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Effectiveness of group cognitive-behavioral therapy in reducing self-stigma in Japanese psychiatric patients

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ABSTRACT

Objective: There is evidence that the stigma surrounding mental illness may be greater in Japan than elsewhere. However, few Japanese studies have focused on self-stigma (the internalization of social stigma), and few interventions to reduce self-stigma exist. To remedy this deficiency, we evaluated the efficacy of group cognitive-behavioral therapy (CBT) in reducing self-stigma and examined the relationship between cognitive restructuring and self-stigma.
Methods: We administered a 10-session group CBT program to 46 Japanese outpatients with anxiety and depressive symptoms (36 men, 10 women; mean age = 38.57 years, *SD* = 8.33; 20 diagnosed with mood disorders; 24 with neurotic, stress-related, or somatoform disorders; and 2 with other disorders). A pretest–posttest design was used to examine the relationship between cognitive restructuring and self-stigma. Outcomes were measured using the Japanese versions of the Devaluation–Discrimination Scale, Dysfunctional Attitude Scale, Beck Depression Inventory-II, State-Trait Anxiety Inventory State-Form, and Rosenberg's Self Esteem Scale.
Results: Participants exhibited significant improvements in depression, anxiety, and maladjusted cognitive bias and reductions in self-stigma. Cognitive bias was significantly correlated with self-stigma.
Conclusions: Group CBT is effective in improving both emotional symptoms and self-stigma in outpatients with anxiety and depressive symptoms. Reduction in self-stigma plays a mediating role in alleviating emotional symptoms and improving cognition.

1. Introduction

"The stigma of mental illness strikes with double misfortune" (Corrigan and Watson, 2002). Social or public stigma leads to difficulties such as inability to find work or housing. Moreover, when mental illness is identified and stigmatized, the individual patient may hold a variety of negative self-beliefs and thus agree with the public's beliefs and negative emotional reactions (Corrigan, 2004). This phenomenon is known as self-stigma, the prejudice that individuals with mental disorders feel toward themselves, and hinders recovery (Livingston and Boyd, 2010). Self-stigma is related to decreased self-esteem, self-efficacy (Corrigan et al., 2006; Link et al., 2001), and treatment adherence (Fung et al., 2008; Sirey et al., 2001), a decline in social adaptation (Perlick et al., 2001), and severe depressive symptoms (Pyne et al., 2004; Yen et al., 2005).

Treatment methods for reducing self-stigma have been investigated in recent years, particularly those incorporating the relationship between cognitive bias and self-stigma. Watson et al. (2007) proposed a cognitive process model explaining how negative self-beliefs may lead to self-stigmatization. Similarly, Corrigan and

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Calabrese (2005) indicated that both negative statements and negative cognitive self-schemas increase self-stigma. These studies suggest that focusing on changing negative beliefs using a cognitive behavioral approach can effectively reduce self-stigma. Therefore, a number of practical interventions have been based on cognitive behavioral therapy (CBT; Fung et al., 2011; Knight et al., 2006; MacInnes and Lewis, 2008; Yanos et al., 2011). Using a waitlist control design, Knight et al. (2006) examined a group CBT intervention aimed at reducing stigma and self-esteem in 21 individuals diagnosed with a schizophrenia spectrum disorder. Findings indicated that CBT reduced self-stigma, raised self-esteem, and mitigated depressive symptoms. Another study (MacInnes and Lewis, 2008) assessed a cognitive therapy-centered program for reducing self-stigma to treat 20 inpatients suffering from severe mental illness. A reduction in self-stigmatization was observed, although there were no significant improvements in either self-esteem or psychological health. A randomized controlled trial (Fung et al., 2011) examined the effectiveness of a largely cognitive behavioral treatment in a self-stigma reduction program in 66 patients with schizophrenia. The program consisted of 12 group and 4 individual follow-up sessions concerning psychoeducation, cognitive restructuring, motivational interviewing, social skills training, and goal attainment. When participants in the intervention group ($n = 34$) were compared to participants in a newspaper-reading group ($n = 32$). Researchers observed reduced self-stigma (in particular, a decrement in self-esteem) in the former, suggesting that the program facilitated improvements in self-esteem, readiness to change one's own problematic behavior, and treatment adherence. However, they also highlighted a need for further investigation regarding the sustainability of these effects.

