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Intervening against mental illness stigma and its internalisation: An organising framework

Interventi contro lo stigma per i disturbi mentali, incluso lo stigma interiorizzato: una cornice di riferimento

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Abstract: *Reviews of interventions targeting of interpersonal stigma and internalised stigma have each identified several methods. Education about mental illness, contact between people with and without experience of mental illness, and protest against stigma have been identified as three means of reducing interpersonal stigma. While there is evidence that education and contact can be effective both separately and in combination, protest has been discouraged because of evidence suggesting that it can be counterproductive. Further there is little research directly addressing the question of whether education and contact are effective for structural level discrimination. On the other hand, the effectiveness of some types of protests against stigmatising organisational decisions suggests researchers should give further consideration to protest. Reviews of interventions targeting internalised stigma identified the following methods as the most used ones in effective interventions: cognitive;*

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narrative; behavioural decision making, and psychoeducational. Since these reviews, recent work has begun to identify contact as effective for reducing internalised stigma. This article aims to synthesise these fields with the following objectives: (i) to highlight the similarities between interventions targeted to interpersonal and internalised stigma and the implications of these similarities; (ii) to draw attention to the need to evaluate structural level interventions; (iii) to create a comprehensive model for intervening against stigma using the 'cycle of oppression' model which is widely applied in diversity and inclusion training. This model is proposed to be useful both to inform decisions about designing and targeting interventions, but can also be used as content for an intervention to reduce internalised stigma and help people with mental illness and their 'allies' to intervene against stigma themselves.

Key Words: *stigma, stereotypes, prejudice, discrimination, oppression*

Riassunto: *Le rassegne sistematiche degli interventi mirati a ridurre lo stigma interpersonale e lo stigma interiorizzato hanno identificato ciascuna diversi metodi utilizzabili. L'educazione sui disturbi mentali, il contatto tra persone con e senza esperienza di disturbo mentale e la protesta contro lo stigma sono stati identificati come tre metodi per ridurre lo stigma interpersonale. Mentre vi sono prove che l'educazione e il contatto interpersonale possano essere efficaci sia separatamente che in combinazione, le campagne di protesta anti-stigma sono state scoraggiate come metodo dal momento che ci sono evidenze che suggeriscono che potrebbero essere controproducenti. Inoltre, vi sono poche ricerche che affrontino direttamente la questione se l'educazione e i contatti interpersonali sociali siano efficaci per combattere e ridurre la discriminazione a livello strutturale. D'altra parte, l'efficacia di alcuni tipi di proteste contro decisioni organizzative stigmatizzanti suggerisce che i ricercatori dovrebbero prendere in considerazione la valutazione ulteriore di tale tipo di intervento. Le rassegne di interventi mirati allo stigma interiorizzato hanno identificato i seguenti metodi come i più utilizzati in interventi risultati efficaci: interventi cognitivi; interventi narrativi; strategie comportamentali e psicoeducative. Da quando sono state pubblicate queste rassegne, recenti lavori di ricerca hanno iniziato a identificare il contatto interpersonale come efficace per ridurre lo stigma interiorizzato. Questo articolo ha lo scopo di sintetizzare questi temi di ricerca con i seguenti obiettivi:*

i) evidenziare le analogie tra gli interventi mirati allo stigma interpersonale e quelli rivolti allo stigma interiorizzato e le implicazioni di queste analogie; ii) richiamare l'attenzione sulla necessità di valutare gli interventi a livello strutturale; (iii) creare un modello globale per intervenire contro lo stigma utilizzando il modello del "ciclo dell'oppressione", ampiamente utilizzato nella formazione sulla diversità e sull'inclusione. Questo modello è proposto come utile sia per guidare le decisioni sulla progettazione e la focalizzazione degli interventi, sia come contenuto di interventi per ridurre lo stigma interiorizzato e aiutare le persone affette da disturbi mentali e i loro "alleati" a intervenire loro stessi contro lo stigma.

Parole Chiave: *stigma, stereotipi, pregiudizio, discriminazione, oppressione*

Introduction

"The exercise of power is determined by
thousands of interactions between the world of the
powerful and that of the powerless, all the more so because
these worlds are never divided by a sharp line: everyone
has a small part of himself in both".
Vaclav Havel

The exercise of power is emphasised in Link and Phelan's influential theory of stigmatisation [1]. This sociological theory describes the process of stigmatisation as beginning with labelling certain aspects of a person's behaviour or appearance in order to create a separation between such people and others. In the context of a power differential, this process of separation incurs a loss of societal status and allows discrimination at the societal level through structural processes such as legislation and policy.

Thus in the field of mental illness stigma research, discrimination is conceived of as operating at both the interpersonal and structural levels. However, regardless of which level is the focus, the targets of anti-stigma research interventions tend to be groups of individuals. Broadly defined groups such as "the general public" or "young people" are chosen when the desired outcomes are interpersonal ones. On the other hand, when there is an interest in impacting on structural discrimination, target groups such as "health professionals", "the police" or "journalists" may be chosen. For all groups, the difficulty of capturing discriminatory behaviour change at either the interpersonal or structural levels means that the same outcomes are often chosen, such as *stereotype endorsement or desire for social distance*. It is more often nongovernmental organisations (NGOs) such as mental health charities and organisations representing mental health professionals which focus directly on structural problems such as discriminatory legislation or relative underfunding for mental health care, however this work is rarely the subject of research.

Other researchers in social psychology have focussed more on the impact of stereotype endorsement on the part of individuals. This leads to prejudice against people labelled with mental illness and interpersonal discrimination. Furthermore, internalised or -self-stigma can occuras a result of awareness

and endorsement of stereotypes on the part of those labelled. Internalised stigma is common, reflecting implicit attitudes learned before diagnosis [31], public stigma awareness, and discrimination experiences [32-34]. Stigma and its internalisation hinder personal recovery due to avoidance of social and economic opportunities, and interfere with treatment engagement [35, 36]. Internalised stigma is thus associated with worse outcomes in self-esteem [37], self-efficacy [4], hope [38], empowerment [39], and worse functional recovery [40] and clinical recovery [41].

This article does not set out to compare the strength of the evidence base for interventions addressing interpersonal or internalised stigma. Rather the aim is to inform the development and evaluation of future interventions by identifying three areas for attention: first, the similarities between interventions for interpersonal and internalised stigma; second, the lack of research on structural level interventions and the possible role of protest at this level; and finally, our recommendation that the 'cycle of oppression' model be adopted to both inform the design and evaluation of interventions, and as a key piece of intervention content in and of itself.

