Supplementary File

Description of Used Terms and Example of Database Search

For the SMD concept, we used terms for general definition of the disorders (“severe mental illness”, “serious mental disorder”) and for the main disorders: schizophrenia, psychosis, bipolar and “personality disorder”. For the anxiety and stress concepts, we included the close-related terms recommended by the APA Thesaurus (anxiety, anxious, stress, distress, "emotion regulation", "coping". For the intervention/self-regulation concept, we used, once more, close-related terms: intervention, program, therapy, training, "self management", "self-regulation", skills. These were combined in each database using Boolean operators (AND/OR) appropriately, and the terms were searched within the subject or major subject heading fields, depending on the database's indexing system, to ensure relevance and specificity in topic coverage. An example of the search string for APA PsycINFO is:

> MJ(“severe mental illness” OR “serious mental disorder” OR schizophren* OR bipolar OR psychosis OR "personality disorder") AND MJ(anxiety OR anxious OR stress OR distress OR "emotion regulation" OR "coping") AND MJ(intervention OR program OR therapy OR training OR "self management" OR "self-regulation" OR skills)

Equivalent terms were used for other databases with adjustments to syntax. We placed no filter on study design in the initial search to maximize sensitivity. In addition to published literature, we searched for grey literature sources, using the ProQuest Dissertations & Theses Global database to find doctoral dissertations or theses related to our topic (e.g., using similar keyword combinations). We also consulted a recent scoping review on self-management in youth to identify any potentially relevant concepts or references that might overlap with adult SMD self-management (Town et al., 2024).

In order to keep the focus of our broad terms on stress/anxiety, self-management/regulation and severe mental health, we limited the search of our descriptors in the main topics, deciding depending on the database classification: word in major subject heading (Medline, PsycINFO, and CINAHL Complete), abstract with Psychology MeSH Qualifier (Web of Science), and main subject (ProQuest Dissertations & Theses Global) categories.

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Atkinson et al. (1996)	UK	57	Quantitative (RCT)	Schizophrenia	-	Educational group program	2	20 weekly sessions (1.5 hrs each)	Problem-solving on symptom and stress management (e.g., stress sessions, relapse prevention); indirect coping strategy discussion	Significant improvements in quality of life (especially social functioning and social networks); no changes in mental state
Barbic et al. (2009)	Canada	33	Quantitative (RCT)	Schizophrenia, Schizoaffective disorder, Bipolar disorder	44.6	Recovery Workbook	2	12 weekly sessions (2 hrs each)	Psychoeducation (stress and stress response comprehension); coping strategies (physical wellness)	Significant improvement in recovery; no significant improvement in quality of life
Chen et al. (2009)	Taiwan	18	Quantitative (RCT)	Schizophrenia (acute phase)	39.1 (exp); 41 (ctrl)	Progressive Muscle Relaxation Training (PMRT)	3	11 daily sessions (25 mins each)	Progressive muscle relaxation (PMRT) using Jacobson's protocol; focused training to reduce physiological and psychological anxiety symptoms	Significant reduction in anxiety (BAI) scores in intervention group levels and improved well-being compared to controls at post-test.

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Chien et al. (2017)	Hong Kong, Taiwan, China	342	Quantitative (RCT)	Schizophrenia Spectrum Disorders	~26	(International) Mindfulness-Based Psychoeducation Group	3	12 sessions over 6 months	Same as Chien & Thompson (2014)	Significant reduction in PANSS scores, reduced hospitalizations.
Chien & Thompson (2014)	Hong Kong	107	Quantitative (RCT)	Schizophrenia	~25	Mindfulness-Based Psychoeducation	3	12 sessions over 6 months	Awareness, problem-solving, thought management, self-empowerment, body sensations management, community support, cultural reframing of emotional experience	Significant improvements in psychiatric symptoms, psychosocial functioning, and shorter hospital readmission durations
Cook et al. (2012a)	USA	519	Quantitative (RCT)	SMI (schizophrenia, schizoaffective, bipolar, MDD)	45.8	Wellness Recovery Action Planning (WRAP)	2	8 weekly sessions (2.5 hrs)	Identify early signs (stress self-management), crisis planning.	Significant reductions in psychiatric symptoms and improvement in quality of life

