

**Implementation Adherence of a Therapy Group Addressing Internalized Stigma Among  
Psychiatric Outpatients**

by

Nikolaus Euwer

Under Supervision of

Kristen Rawlett

Second Reader

Carol Wade

A DNP Project Manuscript

Submitted in Partial Fulfillment of the Requirements for the

Doctor of Nursing Practice Degree

School of Nursing, University of Maryland at Baltimore

May 2024

Author Note

There are no conflicts of interest to report.

### Abstract

**Problem:** Stigma against mental illness brings with it many negative stereotypes that can be internalized by those who live with mental illnesses. The result is called “internalized stigma” or “self-stigma.” The implementation site for this Quality Improvement (QI) project was a 98-patient outpatient clinic providing treatment for schizophrenia-spectrum disorders. An early survey of patients at the site found that nearly half of the patients surveyed (46.94%) experience internalized stigma. There is currently no official treatment approach towards internalized stigma at this site. **Purpose:** The purpose of this QI project was the implementation of an evidence-based psychoeducational group therapy intervention for the treatment of internalized stigma amongst individuals living with mental illness. The intervention is titled “Ending Self-Stigma” and consists of nine manualized group sessions. **Methods:** The chosen framework for this QI project was the Promoting Action on Research Implementation in Health Services, or PARIHS model. Implementation included the administration of the nine manualized treatment sessions in addition to one introductory group session and a final feedback session. Attendance at each session as well as availability of each session were measured and analyzed using run charts. **Results:** Group availability throughout the project implementation period was 100%. Group attendance averaged 94.8%. Program feedback was positive, with participants overwhelmingly reporting enjoyment discussing their experiences with peers. **Conclusions:** The results show the feasibility and value of implementing this group at the site. High levels of attendance showed patient engagement, and feedback suggested high levels of enjoyment as well as relevance and benefits of the intervention.

*Keywords:* mental health, schizophrenia, stigma, self-stigma, internalized stigma, psychoeducation, group therapy

## **Implementation Adherence of a Therapy Group Addressing Internalized Stigma Among Psychiatric Outpatients**

Stereotypes about the mentally ill exist, and one of many unfortunate side-effects of this stigma is that the stereotypes can be internalized by those who live with mental illnesses. This stigma is called “internalized stigma” or “self-stigma.” The Social Cognitive Model of Stigma posits that internalization occurs when individuals become aware of stereotypes, subconsciously agree with those stereotypes, and then apply the resulting prejudice to themselves (see Figure 1) (Catalano et al., 2021). Statistics on the prevalence of self-stigma among mentally ill individuals vary. While there are no official figures, West et al. (2011) found a prevalence around 36% for those living with severe mental illnesses (p. 5), with Gonzalez-Sanguino et al. (2022) citing a figure of 41.7% and other researchers finding prevalence of internalized stigma as high as 54.4% among those living with mental illness (Maharjan & Panthee, 2019).

The clinical site for this Quality Improvement (QI) project was a 98-patient outpatient clinic providing treatment for psychotic disorders exclusively, many of them treatment-resistant. A preliminary survey of patients, conducted using the ISMI (Internalized Stigma of Mental Illness Inventory), found that nearly half of the patients surveyed (46.94%) experienced internalized stigma. Approximately 22.45% were found to experience moderate to severe internalized stigma (a Root-Cause Analysis can be found in Appendix A). It is important to note that internalized stigma increases according to the severity of psychiatric symptoms and is negatively associated with treatment adherence (Livingston & Boyd, 2010, p. 2157). There is also an association between internalized stigma and poorer recovery attitudes and recovery-related outcomes such as hope, self-esteem, self-efficacy, and quality of life (Catalano et al., 2021). The purpose of this project was to address the prevalence of internalized stigma at the

site. This purpose was accomplished through the implementation of an evidence-based therapy group designed to treat internalized stigma amongst individuals with mental illness.

### **Available Knowledge**

The existing evidence supports psychotherapy interventions (Alonso et al., 2019), mainly of the group therapy modality, to address patients' thinking and processing regarding their diagnoses and related stigmatizing beliefs and attitudes. A particularly well-researched group therapy intervention is titled "Ending Self-Stigma" (ESS) and was developed by Dr. Alicia Lucksted of the University of Maryland School of Medicine (Lucksted et al., 2016).

There were 6 relevant experimental studies on ESS in the literature that demonstrated efficacy in reducing internalized stigma. Lucksted et al. (2011) was a level 2 pilot evaluation of ESS that demonstrated the efficacy of the intervention. Lucksted et al. (2017) was a high-quality level 1 study using a randomized controlled design that showed the efficacy of the intervention. Alonso et al. (2019) was a good quality level 2 systematic review of interventions addressing internalized stigma that showed ESS to have strong evidence and demonstrated efficacy compared to other interventions. Harding (2019) conducted a low-quality mixed methods pre and post-test design study that demonstrated the efficacy of ESS conducted in an online learning format. Drapalski et al. (2021a) conducted a good quality level 1 randomized controlled trial showing the efficacy of ESS, though in this study the control group also showed improvements. Drapalski et al. (2021b) conducted a good quality level 1 randomized controlled trial of a modified ESS intervention (ESS-P) that showed the efficacy of the intervention as well. See Appendices B and C for more information on these studies.

### **Rationale**

The chosen framework for this QI project was the PARIHS (Promoting Action on Research Implementation in Health Services) framework (White et al., 2021). PARIHS was chosen for its applicability to this particular QI project. The framework consists of three components: evidence, context, and facilitation (White et al., 2021). See Appendix D for more information.

The research evidence for this implementation project has been discussed and is sufficient for conducting a QI initiative using the “Ending Self-Stigma” manualized group. The impetus for pursuing this intervention was initially due to clinical experience at the site, with staff discussing a need for an evidence-based treatment to address internalized stigma amongst their patients. Patients at this site had discussed their experiences of stigma and internalized stigma with their therapists, showing that patient preferences also suggested an initiative addressing this clinical problem.

White et al. (2021) described the “context” component as “the quality of the context” (p. 46). The organizational culture was generally supportive and devoted to the needs of the special population that they served, namely those with schizophrenia-spectrum disorders. The site was also a university-affiliated clinic devoted to research, so implementation of new initiatives was well within their purview. The leadership at the clinic had expressed support for this initiative, with the Medical Director agreeing to help facilitate Ending Self-Stigma groups.

The “facilitation” component of the PARIHS model was described by White et al. (2021) as “the type of facilitation needed to ensure a successful change process” (p. 46). Not only was the site committed to addressing internalized stigma, the site was also committed to facilitating these manualized groups. External facilitators included the support and direction of the developer

of ESS, Dr Alicia Lucksted, who is a researcher at the University of Maryland School of Medicine.

