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ANALYSIS OF QUALITY OF LIFE EXPERIENCE, SELF-ESTEEM, ANXIETY AND DEPRESSION IN PEOPLE WITH SCHIZOPHRENIA

Análisis de la vivencia de la calidad de vida, autoestima, ansiedad y depresión en personas con esquizofrenia

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ABSTRACT

This research analyzes the perception of the variables Quality of Life, Self-Esteem, Anxiety and Depression in people with schizophrenia, using different tests for their evaluation. There is a sample of 70 participants, 19 of whom belong to users of a Psychosocial Rehabilitation Center, and the remaining 51 to the normative population. This report is a cross-sectional descriptive study which obtained results indicate a marked significant difference in the subscales of Quality of Life corresponding to Physical Health, Psychological Health and Social Relationships. A distinction was also observed in the Self-Esteem and Depression scores, thus confirming the fulfillment of three of the four hypotheses on which the research was based. Nevertheless, the need to extend the research with a larger population to obtain more precise results is pointed out. The conclusions and discussion reflect the need to implement interventions aimed at improving the non-psychotic dimensions of the disease in order to increase the well-being and quality of life of this population group.

Palabras clave:
Esquizofrenia, calidad de vida, autoestima, ansiedad y depresión

RESUMEN

Esta investigación analiza la percepción de las variables, Calidad de Vida, Autoestima, Ansiedad y Depresión en personas con esquizofrenia, utilizando como herramienta de medida diferentes test para su evaluación. Se dispone de una muestra de 70 participantes, de los que 19 personas pertenecen a usuarios de un Centro de Rehabilitación Psicosocial, y los 51 restantes a población normativa. Se trata de un estudio descriptivo transversal, donde los resultados obtenidos indican una marcada diferencia significativa en las subescalas de la Calidad de Vida correspondientes a Salud Física, Salud Psicológica y Relaciones Sociales. Se aprecia, así mismo, una distinción en las puntuaciones de Autoestima y Depresión, confirmándose con ello el cumplimiento de tres de las cuatro hipótesis de la que parte la investigación. No obstante, se señala la necesidad de ampliar la investigación con una población más extensa que permita la obtención de unos resultados más precisos. Las conclusiones y la discusión reflejan la necesidad de implementar intervenciones destinadas a la mejora de las dimensiones no psicóticas de la enfermedad, de cara al incremento del bienestar en la calidad de vida de este grupo poblacional.

Introduction

Schizophrenia is defined as a severe psychotic disorder, which presents important alterations in the individuals who suffer from it. Among the defining signs are positive symptoms, negative symptoms and cognitive disturbances (Faden & Citrome, 2023). According to the DSM-5 (American Psychiatric Association 2014), symptoms must persist for an extended time, usually six months, with one month of intense symptoms.

This disorder usually begins during adolescence or early adulthood (Keshavan et al., 2020), affecting more than 21 million people worldwide (Subdirectorate General for Health Information, 2021); with a permanent lifetime risk of 1% (Lam et al., 2019). Different researches warn that schizophrenia is the result of gene/environment interaction during neurodevelopment in childhood or adolescence (Jaaro-Peled & Sawa,2020). Among its environmental risk factors can be highlighted: complications during pregnancy and childbirth, social isolation, childhood trauma, urbanicity and substance abuse among others, negatively impacting over time and influencing the development of the individual's disorder (Stilo & Murray, 2019).

Recent studies support the existence of the role of glutamate deficient neurotransmission, in the mediation and development of cognitive symptoms (difficulty in attention, working memory and executive function) and negative symptoms (loss of motivation, interest and enjoyment of daily activities (Girdler et al., 2019). This type of psychological alterations is those that are interpreted as fundamental predictors of a possible type of need and dependence, leading to a marked loss of capacity for autonomy, associated with a constant need for care and support, either by the family environment or by a third person who is in charge of providing help or fulfilling the Activities of Daily Living, both basic and instrumental (de León et al., 2016).

Numerous investigations show a negative prognosis of the quality of life of people with schizophrenia, however recently there is the emergence of a new positive hypothesis in relation to this variable, where it is considered that this disorder is heterogeneous, with the possibility of finding some patients who meet the criteria of the disease and have an adequate quality of life, along with autonomy, social ties and economic and organizational independence; currently, studies have shown that optimal pharmacological and psychosocial treatment can improve in 1 out of 7 people, not only the symptoms of the disease itself, but also the social and cognitive functioning of the same, resulting in an improvement in their quality of life (Silva & Restrepo, 2019).

The purpose of this research will be to test whether the perceived levels of quality of life, self-esteem, anxiety and depression in people with schizophrenia are comparable to the levels of these same variables in the normative population.

