DEVELOPMENT OF AN INTERVENTION TO REDUCE SELF-STIGMA IN OUTPATIENT MENTAL HEALTH SERVICE USERS IN CHILE

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Background:
Latin America is characterized by a high prevalence of public stigma toward those with mental illness, and significant self-stigma among labeled individuals, leading to social exclusion, low treatment adherence, and diminished quality of life. However, there is no published evidence of an intervention designed to address stigma in the region. In light of this, a psychosocial intervention to reduce self-stigma among users with severe mental illness was developed and tested through an RCT in two regions of Chile. Objectives: To describe the development of the psychosocial intervention, assess its feasibility and acceptability, and evaluate its preliminary impact. Methods: An intervention was designed and is being tested, with 80 users with severe mental illness attending two community mental health outpatient centers. To prepare the intervention, pertinent literature was reviewed, and experts and mental health services users were consulted. Feasibility and acceptability were assessed, and impact was analyzed, based on follow-up qualitative reports by the participants. Results: The recovery-oriented, ten-session group intervention incorporates the Tree of Life narrative approach, along with other narrative practices, to promote a positive identity change in users, and constructivist psychoeducation, based on case studies and group discussions, to gather tools to confront self-stigma. The intervention was feasible to implement and well evaluated by participants, family members, and center professionals. Participants reported increased self-confidence, and the active use of anti-stigma strategies developed during the workshop. Conclusions: This group intervention promises an effective means to reduce stigma of mental illness within Chile and other Latin American countries and feasibility to scale up within mental health services.
Key words: Community Mental Health Services, Social Stigma, Randomized Controlled Trial, Latin America

Resumen: Antecedentes: Latinoamérica se ha caracterizado por ser una región que presenta una alta prevalencia de estigma público hacia la enfermedad mental, y niveles significativos de auto-estigma entre las personas con diagnóstico psiquiátrico, conduciendo a un alto nivel de exclusión social, baja adherencia al tratamiento y una disminución de la calidad de vida. Sin embargo, no se dispone de evidencia científica sobre alguna intervención diseñada para abordar el estigma a nivel local o regional. Considerando lo anterior, se ha desarrollado y evaluado a través de una ensayo clínico aleatorizado una intervención psicosocial para reducir el auto-estigma entre usuarios de servicios de salud mental en dos regiones de Chile.Objetivos: Describir el desarrollo de una intervención psicosocial anti-estigma y evaluar su confiabilidad, aceptabilidad e impacto inicial entre un grupo de usuarios.Métodos: La intervención fue diseñada y evaluada en 80 usuarios con diagnóstico de trastorno mental severo que estuvieron asistiendo a dos centros ambulatorios de salud mental comunitaria. Para elaborar la intervención, se revisó literatura científica pertinente y se conformaron paneles de discusión con expertos y usuarios de servicios de salud mental. La factibilidad y la aceptabilidad fueron evaluadas y se analizó su impacto inicial entre los participantes, en base a una serie de evaluaciones cualitativas.Resultados: Se generó una intervención orientada a la recuperación, que considera 10 sesiones grupales e incorpora el abordaje del 'Árbol de la Vida', además de otras prácticas narrativas, para promover un cambio positivo en la identidad de los usuarios; adicionalmente, se incluyen elementos de psicología constructivista, basada en estudio de casos y grupos de discusión, para que los usuarios adquieran herramientas para afrontar el estigma. La intervención fue implementada apropiadamente y bien evaluada por participantes, familiares y profesionales de los centros de salud mental. Los participantes reportaron un incremento de la autoconfianza y un activo uso de las estrategias anti-estigma desarrolladas durante las sesiones de trabajo. Conclusiones: La presente intervención grupal demostró un promisorio efecto en la reducción del estigma hacia la enfermedad mental en Chile, y cuenta con el potencial para ser implementado en otros servicios de salud mental de Latinoamérica.

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Introduction

The estimated lifetime prevalence of suffering from a mental disorder ranges from 12.0 to 47.4% worldwide [1], and neuropsychiatric conditions account for more than 22% of the global burden of disease, greatly impacting the quality of life and social inclusion of affected individuals[2]. Along with needing to manage the symptomatology of their conditions and seek professional treatment, those with mental disorders must also navigate the stigma and discrimination associated with having a mental illness, in terms of social (public), structural, and family stigma, as well as self, or internalized, stigma. This latter form of stigma manifests when individuals with a mental illness are aware of the stereotypes and prejudices commonly attached to persons carrying a psychiatric diagnosis (beliefs of their being "dangerous," "incompetent," or "worthless"), agree with those labels, and begin to apply those negative labels to themselves[3]. Self-stigmatization has been shown to be associated with feelings of helplessness, low self-esteem, and social isolation, which lead to reduced treatment adherence and diminished life satisfaction, significantly inhibiting users' recovery process [4–6].

