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Stereotype endorsement, metacognitive capacity, and self-esteem as predictors of stigma resistance in persons with schizophrenia

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Abstract

Objective: While research continues to document the impact of internalized stigma among persons with schizophrenia, little is known about the factors which promote stigma resistance or the ability to recognize and reject stigma. This study aimed to replicate previous findings linking stigma resistance with lesser levels of depression and higher levels of self-esteem while also examining the extent to which other factors, including metacognitive capacity and positive and negative symptoms, are linked to the ability to resist stigma.
Method: Participants were 62 adults with schizophrenia-spectrum disorders who completed self-reports of stigma resistance, internalized stigma, self-esteem, and rater assessments of positive, negative, disorganization, and emotional discomfort symptoms, and metacognitive capacity.
Results: Stigma resistance was significantly correlated with lower levels of acceptance of stereotypes of mental illness, negative symptoms, and higher levels of metacognitive capacity, and self-esteem. A stepwise multiple regression revealed that acceptance of stereotypes of mental illness, metacognitive capacity, and self-esteem all uniquely contributed to greater levels of stigma resistance, accounting for 39% of the variance.
Conclusion: Stigma resistance is related to, but not synonymous with, internalized stigma. Greater metacognitive capacity, better self-esteem, and fewer negative symptoms may be factors which facilitate stigma resistance.
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1. Introduction

Stigmatizing attitudes towards mental illness are found across all levels of society [1] and tend to be relatively stronger towards persons with schizophrenia relative to those with anxiety and affective disorders [2,3] or with physical disabilities [4,5]. Members of the general public, for instance, often report feeling uncomfortable interacting with individuals with schizophrenia and associate that condition with an increased likelihood of behaving in unpredictable, dangerous, and even violent ways [6].

Stigma is a barrier to recovery in a number of ways [7]. Stigmatizing and stereotypic beliefs about schizophrenia often lead to social distance and discrimination, which reduces the likelihood of seeking out access to needed resources [8–10]. Additionally, persons with schizophrenia may also internalize stigma or accept the stereotypes about their illness as true about themselves. Internalized, or self-stigma, may lead persons to not only expect social rejection, but also believe that they deserve to be devalued members of society [11–13]. Not surprisingly, internalized stigma has been linked with a number of poor outcomes including greater amounts of emotional distress [14–17], decreased hope [18,19], self-esteem and self-efficacy [14,20,21], and meaning in life [21], as well as a generally poorer quality of life [15,16,18].

While research continues to document the impact of internalized stigma, less is known about whether there are certain factors which might promote stigma resistance or the

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ability to recognize and reject stigma. Importantly, stigma resistance is not conceptually synonymous with either experiences of stigma or internalized stigma. Thoits [22] defined stigma resistance as "opposition to the mental illness stereotypes by others," and theorized that persons with less severe symptoms and higher levels of psychosocial coping resources would tend to demonstrate more stigma resistance. Past studies of stigma resistance (using the stigma resistance subscale of the Internalized Stigma of Mental Illness Scale) have found that measures of discrimination experiences and stereotype endorsement are only modestly related to stigma resistance [14,15,23,24], but other factors such as symptoms have not been explored. Understanding what may promote effective stigma resistance may therefore have important implications for developing ways to help people better cope with and overcome internalizing stigma, a major barrier to recovery [25].

To date, we are aware of one study of the correlates of stigma resistance. Sibitz et al. [23] found that greater levels of stigma resistance were related to higher levels of self-reported self-esteem, empowerment, and quality of social connections, and to lower levels of internalized stigma and depression among 157 adults with a schizophrenia-spectrum disorder. They speculated that these variables could be considered to be protective factors for stigma resistance. For example, persons might be more inclined to resist stigma if they had higher levels of self-esteem or friends who supported their holding a more positive view of themselves.

In the current study, we have proposed to expand this by replicating the findings of Sibitz et al. [23] linking levels of self-esteem, self-stigma, and emotional discomfort with stigma resistance. We also aimed to examine the extent to which other factors discussed by Thoits [22] might also protect or work towards stigma resistance. The first of these factors was the severity of positive and negative symptoms. Consistent with Thoits [22], we anticipated that higher levels of both positive and negative symptoms might result in lower levels of stigma resistance. We reasoned that with greater levels of positive and negative symptoms persons may face more stigmatizing experiences, and they may be less able to effectively cope with these experiences, making them more likely to internalize and adopt as true the negative beliefs and feelings from these stigmatizing experiences. Persons may also withdraw due to stigma resulting in negative symptoms while withdrawal from society may also crystallize negative expectations [26,27].

The second factor which we thought would affect stigma resistance is metacognitive capacity. Metacognition may be defined as a spectrum of mental activities which involve thinking about thinking, ranging from instances when people recognize they have discrete thoughts and feelings to other instances in which an array of specific thoughts and feelings and connections between events, thoughts, affects and coping strategies are integrated into larger more complex wholes [28–31]. Metacognition has been referred to as a part of social cognition [32] though its relationship to social cognition and related constructs is a matter of debate [28,29]. We reasoned that with higher levels of metacognition, persons would have greater resources for resisting stigma. For instance, a richer or more complex picture of himself or herself might leave a person better able to see how stigma experiences do not match his or her own experiences, and so be able to resist them. Furthermore, the ability to correctly detect the mental processes of other people could allow for more abilities to resist stigma, especially when it is supported by the dominant social discourse [33]. Specifically, those abilities might include recognizing that the conclusions of others are subjective and fallible, counteracting schema-driven attributions, and identifying and seeking support from other people who resist and reject stigma.

A final aim of the study was to examine whether these different factors, positive symptoms, negative symptoms, emotional discomfort, metacognitive capacity, self-esteem, and self-stigma, were independently related to stigma resistance. While we anticipated each might be uniquely related to stigma resistance given that each might affect stigma resistance differently, we had no predictions about which factor might be the largest contributor to stigma resistance, and thus considered the analysis of this final question to be exploratory in nature. To rule out the possibility that disorganized thinking might account for an inconsistent or idiosyncratic response style, thus artificially creating relationships among the variables, we included a measure of disorganization symptoms as well.

2. Methods

2.1. Participants

Sixty-two participants with diagnoses of schizophrenia (n = 39) or schizoaffective disorder (n = 23), confirmed by the Structured Clinical Interview for the *Diagnostic Statistical Manual-IV* [SCID; 34], were recruited from the outpatient psychiatry clinic of a VA Medical Center (n = 62) for a study examining the impact of cognitive remediation and CBT on work capabilities of veterans diagnosed with schizophrenia. All participants were in a stable or post acute phase of their disorder as defined by participation in outpatient treatment with no hospitalizations or changes in housing or psychotropic medication within the last month. Exclusion criteria for this study included evidence, in participant's chart or interview, of organic brain syndrome or mental retardation. On average, participants were 50.92 years old (SD = 10.58), had 12.73 years of education (SD = 2.20), and had a median of three lifetime hospitalizations, with the first occurring at age 29.09 (SD = 11.72). Twenty-five were Caucasian (40%), thirty-six were African American (59%), and one was Latino (1%). Fifty-nine were male (95%) and three were female (5%).

2.2. Instruments

Positive and Negative Syndrome Scale [PANSS; 35] is a 30-item rating scale completed by clinically trained research