

Training mental health activists increases the well-being of participants with high baseline levels of self-stigma: results of the Obertament training evaluation

Francisco José Eiroa-Orosa^{1,2}, María Lomascolo³

1. Section of Personality, Assessment and Psychological Treatment; Department of Clinical Psychology and Psychobiology; Faculty of Psychology; University of Barcelona, Barcelona, Catalonia, Spain
2. Yale Program for Recovery and Community Health, Department of Psychiatry, Yale School of Medicine, Yale University, New Haven, CT, United States
3. Obertament, Catalan Alliance Against Stigma, Barcelona, Catalonia, Spain

Address of correspondence

Dr. Francisco José Eiroá Orosa
Section of Personality, Assessment and Psychological Treatment
Department of Clinical Psychology and Psychobiology
Institute of Neuroscience
Faculty of Psychology
University of Barcelona
Passeig Vall d'Hebron, 171
08035 Barcelona
feiroa@gmail.com, feiroa@ub.edu

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Abstract

There is a strong interest in improving the quality of anti-stigma contact-based interventions. Hence, some mental health anti-stigma campaigns offer prior training to their activists with lived experience of mental disorders. Additionally, collective mobilization seems to impact the identity and well-being of its participants. The main objective of this work was to understand the impact that activism training activities have on the internalized/self-stigma and wellbeing of activists being trained by the Obertament alliance against stigma in mental health. The Internalized Stigma of Mental Illness Inventory and the Pemberton Happiness Index were used to respectively measure internalized stigma and wellbeing at the beginning and the end of anti-stigma training courses. Sixty-eight activists receiving training were enrolled within a pre-test, post-test, one group design. A total of thirty-nine participants were included in repeated measures calculations. Twenty-seven participants did not complete the total training schedule and two more did not complete baseline assessment. Our results show generalized increases in wellbeing and decreases in the internalized stigma of participants. Additionally, a covariation between these changes was found. To further illustrate this covariation, separate groups were created using the baseline median. Hence, greater increases in wellbeing were for those participants with higher levels of baseline self-stigma and vice-versa. This article shows the importance of addressing internalized stigma among mental health activists, thus boosting their recovery process.

Public Policy Relevance Statement

Most mental health anti-stigma campaigns offer prior training to their activists; however, the impact of these activities has been understudied. In this paper we show how the decrease of internalized stigma during the training process covariates with the increase of wellbeing. This work stresses the importance of community self-affirmation activities both in the process of personal recovery as well as in the collective process of social transformation towards a stigma-free society.

Keywords: Social Discrimination, Mental-Health, Activism, Internalized Stigma, Wellbeing

Introduction

The appearance of various campaigns against stigma in the last 15 years has promoted a strong interest in the effectiveness of their activities (Link & Stuart, 2017). Global programs such as Opening Doors (Gaebel & Baumann, 2003; Stuart & Sartorius, 2017); and local ones such as Like Minds, Like Mine in New Zealand (Vaughan & Hansen, 2004); Time to Change in England, UK (Corker et al., 2016; Evans-Lacko, Corker, Williams, Henderson, & Thornicroft, 2014; Henderson et al., 2012; Henderson & Thornicroft, 2009); See Me in Scotland, UK (Mehta, Kassam, Leese, Butler, & Thornicroft, 2009); Opening Minds in Canada (Knaak et al., 2017; Koller & Stuart, 2016; Stuart et al., 2014b, 2014a); Obertament in Catalonia, Spain (Aznar-Lou, Serrano-Blanco, Fernández, Luciano, & Rubio-Valera, 2015; Rubio-Valera et al., 2016, 2018); Hjärnkoll in Sweden (Hansson, Stjernswärd, & Svensson, 2016); One of us in Denmark (Bratbo & Vedelsby, 2017); or See Change in Ireland (Coyle, Lowry, & Saunders, 2017); have disseminated a wide range of evaluations on the impact of their interventions.

