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

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Abstract. 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. Through the databases MEDLINE and PsycINFO, among others, controlled studies on specific interventions to reduce internalized stigma in people with severe mental disorders published between 2008 and 2018 were selected and reviewed. Results showed that the interventions 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. We conclude that 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. Future research should focus on establishing optimal interventions according to characteristics and objectives of individuals.

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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, Rüsch, & 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 (Rüsch, 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, & Bielańska, 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)

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study and 44% in Picco et al.'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, & Rüsch, 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.

Method

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 schizophreni* 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: 1. Applying a specific intervention to reduce internalized stigma in people with mental disorders. 2. Having a control group. 3. Having at least two moments of measurement (pre and post treatment). 4. Being published between 2008 and 2018. 5. Being published in scientific journals indexed in JCR, in English or Spanish.

The search strategy is summarized in Figure 1. 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.

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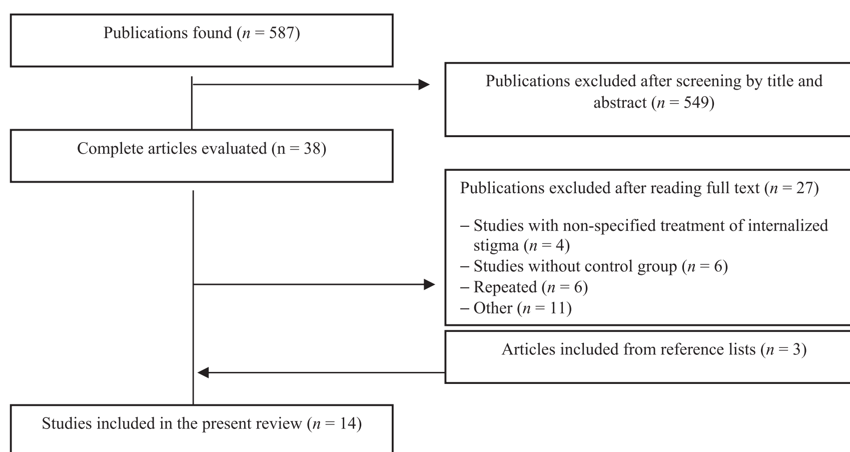

Figure 1. Diagram of the Process of Article Selection for Inclusion in the Present Review.

Results

Participants

The *samples* of the studies had been obtained through mental health institutions and with the help of pamphlets and similar materials. In two 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; Rüsch 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; Rüsch 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 (Rüsch 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.

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Table 1. *Summary of Articles on Interventions to Reduce Internalized Stigma in People with Severe Mental Disorder (2008–2018)*

Authors and year. Country	*N*	Groups	Duration. N° of sessions and format. Moments of measurement	Measures	Main results
Corrigan et al. (2015) USA	*N* =126 individuals with mental disorders	EG: Coming Out Proud (COP) CG: Waiting list	--- 3 group sessions Pre, post, 1 month	– Self-Stigma of Mental Illness Scale (SSMIS) – Stigma Stress Scale – Center for Epidemiological Studies Depression Scale (CESD)	· EG < CG significative in internalized stigma (post and follow-up), stress of stigma (follow-up) and depression only in women (post and follow-up) · No significant differences in the rest.
Çuhadar & Çam (2014) Turkey	*N* = 47 individuals with bipolar disorder	EG: Psychoeducation CG: No treatment	7 weeks 7 group sessions Pre, post	– Internalized Stigma of Mental Illness Scale (ISMI) – Bipolar Disorder Functioning Questionnaire (BDFQ)	· EG < CG significative in internalized stigma (post). · EG > CG significative in performance. · No significant differences in the rest.
Fung, Tsang, & Cheung (2011) China	*N* = 66 individuals with schizophrenia	EG: Self-stigma Reduction Program (SRP) GC: Reading newspaper	Between 8–16 weeks, according to number of sessions per week 16 sessions (12 group sessions and 4 individual follow-up sessions) Pre, intermediate, post, 1, 2, 3 and 4 months	– Chinese Self-stigma of Mental Illness Scale (CSSMIS) – Change Assessment Questionnaire for People with Severe and Persistent Mental Illness (CAQ-SPMI) – Psychosocial Treatment Compliance Scale (PTCS) – Brief Psychiatric Rating Scale (BPRS) – Global Assessment of Functioning Scale (GAF) – Scale to Assess Unawareness of Mental Disorders (SUMD) – Chinese General Self-efficacy Scale (CGSS)	· EG < CG significative in internalized stigma and in fulfillment (post). · EG = CG in self-efficacy and insight. · Follow-up: no differences between both groups for any variable.
Hansson, Lexén & Holmén (2017) Sweden	*N* = 106 individuals with severe mental illness (mainly schizophrenia, depression or anxiety, and others)	EG: Narrative Enhancement/ Cognitive Therapy (NECT) CG: Waiting list	---- 20 group sessions Pre, post, 6 months	– Self-Stigma of Mental Illness Scale-Short Form (SSMIS-SF) – Rosenberg Self-esteem Scale (RSE) – Manchester Short Assessment of Quality of Life (MANSA)	· EG < CG significative in internalized stigma (post and follow-up). · EG > CG significative in self-esteem (and follow-up). · No significant differences in quality of life.
Ivezić, Sesar, & Mužinić (2017) Croatia	*N* = 80 individuals with schizophrenia	EG: *Psychoeducation group program* CG: Waiting list	3 months 12 group sessions Pre, post	– Internalized Stigma of Mental Illness Scale (ISMI) – Boston University Empowerment Scale (BUES) – Perceived Devaluation and Discrimination Scale (PDD)	· EG < CG significative in internalized stigma. · No significant differences in empowerment and in devaluation and perceived discrimination.