Although most stigma-related research to date has been carried out in Europe and North America, a few studies have found that Latin America is also characterized by high levels of public and family stigma toward individuals affected by mental illness [7]. A recent literature review reported that perceived and public stigma were associated with a high level of functional impairment among users in Brazil, Colombia, and Argentina, and that family may be a powerful source of stigmatizing behaviors in Mexico [8]. Moreover, of particular note is a 2004 Chilean study on the use of mental health services, which identified stigma as a significant barrier to outpatient psychiatric treatment access, with one third of respondents admitting to being deterred from accessing professional care due to fear of judgment from others [9]. In line with this, another study in Chile found that, on average, 32% of individuals with a first episode of schizophrenia did not maintain regular treatment contact with centers a year after making initial contact [10]. User self-exclusion from health services is concerning, resulting not only in economic and resource losses, but more importantly, the exacerbation of users' symptoms and an increased risk of relapse, which pose a burden for the informal care network and further socially isolate users, leading to possible chronicity of their condition [11].

In light of this, community mental health reforms in Latin America have included three main objectives: 1) to anchor mental health within primary care, 2) to develop community mental health services, and 3) to reduce the stigma associated with mental illness [12]. Additionally, the WHO Global Mental Health Action Plan 2013-2020 states that reducing stigmatization, discrimination, and human rights violations are relevant goals, which can be pursued through the implementation of mental health promotion and prevention strategies [13]. Nevertheless, a recent evaluation of mental health services in this region has reported that stigma is still an important barrier for recovery in people with mental illness [14]. In Chile, specifically, the Ministry of Health has prioritized interventions to reduce the effects of stigma. The 2011-2020 National Mental Health Strategy aims to tackle discrimination aimed at mental health service users, and to guarantee quality and opportune treatment, based in the community, to support the social inclusion of individuals with mental disorders and improve their quality of life [15]. These objectives, however, have yet to be translated into concrete actions or interventions to address stigma and its consequences. In fact, there is no published evidence of anti-stigma interventions developed in Chile or the Latin American region.

Study Background

In consideration of this local and regional knowledge gap, particularly regarding interventions to reduce stigma among individuals with mental illness, the authors designed and are piloting a psychosocial intervention in self-stigma for mental health service users with severe mental disorders, who attend outpatient community mental health centers (COSAMs), which form part of the public health care network.

The intervention aims to improve treatment adherence, increase quality of life, and decrease self-stigma levels of mental health service users with severe mental disorders, and its effectiveness is being evaluated though a randomized controlled trial (RCT), with 80 participants, recruited from COSAMs in two regions of Chile (COSAM Concon in Region V and COSAM Colina in the Metropolitan Region). Participants are men and women, 18 to 60 years of age, with a diagnosis of a severe mental disorder, who have been users in their respective centers for no longer than 5 years. To measure

effects of the intervention, instruments evaluating self-stigma (Internalized Stigma of Mental Illness, ISMI) [16], psychopathology (PANSS) [17], quality of life (Seville Quality of Life Questionnaire) [18], and alcohol consumption (AUDIT) [19] are applied at baseline and 3 months after randomization (the duration of the intervention participants randomized in the study group), with a 6-month follow-up evaluation. Treatment adherence is operationalized as the period of time each participant remained in contact with the COSAM during the study period.

The study was reviewed and approved by the Ethics Committee of Human Subjects Research of the Faculty of Medicine of Universidad de Chile, and participants signed an informed consent before completing the baseline interview, which explained the potential benefits and risks of participating in the study, the protection of their confidentiality, and their right to withdraw from the study at any time.

Objectives

While the quantitative results of the RCT are forthcoming, since the follow-up evaluation period is ongoing, the objective of the current paper is three-fold: 1) to present the developed self-stigma intervention, 2) to assess the feasibility of its implementation and its acceptability among stakeholders, and 3) to provide a preliminary qualitative report of its impact.

Methods

Development of Self-Stigma Intervention

The construction of the intervention was based on a review of pertinent literature and input from current mental health service users, as well as clinical and academic experts.

Literature Review

The authors reviewed group interventions and therapeutic approaches, which have proved effective in other countries to reduce self-stigma, in order to inform an intervention for the Chilean context.

A 2012 systematic review of self-stigma interventions by Mittal et al classified self-stigma reduction approaches into two camps: 1) interventions that aim to alter mental health users' stigmatizing beliefs and attitudes, and 2) those that enhance coping skills that empower users, improve their self-esteem, and increase their help-seeking behavior (20). The authors noted that the latter method was favored by experts, and indeed, of the fourteen reviewed interventions—over half of which were carried out in the US—the most successful strategy, which showed significant improvements and the largest effect size (of 8.06 for the PDD stigma instrument), was a group psychoeducation intervention focused on coping skills, specifically crisis planning, communication, and stress management [21]. This intervention by Shin and Lukens, a 10-session psychoeducation group for Korean Americans with schizophrenia treated in a New York City outpatient mental health service and their families, included cultural specific components, which made the intervention an appealing basis for possible cultural adaption in Chile.

The benefits of psychoeducation, empowerment, and coping strategies for stigma reduction have also been documented in other studies [22,23]. In particular, constructivist group psychoeducation, focused on the creation of knowledge based on individual or shared experiences, has been highlighted as a method to achieve meaningful learning, that is directly applicable to participants' lives [24]. This can be obtained through group discussions of significant psychoeducation topics (instead of the traditional lecture-style provision of information) and the incorporation of case vignettes into sessions.