Social interventions carried out by anti-stigma campaigns, could be broadly classified into mass media social marketing and activities targeted on specific groups. The latter include educational workshops and/or contact with (ex)service users. However, there may be some overlap between these two broad categories, as many media campaigns use service users' videos for their spots. That is, in both cases the characteristics of the people who have overcome a mental disorder and their recovery history are made visible. According to metanalytic studies, mass media interventions appear to be efficacious to reduce prejudice, but effects on discrimination are not conclusive (Clement et al., 2013).

Regarding targeted interventions, evidence tends to point that social contact has a higher impact than educational interventions at reducing stigma for adults (Corrigan, Scott Morris, Michaels, Jennifer Rafacz, & Rüsç, 2012; Griffiths, Carron-Arthur, Parsons, & Reid, 2014). However, the opposite pattern seems to apply for adolescents (Corrigan et al., 2012). In addition, there is still not enough evidence of the persistence of immediate benefits of contact activities in the long term (Mehta et al., 2015).

Based on all these evaluation experiences and considering sociocultural differences in the populations in which anti-stigma campaigns are applied, there is a strong interest in improving the quality of contact-based interventions. For this reason, campaigns such as One of us or Obertament offer prior training to their activists with lived experience of mental illness. These activities are offered with the aim that messages sent by activists, whether in mass media or in face-to-face activities, may have a greater impact. Although these training activities are aimed at improving a series of skills related to activism and advocacy, it is impossible not to consider the disempowering situations in which many of the participants find themselves. Paradoxically, many of the participants in activities carried out to reduce the social stigma of mental disorders have high levels of self-stigma. Self- or internalized stigma is a term coined by Corrigan and Watson (2002) used to define the process by which people with lived experience of mental disorders endorse stereotypes incorporating them to their identities. In contrast, the aforementioned activist training activities have many mechanisms of action in common with interventions targeting mental health self-stigma, such as social skills training, discussion of pros and cons of disclosing and emphasis on positive attributes (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015).

In addition, there is a growing interest in understanding how collective mobilization in mental health, has an impact on the identity and well-being of participants (Eiroa-Orosa, 2016; Montague & Eiroa-Orosa, 2017). Collective (also called mass, social or popular) mobilization in mental health could be defined as a process engaging a wide range of partners and allies at international and local levels. Its main objective is to raise awareness of and demand for respect of the dignity of people with a lived experience of mental disorders.

Activism in a group that receives the double impact of mental suffering and social discrimination, could be understood as a tool of resilience and recovery (Eiroa-Orosa, 2016). Thus, activism training could be understood as a form of empowerment (Corrigan & Rao, 2012) by reversing the “why try” effect (Corrigan, Larson, & Rüsçh, 2009). In other words, these trainings might reduce self-stigma by increasing their self-esteem through activities where they themselves can make a change on the social vision of mental disorders (Montague & Eiroa-Orosa, 2017).

The present study

For all the aforementioned reasons, after several evaluations of the impact of its interventions (Aznar-Lou, Serrano-Blanco, et al., 2015; Rubio-Valera et al., 2016, 2018), Obertament, the Catalan alliance against stigma, decided to evaluate the impact of the training on their activists. It was decided to operationalize this exploration around the concepts of well-being and internalized or self-stigma. These variables have been chosen since our perception in the day to day of training activities, is that the training not only improves the knowledge and the communication skills of the activists. In addition,

participation also secondarily reduces the self-stigma that activists feel, enhancing their well-being through a new understanding of their experiences. The measure of symptoms was ruled out since the training program is not understood as part of a treatment or psychosocial intervention. Additionally, there is a wide literature on the positive effects of activism on wellbeing and positive development (Montague & Eiroa-Orosa, 2017) that merits further enquiry. Our first hypothesis was that there would be a reduction in self-stigma and an increase in well-being after training. Additionally, we hypothesized that the evolution of these two variables will be interrelated. Finally, our last hypothesis was that these effects would be more intense among the most vulnerable participants, that is, those who started the training with higher levels of self-stigma and lower levels of wellbeing.

