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Group Treatment of Perceived Stigma and Self-Esteem in Schizophrenia: A Waiting List Trial of Efficacy

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Abstract. The experience of stigma by individuals with schizophrenia can impact on self-esteem and potential for recovery. Previous attempts to reduce stigma within society have reported variable success. The present study aimed to formulate and evaluate a therapeutic intervention for those who perceive themselves as stigmatized by their mental illness and who suffer low self-esteem. A waiting-list control design with repeated measures within participants was used. Treatment efficacy was evaluated by a principal outcome measure of self-esteem. Ancillary outcome measures included a measure of perceived stigmatization, and two symptom measures. Assessments were completed on four occasions, which covered a waiting list period, a treatment period and a follow-up. All participants ($N = 21$) received group Cognitive Behavioural Therapy (CBT) focused on stigma and self-esteem. Self-esteem improved significantly following treatment. Levels of depression, positive and negative symptoms of schizophrenia and general levels of psychopathology decreased significantly. A longer-term effect was found for positive and negative symptoms of schizophrenia, and general levels of psychopathology. Participant feedback was predominantly positive. In addition to societal interventions, the potential for limiting the effects of stigma within a therapeutic context should be investigated.

Keywords: Cognitive Behavioural Therapy, schizophrenia, self-esteem, stigma.

Introduction

The existence of stigma towards individuals with schizophrenia (henceforth service-users) is now widely accepted (see Hayward and Bright, 1997, for review). The potentially negative impact of that stigma on people's self-esteem, social functioning and recovery has also been demonstrated through empirical investigations (Wahl, 1999), in-depth qualitative explorations (Knight, Wykes and Hayward, 2003), and first-person accounts (Gallo, 1994). That this opinion is shared both by service-users and the general public (Knight, Wykes and Hayward, 2001) provides further evidence against conceptions of stigma purely as a product of a pathological state associated with psychiatric condition.

Targeting stigma

The aim of this study is to formulate, and evaluate an exploratory therapeutic intervention for those people who perceive themselves as stigmatized by their mental illness and suffer

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from low self-esteem. This represents a new approach. Stigma poses a severe problem to many service-users (see Penn et al., 1994). Any ensuing intervention may focus on providing methods of coping with stigma and its suggested effects. Link, Mirotznik and Cullen (1991) identified three primary methods of stigma coping: secrecy, avoidance-withdrawal, and education. These are defined as coping orientations and incorporate shifts in mental states and/or in behaviours. However, by acknowledging the effects of labelling and its durability, application of these coping orientations is reported to have, "consistent effects in the direction of producing more harm than good" (Link et al., 1991, p. 302). The emphasis of previous research is that stigma is an enduring *social* problem and, as such, cannot be successfully approached on an individual service-user level. Attempts have therefore been made to alter societal views through protest, education, and contact (see Alexander and Link, 2003; Couture and Penn, 2003). These have shown variable levels of success.

Two recent models of the effects of stigma have suggested that it may be possible to break the cycle of negative effects of stigma (Sartorius, 2001; Corrigan and Watson, 2002). In particular, Corrigan and Watson (2002) have developed a model of the personal responses to mental illness in which individuals who perceive negative responses to themselves and their illness as legitimate are likely to display low self-esteem and low self-efficacy (Jetten, Spears, Hogg and Manstead, 2000). In contrast, those individuals who perceive the stigma and discrimination to have low legitimacy display righteous anger. Righteous anger has been validated as conceptually similar to empowerment (Corrigan, Faber, Rashid and Leary, 1999). Critically, although these individuals have a disability, and recognize that it can elicit negative responses from other people, they maintain a positive level of self-esteem.

To the authors' knowledge, there have been only two previous stigma oriented groups for people with mental illness (Link, Struening, Neese-Todd, Asmussen and Phelan, 2002; Wieczynski, 2000). Wieczynski (2000) developed and implemented a stigma management group in which inpatient service-users ($N = 27$) attended three sessions focused on providing stigma coping skills. The results demonstrated that there were no significant increases in participant self-efficacy or knowledge when assessed following the group. However, participants reported that they perceived the group to be helpful, and the majority stated they would recommend the group to other people. This raises several key issues. The intervention itself was based purely on a psycho-educational foundation, without an overarching theoretical framework that focused on the method by which knowledge would be disseminated, and how that may relate to the participants themselves. In addition, the organization of the group as comprising only three sessions may well have proved a limiting factor concerning its efficacy, both for the amount of information that can be presented in this time-span, but also concerning inter-group processes, and the potential for normalization. That participants felt they had benefited from the experience may well reflect that the "outcome measures" subjectively perceived by the service-users were not represented in the study's objective outcome measures.

