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Interventions Targeting Mental Health Self-Stigma: A Review and Comparison

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Objective: With growing awareness of the impact of mental illness self-stigma, interest has arisen in the development of interventions to combat it. The present article briefly reviews and compares interventions targeting self-stigma to clarify the similarities and important differences between the interventions.

Method: We conducted a narrative review of published literature on interventions targeting self-stigma.

Results: Six intervention approaches (Healthy Self-Concept, Self-Stigma Reduction Program, Ending Self-Stigma, Narrative Enhancement and Cognitive Therapy, Coming Out Proud, and Anti-Stigma Photo-Voice Intervention) were identified and are discussed, and data is reviewed on format, group-leader backgrounds, languages, number of sessions, primary mechanisms of action, and the current state of data on their efficacy. **Conclusions and Implications for Practice:** We conclude with a discussion of common elements and important distinctions between the interventions and a consideration of which interventions might be best suited to particular populations or settings.

Keywords: severe mental illness, self-stigma, interventions

Internalized or self-stigma refers to the phenomenon by which negative stereotypes about mental illness (e.g., of dangerousness, incompetence and inability to recover) are accepted and incorporated into the identity of people who have been diagnosed with severe mental illnesses (Ritsher, Otilingam, & Grajales, 2003; Corrigan, Watson, & Barr, 2006). Although discussions concerning the impact of stigma on the identity of people with mental

illness date back at least to the work of Goffman (1963), interest in self- or internalized stigma has increased dramatically since the publication of initial papers on the internalized stigma of mental illness scale (ISMIS; Ritsher et al., 2003; Ritsher & Phelan, 2004) and the self-stigma of mental illness scale (SSMI; Corrigan et al., 2006). These first papers documented the prevalence and impact of self-stigma (Ritsher et al., 2003; Ritsher & Phelan, 2004) and led to a consensus that self-stigma has pervasive negative effects on many people with mental illness and can be a major barrier to recovery (Yanos, Roe, Markus, & Lysaker, 2008). As a result, there has been a shift in interest toward developing interventions to address and ameliorate self-stigma.

The purpose of the present article is to briefly review and discuss interventions targeting mental health self-stigma for which published information is currently available, and to provide practical information on their features to clarify the similarities and important differences among them. The rapid growth in the development of interventions targeting self-stigma is reflected by the fact that a recently published review of internalized stigma treatment approaches (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012) excluded three newer approaches that are discussed in the current review. We note that the Mittal et al. (2012) review also included interventions targeting "perceived stigma" that do not, in our view, specifically address self-stigma, leading to a more muddled perspective on what interventions are available in this area. In addition, some of the interventions discussed in that review were

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not specifically targeted toward individuals with severe mental illness (interventions targeting substance abuse and depression were discussed).

In the current review, our main criterion for designating an intervention as targeting self-stigma is that it explicitly targets negative views about the self that are related to being diagnosed with a severe mental illness and/or being in mental health treatment, distinct from beliefs about others' negative stereotypes (i.e., perceived stigma). Many of the areas that such intervention approaches address correspond to subscales of the major scales for assessing self-stigma, such as the ISMI scale (Ritscher et al., 2003), or the SSMI scale (Corrigan et al., 2006). For example, subscales of the ISMI include "stereotype endorsement" (the endorsement of negative stereotypes about mental illness), "alienation" (a belief that one is separate from general society as a result of having a mental illness diagnosis) and "social withdrawal" (endorsement of a need to avoid others as a result of concern about stigma). By targeting these core areas, interventions that focus on self-stigma aim to increase self-esteem, hope, and self-efficacy (which have all been consistently found to be inversely associated with self-stigma) and decrease social avoidance. Of note, the interventions that we focus on do not take the place of, and should not be confused with, other interventions designed to reduce stigma in general, or interventions designed to help individuals cope with social rejection or discrimination from others. Social stigma regarding mental illness is a widespread problem and efforts should continue to combat it. At the same time, people facing mental health stigma need tools for protecting themselves from internalizing these corrosive messages. Thus, while social stigma is the root cause of self-stigma, each requires distinct amelioration strategies. Many individuals not experiencing significant self-stigma nonetheless find social stigma a main concern and may benefit more from interventions to enhance coping with it rather than self-stigma interventions. Conversely, many individuals impacted by self-stigma may experience diminished hope and self-esteem that fundamentally impact their recovery whether or not social stigma remains a specific problem for them. It is this second group that the interventions that we include in our review seek to benefit.