There is evidence that the stigma surrounding mental illness may be greater in Japan than elsewhere. In a retrospective study, Naganuma et al. (2006) investigated the prevalence of mental disorders and use of mental health services in the Japanese community. Their findings demonstrated that 80% of people who had suffered from a mental disorder for 12 months did not receive treatment, those with major depressive disorder (MDD) were most likely to be treated, and 33% received some form of intervention. In contrast, in research conducted in the United States, an estimated 57.3% of respondents with MDD received some form of treatment in the 12 months preceding the study (Kessler et al., 2003). Furthermore, a WHO study revealed that only 5.7% of Japanese people had received treatment for a mental disorder in the previous 12 months, relative to 15.3%, 12.4%, 10.7%, and 7.8% in the United States, France, the Netherlands, and Germany, respectively (WHO World Mental Health Survey Consortium, 2004). The percentages in Western countries were relatively inconsistent, but higher than that of Japan. Taken together, these results suggest that rates of receiving mental health treatments are notably lower in Japan than in Western countries. This low consultation rate underscores the possibility that stigma surrounding mental disorders may play an important role in reluctance to seek treatment amongst people with mentally illness in Japan. Additionally, in a survey conducted by the Japan Ministry of Health, Labour and Welfare (2007), 43% of participants chose "feeling ashamed" in response to an item assessing their reluctance to consult a mental health professional.

There is little empirical data supporting the notion that attitudes toward mental illness differ between Asian and Western countries. Nevertheless, research has compared the degree of stigma surrounding mental illness in Japan to that in Australia (Griffiths et al., 2006), China (Haraguchi et al., 2009), and Taiwan (Kurumatani et al., 2004); in each case, there was greater stigma in Japan.

Self-stigmatization also occurs in individuals afflicted by mental illness (Corrigan and Watson, 2002). Because psychopathology is highly stigmatized in Japanese society, self-stigmatization may occur with any type of mental illness, regardless of severity. Several recent studies assessing ways to reduce self-stigmatization have been published (e.g., Fung et al., 2011; Knight et al., 2006; MacInnes and Lewis, 2008; Yanos et al., 2011). However, there are few such studies (Shimotsu et al., 2004) and insufficient related interventions in Japan.

The majority of the self-stigma literature focuses on people with severe mental illness. In particular, intervention studies (e.g., Fung et al., 2011; Knight et al., 2006) have included individuals diagnosed with schizophrenia or schizophrenia spectrum disorders. However, self-stigmatization is not exclusive to severe mental illness and affects individuals diagnosed with non-schizophrenic disorders (e.g., bipolar affective disorder, major depression; Borecki et al., 2010; Perlick et al., 2001; Sirey et al., 2001). A large epidemiological study conducted in 16 countries indicated that mental disorders, particularly comorbid depression and anxiety, showed robust associations with perceived stigma (Alonso et al., 2008). Moreover, the rate of perceived stigma in mental disorder patients was higher in Japan than in other countries. Accordingly, this study aimed to initiate self-stigma research in Japan by examining the relationship between group-CBT-related cognitive changes and self-stigmatization changes in depressive and anxious outpatients.

2. Materials and methods

2.1. Participants

Participants were 46 individuals (36 men, 10 women; mean age = 38.57 years, $SD = 8.33$) who underwent group CBT at a mental health clinic in Miyazaki Prefecture, Japan, between September 2007 and July 2012. Attending physicians had diagnosed participants with the following conditions according to the International Classification of Diseases, 10th Revision (ICD-10; WHO, 1992): mood disorders ($n = 20$); neurotic, stress-related, and somatoform disorders ($n = 24$); and other disorders ($n = 2$). All participants had been informed of their specific disorders by their attending physicians. The average time from the initial medical assessment performed at participants' first presentation to the clinic to the first program session was 393.87 days (range: 8–2126 days). The participants' demographic information is shown in Table 1.

The inclusion criteria were diagnosis of depression and/or anxiety and cognitive distortions. The exclusion criteria were delusional, personality, and/or developmental disorders and inability to attend group therapy due to excessive aggression or anxiety. The attending physicians explained to the patients who met the criteria that cognitive distortions or biases were responsible for their anxiety and depressive symptoms. The

Table 1
Participant demographics ($N = 46$).

Age (years)		38.57 ± 7.96
Sex	Male	36
	Female	10
Diagnosis	Mood disorders	20
	Neurotic, stress-related, and somatoform disorders	24
	Other	2
Marital status	Single	22
	Married	24
Living condition	Alone	5
	With family	41
Education	Secondary	16
	Tertiary	30