### **Specific Aims**

The purpose of this QI project was to implement ESS at the clinical site. The process goal was implementation of the weekly group sessions, measured as group availability. The outcome goal was attendance, with a target of 100% attendance for all sessions.

### **Methods**

#### **Context**

The staff at the clinical site for this QI project had expressed an explicit interest in addressing internalized stigma and had shown a measured need through administration of internalized stigma questionnaires. Individuals living with severe mental illnesses tend to have the highest levels of internalized stigma. The treatment population at this clinic consisted of individuals living with psychosis and, in many cases, treatment resistant psychosis. There were approximately 98 patients at the clinic and 11 existing therapy groups. The structures and processes at the clinic were well-positioned to facilitate an additional therapeutic group. There was buy-in from the Medical Director and Sponsor and the therapy team. Rooms in the facility are designated for group therapy sessions and there was an established practice of telehealth therapy sessions being held on the Zoom platform. The site also had an established practice of providing transportation to patients if needed, as well as appointment reminders facilitated by the unit secretary. See Appendices E and F for more information on current processes and desired processes.

## **Intervention**

The ESS intervention was developed by Dr Alicia Lucksted at the University of Maryland School of Medicine (Lucksted et al., 2016). ESS is currently a manualized intervention available for download through the Department of Veteran's Affairs website. ESS consists of 9 separate group therapy sessions, each described in detail in the manual. Group sizes for the intervention are intended to be approximately four to eight individuals. Each session consists of a topic of focus in addition to discussion, review of handouts or previous sessions where applicable, and distribution of handouts and homework. Groups were led by the author of this manuscript and co-led by the Clinical Site Representative. There were 9 ESS sessions in addition to a preliminary "meet and greet" session and a post-intervention feedback session (see Appendix H for session outline).

Strategies for implementation include accountability, buy-in, collaboration, communication, changes in structures, data, and education. Accountability was maintained through formal commitments by the site to host the weekly groups. Buy-in was achieved through presentation of the project plan to the clinical team at the site. Collaboration and communication were constant, with planning coordinated by the author and CSR each week in addition to weekly updates provided to the clinical team at the site. The change in structure was the addition of the ESS group each week. Data was collected over 11 points, one point for each session, and education was ongoing through sharing of attendance, group availability, and barrier information with the clinical team each week.

The schedule for the group included a September 12<sup>th</sup> start date and a November 21<sup>st</sup> finish. The team included the CSR, who was a therapist at the clinic, in addition to the Sponsor,

who was the Medical Director of the clinic. The team included the unit secretary and the therapist team. The patients included in the group were chosen due to their previously measured internalized stigma scores as well as therapist referrals. The intervention was made available to seven individuals from the clinic who chose to participate. See Appendix G for further information on the project timeline.

### **Measures / Study of the Intervention**

Data collected during this project included a process goal of group availability, measured as availability of a session each week out of how many groups were scheduled for that week. The outcome goal of attendance was measured as how many participants, out of the seven enrolled in the group, attended the group for each session. The goal was 100% group availability each week (for every scheduled group, there was a group that took place) and 100% attendance each week (seven out of seven participants coming to each group session). These measurements were not validated through formal research, though they did provide a view of interest, commitment, and efficacy of the QI project. The data provided information on the sustainability of the initiative at the site in the future. After each group, attendance data was entered into RedCap based on the author and CSR's knowledge of the participants and their attendance. The last session included a chance for participants to give feedback on their experience of the group.

### **Ethical Considerations**

This QI project was approved as non-human subjects research by the University of Maryland Institutional Review Board. There was no additional review needed by the clinic site. Each session was held in a private group room at the clinic and attendance information was



entered in private onto the RedCap database following each group. The ESS therapy group was voluntary and held in a private location on-site at the clinic.

### **Results**

Implementation showed consistency in availability of the group each week. There were initial barriers including locating a permanent room for the group, as the location was initially not reserved. Lack of a reserved room led to some confusion over rights to the room amongst staff at the clinic. Confusion over group location was easily remedied by discussion with the unit secretary, which led to reservation of the room for the remainder of the sessions as well as posting of a schedule of use for the group on the room's door. The group had 100% availability each week, showing that the day of each session and group room were appropriately chosen and that the facilitators were committed and available for each session. There were no shifts, runs or trends in the data when looking at the group availability run chart. The goal for group availability, however, was met for each session.

Seven participants were recruited for the ESS group, including five males and two females. There were no shifts, runs or trends in the run charts of group attendance data. The attendance goal, however, was very nearly met with an average of 94.8% attendance over 11 weeks. The data points that deviated from the median, at sessions four, seven, ten, and eleven, each represented one missing participant for those sessions. In each of these cases, the participant had an obligation or engagement that they could not miss (taking care of siblings or medical appointments, for example). Feedback throughout implementation was overwhelmingly positive. One provider who had been treating one of the participants mentioned how his mood had shifted

overwhelmingly in a positive direction since starting the group. This individual had also been reluctant to join groups in the past.

Most participants chose the group out of “curiosity,” with two members having never been in group therapy before and two saying they had experienced stigma before and were curious about the group. Members mentioned throughout the sessions that they enjoyed connecting with others over struggles regarding internalized and public stigma. Members also mentioned that discussing these topics with individuals having similar diagnoses was also meaningful. Participation lagged at times in earlier sessions, but observation by the project lead and CSR verified an increase in participation in later sessions. Several participants noted feeling disappointed to end the group as the final weeks neared. Feedback received in the final feedback session was overwhelmingly positive. The primary statement from participants was that it was incredibly meaningful to be in a group of peers, and that sharing and discussing their experiences of stigma and internalized stigma with each other was healing and productive.

While it is difficult to pinpoint causation in the data, the engagement in and commitment to the weekly meetings showed a high level of success. The clinical team at the site noted how attendance for the group was quite high compared to usual group attendance. Positive feedback, productive in-group discussions increasing over time, and high levels of attendance point to the success of the intervention and the sustainability of conducting this intervention in the future at the site. Availability of the group was made reliable through commitment by the clinic as well as reservation of a dedicated group room. Attendance was likely bolstered by patient interest and by the interpersonal connection that makes group interventions the preferred modality for treatment of internalized stigma.

See Appendices I through L for more information on results.

### **Discussion**

This Quality Improvement project shows the feasibility of conducting a group therapy intervention targeting internalized stigma at this site. Group availability each week reached the goal of 100%, with all scheduled groups taking place. All required elements for the process goal of making an ESS group available each week were reliable and at-hand. Budgeting concerns for implementation of a weekly ESS group were minimal and the project was able to move forward with no changes in budget at the site. The main concerns for ESS group availability are the need for a dedicated group therapy room as well as facilitators for the group. The site has four full-time therapists, one of whom was a co-facilitator of this ESS group in addition to the project lead and manuscript author.