Additionally, narrative practice has emerged as a promising technique, having been shown in a 2012 study to contribute to stigma resistance among users [25]. Michael White and David Epston [26,27] proposed this approach, centered on life narratives and the meaning individuals assign to certain events, to highlight persons' beliefs, values, skills, and relationships, which are available to support them in difficult times. Similar to Van Gennep's Rites of Passage [28], narrative practice emphasizes the externalization of problems and the internalization of personal agency, to promote the reincorporation of individuals' knowledge and their place in the community [29]. Narrative practice often incorporates metaphors, one example of which is the Tree of Life, a psychosocial methodology with narrative therapy ideas, which was developed in a joint effort by Ncazelo Ncube-Mlilo (of REPSSI, an NGO in East and South Africa offering children who are affected by HIV and AIDS, poverty, and conflict psychosocial support) and David Denborough (of the Dulwich Centre) [30,31]. The Tree of Life uses different parts of trees as metaphors to represent distinct aspects of individuals' lives, to encourage and explore stories of perseverance, values, long-term goals, and personal connections. The metaphor of the Tree of Life is further extended with the Forest of Life (community) and Storms of Life (difficult problems or traumas individuals face), which feed into discussions and activities supporting the externalization of

problems and the internalization of agency. Narrative practice aims to transform personal narratives, so that users learn to reframe their life stories and to differentiate themselves from their mental disorder. This approach lessens the damaging effects of self-stigma, which can affect the way individuals tell their life story, see themselves as protagonists, and view their future [32].

Elements of recovery orientation also informed the creation of the intervention. The strength-based perspective, focused on hope, self-determination, revelation, and the empowerment and peer support movement, emphasizes the possibility of recovery and living a meaningful life. Under this model, the purpose of treatment is to improve users' quality of life, not simply to reduce the manifestation of symptoms [33].

Mental Health Service User Feedback

In line with WHO[13], Chilean Ministry of Health [15], and literature recommendations [34,35] to involve mental health service users, or peers, in the creation of interventions for the improvement of services, the authors convened a focus group of six users with severe mental illness from the outpatient center of the Psychiatric Hospital of Valparaiso (not a center of the study) to share feedback on an initial draft proposal of the intervention and to discuss their experiences of discrimination.

Users in the focus group, made up of three men and three women with severe mental disorders, noted the importance of family support, especially at the moment of diagnosis, and the generalizations society makes regarding those affected by a mental disorder. In terms of the intervention, the users spoke positively about the Tree of Life approach and metaphor; the narrative approach is culturally congruent in Chile, which is characterized as an occidental, individualist-type society [36].

The focus group participants also valued starting the workshop not with hierarchical classic psychoeducation on diagnosis and symptom management, but instead with a group discussion on their experiences and resources, which offers a more comprehensive view of the participants as individuals, rather than in the subordinate role as patients. The focus group also supported the use of video case vignettes and discussed sharing their lived experiences of discrimination with the intervention participants.

Expert Panel Input

In addition, three authors, experts in the areas of group psychoeducation and family engagement (E.L), service-based interventions (J.C.S), and stigma (L.H.Y), were consulted during the development of the workshop.

The expert panel noted the importance of considering aspects of stigma that could be specific to Chilean culture, in line with the "What Matters Most" framework [37], and incorporating the use of individual joining sessions between the facilitators and participants prior to the group sessions, coupled with a follow-up session one month after the intervention, to touch base. The consulted experts also highlighted the need to promote the participation of family members in the intervention to support changes in stigma and coping, in at least some of the sessions and through separate family groups, if possible. Further, they recommended ensuring that COSAM professionals, administrators, and staff members are aware of the intervention and its aims, even if they are not directly involved in the preparation and/or implementation of the workshop.

Assessment of Feasibility and Acceptability of Intervention

To assess the feasibility and acceptability of the intervention, authors used the methodology employed by Pinto-Foltz et al to evaluate another anti-stigma psychoeducation intervention [38]. Specifically, feasibility was assessed by tracking how many participants assigned to the intervention group regularly attended meeting sessions and by receiving feedback from the facilitators and COSAM staff about the implementation of the workshop, while acceptability was evaluated by exploring users', family members', and staff's comments about the relevance of content and the method of delivery of this intervention. The acceptability assessment also included the aforementioned expert panel.

Preliminary Evaluation of Intervention's Impact

A follow-up session was held one month after the completion of the workshop, to determine the intervention's preliminary impact, based on participants' self report. In this session, participants discussed how they had applied the workshop discussions and anti-stigma strategies when faced with challenges in their daily lives and other changes they had noticed.

