---|--|--|--|--|
| Corrigan et al. (2015)<br>USA        | N=126 individuals with mental disorders | EG: Coming Out Proud (COP)<br>CG: Waiting list                   | ---<br>3 group sessions<br>Pre, post, 1 month  | – Self-Stigma of Mental Illness Scale (SSMIS)<br>– Stigma Stress Scale<br>– Center for Epidemiological Studies Depression Scale (CESD)   | · EG < CG significant in internalized stigma (post and follow-up), stress of stigma (follow-up) and depression only in women (post and follow-up)<br>· No significant differences in the rest. |
| Çuhadar & Çam (2014)<br>Turkey       | N=47 individuals with bipolar disorder  | EG: Psychoeducation<br>CG: No treatment                          | 7 weeks<br>7 group sessions<br>Pre, post   | – Internalized Stigma of Mental Illness Scale (ISMI)<br>– Bipolar Disorder Functioning Questionnaire (BDFQ)  | · EG < CG significant in internalized stigma (post).<br>· EG > CG significant in performance.<br>· No significant differences in the rest.   |
| Fung, Tsang & Cheung (2011)<br>China | N=66 individuals with schizophrenia     | EG: Self-stigma Reduction Program (SRP)<br>GC: Reading newspaper | Between 8-16 weeks, according to number of sessions per week<br>16 sessions (12 group sessions and 4 individual follow-up sessions)<br>Pre, intermediate, post, 1, 2, 3 and 4 months | – Chinese Self-stigma of Mental Illness Scale (CSSMIS)<br>– Change Assessment Questionnaire for People with Severe and Persistent Mental Illness (CAQ-SPMI)<br>– Psychosocial Treatment Compliance Scale (PTCS)<br>– Brief Psychiatric Rating Scale (BPRS)<br>– Global Assessment of Functioning Scale (GAF)<br>– Scale to Assess Unawareness of Mental Disorders (SUMD)<br>– Chinese General Self-efficacy Scale (CGSS) | · EG < CG significant in internalized stigma and in fulfillment (post).<br>· EG = CG in self-efficacy and insight.<br>· Follow-up: no differences between both groups for any variable.        |
| Hansson,                             | N=106                                   | EG: Narrative  | ----   | – Self-Stigma of Mental  | · EG < CG significant in internalized  |

|                                |   |         |  |   |  |  |
|--------------------------------|---|---------|--|---|--|--|
| Lexén & Holmén (2017)          | individuals with severe mental illness (mainly schizophrenia, depression or anxiety, and others)              | Sweden  | Enhancement/Cognitive Therapy (NECT)<br>CG: Waiting list   | 20 group sessions<br>Pre, post, 6 months            | Illness Scale-Short Form (SSMIS-SF)<br>– Rosenberg Self-esteem Scale (RSE)<br>– Manchester Short Assessment of Quality of Life (MANSA)   | stigma (post and follow-up).<br>· EG > CG significant in self-esteem (and follow-up).<br>· No significant differences in quality of life.  |
| Ivezić, Sesar & Mužinić (2017) | N=80 individuals with schizophrenia   | Croatia | EG: <i>Psychoeducation group program</i><br>CG: Waiting list   | 3 months<br>12 group sessions<br>Pre, post          | – Internalized Stigma of Mental Illness Scale (ISMI)<br>– Boston University Empowerment Scale (BUES)<br>– Perceived Devaluation and Discrimination Scale (PDD)   | · EG < CG significant in internalized stigma.<br>· No significant differences in empowerment and in devaluation and perceived discrimination.  |
| Lucksted, et al. (2017)        | N=268 individuals with mental illness (mainly schizophrenia or schizoaffective disorder and bipolar disorder) | USA     | EG: psychoeducation intervention <i>Ending Self-Stigma</i> (ESS)<br>CG: TAU (minimally improved)                               | 3 months<br>9 group sessions<br>Pre, post, 6 months | – Self-Stigma of Mental Illness Scale (SSMIS)<br>– Internalized Stigma of Mental Illness Scale (ISMI-29)<br>– Maryland Assessment of Recovery in People With Serious Mental Illness (MARS)<br>– General Self-Efficacy Scale<br>– Sense of Belonging Instrument (SOBI)<br>– Brief Symptom Inventory (BSI)<br>– Experiences of Stigma Survey<br>– Beck Cognitive Insight (BCI) Scale<br>– Repeatable Battery of Neuropsychological Status (R-BANS) | · EG < CG in internalized stigma (post).<br>· EG > CG in personal recovery (post).<br>· EG = CG in self-efficacy and in general experience of belonging.<br>· No results are presented for the rest of measures. |
| Michaels et al. (2014)         | N=127 individuals with mental illness   | USA     | EG: psychoeducation intervention <i>Anti-Stigma Project workshop (ASP)</i><br>CG: Other activity: <i>“Steps to a Healthier</i> | 3 hours<br>1 group session<br>Pre, post             | – Attribution Questionnaire (AQ-9)<br>– Awareness Questionnaire (AwQ) (in post)<br>– Error Choice Test (EC) (in post)  | · EG > CG significant in evaluation of recovery<br>· EG < CG significant in prejudice towards individuals with psychiatric difficulties.   |