Quality of Life

It is a complex and multiple concepts, which has been used to study the most relevant areas of people's lives, including both physical and psychological well-being, the economy, social relations, convictions and the life situation itself (Ramón-Arbués et al., 2022). This concept encompasses several dimensions: the state of physical health, the state of psychological health, social relationships and the environment. The assessment of this variable in a patient will describe the impact that the disease and the treatment will be having on the person's perception of happiness (Schwartzmann, 2003).

Quality of life in people with schizophrenia is lower than that of the normative population or people with other types of incurable diseases (Lin et al., 2023).

Self-Esteem

Self-esteem is considered an internal attitude, which is at the basis of personality development and psychic stability, as well as being responsible for adaptive processes in the person's life (Dore, 2017). Different studies revealed that people with low self-esteem, compared to those with high self-esteem, externalized inadequate interpersonal perceptions and behaviors, hindering the development of intimacy and perceiving or provoking less responsiveness in others (Forest et al., 2023).

According to Pardede et al., (2020), 24% of people suffering from schizophrenia, scored below the mean score on this construct, furthermore they stated that these patients presented a notably lower score compared to other psychiatric illnesses.

Anxiety

According to The American Psychiatric Association (2014), anxiety is "the anticipatory response to a future threat," which causes the sufferer to remain in a continuous state of vigilance that triggers fear and inordinate worry. The presence and magnitude of anxiety symptoms, are related to more severe clinical features and worse outcomes in schizophrenia (Braga et al., 2013). People with schizophrenia have 30% to 62% comorbid anxiety disorders associated with a higher overall burden (Howells et al., 2017).

Depression

This disorder is characterized by a permanent melancholic mood and a significant loss of interest in the tasks of daily life, which used to be motivating and pleasurable for the person, not finding the strength to carry them out; all this together with intrusive thoughts related to death and signs of discomfort, both physical and cognitive, causing a decrease in the subject's quality of life (Marx et al., 2023).

Some authors have shown that depressive symptoms are quantitatively and qualitatively among the most significant properties of schizophrenia (Ander Heiden et al., 2005).

Objectives and Hypotheses

The general objective will be to verify if the perception of quality of life, self-esteem, anxiety and depression of people with a diagnosis of Schizophrenia is comparable to that of the rest of the normative population.

The main hypotheses of the study will be:

- People with a diagnosis of schizophrenia have a significantly lower mean "quality of life" than the normative population.
- People with schizophrenia will score statistically lower on the variable "self-esteem" compared to the population without schizophrenia.
- People with the aforementioned disease will be notably more prone to suffer from "depression" than healthy people.
- The population with severe mental illness will present higher rates of "anxiety" than the normative population.

Hypothesis testing will try to decide the probability that the research objective is true or false.

Method

Participants

For this project, the selected sample has a size of 70 subjects, of which 19 will correspond to people with Severe Mental Disorder, in this case, Schizophrenia (clinical group), users of the Psychosocial Rehabilitation Center of Padre Menni and another 51 people will be selected as the normalized population (normative group) aged between 18 and 65 years of age. The recruitment method was discretionary, that is, probabilistic tools were not used. The only inclusion criterion for the selection of participants was, on the one hand, people diagnosed with schizophrenia and, on the other hand, people without any type of mental illness.

Instruments

Quality of Life Scale WHOQOL-BREF

The WHOQOL-BREF questionnaire was designed in 1994 by the World Health Organization (WHO). The Spanish version (Lucas, 1998), consists of 26 items, 2 of which integrate general questions on the perception of quality of life and satisfaction with the state of health and 24 questions grouped into four dimensions: physical health, psychological health, social relations and environment, contemplated in a reference period of two weeks. The response scales are of the Likert type, with 5 response alternatives (Espinoza et al., 2011). For its correct scoring it will be necessary to take into account that not all the items of the different areas are scored directly, since, in the "physical health" variable, items 3 and 4 will have their scores inverted. As for the variable "psychological health", the inverse item corresponds to number 26. In its correction, the higher the score in each dimension, the higher the perceived quality of life of the person evaluated (WHO, 1994). It presents a high overall internal consistency of 0.89, established by means of Cronbach's Alpha coefficient; obtaining "α" values above 0.70 for all the dimensions of the scale (Cronbach & Shavelson, 2004).

Rosenberg Self-Esteem Scale.

This evaluation test was created by Morris Rosenberg (1965) with its subsequent adaptation to Spanish by the authors (Martín-Albo et al., 2007). The questionnaire is made up of 10 items, 5 of which are stated positively and the other 5 negatively. The first 5 items will be scored directly and the following items will be scored inversely. All questions will be evaluated using a Likert scale with 4 response options (Balaguer Pich et al., 2018; Guijarro Orozco & Larzabal Fernández, 2021). The average application time is between 2 and 5 minutes, focusing the application of this instrument on people of the population aged 11 years or older. In relation to the internal consistency of the scale, values of 0.86 are obtained in Cronbach's alpha, which was a clear indicator of the high reliability that the test possesses (Morejón et al., 2013; Schoeps et al., 2019).