Method

A literature review was conducted using the databases PsycInfo and Medline. Search terms included *self-stigma*, *internalized stigma*, and *engulfment*, combined with *mental illness*, *psychiatric disability*, *psychosis*, and *schizophrenia*. Articles were then reviewed and those discussing interventions were identified and reviewed more closely to identify which discussed interventions specifically targeting attitudes about the self related to having or being diagnosed with a severe mental illness or psychiatric disability. Articles discussing interventions primarily targeting perceptions of societal stigma or ways to cope with it were not included. We also excluded articles focusing on stigma related to mental health conditions not usually considered "severe mental illness" (e.g., substance use disorders or personality disorders).

Results

Based on our review of the literature, we identified six intervention approaches meeting our criteria: a) Healthy Self-Concept

(McCay et al., 2006), b) Self-Stigma Reduction Program (Fung, Tsang, & Cheung, 2011), c) Ending Self-Stigma (ESS; Lucksted et al., 2011), d) Narrative Enhancement and Cognitive Therapy (NECT; Yanos, Roe, & Lysaker, 2011), e) Coming Out Proud (Corrigan, Kosyluk, & Rüscher, 2013), and f) Anti-Stigma Photo-Voice Intervention (Russinova et al., 2014). Table 1 presents an overview of each treatment approach, format, group-leader backgrounds, languages, number of sessions, primary mechanisms of action, and the current state of data on its efficacy. As can be seen in Table 1, all the approaches are group-based, with only one approach (Self-Stigma Reduction Program) combining the group and individual formats. English is the predominant language of the approaches, with only the Self-Stigma Reduction Program being unavailable in English; NECT having versions in English, Hebrew, Russian, and Swedish; and Coming Out Proud being available in English and German. The number of sessions varies greatly, ranging from three (Coming Out Proud) to 20 sessions (NECT). Three of the approaches (Self-Stigma Reduction Program, ESS, and NECT) have psychoeducation and cognitive restructuring as major mechanisms of action, while three include narrative or storytelling (NECT, Coming Out Proud and the Photovoice interventions). Of the six approaches, Healthy Self-Concept, the Self-Stigma Reduction Program, the Photovoice intervention, and Coming Out Proud have published significant results through medium ($n < 100$) randomized controlled trials (RCTs), while NECT found significant results in a large ($n > 100$) quasiexperimental study. No findings from large ($n > 100$) RCTs have been published, however ESS and NECT are currently being studied in large RCTs. Below, we describe each intervention in turn regarding conceptual underpinnings, format, structure, and research status. Then, we conclude by integrating what the current nature and status of these interventions suggests about the needs and directions for interventions reducing self-stigma.

Healthy Self-Concept

As described in McCay et al. (2006) and McCay et al. (2007), the Healthy Self-Concept model is a 12-week, manualized, group-based intervention specifically focused on individuals who have recently experienced their first psychotic episode. Group meetings are described as lasting 90 minutes, with two professional group facilitators and roughly five group members attending. Group meetings are described as following a "standardized format" in which hand-outs are distributed and then discussed. While the theoretical foundations of the group model are not explicitly discussed in either of McCay's papers, it appears to be essentially psychoeducational with elements of "group process" derived from group therapy approaches (e.g., Yalom, 1995), specifically "sharing, altruism and group learning." There are five topics that are covered for psychoeducation and processing, including: " (a) developing a personally acceptable interpretation of the illness experience, (b) minimizing self-stigmatizing attitudes, (c) reducing engulfment, (d) developing a sense of future, hopes, and dreams, and (e) developing and pursuit of meaningful life goals for each individual" (McCay et al., 2007). Each topic is discussed for 2 weeks, with the first and last weeks of treatment used to introduce and summarize all topics. There is no indication of formal skills training or cognitive restructuring components in Healthy Self-Concept.

