

Self-Esteem and Psychosis: A Pilot Study investigating the Effectiveness of a Self-Esteem Programme on the Self-Esteem and Positive Symptomatology of Mentally Disordered Offenders

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Abstract. The importance of self-esteem in the development and maintenance of psychotic experiences has been shown in previous research. However, there has been little research into the role this plays in individuals with psychosis and forensic histories. The current study investigated the effectiveness of a standardized group programme for improving self-esteem in individuals with psychosis living in high security settings. Fifteen participants were included in the group programme and measures were taken to record changes in self-esteem and symptomatology. The results demonstrated significant improvements in self-esteem over the course of the group intervention, with some effects maintained at 3-month follow-up. Improvements in depressed mood were also found. The results demonstrated the effectiveness of a group intervention for self-esteem in individuals with psychosis. The findings of this study, alongside implications for further research, are discussed.

Keywords: Self-esteem, psychosis, cognitive-behavioural therapy, offenders.

Introduction

Research into self-esteem and psychosis has shown that low self-esteem is a common problem (Bowins and Shugar, 1998; Freeman et al., 1998; Lecomte et al., 1999; Silverstone, 1991), which may be related to poorer clinical outcomes. Low self-esteem has been implicated in the formation of persecutory delusions (Bentall, Kinderman and Kaney, 1994) and in the maintenance of delusions and hallucinations in patients diagnosed with schizophrenia (Garety, Kuipers, Fowler, Freeman and Bebbington, 2001; Smith et al., 2006).

The relevance of self-esteem in the treatment of psychosis is perhaps not surprising, given that the process of developing psychosis and the sequelae that follow can be traumatic, with significant implications for the development of negative self-concept. It has therefore been recommended that self-esteem is considered an important outcome measure in therapy, and is specifically targeted in the course of treatment. Barrowclough et al. (2003) have proposed that interventions that target negative self-worth may have a beneficial impact on positive symptoms. Psychological interventions have therefore developed, with self-esteem being the specific target of therapy (Hall and Tarrier, 2003; Lecomte et al., 1999). The findings of studies that have evaluated these interventions have produced mixed results, with some finding an increase in self-esteem, and a decrease in positive symptomatology (Hall and Tarrier, 2003). However, other studies have found that the self-esteem intervention resulted in an increase in the use of active coping strategies and a decrease in positive symptoms, but no direct effect on self-esteem (Lecomte et al., 1999). Conflicting results may be due to different methodologies (e.g. group therapy or individual therapy) and different measures of self-esteem.

Little research has been conducted into self-esteem and psychosis in mentally disordered offenders. This population present with issues that make them distinct, which may pose particular challenges to conducting clinical work in this group. For example, clinical experience suggests that mentally disordered offenders generally present with more long-standing, complex, and co-morbid mental health difficulties. Furthermore, these service users have the double stigma of having both psychosis and a history of offending behaviour. Detainment in hospital means that service users do not have readily available access to family or friends, they are not in employment, and are unable to easily access many resources that might have a beneficial effect on their self-esteem.

Given the emerging importance of self-esteem in the treatment and outcome of psychosis, it seems important to explore self-esteem in this group of service users. Therefore the aim of this study was to pilot a self-esteem group with service users with a background of offending behaviour who were detained in a high secure hospital and to investigate the impact of this group intervention on measures of self-esteem and psychiatric symptomatology.

Aims

The principle aim of this pilot evaluation was to test the following hypotheses:

- Does completing the self-esteem group improve self-esteem?
- Does completing the self-esteem group reduce psychiatric symptomatology?
- Does completing the self-esteem group alleviate depressed mood?

Method

Design

A within-subjects design was used. Participants were assessed at baseline, mid-way (5 weeks) through the programme, at the end of the programme (10 weeks) and at 3-month post group follow-up.

Participants

Participants were considered eligible for the group if they had a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder and experienced low self-esteem. Potentially eligible participants were excluded from the study if they had an organic illness, severe intellectual disability, and were not able to provide informed consent. Participants were also excluded if they were involved in other research. All participants in this study had a primary diagnosis of schizophrenia.

Procedure

Ethical approval was given by the Local Research Ethics Committee (LREC number 05/s1102/15). Participants were recruited from a high security inpatient NHS setting. Letters were sent to responsible medical officers and clinical psychologists in the hospital in order to identify potential participants. Prior to seeking informed consent from potentially eligible patients, the respective patient's responsible medical officers were asked to provide consent for their patient to be approached. Following consent, patients were approached by a chartered clinical psychologist (HL), and following a full description of the study, patients were invited to participate.