Link et al. (2002) conducted a study with members of a community-based psychiatric rehabilitation clubhouse program. Participants ($N = 88$) had a range of psychiatric diagnoses, the most common being schizophrenia (37%). The focus of the 16-session intervention, led by a social worker, was to discuss personal experiences, and suggest behavioural strategies to cope with or combat the social consequences of stigma. As before, the study may have been limited by its educational interactive format. In addition, as the sample incorporated individuals with

a range of psychiatric diagnoses, the intervention may have been less focused on the stigma issues pertinent within each client group (e.g. myths concerning dangerousness for persons with schizophrenia). Nonetheless, these studies provides impetus for further exploration of whether the experience and ramifications of stigma can be understood and challenged if approached from a multi-level perspective, combining the benefits of education and group experience, within a structured, therapist-led format.

The intervention proposed here uses a Cognitive Behavioural Therapy (CBT), rather than a purely educational approach, as CBT addresses negative self-evaluations that may be involved with the processes of maintaining positive symptoms. This approach to improvements in self-esteem has a better success rate (e.g. Hall and Tarrier, 2003; Lecomte et al., 1999).

Hall and Tarrier (2003) found a significant increase in levels of self-esteem following a seven-session CBT intervention (individual, not group) in which self-esteem was the primary focus. This increase was maintained to a significant level at follow-up. Participants ($N = 23$) in this randomized control trial were encouraged to elicit positive self-attributes, rate their belief that they held the identified quality, and identify specific behavioural examples as "evidence". Following identification of these examples, emphasis was given to any consequential increase in ratings. The authors comment that the simplicity of the intervention and the positive focus of the sessions may have contributed to its success.

The present intervention

The focus of this intervention is to target the service-user's response to public and self-stigma (see Dickerson, Sommerville and Origoni, 2002), challenge the legitimacy of the stigmatizing and discriminatory attitudes by others, and combine this with previously utilized self-esteem and empowerment techniques (Lecomte et al., 1999; Wykes, Parr and Landau, 1999). Interactive exchange between group members and therapists should provide diverse benefits to the service-users in terms of beneficial and detrimental coping strategies. The group format provides additional support that should counter the sense of isolation and exclusion frequently experienced by victims of stigma. Dickerson (2000) emphasizes the role of the normalizing rationale to "de-stigmatize the symptoms and lay them open to rationale argument" (Dickerson, 2000, p. 79; see also, Wykes, 2001).

It is expected that participants will demonstrate an increase in levels of self-esteem, empowerment, and a reduction in levels of psychopathology (Lecomte et al., 1999; Wykes et al., 1999). This intervention is not attempting to modify or invalidate "faulty" beliefs about stigma or discrimination. Stigma, prejudice and discrimination are present in society, and service-users are accurate in their perception that stigma exists. As such, the authors recognize the appropriateness of service-user views of stigma, their concurrent representation within the general population, and the negative ramifications. The aim is to challenge the legitimacy and subsequent assimilation of the stigma perceptions, thereby treating the putative negative effects of stigma on an individual level. It is thus anticipated that there will be no significant change in levels of perceived stigma recorded by participants.

The results of this intervention will further inform our understanding of how stigmatization affects self-esteem, and how those negative effects may be countered, and provide information as to the transferability and utility of CBT in novel and alternate applications. Furthermore, it will provide longitudinal evidence to elucidate the ramifications of stigma on individual self-esteem.

