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An integrative cognitive model of internalised stigma in psychosis

Abstract

Background: Internalised stigma is a significant difficulty for those who experience psychosis but it has never been conceptualised using cognitive theory.

Aims: The aim of this paper is to outline a cognitive model conceptualising internalised stigma in people who experience psychosis.

Method: Previous literature is reviewed, critiqued and synthesised to develop the model. It draws upon previous social cognitive models of internalised stigma and integrates cognitive-behavioural theory and social mentality theory.

Results: This paper identifies key cognitive, behavioural and emotional processes which contribute to the development and maintenance of internalised stigma, whilst also recognising the central importance of cultural context in creating negative stereotypes of psychosis. Moreover, therapeutic strategies to alleviate internalised stigma are identified. A case example is explored and a formulation and brief intervention plan was developed in order to illustrate the model in practice.

Conclusion: An integrative cognitive model is presented which can be used to develop individualised case formulations, which can guide cognitive behavioural interventions targeting internalised stigma in those who experience psychosis. More research is required to examine the efficacy of such interventions. In addition, it is imperative to continue to research interventions which create change in stigma at a societal level.

Key words: Cognitive, psychosis, internalised stigma, social mentality theory.

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Introduction

Stigma is experienced when "individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context" (Crocker et al., 1998). Negative public attitudes towards people who experience psychosis continue to prevail despite widely-publicised anti-stigma media campaigns such as Rethink Mental Illness's 'Time to Change' initiative in the UK (Henderson & Thornicroft, 2013; TNS BMRB, 2014), which may be due to these campaigns addressing general mental health rather than psychosis specifically. Internalised stigma occurs when an individual becomes aware of negative stereotypes and applies them to oneself, often resulting in emotional distress (Corrigan & Watson, 2002a). The internalised stigma of psychosis is associated with negative personal impacts including increased hopelessness, depression, low self-esteem and self-efficacy, reduced social networks, and reduced engagement with mental health services (Corrigan et al., 2006; Link et al., 2001; Livingston & Boyd, 2010).

Internalised stigma is a particularly prevalent issue among people with psychosis; 41.7% of a large European sample reported moderate to high levels of internalised stigma (Brohan et al., 2010a). As a consequence, the construct of internalised stigma and its theoretical underpinnings have been increasingly scrutinised. To date, it has not been conceptualised from a cognitive-behavioural perspective despite internalised stigma having cognitive and behavioural consequences (Rüsch et al., 2006). The majority of theoretical models have been developed using social cognitive theory, and relate to the broader concept of 'severe mental illness' (SMI), and have therefore lacked specificity. There is a model of social anxiety that incorporates stigma in psychosis (Birchwood et al., 2007), but this was not specific to internalised stigma. We propose a theoretical framework which conceptualises internalised stigma in psychosis from a cognitive-behavioural perspective.

Social cognitive theory of stigma

Link and Phelan (2001) outlined one of the original social cognitive conceptualisations of stigma. Drawing upon evolutionary theories of social and natural selection, they explain that people distinguish and label human difference. Dominant cultural beliefs connect the labelled person to undesirable characteristics, and the person is then placed in a distinct category different to us, which allows for emotional distancing and results in status loss. Due to social, economic and political power, the stigmatised individual experiences disapproval, rejection, exclusion, and discrimination in society. The person develops appraisals that others

will reject and devalue them, which consequently causes emotional distress and impacts on their behaviours, causing them to withdraw and avoid social situations (Link et al., 2004). Corrigan and Watson (2002b) built upon this theory and distinguished between public and self-stigma. Public stigma comprises three components: stereotypes (negative beliefs about a group), prejudice (agreement with the belief and/or negative emotional reaction), and discrimination (negative behavioural response to prejudice). Self-stigma also comprises the same three components but applied to one's self. They further detail that appraisals of stigma can lead to low self-esteem and self-efficacy if the perceived legitimacy of public stigma is high, or righteous anger if the perceived legitimacy is low and there is high group identification.

Further refinement by Brohan et al. (2010b) focused on personal stigma and identified three distinct categories which form the construct: experienced, perceived and internalised stigma (Brohan et al., 2010b). Experienced stigma has been defined as "instances of discrimination ...on the grounds of their perceived unacceptability or inferiority" (Scrambler & Hopkins, 1986). Perceived stigma is that extent to which the stigmatised person believes that others associate them with the negative stereotypes (Link, 1987). Internalised stigma, as defined by Corrigan and Watson (2002), is the agreement with the negative stereotypes and the consequential emotional distress.