Methods

Participants

Sixty-eight activists receiving training during 2016 and the first half of 2017 were consecutively recruited for this study. Eligible participants had been voluntarily enrolled in the Obertament trainings through their website, distribution email list or related consumer and survivor groups. The current analyses included five editions of the course carried out in four different locations in Catalonia (Barcelona twice, Sabadell, Berga and Amposta).

Procedure

This was a prospective pre-post, non-controlled study. The questionnaires were administrated before the first day of training and then again after the last. From an initial pool of sixty-eight participants, a total of thirty-nine participants were included in repeated measures calculations. Twenty-seven participants did not complete the total training

schedule and were only included in cross-sectional baseline calculations. Finally, one participant did not attend the first session, and another did not agree to complete all the questionnaires, and both were excluded from the study.

The Obertament activism training

It is not possible to conceive a project demanding collective rights for a specific stigmatized group without relying on the voice of the members of that group. For this reason, the Obertament training for mental health activists with lived experience of mental disorders, intends to empower people who have had that experience. The project aims to weave a network of activists against stigma by means of training activities and coordination with target groups such as journalists, police officers or physicians. Activists participate actively, so they can be themselves who lead the action against their stigma and discrimination. Developing the project in this way, people involved in the activists network gets empowered, leading to a social participation movement (Aznar-Lou, Rubio-Valera, Serrano-Blanco, & Sabés Figuera, 2015).

The training is provided by two Obertament technicians in charge of a) participation and activism promotion technician and b) media and spokespersons. It consists of four six-hour training sessions. The training's main objective is to provide the necessary skills to carry out the fight against stigma and discrimination through the story of one's own experience. The training is divided into three blocks: introduction, awareness and communication:

- During the introductory block, which takes place in the first session, relevant concepts such as mental health, labeling, or stigma and discrimination are addressed. For this

purpose, different group dynamics are made in which the ease with which people award labels to different objects or social groups becomes evident. Teamwork is also stimulated through group activities in which participants become aware of the importance of collective mobilization to achieve complex goals.

- The awareness block reflects on the various strategies to combat stigma and discrimination. This block spans through the second and fourth session. In the first session, work with life stories is initiated. Life stories of the future activists are considered a fundamental instrument in the fight against stigma as they humanize the stories of people who are often judged by their label. Likewise, activists are prepared so that they can carry out and stimulate awareness activities. In the fourth session there is a practical exercise consisting in reading one's own life story. Additionally, the possibilities of cyberactivism are discussed. The main component of this block is the personal story of the participants and their experiences with stigma, but also resilience and recovery. Dialogue between participants with different perspectives, and exposure to the possibility of public disclosure are encouraged.
- The communication block (third session) focuses on the mass media as a specific target for awareness rising and as a tool to spread the fight against stigma and normalize the vision of mental disorders. In this block, experimentation with various activities related to the need to launch clear and specific messages when intervening in a media is invited. Activities are common in which, for example, by passing an object to create a surprise effect, participants must express an idea in a very condensed way.

Measures

Sociodemographic information included age, gender, couple status, cohabitation, level of studies, employment situation and self-perceived social class. No information on participants' diagnoses was included as it would go against the ethos of the campaign.