An organising framework for intervention: the cycle of oppression

In fields such as the study of racial discrimination and feminism, the systematisation of discrimination has been termed oppression. This distinguishes between individual acts of interpersonal discrimination and structural level processes by highlighting the need for power to be available to convert interpersonal discrimination to that at the structural level. The 'cycle of oppression' also describes a self-fulfilling process whereby the impacts of oppression result in behaviour which lends itself to stereotype endorsement (see Figure 1). This 'oppressed group behaviour' was first described in colonised groups [2], but has since been described in other groups including also in nurses [3]. It can be applied to people with mental illness. For example, social distancing (the avoidance of people perceived as having a mental illness) and the anticipation of discrimination by someone diagnosed with a mental illness are likely to create social anxiety or anger in the person with a mental illness, increasing the risk they may be perceived as odd, awkward or aggressive. The internalised stigma of mental illness may be seen according to this model as similar to the psychological effects of domination by another group, namely feelings of inferiority, low self-esteem, and fear. It seems possible that just as the effects of institutionalisation were in the past conflated with symptoms of

mental illness, so may be those oppressed group behaviours which result from the internalisation of stigma. We return to the use of this cycle at the end of the article after summarising interventions for interpersonal and internalised stigma.

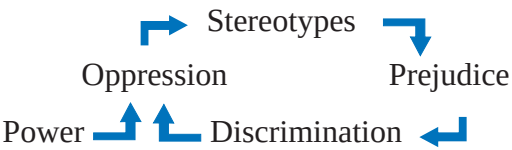

Figure 1. The cycle of oppression

Interpersonal stigma interventions

Reviews of anti-stigma interventions across the variety of groups targeted have described three main approaches which can be delivered separately or in combination: education; contact; and protest [4]. Education aims to replace myths about mental illness with accurate knowledge. Contact uses direct or indirect – i.e. that is, parasocial - interactions with people who have a mental illness to reduce prejudice; protest aims to reduce manifestations of stigma such as stereotypical representations of mental illness or discriminatory policies. Education and contact have been found to be the most commonly used [5].

Early anti-stigma efforts often used educational approaches. For example, an intervention in the 1950s by Cumming and Cumming in a town in Canada [6] attempted to reduce stigma through providing mental health education via group discussions and films. In the UK, the 'Defeat Depression' campaign in the early 1990s aimed to reduce stigma through the provision of information on depression to the public and professionals [7]. Interventions for health professionals often rely on educational approaches [8]. However, it should be noted that educational approaches vary widely in terms of what information they aim to convey. For example, mental health literacy programmes aim to increase knowledge of mental health problems, improve attitudes, and stimulate helping behaviours, [9], while rights-based programmes such as See Me in Scotland (https://www.seemescotland.org/our-movement-for-change/change-networks/human-rights/) focus on the legal rights of people with mental health problems.

Over time, the use of intergroup contact has increased, especially following a meta-analysis by Corrigan and colleagues in 2012 which highlighted its effectiveness in reducing stigmatising attitudes [5]. Intergroup contact has a good evidence base as a means to reduce prejudice between groups with a history of conflict [10]. However, to be effective certain facilitating factors are needed. Allport's 'contact hypothesis' [11] proposes that for contact between members of in- and out-groups to lead to favourable outcomes for the out-group members, the two groups need to be afforded equal status during the interaction, and the interaction needs to involve a mutual goal. Other conditions identified in existing literature [10, 12] as necessary for successful intergroup contact include: the opportunity to get to know the out-group members during the interaction; exposure to more than one person in the out-group; interaction disconfirming negative stereotypes; active co-operation; and a structured interaction.

Below we discuss how education and contact approaches have been used separately and together in population-level interventions and when targeted at specific groups.

Anti-stigma interventions for the general public

At the time of writing there has been a proliferation of national and regional programmes which have either recently finished or are ongoing. The summary below exemplifies the current status of programmes rather than providing a comprehensive description. 'Beyondblue' is a depression-specific programme in Australia which has been associated with improved public attitudes and knowledge with greater effects associated with greater exposure to the programme [13]. The 'Like Minds, Like Mine' anti-stigma programme in New Zealand was associated with reduced overall levels of discrimination [14], and there have also been indications of improved knowledge and attitudes following this work. 'See Me' is a national programme aiming to end mental health-related stigma and discrimination running in Scotland that was launched in 2002. It is credited with improvements in some aspects of media reporting on mental illness [15]. The 'Hjärnkoll' programme in Sweden utilised a contact-based strategy; over four years (2010-2014) there was evidence of a positive impact on mental health literacy, attitudes, and intended social contact with people with mental illness [16].

The 'Time to Change' programme in England (launched in 2008) [17] and 'Opening Minds' in Canada (launched in 2009) [18] allow comparison of

two programmes adhering to different frameworks [19]. Whereas the Time to Change programme used a public health perspective, defining stigma in terms of problems relating to knowledge, attitudes, and behaviours [20], the Opening Minds programme used a sociological framework where stigma is considered reflective of the co-occurrence of labelling, stereotyping, separation, status loss and discrimination [1]. Both programmes built on evidence-based approaches to stigma-reduction, with an emphasis on contact-based education strategies. Time to Change primarily aimed to target the general population via large-scale, mass media, social marketing campaigning [21]. The initial focus was on education-based "myth busting", followed by a focus on reducing prejudice and changing behaviours. Additionally, Time to Change involved local initiatives and work with target groups such as medical students and employers [22, 23]. In contrast, Opening Minds did not include a mass media element, after the results of a short term media campaign suggested little or no impact on stigma-related knowledge or desire for social distance [24]. Rather, it focused solely on intensive, targeted work with specific groups across the country – young people, healthcare providers, the news media, and the workforce – through grassroots input and community programmes [18].

Systematic academic evaluation has been carried out on several programme components of both Time to Change and Opening Minds, and on the overall impact of Time to Change among the general population and among users of mental health services [19]. The results of these evaluations indicate that both programmes have been successful in reducing stigma. In England, following Time to Change, benefits were observed in terms of population-level improvements in stigma-related knowledge, attitudes, social distance and reported contact with people with mental illness [25, 26]. Positive changes were also evident in mental health service users' reduced reporting of experiences of discrimination [27]. Evaluation of the localised programmes in Canada also indicated positive changes. For example, interventions focusing on high school students were generally associated with improvements in students' intended behaviour towards people with a mental illness [28]. Similarly, programmes amongst healthcare providers generally produced positive results in terms of their attitudes [29]. The next goal of Opening Minds is to replicate successful programmes at a national level.