Group attendance was very close to the goal of 100%. Such a high level of attendance, week after week, shows engagement and commitment by participants. The final feedback session also provided evidence that the group was well-received and relevant to the needs and concerns of participants. Alonso et al. (2019) found that group therapy interventions addressing internalized stigma tended to be the most effective, which is in line with the patient feedback received during this QI project. That is, connection and processing with peers was the primary feedback received in the final feedback session. In the research on ESS, group attendance was often a concern among the studied populations of individuals living with mental illness. For example, Lucksted et al. (2017) found that only 43% of participants attended between seven and nine sessions. Drapalski et al. (2021a) reported that only 48% of participants attended five or more sessions. In this QI project, attendance was not a concern. Therapists at the site mentioned

that attendance for the ESS group was quite high, to the extent of being somewhat out of the ordinary. The fact that attendance was not 100% is due to four absences over eleven weeks that were accounted for by illness or prior obligations.

There is currently interest in conducting the group from other members of the behavioral health campus to which the project site belongs. Dissemination of the project findings will include dissemination to this neighboring clinical site with the hopeful adoption of ESS for their treatment population.

The primary limitation of this project was the fact that group times were limited to sixty minutes. While the ESS manual specifies group times of ninety minutes, the project site team did not find it feasible to conduct a ninety-minute group for their patient population. The plan for a sixty-minute group was relayed to the developer of ESS, who stated that the group could be accomplished in sixty minutes and that this limitation should simply be stated when reporting results of the project. Reducing the length of the sessions came with a certain amount of extra planning, though the two group facilitators were able to fit the curricular elements of the manual into the allotted sixty-minute group time.

### **Conclusion**

This project represents an important step towards addressing internalized stigma in the treatment of mental illness. Interventions geared towards treatment of internalized stigma are rare, and their use even more so. ESS represents the most evidence-based intervention for addressing internalized stigma, and its implementation for this QI project is a step in the right direction. Internalized stigma itself is not rare and general data on its prevalence amongst the

mentally ill, as well as local data collected at the project site, show that it is a disruptive element in the treatment of, and recovery from, mental illness. Successful implementation of ESS at a clinic that treats arguably the most stigmatized category of mental illness shows that it is and should be feasible on a larger scale. While this QI project is not research, there is potential for spread of this intervention at the current project site as well as a local and affiliated site.

Due to this project's Quality Improvement background, there was a notably human element in the data collected. While one cannot say from the collected data whether the participants' levels of internalized stigma changed by the end of the intervention, one can say that they were committed to attending the group and found it relevant and meaningful. Especially when one considers the highly stigmatized nature of Schizophrenia-spectrum disorders and their place in society, tailoring interventions to the needs and mental well-being of patients with these disorders becomes clear. This project was able to address a very real and impactful clinical problem and found positive and encouraging results.

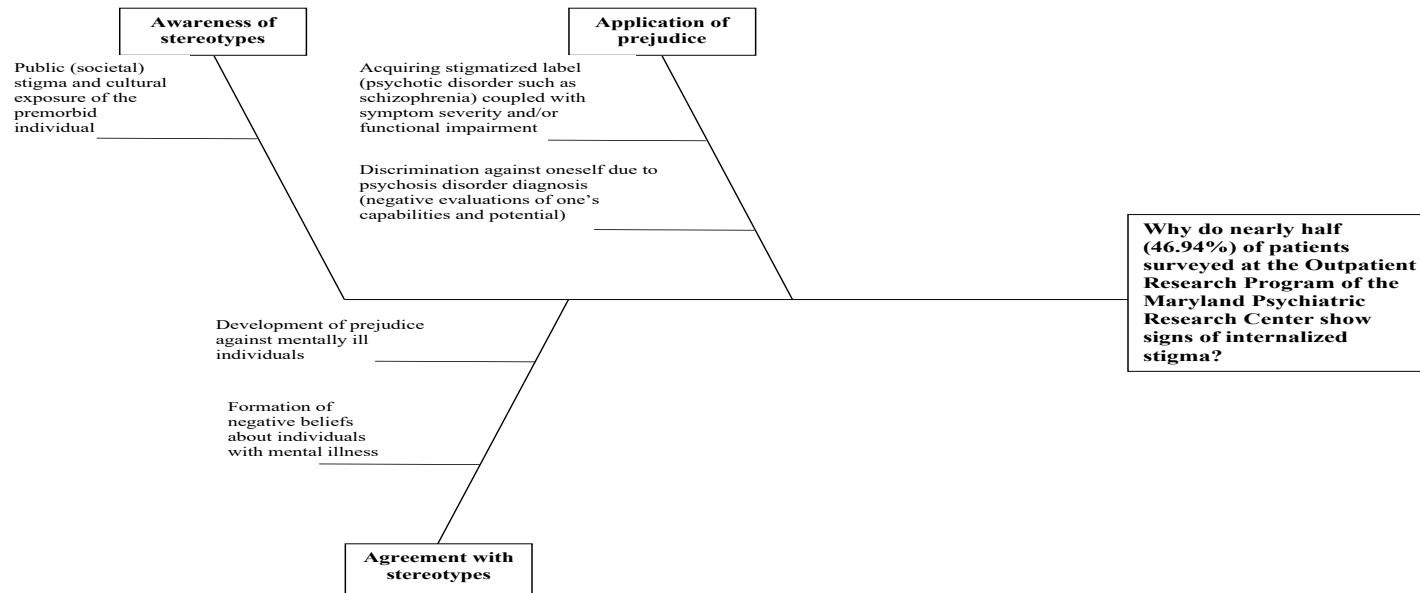
### References

- Alonso, M., Guillén, A., & Muñoz, M. (2019). Interventions to reduce internalized stigma in individuals with mental illness: A systematic review. *The Spanish Journal of Psychology*, 22. <https://doi.org/10.1017/sjp.2019.9>
- Catalano, L. T., Brown, C. H., Lucksted, A., Hack, S. M., & Drapalski, A. L. (2021). Support for the social-cognitive model of internalized stigma in serious mental illness. *Journal of Psychiatric Research*, 137, 41–47. <https://doi.org/10.1016/j.jpsychires.2021.02.014>
- Drapalski, A. L., Aakre, J., Brown, C. H., Romero, E., & Lucksted, A. (2021b). The ending self-stigma for posttraumatic stress disorder (ess-p) program: Results of a pilot randomized trial. *Journal of Traumatic Stress*, 34(1), 69–80. <https://doi.org/10.1002/jts.22593>
- Drapalski, A. L., Lucksted, A., Brown, C. H., & Fang, L. (2021a). Outcomes of ending self-stigma, a group intervention to reduce internalized stigma, among individuals with serious mental illness. *Psychiatric Services*, 72(2), 136–142. <https://doi.org/10.1176/appi.ps.201900296>
- González-Sanguino, C., González-Domínguez, S., Castellanos, M. A., & Muñoz, M. (2022). Mental illness stigma. a comparative cross-sectional study of social stigma, internalized stigma and self-esteem. *Clínica y Salud*, 33(2), 59–64. <https://doi.org/10.5093/clysa2021a16>
- Harding, S. (2019). *A web-based learning adaptation of the Ending Self-Stigma (ESS) program* [Doctoral Thesis]. Proquest. Available at <https://sigma.nursingrepository.org/bitstream/handle/10755/21937/Dissertation.pdf?sequence=1&isAllowed=y>

- Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150–2161. <https://doi.org/10.1016/j.socscimed.2010.09.030>
- Lucksted, A., Drapalski, A., Calmes, C., Forbes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal*, *35*(1), 51–54. <https://doi.org/10.2975/35.1.2011.51.54>
- Lucksted, A., PhD, Drapalski, A., PhD, Boyd, J., PhD, DeForge, B., PhD, Calmes, C., PhD, Goldberg, R., PhD, Murray-Swank, A., PhD, Forbes, C., PhD, Aakre, J., PhD, & Wilson, C., MA. (2016). *Ending Self-Stigma* (ESS Manual: April 2016 Edition) [Manual].
- Lucksted, A., Drapalski, A. L., Brown, C. H., Wilson, C., Charlotte, M., Mullane, A., & Fang, L. (2017). Outcomes of a psychoeducational intervention to reduce internalized stigma among psychosocial rehabilitation clients. *Psychiatric Services*, *68*(4), 360–367. <https://doi.org/10.1176/appi.ps.201600037>
- Maharjan, S., Panthee, B. Prevalence of self-stigma and its association with self-esteem among psychiatric patients in a Nepalese teaching hospital: a cross-sectional study. *BMC Psychiatry* *19*, 347 (2019). <https://doi.org/10.1186/s12888-019-2344-8>
- West, M. L., Yanos, P. T., Smith, S. M., Roe, D., & Lysaker, P. H. (2011). Prevalence of internalized stigma among persons with severe mental illness. *Stigma Research and Action*, *1*(1). <https://doi.org/10.5463/sra.v1i1.9>
- White, K. M., Dudley-Brown, S., & Terhaar, M. F. (2021). *Translation of evidence into nursing and healthcare* (3rd ed.). Springer Publishing Compan

Appendix A

Root Cause Analysis of Internalized Stigma at Project Site



Note. Fishbone diagram showing hypothesized social-cognitive process at intervention site.



## Appendix B

## Evidence Appraisal Table

	Study Purpose	Design	Sample	Intervention	Outcomes/Results	JHU Level and Grade
Lucksted et al., 2011 <a href="#">Hyperlink</a>	Pilot evaluation of Ending Self-Stigma (ESS)	Pre and post-test quasi-experimental design	34 outpatient psychiatric clients at VA health centers in Baltimore and San Francisco, recruited through convenience sampling (flyers). Inclusion criteria of self-reported diagnosis of schizophrenia, schizoaffective disorder, or major mood disorder; minimum one year of outpatient mental health care; willingness to attend all ESS classes and meetings. Participants were mostly male (97.1%) and black (58.8%).	9 weekly 90-minute sessions of Ending Self-Stigma (ESS) group therapy, consisting of lecture, group discussion, discussing personal experiences, teaching and utilization of skills, support, and problem-solving.	Statistically significant decrease in internalized stigma among participants as measured by ISMI (Internalized Stigma of Mental Illness scale). At post-test, 32% of patients experienced significant internal stigma (ISMI score of 2.5 and above) compared to 47% at baseline. Paired sample t-tests were used for statistical analysis and results showed moderate effect size (Cohen's $d$ of .57-.55).  Secondary measures included recovery orientation and perceived social support which both increased as well.	Level 2, good quality
Lucksted et al., 2017	Randomized controlled trial of	Randomized controlled trial; sample randomly	268 participants from five Maryland psychosocial	9 weekly sessions of manualized Ending Self-Stigma	Measures of internalized stigma were analyzed using	Level 1, high quality

<p><a href="#">Hyperlink</a></p>	<p>Ending Self-Stigma (ESS)</p>	<p>assigned to either intervention group or “minimally enhanced treatment as usual” group.</p> <p>Assessments were taken at baseline, posttreatment (three months after baseline) and at follow-up (at six months posttreatment).</p>	<p>rehabilitation programs serving severely mentally ill adults. Diagnoses of patients at this site included schizophrenia, bipolar disorder, recurrent major depressive disorder, schizotypal personality disorder, borderline personality disorder, or delusional or psychotic disorder with functional impairments.</p> <p>Eligibility criteria included 18 to 90 years of age, receiving services at the sites, able to give full informed consent, and willing to attend intervention groups.</p> <p>The only exclusion criterion was severe or profound mental retardation.</p> <p>Sampling techniques consisted of recruitment through flyers,</p>	<p>(ESS) group therapy vs. a control group of “minimally enhanced treatment as usual”</p> <p>The treatment group was conducted by two master’s level therapists who attended a full day of training in the intervention led by the principal investigator. Sessions were chosen randomly to be rated using process and content scales to determine fidelity.</p>	<p>a repeated-measures mixed model using data from three time points (baseline, post-treatment, and follow-up).</p> <p>The intervention group showed statistically significant decreases in elements of internalized stigma measured by SSMIS (Self-Stigma of Mental Illness Scale) and ISMI (Internalized Stigma of Mental Illness) scales. These elements included “stereotype agreement” (effect size = -.31) and “self-concurrence” (effect size = -.30) on the SSMIS and “alienation” (effect size = -.19) and “stigma resistance” (effect size = -.27) on the ISMI.</p> <p>On the SSMIS participants did not show statistically significant improvements on</p>	
----------------------------------	---------------------------------	---	---	--	---	--

			<p>announcements, and clinician recommendations.</p> <p>The largest demographic groups were male (61%) and African American (47%) with a most common diagnosis of schizophrenia (31%).</p>		<p>certain subscales, namely awareness or self-esteem decrement. On the ISMI-29 participants did not show improvement on stereotype endorsement, discrimination, and social withdrawal or on the total score. While no significant differences in the ESS group remained at six-month follow-up, improvements made by ESS participants between baseline and post-intervention on key subscales (stereotype agreement on the SSMIS, alienation on the ISMI-29, and stigma resistance on the ISMI-29) remained.</p> <p>There was a statistically significant improvement in “recovery orientation” between the intervention and control groups.</p>	
--	--	--	--	--	---	--