For this study we used the Internalized Stigma of Mental Illness Inventory (ISMI, Ritsher, Otilingam, & Grajales, 2003), to measure self-stigma. This inventory contains 29 1-4 Likert-scaled items. The instrument is considered the gold standard for the measurement of internalized stigma in the world. It has been translated into more than 50 languages (Boyd, Adler, Otilingam, & Peters, 2014). The Cronbach's alphas in our study (carried with the sample of participants who completed the training) were high for the whole questionnaire ($\alpha_{pre} = .839$, $\alpha_{post} = .842$), both similar to reliabilities reported by the original authors. The different subscales of this instrument measure Alienation ($\alpha_{pre} = .756$, $\alpha_{post} = .772$), Stereotype Endorsement ($\alpha_{pre} = .628$, $\alpha_{post} = .733$), Perceived Discrimination ($\alpha_{pre} = .851$, $\alpha_{post} = .483$), Social Withdrawal ($\alpha_{pre} = .812$, $\alpha_{post} = .697$) and Stigma Resistance ($\alpha_{pre} = .310$, $\alpha_{post} = .609$). The first four scales are positively proportional to the underlying levels of self-stigma, while the fifth is negatively. In this study, to facilitate interpretation, we calculated mean values so that the range of possible scores was 1 to 4. Due to their low reliability, we examined the alphas if items would be deleted from the Perceived Discrimination and Stigma Resistance subscales. Deleting item 15 (*People often patronize me, or treat me like a child, just because I have a mental illness*) improved the reliability of the post intervention Perceived Discrimination score without substantially affecting the baseline ($\alpha_{pre} = .816$, $\alpha_{post} = .574$). Likewise, deleting items 7 (*People with mental illness make*

important contributions to society) and 14 (*I feel comfortable being seen in public with an obviously mentally ill person*) improved both baseline and post scores ($\alpha_{\text{pre}} = .563$, $\alpha_{\text{post}} = .657$). Therefore, these items were deleted from the repeated measures calculations by subscales.

The Pemberton Happiness Index (PHI, Hervás & Vázquez, 2013), was used to measure wellbeing. This is a 21-item integrative measure of well-being, including components of hedonic, eudemonic, social, and experienced well-being. While hedonic well-being underscores the importance of life satisfaction, eudemonic well-being is focused on optimal psychological functioning and self-fulfillment. Experienced well-being refers to momentary affective states and feelings. Cronbach's alphas for the whole questionnaire in our repeated measures analyses ($\alpha_{\text{pre}} = .850$, $\alpha_{\text{post}} = .841$), were slightly lower than those found in the validation study (Hervás & Vázquez, 2013). The instrument includes two subscales: Remembered wellbeing (PHI-RW; $\alpha_{\text{pre}} = .916$, $\alpha_{\text{post}} = .899$), related to eudemonic, hedonic and social constructs and Experienced wellbeing (PHI-EW; $\alpha_{\text{pre}} = .597$, $\alpha_{\text{post}} = .546$), more related to concrete events. The PHI-RW is made of 11 questions, scored on a 10-point Likert scale. These scores are averaged producing a partial score (range 1-10). The PHI-EW comprises 10 dichotomous ('yes', 'no') questions that measure, on a range from 1 to 10 (product of the sum of positive scores), wellbeing in the preceding 24 hours. This scale was chosen because of the naturalness with which it approaches elements of well-being and psychological distress without evoking psychiatric symptomatology nor the treatment process.

Analyses

A description of the sample was carried out using frequencies, means and standard deviations. The baseline sample of participants was used to compare wellbeing and self-stigma scores between those who completed the schedule from those who not. Repeated measures calculations were carried out using the sample of participants who completed the training. With the aim of replying to our main research questions, changes in self-stigma and well-being were analyzed using paired samples t-tests and correlated using Pearson's r . Additionally, multilevel linear models were performed using measures of wellbeing and self-stigma as within-subject variables. To further clarify the covariation of internalized stigma and well-being, different groups were created. Participants were divided according to their baseline levels of self-stigma and well-being using the median of these scores in our sample (1.86 and 6.82 respectively). Sociodemographic characteristics were compared between higher and lower self-stigma and well-being groups using Chi squared and t-tests. These groups were also used to plot the repeated measures calculations and test time by baseline levels of stigma and well-being interactions using repeated measures analyses of covariance (RM ANOVAs). Bonferroni corrections were used to account for multiple comparisons.