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Cook et al. (2012b)	USA	519	Quantitative (RCT)	SMI (schizophrenia, schizoaffective, bipolar, MDD)	45.8	Wellness Recovery Action Planning (WRAP)	2	8 weekly sessions (2.5 hrs)	Identify early signs (stress self-management), crisis planning.	WRAP significantly reduced anxiety (BSI subscales) and increased recovery (RAS) scores over time.
Dalum et al. (2018)	Denmark	198	Quantitative (RCT)	Schizophrenia (76.8%), Bipolar (23.2%)	~43	Illness Management and Recovery (IMR) Program	2	9 months, weekly 1-hr sessions	Psychoeducation about stress-vulnerability, stress management techniques (relaxation, coping skills).	No significant differences between IMR and control on functioning (GAF-F), symptoms (PANSS)
Davis et al. (2015)	USA	34	Quantitative (RCT Feasibility Study)	Schizophrenia or schizoaffective disorder	~53	MIRRORS (Mindfulness Intervention for Rehabilitation and Recovery in Schizophrenia)	3	16 weeks, 2 sessions/week (75 min); plus orientation & individual check-ins	Adapted Mindfulness-Based Stress Reduction (MBSR) techniques to the work setting – included mindfulness meditation, body scan, and mindful coping strategies	Participants in MIRRORS noted improved stress coping

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
									taught in group sessions (letting go of distressing thoughts/emotions)	
Derks et al. (2019)	Netherland	5	Quantitative (multi-cycle usability testing)	Borderline Personality Disorder (low emotional awareness)	28	Sense-IT Biofeedback App	3	3 development/test cycles	Ambulatory biofeedback via smartwatch to increase emotional awareness, monitor physiological arousal, promote self-observation	Increased self-awareness
Elkington et al. (2023)	UK	12	Qualitative (within RCT)	Bipolar I & II	50.4	Image-Based Emotion Regulation (IBER)	3	12 sessions within 16 weeks	Imagery rescripting, sensory cueing, meta-cognitive distancing, building positive imagery, competing imagery tasks, personalised anxiety image restructuring	Participants reported increased emotion regulation. Anxiety triggers was reduced.
Färdig et al. (2011)	Sweden	41	Quantitative (RCT)	Schizophrenia, Schizoaffective	~40	IMR	2	40 sessions over 9 months	Psychoeducation about stress-vulnerability, stress	Significant improvements in illness

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
									management techniques (relaxation, coping skills).	management, psychiatric symptoms (including anxiety)
Georgiev et al. (2012)	Bulgaria	64	Quantitative (RCT)	Schizophrenia (chronic)	~43	Progressive Muscle Relaxation (PMR)	3	Single PMR session (20 minutes)	PMR training (muscle tension-release technique)	Significant reduction in state anxiety and stress, and improved subjective well-being
Hasson-Ohayon et al. (2007)	Israel	210	Quantitative (RCT)	Schizophrenia, Bipolar, Depression	~34	IMR	2	~8 months, weekly sessions	Standard IMR	Improvements in knowledge, goal attainment, and clinician-rated coping
Hood et al. (2024)	Canada	240	Quantitative (RCT, Mechanisms Analysis)	Borderline Personality Disorder	27.75	Dialectical Behavior Therapy (DBT)	2	6 or 12 months	DBT modules on mindfulness, emotion regulation, distress tolerance	Emotion regulation partially mediated the relationship between increased mindfulness and reduced BPD symptoms
Jensen et al. (2019)	Denmark	198	Quantitative (RCT)	Schizophrenia (76.8%),	~43	Illness Management	2	9 months, weekly	Psychoeducation about stress-	No significant effect on clinical or