State-Trait Anxiety Inventory (STAI).

This instrument was developed by Spielberger et al., (1970), later adapted to Spanish by the authors Buela-Casal et al., (2011). It is a self-administered test, for individual or collective application for the evaluation of anxiety in adolescents from 16 years of age onwards, as well as in the adult population. It is composed of two scales of 20 items each, with independent criteria of anxiety: "state anxiety" and "trait anxiety".

The "state anxiety" scale will measure anxiety as a transient condition, characterized by subjective and consciously perceived feelings of stress and attachment among others (e.g., exams, job interviews). As for the "trait anxiety" scale, this concept

would explain the relatively stable anxious propensity that the person has and the tendency to perceive most situations in daily life as threatening, continuously raising their state anxiety (e.g. at work, social relationships) (Castillo Pimienta et al., 2016; Marteau & Bekker, 1992).

In the adaptation to the Spanish version of the STAI, in the "state anxiety" factor (A/E), an internal consistency of 0.94 is estimated, and for the "trait anxiety" subscale (A/R) it is 0.90, thus reflecting a high reliability index (Riquelme & Casal, 2011). In relation to the instrument as a whole, Cronbach's alpha in normal population is 0.94, and 0.98 in clinical population, reflecting equally a very good internal consistency (Ortuno-Sierra, et al., 2016).

Beck Depression Inventory (BDI)

This instrument was originally developed by Beck and his collaborators in 1961. It includes 21 questions that will evaluate the symptomatology and intensity, which the person presents around depression (e.g., sadness, thoughts of suicide and others), ordered by the level of severity, the subject will choose the option that best approximates his intermediate state in the last week, incorporating the day on which the test will be performed. Bearing in mind that if, for different reasons, the subject is confused in the choice and checks more than one box, the choice that reflects the highest severity will be considered valid (Vazquez & Sanz, 1999).

The BDI gives a Cronbach's alpha coefficient of 0.83, indicating good internal consistency (Beck et al., 1988).

Procedure

The study consists of conducting a series of psychometric tests, to later carry out a comparison of the results obtained during the evaluation of two different groups.

Before starting the selection process of the study participants, the approval of the Research Ethics Committee of the Universidad Europea del Atlántico was necessary and essential. On the other hand, it was also necessary to have the consent of the management of the Padre Menni Psychosocial Rehabilitation Center for the elaboration of questionnaires and their correction, being also essential the generosity and collaboration of the internship tutor (carried out in that center for 4 months).

The "normative group" is composed of 51 participants belonging to the general population, while the "clinical group" is made up of 19 people with severe mental illness, whose main diagnosis is schizophrenia.

The research project begins with the delivery of the information sheet to the selected participants about the study to be conducted. They are told that it is not necessary to answer at the time, and are asked to read the letter carefully, and can take it home for consultation, if necessary, with their family and/or friends.

Once participation is accepted, the research process begins, with the appropriate explanation to each person (clinical/regulatory group) about the project, which will be voluntary. Thanking them for their participation, they are informed that this involves the measurement of a series of variables, for which the completion of four questionnaires will be essential: Quality of Life Scale (WHOQOL-BREF), Rosenberg Self-Esteem Scale, Beck Depression Inventory (BDI) and the State-Trait Anxiety Inventory (STAI). The collection of sociodemographic data is carried out by means of the "Informed Consent", a document designed with the purpose of inviting each of the selected persons to participate in the research work, offering all the necessary information and clarifying all the doubts that may arise prior to the study; taking the decision to collaborate voluntarily in the study, which they may also revoke, if for any reason, they do not wish to continue participating

in it, signing the document at the end of its reading and keeping it under the responsibility of the researcher. The importance of the ethical commitment of all psychologists is explained to them, in relation to the confidentiality of the personal data of each of the persons who will participate in the study. It is indicated that the questionnaires to be completed are totally anonymous, with the clarification in one of them, since "Beck's inventory" presents data at the top of the questionnaire that should be obviated, i.e., not filling them in, respecting anonymity and avoiding possible doubts regarding confidentiality that could arise from not reviewing this point, being checked at each delivery and erasing them, if by mistake they had been written, in front of the participant for their complete peace of mind; the participants themselves will be the ones to integrate them in a random way, in a file cabinet specifically for this purpose.

Subsequently, the questionnaires were corrected using the scales provided by the creators of the questionnaires. The data are then added to an Excel spreadsheet to create the variables that will be used in the statistical analyses. The data are then exported to the statistical program, where the pertinent analyses are carried out and the discussion and conclusions of the present study are written.

Statistical Analysis

This was a cross-sectional descriptive study whose statistical data were analyzed with the SPSS program. The statistical analysis is based on the interpretation of the difference of means in the study variables, by means of the T-student test, by means of which the value of statistical significance and the size of the effect "Cohen's D" is obtained.