Results

Baseline characteristics

The mean age of participants was forty-five years of age. Fifty-eight per cent of the participants were women, 70% were single, 42% were living alone (vs. 25% with family of origin and 32% with own family), 48% had university studies, 57% were paid a disability

pension and 52% identified themselves as middle class (mean=3.16, range 1-5). With a mean of 1.91 ± 0.48 , more than a third (37%) of participants had self-stigma scores above 2, meaning mild internalized stigma, but only 7.5% above 2.5 which is the cutoff to consider high Internalized stigma (Ritscher & Phelan, 2004). Levels of remembered (6.90 ± 1.73) as well as experimented wellbeing (6.64 ± 2.23) were similar to those found in the general population in the validation study (Hervás & Vázquez, 2013). Baseline scores were compared between completers and non-completers finding statistical significance for wellbeing (completers= 7.14 ± 1.51 , non-completers = 6.04 ± 2.11 , $t = 2.509$, $p = 0.015$, $d = 0.62$) but not for internalized stigma. The correlation between the baseline wellbeing and self-stigma scores was $r = -.624$ ($p < .0001$) and $r = -.648$ ($p < .0001$) for the whole sample and for those completing the training schedule.

Table 1 shows sociodemographic characteristics and baseline scores of participants by baseline levels of internalized stigma and wellbeing (dichotomized using the median). As can be seen on the left of the table, no statistically significant differences between high versus low internalized-stigma baseline groups were found for any of the sociodemographic characteristics. However, large differences were found for the three wellbeing scores. We also compared participants with baseline levels of low versus high wellbeing. Lower baseline levels of wellbeing were related to female gender and higher scores for all internalized stigma scores.

Table 1. Sociodemographic and baseline scores by baseline internalized stigma and wellbeing dichotomized using the median

	Internalized stigma							Wellbeing						
	Lower (n=35)		Higher (n=32)		Statistical significance			Lower (n=33)		Higher (n=34)		Statistical significance		
	N	%	N	%	OR	95% CI	p	N	%	N	%	OR	95% CI	p
Gender (% females)	18	51.4	21	65.6	.555	.207-1.486	.193	26	78.8	13	38.2	6.00	2.30-17.738	.001
Couple (% married or in a relationship)	12	34.3	8	25.0	1.565	.541-4.526	.191	7	21.2	13	38.2	.435	.147-1.286	.128
Cohabitation (% living alone)	13	37.1	15	46.9	.670	.252-1.777	.464	14	42.4	14	41.2	1.053	.399-2.780	.918
Education (% university)	15	42.9	17	53.1	.662	.252-1.736	.263	18	54.5	14	41.2	1.714	.652-4.511	.273
Employment situation (% disability pension)	18	51.4	20	62.5	.635	.240-1.685	.289	17	51.5	21	61.8	.658	.249-1.738	.397
	M	SD	M	SD	d	t	p	M	SD	M	SD	d	t	p
Age	45.26	9.04	44.70	10.93	.06	.225	.862	43.26	11.19	46.58	8.37	-.34	-1.367	.177
Social class (1-5)	3.20	.90	3.13	.91	.08	.346	.838	3.21	.89	3.12	.88	.11	.436	.644
Wellbeing														
Remembered wellbeing	7.68	1.38	6.04	1.69	1.07	4.365	<.0001							
Experienced wellbeing	7.63	1.99	5.56	2.00	1.04	4.240	<.0001							
Total wellbeing	7.66	1.39	5.81	1.44	1.31	5.351	<.0001							
Internalized stigma														
Alienation								2,30	0,55	1,61	0,47	1.34	5,477	<.0001
Stereotype Endorsement								1,82	0,45	1,46	0,42	.84	3,424	<.001
Discrimination Experience								2,29	0,70	1,86	0,69	.63	2,559	.013
Social Withdrawal								2,12	0,68	1,58	0,53	.88	3,616	<.001
Stigma Resistance								2,65	0,56	3,05	0,49	-.76	-3,118	.003
TOTAL								2,15	0,45	1,67	0,38	1.16	4,736	<.0001

Table 2. Results of the paired samples t-tests (n=39).