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
				Bipolar (23.2%)		and Recovery (IMR)		group sessions	vulnerability, stress management techniques (relaxation, coping skills).	personal recovery at one-year follow-up; no differences in symptoms, functioning
Jonikas et al. (2013)	USA	519	Quantitative (RCT)	SMI	-	WRAP (peer-led)	2	8 sessions (2.5 hrs each)	Identify early signs (stress self-management), crisis planning, self-advocacy.	WRAP significantly improved environmental quality of life, and psychiatric symptoms.
Kaplan et al. (2024)	Turkey	71	Quantitative (Quasi-experimental with control group)	Bipolar Disorder	~Mid-30s	Mindfulness-Based Psychoeducation Program	3	6 sessions over 3 weeks (2/week)	Mindfulness practices, stress psychoeducation, breathing and body scanning, present-moment awareness	Significant improvement in emotion regulation, and reduction in perceived stress
Lee et al. (2006)	Taiwan	29	Quantitative (Crossover RCT)	Chronic Schizophrenia	39.4	Work-related Stress Management Program	3	12 weekly sessions (1 hr)	Focused on managing workplace stressors: included psychoeducation about stress, relaxation training	Significant reductions in perceived work-related stress. At 3-month follow-up, they maintained

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
									(deep breathing, stretching) at work, problem-solving for job challenges, and improving coping self-efficacy	better stress management at work
Lee et al. (2022)	Australia	57	Quantitative (Pre-post, two-group comparison)	Borderline Personality Disorder (diagnosed and traits)	37.1	DBT-Comprehensive (DBT-C) and DBT-Skills Only (DBT-S)	2	6 months (DBT-S: 20 weeks; DBT-C: 12 months)	Stress tolerance, emotions identification and mindfulness	Significant reductions in psychological distress and emotion regulation was the strongest predictor of symptom improvement
Levitt et al. (2009)	USA	104	Quantitative (RCT)	SMI	52.9	IMR	2	20 weeks, 2x/week sessions	Taught residents skills for managing symptoms and stress (e.g. recognizing early signs of relapse, using relaxation or coping self-talk)	IMR improved illness self-management, QoL, and BPRS symptoms, esp. anxiety subscale

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Liakopoulou et al. (2023)	Greece	72	Quantitative (Pre-post)	Borderline Personality Disorder + Eating Disorders (AN/BN)	26.7	Standard DBT + CBT-E Strategies	2	12 months (weekly therapy and group sessions)	Distress tolerance, body awareness	Significant improvements in BPD symptoms (BSL-23), ED symptoms (EDE-Q), coping skill improvement linked to symptom reduction
Lin et al. (2013)	Taiwan	26	Quantitative (Pre-post, pilot)	Schizophrenia, Schizoaffective disorder	36.4	Intensive IMR (discharge-focused)	2	6 sessions over 3 weeks (90 min each)	Modified IMR focusing on relapse prevention planning, medication self-management, and stress-coping strategies for transition to community	Improved illness knowledge, insight, and affective symptoms
Meins et al. (2023)	Netherland	116	Quantitative (RCT, Protocol)	Schizophrenia-spectrum & other psychotic disorders	18–40 (targeted)	VR-SOAP (VR-Social Activities and Participation)	2	14 sessions over 14 weeks	Modular treatment with components on stress/anxiety: social anxiety, relaxation via VRelax in control group	-

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Melo-Dias et al. (2019)		5	Review	Schizophrenia	Adults	Relaxation techniques: PMR (Progressive Muscle Relaxation), exercise	3		Emphasis on PMR techniques—relaxation of muscle groups, breathing, mindfulness of tension	Significant reductions in state anxiety reported in 4/5 studies
Monroe-DeVita et al. (2018)	USA (multi-site)	101	Quantitative (Cluster RCT)	Schizophrenia-spectrum, Bipolar disorder	~44	IMR integrated into assertive community treatment (ACT)	2	Up to 42 sessions over 12 months	IMR modules	Clinician-rated illness self-management significantly improved; medium effect size on QLS-A
Morales-Alonso et al. (2024)	Spain	15	Qualitative study (Phenomenological interpretative approach)	Borderline Personality Disorder	36.6	Zentangle® Method-based nursing intervention	3	6 monthly sessions	Self-awareness (mindfulness practice), body relaxation (breathing, tension release), reflection about feelings.	Qualitative reports of reduction of anxiety, better emotional management, improvement of well-being.

