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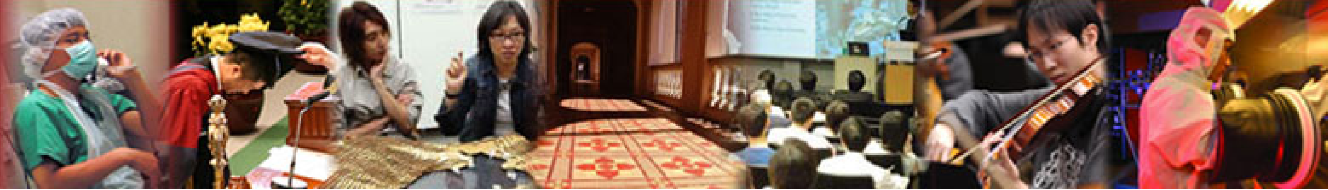

Title	The role of cognitive functioning and symptomology in self-stigma formation in psychosis
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Relationship between Cognitive Function and Symptomology with Self-stigma in Patients with Schizophrenia-spectrum Disorders

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Background

Self-stigma can be understood as a process of an individual gaining awareness of the associated stereotypes, agreeing with them and thus applying them to oneself [1]. This suggests the involvement of complex cognitive processes behind the development of self-stigma. Previous studies have also suggested that clinical symptoms are related to both cognitive function and self-stigma [2,3]. The current study examined the relationship of cognitive functions, clinical symptoms and self-stigma.

Method

Sixty-four participants with schizophrenia-spectrum disorders completed the Chinese validated version of the Internalized Stigma of Mental Illness Scale (ISMI) and a brief battery of cognitive assessments. Clinical symptoms and role function were assessed respectively by the Positive and Negative Syndrome Scale (PANSS) and the Role Functioning Scale (RFS).

References

[1] Corrigan P, Rafacz J, Rüsch N. Examining a progressive model of self-stigma and its impact on people with mental illness. Psychiatry Res 2011;189:339–43.

[2] Lysaker P, Vohs J, Tsai J. Negative symptoms and concordant impairments in attention in schizophrenia: Associations with social functioning, hope, self-esteem and internalized stigma. Schizophr Res 2009;110:165–72.

[3] Tsai J, Lysaker P, Vohs J. Negative symptoms and concomitant attention deficits in schizophrenia: Associations with prospective assessments of anxiety, social dysfunction, and avoidant coping. J Ment Heal 2010;19:184–92.

Results

Table 1: Correlations Among Cognition, Self-stigma, Functioning and Symptomology (corrected with false discovery rate).

	Composite Cognitive Score	ISMI[3] Alienation	ISMI Stereotype Endorsement	ISMI Discrimination Experience	ISMI Social Withdrawal
RFS[1] Total	0.34*	-0.05	-0.38*	-0.30*	-0.32*
RFS Work	0.23	-0.10	-0.30*	-0.28	-0.32*
RFS Independent Living	0.19	-0.05	-0.24	-0.18	-0.21
RFS Immediate Social	0.42**	-0.020	-0.38*	-0.25	-0.26
RFS Extended Social	0.32*	-0.020	-0.37*	-0.37*	-0.27
PANSS[2] Negative		0.20	0.42*	0.34*	0.34*
Composite Cognitive Score		-0.08	-0.32*	-0.29*	-0.22

Key: [1]Role Functioning Scale (RFS), [2]Positive and Negative Syndrome Scale (PANSS); [3]Internalized Stigma of Mental Illness (ISMI), * p < .05; ** p < .01 (after correcting with false discovery rate).

Further linear regression analyses were performed:

- Cognitive function explained 16.4% variance of **Stereotype Endorsement** ($F_{1,62}$ = 13.39, p = .001, R^2 = .178, adjusted R^2 = .164). Adding negative symptoms to the model, the two variables explained 21.2% variance of Stereotype Endorsement ($F_{1,61}$ = 9.46, p = .000, R^2 = .237, adjusted R^2 = .212)
- Cognitive function explained 7.9% variance of **Discrimination Experience** ($F_{1,62}$ = 6.43, p = .014, R^2 = .094, adjusted R^2 = .079).
- Negative symptoms explained 8.3% variance ($F_{1,62}$ = 6.69, p = .012, R^2 = .097, adjusted R^2 = .083) of **Social Withdrawal**.

Discussion

The results suggest that poor cognitive function is associated with self-stigma, though the specific nature of such a link was not explored due to the limitation of the study methodology. On the other hand, the link between self-stigma and role function provides an opportunity to form a hypothesis about the nature of the link between cognitive function and self-stigma. The study has further confirmed the link between negative symptoms and self-stigma. Future longitudinal study with a larger sample of patients with schizophrenia spectrum disorder at the same illness stage should be conducted to confirm the nature of such a proposed relationship.

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