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Table 1 *(Continued)*

Authors and year. Country	*N*	Groups	Duration. N° of sessions and format. Moments of measurement	Measures	Main results
Lucksted, et al. (2017) USA	*N* = 268 individuals with mental illness (mainly schizophrenia or schizoaffective disorder and bipolar disorder)	EG: psychoeducation intervention *Ending Self-Stigma* (ESS) CG: TAU (minimally improved)	3 months 9 group sessions Pre, post, 6 months	– Self-Stigma of Mental Illness Scale (SSMIS) – Internalized Stigma of Mental Illness Scale (ISMI–29) – Maryland Assessment of Recovery in People With Serious Mental Illness (MARS) – General Self-Efficacy Scale – Sense of Belonging Instrument (SOBI) – Brief Symptom Inventory (BSI) – Experiences of Stigma Survey – Beck Cognitive Insight (BCI) Scale – Repeatable Battery of Neuropsychological Status (R-BANS)	· EG < CG in internalized stigma (post). · EG > CG in personal recovery (post). · EG = CG in self-efficacy and in general experience of belonging. · No results are presented for the rest of measures.
Michaels et al. (2014) USA	*N* = 127 individuals with mental illness	EG: psychoeducation intervention *Anti-Stigma Project workshop (ASP)* CG: Other activity: *"Steps to a Healthier You"*	3 hours 1 group session Pre, post	– Attribution Questionnaire (AQ–9) – Awareness Questionnaire (AwQ) (in post) – Error Choice Test (EC) (in post) – Recovery Assessment Scale (RAS)	· EG > CG significative in evaluation of recovery · EG < CG significative in prejudice towards individuals with psychiatric difficulties.
Morrison et al. (2016) Great Britain	*N* = 29 individuals with psychotic disorders (schizophrenia, schizoaffective disorder, delusional disorder)	EG: Cognitive therapy (CT) + Usual treatment CG: Usual treatment	16 weeks 12 individual sessions Pre, post, 7 months	– Internalized Stigma of Mental Illness Scale – Revised (ISMI-R) – Semi-Structured Interview Measure of Stigma (SSIMS) – 16-item version of Stigma Scale (KSS) – Process of Recovery Questionnaire Short form (QPR) – Beck Depression Inventory for Primary Care (BDI–7) – Beck Hopelessness Scale (BHS) – Social Interaction Anxiety Scale (SIAS) – Self-Esteem Rating Scale Short form (SERS-S) – Internalized Shame Scale (ISS)	· EG < CG significative in internalized shame, depression and despair (post and follow-up). · EG > CG significative in subjective recovery (post and follow-up). · EG = CG in internalized stigma, social anxiety and self-esteem (post and follow-up). ·