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Norman et al. (2002)	Canada	121	Quantitative (RCT)	Schizophrenia	~35	Stress Management Program	3	12 group sessions + 12 individual follow-ups	Training in recognizing personal stress triggers, relaxation techniques (breathing, muscle relaxation), cognitive strategies for coping with daily stressors, problem-solving	No significant differences in symptoms, perceived stress, or life skills vs. control; fewer hospitalizations in stress management group over 1 year
Salyers et al. (2010)	USA	324	Quantitative (Cluster RCT)	SMI (schizophrenia, schizoaffective, bipolar	~42	ACT + IMR (peer-led)	2	2-year program (IMR offered as structured modules within ACT)	IMR strategies	IMR participants had reduced hospital use
Shon & Park (2002)	South Korea	40	Quantitative (Pre-post)	Schizophrenia	-	Medication and Symptom Management Education Program with	1	6 weekly sessions (1 hr)	Psychoeducation on stress, coping (muscle relaxation), self-efficacy	Significant reduction in stress levels and improvement in

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
						focus on self-efficacy				coping skills after intervention
Sosic-Vasic et al. (2024)	Germany	48	Quantitative (RCT)	Borderline Personality Disorder	~26	Imagery Rescripting (IR) for Emotion Dysregulation	3	2 sessions (1/week) + homework	Imagery rescripting of emotionally dysregulated behavior (EDB) imagery; cognitive reappraisal; distress tolerance; reducing intrusive imagery	Significant improvements in adaptive emotion regulation, emotional distress, and EDB; large effect sizes; gains sustained at 3-month follow-up
Stoffers-Winterling et al. (2022)		32 (qualitative), 31 (meta-analysis)	Review and meta-analysis	Borderline Personality Disorder (BPD		Psychotherapies: DBT, CBT, DBT-skills training, DDP	2		DBT explicitly addresses emotional dysregulation and distress tolerance (indirect stress/anxiety coping)	DBT and related therapies significantly improved BPD symptoms and indirectly supported stress/anxiety regulation, but this was not always isolated as a separate outcome

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Tan et al. (2017)	Singapore	50	Quantitative (RCT)	Schizophrenia, Bipolar, Depression, Schizoaffective	44.2	IMR- Singapore adaptation	2	12 months, biweekly sessions	Similar IMR curriculum focusing on symptom management (deep breathing, scheduling enjoyable activities) and social functioning.	The IMR group showed reduced psychiatric symptoms and perceived stress, and improved social functioning
Tan et al. (2021)	Singapore	40	Quantitative (Pilot RCT)	Schizophrenia, Depression, Bipolar Disorder	-	V-DESSERTS (Virtual screen-based stress management)	3	2 sessions over 2 days	Psychoeducation on stress and relaxation; VR-based guided imagery and relaxation; abdominal breathing; muscle relaxation; medication-related stress education	Significant improvements in perceived relaxation and knowledge; some reduction in subjective/objective stress, though not consistent across all measures
Van Den Berg et al. (2023)	Netherland	62	Quantitative (RCT)	Bipolar I & II	~45	Imagery-Focused CBT (ImCT) vs.	3	ImCT: 12 weekly 1-hr sessions; PE: 6	ImCT included mapping of problematic imagery, imagery	Both groups reduced anxiety; ImCT showed significantly

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
						Psychoeducation		weekly 2-hr sessions	rescripting, metacognitive distancing, positive/soothing imagery, and relapse prevention	greater reduction in daily anxiety
Vancampfort et al. (2011a)	Belgium	64	Quantitative (RCT)	Schizophrenia	-	Single-Session Progressive Muscle Relaxation (PMR)	3	25-minute session	Guided progressive muscle relaxation (systematically tensing and relaxing muscle groups) to alleviate acute anxiety and stress	Significant reduction in state anxiety and psychological stress; increased well-being; large effect sizes (d = 1.26 for well-being)
Vancampfort et al. (2011b)	Belgium	40	Quantitative (Within-subject trial)	Schizophrenia, Schizoaffective	~33	Exercise vs. Yoga Pilot Study	3	3 sessions (30/20 min each)	Breath control, relaxation (yoga); aerobic cycling at self-paced intensity; both aimed at reducing anxiety/stress and improving well-being	Both yoga and aerobic sessions significantly reduced anxiety/stress and improved well-being vs. control; large effect sizes (0.82–1.01)