Methodology

Design

A waiting-list control design was used, with four repeated measures within participants: start of trial (T^0, week zero); pre-intervention (T^1, week six); post-intervention (T^2, week twelve); 6-week follow-up (T^3, week eighteen). The efficacy of treatment was evaluated using a measure of self-esteem. Secondary outcomes included measure of perceived stigmatization, and two symptom measures. Participants were allocated to one of three groups via a rolling programme of referrals from local community mental health teams. All groups underwent a 6-week evaluation (control) period, and all groups received therapy. Each group met weekly, for one hour, over a 6-week period, with a follow-up session 6 weeks later.

Intervention

The structural basis of the group is founded on two CBT interventions; group treatment of auditory hallucinations (Wykes et al., 1999), and the "I am super" group treatment for self-esteem (Lecomte et al., 1999). The goal was to inform, educate, and emphasize the similarity of experience of group members and by focusing on self-esteem, highlight potentially maladaptive coping strategies. Potential strategies that make the stigma experience controllable were developed with the overall aim of making the experience and impact of stigma surmountable.

CBT techniques were used as a basis for the intervention. A problem-solving approach, emphasizing the importance of social support within the group structure, was adopted. Themes of public and self-stigma, discrimination, coping, and labelling were discussed using the normalizing rationale as a leitmotif for the treatment. Within this, key themes and issues were raised, including; negative evaluations of self, selective disclosure of group leader experiences of stigma, the continuum of abnormal/normal behaviour, safety behaviours, myths and realities about schizophrenia, and myths and realities about dangerousness. Group leaders aimed to highlight the shared experiences of individual group members. In addition, sessions included elements of didactic psycho-education concerning information of stigma and mental illness, and the promotion of advocacy within a psycho-social framework. Information handouts were given to clients on the issues of mental illness, and advocacy.

Two therapists trained in methods of CBT, and with experience of therapy with persons who have schizophrenia, were present in each group (see Wykes et al., 1999). A summary of the intervention group protocol is given in Table 1.

Participants

All participants were aged between 18–65 years, provided informed consent and met DSM-IV criteria for schizophrenia spectrum disorders. They were also not currently experiencing an acute psychotic episode and were on stable doses of medication. Participants also had:

- A clinically significant low level of self-esteem (Index of Self-Esteem (ISE), Hudson 1982).
- A significant perception of public stigma (Perceived Devaluation and Discrimination Scale, Link, 1985).

Table 1 Outline of the CBT for stigma and self-esteem group intervention

Treatment session	Session theme	Elements of discussion
Week One	Stigma: concept and experience	Issues of discrimination, prejudice, relationship with service-user status
Week Two	Stigma: mental illness	Schizophrenia: self-perception, facts/myths, academic/theoretical models
Week Three	Stigma: dangerousness	Relevance to self, media representation, facts/myths, violence debate
Week Four	Stigma: coping	Sharing of coping methods, models of coping, hidden stigmas
Week Five	Stigma: self-esteem	Self-esteem game, responses to overt stigma – formal/informal, other stigmas
Week Six	Stigma: empowerment	Assertiveness techniques and role-play, advocacy
Week Seven	Stigma: follow-up	Progress following group. Coping methods employed

Table 2 Participant information

Information	Participants
Age in years	Mean: 39.32, *SD*: 8.785
Gender	Female: 10
	Male: 11
Ethnicity	White: 9
	Black: 8
	South Asian: 1
	Other: 3
Diagnosis	Schizophrenia: 8
	Paranoid schizophrenia: 12
	Schizo-affective disorder: 1
Current hospital status	Inpatient service-user: 7
	Outpatient Service-user: 14
Age of onset	Mean: 25.89, *SD*: 7.661 ($N = 20$)

- A belief that stigma was personally relevant/justified (self-stigma). Assessed qualitatively through consultation with mental health key workers. This focused on whether the issues of prejudice, discrimination, labelling, and stigma had been raised by or discussed with the service-user, and whether the service-user believed that these were personally relevant, and/or whether these had had ramifications within their personal life.

Twenty-one participants were recruited from the South London and Maudsley NHS Trust (see Table 2).

Measures: Main outcome measure

Self-esteem. Measured using the Index of Self-Esteem (ISE, Hudson, 1982). This is a 25-item self-report measure that "taps the subjective evaluation of self, as well as how one

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thinks others perceive him or her" (Brekke, Levin, Wolkon, Sobel, and Slade, 1993, p. 602), and has been used extensively (e.g. Brekke and Long, 2000; Nugent, 1994). The scale has a range of 0–100. Scores of 30 or above represent a clinically significant problem, 70 or higher indicates severe distress.