	Pre		Post		Statistical significance		Effect size
	M	SD	M	SD	t	p	d
Wellbeing							
Remembered wellbeing	7.08	1.64	7.34	1.50	-1.763	.086	.28
Experienced wellbeing	7.21	1.88	7.95	1.70	-2.326	.025	.37
TOTAL	7.14	1.51	7.65	1.22	-2.583	.014	.41
Internalized Stigma							
Alienation	1.95	.62	1.56	.49	5.342	<.0001	.85
Stereotype Endorsement	1.66	.49	1.41	.44	2.819	.008	.45
Discrimination Experience ¹	2.15	.79	1.93	.48	2.299	.027	.37
Social Withdrawal	1.88	.67	1.65	.53	2.515	.016	.40
Stigma Resistance ²	2.88	.66	3.00	.81	-0.796	.431	-.13
TOTAL	1.94	.49	1.68	.35	4.649	<.0001	.74

1. Item 15 (People often patronize me, or treat me like a child, just because I have a mental illness) not included to improve reliability. 2. Items 7 (People with mental illness make important contributions to society) and 14 (I feel comfortable being seen in public with an obviously mentally ill person) not included to improve reliability. * p<.05, ** p<.01, *** p<.001. Bold: subscales overcoming Bonferroni adjustment.

Table 3. Correlations between pre, post and change self-stigma and wellbeing scores (n=39).

	Internalized stigma pre	Internalized stigma post	Internalized stigma change	Wellbeing pre	Wellbeing post	Wellbeing change
Internalized stigma pre	-	.694***	.695***	.648***	.389*	.416**
Internalized stigma post		-	.035	.503**	.370*	.253
Internalized stigma change			-	.398*	.170	.324*
Wellbeing pre				-	.625***	.616***
Wellbeing post					-	.230
Wellbeing change						-