Table 1
Comparison of Interventions Targeting Mental Health Self-Stigma

Treatment approach/Authors	Format	Peer or professionally run?	Languages	# of Sessions	Primary mechanisms of action	State of data on efficacy
Healthy Self-Concept/McCay et al. (2006, 2007)	Group	Professional	English	12	Psychoeducation, support; emphasis on positive attributes	Significant impact on self-stigma, hope and self-esteem from medium RCT
Self-Stigma Reduction Program: Fung et al. (2011)	Group and individual	Professional	Mandarin Chinese	12 Group, 4 Individual	Psychoeducation; cognitive restructuring; motivational interview; social skills training	Significant impact on self-esteem and treatment participation from small RCT
Ending Self-Stigma (ESS)/Luckssted et al. (2011)	Group	Either	English	9	Psychoeducation; cognitive restructuring	Significant impact on self-stigma, recovery, perceived social support and self-esteem from uncontrolled pilot; large RCT in progress
Narrative Enhancement and Cognitive Therapy (NECT)/Yanos, Roe, & Lysaker, (2011); Yanos et al., (2012); Roe et al. (2010, 2014)	Group	Professional	English; Hebrew; Russian; Swedish	20	Psychoeducation; cognitive restructuring; narrative enhancement	Significant impact on self-stigma, hope, self-esteem and subjective quality of life from quasiexperimental study; nonsignificant impact from small RCT; large RCT in progress
Coming Out Proud/ Corrigan et al. (2013); Rütisch et al. (2014)	Group	Peer	English, German	3	Discussion of pros and cons of disclosure; telling one's story	Significant impact on stigma stress, secrecy and disclosure stress from medium RCT
Anti-Stigma Photovoice Intervention/ Russinova et al. (2014)	Group	Peer	English	10	Psychoeducation; Taking and sharing of photographs; writing narrative relating to photographs	Significant impact on self-stigma, coping with societal stigma, greater increase in a sense of community activism, and perceived recovery and growth from medium RCT

Findings from two research studies on Healthy Self-Concept have been published. The first (McCay et al., 2006) was a non-randomized study of 52 young adults meeting criteria for schizophrenia-spectrum disorder, 26 of whom were assigned to Healthy Self-Concept or treatment as usual. Only three participants dropped out of Healthy Self-Concept, suggesting that it is a tolerable treatment approach. Participants showed significant reductions in scores in the Modified Engulfment Scale (McCay & Seeman, 1998, designed to measure the impact of schizophrenia on one's self concept, closely tied to self-stigma) in contrast with the control group, and also showed improvements in positive and general psychiatric symptoms. The second study was a randomized controlled trial of 67 young adults with schizophrenia-spectrum disorder, 41 assigned to Healthy Self-Concept and 21 assigned to treatment as usual. As in the first study, significant reductions were observed in Engulfment among participants in the experimental group in contrast with the control group. In addition, participants in the experimental group demonstrated improvements in a measure of hopefulness as well as increases in social functioning. The findings of these two studies suggest that Healthy Self-Concept is a promising approach to addressing the effects of self-stigma specifically among individuals dealing with their first psychotic episode. Findings suggest that the groups impact self-stigma and may also have a positive impact on psychiatric symptoms and social functioning.

Self-Stigma Reduction Program

Described in Fung et al. (2011), the Self-Stigma Reduction Program is a 16-week, manualized intervention that utilizes both group (12 sessions) and individual (four sessions) formats for sessions. The Self-Stigma Reduction Program is based on a theoretical framework that individuals with self-stigma are more likely to demonstrate poorer insight regarding the benefits of participation in psychosocial intervention. Reduced insight into these benefits can then lead to less readiness to change, which, in turn, leads to less treatment participation. The program covers a number of different strategies including psychoeducation, cognitive-behavioral therapy (CBT), motivational interviewing (MI), social skills training, goal setting and action planning, addressed through a series of group sessions. The first two sessions involve psychoeducation about recovery and stigma; the next five involve CBT and MI and include discussion about social and self-stigma as barriers to recovery and strategies for combating self-stigma. The next two sessions concern social skills training around assertiveness and dealing with stigmatizing social situations, the following two on goal attainment including goal setting and action planning, and one final session is used as a review and wrap-up. Group sessions are followed by four individual sessions, described as an opportunity to monitor progress and use of skills (Fung et al., 2011).