One of the main drawbacks of these models of stigma is that they lack clinical applicability and there is insufficient emphasis on the complex relationships between the components of stigma. Moreover, they have been broad and not solely focused on those who experience psychosis. This broadness has restricted the models' specificity to include the complex interaction between stigma and pre-existing experiences of psychosis (Drapalski et al., 2013). This led to more clinically focused models being developed.

Major and O'Brien (2005), further examined by Rusch et al. (2009), developed a stress-coping model of stigma which identified why some individuals internalise stigma as distressing and others do not. This internalisation is dependent on sensitivity to rejection, perceived legitimacy of stereotypes, experiences of discrimination, identification with labelled group and stigma appraisals, which leads to stress (Rusch et al., 2009). This can impact on the behavioural outcomes for the individual, for example, lead to avoidance and withdrawal. Drapalski et al. (2013) and Schrank et al. (2014) proposed and tested two further models of internalised stigma which incorporated the impacts on psychiatric

symptoms. Internalised stigma was core to development and maintenance of psychiatric symptoms in both models. These models are the first clinical models of internalised stigma to include the impacts on psychiatric symptoms of psychosis. However, both models have significant limitations, being simplistic and lacking specificity regarding the psychological processes involved in the development and maintenance of internalised stigma.

Only one model has examined the role of stigma in maintaining distress in people who experience psychosis using cognitive-behavioural theory (Birchwood et al., 2007); however, this was focused on understanding social anxiety in psychosis, utilising stigma shaming beliefs as one component of the model. This model does not capture the complex emotional reactions to internalised stigma (such as depression, hopelessness, anger), or attempt to explain why only some people experience internalised stigma, and does not draw upon relevant stigma theory, for example, Link & Phelan (2001), and Corrigan & Watson (2002). Birchwood et al. (2007) suggested that internalised cultural values of mental illness stigma lead the person to develop an other-to-self focus; i.e. worries that he/she will be judged or rejected by others. This leads to a self-focus, which results in the individual becoming hypervigilant towards how they look or perform in social situations (Clark, 2001). These collectively cause catastrophic shaming beliefs, which either results in anger or anxiety responses. Despite limitations, the theory described by Birchwood et al. (2007) has informed the current proposed model; however, it primarily seeks to explain the development and maintenance of social anxiety in psychosis, rather than internalised stigma.

A cognitive model of internalised stigma in psychosis

To date, the proposed theoretical models of stigma indicate a role for cognitive and behavioural components, which maintain internalised stigma in SMI (Corrigan & Watson, 2002a; Rusch et al., 2009). Furthermore, these models have also suggested the role of aspects of evolutionary psychology such as loss of social status and learned helplessness (Link & Phelan, 2001). However, the psychological models described to date have not simultaneously drawn upon cognitive theory which appears imperative to understanding internalised stigma, nor have they outlined why some people experience internalised stigma and others do not, or described a theoretical model which could inform therapeutic practice. This paper presents a model which will address these issues by integrating elements of the existing stigma models with social mentality theory (SMT; Gilbert, 2000) and a cognitive

model of psychosis (Morrison, 2001) to describe a cognitive model of internalised stigma specifically for people who experience psychosis. This model is shown in figure 1.

[INSERT FIGURE 1 HERE]

Cultural context

The cultural context of the stigmatised person is extremely important to consider in the development and maintenance of internalised stigma. In their conceptualisation of stigma, Link and Phelan (2001) comment upon social, economic and political power in causing and maintaining stigma, and Green (2009) explains that stigma would not exist without it. Negative media portrayals and the medicalisation of psychosis continue to maintain stigmatising public attitudes towards people who experience psychosis (Read & Harre, 2001). Consequently, people with psychosis are associated with the most negative stereotypes such as dangerousness, unpredictability and an inability to recover (Crisp et al., 2005). Moreover the medicalisation of psychosis and the depiction of it as a biological mental illness has been found to perpetuate stigma by reinforcing an "us and them" paradigm (Angermeyer et al., 2011). Read and Harre (2001) found that biological and genetic explanations of mental health difficulties were directly related to negative stereotypes (being seen as dangerousness, antisocial and unpredictable) and also with a reluctance to develop relationships. Therefore, an individual with psychosis is likely to develop an awareness of the stigma of psychosis prior to experiencing it themselves.