Secondary outcome measures

Coping with stress. Measured using the Cybernetic Coping Scale (CCS; Edwards and Baglioni, 1993), a 20-item version with items separated into two coping strategies; active and passive (Lecomte et al., 1999). Scores of 10 indicate no usage of that strategy, and 70 indicating maximum usage. A summative score of coping was used as the outcome variable.

Empowerment. Measured using a 4-point Likert type scale (1 = low empowerment, Rogers et al., 1997).

Perceived devaluation and discrimination. Measured using a 5-point Likert-type scale (1 = low belief, Link, 1985)

Psychotic symptoms. Measured using the clinical assessment tool, the Positive and Negative Syndrome Scale (PANSS; Kay, Fizbein and Opler, 1987). The potential ranges are 7 to 49 for the Positive and Negative Scales, and 16 to 112 for the general Psychopathology Scale.

Depression. Measured using the Beck Depression Inventory (Beck, Ward, Mendelson, Mock and Erbaugh, 1961), range 0 – 63 (most severe).

Statistical analyses

A random effects modelling procedure was used to investigate the potential changes in participants' self-concept, functioning, psychopathology, and affect during the CBT intervention, with subject as a random factor, and time a within-subject factor. The model "tracked" individual participant changes within the overall sample, and was fitted using restricted maximum likelihood methods that allowed participants with incomplete measurements to be used in the analysis (see Venables and Ripley, 1999).

Analyses were conducted on the level of change pre-treatment, during treatment, and treatment to follow-up. The interpretation of change over time defined as of "clinical importance" was then examined. For self-esteem, a clinical improvement was designated as an increase of 10%, and for symptom measures (psychopathology, depression) it was a 20% reduction.

To explore the potential associations of psychopathology and perceived discrimination at cross-sectional time points, correlation and partial correlation analyses (Pearson's r) were used.

Results

Participants

The participant sample was representative of those continuing to attend mental health services with a diagnosis of schizophrenia-spectrum disorders (Wykes et al., 1999), and those

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Table 3 Participant scores across time points

Measure	Assessment time point: mean (*SD*) and range			
	T^0	T^1	T^2	T^3
Self-esteem*	50.44 (*SD:* 13.659) 30 – 74	51.72 (*SD:* 15.925) 27 – 82	47.64 (*SD:* 13.759) 25 – 80	48.05 (*SD:* 13.861) 23 – 81
Coping	70.80 (*SD:* 25.341) 30 – 110	74.24 (*SD:* 15.636) 40 – 99	77.05 (*SD:* 21.775) 45 – 134	72.05 (*SD:* 20.236) 47 – 108
Empowerment*	2.35 (*SD:* 0.367) 1.89 – 3.25	2.16 (*SD:* 0.614) 0.00 – 2.93	2.18 (*SD:* 0.304) 1.79 – 2.82	2.31 (*SD:* 0.321) 1.71 – 3.00
Perceived discrimination	3.60 (*SD:* 0.606) 2.42 – 5.00	3.54 (*SD:* 0.776) 2.17 – 4.92	3.53 (*SD:* 0.692) 2.42 – 5.00	3.54 (*SD:* 0.729) 2.42 – 4.83
Positive symptoms	18.63 (*SD:* 5.550) 9 – 30	18.05 (*SD:* 4.588) 11 – 30	15.21 (*SD:* 6.188) 7 – 37	15.21 (*SD:* 6.520) 7 – 32
Negative symptoms	16.63 (*SD:* 4.400) 9 – 23	17.57 (*SD:* 4.214) 11 – 26	13.32 (*SD:* 4.448) 8 – 22	14.32 (*SD:* 4.522) 9 – 26
General psychopathology	37.68 (*SD:* 6.750) 29 – 52	39.05 (*SD:* 7. 110) 29 – 53	29.79 (*SD:* 8.574) 21 – 55	31.42 (*SD:* 10.787) 18 – 53
Depression	18.80 (*SD:* 9.157) 3 – 34	20.14 (*SD:* 9.759) 4 – 36	13.89 (*SD:* 8.082) 1 – 35	18.68 (*SD:* 13.703) 2 – 47

*Note: Self-esteem and empowerment measures are inversely scored

participating in CBT randomized controlled trials (Pilling et al., 2002). Trial attrition ($N = 2$) was very low.