One research study on the Self-Stigma Reduction Program has been published to date. This study was a small RCT ($N = 66$) of individuals with a diagnosis of schizophrenia, with 33 assigned to the self-stigma reduction program and 34 assigned to a newspaper reading control group. All participants reported a significant amount of self-stigma, defined as reporting at the mean score or higher on a measure of self-stigma (Fung et al., 2011). Participants in the attendance group attended about 80% of the sessions, on

average, and none of the participants dropped of the intervention, suggesting that the intervention was acceptable to participants. Participants in the stigma-reduction program demonstrated a significant reduction in self-esteem decrement both midway through and after completing the intervention, and improvements in participation in treatment as rated by the participants' clinician after completing the program. However, significant changes in insight, self-efficacy, and other aspects of self-stigma (e.g., agreement with self-stigmatizing beliefs) were not reported (Fung et al., 2011). These results provide some preliminary support for potential benefits of the intervention with regards to self-esteem and participation in care for individuals with schizophrenia.

Ending Self-stigma (ESS)

ESS was created over several years by a group of clinical and mental health services researchers, some with lived experience of mental illness and most with experience providing mental health care. Early participants also helped to revise the intervention. Framing self-stigma as a common and hard-to-avoid consequence of being exposed repeatedly to societal prejudice and discrimination, ESS is presented to participants as offering a range of strategies they can learn and use to reduce self-stigma and its harmful effects.

The theoretical underpinnings of the ESS curriculum are varied, as the goal was to make the curriculum useful to a wide variety of individuals and to address multiple facets of self-stigma. Therefore it uses principles and strategies from research on societal and self-stigma regarding mental illness and other marginalized identities (internalized racism, homophobia, ableism, sexism), empowerment and recovery paradigms, lived experience, cognitive-behavioral therapy, and psychoeducation.

In format, ESS is a manualized, psychoeducational group/class of nine sessions, each 75–90 minutes long, usually held once a week. ESS courses generally involve 5–8 adults in a closed-group format and are co-led by one or two facilitators. Facilitators may be people with lived experience of mental illness or not and commonly include psychosocial rehabilitation or other mental health staff, peer counselors or peer specialists, and mental health trainees. The nine sessions combine information, reflection and experience sharing, mutual support and discussion, skill/strategy practice, interactive exercises, and home-based practice. Each session follows a basic format: welcome, discussion of home practice and review of the previous session, introduction of new strategy including relevant personal experiences, discussion and in-session practice, and preparation for between-session home practice.

Within this basic structure, the group is flexible and interactive, designed so participants may tailor the application of the information and strategies to their personal experiences and preferences. The strategies include: telling myth and stereotype from fact (Session 1), using cognitive-behavioral principles to change one's self-stigmatizing thinking (Sessions 2 and 3), strengthening positive aspects/views of one's self (Session 4), increasing belongingness and reducing alienation in the community (Session 5) and with family/friends (Session 6), and responding to societal prejudice and discrimination (Session 7). Session 8 reviews, practices, and further integrates all strategies, and Session 9 guides participants to plan next steps for reducing self-stigma beyond the course.

A 2011 article (Lucksted, Drapalski, Calmes et al., 2011) reports the only published research on ESS to date: a small ($n = 34$) uncontrolled trial of seven ESS classes held at two VA medical centers. Participants were U.S. military veterans, mostly male, with self-reported diagnoses of schizophrenia, schizoaffective disorder, or major mood disorder and were currently receiving outpatient mental health care. Participants completed an assessment before and after taking the ESS course that included measures of internalized stigma, perceived recovery, perceived social support, and empowerment). Results of the pilot showed significantly reduced internalized stigma and significantly increased recovery orientation perceived social support and empowerment in individuals that participated in the group.

These pilot results, coupled with positive participant review of the intervention, has led to two large ($n > 200$) randomized trials of ESS, one in the VA Health Care System and the other in community-based psychosocial rehabilitation programs, both still underway as of March, 2014. At the same time, increasing numbers of mental health programs have requested and been given permission to offer ESS under a limited use memo of understanding, mutually agreeing on a few conditions. To date, 49 such agencies have offered ESS across the United States (within both VA and community mental health systems) and two in Australia. While these sites are not part of any research, their informal feedback has been valuable for learning about ESS real-life implementation and for developing ESS ancillary resources, supplemental materials, and guidelines.

Narrative Enhancement and Cognitive Therapy (NECT)

Influenced by writings from members of the consumer/survivor movement (e.g., Deegan, 1988) as well as sociological discussions of the impact of stigma on identity (e.g., Estroff, 1989) and constructivist understanding of the role of narrative and sense of self, NECT was developed to address the fundamental impact of stigma on identity (Yanos et al., 2011). As well-captured by Deegan (1988), it confronts the reality that, for many people diagnosed with severe mental illness, a central question is “How do we develop a sense of ourselves and again reclaim and recover our sense of value when we have been devalued and dehumanized?”