It is important to emphasise the importance of pre-existing trauma and mental health difficulties in the cause and maintenance of internalised stigma. It is acknowledged that increased levels of trauma worsen the severity of psychotic symptoms (Shelvin et al., 2008). It is postulated that the more severe the experiences of trauma, the more likely it is that the person will experience internalised stigma and become distressed. This is due to the likely increase of sensitivity to threatening experiences such as stigma (Gilbert, 2010). Collectively, this social context perpetuates stigma and can act as a causal and maintenance factor. It shapes the person's pre-existing conceptualisations of psychosis which influence how they interpret their own experiences.

Group identification and stigma awareness

Watson et al. (2007) describe that an integral part of internalising stigma was to (a) identify with the stigmatised group and (b) to believe that this group identification was legitimate,

which is also integral to this model. Key factors such as having insight (Hasson-Ohayon et al., 2012), pre-existing low self-esteem or shame (Corrigan et al., 2006), and pre-existing social identity (Yanos et al., 2010) have all been found to contribute to group identification and the consequential development of internalised stigma.

It has been identified that experiencing a first episode of psychosis can result in a fear of stigma, therefore it is likely that group identification can begin at this point (Franz et al., 2010; Iqbal et al., 2000). Furthermore, a recent service user-led study examining the impact of diagnosis found that receiving a diagnosis of psychosis or schizophrenia-spectrum disorder led to feelings of internalised stigma (Pitt et al., 2009). Participants described that once they had received a diagnosis they felt "labelled" which was a cause of "social exclusion" (p.421). It is likely that an event such as receiving a psychiatric diagnosis which confirms the belongingness to the stigmatised group can trigger this process.

Stigma awareness (Watson et al., 2007), which has also been described as perceived stigma (Brohan et al., 2010b) and anticipated stigma (Gerlinger et al., 2013), occurs at this stage and is the belief that others view people with psychosis negatively and associate them with negative stereotypes. Stigma awareness has been found to be directly related to internalised stigma causing experiences such as withdrawal and poor self-efficacy in those who experience psychosis (Kleim et al., 2008). This relationship was also found in a large international study (n=1229) where internalised stigma was predicted by perceived discrimination (Brohan et al., 2010a).

Our model postulates that group identification and stigma awareness would cause people to evaluate their social roles, supported by (SMT; Gilbert, 2000). SMT based within evolutionary psychology theory, outlines a model to understand humans' abilities to detect threats within their social environment (Gilbert, 2010). Social mentalities coordinate our cognition, affect and behaviours in order to undertake our social roles. If we experience significant threat, our social role is devalued and shame is experienced. This is supported by stigma-relevant research; for example, Rusch et al. (2010) found that perceived legitimacy of stigma was directly associated with automatic shame-related associations in a group of people with mental health problems.

Stigma triggers

'Stigma triggers' are internal and external factors which can activate internalised stigma. The primary external trigger is experienced stigma. The most common experiences of stigma are verbal abuse, physical abuse, loss of contact or rejection, patronising attitudes, disapproval and being judged (Dinos et al., 2004). Within SMT, experienced stigma would be considered a social threat which would trigger the threat system (our emotional system which reacts to threatening situations; Gilbert, 2010) in stigmatised people (Gumley & Schwannauer, 2006).

Some research has illustrated that a stigmatised person can internalise stigma without experiencing stigma if they perceive stigma to be an ongoing threat (Quinn et al., 2015). As a consequence, triggers of stigma have been noted to include witnessing a stigmatising event or news story (Brohan et al., 2010b). The present authors would also hypothesise that neutral triggers, as identified in the psychosis model (Morrison, 2001), may also trigger internalised stigma. Similarly, neutral internal bodily sensations may also be interpreted in a catastrophic manner and trigger internalised stigma, as outlined in other cognitive models of psychosis (Morrison, 2001) and panic (Clark, 1986).

Qualitative interviews with service users have identified that auditory hallucinations and intrusive stigma-oriented thoughts or memories can act as triggers of internalised stigma (Wood et al., 2016b). Participants explained that certain auditory hallucinations had stigmatising content, telling them that they were "mad" and "bad". Furthermore, they reported experiencing intrusive thoughts, images or memories related to an incident of experienced stigma. Relatively little is known about the relationship between internal triggers and internalised stigma; the few studies available have examined stigma and psychosis more broadly. For example, Lysaker et al. (2007a) examined a small sample (n=36) of people with schizophrenia and found that ongoing positive symptoms significantly predicted internalised stigma (although the specific psychotic symptoms were not identified).