Measures

Table 3 provides the data across all four assessments for all available data. No departures from normality were observed in the data.

Assessment of change over time

Assessments were undertaken to examine the putative changes over time in the primary and secondary outcomes. This was conducted by examination of the Control period ($T^0 - T^1$), Treatment period ($T^1 - T^2$, see Table 4), and for long-term effect, the Treatment/Follow-up

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Table 4 Estimated change in outcome measures over treatment period ($T^1 - T^2$)

Treatment period	Estimated change	Test of significance	Confidence interval	
			Lower bound	Upper bound
Self-esteem*	−4.49	$p = .044$	−0.12	−8.85
Coping	3.24	$p = .568$	−8.09	14.57
Empowerment*	−0.07	$p = .330$	0.07	−0.22
Perceived discrimination	−0.00	$p = .969$	−0.19	0.19
Positive symptoms	−2.91	$p = .001$	−4.64	−1.19
Negative symptoms	−4.23	$p < .001$	−5.88	−2.59
General psychopathology	−9.37	$p < .001$	−12.63	−6.10
Depression	−6.46	$p = .008$	−11.14	−1.77

*Note: Self-esteem and empowerment measures are inversely scored

Table 5 Estimated change in outcome measures over treatment-follow-up period ($T^1 - T^3$)

Treatment: follow-up period	Estimated change	Test of significance	Confidence interval	
			Lower bound	Upper bound
Self-esteem*	−4.10	$p = .067$	0.29	−8.43
Coping	−1.76	$p = .757$	−13.09	9.57
Empowerment*	0.05	$p = .500$	0.20	−0.10
Perceived discrimination	0.00	$p = .965$	−0.19	0.19
Positive symptoms	−2.91	$p = .001$	−4.64	−1.19
Negative symptoms	−3.23	$p < .001$	−4.88	−1.59
General psychopathology	−7.73	$p < .001$	−11.00	−4.47
Depression	−1.67	$p = .479$	−6.35	3.02

*Note: Self-esteem and empowerment measures are inversely scored

Period ($T^1 - T^3$, see Table 5). There were no significant changes over the control period in any of the measures. However, there was a significant change in self-esteem across the treatment period, and significant effects in positive, negative and general psychopathology, and depression. These findings were unlikely to occur due to other temporal changes as there were no significant changes over the control period. No significant effects were observed in coping and empowerment. In the Treatment-Follow-up period, the self-esteem effect reduced to a trend, but significant effects in positive, negative and general psychopathology remained.

In summary, the results demonstrated a significant treatment effect on the primary outcome measure and symptom measures. Levels of self-esteem increased significantly, while levels of depression, positive, negative, and general levels of psychopathology decreased significantly. A long-term effect (decrease between pre-treatment and follow-up) was found for positive, negative, and general levels of psychopathology.

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Clinically significant changes

Analyses were undertaken to assess the proportion of participants who demonstrated a change in the beneficial direction (e.g. increase in self-esteem), and the proportion who demonstrated a clinically significant change. Most participants demonstrated a beneficial change. Close to half of the participants demonstrated a clinically significant change on the measures of self-esteem (47.4%), positive symptoms (47.4%), and depression (42.1%). This rose to 78.9% on the negative symptoms scale, and 89.5% on the general psychopathology scale.

Most participants continued to report a change in the beneficial direction at follow-up. For 57.9% there remained a clinically significant reduction in positive symptoms and for 73.7% there remained clinically significant reductions in negative symptoms, and general psychopathology.

Exploratory analysis

Perceived discrimination was not associated with levels of psychopathology pre-treatment and as predicted did not change during the treatment period. Exploratory analyses using partial correlations did not reveal any associations between levels of perceived discrimination post-treatment and observed change in psychopathology over the treatment period.