Assessments

Assessments were administered to participants at baseline, mid-group (5 weeks), post-intervention (10 weeks) and 3-month post group follow-up. All the clinical outcome measures were standardized measures, either self-report questionnaires or structured interviews with acceptable psychometric properties.

Self-esteem

Three self-esteem measures were used. This decision was made due to there being a lack of self-esteem measures that have been specifically developed for this patient population. The measures chosen have been routinely used with other patient populations and for research purposes. Three measures were used in order to ensure that where changes in self-esteem occurred, this was reflected in more than one measure, thus increasing the robustness of findings.

The Rosenberg Self-Esteem measure. (RSE; Rosenberg, 1965; Rosenberg, Schooler, Schoenbach and Rosenberg, 1995) is a 10-item self-report measure of self-esteem. Higher scores (range 0–30) are indicative of higher self-esteem.

The Robson Self-Concept Questionnaire. (RSCQ; Robson, 1989) is a 30-item self-report measure of self-esteem on which each item is scored on a 0–7 point scale. The scale provides a composite measure of self-esteem based on the dimensions of self-worth and significance, attractiveness, competence and ability to satisfy aspirations. The range of self-esteem scores for individuals with no evidence of psychological disorder is 132–142 (mean 137), with higher scores indicative of good self-esteem (Hall and Tarrier, 2003).

The Self-Image Profile for Adults. (SIP-AD; Butler and Gasson, 2004) consists of 30 self-descriptions and is a self-report questionnaire. Participants are invited to rate both themselves as they are and how they would like to be (ideal) along each self description. A self-image score (SI) represents how the individual feels about him/herself. A high self-image score suggests the person has a positive view of him/herself. Self-esteem (SE) reflects an individual's evaluation of him/herself. On the SIP-AD this is operationalized as the discrepancy between how the person sees him/herself and how they wish to be (ideal). A high score reflects a wide discrepancy and therefore lower scores are interpreted as reflecting high self-esteem.

Psychiatric symptomatology

The Positive and Negative Syndrome Scale. (PANSS; Kay, Fiszbein and Opler, 1987) measures 32 symptoms on 7-point Likert scales, deriving three composite subscales: Positive, Negative, and General Psychopathology. Higher raw scores indicate more severe symptomatology. The PANSS Depression item is a single item from the PANSS general psychopathology scale and was used to measure depression (score range = 1–7).

The PSYRATS. (Haddock, McCarron, Tarrier and Faragher, 1999) consists of two scales designed to rate auditory hallucinations and delusions. The auditory hallucinations subscale is an 11-item scale. The delusions subscale is a 6-item scale, which assesses dimensions of delusions. A 5-point ordinal scale (0–4) is used to measure both scales. A higher score reflects greater levels of symptomatology.

The Beck Depression Inventory. II (Beck, Steer and Brown, 1996) was used as a self-report measure of mood (score range 0–63).

Inter-rater reliability

Assessments were conducted by four raters. The same four raters evaluated their participants from baseline through to the 3 month follow-up. Three of the raters were involved in facilitating the self-esteem programme. A rater separate from the programme administered the PANSS assessments. All PANSS raters had undergone training using video assessment (with reliability at $r > 0.80$).

Treatment

The self-esteem programme was delivered by a chartered clinical psychologist (HL), a clinical nurse specialist in cognitive behaviour therapy, and an assistant psychologist. The self-esteem programme was based on Hall and Tarrier's self-esteem intervention (2003). The group programme was adapted for the forensic environment by one of the authors (AB). The principle

emphasis of the programme was the acquisition of skills in monitoring, noting and rehearsal of evidence of positive qualities. Additionally co-facilitators encouraged group members to recognize what they have done well within each group session.

The programme also involved cognitive restructuring of negative self-evaluations or self-criticism. To achieve this, the programme helped develop skills in awareness of self-criticism, weighing of evidence for such criticism, and the reappraisal of negative self-critical thoughts. Group members were also coached using the same method to cope with criticism from others.

Repeated rehearsal of skills was used to promote learning. The skills were modelled by co-facilitators so that group members were able to observe the component skills in action. The reliance on collecting evidence for positive qualities ensured that improvements in self-esteem were grounded in real life experiences. The programme ran for 10 weeks (one session per week, lasting approximately 2 hours 30 minutes).

Results

Participant characteristics

Two groups were run in the hospital. There were 15 (all male) participants in total. All participants completed the programme. The mean age of the participants was 35.27 years of age (SD 8.8) and the mean duration in hospital was 7 years. All participants had a psychiatric diagnosis of schizophrenia.

