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Self-Esteem Prevalence Amongst Acute Psychiatric Inpatients; Socio-Demographic Correlates and Association with Internalized Stigma and User Satisfaction

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Abstract

Objective: A field research on the prevalence of self-esteem among discharged patients from acute mental health wards was performed, including its socio-demographic correlates and the association with internalized stigma and user satisfaction.

Method: Discharged patients from psychiatric acute units were recruited (N=311). Participants were asked to complete questionnaires including the Rosenberg Self-Esteem Scale (RSES), the Internalized Stigma of Mental Illness (ISMI) scale and the Satispsy-22-E.

Results: Length of stay over 30 days (OR=0.422, p<0.01), voluntary admission (OR=0.295, p<0.0001), diagnosis of bipolar disorder (OR=3.926, p<0.01) and diagnosis of schizophrenia (OR=2.333, p-value<0.05) were significantly associated to preserved self-esteem. Subjects with higher self-esteem reported lower internalised stigma.

Conclusion: The combination of stigma and low self-esteem usually leads to a lack of illness insight and, consequently, to a poorer psychological and pharmacological treatment adherence. Therefore, these factors might lead to worse outcomes. Stigma and self-esteem should be targeted as early goals when developing treatment plan regardless the patient's diagnosis.

Keywords: Self-esteem; Inpatients; Mental health; Stigma; User satisfaction

1. Introduction

Over the last few years, self-esteem has been suggested as a variable that may explain some behaviours regarding major public health issues including non-suicidal self-injury [1] and suicidal ideation [2, 3]. Low self-esteem is of considerable interest, not only as a possible consequence of stigmatization and internalized stigma [4] but also, according to some authors, as a potential cause of psychiatric symptoms [5]. Low self-esteem and depression seem to be strongly related, however the causal direction of this relationship –if any- has not been demonstrated yet [6]. Low self-esteem has been also related to eating disorders and substance abuse [7]. In addition, it has been involved in psychotic disorders both in the development of delusions [8] and the maintenance of psychotic symptoms.

Low self-esteem has been associated with suicide risk in population with schizophrenia. In particular, low self-esteem was significantly associated with the existence of previous suicide attempts, even after controlling for depression and perceived stigma [9]. On the other hand, significantly higher self-esteem has been positively related to age, educational achievement and income.

Female patients had a significantly lower self-esteem compared to male patients [10]. Interestingly, the literature on non-affected population does not strongly support this finding; women show more or less (or equal) self-esteem than men depending on the self-esteem domain [11]. Finally, self-esteem acts as a protective factor and, at the same time, can be influenced by different factors involved in mental illnesses. Discharge from acute inpatient mental health settings usually constitutes a significant moment in the patient's recovery and little is known about the self-esteem levels of these discharged patients. Hereby, we present a field study on the prevalence of self-esteem among discharged patients from acute mental health wards, its socio-demographic correlates and association with internalized stigma and user satisfaction.

2. Material and Methods

2.1 Study design and participants

The present study was carried out in the inpatient psychiatric unit of the Institute of Neuropsychiatry and Addictions (INAD) of Parc de Salut Mar. The INAD provides psychiatric services to a catchment area of almost 600,000 adult people. The sample of the current study was obtained from several wards of INAD's trust between May and October

2016. The final sample consisted of 311 discharged patients (N=311). Sample characteristics are shown in Table 1. Patients were invited to enter the study by the treating staff and signed informed consent was obtained from all participants. Scales were administered by the nursing staff. The study was approved by the Ethics Committee of Clinical Research of the Parc de Salut Mar (2015/6531/l).

2.2 Measures and instruments

Socio-demographic and clinical data were obtained from medical records. Self-esteem was assessed by means of the Rosenberg Self- Esteem Scale (RSES) [12]. This is a 10-item self-report instrument that is answered using a 4-pointsLikert scale format ranging from strongly agree to strongly disagree. The validated Spanish version of the RSES was used for this study [13].