Although Time to Change includes smaller efforts with a local or target focus, the intended population-level exposure to the mass media elements of the programme makes it impossible to examine the impact of these components separately. In contrast, Opening Minds built on community-based efforts only,

which all employed contact-based education strategies that were heterogeneous in nature [18]. This variability has enabled identification of how to effectively tailor stigma-interventions for different populations [30], and of the effective programme ingredients [29]. These findings are summarised and discussed further below in relation to work focused on key target groups.

Anti-stigma interventions for key target groups

Target groups have been identified on the basis of: high levels of contact with service users (healthcare professionals), position of power (law enforcement officers), or potential for changing the future (students and young people) [31].

(a) Healthcare professionals

Evidence regarding anti-stigma efforts amongst healthcare professionals has been discussed, for example, by Henderson and colleagues [8]. Their review identified 16 intervention studies using various designs including randomised, non randomised controlled and uncontrolled pre-post studies, examining stigma-reduction in relation to mental health generally or specific mental health conditions (e.g. borderline personality disorder, substance misuse) amongst various groups of healthcare and mental healthcare professionals. Most interventions were educational but examined attitudinal outcomes which were generally reported to be more positive following the intervention. Some of the studies measuring other outcomes also reported improved knowledge, behavioural intentions and/or clinical competence after the intervention or associated with having received it. When follow-up assessments were conducted these generally indicated that the positive changes had been sustained over a period of e.g. 12 months [32], however, only a few studies had examined this.

Two studies had examined internet-based stigma-reduction in relation to mental illness in general [33, 34]. In the first [33], significantly lowered scores for social distance were reported amongst Turkish psychiatrists randomly assigned to receive an instructional email about stigma, compared to controls who received a questionnaire on social distance. However, this study did not include any baseline measures; this makes statistical analysis more problematic, although an advantage is that respondents are not 'anchored' by their baseline responses and so the follow up is less biased by this and the potential 'demand effect' of responding after an intervention clearly aimed at the outcomes. The other intervention comprised internet-based education on mental illness to

professionals working in long-term care facilities in the USA [34]. Significant positive differences between randomised intervention and control groups were found for all outcomes immediately after training completion including measures of knowledge, attitudes (stereotype endorsement), empathy, self-efficacy, and intended behaviour.

Face-to-face stigma-reduction training for healthcare providers was conducted within Canada's Opening Minds anti-stigma programme [29]. Thirty-seven contact-based education programmes funded by the programme were evaluated using a mixed methods approach, to identify the key ingredients associated with attitude change; no behavioural measures were used. The most critical ingredients identified were multiple forms of contact with people with lived experience and an emphasis on recovery. Others were: the inclusion of personal testimonies of people with lived experience; myth-busting; the need for enthusiastic, patient-focussed training; and the inclusion of skills training regarding behaviours to avoid stigmatisation. While useful, this analysis did not explicitly refer to the previously identified facilitators of intergroup contact described above, so it did not provide a direct test of them with respectrepect to mental illness stigma.

More recently, health professionals with personal experience of mental illness have been identified as a group vulnerable to the adverse impact of workplace mental illness stigma and managerial inaction. A randomised controlled trial of a tailored, contact based education course was compared to a standard mental health literacy course with respect to mental health literacy outcomes, stigmatising beliefs, attitudes to help-seeking for mental ill health and help-seeking and help-outreach behaviours [35]. At three month follow-up, there were improvements in literacy and attitudes in both groups, and the reduction in stigma was more sustained for the tailored intervention. However no changes were observed in help-seeking or help-outreach for either group. While this apparent lack of effect on behaviour may have been related to limitations in the length of follow-up time and the data collection method, it may also reflect the lack of any organisational component in either intervention. Without any changes at the level of the workplace, some of the barriers identified by other research to seeking help or encouraging others to do so are likely to remain, including feeling guilty for taking time off and letting colleagues down [36-38], and working patterns which impede access to care [39]. While it is not usually possible for researchers to influence change at this level, workplace variation across time or place in important aspects would provide opportunities for observational research.

(b) Police officers

Criminal justice professionals are another key group for stigma reduction interventions [31]. The deinstitutionalisation of mental health services has led to a significant increase in contact between the police and those with mental illness, and it has been argued that police officers should be provided education and training to improve their interactions with people with mental illness. Few studies have been conducted in this area, but evidence from two is summarised below.

Pinfold and colleagues [40] evaluated a training intervention with one police force in England. Police officers' (n=109) knowledge, attitudes and behavioural intentions in relation to mental illness were assessed before and after attending two educational workshops delivered by service users, carers, and people working in the field of mental health. The results indicated no changes in perceived knowledge. Also, although the intervention produced some improvements in reported attitudes, the stereotypical linking of people with mental health problems and violent behaviour was not successfully challenged. However, a third of the participants reported positive impacts on police work at follow-up, particularly improvements in communication between officers and persons with mental health problems.

Hansson and colleagues [41] examined the effectiveness of an anti-stigma intervention in a police officer training programme in Sweden (n=120), through a controlled pre-post intervention study design with a comparison group of trainees who did not receive the programme, and six-month follow-up of the intervention group. They found that the intervention improved police officers' attitudes, mental health literacy and intentional behaviours. At 6 month follow up of the intervention group only, the within subject changes were generally still present. The intervention was well received amongst the trainees, and some of its key elements have been retained in the regional police training programme.

(c) Students

A systematic review of the overall effect of a variety of interventions delivered to student groups [42] identified 35 studies (involving 4,257 students) covering a range of interventions including contact with a person with mental health problems, and education via text, lecture, film or role play. Narrative synthesis indicated that live or video-based social contact with people with mental health problems were the most effective interventions in improving attitudes and reducing desire for social distance. Evidence from one study suggested that

providing treatment information might enhance students' attitudes towards the use of services [43].

Overall, anti-stigma interventions based on direct or parasocial contact and/or education appear to result in small-to-moderate sized effects (as assessed using Cohen's interpretation; [58]) with respect to knowledge and attitudes. However, most studies lack process evaluation to assess the mechanisms or mediating variables by which they achieve these effects. We discuss the importance of this below.