Results

In the total sample, the percentages of the sociodemographic variables are presented below: in relation to "sex", the sample is divided into: the "women" group (65.70%), while the "men" group (34.30%). With respect to "age", the sample is divided into three age groups: "18 to 30 years" (10.00%), "31 to 45 years" (24.30%) and "46 to 65 years" (65.70%). In terms of "level of studies" the sample was divided into: "primary studies" (17.10%), "intermediate level studies" (60.00%) and "university studies" (22.85%). In relation to "marital status", the sample is divided into: living "in a couple" (17.14%), being "married" (32.85%), being "separated" (14.28%), being "single" (34.28%) and being "widowed" (1.42%).

The following table shows the sociodemographic data of the sample (see Table 1).

Table 1

Sociodemographic data

		Clinical (N=19)	Normative (N=51)
Sex	Men	8	16
	Women	11	35
Age	18-30 years	0	7
	34-45 years	4	13
	45-65 years old	15	31
Studies	Basics	6	6
	Media	11	31

	University students	2	14
Marital status	As a couple	2	10
	Married	0	23
	Separated	4	6
	Single	13	11
	Widowed	0	1

Based on the above, the two groups were equivalent in terms of sex ratio, $\chi^2(1) = 0{,}71$, $p = 0{,}40$, in terms of age group, $\chi^2(2) = 3{,}42$, $p = 0{,}.181$, and in terms of educational level, $\chi^2(2) = 4{,}92$, $p = 0{,}085$. In the marital status variable, there were differences between the groups, $\chi^2(4) = 19{,}31$, $p = 0{,}001$, so that in the clinical group there were significantly more single people, and in the normative group, more married people and couples. Therefore, this variable is introduced into the analysis as a covariate.

Statistical analysis: MANCOVA

In this study, this analysis is used to determine whether there are significant differences between the means of the independent variable (people with or without schizophrenia) and the covariate (marital status).

A significant multivariate effect was found as a function of the group variable, $F(8, 59) = 6.12$, $p < 0.001$. Marital status had no significant effect, $F(8, 59) = 1.08$, $p = 0.390$. The univariate data are presented in the table below (see Table 1).

Table 2

Comparison of group means (clinical and normative)

	Group				*F*	η^2
	Clinical (n = 19)		Normative (n = 51)			
	M	SD	M	SD		
Cal. Life - Physics	22,06	4,385	27,80	3,335	32,16***	0,33
Cal. Life - Psychological	18,83	3,808	22,57	2,722	15,01***	0,19
Cal. Life - Rel. Soc.	9,22	1,865	11,37	2,400	6,31***	0,09
Cal. Life - Environment	28,17	4,817	29,39	4,792	0,70	0,01
Self-esteem	30,67	4,790	34,55	5,522	6,83*	0,09
Depression	9,33	8,218	5,02	5,526	4,89*	0,07
Ans. State	17,72	11,686	16,61	8,836	0,04	0,00
Ans. Feature	22,11	12,014	16,63	9,537	2,90	0,04

Note.

*p< 0,05, ** p < 0,01, *** p < 0,001

It has been observed that the measurement of depression presents a significant difference when comparing both groups. The same is true for the comparison of the "self-

esteem" variable, where the normative group has a higher statistical mean than the clinical group.

In relation to the variables that present greater significance, there are three subscales within the "quality of life" construct. The results show that in the items that make up the "physical quality of life", there is a significant difference in means, due to the fact that the normative group shows a higher score in relation to this variable. If "psychological quality of life" is considered, another significant difference in means can be seen, repeating the previous pattern: the group without disease obtains higher values in relation to the clinical group. To conclude, the last significant difference found in the research is found when studying the "quality of life in social relations", again observing a higher mean in the normative group.

Discussion and Conclusions

The present study corroborates previous research, which affirms that people with schizophrenia present lower scores in quality of life measures in relation to the normative population, according to the respective instruments used (Lin et al., 2023), with lower scores in the variable "self-esteem" (Pardede et al., 2020), with higher scores in both "state/trait anxiety" at a general level (Kaneda et al., 2003), highlighting the negative power of the confluence of depression/schizophrenia symptoms thus generating a decrease in the global functionality of these people (Conley et al., 2007). On the other hand, contrary evidence has been found, in relation to the quality of life of some people with a diagnosis of schizophrenia that affirm that, the combination of two appropriate treatments (pharmacological and psychosocial), provides in these patients an improvement in the symptoms of the disease, in cognitive and social functioning and ultimately in their quality of life (Silva & Restrepo, 2019).