					<p>Importantly, it was noted that attendance in ESS groups was associated with subscales of Self-Stigma that showed improvement. Only 43% of the intervention sample attended 7 or more of the 9 sessions.</p>	
<p>Alonso et al., 2019</p> <p><a href="#">Hyperlink</a></p>	<p>Systematic review of current studies on interventions to reduce internalized stigma</p>	<p>Systematic review</p>	<p>Inclusion criteria: application of a specific intervention to reduce internalized stigma amongst those with mental illnesses; presence of a control group; existence of at least two points of measurement (pre and post treatment); publish date between 2008 and 2018; being published in scientific journals in English or Spanish.</p>	<p>Interventions were divided into several categories: psychoeducational interventions (ie, Ending Self-Stigma or ESS); cognitive-behavioral interventions addressing self-stigmatizing beliefs; interventions concerning the topic of disclosure of illness status; and interventions that combine the above categories.</p>	<p>Lucksted et al.'s (2017) study was noted to be in the highest quality category of all studies, with a methodological quality score of 5 out of 6. It was also noted to be one of the most detailed of all studies and had the largest sample of any study reviewed.</p> <p>Psychoeducational interventions (including Ending Self-Stigma) were noted to be the most well-studied with demonstrated significant results on internalized stigma.</p>	<p>Level 2, high quality</p>

					<p>Importantly, subjective appraisal of recovery improved in all studies in which it was measured, regardless of the type of intervention applied.</p> <p>It was noted that individual interventions (those not delivered in group format) did not show any significant results regarding levels of internalized stigma.</p> <p>In general, this study showed that patients showed improvements in important areas of measured self-stigma following the intervention.</p>	
<p>Harding, 2019</p> <p><a href="#">Hyperlink</a></p>	<p>Testing a web-based delivery format of Ending Self-Stigma (ESS)</p>	<p>Mixed methods, pre and post-test design</p>	<p>32 individuals were enrolled in the study and 18 completed the intervention and post test.</p> <p>Individuals were recruited using flyers in the Behavioral Health waiting area of a</p>	<p>A web-adapted ESS intervention presented as 6 self-study learning modules.</p>	<p>Statistically significant reduction in self-stigma as measured by the SSMIS-SF (Self-Stigma of Mental Illness Scale – Short Form). This was measured using a two-tailed Wilcoxon signed rank test. Recovery</p>	<p>Level 2, low quality</p>

			<p>large, multi-specialty outpatient medical group setting. Inclusion criteria were: at least 18 years of age; diagnosed mental illness by self-report; ability to read and write in English.</p> <p>Most participants were white (72%) and female (55.6%). The most common primary diagnosis was that of anxiety (27.8%).</p>		<p>orientation was also measured and did not show a significant improvement.</p> <p>Qualitative questions were included in the modules as to the perceived benefits of the modules. Themes included “simple and useful ways of thinking about mental health and self,” “review of prior learning experiences,” “site appearance and navigation,” “self-help,” “effects of social or public stigma,” “coping requires ongoing effort,” “hope and treatment as parts of recovery,” and “recovery as a process.”</p>	
<p>Drapalski et al., 2021a</p> <p><a href="#">Hyperlink</a></p>	<p>Randomized controlled trial of Ending Self-Stigma (ESS)</p>	<p>Randomized controlled trial comparing intervention group (Ending Self-Stigma) with a control (Health and Wellness) group</p>	<p>249 veterans recruited from outpatient mental health programs at three U.S. Department of Veterans Affairs medical centers in the VA Capitol</p>	<p>9 weekly sessions of manualized Ending Self-Stigma group therapy vs. a control “Health and Wellness” group.</p> <p>The “Health and Wellness” group</p>	<p>This study used a repeated measures, mixed-effects model to study changes to measured scales between both groups.</p>	<p>Level 1, good quality</p>

			<p>Health Care Integrated Service Network. Eligibility criteria included ages 18-80; a charted diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depression with psychotic features; and receiving mental health services through the VA.</p> <p>Exclusion criteria included severe or profound intellectual disability and previous participation in ESS.</p> <p>Sampling was accomplished through clinician referrals, review of clinic rosters, and flyers distributed for recruitment.</p> <p>Most participants were male (87%) and had a diagnosis of bipolar disorder (42%).</p>	<p>was an education and support group oriented around physical health and well-being. Like ESS, these were once-weekly sessions. Length of sessions was approximately 75-90 minutes and the groups covered topics such as physical activity, diet, sleep, relaxation techniques, substance use issues, and medication.</p> <p>Twenty sessions from each group (intervention and control) were rated by independent reviewers for fidelity. Both conditions achieved high ratings during review.</p>	<p>Both the intervention and control groups showed reductions on the ISMI total score and the “agreement” and “harm to self-esteem” scales of the SSMIS.</p> <p>Importantly, exploratory analysis showed that high psychosis symptoms in the Ending Self-Stigma group modified the treatment effect. In other words, those with high baseline psychosis symptoms experienced a greater reduction in the ISMI score from baseline to posttreatment in the ESS group than participants in the Health and Wellness group.</p> <p>There were no significant effects on recovery orientation.</p> <p>Generally, both groups showed</p>	
--	--	--	---	---	---	--

			Only 48% of participants attended five or more sessions.		<p>significant reductions in self-stigma and increases in measured sense of belonging.</p> <p>There might have been a confounding effect of discussion of self-stigma in the Health and Wellness Group. In addition, participants only attended approximately half of the groups.</p>	
<p>Drapalski et al., 2021b</p> <p><a href="#">Hyperlink</a></p>	<p>Pilot randomized trial of “Ending Self-Stigma” adapted for PTSD (ESS-P).</p>	<p>Randomized controlled trial with intervention group (ESS-P) and control group (enhanced treatment as usual)</p>	<p>57 participants recruited from outpatient trauma and mental health clinics and programs at the Baltimore VA Medical Center. Eligibility criteria included: 18-70 years of age; charted diagnosis of PTSD; currently receiving outpatient mental health treatment at study site.</p> <p>Of note: exclusion criteria included diagnoses of schizophrenia,</p>	<p>9 weekly sessions of ESS-P treatment vs control condition of enhanced treatment as usual.</p> <p>ESS-P is a nine session group therapy treatment with a similar curriculum to ESS. Each session was conducted by a psychiatric registered nurse.</p> <p>The control condition consisted of treatment as usual in addition to a brief (10-15 minute) review of</p>	<p>Significant decrease in ratings of self-stigma (using the ISMI or Internalized Stigma of Mental Illness scale) in ESS-P group compared to controls. Cohen’s d was -0.77, indicating a moderate effect size.</p> <p>A linear mixed-model with random intercept was used in comparing ISMI scores between the intervention and control groups.</p>	<p>Level 1, good quality</p>



			<p>schizoaffective disorder, bipolar disorder, or major depression with psychotic features.</p> <p>Participants were selected through clinician referrals, review of clinic rosters, recruitment flyers, and through presentations held during meetings at the clinics and programs.</p> <p>Most participants were male (94.7%) and black (49.1%).</p>	<p>information on social and internalized stigma provided by a trained research assistant.</p> <p>Four sessions of ESS-P were randomly selected to be rated for fidelity by primary researchers.</p>	<p>No significant change in recovery orientation.</p>	
--	--	--	--	--	---	--

*Note.* “Recovery orientation” as mentioned is a measure of patients’ subjective appraisal of their own recovery; in most studies it has been measured using the Maryland Assessment of Recovery in People with Serious Mental Illness (MARS) scale. This was a secondary measure in these studies. Internalized stigma in these studies was measured using the ISMI and the SSMIS. The Internalized Stigma of Mental Illness scale (ISMI) is a measure of internalized stigma with five subscales, including alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. The Self-Stigma of Mental Illness Scale (SSMIS) is a measure with four subscales including stereotype awareness, stereotype agreement, self-concurrence, and self-esteem decrement.