A meta-analysis of over 500 studies in the wider field of intergroup contact research [44] confirmed that contact can diminish prejudice by reducing anxiety about contact, and increased empathy and perspective taking. A further key factor was enhanced knowledge regarding the outgroup, however, the mediational value of this influence was weaker than that of reduced anxiety and increased empathy. More recently, the importance of threats, both realistic and symbolic, perceived by one group about the other have been identified as important mediators [10]. Realistic threats include that of violence or loss of access to resources as a result of increased contact with another group; symbolic threats are those that apply to the values and beliefs of a group.

These mediators should be considered when designing interventions for target groups, with the interventions directly designed to effect change in the mediating variables. Anxiety and the perception of a realistic threat are likely to be high in groups with little prior contact or knowledge, such as the general population, in particular young people. These were found to be important mediators in a study of the relationship between contact and desired avoidance among students [45]. On the other hand, groups with frequent contact, such as healthcare professionals, are unlikely to have high levels of anxiety. Studies showing stigma among health professionals at levels similar to those of the general public [8] have been interpreted as showing that contact may not reduce stigma, however the circumstances of clinical contact have rarely been examined in relationship to intergroup contact theory. Equal status is not typical in clinical encounters with health professionals however it is important for contact to succeed [12]. Intergroup contact theory likewise highlights the importance of stereotype disconfirmation and acquaintanceship; aspects which may be harder to achieve when mental health professionals see only those most severely affected by mental illness and at the times when they are most ill, and over a short period of time. Loss of empathy, for example, due to short term stress or longer term burnout [46], may be a relatively more

important mediator in this and other groups with contact under circumstances which are not ideal, such as emergency services personnel. Furthermore, the type of knowledge which is effective may vary depending on the target group. Biological knowledge about mental illnesses has been suggested as potentially having a positive effect on doctors' attitudes to people with mental illness [47]. In contrast, a meta-regression of public attitude surveys suggested that agreement with biological causal explanations of mental illness among the general population may have a negative effect [48]. A model conceptualising symptoms as occurring along a continuum may in contrast be associated with more positive attitudes [49].

Intergroup contact researchers in the UK [45] have discussed the application of intergroup contact theory to mental health-related stigma. This study examined the influence of different types of imagined contact with people with schizophrenia and concluded that imagined contact might, in this case, increase intergroup anxiety (and thus desire for social distance), unless it was purposefully structured to reflect a positive imagined contact experience.

What about protest?

From the above summary it is clear that protest is not generally used anti-stigma research interventions. This reflects the observation from psychological research that stereotype suppression, or asking people to control thoughts based on stereotypes, can be counter-productive due to a 'rebound' effect on thinking [50]. This avoidance of the use of protest or social activism in research on ways to reduce interpersonal stigma contrasts sharply to interventions to reduce structural discrimination carried out by many people and groups other than researchers. As noted above, one of the chief roles of many mental health NGOs is to lobby for change to reduce structural discrimination. While constructive relationships with media organisations and policymakers are also vital for influencing change, NGOs advocating for people with mental illnesses also protest about structural problems. Examples include stigmatising media coverage, inequalities between mental and physical health care provision, and legislation or policies which adversely impact and/or have a disproportionate negative impact on people with mental illness, such as cuts to welfare benefits [51]. Organisations representing mental health professionals have a similar role in terms of advocating for patients.

Individuals affected by mental illness may also protest either by adding their voices to the concerns of NGOs and professional groups or bringing attention to instances of stigma. Social media have made such protest far easier and afford creative forms of protest with little or no organisation required [52]. Further, this form of protest provides virtual contact and can include educational content, blending all three stigma reduction approaches. One illustration is a protest on Twitter which took place in September 2013. Thousands of people, offended by the 'mental patient' Halloween costume advertised on two UK supermarket websites, sent tweets to show their disapproval. The topic 'went viral' with tweets passed rapidly and across networks. The protest was backed by campaigning organisations the next day, which amplified the conversation. This activity became a national news item the next day with mainstream media sourcing their information from Twitter. The retailers removed the costumes from sale, apologised, and made donations to England's Time to Change anti-stigma campaign.

During the protest, a #mentalpatient hashtag was created by people with personal experience of a mental illness. They posted photographs of themselves known as 'selfies' alongside text such as 'this is my mental patient costume'. The hashtag, which creates a searchable string, was used 6,694 times in 24 hours. The sharing of tweets by thousands of people may create a sense of solidarity, as well as making it harder to ignore or minimise their experience and providing multiple experiences of contact, shown to be more effective that a single instance which may be discounted as exceptional [10].

Clearly, the effects of this type of spontaneous protest cannot be studied using the same designs as interventions such as contact-based interventions. Other study designs are needed to explore the effects on the protesters; their targets, in the form of individual and organisational responses; and those who witness such protests. Regarding the protesters, one research question is what is the impact of taking part in a protest? The routine involvement of people with experience of mental illness in the ever-growing number of anti-stigma programmes provides an opportunity to study the impact of their campaigning activity on them, however this involvement may involve the provision of contact-based education rather than protest. Furthermore, intervention research to reduce self-stigma has not included protest [53], although an intervention could in theory include training people on effective forms of protest such as tips on social media use or writing a letter of complaint.

Active components of internalised stigma interventions

A recent review by Yanos et al. [53] identified four elements, shared by two or more published internalised stigma interventions, for which there is evidence of effectiveness with respect to some outcomes of interest. Many interventions apply two or more elements. We summarise these below. In terms of the strength of these effects, in general these are small, and the majority of studies are fairly small, especially those for severe mental illness [54].

Psychoeducation

Psychoeducation aims to increase and apply knowledge using critical thinking to reject stereotypes [46]. A recent systematic review [54] of psychosocial interventions for internalised stigma for people with schizophrenia spectrum disorders identified 12 studies, eight of which included psychoeducation. The content most often included was accurate information about schizophrenia and related psychoses. An intervention studied by Link et al [55] included education on stigma; its internalisation; how to recognise it in interpersonal interactions; and how to cope with it.