Internalized stigma and stigma resistance were measured by means of the Internalized Stigma of Mental Illness Scale (ISMI), which is a 29-item scale that assesses self-stigma across 5 subscales: alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance. All items are answered using a 4-points Likert scale format ranging from strongly disagree to strongly agree. The ISMI produces a resulting score for each subscale, as well as a total score. Research has suggested that the Stigma Resistance subscale is conceptually different to the other subscales. For this reason, stigma resistance (SR) is considered as a separate construct to self-stigma [14, 15].

Patient satisfaction was assessed using the Satispsy-22-E questionnaire. It is a specific and self-administered scale based on the psychiatric patients' perspective and provides a multidimensional profile in relation to satisfaction during hospitalization. It contains 22 items describing 6 dimensions related to hospitalization: satisfaction with the staff, quality of care, personal experience, information, activity and food. Satispsy-22 also includes a total index score. Both the different dimensions and the total index scores range from 0 to 100 [16]. The Spanish version used in this study was validated by Frías et al. [17].

2.3 Statistical analysis

Descriptive statistics of the sample included frequencies and percentages of categorical variables, means and standard deviations of continuous variables. In addition, self-esteem was transformed into a dichotomous variable according to its mean scores: 0 for mean scores equal or lower than 25 (low level), and 1 for mean scores higher than 25 (high-mid level). Descriptive analyses were conducted to study the sample characteristics. Pearson's correlation coefficients were used to describe relationships between self-esteem and internalized stigma (and its subscales), as well as stigma resistance and hospitalized patient' satisfaction (and its subscales). This was followed by an analysis of variance (ANOVA) to compare means and detect differences between internalized stigma, stigma resistance and hospitalized patient' satisfaction, and the two self-esteem levels: high-mid and low. With the aim of establishing variables associated with self-esteem, our dependent variable, logistic regression models were applied to the following independent variables: (1) ISMI and (2) its four subscales; (3) Stigma resistance; (4) Satispsy-22-E and (5) the six subscales of Satispsy-22-E. For all the analyses, the level of statistical significance was defined as a less than 0.05. Data analyses were performed using the R statistical software.

3. Results

3.1. Socio-demographic and clinical characteristics

Socio-demographic and clinical features of the study sample are reported in Table 1. Participants had a mean age of 45 years and 45% were women. All patients were Caucasian. The percentage of voluntary admissions for inpatient treatment was 42.7 and 61.4% were readmissions. According to length of hospitalization, 28.2% of patients stayed longer than 30 days. As for diagnoses, 30.8% presented with schizophrenia spectrum disorders and 23.4% with bipolar disorder. The prevalence of low self-esteem was 24.4%.

Variable	**n**	**%**	**self-esteem**	**N (%)**
			High-mid	**Low**
Overall	311		235 (75.56)	76 (24.44)
Gender				
Male	171	55	137 (80.12%)	34 (19.88%)
Female	140	45	98 (70%)	42 (30%)
Age Mean (SD)	311		45.47 (14.78)	44.63 (14.31)
Marital Status				
Married	59	19	41 (69.49%)	18 (30.51%)
Not Married	252	81	194 (76.98%)	58 (23.02%)
Education Level				
Basic	199	64	152 (76.38%)	47 (23.62%)
Secondary/University	112	36	83 (74.11%)	29 (25.89%)
Economic Income				
Yes (employed/pensioner)	203	65	156 (76.85%)	47 (23.15%)
No (unemployed)	108	35	79 (73.15%)	29 (26.85%)
Diagnosis[a]				
Bipolar Disorder	73	23	64 (87.67%)	9 (12.33%)
Depression	40	13	21 (52.5%)	19 (47.5%)
Schizophrenia	96	31	76 (79.17%)	20 (20.83%)
Other non-organic Psychosis	38	12	30 (78.95%)	8 (21.05%)
Other Diagnosis[b]	64	21	44 (68.75%)	20 (31.25%)
Drug Abuse				
Yes	143	46	112 (78.32%)	31 (21.68%)
No	168	54	123 (73.21%)	45 (26.79%)
Readmission				
Yes	191	61	137 (71.73%)	54 (28.27%)
No	120	39	98 (81.67%)	22 (18.33%)
Type of Admission				
Voluntary	133	43	81 (60.9%)	52 (39.1%)