Results

Development of Self-Stigma Intervention Structure

The developed workshop consists of ten sessions, which were held on a weekly basis for 90 minutes in the COSAMs, with groups of no more than ten

participants, to promote group cohesion and active participation of all members. The intervention was facilitated by two mental health professionals: a member of the research team, with clinical experience (SS in Colina and JAB in Concon), and a professional from the mental health center (CA, an occupational therapist from COSAM Colina, and PA, a nurse from COSAM Concon). The latter professionals' participation was especially important, both to increase users' comfort level during the sessions and connection to the COSAM, and to facilitate the later transference of the intervention to the centers. Before beginning the sessions, the facilitators held joining sessions with each participant randomized into the intervention, to get to know each person and his or her interests on an individual basis, introduce the workshop and its goals, and respond to any questions. This also served as a moment to identify participants who would require more support (e.g. participants who were illiterate or had an intellectual disability).

Whenever possible, and when permitted by the participants, family members were contacted for a group or individual orientation session, to explain the intervention and their role in the process. COSAM professionals, administrators, and staff were also informed of the intervention and its objectives.

Content

Table 1 presents a session-by-session summary of the intervention. Each session ended with a debriefing activity between the facilitators, to discuss observed group dynamics, participants that may require specific attention, and significant learning moments, to plan for the next sessions. At the end of each session, the facilitators also gave the participants a recommended, although optional, take home activity, which is a topic or question to reflect on or write/draw about in a journal between sessions (a journal was given to the participants during the first session by facilitators, with a brief orientation on how to use it, as a notebook or sketch pad, given that some participants were illiterate).

Workshop sessions combine constructivist group psychoeducation discussions with identity work, centered on the Tree of Life narrative activity. Facilitators were instructed to position themselves as equals, in contrast to the traditional professional-to-patient hierarchy, and were encouraged to share their own experiences, with obstacles ("storms") and discrimination, for example, as they felt comfortable. Their responsibility was to ensure a safe group environment and promote the active participant of all members.

The first two workshop sessions are dedicated to the creation of the Tree of Life, which encourages participants to expand their life narratives and generate a more comprehensive, positive view of themselves, to include their childhood memories, interests and routines, strengths and abilities, goals, significant individuals, and available supports, so that participants begin to implicitly question aspects of stigma that tend to narrowly define users based on their psychiatric diagnoses. The Tree of Life activity also serves to connect the participants' pasts to their present activities and future goals, supporting a longitudinal analysis of their lives.

With the participants' presentation of the Trees of Life in the third session, coupled with the Definitional Ceremony (another narrative technique), followed by the Forest of Life activity, participants begin to see similarities between their own experiences and goals and those of their peers, while viewing themselves (their Trees) as members of a diverse society (the Forest). Only in the fourth session does the group begin to directly discuss topics related to mental illness, using the Storms of Life metaphor (part of Tree of Life activity) and working toward the "Externalization of the Problem," as described in the first stage of Van Gennep's Rites of Passage. Recovery and empowerment are also discussed in this session. A case video vignette of another Chilean user, currently working as a peer support worker in another community mental health initiative, is shown, the first of a series of three.

The fifth session is focused on a group discussion of discrimination experiences, social stigma, and self-stigma, and incorporates a video of a stigmatizing Chilean media news report from a national television channel on mental health, to motivate a discussion of stereotypes, social stigma, and common myths and realities regarding mental illness. The second case vignette video is also shown in this session.

In the sixth and seventh session, the participants work on internalizing agency (Van Gennep's second stage), through the creation of a list of strategies to resist the effects of stigma and self-stigma, based on participants' past experiences and a brainstorming group discussion. The final video vignette is shown in session six, and individualized crisis prevention and preparation plans are created in session seven, to assist the participants in identi