Stigmatising core beliefs

When the individual has (a) identified with the group and perceives stigma as legitimate and (b) experienced a stigma trigger, they will go on to activate stigma based core beliefs. Core beliefs are defined as fundamental, inflexible, absolute, and generalised beliefs that people hold about themselves, others and the world (Beck, 1979). Extensive research has been conducted to understand the core beliefs of people who experience psychosis (Fowler et al., 2006; Smith et al., 2006). They broadly fall into two categories: beliefs of negative self-evaluation, particularly of being different (Gumley & Schwannauer, 2006), and beliefs that

others are hostile, rejecting and untrustworthy (Fowler et al., 2006). Stigma-specific core beliefs have been documented as associated with internalised stigma (Birchwood et al., 2007; Hinshaw, 2007). Most commonly, an individual can internalise the stereotypes and believe that they are dangerous, mad and unpredictable (Ritsher et al., 2003), therefore core beliefs regarding the self are likely to incorporate this content. Furthermore, stigma-related core beliefs are also going to reflect existing core beliefs related to experiences of psychosis; for example, beliefs of being different and others being hostile/rejecting are common in psychosis (Fowler et al., 2006). This is unsurprising given the high prevalence of experiences of adversity that are also commonly stigmatised, such as sexual abuse and institutional care (Varese et al., 2012).

Stigma appraisals

Stigma-related appraisals are core to internalised stigma and have been described as intrusive and automatic (Rusch et al., 2010). The stigmatised person is also likely to have a cognitive-attentional bias (Morrison, 2001), which consequentially leads them to have heightened self-focused attention, attentional bias and ruminative processes (Wells, 1995; Wells & Matthews, 1994) regarding stigma. We hypothesise that there are three subtypes of appraisals which pertain to different emotional responses. The first subtype of appraisal would relate to social anxiety and paranoia, and refer to perceived social danger (Michail & Birchwood, 2009, 2013). If socially anxious, the person would process themselves as a social object (detailed monitoring of themselves in social situations) (Birchwood et al., 2007; Clark, 2001). Secondly, stigma-specific negative automatic thoughts (NATS) and self-criticism are widely documented to be associated with depression (Beck, 1979; Gilbert & Procter, 2006), and more recently have been demonstrated in people with psychosis (Shahar et al., 2004; Waite et al., 2015). Finally, cognitions pertaining to injustice and unfairness are also considered important; for example, Watson et al. (2007) report that when people perceive stigma to be unfair or unwarranted, or they feel disrespected, they will experience righteous anger and frustration.

Emotional and physiological consequences

The subtypes of stigma appraisals are hypothesised to lead to three key emotional responses in relation to stigma. Firstly, it is proposed that appraisals related to social danger and processing the self as a social object will lead to social anxiety. This has been identified in a number of studies with people who experience psychosis (Lysaker et al., 2010; Markowitz,

1998). In the qualitative literature, (social) anxiety and fear have also been identified by service users as a response to stigma (Wood et al., 2015). Birchwood et al. (2007) illustrated that in a sample of people experiencing first episode psychosis that social anxiety was associated with greater shame, that their diagnosis socially marginalised them and resulted in loss of social status.

Secondly, shame and depression are recognised as emotional responses to stigma due to a loss of social rank (Gilbert, 2010). This has also been widely documented in systematic reviews of internalised stigma (Livingston & Boyd, 2010), service user literature (Wood et al., 2016b), and quantitative explorations through path analysis (Lysaker et al., 2007b; Vass et al., 2015; Yanos et al., 2008). Shame and depression have been illustrated to be directly predicted by different forms of stigma but also mediate the relationship between stigma, recovery, positive symptoms on psychosis and recovery (Vass et al., 2015).

Finally, anger has been identified as a response to stigma, although there has been less exploration of its relationships with stigma compared to the other emotional responses. Anger has been described as a positive response to stigma and considered righteous and empowering (Watson et al., 2007). Anger occurs when an individual identifies with the stigmatised group but perceives the stigma to be unjust or unfair (Rusch et al., 2005). This has also been described as important by service users who experience psychosis in qualitative interviews (Dinos et al., 2004; Wood et al., 2015).