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
Veltro et al. (2024a)	Italy	63	Quantitative (Pre-post)	Schizophrenia (82.5%), Bipolar w/ psychotic features (17.5%)	-	Functional Management and Recovery (FMR)	2	24 sessions over 3 months (2/week)	Muscle relaxation training; see stressful events as challenges (stress reinterpretatiom)	Significant improvements in functioning, recovery, BPRS, and stress management
Veltro et al. (2024b)	Italy	13	Observational (1-year real-world follow-up)	First-Episode Psychosis (Schizophrenia-spectrum)	Young adults (18–30)	Falloon Family Psychoeducation (Adapted for FEP)	2	1 year (flexible sessions)	Stress-vulnerability model, early stress/crisis management	Significant improvement in stress management, social functioning, and no relapses or dropouts across 12 months
Wibbelink et al. (2022)	Netherland	200	Quantitative (Multicenter RCT, Protocol)	Borderline Personality Disorder	18–65	DBT vs. Schema Therapy (ST)	2	Up to 25 months (group + individual; with maintenance phases)	DBT: Emotion regulation, distress tolerance, mindfulness	-
Zeifman et al. (2020)	Canada	84	Quantitative (RCT, Mechanisms Study)	Borderline Personality Disorder	29.7	DBT Skills Training (DBT-S)	3	20 weeks (weekly 2-hour group sessions)	Mindfulness and distress tolerance	Both mindfulness and distress tolerance improvements

Table S1

Included Studies Characteristics

Ref.	Country	N	Study design	Diagnoses	Age (Mean years)	Intervention	Stress/ anxiety focus	Length	Stress/ Anxiety Self-Regulation/Management Components	Results
										significantly mediated the effect of DBT-S on general psychopathology (distress, functioning)
Zoromba et al. (2024)	Egypt	65	Quantitative (RCT)	Primary Psychoses (schizophrenia -spectrum)	-	Acceptance and Commitment Therapy (ACT)	3	6 weekly sessions (90 min)	Psychological flexibility, mindfulness, acceptance, defusion, values-guided action, agency	Significant improvements in emotional regulation (DERS), recovery (RAS).

Note. ~: used when exact data not stated for the full sample. Stress/ anxiety focus: 1: Not Stress-Anxiety Focused, where it is focused on other components but has at list one part of stress/ anxiety management; 2: Partially Stress-Anxiety Focused (partially addresses anxiety/stress, mixed with other topics, more or less dedicating the same amount of time or sessions to both); or 3: Stress-Anxiety Focused (explicitly focuses on anxiety/stress reduction).

Table S2

Extended Illustrative Examples of Self-regulation Strategies Used in Anxiety/ Stress Interventions for SMDs, Categorized by Pintrich's SRL Phases

SRL Phase (Pintrich)	Strategies	Illustrative Interventions (source)
1. Forethought / Planning	*1. Psychoeducation* about illness, anxiety/stress (cognitive & contextual)	IMR (Dalum et al., 2018; Lin et al., 2013; Tan et al., 2017) includes early modules on stress-vulnerability and anxiety, or teaching individuals how to navigate mental health services effectively, including how to articulate their needs and access appropriate support within the healthcare system. WRAP (Cook et al., 2012a, 2012b) uses illness education and symptom anticipation.
	2. Goal setting for coping or recovery (cognitive & motivational)	WRAP (Jonikas et al., 2013) asks participants to set personal recovery and wellness goals, often related to anxiety triggers. DBT pretreatment (Lee et al., 2021; Zeifman et al., 2020) includes commitment and life planning.
	3. Action planning and contracts (cognitive and behavioral)	Färdig et al. (2011) and Norman et al. (2002) structured relapse prevention and symptom management plans with patient-generated steps.
	4. Enhancing motivation/hope (motivational/ affective)	Barbic et al. (2009) included empowerment and hope-building exercises; Zoromba et al. (2024) used values-guided action to increase perceived agency.
2. Monitoring *(Self-observation and awareness)*	*1. Self-monitoring of symptoms* (cognitive domain)	Derks et al. (2019 used real-time biofeedback for emotional awareness (the Sense-IT app). Cook et al. (2012a) WRAP plans include symptom journaling.
	2. Awareness of triggers (contextual)	Kaplan et al. (2024)'s mindfulness-based intervention trains identification of personal stress responses.
	3. Monitoring physical/bodily signs of anxiety (behavioral)	Chen et al. (2009); Vancampfort et al. (2011a) focused on recognizing and reducing physiological tension through PMR.
	4. Mindfulness (cognitive, motivational/ affective)	Chien & Thompson (2014); Morales-Alonso (2024); Zeifman et al. (2020) taught patients to observe emotions nonjudgmentally.
	5. Use of self-rating scales (cognitive)	Elkington et al. (2024) included reflective self-monitoring of anxiety imagery; Sosic-Vasic et al. (2024) used adaptive measures of distress and impulsivity.
3. Control / Regulation *(Implementing strategies to manage internal states or environment)*	*1. Cognitive restructuring* (cognitive)	Kaplan et al. (2024) and Van Den Berg et al. (2023) used imagery and cognitive reappraisal to reframe distressing thoughts.
	2. Problem-solving (cognitive)	Atkinson et al. (1996) and Hasson-Ohayon et al. (2007) incorporated group-based problem-solving for stress reduction.
	3. Relaxation techniques (behavioral/ physiological)	Chen et al. (2009), Vancampfort et al. (2011a, 2011b), and Georgiev et al. (2012) taught breathing and PMR.