Cognitive techniques

These are used to challenge and replace self-stigmatising thoughts and beliefs based on stereotypes and applied to the self (for example, 'people with schizophrenia are incompetent'; 'I am incompetent'; 'other people see me as incompetent'). The therapist may test the beliefs with others and feed back their responses to the client [56]. Cognitive techniques are a validated method of helping people to access more helpful thinking patterns. They will also be familiar to some people with mental illness who have received CBT for their presenting problems. However, while a feasibility trial [56] showed evidence of possible effectiveness for some outcomes (though not internalised stigma) there are several limitations to this approach. CBT has been criticised for pathologising an understandable response to awareness of public stigma and experiences of discrimination [57]. In addition, CBT relies on the individual fully engaging with "homework" to provide positive social interaction to counter experiences of discrimination or its anticipation; and does not typically involve those in the person's network who act as reinforcers of internalised stigma through discriminatory behaviour [27].

Narrative methods

Photovoice [58] involves taking photographs, in this case to help express the personal impact of stigma and facilitate group discussion of how these impacts can be overcome. One randomised controlled trial of a photovoice intervention for people with severe mental illness has shown positive results with respect to self-stigma, greater use of proactive coping with societal stigma, greater increase in a sense of community activism, and perceived recovery and growth [58]. Narrative enhancement and cognitive therapy [59], an elaboration of cognitive and behavioural therapy, aims to help people to make sense and create meaning from past experiences including those of mental illness, and to experience the self as an active agent. A recent trial [59] found a positive impact for self-stigma and self-esteem but not for quality of life.

Individual decision making

This uses tools and experiences to increase hope, empowerment and action directed at one's goals, according to one's values [60]. For example, the interventions Coming Out Proud and Honest Open Proud focus on decision-making about disclosure, on the basis that selective disclosure can be experienced as empowering and can also allow the individual to receive more support from others. A randomised controlled trial of Coming Out Proud showed some short term positive impacts on stigma stress and the perceived benefits of disclosure, but at three weeks these effects appeared to be diminishing [60].

Intergroup contact

Since the reviews by Yanos et al. [53] and Wood et al. [54] a small pre-post study by Martinez-Hidalgo et al has used intergroup contact between young people with and without experience of a mental health problem to address internalised stigma, with promising results [61]. The intervention employed workshops of small groups in photography, cooking, theatre, radio and video, and art and painting to facilitate intergroup contact.

Active components common to internalised and interpersonal stigma interventions

Table 1 provides an overview of how similar approaches have been used to reduce internalised stigma and interpersonal stigma.

Table 1. Methods to reduce internalised and interpersonal stigma

Method	Application to Internalised stigma	Application to Interpersonal Stigma
Education	Psychoeducation [53]	Education for multiple target groups [71]; psychoeducation for carers [62, 63]
Cognitive techniques	Cognitive therapy [56]	Awareness raising [21]
Individual decision making	Decisions to disclose [7], educate or challenge others	Training for health professionals [8, 29] and police [41]
Narration	Photovoice [58]; narrative enhancement and cognitive therapy [59]	Contact-based education [72]
Contact	One study [61]	Widely used [72]
Protest	Not studied alone but challenging stigma is an aspect of individual decision making [53, 54]	Should be researched given challenging stigma is included for internalised stigma.

Education has been the mainstay of anti-stigma interventions for certain groups such as mental health professionals [67] and young people, increasingly in combination with contact. Psychoeducation is a key component of family intervention [62, 63], which may be used to reduce stigmatising responses by family members towards their ill relative. Likewise, psychoeducation has been identified as an active component of internalised stigma interventions.

Contact between the stigmatised group and others has been used mainly to reduce interpersonal stigma but has recently been shown to be effective for internalised stigma [45].

Narration is used in internalised stigma interventions [47, 48] and extensively in contact-based anti-stigma interventions. First person narratives of experiences of illness, stigma and recovery promote empathy, a key mediator of the effectiveness of intergroup contact [61].

Individual decision making can help empower people to address interpersonal stigma and to pursue valued goals, and so has been included in internalised stigma interventions. It is used rather less in interventions to reduce

interpersonal stigma but is included for target groups who have professional contact with people with mental illness, in particular interventions for health professionals [8, 29] and the police [41] in the form of skills training.

Cognitive techniques have been largely confined to internalised stigma interventions, as far as research interventions are concerned. However they may be useful in helping members of target groups identify and combat their own stigmatising thoughts based on stereotypes. Indeed, awareness raising of cognitive biases is a component of training on equality and diversity in workplaces and at universities, while awareness raising about the ubiquity of mental illness stigma is frequently used as a first step in anti-stigma programmes delivered by NGOs [17]. They may be particularly helpful for mental health professionals who are already familiar with cognitive methods through their clinical work.

Finally, we return to protest. It seems that because of the counterproductive impact of asking people to suppress thoughts based on stereotypes [50], this has not been included in research interventions on interpersonal stigma reduction. However, as discussed above, protest is not only used by NGOs and individuals with regards to stigma at organisational levels. Challenging interpersonal stigma may be seen as a form of protest and is included in those internalised stigma interventions incorporating individual decision making. We therefore recommend research into the impact of challenging at both the organisational and individual levels of stigma. Research into the effectiveness of protest at the organisational level may require different methods to those used to study individual members of target groups. Collaboration with researchers in other disciplines such as policy analysis may therefore be needed.

Implications of common methods for reducing interpersonal and internalised stigma

We identify two implications of our comparison of methods for reducing interpersonal and internalised stigma. First, this comparison identifies methods to be further considered for effectiveness research. This includes methods so far little used for one problem but widely used for the other, such as contact, or widely used in both but under-researched for one problem such as cognitive techniques.

Second, the commonality of methods raises the question of whether the same intervention may be delivered to groups of people with and without personal

experience of mental illness, with positive effects on both internalised and interpersonal stigma. In practice, any intervention on interpersonal stigma delivered to any target group will be delivered to people with and without personal experience, including people with some degree of internalised stigma as a result of their own personal experiences. We do not know how effective such interventions are for internalised stigma, and therefore we do not know how such interventions compare to those delivered specifically for reducing internalised stigma to groups with personal experience. This question could be explored provided people with lived experience are willing to self-disclose their experience to researchers. Given the widespread awareness of national anti-stigma programmes, their impact on internalised stigma could be highly cost-effective. So far the impact of the national programmes on people with mental illness has focussed mainly on experienced discrimination, responses to the anticipation of discrimination [27], and the use of education and challenging responses to discrimination [64]. The positive results with respect to some of these outcomes, mainly a reduction in experienced discrimination, suggests that such programmes may also reduce internalised stigma.