**Appendix C**

**Evidence Synthesis Table**

Project Title: Implementation of “Ending Self-Stigma” (ESS) to Decrease Internalized Stigma Among Psychiatric Outpatients			
JHNEBP Model Level	Total Number of Sources	Author and Quality Rating of each study	Synthesis of Findings
<p><b>Level 1</b>                      Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis</p>	3	<p>Lucksted et al., 2017 (good but conflicting evidence)</p> <p>Drapalski et al., 2021a (good but conflicting evidence)</p> <p>Drapalski et al., 2021b (good and consistent evidence)</p>	<p>All three studies showed decreases in measures of internalized stigma following the ESS intervention. In addition, all three studies mention subjective enjoyment of the intervention by participants, though this is not quantitatively measured.</p> <p>Lucksted et al. (2017) showed some variation in effects on subscales of instruments used; some subscales improved following the intervention, others did not. In this study there was an association between number of groups attended and the subscales which did improve. Only 43% of the intervention sample attended 7 or more of the 9 groups, so attendance had a likely effect on the results.</p> <p>Drapalski et al. (2021a) showed improvement in measures of internalized stigma, though this was seen in both the intervention and control groups. There was a possible confounding effect due to the control (“Health and Wellness”) group discussing aspects of internalized stigma during their sessions. Unlike other studies on ESS, this was not a “treatment as usual” control group. Importantly, exploratory analysis showed that high psychosis symptoms in the Ending Self-Stigma group modified the treatment effect. In other words, those with high baseline psychosis symptoms experienced a greater reduction in the ISMI score from baseline to posttreatment in the ESS group than participants in the Health and Wellness group.</p>

			<p>Drapalski et al. (2021b) showed statistically significant improvements in ratings of internalized stigma. This was the most clear-cut of these studies, though applied to a slightly different population (individuals with PTSD). Nonetheless, this represents a group therapy intervention targeting a stigmatized mental illness.</p>
<p><b>Level II</b>                  Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis</p>	<p>3</p>	<p>Lucksted et al., 2011 (good and consistent evidence)                  Alonso et al., 2019 (good and consistent evidence)                  Harding, 2019 (good and consistent evidence but with small sample)</p>	<p>All three sources demonstrated evidence in favor of ESS and its effects on internalized stigma. In addition, all three studies mention subjective enjoyment of the intervention by participants, though this was not quantitatively measured.</p> <p>Lucksted et al. (2011) was a pilot study of ESS, though it did show statistically significant reductions in internalized stigma and improvements in recovery orientation (though this is a secondary measure).</p> <p>Alonso et al. (2019) provided a systematic review of current evidence on interventions targeting internalized stigma. Lucksted et al.'s (2017) study was noted as having the largest sample of any study to date as well as a high level of methodological quality. Alonso et al. (2019) also mention that the psychoeducational interventions (such as ESS) are generally the most researched and demonstrate significant effects on internalized stigma. Alonso et al. (2019) also note that subjective appraisal of recovery improved in all studies in which it was studied, showing the subjectively beneficial effect of targeting internalized stigma for patients. This comes with the caveat that individual therapy interventions for self-stigma were shown to be ineffective compared to those that had a group format. Group formats, it seems, likely add the beneficial effects of camaraderie and support.</p>

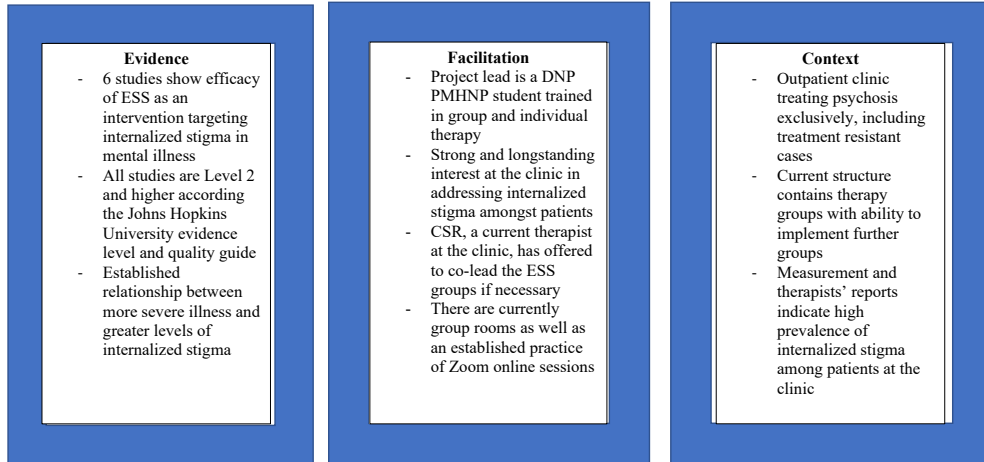
			Harding (2019) described a web-learning adaptation of ESS and described a statistically significant decrease in internalized stigma, though with a small sample. This is a doctoral dissertation but is included in level 2 due to its quasi-experimental pre and post-test measurement. This also demonstrated an attempt to increase attendance in sessions as prior studies had demonstrated difficulty in maintaining patients for all 9 sessions of the ESS group intervention.
<b>Level III</b> Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis			
<b>Level IV</b> Opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence			
<b>Level V</b> Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence			
<b>Overall Quality Rating w/rational and Recommendation:</b>			
<b>Recommendations Based on Evidence Synthesis</b> <ul style="list-style-type: none"> <li>• Strong, compelling evidence, consistent results: solid indication for a practice change.</li> <li>• Good and consistent evidence – practice change</li> <li>• Good but conflicting evidence: questionable indication for practice change; consider risk/benefit analysis</li> <li>• Little or no evidence: no indication for practice change</li> </ul>			

*Note.* Internalized stigma in these studies was measured using the ISMI and the SSMIS. The Internalized Stigma of Mental Illness scale (ISMI) is a measure of internalized stigma with five subscales, including alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. The Self-Stigma of Mental Illness Scale (SSMIS) is a measure with four subscales including stereotype awareness, stereotype agreement, self-concurrence, and self-esteem decrement. “Recovery orientation”

as mentioned is a measure of patients' subjective appraisal of their own recovery; in most studies it has been measured using the Maryland Assessment of Recovery in People with Serious Mental Illness (MARS) scale.