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Table 1 *(Continued)*

Authors and year. Country	*N*	Groups	Duration. N° of sessions and format. Moments of measurement	Measures	Main results
Roe et al. (2014) Israel	*N* = 119 individuals with severe mental disorder	EG: Narrative Enhancement/ Cognitive Therapy (NECT) CG: Usual treatment	6 months approximately 20 group sessions Pre, post	– Internalized Stigma of Mental Illness Scale (ISMI) – Manchester Short Assessment of Quality of Life (MANSA) – Adult Dispositional Hope Scale (ADHS) – Rosenberg Self-Esteem (RSE)	· EG < CG significative in internalized stigma. · EG > CG significative in self-esteem, quality of life and hope.
Rüsch et al. (2014) Switzerland	*N* = 100 with mental illness (schizophrenia spectrum, depressive disorder, bipolar disorder)	EG: Coming Out Proud (COP) CG: Usual treatment	3 weeks 3 group sessions Pre, post, 6 weeks	– Internalized Stigma of Mental Illness Inventory (ISMI) – Empowerment Scale – Stigma Stress Scale – Stigma Coping Orientation Scale (SCOS) – Coming Out with Mental Illness Scale (COMIS) – Disclosure-related distress – Disclosure-related self-efficacy	· EG = CG in internalized stigma, empowerment and self-efficacy related to disclosure of certain information (post and follow-up). · EG > CG significative in coping strategies of stigma (post), and in perceived benefits of revealing information. · EG < CG significative in stress of stigma (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". CG: Waiting list	10 weeks—group sessions Pre, post, 3 months	– Internalized Stigma of Mental Illness Scale (ISMI) – Approaches to Coping With Stigma scales – Center for Epidemiological Studies Depression Scale (CESD) – Empowerment Scale – Generalized Perceived Self-Efficacy Scale – Personal Growth and Recovery Scale (PGRS)	· EG < CG significative in internalized stigma (post). · EG > CG significative in coping strategies and empowerment (post). · EG > CG significative in personal growth and total recovery (post and follow-up) · EG = CG in depression and self-efficacy.

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Table 1 *(Continued)*

Authors and year. Country	*N*	Groups	Duration. N° of sessions and format. Moments of measurement	Measures	Main results
Uchino, Maeda, & Uchimura (2012) Japan	*N* = 56 individuals with schizophrenia or schizoaffective disorder	EG: Psychoeducation program CG: Usual treatment	6 weeks 6 group sessions Pre, post	– Social Distance Scale (SDS-J) – Knowledge of Illness and Drugs Inventory (KIDI) – Drug Attitude Inventory (DAI–10) – Birchwood's Psychosis Insight Scale (BPIS) – Global Assessment of Functioning Scale, (GAF)	· EG < CG significative in prejudice against individuals with mental illness. · EG > CG significative in knowledge about mental illnesses and their treatment and in insight · No significant differences in the rest.
Wood, Byrne, Enache, & Morrison (2018) Great Britain	*N* = 30 individuals with diagnosis within the schizophrenia spectrum	EG: Cognitive-behavioral therapy (CBT) CG: Psychoeducation	2 weeks 1 or 2 individual sessions (2 hours) Pre, post, 1 month	– Internalized Stigma of Mental Illness Inventory-Shortened (ISMI-S) – Stigma Scale (SS) – Self-Esteem Rating Scale (SERS) – Process of Recovery Questionnaire – short form (QPR) – Beck Depression Inventory-Primary Care (BDI-PC) – 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) USA	*N* = 39 individuals with schizophrenia, schizoaffective disorder, bipolar disorder or depression	EG: Narrative Enhancement/ Cognitive Therapy (NECT) · EG1: Exposed: they have attended at least 6 group meetings or have completed a treatment module · EG2: Not exposed CG: Usual treatment	20 weeks 20 group sessions Pre, post, 3 months	– Internalized Stigma of Mental Illness Inventory (ISMI) – Structured Clinical Interview for DSM–IV Disorders (SCID) – Beck Hopelessness Scale (BHS) – Coping with Symptoms Checklist (CSC) – Quality of Life Scale (QLS) – Positive and Negative Syndrome Scale (PANSS) – Scale for Assessing Unawareness of Mental Disorder (SUMD) – Rosenberg Self-esteem Schedule (RSES)	· EG1 < EG2 significative in internalized stigma (pos and follow-up) and in improvement of insight (follow-up). · No significant differences in the rest

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

In two of the studies, the multicomponent program “Coming Out Proud” (COP) was applied (Corrigan et al., 2015; Rüsch 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” (Russinova 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 (Russinova 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; Rüsch 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; Rüsch 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; Rüsch 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).

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; Rüsch 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.

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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	Psychoed.	No treatment	✓										✓	
Ivezić et al., 2017		Waiting list	✓								×			
Lucksted et al., 2017		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	NECT	Waiting list	✓		✓				×					
Roe et al., 2014		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.

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 five 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 nine 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 ten of the 14 articles, and in seven of the 9 articles that include the follow-up period, the drop-out rate is indicated during said period.

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; Rüsch et al., 2014); (d) multi-component 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

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Table 3. *Methodological Quality of the Studies included in the Present Review*

Author, year	Control group	Randomization[a]	Randomization method[b]	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., 2017	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., 2014	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

Note: 0 = No; 1 = Yes; NA = Not applicable (there is no follow-up)
[a]Study described as randomized.
[b]The randomization method is adequately described.

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 statistically significant 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; Rüsch 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, McKinnon, Ward, Reynolds, & 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.

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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