Table 1: Workshop Structure

Session	Content
Pre	· Joining Sessions with participants
	· Orientation session with family members
	· Presentation of intervention with COSAM professionals and staff
1	· Ice-breaker and establishment of group norms (determined by participants and reviewed at the beginning of each session)
	· Hand out journals, for participants to use as they wish (write, take notes, draw)
	· Identity work: Tree of Life (part 1) – roots (origins, past, family history), ground (daily life activities), trunk (skills, strengths)
	· Recommended at home activity: Discuss history with family and friends, to add information to Tree
2	· Identity work: Tree of Life (part 2) – branches (goals), leaves (important individuals, alive or deceased), fruit (gifts received, mate rial or otherwise)
	· Recommended at home activity: Reflect on importance of support network (family, friends)
3	· Identity work: Presentation of Trees with Definitional Ceremony
	· Identity work: Forest of Life activity
	· Recommended at home activity: Reflect on meaning of "mental health," both positive and negative concepts
4	· Constructivist group psychoeducation: conversation about mental health
	· Identity work: Metaphor of Storms of Life / Externalization of problem
	· Constructivist group psychoeducation: Conversation about losses, recovery, and hope, including watching NAMI video on reco-very narratives
	· User vignette (1 of 3): Concerning illness evolution, psychiatric diagnosis and experiences, losses and hope, and familial and professional support
	· Recommended at home activity: Reflect on challenges posed by discrimination (explicit and implicit) directed at individuals with a mental disorder
5	· Identity work: Storms of Life metaphor continuation
	· Constructivist group psychoeducation: Explicit and implicit discrimination, social stigma, self stigma, including watching a local Chilean news report about mental illness and debating its representation of users and mental health
	· Activity of myths vs. reality
	· Discussion of users rights and responsibilities (regarding Chilean law)
	· User vignette (2 of 3): Concerning experience of discrimination, stigma, and self-stigma, and how he overcame the negative ef fects
	· Recommended at home activity: Reflect on what group participants can do to resist the effects of stigma and discrimination
6	· Constructivist group psychoeducation and Identity work: Brainstorming and creation of list of strategies that participants have used in the past or could use in the future to resist the effects of stigma and self-stigma (and other "storms") / Internalization of agency
	· User vignette (3 of 3): Continued comments on strategies to overcome effects of stigma and self-stigma and reflections on reco-very process and peer work
	· Recommended at home activity: Continue reflecting on strategies
7	· Identity work: Internalization of agency – review list of strategies and incorporate any additions or edits
	· Creation of home-based crisis prevention and preparation plan (identification of triggers and early warning signs and proposal of action plan for user, family members, and informal and formal support network)
	· Recommended at home activity: Review crisis plan with family/informal support network
8	· Identity work: Reincorporation of knowledge via creation of Collective Document
	· Update Tree of Life, if necessary
	· For home: Invite family members or close friends to next session(s)
9/10*	NOTE: Participants are encouraged to invite family members/close friends/other informal supports to the final session(s)
	· Brief overview of workshops, activities, and goals by facilitators
	· Identity work: Presentation of participants' Trees of Life, followed by Definitional Ceremony with their invited person
	· Presentation of Collective Document and list of anti-stigma strategies, created by participants
	· Hand out diplomas recognizing successful completion of workshop
	*This session can be combined or divided into two, depending on the number of participants and time available
Post (1 month)	Follow-up session to discuss changes the participants have noticed in their lives and how they have applied the workshop discussions and strategies when faced with challenges

fying triggers of past crises and early warning signs, and to propose an action plan for the participants, his or her family members, and informal (friends, neighbors) and formal (COSAM, hospital) supports, to prevent or quickly respond to crises.

The eighth session is the final Rites of Passage step – reincorporation. Participants create a Collective Document [31], to register the coping and anti-stigma strategies that they have identified and the knowledge they have gained about their strengths and supports. Each participant responds to a series of questions about an ability that has aided them in difficult times, to confront the effects of stigma; the story of how they learned and have used that ability; and how it is associated to a familial, community, or cultural tradition. This activity connects the users, and their strengths, to the larger community, thus supporting their reincorporation.

On the basis of the participants' responses, the facilitators create one group Collective Document, which is presented in sessions nine and ten to the participants' family members, friends, or significant others, who are invited by the participants to the final session(s) (depending on time and availability of guests, session nine and ten activities can be broken into two sessions or combined into one). The list of strategies the participants compiled in the previous sessions is also shared, and the participants present their Trees of Life to the invited guests, and the Definitional Ceremony narrative practice interaction is performed, with their personal guest. Certifications of successful completion of the workshop are ceremoniously handed out to each participant, in recognition of their involvement in and dedication to the pilot intervention.

One month after the final session(s) with invited guests, participants meet with the facilitators for a follow-up discussion, to share experiences and reflect on how the strategies and knowledge gained in the workshop have affected their handling of situations and any impact they may have noticed in their daily lives.

Assessment of Feasibility and Acceptability of Intervention

At the time of preparation of this article, the first group of participants had completed the intervention in Concon and Colina. Concon's group regularly had seven of nine enrolled participants attend the sessions, and in Colina, this figure was six of ten. Therefore, in total, there was a 68% rate of consistent attendance.

The workshop facilitators do not report any significant barriers associated with implementing the intervention, noting that the group modality aligns well with the usual service offerings, to which COSAM professionals and users are accustomed. The center administrators and staff also received the intervention and its implementation positively. Likewise, family members who attended the final session(s) valued the presented activities and spoke of being impacted by the changes they observed in the participants and their transformed narratives.

In terms of acceptability, workshop participants expressed enjoying the innovative modality of the intervention, which provided a space for discussion and reflection among users, not commonly seen in current mental health service offerings in Chile. They spoke positively of the Tree of Life activity; the focus on their experiences, strengths, and goals, to begin the workshop; and the use of the three video case vignettes, featuring a fellow mental health service user who attends a COSAM in Santiago.

Preliminary Evaluation of Intervention's Impact

At the one-month follow-up in-person session with the workshop facilitators, participants in the invention group reported increased confidence, improved communicative abilities, and strengthened connections with their COSAM. They also shared that they referred to the list of anti-stigma strategies for orientation during the interim period and reflected more actively on their treatment and recovery path. These qualitative results are awaiting corroboration via ongoing quantitative assessment between the two groups.

The participants wish to disseminate the list of anti-stigma and self-stigma strategies they devised, with the hope that they would be useful for other users, in their own recovery processes and daily lives, to confront the effects of stigma and prevent crises. Table 2 shares an excerpt of some of their proposed strategies (translated into English), categorized into "coping with others," or support network, strategies and "self-coping and resisting self-stigma" strategies.