|                        |  | <i>You''</i>  |   |   |   |
|------------------------|--|---|---|---|---|
| Morrison et al. (2016) | N=29 individuals with psychotic disorders (schizophrenia, schizoaffective disorder, delusional disorder) | EG: Cognitive therapy (CT) + Usual treatment<br>CG: Usual treatment       | 16 weeks<br>12 individual sessions<br>Pre, post, 7 months | – Recovery Assessment Scale (RAS)<br>– Internalized Stigma of Mental Illness Scale – Revised (ISMI-R)<br>– Semi-Structured Interview Measure of Stigma (SSIMS)<br>– 16-item version of Stigma Scale (KSS)<br>– Process of Recovery Questionnaire Short form (QPR)<br>– Beck Depression Inventory for Primary Care (BDI-7)<br>– Beck Hopelessness Scale (BHS)<br>– Social Interaction Anxiety Scale (SIAS)<br>– Self-Esteem Rating Scale Short form (SERS-S)<br>– Internalised Shame Scale (ISS) | · EG < CG significant in internalized shame, depression and despair (post and follow-up).<br>· EG > CG significant in subjective recovery (post and follow-up).<br>· EG = CG in internalized stigma, social anxiety and self-esteem (post and follow-up).   |
| Roe et al. (2014)      | N=119 individuals with severe mental disorder  | EG: Narrative Enhancement/Cognitive Therapy (NECT)<br>CG: Usual treatment | 6 months approximately<br>20 group sessions<br>Pre, post  | – Internalized Stigma of Mental Illness Scale (ISMI)<br>– Manchester Short Assessment of Quality of Life (MANSA)<br>– Adult Dispositional Hope Scale (ADHS)<br>– Rosenberg Self-Esteem (RSE)  | · EG < CG significant in internalized stigma.<br>· EG > CG significant in self-esteem, quality of life and hope.  |
| Rüsch et al. (2014)    | N=100 with mental illness (schizophrenia spectrum, depressive disorder, bipolar disorder)                | EG: Coming Out Proud (COP)<br>CG: Usual treatment                         | 3 weeks<br>3 group sessions<br>Pre, post, 6 weeks         | – Internalized Stigma of Mental Illness Inventory (ISMI)<br>– Empowerment Scale<br>– Stigma Stress Scale<br>– Stigma Coping Orientation Scale (SCOS)<br>– Coming Out with Mental  | · EG = CG in internalized stigma, empowerment and self-efficacy related to disclosure of certain information (post and follow-up).<br>· EG > CG significant in coping strategies of stigma (post), and in perceived benefits of revealing information.<br>· EG < CG significant in stress of stigma |