The results obtained take into account the notable inequalities that appear between the two study groups (clinical and normative). In relation to the sociodemographic data, a significant difference was observed in the clinical group (schizophrenia), in the variable "marital status" (covariate). It is known that marriage is a community institution that requires social skills to develop good communication within the couple. Schizophrenia can diminish these competencies and make it difficult for these people to relate well; this is related to a low rate of marriages, mainly in men (Thara & Srinivasan, 1997). Similarly, patients with severe mental illness often present frequently with sexual dysfunction, either as a consequence of the illness itself or produced by the adverse effects of the medication of the illness, which limits the likelihood of establishing interpersonal and sexual relationships (Fanta et al., 2018). With respect to the main variables of this research, "quality of life, self-esteem, anxiety and depression", the results are explained in more detail below.

Focusing on the variable "quality of life" and dividing it into the subscales presented by the WHOQOL-BREF questionnaire, a significant difference was observed in the "physical health" of the clinical population, which can be explained by several factors: the first of these may indicate a lack of awareness or recognition of the disease, with the understanding that, as the cognitive functions in these patients are altered, this hinders adherence to treatment, leading to a worse evolution of the disease and resulting in greater relapses and a poorer prognosis (Sotelo et al., 2021), being the lack of empirical information what leads these people to have objectively erroneous perceptions about this variable. The next issue that is taken into account are the constant somatizations that these patients manifest in their daily life, believing that they happen to them because they

are physically ill. On the one hand, this psychotic distress manifested by these patients is responsible for all those physical symptoms that are difficult to explain, among which are dry mouth (52%), gastrointestinal problems (31%) and skeletal-muscular complaints (30%), leading to a prevalence of 24% in this clinical population (Calvo et al., 2003). On the other hand, the need to maintain constant monitoring of the disease (outpatient/hospital setting), due to the possible relapses and admissions that occur unpredictably, increasing an added danger in the decompensation that this disease produces in these people (Ayala Coronado, 2022), a reason that can influence in the same way, the perception that they express in their scores on physical health.

As for the variable "psychological health", a significant difference is also shown and a lower mean score is observed in the clinical group. The current situation of people with schizophrenia participating in this study is taken into account, since they regularly attend a psychosocial rehabilitation center, where professionals collaborate in the different areas of improvement or in the management of their weaknesses, helping in the same way in the enhancement of their strengths in their own environment (Florit-Robles, 2006), so it seems logical to think that their psychological well-being is more affected in this clinical group, more specifically, with everything related to the negative symptoms of the disease, which influence and directly affect the psychological health of these patients (Amador et al., 2019), so it is possible that this is the reflection of the scores obtained in the study of this variable.

Assessing the significant differences in "social relationships", it is not surprising that these scores are equally lower in clinical subjects, as confirmed by the numerous investigations reviewed for this work on this variable. Generally speaking, people suffering from schizophrenia usually have a childhood development marked by significant difficulties, which are considered predisposing to the future acquisition of schizophrenia, such as, for example, drug use in their developmental stage, affecting personal and social relationships (Stylo & Murray, 2019), or the abuse of alcohol, that even not knowing for sure, if the symptoms of the disease have favored such consumption, or if on the contrary have been the effects of the same, which have triggered schizophrenia; what is certain is that alcohol abuse is positively correlated with poor functioning in the social interaction of the daily life of these people (Villamil Salcedo et al., 2005), resulting in a negative perception of their social relationships and quality of life.

Next, it is observed in the variable "self-esteem", that people with schizophrenia present a significantly lower mean score than in the normative group, as in numerous research analyses on this variable, where high scores are not found in their results, which support a good self-esteem in these patients (Aragao & Silva, 2020). It is important to highlight the influence of social stigma, this includes a set of feelings, behaviors, beliefs and attitudes that determine in some way those prejudices and negative consequences of discrimination towards these people (Chang Paredes et al., 2018), otherwise, the subjective vision that these patients have about how others in their community see them and mainly how their family and friends see them with respect to the disease they suffer, considerably influences self-esteem in a negative way if they perceive it as unfavorable (self-stigma), hindering in many occasions, the adequate rehabilitation provided in Psychosocial Rehabilitation Centers (CRPS) to these patients (Ochoa et al., 2011).

On the other hand, in the variable "depression", it is observed that the subjects of the clinical group, score higher in this variable than in the normative population, which is not strange, since people suffering from this disorder, manifest in their daily life a symptomatology difficult to bear as the distressed mood with the loss of interest in any activity and that lack of energy that is accompanied by negative and ruminating thoughts

about different concerns (Marx et al., 2023), symptoms that remain present in schizophrenia, as the main characteristic of this disease (Ander Heiden et al., 2005), so it is logical to understand that the hypothesis initially put forward in this study is fulfilled.

All of the above confirms some of the hypotheses proposed in this research. However, it was also surprising to find that some of the variables analyzed in this study did not show significant differences in their results, so we will now try to find the relationship or limitations in these variables.