The participants' strategies acknowledge their understanding of the importance of family, friends, and professional supports, and seeking help when needed; of pursuing various activities for their well-being, in order to not define themselves solely on the basis of their psychiatric diagnoses; and the real possibility of recovery. Participants expressed their desire that the strategies serve as a tool to reduce and resist the pervasive effects of discrimination, stigma, self-stigma, and crises, not only for their

Table 2: Participants' strategies for confronting effects of stigma and self-stigma and avoiding crises

Group	Strategies
	Coping with others
	1. Go to a person we trust for support, who knows how we feel and the importance of mental health. Put him or her on speed dial, so we can contact him/her quickly.
	2. Tell someone who can help you what you are feeling and thinking, receive their love, understanding, and hope.
	3. Surround ourselves with loved ones who give us strength
	4. Get support from the mental health teams. Make an appointment to tell them what is happening and they can help us. If the crisis is intense, someone will able to go with you to receive emergency services.
	5. Get to know and talk to other people who have overcome or live well with their illness: you can get better and be happy.
Concon	
	Self-coping and resisting self-stigma
	6. Try to relax and not focus too much on our minds or wind ourselves up into too many problems. Perhaps become involved in an activity that doesn't involve too much thinking. Write, go for a walk, read.
	7. Don't make the problems your entire life. Participate in other activities.
	8. The world is not going to end. Think that, after this, you will recover and carry on. Have faith. Many people have overcome crises and problems. Have patience.
	9. Be happy, do positive things for yourself and others. Work, save money if you can, focus on your family and/or significant other. Doing "normal" things makes us feel "normal."
Colina	**Coping with others**
	1. Seek help and support from individuals, such as friends, relatives, and significant others, and institutions, such as the COSAM, primary care, the hospital, and their respective professionals.
	2. Achieve a better quality of life not only for ourselves but also for our loved ones. It's important to think of others, as well.
	Self-coping and resisting self-stigma
	3. Take time to reflect and identify our strengths and weaknesses, to discover what "we are good at."
	4. Thinking positively, that we are "not defined by a diagnosis," that we are rational and emotional individuals. That we preserve. That we are strong.
	5. Believe that we are capable of overcoming obstacles, and become involved in activities and following our goals, take a chance
	6. If people don't contact us or keep their distance, we could contact them and make the effort to show that we are bigger than they think we are. We are more than X characteristic, which they stigmatize us for, and we have achieved many things in spite of X.
	7. Remember that the world is not between four walls, that we should not close ourselves in but leave, go outside to discover the world, step by step.
	8. Take faith in history of our peers (like the mental health service user from the vignette), who have overcome diversity.
	9. "If a door is closed, push it to force it open, or look for how to open a window, or if that's not possible, jump the fence" – in other words, look for alternatives and evaluate other ways to achieve our goals.

own use but also for other mental health service users in Chile and the Latin American region.

It is noteworthy that the first group of participants took the initiative to continue to meet together regularly, after the sessions ended, as a byproduct of having formed a bond during the workshop; users from one of the COSAMs (Concon) formed a book club in the center, and members of the other group (Colina) meet on a weekly basis to share their daily experiences and reflections and discuss peer support.

One suggestion shared by the participants in the follow-up session is to include more community-based activities as a part of the intervention, whereby users could test the created list of coping strategies by using them in different social situations and settings. Participants believed that through interacting with community members and discussing their experiences openly, they could demystify erroneous beliefs associated with users and mental illness, to directly tackle social stigma and their own associated self-stigma.

Discussion

This is the first evidence-based intervention to address self-stigma among outpatient mental health services users with severe mental illness in Chile, and the first published study to do so in the Latin

America region.

The first two objectives of this paper were to present the constructed intervention, and to evaluate its feasibility and acceptability. The development of the 10-session group workshop was informed by pertinent international literature, a focus group of users, and an expert panel, and the intervention was successfully implemented. Its innovative use of the narrative Tree of Life metaphor, Van Gennep's Rite of Passage, and other narrative techniques (Definitional Ceremony and Collective Document), paired with constructivist group psychoeducation, was positively evaluated by the participants, as well as by the intervention facilitators, COSAM administrators and professionals, and family members.

Furthermore, in terms of the third objective of this paper, to provide an initial report of the interventions' impact, preliminary indications are positive. The strategies devised by the study participants, and the qualitative changes observed by the workshop facilitators over the course of the sessions—in terms of participants' improved self-confidence, communicative abilities, and increased connection with the COSAMs, professionals, and fellow users—suggest that that the intervention may serve to effectively reduce stigma, within Chilean mental health service users, so that they may withstand and prevent the deleterious effects of social- and self-stigma. These conclusions will hopefully be confirmed by the RCT's quantitative results, when the follow-up analysis of the participants' treatment adherence and scores on the various instruments is complete.

The developed intervention has a number of strengths to highlight. Peer contact through the video vignette series with another Chilean mental health service user, sharing his experiences, was well received by the participants, who were inspired to form their own peer support groups. Future interventions should consider expanding the involvement of peers, to include a mental health service user who has previously participated in the intervention or served as a peer support worker, in some capacity, as another facilitator [39,40].