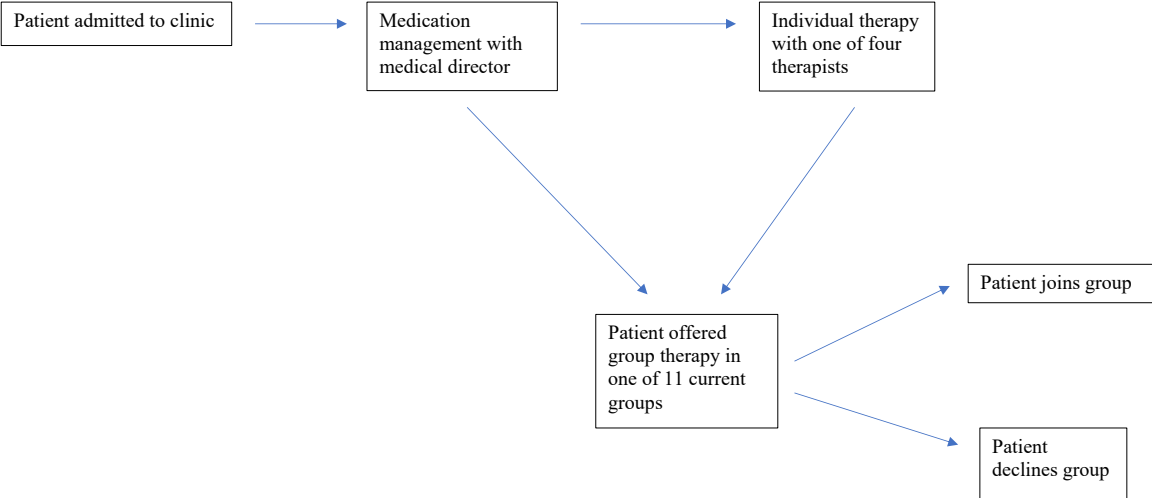
**Appendix D**

**PARIHS Framework Diagram**



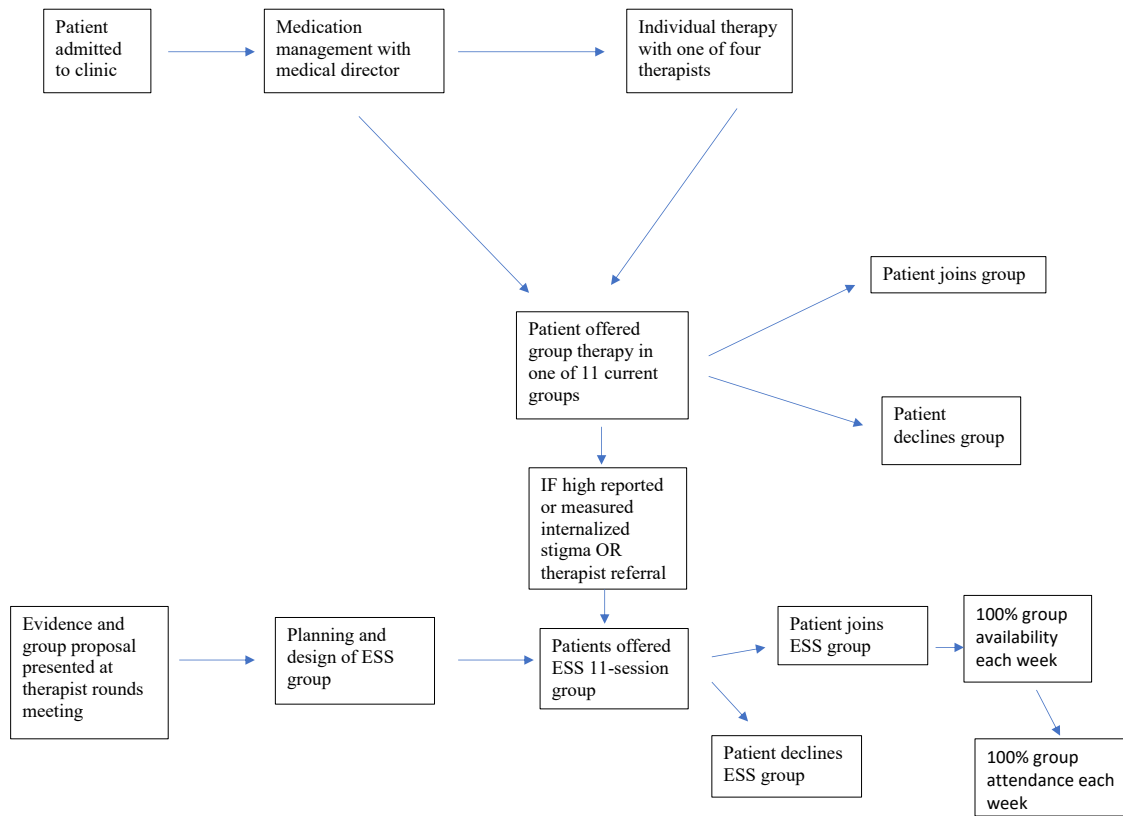
*Note.* Information on the PARIHS framework and its application to this QI project

**Appendix E**  
**Current Process Map**



*Note.* Diagram showing current processes at clinic.

**Appendix F**  
**Desired Process Map**



*Note.* Diagram showing desired processes at the clinical site.