NECT is a structured, manual-based group intervention. There are a total of 20 sessions, each roughly 60 minutes in length, which are divided into five stages. First, participants are invited to describe themselves, their experience with psychiatric illness or treatment and the interactions and mutual influences between one’s self and illness over time. This begins a process in which participants are welcomed and encouraged to reflect upon and flexibly define their experience of self and illness over time, and sets the tone of the constructivist spirit of the intervention. The second stage entails a more structured psychoeducation component which presents the concepts of stigma and self-stigma. Common myths or false generalized ideas about mental illness (, e.g., that “people with mental illness cannot work”) are discussed and challenged by research evidence. In this section participants have the opportunity to ponder and share some of their personal experiences of public stigma and the risk and consequences of adapting such stigmatizing attitudes and directing them toward oneself.

Special emphasis is put on the fact that self-stigma is a social construction deriving from public stigma. The third section of NECT focuses on learning and practicing cognitive restructuring techniques to identify and combat self-stigmatizing beliefs. This proceeds from the perspective that acquiring effective tools to cope and reduce the impact of self-stigma helps participants feel a greater sense of self-efficacy, control, and hope. The fourth stage of NECT is the heart of the intervention and focuses on narrative enhancement. In this segment participants are encouraged to tell personal stories and reflect upon them. The purpose of this stage is to help participants construct meaning out of their experiences, including those with mental illness, and to develop narratives which are personally meaningful, understandable by others, and free of self-stigma. With constructive feedback from other participants and the group facilitator participants can develop new perspectives on their experiences. The process of constructing and sharing a narrative that helps integrate and make sense of out of a set of complicated and often emotionally charged events is a fundamentally nonstigmatizing act. Finally, NECT ends as it starts, with the invitation to participants to describe themselves, their experience with psychiatric illness or treatment and the interactions and mutual influences between one’s self and illness over time, this time after the NECT journey and its potential gains. Comparing one’s own and each other’s responses at the start versus at the end of NECT often offers further opportunity for exploration and reflection about one’s journey to overcome self-stigma.

To date, NECT has been implemented in the United States and Israel. In the United States it was studied in a small ($n < 40$) RCT with sites in New York and Indianapolis, IN (Yanos, Roe, West, Smith, & Lysaker, 2012). While this study did not find significant effects on any outcome variables, there were nonsignificant trends toward reduction in stereotype endorsement and improvement in insight. A large ($n > 100$) quasiexperimental study of NECT (Roe et al., 2014) in Israel revealed significant reductions in self-stigma, and improvements in self-esteem, hope, and subjective quality of life in contrast with treatment as usual, which showed no evidence of change in these areas. In addition, a qualitative analysis of semistructured interviews conducted with 18 NECT completers in Israel also supports that the intervention is perceived to impact the domains that it is intended to impact (Roe, Hasson-Ohayon, Derhi, Yanos, & Lysaker, 2010). Presently, NECT is being studied in a large RCT with sites in New Jersey and Indianapolis. In addition, there are plans underway for its implementation in Sweden, and the manual has been translated into Swedish.

Coming out Proud (COP)

Coming Out Proud is a newer intervention approach, first described by Corrigan et al. (2013). It differs from the other approaches described above primarily in that it focuses on encouraging persons with mental illness to explore and consider disclosure as a primary method of overcoming self-stigma. This design is based on research with other stigmatized groups, such as members of the Gay, Lesbian, Bisexual, and Transgendered (GLBT) communities, supporting that acceptance and disclosure are related to reduced self-stigma as well as other positive outcomes.

While, like the other approaches, Coming Out Proud is a manualized, group-based intervention, it is distinguished by brevity (only three sessions) and being solely peer-led (by people with lived experience of mental illness). Each course is usually delivered via three 2-hour sessions, once a week over 3 weeks to groups of 6–10 persons attending and two peer facilitators. Its core ideas were drawn from research regarding the experiences of people with minority sexual orientations and people with first-person experience of mental illness with secrecy as a harmful coping strategy in response to experienced or anticipated societal stigma. Therefore, overall the purpose of COP is to “support people with mental illness in their decision regarding disclosure and secrecy in different settings” (Rüsch et al., 2014, p. 2). The course is designed to help participants reflect on their personal stories regarding mental illness and gain information and empowerment for making personal choices about disclosure in various contexts of their life. In descriptions of COP, Corrigan positions it as “a new angle” on reducing self-stigma because its focus on issues of disclosure.