In addition, beginning the workshop sessions with the Tree of Life technique, so that participants identified strengths and resources and cultivated a more positive identify before using the "Storms of Life" metaphor to transition into a discussion of stigma associated with mental illness and strategies, framed by Van Gennep's "Externalization of Problems," "Internalization of Agency," and "Reincorporation" stages, was positively evaluated. The facilitators' supportive involvement and openness with their own experiences of "storms" encouraged users to contribute to group discussions.

The intervention also faced a few limitations in its pilot implementation. Low attendance to the intervention sessions, especially in one center (Colina), which traditionally has had low treatment adherence among its user population, was an obstacle, despite all participants prior to randomization confirming that they were available to join in weekly sessions in the center on an indicated DATE and time. Additionally, as participants had varied familial and support situations (with approximately half of the participants reporting not having family members involved in their treatment, or in their lives at all), it was difficult to regularly convene family members, apart from the final sessions.

The authors believe that the workshop has promise to be applied throughout Latin America. The intervention could be easily adapted to the unique context of other countries in the region and different service settings, guided by the Spanish-language intervention manual and handouts created by the authors (requests for the manual should be sent to contact author), since it requires few human and physical resources to be implemented. Nevertheless, facilitators should undergo a short training in narrative therapy and the Tree of Life technique and should have prior experience leading psychosocial groups, although specialized mental health professionals (psychiatrists or psychologists) are not necessarily required.

Conclusions

It was feasible to develop and pilot a psychosocial intervention in self-stigma for outpatient community mental heath services users in Chile with severe mental disorders. The constructed group workshop was positively accepted by the relevant stakeholders, including users, family members, center professionals and administrators, and facilitators. More over, the preliminary qualitative findings of the intervention are promising, with participants valuing the innovative approach and content of the sessions, and having reported using the anti-stigma strategies they created during the course of the workshop in their daily lives to counteract the negative effects of social- and self-stigma and possible prevent crises. Contingent on the quantitative results of the RCT, the intervention could be adapted and implemented throughout the Latin America region.

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References

1. Kessler RC, Aguilar-Gaxiola S, Alonso J, Chatterji S, Lee S, Ormel J, et al. The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. Epidemiol Psichiatr Soc. 2009;18(1):23–33.

2. Whiteford H, Degenhardt L, Murray CJL, Vos T, Lopez AD. Commentary: Improving the mental health and substance use estimates in the Global Burden of Disease study: strengthening the evidence base for public policy. Int J Epidemiol [Internet]. 2014 Apr [cited 2015 May 5];43(2):296–301. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24639446

3. Corrigan P, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can J Psychiatry. 2012;57(8):464–9.

4. Fung KMT, Tsang HWH, Chan F. Self-stigma, stages of change and psychosocial treatment adherence among Chinese people with schizophrenia: a path analysis. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2010 May [cited 2015 Apr 14];45(5):561–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19649752

5. Wahl OF. Stigma as a barrier to recovery from mental illness. Trends Cogn Sci [Internet]. 2012 Jan [cited 2015 Apr 20];16(1):9–10. Available from: http://linkinghub.elsevier.com/retrieve/pii/S136466131100235X

6. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, et al. What is the impact of mental health-realted stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015;45(1):11–27.

7. Acuña C, Bolis M, PAHO. Stigmatization and access to health care in Latin America: Challenges and perspectives. 2005.

8. Mascayano F, Schilling S, Tapia T, Lips W, Tapia E, Alvarado R, et al. Stigma toward mental illness in Latin America and the Caribbean: a systematic review. Rev Bras Psiquiatr. 2015;In press.

9. Saldivia S, Vicente B, Kohn R, Rioseco P, Torres S. Use of mental health services in Chile. Psych Serv. 2004;55(1):71–6.

10. Markkula N, Alvarado R, Minoletti A. Adherence to Guidelines and Treatment Compliance in the Chilean National Program for First-Episode Schizophrenia. Psych Serv. 2011;62(12):1463–9.

11. Killaspy H, Banerjee S, King M, Lloyd M. Prospective controlled study of psychiatric out-patient non-attendance. Br J Psychiatry. 2000;176:160–5.

12. González Uzcátegui R, Levav I. Reestructuración de la atención psiquiátrica: bases conceptuales y guías para su implementación. Washington, DC: Organizaión Panamericana de la Salud; 1991.

13. WHO. Mental Health Action Plan 2013-2020. 2013.

14. de Almedia J, Horvitz-Lennon M. An Overview of Mental Health Care Reforms in Latin America and the Caribbean. Psych Serv. 2010;61(3):218–21.

15. Department of Mental Health. MINSAL. Estrategia Nacional de Salud Mental: Un Salto Adelante. 2011.

16. Ritsher J, Otilingam P, Grajales M. Interalized stigma of mental illness: psychometric propertieis of a new measure. Psychiatry Res. 2003;121(1):31–49.

17. Peralta Martín V, Cuesta Zorita M. Validation of positive and negative symptom scale (PANSS) in a sample of Spanish schizophrenic patients. Actas Luso Esp Neurol Psiquiatr Cienc Afines. 1994;22(4):171–7.