Outcome measures

Analyses were carried out using SPSS for Windows (Version 12). Descriptive statistics were conducted and further analyses were carried out using non-parametric tests. Friedman's analysis was carried out to test for any overall effects. Where a significant effect was identified, follow-up analysis using Wilcoxon signed ranks test was conducted to identify specifically where the effects were located.

Self-esteem measures

As shown in Table 1, Friedman's test demonstrated an overall significant effect for improvements in self-esteem as measured by the Rosenberg Self-Esteem Inventory, the Self-Image and Self-Esteem components of the SIP-AD. No overall significant effects were found on the Robson Self-Concept questionnaire. Further analysis using the Wilcoxon signed ranks test showed significant effects on the Rosenberg Self-Esteem inventory at the end of the group ($Z = 2.45$, $n\text{-ties} = 15$, $p < .05$) and at three month follow-up ($Z = 2.43$, $n\text{-ties} = 14$, $p < .05$). Significant effects were found at the end of the group for Self-Image ($Z = 2.48$, $n\text{-ties} = 13$, $p < .05$) and on the Self-Esteem components of the SIP-AD ($Z = 2.67$, $n\text{-ties} = 14$, $p < .01$). This effect was not maintained at 3 month follow-up.

Psychiatric symptomatology

There were no significant overall effects found on the PANSS positive or PANSS negative scales. Friedman's analysis revealed an overall effect on the delusions rating scale of the

Table 1. Change in assessment measures over course of treatment (mean, median and Friedman's analysis)

Measure	Pre-treatment mean, median and <i>SD</i>	Mid group mean, median and <i>SD</i>	Post-treatment mean, median and <i>SD</i>	3 month-follow up mean, median and <i>SD</i>	X ² ¹ (<i>df</i>)	<i>p</i>
Rosenberg	14.60, 16.00 (5.48)	16.53, 16.00 (5.78)	18.53, 19.00 (5.91)	17.93, 18.00 (5.47)	9.04 (3)	.03*
Robson SCQ	101.53, 105.00 (29.68)	114.40, 109.00 (32.79)	117.20, 112.00 (31.65)	115.47, 115.00 (26.02)	4.64 (3)	.20
Self-Image Profile (SI)	109.40, 108.00 (25.82)	113.67, 113.00 (30.44)	120.53, 120.00 (30.39)	118.33, 122.00 (28.72)	9.80 (3)	.02*
Self-Image Profile (SE)	46.60, 48.00 (20.36)	39.73, 39.00 (22.75)	35.87, 26.00 (25.64)	35.67, 26.00 (26.62)	12.16 (3)	.007*
PANSS** positive	13.27, 10.00 (6.56)	No mid group assessment	10.67, 12.00 (3.02)	11.20, 9.00 (4.62)	3.59 (2)	.17
PANSS** negative	16.27, 16.00 (6.42)	No mid group assessment	12.87, 12.00 (4.61)	12.80, 13.00 (4.31)	4.53 (2)	.10
PANSS** depression	10.07, 11.00 (3.15)	No mid group assessment	7.20, 8.00 (2.30)	8.56, 8.00 (2.80)	11.58 (2)	.003*
PSYRATS AH	7.40, 0 (14.22)	6.93, 0 (12.67)	2.40, 0 (7.37)	1.93, 0 (6.03)	6.07 (3)	.10
PSYRATS DR	5.67, 0 (8.69)	1.20, 0 (3.36)	3.47, 0 (6.51)	2.13, 0 (5.46)	9.72 (3)	.02*
BDI II	24.20, 25.00 (12.97)	17.47, 16.00 (10.50)	15.47, 15.00 (11.27)	15.07, 15.00 (10.26)	12.85 (3)	.005*

*significant results. **raw scores are reported for the PANSS scales.

¹Friedman's ANOVA.

PSYRATS AH – Auditory Hallucinations scale.

PSYRATS DR – Delusions rating scale.

PSYRATS, but not on the auditory hallucinations scale. Specific effects were found on the PSYRATS delusions scale between the start of the group and mid treatment ($Z = 2.023$, $n = 15$, $p < .05$).

An overall effect was found on the BDI II and on the PANSS depression scale. Significant effects were found on the BDI II between baseline and mid treatment ($Z = 2.25$, n -ties = 15, $p < .05$), baseline and end of treatment ($Z = 2.89$, n -ties = 14, $p < .05$) and baseline and 3 month follow-up ($Z = 2.84$, n -ties = 15, $p < 0.05$). A significant effect was found for the PANSS depression scale between baseline and end of treatment ($Z = 2.59$, n -ties = 13, $p < .05$). This effect was not maintained at follow-up.