Coming Out Proud does not describe itself as psychoeducational or therapeutic in orientation, and has more in common with peer-oriented methods aimed to facilitate “consciousness-raising.” However, it does include some methods that are derived from motivational interviewing, such as weighing the pros and cons of disclosure. Additionally, considering whether and how one wants to disclose facets of one’s life or self to various people in diverse settings has much in common with personal narrative creation and meaning making, although COP does not explicitly reference that as a theoretical foundation.

The first of the three COP session focuses on “Considering the Pros and Cons of Disclosing” one’s mental illness in various settings. Participants discuss how to frame their experiences and identities regarding mental illness, and the costs and benefits of disclosure in different situations and settings. Then, the second session is entitled “Different Ways to Disclose.” In it, participants discuss five levels of disclosure, from none (secrecy), to publically broadcasting one’s experiences, and the pros and cons of each in different circumstances. It also includes discussion of how to assess whether to disclose to a given person and responding to others reactions to one’s disclosure. Finally, “Telling Your Story” is the final session of Coming Out Proud. It focuses on different ways to effectively tell one’s story regarding mental illness in various contexts and finding peer support for coming out.

In a recently published first study of COP (Rüsch et al., 2014), 100 people with mental illness diagnoses volunteered and were randomized to take COP or continue with “treatment as usual” without COP. Participants were adults in and around Zurich Switzerland who responded to recruitment materials posted in mental health and self-help programs, and supported employment sites. Eligible participants were 18 and over, had at least one self-reported *DSM-IV* Axis I or II diagnoses and reported at least moderate disclosure-related distress (on one item with 1 to 7 response scale). Pre, Post, and 3-week follow-up assessments measured self-stigma, disclosure related stress and secrecy, stigma stress, empowerment, and disclosure-related self-efficacy. The COP manual and materials were translated into German by the study team, and groups were led by trained peer facilitators.

Although this study did not find that COP reduced self-stigma or increased empowerment, it did find beneficial reductions in stigma stress, secrecy, and beneficial increases in perceived benefits of

disclosure. Further, self-reported disclosure-related stress not only decreased significantly pre to post, but was further reduced at follow-up (Rüsch et al., 2014).

Anti-Stigma Photovoice Intervention

The Anti-Stigma Photovoice program developed by Russinova and colleagues (2014) is a new intervention approach that bears some similarities to other interventions described in this review, but also incorporates the unique element of having participants take pictures and record narratives that relate to their experience. As described by Russinova et al. (2014), it is a 10-week group-based intervention delivered in 90-min sessions, which are designed to be led by trained peer facilitators. In the intervention sessions, there is “psychoeducation about stigma,” which is integrated with “experiential exercises designed to reduce endorsement of stereotypes about mental illness.” Specifically, participants are taught to use the photovoice methodology, which involves the use of cameras to photograph “objects or events in their daily lives that concern them.” The photovoice methodology, which originated as a research methodology seeking to empower participants to reflect on personal and community strengths by creating a “critical dialogue” (Catalani & Minkler, 2010), was adapted as an intervention model in this approach. In a personal communication, Russinova reported that the theoretical perspectives which underpin this approach include education for critical consciousness (Wang & Redwood-Jones, 2001), feminist theory, (Wang & Redwood-Jones, 2001), and the documentary photography approach established by photographer and educator Jo Spence, viewing photography as a public tool for social change (Wang & Redwood-Jones, 2001).

Photos documenting “everyday health and/or work realities of concern” that are taken outside of group are then brought to group and participants are encouraged to generate narratives about themselves that relate to the photos. Narratives for each photograph are generated using guided questions based a technique with the acronym SHOWED: a) What do you See here? b) What is really Happening here? c) How does this relate to Our lives? d) Why does this problem, concern, or strength exist? e) How could this image Educate others? and f) What can we Do about it? (Russinova, personal communication, 2014). It is not clear how many photos participants typically take during the course of the intervention; however, Russinova et al. (2014) states that “each participant creates at least one photovoice piece that combines a photograph and narrative relevant to encountering or coping with psychiatric stigma.” Psychoeducation components are described as proceeding concurrently with the photovoice exercises and largely confront stereotypes about mental illness and teach “proactive” coping strategies for dealing with perceived stigma and self-stigma.