Safety seeking strategies

Safety seeking behaviours are utilised to prevent a feared catastrophe and are widely documented in cognitive models (Clark & Wells, 1995; Salkovskis et al., 1999). Within psychosis, safety seeking behaviours are also prevalent and broadly pertain to avoidance and resistance (Tully et al., under review). Safety seeking behaviours within internalised stigma in psychosis would serve to protect the individual from feeling stigmatised by others. One of the most significant safety behaviours for internalised stigma is the avoidance of disclosure about experiences of psychosis to all areas of their social network (e.g. friends, family, employers) (Corrigan et al., 2013). Service users have also described having to "act normally" when they are around others by hiding their experiences of psychosis (Pyle & Morrison, 2013). Social avoidance is also an identified coping strategy for stigma by keeping a distance from others and not having relationships in order to protect against rejection.

Furthermore, stigmatised people are more likely to avoid mental health services due to concerns regarding stigma (Rusch et al., 2005).

Another potential safety seeking behaviour is heightened awareness and threat monitoring of stigma. It is widely documented that people who experience psychosis and trauma have a heightened threat system due to actual threat experiences (Freeman et al., 2001; Morrison, 2001; Morrison et al., 2003). In particular, psychosis is underpinned by interrelational trauma and is thought to be at the core of the development and maintenance of psychosis (Braehler et al., 2013). In a similar vein, experienced and perceived stigma are additional social threats which could increase hypervigilance and attunement to social cues regarding stigma (Birchwood et al., 2007). Additionally, another safety behaviour identified is submission within relationships. Submissive behaviour is a widely documented safety behaviour with cognitive models of depression (Gilbert & Allan, 1998). From an evolutionary perspective, submissive behaviours are a result of low social rank, i.e. seeing oneself as not good enough in comparison to others, and show themselves in the context of others who are more powerful (Gilbert & Allan, 1998). Within the context of internalised stigma, submission can be understood as protecting the individual from powerful and stigmatising others.

Other types of safety-seeking responses include cognitive strategies which aim to manage the distressing cognitions and emotions as a response of internalised stigma. Such strategies are often described as metacognitive and include tactics such as anticipatory processing, post-event rumination, selective attention to unwanted thoughts and cognitive avoidance or suppression. Such strategies are widely noted in the psychosis literature as an attempt to manage the cognitive and emotional distress (Morrison, 2001).

Protective Factors

A number of protective factors are suggested by the proposed theoretical model, which have been drawn from existing evidence. Firstly, social network support has been outlined. Supportive relationships and secure attachments are important to our well-being and can protect us from social threats such as stigma (Gumley et al., 2010). This is widely documented in the stigma literature (Chronister et al., 2013), particularly from qualitative explorations of service user perspectives (Pyle & Morrison, 2013). Even when an individual has multiple experiences of stigma, the close social network of family and friends acts as a

buffer (Wood et al., 2015), which has been supported by a recent mediation analysis (Chronister et al., 2013).

The second most commonly cited protective factor against stigma is peer support, for similar reasons as those outlined above. In addition, peer support offers understanding, normalisation and empathy (Russinova et al., 2014). Peer support has been shown to improve self-identity and self-esteem, make the individual feel more valued, and ultimately reduce internalised stigma (Repper, 2013). Qualitative accounts have supported this finding; service users state they appreciate "being around people who are the same", and that it brings "a silent understanding" (Wood et al., 2016b). Interventions for internalised stigma which have included peer support have also shown promising results (Corrigan et al., 2013; Russinova et al., 2014).

Developing personal recovery goals have been identified as an important protective factor. The 'recovery movement' has long emphasised the importance of overcoming stigma as part of the recovery process (Allot et al., 2002; Pitt et al., 2007). In addition to overcoming stigma, qualitative research has identified that having idiosyncratic goals are important to achieve despite stigma, for example gaining employment, accessing education and developing relationships (Andreasen et al., 2003; Wood et al., 2016b). In addition, having stable experiences of psychosis has been identified as an important protective factor against stigma as experiencing overt symptoms, such as responding to auditory hallucinations, can make you a vulnerable target for experienced stigma (Rusch et al., 2005; Wood et al., 2016b). Finally, and in relation to empowerment and righteous anger, service users have noted that that activism, such as open disclosure about personal experiences, or involvement in a service user movement such as the Hearing Voices Network (Corstens et al., 2014) and Mad Pride (Dellar et al., 2003), can be helpful in tackling both internalised and public stigma .

Case example

In order to demonstrate the application of this formulation a case formulation is presented with a brief treatment plan.