### Appendix G

### Planning and Timeline Gantt Chart

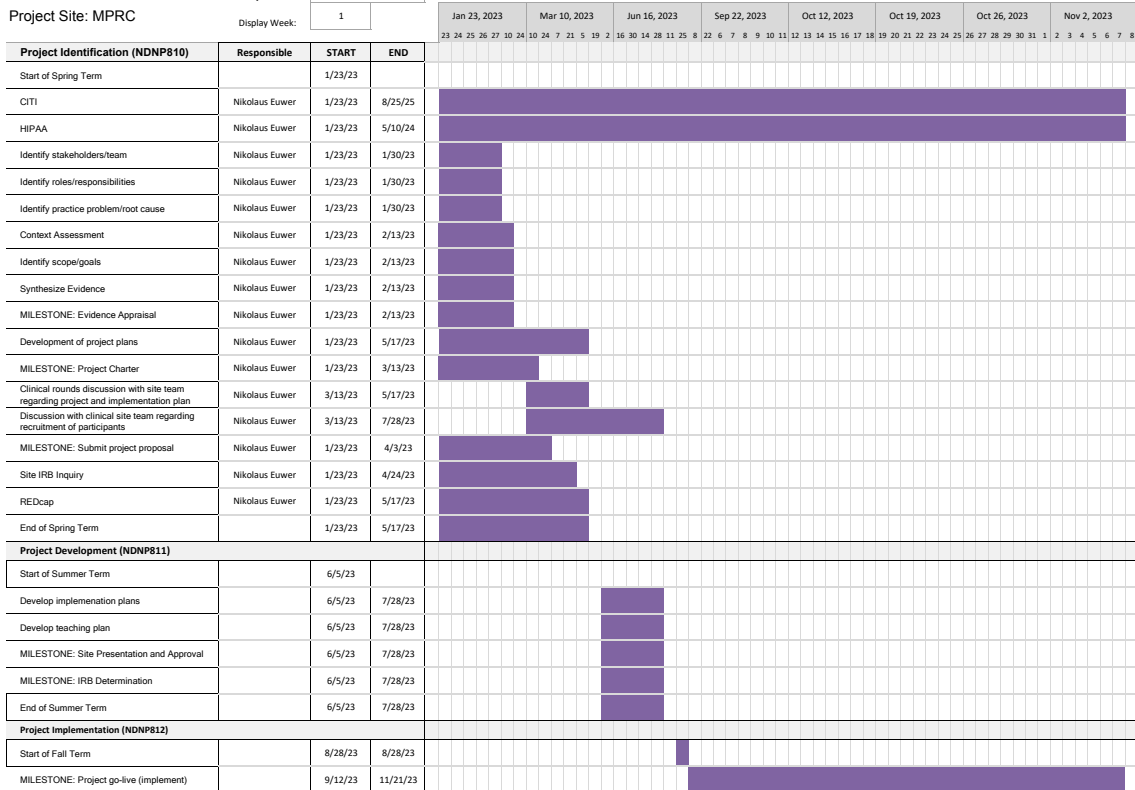
DNP Project Title: Implementation of "Ending Self-Stigma" to Decrease Internalized Stigma Among Psychiatric Outpatients

Student: Nikolaus Euwer

Project Start: Mon, 1/23/2023

Project Site: MPRC

Display Week: 1



Note. Gantt chart showing current project design plan.

## **Appendix H**

### **Session Outline**

1. Preliminary Session, Meet and Greet
2. Introduction to Stigma and Internalized Stigma
3. The 3 C's: Catch it, Check it, and Change it, Part I
4. The 3 C's: Catch it, Check it, and Change it, Part II
5. Strengthening Parts of Yourself
6. Increasing Belonging in Your Community
7. Increasing Belonging with Family and Friends
8. Discrimination: Dealing with Stigma From Others
9. Ending Self Stigma Course Review
10. Next Steps
11. Final Feedback Session

**Appendix I****Participant Information Table**

Males	Females	Total
5	2	7

*Note.* Table showing participant gender and total number of participants.

**Appendix J****Group Availability Data by Week**

Week	Scheduled Groups	Available Groups
1	1	1
2	1	1
3	1	1
4	1	1
5	1	1
6	1	1
7	1	1
8	1	1
9	1	1
10	1	1
11	1	1

*Note.* Table showing group availability, as available groups out of scheduled groups, by week to date.

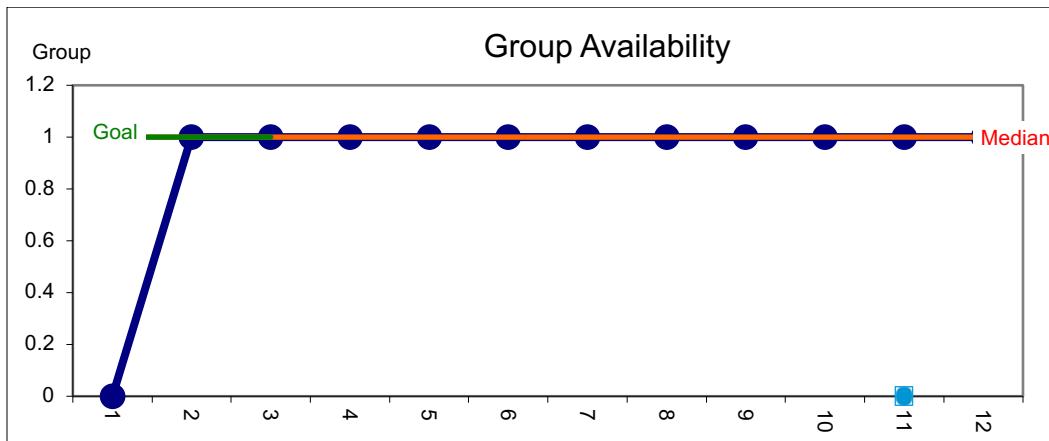
**Appendix K****Group Attendance Data by Week**

Session	Attendance
1	7/7
2	7/7
3	7/7
4	6/7
5	7/7
6	7/7
7	6/7
8	7/7
9	7/7
10	6/7
11	6/7

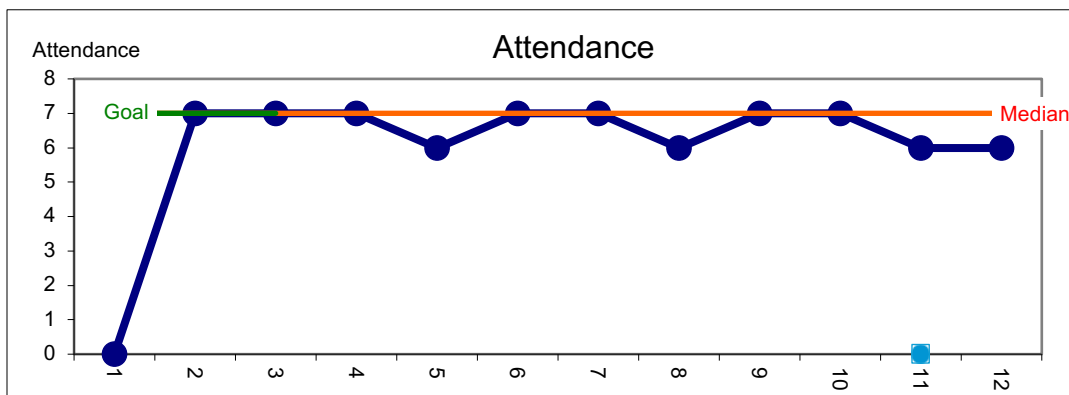
*Note.* Table showing group attendance by week to date, as number of participants attending out of total number recruited.

Appendix L

Group Availability and Group Attendance Run Charts



*Note.* Run chart depicting group availability by week to date. The first week shows pre-implementation.



*Note.* Run chart depicting group attendance by week to date. The first week shows pre-implementation.