Involuntary	178	57	154 (86.52%)	24 (13.48%)
Length of Stay				
<30 days	223	72	180 (80.72%)	43 (19.28%)
≥30 days	88	28	55 (62.5%)	33 (37.5%)

[a]Psychiatric diagnosis defined by the International Classification of Diseases (ICD-9); [b]Personality disorder, Anxiety, Drug dependence, Nondependent abuse, Adjustment reaction, Disturbance of conduct.

Table 1: Socio-demographic and clinical characteristics by level of self-esteem.

3.2. Correlates of self esteem

Logistic regression analysis of socio-demographic and clinical features revealed that gender (female), age, length of stay (≥30 days), diagnosis (bipolar disorder and schizophrenia) and type of admission (voluntary), were significantly associated to self-esteem (Table 2).

		95% Conficence Interval(CI)		
	Odds Ratio	**Lower CI**	**Upper CI**	**P-value**
Woman	0,523	0,279	0,981	0,043*
Age	1,029	1,004	1,055	0,021*
Length of Stay (≥30)	0,422	0,226	0,788	0,007*
Educational Level (Secondary/University)	0,890	0,479	1,654	0,713
Economic Income (No)	0,710	0,369	1,365	0,305
Not Married	1,350	0,624	2,921	0,446
Readmission (Yes)	0,514	0,263	1,001	0,050
Bipolar Disorder	3,926	1,494	10,315	0,006*
Depressive Disorder	0,804	0,311	2,076	0,652
Schizophrenia	2,333	1,022	5,326	0,044*
Other non-organic psychosis	1,519	0,539	4,282	0,430
Drug Abuse	1,000	0,521	1,920	1,000
Voluntary Admission	0,295	0,154	0,564	0,000**
Constant	2,451	0,494	12,151	0,273

* <0.05; **<0.001

Table 2: Socio-demographic and clinical correlates of self-esteem.

3.3. Correlation of self-esteem with internalised stigma, stigma resistance and inpatients satisfaction

As presented in the results of correlation analysis (Table 3), self-esteem was negatively correlated with internalised stigma and all four subscales of ISMI. Also, self-esteem was positively correlated with stigma resistance. The satispsy-22-E scale does not correlate with self-esteem.

Scales/dimensions	RSES	Alienation	Stereotype Endorsement	Discrimination Experience	Social Withdrawal	ISMI Total score	Stigma_resistance
ISMI							
Alienation	-0.69 **						
Stereotype endorsement	-0.568 **	0.653 **					
Discrimination experience	-0.423 **	0.602 **	0.563 **				
Social withdrawal	-0.556 **	0.734 **	0.682 **	0.633 **			
ISMI Total score	-0.663 **	0.888 **	0.846 **	0.795 **	0.894 **		
Stigma Resistance	0.438 **	-0.328 **	-0.46 **	-0.153 *	-0.315 **	-0.373 **	
Satispsy-22-E Total score	-0.036	0.048	0.008	-0.142 *	0.057	0.002	0.017
* <0.05							
**<0.001							
RSES: Rosemberg self-Esteem Scale.							
Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal and Stigma resistance are subscales of the ISMI.							
ISMI was calculated using the following subscales: Alienation, Stereotype Endorsement, Discrimination Experience and Social Withdrawal.							

Table 3: Correlations between self-esteem, internalized stigma, stigma resistance and satisfaction.

3.4. Anova of internalised stigma, stigma resistance and hospitalisation satisfaction by self-esteem

The mean scores of internalised stigma and all subscales were significantly different between participants with low and high self-esteem. Results showed that those with high self-esteem reported lower internalised stigma, while patients with low self-esteem reported higher scores (Table 4).