Intervening in the cycle of oppression

Having summarised the components of interventions for interpersonal and internalised stigma and highlighted their similarities in Table 1, we may now identify at which points in the cycle of oppression they can be applied to disrupt it.

From stereotypes to prejudice

Educational methods can allow for the identification of the influence of stereotypes at the individual level for interpersonal and internalised stigma. 'Myths' based on misinformation are replaced with facts, and additional knowledge is provided so that people are better equipped to identify and respond appropriately to mental health problems in themselves and others. This 'mental health literacy' approach has been shown to lead to good outcomes at the level of both knowledge and attitudes [9], showing that education can disrupt the process of stereotypes leading to prejudice. Narrative methods can be utilised as an educational method, which can be highly effective particularly for people with relatively lower educational attainment. Personal narratives help dispel stereotypes through their individuality and richness.

At the structural level, NGOs work with and/or complain to media organisations to avoid representation of people with mental illness based on negative stereotypes. This can range from lobbying to stop the use of 'headclutcher' photographs to represent people with mental illness [65] and the provision of alternative photographs, to collaboration on the development of fictional characters and storylines in TV or radio series. Besides fictional representations, positive representation requires disclosure by individuals with a mental illness. This is becoming more common in some countries and for some disorders, typically more common mental illnesses. Disclosure of a psychotic illness is less common. In the UK, content analysis of newspaper coverage suggests that coverage of most mental illnesses is now less likely to show the influence of negative stereotypes, but this change was not observed for coverage of schizophrenia [66].

From prejudice to discrimination

Once an educational method has been used to falsify stereotypes other methods are still needed to try to ensure people do not act on them, since they cannot be completely unlearned. This is evident from implicit attitudes testing [67] and applies to those with and without personal experience, since stereotypes are usually learned in childhood before the onset of an illness. Intergroup contact that pays attention to the facilitators of effective contact has a good evidence-base for prejudice reduction, as discussed above. Cognitive techniques to raise awareness of the influence of stereotypes we cannot completely unlearn may be useful here, such as identifying thoughts and behaviours based on stereotypes and challenging or replacing them. This could be useful in particular for those with ongoing or repeated contact, such as carers and occupation groups such as health professionals and the police. This awareness-raising process should include education about when people are more likely to behave in a way that is influenced by stereotypes, for example when under stress or when experiencing professional burnout [68].

From discrimination to oppression in the context of a power differential

Addressing interpersonal discrimination will reduce the extent to which oppression occurs. Training people to address discrimination in interpersonal situations for example using role play is included in some internalised

stigma interventions [53]. Contact-based education for professional groups has included skills training aiming to reduce discriminatory experiences of people they serve, but there has been little work approaching for example family members, friends, and mental health professionals as 'allies' of people with mental illness. These potential allies often witness others' discriminatory behaviour in the same social or professional networks. Allies are also a common source of discriminatory experiences for people with mental illness [27], in keeping with the quote by Vaclav Havel above. However, provided these individuals identify themselves as allies they may be motivated to learn how to both reduce their own discriminatory behaviour and increase their anti-stigma agency. We are aware of one small but promising study in this area involving mental health professionals [69], and a study currently underway of training for medical students in multiple countries [70].

It seems that an anti-stigma programme may need to work at all points in the cycle of oppression to be effective. For example, as has been acknowledged by internalised stigma-researchers [57], working at the cognitive level of stereotype endorsement vs. rejection on the part of people experiencing internalised stigma will not prevent widespread discrimination by others with more power; it is the resulting oppression which in turn feeds these stereotypes.

Conclusions

In this article we recommend a model from the field of diversity and inclusion training, the cycle of oppression, when considering the design and evaluation of any anti-stigma intervention. The model's strengths include the use of oppression as a separate term to describe and thus highlight structural level problems as a target for intervention; and the self-sustaining nature of the problem of stigma if there is not disruption at each step in the cycle. In the process of considering the methods used in effective interventions to reduce both interpersonal and internalised stigma, we have identified methods to intervene at each point in the cycle, some of which require further research with respect to one or more of internalised stigma, interpersonal discrimination or structural level discrimination/oppression. Finally, returning to Vaclav Havel's quote, the model shows how we all play a role in sustaining this cycle but may all also function as anti-stigma agents. Research on interventions to help support people who identify as 'allies' of people with mental illness in this role is almost entirely lacking; we recommend further development and evaluation of such interventions.

References

[1] Link BG, Phelan JC. Conceptualizing stigma. Annual Review of Sociology 2001; 27: 363-385.

[2] Freiere P. The Pedagogy of the Oppressed. New York: Seabury; 1970.

[3] Roberts SJ, Demarco R, Griffin M. The effect of oppressed group behaviours on the culture of the nursing workplace: a review of the evidence and interventions for change. Journal of Nursing Management 2009; 17: 288-293.

[4] Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K, Campion J et al. Three strategies for changing attributions about severe mental illness. Schizophrenia Bulletin 2001; 27: 187-195.

[5] Corrigan PW, Morris SB, Michaels PJ, Rafacz JD, Rüsch N. Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatric Services, 2012; 63: 963-973.

6] Cumming E, Cumming J. Closed Ranks. An Experiment in Mental Health. Cambridge, Massachusetts: Harvard University Press; 1957.

[7] Rix, S, Paykel ES, Lelliot P, Tylee AT, Freeling P, Gask L, Hart D. Impact of a national campaign on GP education: an evaluation of the Defeat Depression Campaign. British Journal of General Practice 1999; 49: 99-102.

[8] Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O et al., Mental health-related stigma in health care and mental health-care settings. Lancet Psychiatry 2014; 1: 467-482.

[9] Jorm AF, Kitchener BA. Noting a landmark achievement: Mental Health First Aid training reaches 1% of Australian adults. Australian and New Zealand Journal of Psychiatry. 2011; 45: 808-813.

[10] Al Ramiah A, Hewstone M. Intergroup contact as a tool for reducing, resolving, and preventing intergroup conflict: evidence, limitations, and potential. The American Psychologist 2013; 68: 527-542.

[11] Allport G. The Nature of Prejudice. New York: Doubleday Anchor Books; 1954.