|  |   |   |   |  |  |
|--|---|---|---|--|--|
|  |   |   |   | Illness Scale (COMIS)<br>– Disclosure-related distress<br>– Disclosure-related self-efficacy   | (post and follow-up) and in stress of disclosure of certain information (post).  |
| Russinova et al. (2014)                                    | N=82 with severe mental disorder                                  | EG: Anti-stigma program “Photo-Voice”.<br>CG: Waiting list    | 10 weeks—group sessions<br>Pre, post, 3 months                        | – Internalized Stigma of Mental Illness Scale (ISMI)<br>– Approaches to Coping With Stigma scales<br>– Center for Epidemiological Studies Depression Scale (CESD)<br>– Empowerment Scale<br>– Generalized Perceived Self-Efficacy Scale<br>– Personal Growth and Recovery Scale (PGRS)               | · EG < CG significant in internalized stigma (post).<br>· EG > CG significant in coping strategies and empowerment (post).<br>· EG > CG significant in personal growth and total recovery (post and follow-up)<br>· EG = CG in depression and self-efficacy. |
| Uchino, Maeda, & Uchimura (2012)<br><br>Japan              | N=56 individuals with schizophrenia or schizoaffective disorder   | EG: Psychoeducation program<br>CG: Usual treatment            | 6 weeks<br>6 group sessions<br>Pre, post                              | – Social Distance Scale (SDS-J)<br>– Knowledge of Illness and Drugs Inventory (KIDI)<br>– Drug Attitude Inventory (DAI-10)<br>– Birchwood's Psychosis Insight Scale (BPIS)<br>– Global Assessment of Functioning Scale, (GAF)  | · EG < CG significant in prejudice against individuals with mental illness.<br>· EG > CG significant in knowledge about mental illnesses and their treatment and in insight<br>· No significant differences in the rest.                                     |
| Wood, Byrne, Enache & Morrison (2018)<br><br>Great Britain | N=30 individuals with diagnosis within the schizophrenia spectrum | EG: Cognitive-behavioral therapy (CBT)<br>CG: Psychoeducation | 2 weeks<br>1 or 2 individual sessions (2 hours)<br>Pre, post, 1 month | – Internalized Stigma of Mental Illness Inventory-Shortened (ISMI-S)<br>– Stigma Scale (SS)<br>– Self-Esteem Rating Scale (SERS)<br>– Process of Recovery Questionnaire – short form (QPR)<br>– Beck Depression Inventory-Primary Care (BDI-PC)<br>– Attitudes towards Mental Health Problems (AMHP) | · EG = CG in internalized stigma in post and follow-up, stress of stigma, depression and attitudes towards mental health problems  |

|                            |  |  |  |   |  |
|----------------------------|--|--|--|---|--|
| Yanos et al. (2012)<br>USA | N=39<br>individuals with schizophrenia, schizoaffective disorder, bipolar disorder or depression | EG: Narrative Enhancement/Cognitive Therapy (NECT)<br>· EG1: Exposed: they have attended at least 6 group meetings or have completed a treatment module<br>· EG2: Not exposed<br>CG: Usual treatment | 20 weeks<br>20 group sessions<br>Pre, post, 3 months | <ul style="list-style-type: none"> <li>– Internalized Stigma of Mental Illness Inventory (ISMI)</li> <li>– Structured Clinical Interview for DSM-IV Disorders (SCID)</li> <li>– Beck Hopelessness Scale (BHS)</li> <li>– Coping with Symptoms Checklist (CSC)</li> <li>– Quality of Life Scale (QLS)</li> <li>– Positive and Negative Syndrome Scale (PANSS)</li> <li>– Scale for Assessing Unawareness of Mental Disorder (SUMD)</li> <li>– Rosenberg Self-esteem Schedule (RSES)</li> </ul> | <ul style="list-style-type: none"> <li>· EG1 &lt; EG2 significant in internalized stigma (pos and follow-up) and in improvement of insight (follow-up).</li> <li>· No significant differences in the rest</li> </ul> |
|----------------------------|--|--|--|---|--|

*Note.* EG = experimental group; CG = control group; ES = effect size

Table 2

*Summary of the results of interventions in internalized stigma and in other evaluated variables.*