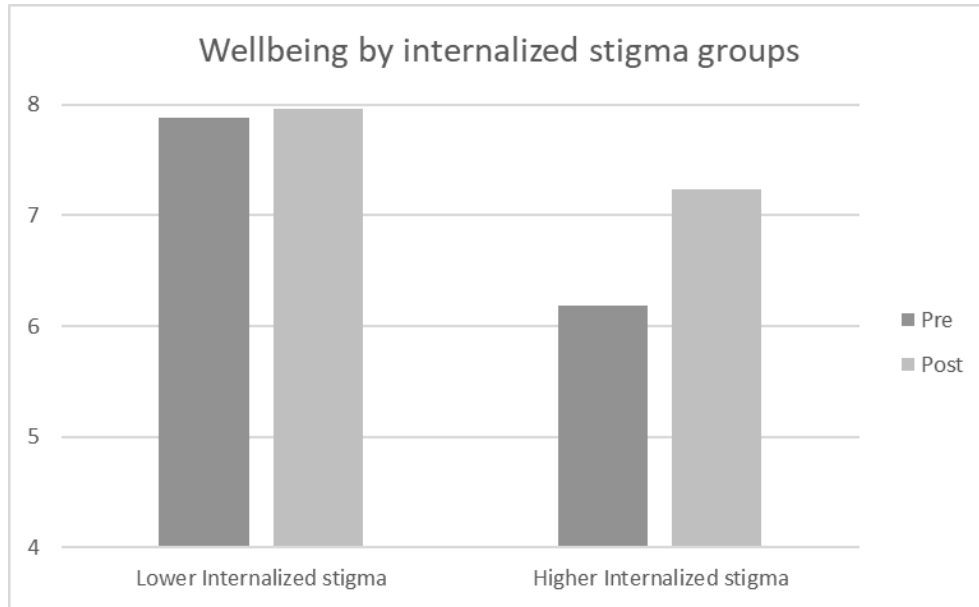
* p<.05, ** p<.01, *** p<.001

Repeated measures analyses

To test our hypotheses, we carried a series of repeated measures analyses. Results of the paired samples t-tests can be seen in table 2. Statistically significant decreases were found for the all Internalized Stigma scores except for Stigma resistance. Discrimination experience and Social withdrawal reached statistical significance but would be discarded if accounting for multiple comparisons. Conversely, experienced and total (but not remembered) wellbeing were found to have statistically increased, although none of them would pass Bonferroni corrections. Correlations between self-stigma and wellbeing levels at baseline, follow-up and change scores can be seen in table 3. The correlation between the reduction of self-stigma and the increase of wellbeing scores was $r = .324$ ($p = .044$). Increases in wellbeing were statistically correlated with baseline self-stigma and its decrease, but not with its post-intervention levels.

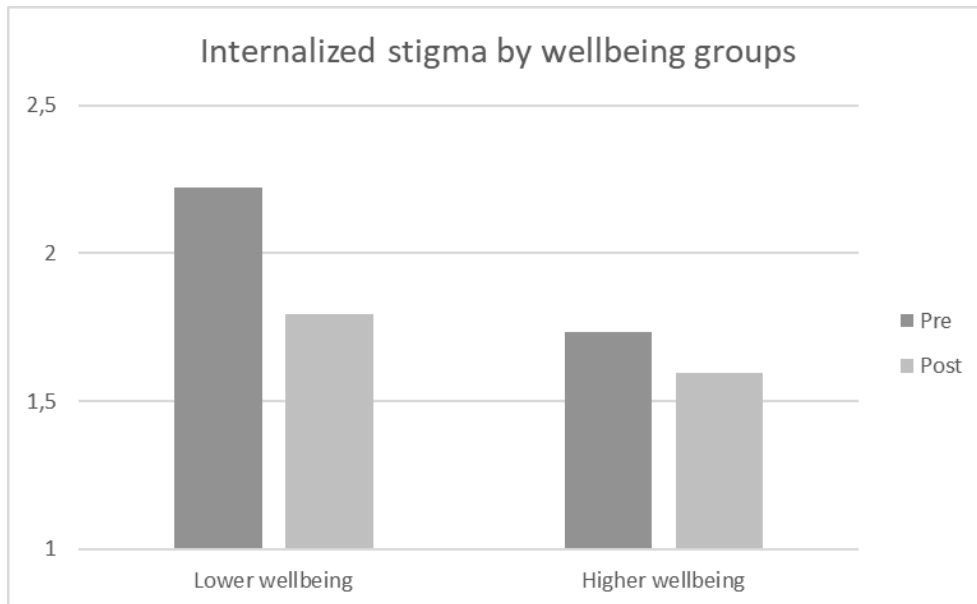
The results of the multilevel linear models using Self-stigma and Wellbeing as within subjects' variables, showed a statistically significant covariation ($F(1,76) = 35.7791$, $p > .0001$). Figures 1 and 2 show, respectively, the evolution of wellbeing and internalized stigma by the baseline score of the other variable dichotomized using the median and the results of the interaction of group by time (RM ANOVA).

Figure 1. Evolution of wellbeing by baseline internalized stigma groups.



RM ANOVA (time x baseline self stigma): $F(1,37) = 6.990$, $p = .012$, $\eta^2 = .159$, power=.731

Figure 2. Evolution of internalized stigma by baseline wellbeing groups.



RM ANOVA (time x baseline wellbeing): $F(1,37) = 8.899$, $p = .005$, $\eta^2 = .194$,

power=.828 **Discussion**

Discussion

To our knowledge this is the first study evaluating the impact of a mental health activists' training activity on self-stigma and wellbeing. Most participants were middle class, single people with university studies receiving a disability pension. Completion was predicted by remembered wellbeing at baseline. No differences were found in sociodemographic characteristics between low and high baseline internalized stigma groups. On the contrary, gender differences were found for baseline wellbeing, with women having lower levels of wellbeing. There were generalized improvements for Internalized stigma and Wellbeing for the whole sample, although just the decrease on alienation had enough strength to show statistically significant changes after adjusting for multiple comparisons. The reduction in self-stigma showed covariance with the increase in wellbeing. Further analyses showed how the participants with lower levels of baseline internalized stigma and higher of wellbeing, remained at the same levels, while their counterparts improved.