In relation to "quality of life", it should be noted that the "environment" subscale does not show significant differences in this variable. The questions in the questionnaire seem to be more suitable for people with disabilities, where the architectural barriers of the city, access to transportation, housing conditions, leisure activities..., (issues of this variable), are aimed at the safety and satisfaction of the person within the context in which he/she lives, being able to present different problems of mobility and autonomy among others, being more relevant their answers in relation to the perception they have of their quality of life in this variable. On the contrary, the users in the sample of this study (clinical population), are people who regularly attend the Psychosocial Rehabilitation Center (CRPS) and participate in different activities both for enjoyment and training. Their social relationships are adequate (friends, companions, partner...) and reinforced by the center, with autonomy in moving around, so it is less likely that they would be negatively influenced in the perception of this variable, showing no significant differences in it, compared to the normative population.

In relation to the variable "anxiety", and the hypothesis formulated "The population with mental illness will present higher levels of anxiety than the normative population", this hypothesis, initially proposed in this study, is not confirmed, i.e., no significant differences are found in the clinical population. The possible causes of the differences presented between the results of this study and those found in the literature reviewed for this research may be due to the limitation of the clinical sample, which may be insufficient (19 persons) for its evaluation, since, in the studies reviewed in relation to this variable, the samples presented in them are much larger and their results may be more precise.

Another of the limitations encountered was the failure to consider other equally important variables, such as "social stigma" and "self-stigma", variables that are very present in people suffering from schizophrenia and that negatively and intensely affect their quality of life, shedding more light on the study and providing relevant information for possible future treatments and/or psychosocial interventions.

At the same time, in order for these people to have a quality of life similar to that of the general population, it will be necessary to help by working on the elimination of the inadequate barriers produced by medication and collaborating in the indispensable needs for survival (del Cura Bilbao & Sandín Vázquez, 2021).

Conclusions

While it is true that increasing the study variables such as those mentioned above enriches the results and helps in the expansion of data and knowledge about the disease and its consequences, it is no less true that the intense effort required by these users to actively participate in the research by filling out the questionnaires, adding reading, understanding the instructions and paying full attention to them, is often difficult to achieve. As simple as it may seem and not generalizing in any case, it should be noted that there are people who find it very difficult to concentrate, who feel evaluated, with the

added fatigue and uncertainty generated by the research study and results, including the continuity of their participation, as has been the case of several users who, once their collaboration began, decided to decline their participation. This may provide the key to the fear generated by the possibility of believing that they are being evaluated and perceived in a negative way.

The main limitations of this study were the small size of the clinical population and the number of variables analyzed.

For all these reasons, it is very necessary to make society in general aware of the need to change the negative image of serious mental illness, particularly schizophrenia.

References

Amador, A. G. L., Saavedra, D.R., Garfia, C.X.D., & Chávez, J.J. (2019). Trastorno psiquiátrico-esquizofrenia. *TEPEXI Boletín Científico de la Escuela Superior Tepeji del Río,6*(11), 34-39.

American Psychiatric Association. (2014). *Manual diagnóstico y estadístico de los trastornos mentales* (DSM-5) (5a ed.).

An der Heiden W, Konnecke R, Maurer K, Ropeter D, Hafner H. (2005). Depression in the long-term course of schizophrenia. Eur Arch Psychiatr Clin Neurosci. 255:174-84.

Aragao, G., & da Silva, D.A. (2020). Avaliação da autoestima em pessoascom esquizofrenia. *Pesquisa, Sociedade e Desenvolvimento, 9* (8), e821986449-e821986449.

Ayala Coronado, R. (2022). Hospitalizaciones y recaídas durante cuatro años de seguimiento mediante telemedicina en pacientes con esquizofrenia de la Clínica Psiquiátrica Dr. Everardo Neumann Peña.

Balaguer Pich, N., Sánchez-Gómez, M., & Díaz-García, A. (2018). *Relación entre la regulación emocional y la autoestima*. [PDF File]

Beck A. T., Steer R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory. Twenty-five years of evaluation. *Clinical Psychology Review,8*,77100.

Beck A.T., Ward C.H., Mendelson M., Mock, J., & Erbaugh, J. (1961*).* An Inventory for measuring depression. *Archives of General Psychiatry*, (4)561-571.

Braga, R. J., Reynolds, G. P.&Siris, S.G. (2013). Anxiety comorbidity in schizophrenia*. Research in Psychiatry, 210* (1), 1-7.

Buela-Casal, G., Guillén-Riquelme, A., & Seisdedos Cubero, N. (2011). *Cuestionario de ansiedad estado-rasgo: Adaptación española*. Madrid: TEA Ediciones.