Discussion

This preliminary study aimed to explore the effectiveness of a group intervention for self-esteem in patients with psychosis living in a forensic setting. The primary aim of the study was to evaluate whether the group programme would improve self-esteem in participants at the end of treatment and at 3-month post group follow-up. A secondary objective was to evaluate the effect of the programme on participants' psychiatric symptomatology and depressed mood.

The findings demonstrated an overall treatment effect for self-esteem at the end of treatment on the Rosenberg Self-Esteem Inventory and the Self-Image and Self-Esteem components of the SIP-AD. These effects were only maintained at 3-month post group follow-up on the Rosenberg Self-Esteem Inventory. No significant effects were found on the Robson Self-Concept Questionnaire. This is an interesting finding, especially as the Robson Self-Concept Questionnaire has items that require participants to reflect on quality of interpersonal relationships. Therefore, this measure may tap into measures of self-concept not targeted by the programme. Given this, overall the findings suggest that particular aspects of self-esteem were improved at the end of treatment compared with baseline. The evidence for maintenance of effects at 3-month follow-up was less convincing, with only the Rosenberg Self-Esteem Inventory revealing significant effects at follow-up.

Significant results were found for the Beck Depression Inventory II (BDI II). These effects were maintained at 3-month post group follow-up. It is noteworthy that there were strong correlations between the self-esteem measures and the BDI II. That is lower self-esteem was associated with more severe depressed mood. Therefore it is unclear whether changes in self-esteem were related to changes in depressed mood or vice versa. It is noteworthy that a large component of the self-esteem programme focused on identifying and challenging self-critical thinking. Self-critical thinking biases have been shown to be influential in the development and maintenance of psychopathology, in particular depression (Gilbert, 2005). Therefore it is entirely understandable that a programme that focuses on participants developing skills in monitoring, identifying and challenging self-criticism would lead to an improvement in mood in addition to self-esteem.

The study conducted by Hall and Tarrier (2003) demonstrated a reduction in patient symptomatology as a result of the self-esteem intervention. These findings were maintained at follow-up. The present study did not find a significant reduction on psychiatric symptomatology as measured by the PANSS, although there was a significant reduction found on the delusions rating scale measured by the PSYRATS. Most of the patients who entered the study were categorized as “below average” on the PANSS positive and PANSS negative scales. Subsequently, a significant improvement in these ratings would perhaps not be expected.

There were several limitations to this study. In particular, the study was conducted with a small sample of patients, without any matched control group. Future research should incorporate a larger sample size and include a matched control group, which would improve the reliability and generalizability of the findings. Furthermore, self-report measures of self-esteem and patient symptomatology were used. Such measures have not been validated with a forensic population or those experiencing psychosis. This may indeed explain why changes were not found on the RCSQ at the end of the group intervention. Future research could therefore include a measure that has been developed to assess perceptions of sense of self and others (aspects of self-esteem) in individuals with psychosis. For example, the Brief Core Schema Scale (BCSS; Fowler et al., 2006) is a new measure, which looks at schemata exploring self and others in psychosis, and preliminary findings demonstrate that it has good psychometric properties.

Facilitators involved in the delivery of the group intervention also aided participants in the completion of psychometric assessments. To reduce bias, an external rater who was not involved in delivering the programme administered the PANSS assessments. Future evaluation of the programme would be improved by using raters independent of the treatment programme.

Although significant treatment effects were found for self-esteem at the end of the group programme, it is less certain whether these treatment effects were maintained at 3-month post group follow-up. There may be several reasons for this. This is a population with highly complex needs, which may suggest that a more prolonged intervention is necessary for long-term effects. Furthermore, as suggested by Knight, Wykes and Hayward (2006), an intervention focusing on core schema might be necessary for long-term change. Participants in this group had limited access to resources and experiences that might enhance their self-esteem, making a group of this kind more challenging. Future groups may need to adapt the content and structure of the programme to take into account the limitations faced by participants in accessing experiences that improve self-esteem.

A large component of the programme focused on participants developing rational alternatives to their self-critical thoughts, in order to improve their self-esteem. Lee (2005), however, states that, although some individuals can generate alternative thoughts to self-criticism, they rarely feel reassured by such efforts and may continue to experience shame and low mood. A further development to the current self-esteem programme would therefore be to incorporate elements of Compassionate Mind Training (Gilbert and Irons, 2005) to facilitate participants' understanding of self-criticisms, and criticism from others.

In conclusion, the current study evaluated a self-esteem group intervention for patients with psychosis residing in a high security setting. The findings demonstrated an improvement in self-esteem over the course of the intervention, with a parallel improvement in depressed mood. Future replication of this study could involve a waiting list control group and independent rating of change in outcome. The programme content could be enhanced by inclusion of techniques developed from compassionate mind training techniques.

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