Variable	Self-esteem			
	High-Mid*	Low**	F	P
ISMI				
Alienation	1.797(0.545)	2.682(0.627)	2038.64	<0.01
Stereotype Endorsement_	1.611(0.427)	2.056(0.564)	2164.44	<0.01
Discrimination_Experience_	1.997(0.557)	2.418(0.587)	2168.57	<0.01
Social_Withdrawal_	1.842(0.554)	2.401(0.579)	1965.7	<0.01
Total_Score_without_Stigma_Resistance	1.796(0.435)	2.374(0.473)	2999.56	<0.01
Stigma_Resistance	2.99(0.569)	2.658(0.594)	3990.34	<0.01
SATISPSY-22-E				
Staff	87.28(13.973)	86.264(20.067)	4140.56	<0.01
Qualiy of care	82.635(16.322)	80(19.685)	30.48.96	<0.01
Personal experience	50.216(26.759)	48.942(27.898)	456.62	<0.01
Information	69.951(27.177)	65.769(29.338)	829.74	<0.01
Activity	57.574(35.001)	62.308(30.014)	488.73	<0.01
Food	73.768(24.969)	72.115(26.587)	1120.92	<0.01
Total Score	70.237(14.867)	69.233(18.09)	2662.39	<0.01

* self-esteem high-mid >25 RSES; **self-esteem low <=25 RSES

Table 4: Score of interalised stigma, stigma resistance and hospitalization satisfaction [mean (SD)] by level of self-esteem.

3.5 Internalised stigma, stigma resistance and hospitalization satisfaction as predictors of self-esteem

Separate logistic regression revealed that while ISMI total score and Alienation were negatively associated with self-esteem, stigma resistance was positively associated (Table 5).

	Odds Ratio	**Lower CI (95%)**	**Upper CI(95%)**	**P-Value**	**AIC**
ISMI					
Alienation	0.084	0.036	0.183	<0.001	249.547
Stereotype Endorsement	0.646	0.256	1.581	0.346	
Discrimination Experience	1.212	0.575	2.636	0.618	
Social Withdrawal	1.165	0.492	2.803	0.73	
Total Score without Stigma Resistance	0.061	0.027	0.123	<0.001	269.086

Stigma Resistance	2.612	1.667	4.177	<0.001	331.84
SATISPSY-22-E					
Staff	0.997	0.974	1.02	0.821	305.39
Quality of care	1.011	0.99	1.032	0.298	
Personal experience	1.003	0.991	1.015	0.648	
Information	1.006	0.995	1.017	0.262	
Activity	0.989	0.978	1	0.059	
Food	1.004	0.991	1.016	0.558	
Total Score	1.004	0.986	1.022	0.653	300.735

Table 5: Associations between self-esteem and internalised stigma, stigma resistance and hospitalization satisfaction.

4. Discussion

The socio-demographic characteristics show women are less likely to have high or mid self-esteem levels. Gender patterns are often reported in self-esteem studies. However, the evidence for an inner-relationship between female gender and low self-esteem in the general population is weak, and most of the existing articles point to gender differences in some self-esteem domains, in all possible directions, rather than a strong and direct association between poor self-esteem and female gender. Interestingly, morale and ethics self-esteem-related domains are higher amongst women [11]. Those domains could be more likely to change with the appraisal of a mental condition and, of course, with the occurrence of a psychiatric admission. Interestingly enough, women suffering from psychotic disorders reported a high prevalence of sexual trauma [18] which is known as a risk factor for low self-esteem. Actually, the sense of this association has led to several speculations, with some groups defending than (pre)psychotic women may constitute a sort of propitiatory victim [19] and others that sexual trauma leads to or worsens psychosis [20, 21].

We found out that bipolar and schizophrenic patients were more likely to have self-esteem completely preserved. This outcome in a population with bipolar disorder is consistent with other studies reporting higher self-esteem in bipolar patients compared to other conditions [22]. Several studies pointed out distinctive features of self-esteem during the course of remission in bipolar disorder: continuous mood and perception shifting include fluctuations in self-esteem [23, 24]. However, other studies suggest that despite self-esteem fluctuates in patients with bipolar disorder or remitting bipolar disorder, who seem to have higher self-esteem, it tends to be low overall [25].