18. Alvarado R, Muñoz K. Estudio psicométrico de Cuestionario Sevilla para valorar la calidad de vida en personas con trastornos mentales severos, en una muestra chilena. Rev Chil Neuro-Psiquiatr. 2006;44(4):249–57.

19. Alvarado ME, Garmendia ML, Acuña G, Santis R, *Arteaga O. Validez y confiabilidad de la versión chilena del Alcohol Use Disorders Identification Test (AUDIT). Rev Med Chile. 2009;137:1463–8.*

20. Mittal D, Sullivan G, Chekuri L, Allee E, Corrigan PW. Empirical Studies of Self-Stigma Reduction Strategies: A Critical Review of the Literature. Psych Serv [Internet]. 2012 Oct [cited 2015 Mar 11];63(10):974–81. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22855130

21. Shin S, Lukens E. Effets of psychoeducation for Korean Americas with chronic mental illness. Psych Serv. 2012;53:1125–31.

22. Lukens E, Thorning H. Psychoeducational Family Groups. In: Rubin A, Springer D, Trawver K, editors. Psychsocial Treatment of Psychizophrenia. Hoboken, New Jersey: John Wiley & Sons, Inc.; 2010. p. 89–144.

23. Phillips L, Schade D. Implementing Empowement Psychoeducation in a Psychosocial Rehabilitation Setting. Int J Psychosoc Rehabil. 2012;16(1):112–9.

24. Novak JD. Meaningful Learning : The Essential Factor for Conceptual Change in Limited or Inappropriate Propositional Hierarchies Leading to Empowerment of Learners. Kelly GJ, Mayer RE, editors. Sci Edu. 2002;86(4):548–71.

25. Yanos PT, Roe D, West ML, Smith SM, Lysaker PH. Group-based treatment for internalized stigma among persons with severe mental illness: findings from a randomized controlled trial. Psychol Serv [Internet]. 2012 Aug [cited 2015 Apr 21];9(3):248–58. Available from: http://www.pubmedcentral.nih.gov/articlerender.fcgi?arti

d=3413784&tool=pmcentrez&rendertype=abstract
26. White M. Re-Authoring Lives: Interviews and Essays. Adelaide: Dulwich Centre Publications; 1995.
27. White M, Epston D. Narrative Means to Therapeutic Ends. Adelaide: Dulwich Centre Publications; 1990.
28. Van Gennep A. The Rites of Passage. London: Routledge & Kegan Paul; 1960.
29. Tomm K. Externalizing the Problem and IInternalizing Personal Agency. J Strateg Syst Ther. 1989;8(1).
30. Ncube-mlilo N, Denborough D. Tree of Life. Randburg, South Africa; 2007.
31. Denborough D. Collective Narrative Practice: Responding to individuals, groups, and communities who have experienced trauma. Adelaide: Dulwich Centre Publications; 2008.
32. Yanos PT, Roe D, Lysaker P. Narrative Enhancement and Cognitive Therapy: A New Group-Based Treatment for Internalized Stigma among Persons with Severe Mental Illness. Int J Gr Psychother. 2011;61(4):576–95.
33. Vasconcelos E. Abordagens Psicossociais. Reforma Psiquiátrica e Saúde Mental na Ótica da Cultura e das Lutas Populares. II. São Paulo: Hucitec; 2008.
34. Tait L, Lester H. Encouraging user involvement in mental health services. Adv Psychiatr Treat. 2005;11:168–75.
35. Tansella M, Thornicroft G, Lempp H. Lessons from community mental health to drive implementation in health care systems for people with long-term conditions. Int J Env Res Public Heal [Internet]. 2014 May [cited 2015 Apr 20];11:4714–28. Available from: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4053874&tool=pmcentrez&rendertype=abstract
36. Araujo K, Martuccelli D. Beyond institutional individualism: Agentic individualism and the individuation process in Chilean society. Curr Sociol [Internet]. 2013;62(1):24–40. Available from: http://csi.sagepub.com/content/early/2013/11/26/0011392113512496\nhttp://csi.sagepub.com/content/early/2013/11/26/0011392113512496.abstract
37. Yang LH, Valencia E, Alvarado R, Link B, Huynh N, Nguyen K, et al. A theoretical and empirical framework for constructing culture-specific stigma instruments for Chile. Cad Saude Colet. 2013;21(1):71–9.
38. Pinto-Foltz M, Logsdon M, Myers J. Feasibility, acceptability, and initial efficacy of a knowledge-contact program to reduce mental illness stigma and improve mental health literacy in adolescents. Soc Sci Med. 2011;72(12):2011–9.
39. Stastny P. Introducing peer support work in Latin American mental health services. Cad Saude Colet. 2012;20(4):473–81.
40. Corrigan PW, Rafacz JD, Hautamaki J, Walton J, Rüsch N, Rao D, et al. Changing stigmatizing perceptions and recollections about mental illness: The effects of NAMI's in our own voice. Community Ment Heal J. 2010;46(5):517–22.