The implications of this study are manifold. On the one hand, baseline experienced wellbeing could be understood as a mild predictor of course dropout. The lack of vital enjoyment could lead to a lack of motivation for some participants. Lack of enjoyment has classically been identified as a risk factor for dropout in a wide range of activities such as sports (Crane & Temple, 2015). However, with the information we have, although we know that the general level of vital enjoyment was lower in this group of participants, we cannot know if the reason for their abandonment was because they also found no enjoyment in participating in the course.

On the other hand, alienation feelings play a key role in the experience of becoming a mental health activist, as can be seen in the great decrease in the alienation subscale. Indeed, the association between alienation and wellbeing has been studied in relation with the mediational effect of resilience and resistance. For instance, Ifeagwazi, Chukwuorji, & Zacchaeus (2015), found that resilience might buffer the negative relationship of alienation to psychological wellbeing. Thoits and Link (2016) found a negative link between internalized stigma and wellbeing. They found that people who tend to not engage in stigma resistance activities, thus maintaining secrecy or avoiding other people (called concealment activities by the authors), had lower self-esteem and greater depression. On the contrary, those who challenged stereotypes had higher self-esteem and more positive quality of life. In our case, it seems clear that a process of social participation, in which participants can speak openly about the prejudices on the very problem that has caused their alienation, decreases the latter while increasing levels of well-being.

It also seems important to consider the need to address the initial levels of internalized stigma in this type of training, since this feature has a great association with the increase of well-being among new activists. The fact that participants with higher levels of self-stigma experienced higher increases in their well-being, and participants with low levels of well-being decreased their internalized stigma to a greater extent, should be analyzed with caution. We could understand that there was a ceiling effect. This could be because the instruments used were not able to capture the benefits in people with fewer deficits at the beginning of training. In the case of these people, it is possible that they are given acquisitions in areas related to the skills that are acquired in the training itself. A

recommendation derived from this study could be to intensify this type of activities among people with higher levels of self-stigma, prioritizing them against people with lower levels. However, in practice, recovered people contribute fostering the motivation of their peers in a preceding state of recovery. The training, therefore, is also a space where people who are in different stages of recovery meet and share experiences.

We should also discuss the limitations of this study. As in many similar contexts, the design used did not allow us to extract causal relationships. Additionally, given our design, as well as considerable dropout, an additional explanation of the interaction found might be the regression to the mean upon subsequent evaluation of participants low on well-being or high on internalized stigma at baseline. Nevertheless, adding a randomization would not only have been logistically complicated, since, as can be seen by the dropout rate, it is difficult to keep the participants in these courses, but would also question the spirit of the Obertament alliance. Our goal was to ensure that these training activities, in addition to providing activism tools, help to decrease self-stigma and increase well-being, and to explore the association between these two variables. We did not aim to demonstrate the effectiveness of these training activities in a clinical sense, since they are not considered a treatment, although, as discussed above, shares many components with interventions aimed at reducing self-stigma (Yanos et al., 2015). Furthermore, although the profile of participants does not correspond to the average of people with severe mental disorders, it is indeed the typical profile among activists against stigma. All mental health activism groups work hard to mobilize people who have had extreme experiences in different stages of recovery and social inclusion. However, we must not forget that still today many people

do not receive adequate attention leading them to long processes of suffering and relapse. In many cases, chronification produces dependence preventing social participation.

Take home message

Our results show the importance of addressing the internalized stigma of mental health activism training participants, as it interacts with their well-being, and thus with their recovery process. We consider it important that campaigns against stigma at the global level should adequately analyze not only the skills that their activists acquire, but also disseminate how social participation as full citizens of people experiencing or having overcome a mental disorder is part of their long road to recovery (Eiroa-Orosa & Rowe, 2017).

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