Participant feedback

Participants were asked a series of quantitative and qualitative based questions concerning the group treatment experience. Initial questions were based on a 7-point Likert-type scale, (1 = most negative, 7 = most positive). In all responses, mean participant feedback was positive, with the overall group experience viewed most highly (mean feedback score across questions = 5.86).

Participants were invited to provide qualitative comments about the group experience. These were not subjected to formal analytic procedures, but certain themes recurred. For the service-users, listening to others' experiences, and not being alone in having the experiences discussed, was cited frequently, as was the ability to express one's views and "not [be] told off".

Discussion

This study aimed to explore the effectiveness of a group therapeutic intervention to counter the negative ramifications of the perception of stigma. The primary focus was whether service-user self-esteem would change as a result of CBT, with attention also directed at service-user empowerment, coping skills, and levels of psychopathology. It was hypothesized that self-esteem, empowerment, and coping would increase, that stigma perceptions would not change significantly, and that levels of psychopathology would decrease. The majority of these predictions were supported by the findings.

Change over time

The primary outcome measure, self-esteem, demonstrated a significant increase over the treatment period, which reduced to a non-significant trend at follow-up. As there was no

change in levels of self-esteem during the 6-week control period, it is probable that the treatment was instrumental in the reported increase. This finding is not only statistically significant but just under half of the participants displayed a clinical change in levels of self-esteem (increase of >10%) over the treatment period. A shift of 10% in self-esteem within a 6-week period represents a substantial improvement in the evaluative component of one's self-concept. The finding further demonstrates the potential efficacy of this intervention for these individuals.

Focusing directly on self-esteem, Hall and Tarrier (2003) report significant increases that were maintained at follow-up. That a necessary part of the current intervention was to explore difficult subject-matter (e.g. discrimination), this negated the possibility of treatment being exclusively positive in its content, and simple in its format – noted strengths of the Hall and Tarrier study. In a group format that was aimed directly at levels of self-esteem, Lecomte et al. (1999) did not find a significant effect. Interventions that have utilized CBT without a central focus on self-esteem (e.g. Kuipers et al., 1997; Wykes et al., 1999) have similarly found no significant effects on self-esteem, although Wykes et al. (1999) do report a non-significant trend.

Comparison between this study and previous interventions is limited by the novel approach taken in the current trial. The proposed link of the perception and internalization of stigma (Corrigan and Watson, 2002) has been indirectly tested and supported. Similarly, the assertion by Sartorius (2001) that the negative cycle of stigma, discrimination and lowered self-esteem can be broken at any point has been tentatively borne out by these findings. As predicted, the level of perceived stigma did not alter as a result of the CBT intervention. Service-users were neither challenged in their beliefs as to the extent that stigma and discrimination exist in society, nor was it suggested that stigma was a function of their psychopathology. Stigma was acknowledged, and the experience of it validated. However, the legitimacy of the stigma, and the extent to which the negative perceptions should be assimilated into a self-stigma, was discussed and challenged. Nonetheless, the size of the effect on self-esteem, although significant, was small, and did reduce after a short follow-up period to a trend. As such, caution must be applied in the interpretation and expected durability of these positive findings.

That these benefits were not retained at follow-up supports the proposal that the group may require more sessions to maintain the observed improvements. Pilling et al. (2002) highlight that "there is some suggestion that longer-term treatments are associated with a better outcome" (Pilling et al., 2002, p. 779), and the longevity of the self-esteem increase might be better evaluated through a longer intervention. Furthermore, while the treatment incorporated attempts to address negative self-evaluations (see Fowler, Garety and Kuipers, 1995), individuals may benefit from more extensive focus at a schema-based level (e.g. Fennell, 1998).

The predictions that levels of empowerment and coping would increase were not supported by the results. Corrigan and Watson (2002) propose that service-users who perceive the stigmatizing responses of others as having low legitimacy, display "righteous anger", validated as conceptually similar to empowerment (Corrigan et al., 1999). This reaction is embodied in advocacy and clubhouse rehabilitation models (Dickerson, 1998). The current intervention presented information regarding advocacy through discussion and handouts, as a "next-stage" for the service-users to take on if they so wished. Service-users were essentially "guided" through the therapy process, with transport and group reminders, and may have perceived that they were not asserting their independence *during* the treatment process. Therapy may

be viewed as a pre-empowerment stage, in which foundations are laid for later service-user empowerment.