Different studies have been published about the relation between psychotic symptoms and self-esteem, showing a relatively strong association between self-esteem and self-stigma in people with schizophrenia. Moreover, it has been suggested that premorbid functioning is an important aspect in the development of self-esteem.

Some authors have reported an association of lower self-esteem in schizophrenic subjects with poor evolution signs including increased negative symptoms and attention problems [26]. Interestingly, this would nicely fit with our

finding of a higher self-esteem associated to recovery signs in schizophrenia. Future studies should consider examining its fluctuations across the course of illness.

In our sample, self-esteem was negatively correlated with internalized stigma and all of its subscales. This is in line with recent studies reporting that, in fact, self-esteem is significantly and negatively associated with internalized stigma amongst psychiatric outpatients [27]. Yanos et al. (2008) described how internalized stigma reduced sense of hope and self-esteem, which in turn resulted in negative outcomes related to recovery including social avoidance, depressive symptoms and a preference for using avoidant coping style. Stigma and low self-esteem might be on the origins of lack of self-awareness and lack of illness insight-. This presentation may enhance treatment adherence problems [28]). Stigma and self-esteem should become therapeutic goals in every integrative prophylactic intervention [27-29].

Our findings from logistic regression analyses revealed that only internalized stigma and alienation were significantly associated with self-esteem; participants with high internalized stigma or alienation were less likely to develop high-mid self-esteem respectively. The strong association between the alienation subscale and self-esteem is not surprising and confirms that this aspect of self-stigma is the strongest predictor of self-esteem as suggested in previous studies [30, 31]. This could support theories about self-esteem pointing at the importance of interpersonal appraisals in the value of self [32]. The feeling of alienation can be increased by other factors like admission to restrictive wards.

Self-esteem was positively correlated with stigma resistance, which is higher in individuals with high-mid self-esteem than in those with low self-esteem. Some people with mental illness who internalize stereotypes, negative beliefs of dangerousness, prejudice and discrimination suffer from significant self-esteem and self-efficacy slumps, which may undermine goal pursuit related to aspects of living independently, such as employment [33]. On the other hand, it seems that those people who developed skills to fight against self-stigma and increase self-esteem may become, somehow, resilient to stigma [34], which would be in line with results from previous studies.

This is a study focussing a major interest subject, caring for the final client subjective feelings about him /herself and collecting quite a significant sample. However, the present study shows a number of limitations that should be taken into consideration. Firstly, all participants were inpatients and their level of self-esteem is likely to differ from outpatients' due to the different severity of mental illness. Furthermore, it is important to acknowledge the heterogeneity of the current sample which comprised participants with different diagnoses. On the other hand, low self-esteem could be some by-product of symptoms, so it's needed to clarify its variation or stability along the illness evolution. Experience sampling method might be a way of investigating whether self-esteem precedes symptoms or symptoms are preceded by self-esteem, especially since many studies suggest that self-esteem fluctuates on a daily basis in response to negative and positive events [35].

We did not collect non-suicidal self-injuries. Safety procedures of psychiatric wards are, of course, designed to avoid users harming themselves or others so it makes little sense to try collecting such an uncommon event.

However, non-suicidal self-injuries are related to low self-esteem in both clinical and non-clinical populations [1], so they constitute an excellent predictive hint that we could not validate in our study. Finally, since our study was conducted in a clinic setting, all participants were already seeking treatment for their mental illness when the recruitment took place, so it is possible the self-esteem levels reported have not reflected the actual levels of people with mental conditions.

5. Conclusions

The combination of stigma and low self-esteem usually leads to a lack of illness insight and, consequently, to a poorer psychological and pharmacological treatment adherence. Therefore, these factors might lead to worse outcomes. Stigma and self-esteem should be targeted as early goals when developing treatment plan regardless the patient's diagnosis.

More research targeting the subjective feelings, emotions and uncovered needs of the mental health final client should be performed, as this is the only way to build a more human an ethic health provision.

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Conflicts of Interest

The authors declare that have no competing interest with respect to the authorship and/or publication of this article.

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