[12] Desforges DM, Lord CG, Ramsey SL, Mason JA, Van Leeuwen MD, West SC et al. Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. Journal of Personality and Social Psychology 1991; 60: 531-544.

[13] Jorm AF, Christensen H, Griffiths KM. Changes in depression awareness and attitudes in Australia: the impact of beyondblue: the national depression initiative. Australian and New Zealand Journal of Psychiatry, 2006. 40: 42-46.

[14] Thornicroft C, Wyllie A, Thornicroft G, Mehta N. Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination. Australian and New Zealand Journal of Psychiatry 2014; 48: 360-370.

[15] Knifton L, Quinn N. Media, Mental Health and Discrimination: A Frame of Reference for Understanding Reporting Trends. International Journal of Mental Health Promotion 2008; 10: 23-31.

[16] Hansson L, Stjernswärd S, Svensson B. Changes in attitudes, intended

behaviour, and mental health literacy in the Swedish population 2009–2014: an evaluation of a national antistigma programme. Acta Psychiatrica Scandinavica 2016; 134: 71-79.
[17] Henderson C, Thornicroft G. Stigma and discrimination in mental illness: Time to Change. Lancet 2009; 373: 1928-1930.
[18] Stuart H, Chen S, Christie R, Dobson K, Kirsh B, Knaak S et al., Opening minds in Canada: targeting change. Canadian Journal of Psychiatry 2014; 59 (Suppl 1): S13-18.
[19] Henderson C, Stuart H, Hansson L. Lessons from the results of three national antistigma programmes. Acta Psychiatrica Scandinavica 2016; 134: 3-5.
[20] Thornicroft G, Rose R, Kassam A. Stigma: ignorance, prejudice or discrimination. British Journal of Psychiatry 2007; 190: 192-193.
[21] Sampogna G, Bakolis I, Evans-Lacko S, Robinson E, Thornicroft G, Henderson C. The impact of social marketing campaigns on reducing mental health stigma: Results from the 2009-2014 Time to Change programme. European Psychiatry 2017; 40: 116-122.
[22] Friedrich B, Evans-Lacko S, London J, Rhydderch D, Henderson C, Thornicroft G. Anti-stigma training for medical students - the Education Not Discrimination project. British Journal of Psychiatry 2013; 202(Suppl 55): s89-s94.
[23] Henderson C, Williams P, Little K, Thornicroft G. Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010. British Journal of Psychiatry 2013; 202(Suppl 55): s70-s76.
[24] Stuart H, Chen SP, Christie R, Dobson K, Kirsh B, Knaak S et al. Opening minds in Canada: background and rationale. Canadian Journal of Psychiatry 2014; 59(10 Suppl 1): s8-s12.
[25] Henderson C, Robinson E, Evans-Lacko S, Corker E, Rebollo-Mesa I, Rose D et al., Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. Acta Psychiatrica Scandinavica 2016; 134: 23-33.
[26] Evans-Lacko S, Corker E, Williams P, Henderson C, Thornicroft G. Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: an analysis of survey data. Lancet Psychiatry 2014; 1:121-128.
[27] Corker E, Hamilton S, Robinson E, Cotney J, Pinfold V, Rose D et al., Viewpoint survey of mental health service users' experiences of discrimination in England 2008–2014. Acta Psychiatrica Scandinavica 2016; 134: 6-13.
[28] Koller M, Stuart H. Reducing stigma in high school youth. Acta Psychiatrica Scandinavica 2016; 134: 63-70.
[29] Knaak S, Modgill G, Patten SB. Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. Canadian Journal of Psychiatry 2014; 59(10 Suppl 1): s19-s26.
[30] Knaak S, Patten S. A grounded theory model for reducing stigma in health professionals in Canada. Acta Psychiatrica Scandinavica, 2016; 134: 53-62.
[31] Corrigan PW. Target-specific stigma change: a strategy for impacting mental illness stigma. Psychiatric Rehabilitation Journal 2004; 28: 113-121.
[32] Graham AL, Julian J, Meadows G. Improving responses to depression and related disorders: evaluation of a innovative, general, mental health care workers training program. International Journal of Mental Health Systems 2010; 4: 25.

[33] Bayar M, Poyraz B, Aksoy-Poyraz C, Arıkan MK. Reducing Mental Illness Stigma in Mental Health Professionals Using a Web-based Approach. Israel Journal of Psychiatry and Related Sciences, 2009; 46: 226-230.
[34] Irvine BA, Billow MB, Bourgeois M, Seeley JR. Mental Illness Training for Long Term Care Staff. Journal of the American Medical Directors Association 2012; 13: 81.e7-81.e13.
[35] Moll SE, Patten S, Stuart H, MacDermid JC, Kirsh B. Beyond Silence: A Randomized, Parallel-Group Trial Exploring the Impact of Workplace Mental Health Literacy Training with Healthcare Employees. The Canadian Journal of Psychiatry 2018; 63: 826-833.
[36] Henderson M, Brooks SK, del Busso L, Chalder T, Harvey SB, Hotopf M et al. Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: a qualitative study. BMJ Open 2012; 2 (5).
[37] Cromie JE, Robertson VJ, Best MO. Work-related musculoskeletal disorders and the culture of physical therapy. Physical Therapy 2002; 82: 459-472.
[38] Joyce T, Hazelton M, McMillan M. Nurses with mental illness: their workplace experiences. International Journal of Mental Health Nursing 2007; 16: 373-380.
[39] Health, D.o. Invisible patients: a report of the working group on the health of health professionals. London; 2010.
[40] Pinfold V, Toulmin H, Thornicroft G, Huxley P, Farmer P, Graham T. Reducing psychiatric stigma and discrimination--evaluating an educational intervention with the police force in England. Social Psychiatry and Psychiatric Epidemiology 2003; 38: 337-344.
[41] Hansson L, Markstrom U. The effectiveness of an anti-stigma intervention in a basic police officer training programme: a controlled study. BMC Psychiatry 2014; 14: 55.
[42] Yamaguchi S, Wu SI, Biswas M, YateM, Aoki Y, Barley EA, Thornicroft G. Effects of short-term interventions to reduce mental health-related stigma in university or college students: a systematic review. Journal of Nervous and Mental Disorders 2013; 201: 490-503.
[43] Sharp W, Hargrove DS, Johnson L, Deal WP Mental Health Education: An Evaluation of a Classroom Based Strategy to Modify Help Seeking for Mental Health Problems. Journal of College Student Development 2006; 47: 419-438.
[44] Pettigrew TF, Tropp LR. How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. European Journal of Social Psychology 2008; 38: 922-934.
[45] West K, Hewstone M, Lolliot S Intergroup contact and prejudice against people with schizophrenia. The Journal of Social Psychology 2014; 154: 217-232.
[46] Hayes SC, Bissett R, Roget N, Padilla M, Kohlenberg BS, Fisher G et al. The Impact of Acceptance and Commitment Training and Multicultural Training on the Stigmatizing Attitudes and Professional Burnout of Substance Abuse Counselors. Behavior Therapy 2004; 35: 821-835.
[47] Knaak S, Patten S, Ungar T. Mental illness stigma as a quality-of-care problem. Lancet Psychiatry 2015; 2: 863-864.
[48] Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, Carta MG, et

al. Evolution of public attitudes about mental illness: a systematic review and meta-analysis. Acta Psychiatrica Scandinavica 2012; 125: 440-452.