SRL Phase (Pintrich)	Strategies	Illustrative Interventions (source)
	4. Mindfulness and meditation practices (cognitive, motivational/ affective)	Chien et al. (2017), Morales-Alonso (2024), and Tan et al. (2021) used meditation, Zentangle®, breathing, body scan.
	5. Emotion regulation skills (affective)	DBT (Hood et al., 2024; Wibbelink et al., 2022; Zeifman et al., 2020) taught skills like opposite action, distress tolerance.
	6. Social skills and assertiveness training (behavioral)	FMR (Veltro et al., 2024a) included assertiveness, group sharing, and emotional expression training.
	7. Behavioral activation & routine (behavioral, contextual)	Tan et al. (2017); WRAP emphasized activity scheduling and structure for stress relief.
	8. Exposure techniques (behavioral)	Meins et al. (2023) included modules for social anxiety and paranoia via VR exposure.
	9. Medication adherence strategies (behavioral)	Lin et al. (2013) and Shon & Park (2002) taught adherence to reduce relapse-related anxiety.
	10. Seeking social support (contextual)	WRAP, IMR, DBT groups (Lee et al., 2021) emphasize peer support, shared experiences, and collaborative coping.
4. Reaction & Reflection *(Self-reflection, metacognitive evaluation, and adaptation)*	*1. Reflective discussion* of what worked (cognitive)	Elkington et al. (2024) asked participants to describe which techniques helped with anxiety (transformative vs. practical use).
	2. Self-assessment of progress (cognitive)	Morales-Alonso (2024) and Zeifman et al. (2020) included reports of symptom reduction and increased awareness of coping.
	3. Attribution training (cognitive, motivation/ affective)	DBT therapists (Lee et al., 2021) often reinforced self-efficacy by attributing success to skill use.
	4. Booster sessions and relapse prevention (motivational/affective, contextual)	Cook et al. (2012a); Norman et al. (2002); IMR included relapse prevention modules and follow-up plans.
	5. Journaling (cognitive, motivational/ affective)	WRAP (Jonikas et al., 2013); Davis et al. (2015) used stress diaries and structured reflections.
	6. Feedback and graduation (cognitive)	Group-based CBT/DBT programs (Lee et al., 2021; Morales-Alonso, 2024) incorporated closure sessions for consolidating learning.
	7. Revising the plan (all)	WRAP updates (Cook et al., 2012a) encouraged participants to add/remove strategies based on lived experience.

Note. Strategies are categorized according to Pintrich's (2000) four-phase self-regulated learning (SRL) model and mapped across cognitive, affective, behavioral, and contextual domains. Many interventions include strategies spanning multiple phases or domains. Examples reflect representative interventions but are not exhaustive. Abbreviations: IMR = Illness Management and Recovery; WRAP = Wellness Recovery Action Plan; DBT = Dialectical Behavior Therapy; PMR = Progressive Muscle Relaxation; FMR = Functional Management and Recovery; VR = Virtual Reality.