The Anti-Stigma Photovoice intervention has been studied in a medium ($n = 82$) RCT with individuals with a variety of psychiatric diagnoses. Participation in the Photovoice intervention was found to have a significant impact on overall self-stigma, stigma coping, and “personal growth and recovery,” in contrast with assignment to a wait list control group. There was no evidence for an impact on hopefulness or self-esteem.

Discussion

Our review of published interventions designed to reduce self-stigma reveals a notable increase in the development, implementation and investigation of such interventions in the decade since the publication of initial papers focusing on self-stigma measurement, prevalence and impact (Corrigan et al. 2006; Ritsher et al., 2003; Ritsher & Phelan, 2004). The diversity of these interventions moves us forward in our effort to tackle mental-health-related self-stigma for and with a wide variety of people in varied situations, settings, and even countries. Within this intervention diversity there are several common mechanisms employed, in different forms and emphases. First, using psychoeducation and information to counteract myths about mental illness is common to all approaches. Acquiring corrective knowledge is an important tool with which to develop one's abilities to think critically and reject rather than internalize the prejudicial sentiments and behaviors one is subject to via societal stigma. Second, cognitive techniques that offer opportunities to learn and practice skills to identify and combat self-stigmatizing thoughts and beliefs are central to many of these interventions, such as NECT, ESS, and Self-Stigma Reduction Program. Some of the interventions reviewed foreground these techniques explicitly, while in others they are more implicitly embedded in other activities. Third, with notable variations, the interventions also include an emphasis on narration and its potential to help persons make sense and create meaning out of past experiences and to help them experience themselves as active agents within their own lives. Finally, almost all the interventions also include some degree of behavioral decision making, and offer tools and experiences designed to increase or elicit hope, empowerment, and motivation to act toward one's goals and according to one's values.

Despite these important common factors, the interventions are clearly unique in their development and emphasis, suggesting that some interventions may be best suited to certain people and contexts. Healthy Self-Concept, for example, was particularly developed for use with persons who have experienced their first psychotic episode, and therefore might be well-suited for use in this context. Coming Out Proud and the Anti-Stigma Photovoice interventions were designed for use with peer facilitators, and therefore might be fit best within peer-support settings. NECT and ESS are both group-based interventions that can be used with professional facilitators, but given differences in length (9 sessions vs. 20), service settings might find it helpful to select one or the other based on the typical length of stay within their program (acknowledging that length is only one of several differences between them). NECT also seeks to integrate interventions that are not often combined, including cognitive therapy and narrative therapy, and so might require slightly more extensive training. There may also ultimately be opportunities for combining the interventions. For example, Coming Out Proud might serve as a "gateway" intervention, since it is so brief, leading to one of the longer-term interventions (we know of at least one site that is using it prior to ESS).

The status of research on these interventions is encouraging in both that what has already been conducted shows positive impact and that several interventions are in the process of rigorous studies (including larger RCTs). However, outcome and implementation research is clearly in early stages; further evaluation is needed to

understand the potential of many programs. We hope that such future work will help develop not only those specific interventions, but also a more sophisticated cross-intervention understanding of the useful components/mechanisms and the match of intervention with setting and person. Although the interventions are still in the early stages of development and the results of pilot studies must be interpreted with caution, it is still impressive that a wide range of interventions conducted in different settings collectively lend support for their impact in reducing self-stigma and improving desired outcomes.

Several future challenges await. First, there is a need to learn from initial pilots and implementation to develop user-friendly manualized toolkits that can be shared broadly, including fidelity scales. Second, more research is needed on all the programs, to both learn more about the impact of these interventions and to move beyond simple questions such as whether they are effective toward more specific tailoring efforts to identify what interventions yield the best results for whom, including whether "whom" is most productively defined by demographic characteristics, specific levels or types of self-stigma, diagnosis, recovery orientation, setting, or other factors. Incorporating newer assessment strategies such as experience sampling methods (Ben-Zeev, Frounfelker, Morris, & Corrigan, 2012) might also help us learn more about the fluctuation of self-stigma over time and across contexts and help improve interventions and their delivery. Finally, more work is needed to learn how these interventions can be best delivered within different contexts and cultures, including how to navigate the dialectic of fidelity versus local tailoring.

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