Calvo, J., Retuerto, M. P., Zotes, A. G., Valero, J., Puigdevall, M., Pifarre, J., & Labad, A. (2003). Somatizations and long-standing schizophrenia: Are they related? *Revista de Psiquiatría de La Facultad de Medicina de Barcelona, 30*(5), 269-275

Castillo Pimienta, C., Chacón de la Cruz, T., & Díaz-Véliz, G. (2016). Ansiedad y fuentes de estrés académico en estudiantes de carreras de la salud. *Investigación en educación médica, 5*(20), 230-237.

Chang Paredes, N., Ribot Reyes, V. de la C., & Pérez Fernández, V. (2018). Influencia del

estigma social en la rehabilitación y reinserción social de personas esquizofrénicas. *Revista Habanera de Ciencias Médicas*, *17* (5), 705–719.

Conley, R., Aschersvanum, H., Zhu, B., Faries, D., &Kinon, B. (2007). The burden of depressive symptoms in the long-term treatment of patients with schizophrenia. *Schizophrenia Research, 90* (1-3), 186-197

Cronbach, J., & Shavelson, R. (2004). My current thoughts on coefficient alpha and successor procedures. *Educational and Psychological Measurement, 64*(3), 391-418.

de León, N., Bagnato, M.J., Luzardo, M. (2016). Proceso de cronificación en el campo de salud mental: índice de cronicidad, concepto y medición. *Revista Uruguaya de Enfermería11*(1).

del Cura Bilbao, A., & Sandín Vázquez, M. (2021). Activos para la salud y calidad de vida en personas diagnosticadas de enfermedad mental grave. *Gaceta sanitaria, 35* (5), 473–479.

Doré, C. (2017). L'estime de soi: analyse de concept. *Recherchesensoinsinfirmiers*, (2), 18-26.

Espinoza, I., Osorio, P., Torrejón, M. J., Lucas-Carrasco, R., & Bunout, D. (2011). Validación del cuestionario de calidad de vida (WHOQOL-BREF) en adultos mayores chilenos. *RevistaMédicadeChile,139* (5),579-586.

Faden, J., & Citrome, L. (2023). Schizophrenia: one name, many different manifestations. *The Medical Clinics of North America, 107*(1),61-72.

Fanta, T., Haile, K., Abebaw, D., Assefa, D. and Hibdye, G. (2018). Assessment of sexual dysfunction and associated factors among patients with schizophrenia in Ethiopia, 2017. *BMC Psychiatry, 18* (1).

Florit Robles, A. (2006). La rehabilitación psicosocial de pacientes con esquizofrenia crónica. *Apuntes de Psicología, 24 (1-3), 223-244.*

Forest, A. L., Sigler, K. N., Bain, K. S., O'Brien, E. R., & Wood, J. V. (2023). Impacts of self-esteem on intimacy construction: pathways through self-disclosure and responsiveness. *Current opinion in psychology, 52* (101596), 101596.

Girdler, S. J., Confino, J. E., & Woesner, M. E. (2019). El ejercicio como tratamiento para la esquizofrenia: una revisión. *Boletín de Psicofarmacología, 49*(1), 56.

Guijarro Orozco, C. A., & Larzabal Fernández, A. (2021). Autoestima y factores de bullying en estudiantes de bachillerato de la provincia de Chimborazo. *Revista Eugenio Espejo, 15*(3),49-58.

Howells, F. M., Kingdon, D. G., & Baldwin, D. S. (2017). Current and potential pharmacological and psychosocial interventions for anxiety symptoms and disorders in patients with schizophrenia: a structured review. *Human Psychopharmacology, 32* (5).

Jaaro-Peled, H., & Sawa, A. (2020). Neurodevelopmental factors in schizophrenia. *The Psychiatric Clinics of North America, 43* (2),263-274.

Kaneda, Y., Nagamine, I., &Fujii, A. (2003). Ansiedad-Estado en la Esquizofrenia*. La Revista Europea de Psiquiatría, 17* (2), 101-107

Keshavan, M. S., Collin, G., Guimond, S., Kelly, S., Prasad, K.M., &Lizano, P. (2020). Neuroimaging in schizophrenia. *Neuroimaging Clinics of North America, 30* (1), 73-83.

Krynicki, C. R., Upthegrove, R., Deakin, J. F. W., &Barnes, T. R. E. (2018). The relationship between negative symptoms and depression in schizophrenia: a systematic review. *Acta Psychiatrica Scandinavica, 137* (5), 380-390.

Lam, M., Chen, C. Y., Li, Z., Martin, A. R., Bryois, J., Ma, X., ..., & Huang, H. (2019). Comparative genetic architectures of schizophrenia in East Asian and European populations. *Nature genetics, 51*(12), 1670-1678.

Lin, C., Wan, X., Zhang, R., Yang, X., & Liu, Y. (2023). Quality of life and its influencing factors in patients with schizophrenia. *Zhong NanDaXueXueBao.Yi XueBan [Journal of Central South University Medical Sciences],48* (3).