Mark was a 39 year old, White British, single man with a diagnosis of Paranoid Schizophrenia who had a history of experiencing auditory hallucinations and paranoid beliefs since university in his early twenties. He had recently been admitted into a psychiatric inpatient ward following a relapse of his psychosis. He was in hospital for four months and

nearer discharge was becoming more preoccupied with readjusting to his life away from hospital. In particular he was concerned about experiencing stigma and discrimination in social situations. Mark enjoyed going to the local pub to watch football but was reluctant to do so as he was concerned that others will judge him and verbally abuse him when he was out. His experiences of internalised stigma have been included in a formulation outlined in figure 2. Mark identified with the stigmatised group and has done since he received a diagnosis of Paranoid Schizophrenia a few years after his first episode of psychosis. Since this time, he has been concerned about stigma due to the negative media portrayals of "schizophrenics" being "crazy" and "violent". He has experienced verbal discrimination in the past as a result of responding to his voices in public, when passers-by called him "crazy" and a "nutjob". The recent trigger for his current internalised stigma cycle was being offered home leave from hospital. This triggered his core beliefs of being different and that others would be judgemental and rejecting.

In regard to the maintenance cycle of Mark's stigma beliefs, his appraisal was that when going out on leave others will call him "crazy" when he is out in public. This caused him to experience anxiety and fear in relation to the social context and activated his safety seeking behaviours of only going out when he really needed to, masking his voices, and being hypervigilant towards them. These safety behaviours in turn maintained his cycle of internalised stigma. Mark was keen to break the cycle of internalised stigma and we set up a series of behavioural strategies in order to challenge his belief that he would be called "crazy" when out on leave. Mark's behavioural experiments related to going out with his sister to the local pub as he was less likely to respond to voices when in the company of others and people were less likely to notice if he did as they would assume he was speaking to his sister. Mark became less preoccupied with what others thought of him and he was able to go out with his sister on a number of occasions which reduced his anxiety, and then later was able to go out on his own.

Clinical Implications

The outlined cognitive model of internalised stigma in psychosis is the first of its kind and has some important clinical implications in supporting service users to overcome internalised stigma. Essentially, it is imperative that future clinical interventions for psychosis target the cognitive and behavioural responses that are affected by stigma. To date, the research

examining the efficacy of interventions to reduce internalised stigma has been inconsistent with most trials not finding a significant improvement in their primary outcome (Wood et al., 2016c). In a systematic review of internalised stigma interventions, Wood et al. (2016c) concluded that the inconsistent findings were potentially due to the lack of formulation or conceptualisations of individual participants' internalised stigma difficulties. This present paper outlines a framework to support the development of idiosyncratic formulations of internalised stigma in order to inform clinical interventions. Furthermore, an idiosyncratic formulation would also facilitate personal understanding and normalisation which have been identified as important factors within internalised stigma interventions by service users (Wood et al., 2016a).

Specific recommendations for intervention include identification of the different levels of stigma cognitions (core beliefs and stigma appraisals) and identification of safety behaviours, which are both likely to be crucial in optimising the efficacy of intervention. Techniques for modifying cognitions in relation to internalised stigma include psychoeducation, normalisation, behavioural experiments, reducing avoidance and generating alternative explanations of stigma beliefs which have been used in previous internalised stigma cognitive therapy trials (Morrison et al., 2016; Uchino et al., 2012). Psychoeducation and normalisation have been highlighted as particularly helpful in alleviating internalised stigma by service users who experience psychosis (Wood et al., 2016a). In the same study, the therapeutic relationship was highlighted as particularly important and a process which modelled a non-stigmatising relationship. As a consequence, it is proposed that a good therapeutic relationship is important in implementing therapy for internalised stigma based on the model proposed here.

Finally, this model demonstrates the importance of the cultural context in causing and maintaining stigma, and that internalised stigma would not exist without it (Corrigan & Watson, 2002a). Therefore a final implication is the continued need to develop interventions which tackle stigma at a societal level through service user activism and public education.

In conclusion, this paper has presented a theoretical model of understanding internalised stigma using cognitive theory and SMT. It is the first model developed which can be used in clinical practice to develop a formulation with a person with experience of internalised stigma related to psychosis. It provides a framework for developing an idiosyncratic formulation and structuring a cognitive therapy intervention. Further randomised controlled

trials of cognitive therapy interventions for internalised stigma are required based on this theoretical model. Moreover, future studies should also test the mechanisms of action within the model. For example, examine whether cognitive strategies such as psychoeducation or normalisation reduces internalised stigma through impact on stigma appraisals and core beliefs. However, we also require change in public attitudes at a societal level, since eliminating the negative stereotypes of psychosis would ensure that there are no stigmatising attitudes to internalise.

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