[49] Schomerus G, Angermeyer MC, Baumeister SE, Stolzenburg S, Link BG, Phelan JC. An online intervention using information on the mental health-mental illness continuum to reduce stigma. European Psychiatry 2016; 32: 21-27.

[50] Macrae CNB, Bodenhausen GV, Milne AB, Jetten J. Out of mind but back in sight: stereotypes on the rebound. Journal of Personality & Social Psychology 1994; 67: 808-817.

[51] Shefer G, Henderson C, Frost-Gaskin M, Pacitti R. Only Making Things Worse: A Qualitative Study of the Impact of Wrongly Removing Disability Benefits from People with Mental Illness. Community Mental Health Journal 2016; 52: 834-841.

[52] Betton V, Borschmann R, Docherty M, Coleman S, Brown M, Henderson C. The role of social media in reducing stigma and discrimination. British Journal of Psychiatry 2015; 206: 443-444.

[53] Yanos PT, Lucksted A, Drapalski AL, Roe D, Lysaker P. Interventions targeting mental health self-stigma: A review and comparison. Psychiatric Rehabilitation Journal 2015; 38: 171-178.

[54] Wood L, Byrne R, Varese F, Morrison AP. Psychosocial interventions for internalised stigma in people with a schizophrenia-spectrum diagnosis: A systematic narrative synthesis and meta-analysis. Schizophrenia Research 2016; 176: 291-303.

[55] Link BG, Struening EL, Neese-todd S, Asmussen A, Phelan JC. On describing and seeking to change the experience of stigma. Psychiatric Rehabilitation Skills 2002; 6: 201-231.

[56] Wood L, Byrne R, Enache G, Morrison AP. A brief cognitive therapy intervention for internalised stigma in acute inpatients who experience psychosis: A feasibility randomised controlled trial. Psychiatry Research 2018; 262: 303-310.

[57] Pyle M, Pilling S, Machin K, Allende-Cullen G, Morrison AP. Peer support for internalised stigma experienced by people with psychosis: rationale and recommendations. Psychosis, 2018; 10: 146-152

[58] Russinova Z, Rogers ES, Gagne C, Bloch P, Drake KM, Mueser KT. A randomized controlled trial of a peer-run antistigma photovoice intervention. Psychiatric Services 2014; 65: 242-246.

[59] Hansson L, Lexen A, Holmen J. The effectiveness of narrative enhancement and cognitive therapy: a randomized controlled study of a self-stigma intervention. Social Psychiatry and Psychiatric Epidemiology 2017. 52: 1415-1423.

[60] Rusch N, Abruzzese E, Hagerdon E, Hartenhauer D, Kaufmann I, Curschellas J, et al., The efficacy of Coming Out Proud to reduce stigma's impact among people with mental illness: pilot randomised controlled trial. British Journal of Psychiatry 2014; 204: 249-251.

[61] Martinez-Hidalgo MN, Lorenzo-Sanchez E, Lopez Garcia JJ, Regadera JJ. Social contact as a strategy for self-stigma reduction in young adults and adolescents with mental health problems. Psychiatry Research 2017; 260: 443-450.

[62] Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database of Systematic Reviews 2010; 12: CD000088.
[63] Sin J, Gillard S, Spain D, Cornelius V, Chen T, Henderson C. Effectiveness of psychoeducational interventions for family carers of people with psychosis: A systematic review and meta-analysis. Clinical Psychology Review 2017; 56: 13-24.
[64] Sampogna G, Bakolis I, Robinson E, Corker E, Pinfold V, Thornicroft, G, Henderson C. Experience with the Time to Change programme in England as predictor of mental health service users' stigma coping strategies. Epidemiology and Psychiatric Sciences 2017; 26: 517-525.
[65] 2018; Available from: https://www.time-to-change.org.uk/media-centre/responsible-reporting/using-images/get-picture-campaign.
[66] Change Tt. For first time, print media reporting of mental health is significantly more balanced and responsible with more coverage than ever before – latest study shows. 2017: https://www.time-to-change.org.uk/news/first-time-print-media-reporting-mental-health-significantly-more-balanced-and-responsible-more.
[67] Rusch N, Corrigan PW, Todd AR, Bodenhausen G. Implicit self-stigma in people with mental illness. Journal of Nervous and Mental Disorders 2010; 198: 150-153.
[68] Schulze B. Stigma and mental health professionals: A review of the evidence on an intricate relationship. International Review of Psychiatry 2007; 19: 137-155.
[69] Zaske H, Freimuller L, Wolwer W, Gaebel W. [Anti-stigma competence for mental health professionals: results of a pilot study of a further education programme for people working in psychiatric and psychosocial settings]. Fortschritte der Neurologie Psychiatrie 2014; 82: 586-592.
[70] Thornicroft G, Bakolis I, Evans-Lacko S, Gronholm PC, Henderson C, Kohrt B, Koschorke M, Milenova M, Semrau M, Votruba N, Sartorius N. Key lessons learned from the INDIGO global network on mental health related stigma and discrimination. World Psychiatry 2019; 18; 229-230.
[71] Gronholm PC, Henderson C, Deb T, Thornicroft G. Interventions to reduce discrimination and stigma: the state of the art. Social Psychiatry and Psychiatric Epidemiology 2017; 52: 249-258.
[72] Thornicroft G, Mehta N, Clement S, Evans Lacko S, Doherty M, Rose D, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. Lancet 2015; 387: 1123-1132.

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