Lucas, R. (1998). *Versión española del WHOQOL*. Madrid: Ergon Editions.

Marteau, T. M., & Bekker, H. (1992). The development of a six-item short-form of the state scale of the Spielberger State-Trait Anxiety Inventory (STAI*). British Journal of Clinical Psychology, 31*(3), 301-306.

Martín-Albo, J.L; Núñez, J.L.; Navarro, J.G.; & Grijalvo, F. (2007). The Rosenberg Self-Esteem Scale: Translation and Validation in University Students. *The Spanish Journal of Psychology,10*(2),458-467.

Marx, W., Penninx, B. W.J.H., Solmi, M., Furukawa, T. A., Firth, J., Carvalho, A. F., & Berk, M. (2023). Major depressive disorder. Nature reviews. *Disease Primers, 9* (1), 44.

Morejón, A. J. V., Jiménez, R. V. M., &Zanin, G. B. (2013). Fiabilidad y validez de la Escala de Autoestima de Rosenberg (EAR) en pacientes con diagnóstico de psicosis. *Apuntes de psicología, 31*(1), 37-43.

Ochoa, S., Martínez, F., Ribas, M., García-Franco, M., López, E., Villellas, R., Arenas, O., Álvarez, I., Cunyat, C., Vilamala, S., Autonell, J., Lobo, E. and Haro, JM (2011). Estudio cualitativo sobre la autopercepción del estigma social en personas con esquizofrenia. *Revista de La Asociación Española de Neuropsiquiatría*, *31* (3), 477–489

Ortuno-Sierra, J., Garcia-Velasco, L., Inchausti, F., Debbane, M., &Fonseca-Pedrero, E. (2016). New approaches on the study of the psychometric properties of the STAI. *Actas españolas depsiquiatría,44*(3), 83-92.

Pardede, J. A., Keliat, B. A., & Wardani, I. Y. (2020). The Symptoms of Low Self Esteem Decline after Being Given Acceptance and Commitment Therapy. *Adv Practice Nurs* 5 170.

Ramón-Arbués, E., Echániz-Serrano, E., Martínez-Abadía, B., Antón-Solanas, I., Cobos-Rincón, A., Santolalla-Arnedo, I., Juárez-Vela, R., & Adam Jerue, B. (2022). Predictors of university students' quality of life: A cross-sectional study. *International Journal of Environmental Research and Public Health, 19*(19), 12043.

Riquelme, A. G., & Casal, G. B. (2011). Actualización psicométrica y funcionamiento diferencial de los ítems en el State Trait Anxiety Inventory (STAI). *Psicothema, 23*(3), 510-515.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Press: New Jersey.

Silva, M., & Restrepo, D. (2019). Recuperación funcional en la esquizofrenia. *Revista colombiana dePsiquiatría,48* (4), 252-260.

Schoeps, K., Chulia, A. T., Barrón, R. G., &Castilla, I. M. (2019). Competencias emocionales y autoestima en la adolescencia: impacto sobre el ajuste psicológico. *Revista de Psicología Clínica con Niños y Adolescentes,6*(1),51-56.

Schwartzmann, L. (2003). Health-related Quality of Life: Conceptual aspects. *Science and Nursing (Print), 9* (2), 09-21.

Sotelo, D., Grasso, V., & Meloni, G. (2021). Characteristics of insight in schizophrenia. A literature review. *Vertex Revista Argentina de Psiquiatría*, *32*(151, ene.-mar.), 71-78.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). Stai. Manual for the State-Trait Anxiety Inventory (Self Evaluation Questionnaire). *Palo Alto California: Consulting Psychologist*, 22, 1-24.

Stilo, S. A., & Murray, R. M. (2019). Non-genetic factors in schizophrenia. *Current Psychiatry Reports, 21*(10).

Subdirección General de Información Sanitaria (2021). Salud mental en datos: prevalencia de los problemas de salud y consumo de psicofármacos y fármacos relacionados a partir de registros clínicos de atención primaria. *BDCAP Series 2*. Madrid: Ministerio de Sanidad.

Thara, R. and Srinivasan, TN (1997). Marriage outcome in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 32* (7), 416-420.

Vázquez, C., & Sanz, J. (1999). Fiabilidad y validez de la versión española del Inventario para la Depresión de Beck de 1978 en pacientes con trastornos psicológicos. *Clinical and*

Villamil Salcedo, V., Valencia Collazos, M., Díaz Martínez, L. R., Medina-Mora Icaza, M. E., & Juárez, F. (2005). Funcionamiento psicosocial de pacientes esquizofrénicos de acuerdo con su consumo de alcohol. *Salud mental, 28*(4), 40-48.

World Health Organization. (1994). Quality of life Assessment. An annotated bibliography. Geneva: WHO(MNH/PSF/94.1) [https://iris.who.int/handle/10665/61629]