The level of service-user coping showed a similar level of stability to empowerment, with no change reported during any of the trial periods. There are a number of potential causes of this. First, discussion in the treatment highlighted that prior to treatment, service-users were using maladaptive methods of coping in addition to other adaptive strategies. The participants may therefore be responding to this by using a greater number of strategies outlined as productive, but reducing the number of maladaptive strategies. Subsequent investigation with a larger sample size may benefit from a more detailed coping assessment.

In line with the study predictions, service-user depression reduced over the treatment period, but this improvement was not maintained at follow-up. However, over two-fifths of the service-users reported a reduction of 20% or more, indicating a substantial drop in feelings of e.g. sadness, loneliness, suicidality, and guilt, in comparison with the pre-treatment control period. As with the self-esteem findings, this could be influenced if more treatment sessions were provided.

In line with the study predictions, service-user psychopathology as measured by ratings of positive, negative and general symptoms, reduced over the treatment period and these changes remained significant at follow-up. Reductions in positive symptoms have been reported in interventions that were focused directly on self-esteem (e.g. Hall and Tarrier, 2003; Lecomte et al., 1999) in addition to those specifically focused on such symptoms (see Dickerson, 2000; Pilling et al., 2002, for review). Lecomte et al. (1999) propose "the decrease in positive symptoms we found stemmed from the group's empowering effect, which apparently somewhat buffered psychotic manifestations" (Lecomte et al., 1999, p. 412). Hall and Tarrier (2003) suggest it may be that "global symptom improvements are due to a 'halo effect', in that chronic and severely ill patients become less attentive to their psychopathology" (Hall and Tarrier, 2003, p. 329). Close and Garety (1998) propose that low self-esteem is a maintaining factor for the experiences of hallucinations and delusions, and in the current study, an increase in one, as predicted, may correspond with a decrease in the other. As there were no improvements in service-user empowerment and the change in positive symptoms remained after the potential halo effect of improved self-esteem had disappeared, unlike the Hall and Tarrier (2003) investigation, the proposition by Close and Garety (1998) appears the most likely. It may thus be that addressing issues of stigma has subsequent effects on positive symptoms.

Feedback

The feedback questionnaire represents an important aspect of the overall intervention, providing service-user input on the group process and group structure. The majority of the feedback given was positive, and this may provide some indication of why the study attrition rate was so low. Of the 21 participants, only one person who attended a treatment session left the group, with the other dropping out pre-intervention. With the exception of one person, feedback similarly supported the use of a group intervention, as participants noted the benefits of speaking with, and listening to, other service-users' experiences. A number of individuals felt that the number of sessions could be increased. This finding, combined with the overall positive appraisal and the statements that some service-users would recommend it to others, indicates the potential for a more in-depth therapy programme in the future.

There are a number of limitations to the current investigation. The sample is small, and although fairly representative of people receiving mental health treatment, caution must be applied as to generalization. The waiting list design is also not the most powerful to assess effects, and the follow-up period of 6 weeks is comparatively brief. However, the positive results suggest that the intervention should be a focus for further investigation. To evaluate the potential effects of "participating in a group", future research in which a control group participated in a similar "structured", but non-CBT, group activity, such as a psychosocial group intervention would further elucidate the suggested benefits of this current treatment.

Conclusion

Long term macro-social interventions to facilitate service-user recovery and community integration are essential, yet have to date shown variable levels of success (Couture and Penn, 2003). It has been acknowledged that even if progress is made, "we will never eliminate stigma" (Penn and Wykes, 2003, p. 207). If one considers that stigma may represent a method to maintain positive in-group biases, protect against existential anxiety, or maintain a hierarchical status quo (see Miller and Major, 2000; Sidanius, 1993), and that stigma and mental illness have been documented as connected for over 2000 years (see Simon, 1992), a paradigm shift of epic proportion would be required to remove stigma at its origins.

One should therefore additionally investigate the potential of limiting the effects of stigma. The reported benefits of CBT for stigma and self-esteem demonstrate the potential for addressing the issue of stigma through the service-user perspective, with short-term gains across a number of domains. Further investigations may confirm this reported utility.

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