| Author and year        | EG          | CG             | Internalized stigma | Recovery | Self-esteem | Depression | Insight | Self-efficacy | Quality of life | Stress of stigma | Empowerment | Hope | Performance | Coping |
|------------------------|-------------|----------------|---------------------|----------|-------------|------------|---------|---------------|-----------------|------------------|-------------|------|-------------|--------|
| Çuhadar & Çam, 2014    |             | No treatment   | ✓                   |          |             |            |         |               |                 |                  |             |      | ✓           |        |
| Ivezić et al., 2017    |             | Waiting list   | ✓                   |          |             |            |         |               |                 |                  | ×           |      |             |        |
| Lucksted et al., 2017  | Psychoed.   | TAU            | ✓                   | ✓        |             |            | N       | ×             |                 |                  |             |      |             |        |
| Michaels et al., 2014  |             | Other activity | ×                   | ✓        |             |            |         |               |                 |                  |             |      |             |        |
| Uchino et al., 2012    |             | TAU            | ✓                   |          |             |            | ✓       |               |                 |                  |             |      | ×           |        |
| Morrison et al., 2016  | CT+TAU      | TAU            | ×                   | ✓        | ×           | ✓          |         |               |                 |                  |             | ✓    |             |        |
| Wood et al., 2018      | CBT         | Psychoed.      | ×                   |          |             | ×          |         |               |                 | ×                |             |      |             |        |
| Corrigan et al., 2015  | COP         | Waiting list   | ✓                   |          |             | ✓          |         |               |                 | ✓                |             |      |             |        |
| Rüsch et al., 2014     |             | TAU            | ×                   |          |             |            |         |               |                 | ✓                | ×           |      |             | ✓      |
| Russinova et al., 2014 | Photo-voice | Waiting list   | ✓                   | ✓        |             | ×          |         | ×             |                 |                  | ✓           |      |             | ✓      |
| Hansson et al., 2017   |             | Waiting list   | ✓                   |          | ✓           |            |         |               | ×               |                  |             |      |             |        |
| Roe et al., 2014       | NECT        | TAU            | ✓                   |          | ✓           |            |         |               | ✓               |                  |             | ✓    |             |        |
| Yanos et al., 2012     |             | TAU            | ×                   |          | ×           |            | ✓       |               | ×               |                  |             | ×    | ×           |        |
| Fung et al., 2011      | SRP         | Other activity | ✓                   |          |             |            | ×       | ×             |                 |                  |             |      |             |        |

*Note.* EG = experimental group; CG = control group; Psychoed. = Psychoeducation; TAU = usual treatment; CT = cognitive therapy; CBT = Cognitive-behavioral therapy; COP = Coming Out Proud; NECT = Narrative Enhancement/Cognitive Therapy; SRP = Self-stigma Reduction Program.

✓ Significant results, × Non-significant results

Table 3

*Methodological quality of the studies included in the present review.*

| Author, year           | Control group | Randomization <sup>a</sup> | Randomization method <sup>b</sup> | Rejection rate | Drop-out rate in post | Drop-out rate in follow-up | TOTAL (0-6) |
|------------------------|---------------|----------------------------|-----------------------------------|----------------|-----------------------|----------------------------|-------------|
| Corrigan et al., 2015  | 1             | 1                          | 0                                 | 0              | 1                     | NA                         | 3           |
| Çuhadar & Çam, 2014    | 1             | 1                          | 1                                 | 0              | 1                     | NA                         | 4           |
| Fung et al., 2011      | 1             | 1                          | 1                                 | 0              | 0                     | 0                          | 3           |
| Hansson et al., 2017   | 1             | 1                          | 1                                 | 0              | 1                     | 1                          | 5           |
| Ivezić et al., 2017    | 1             | 1                          | 1                                 | 0              | 0                     | NA                         | 3           |
| Lucksted, et al., 2016 | 1             | 1                          | 1                                 | 1              | 1                     | 0                          | 5           |
| Michaels et al., 2014  | 1             | 1                          | 1                                 | 0              | 0                     | NA                         | 3           |
| Morrison et al., 2016  | 1             | 1                          | 1                                 | 1              | 1                     | 1                          | 6           |
| Roe et al., 2014       | 1             | 0                          | 0                                 | 0              | 1                     | 1                          | 3           |
| Rüsch et al., 2014     | 1             | 1                          | 1                                 | 1              | 1                     | 1                          | 6           |
| Russinova et al., 2012 | 1             | 1                          | 0                                 | 0              | 1                     | 1                          | 4           |
| Uchino et al., 2012    | 1             | 0                          | 0                                 | 0              | 0                     | NA                         | 1           |
| Wood et al., 2018      | 1             | 1                          | 1                                 | 1              | 1                     | 1                          | 6           |
| Yanos et al., 2012     | 1             | 1                          | 1                                 | 1              | 1                     | 1                          | 6           |

<sup>a</sup> Study described as randomized.

<sup>b</sup> The randomization method is adequately described.

*Note.* 0 =No; 1 = Yes; NA =Not applicable (there is no follow-up)