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SPANISH ADAPTATION OF THE ABBREVIATED FORM FOR THE SELF-ESTEEM RATING SCALE

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Abstract. Introduction: self-esteem could be a mediating variable in the success of the rehabilitation in schizophrenia. Some authors recommend the use of scales that differentiate between the positive and negative dimensions of self-esteem, such as the Self-Esteem Rating Scale (SERS). This study aims to validate the abbreviated form of this scale into Spanish (SERS-SF). Method: the study was carried out with 370 participants, 328 control subjects and 42 belonging to a clinical group (diagnosis of schizophrenia). The existence of two dimensions of self-esteem was analyzed by means of a confirmatory factorial analysis, and the test-retest reliability, the criterion validity and the internal consistency for each dimension were calculated. The relationships between self-esteem and socio-demographic variables were also analyzed in both samples, as well as the symptomatology in the patients' case. Lastly, the level of self-esteem between the controls and patients was compared. Results: the Spanish version of the SERS-SF showed good psychometric properties in both samples. No significant relationships were obtained with any socio-demographic variable. In the case of the patients, the positive dimension of self-esteem was related to symptoms of grandiosity, lack of judgment and insight, and depression. The comparison between the control subjects and the patients showed that the latter had worse self-esteem, although it was within normalized values in a high percentage. Discussion: The results obtained enable us to conclude that the Spanish version of the SERS-SF is a good test for evaluating the positive and negative dimensions of self-esteem in a differentiated way.

Keywords: Self-esteem, schizophrenia, scales

ADAPTACIÓN AL ESPAÑOL DE LA FORMA ABREVIADA DE LA SELF-ESTEEM RATING SCALE

Resumen. Introducción: la autoestima puede ser una variable mediadora en el éxito de los procesos de rehabilitación en esquizofrenia. Algunos autores recomiendan el uso de escalas que diferencien entre las dimensiones positiva y negativa de la autoestima, como la Self-Esteem Rating Scale (SERS). El presente estudio pretende validar en español la forma abreviada de esta escala (SERS-SF). Método: el estudio se llevó a cabo con 370 participantes, 328 sujetos control y 42 pertenecientes a un grupo clínico (diagnóstico de esquizofrenia). Se analizó la existencia de dos dimensiones de la autoestima mediante un análisis factorial confirmatorio, y se calcularon la fiabilidad test-retest, la validez de criterio y la consistencia interna para cada dimensión. También se estudiaron las relaciones entre autoestima y variables sociodemográficas en ambas muestras, así como con la sintomatología en el grupo clínico. Por último, se comparó el nivel de autoestima entre ambos grupos. Resultados: la adaptación al español de la SERS-SF mostró buenas propiedades psicométricas en ambas muestras. No se obtuvieron relaciones significativas con ninguna variable sociodemográfica. En el grupo clínico, la dimensión positiva de la autoestima se relacionó con los síntomas de ideas de grandeza, conciencia de enfermedad y depresión. La comparación entre sujetos control y clínicos mostró que éstos tenían peor autoestima, aunque en un alto porcentaje estaba dentro de valores normalizados. Discusión: estos resultados permiten concluir que la versión en español de la SERS-SF es una prueba adecuada para valorar de manera diferenciada las dimensiones positiva y negativa de la autoestima.

Palabras Clave: Autoestima, esquizofrenia, escalas

Introduction

Compared to such areas as cognitive functioning or social cognition, self-esteem is a variable that has received less attention in schizophrenia research. However, studies have shown that it too is an important variable due to its connection with such concepts as internalized stigma (Lysaker, Roe, Ringer, Gilmore & Yanos, 2012; Segalovich, Doron, Behrbalk, Kurs & Romem 2013) and quality of life (Costa et al., 2018; Wartelsteiner et al., 2016), or its influence as a mediating variable in patients' success for rehabilitation and social adjustment processes (Davis, Kurzban & Brekke, 2012; Lysaker, Ringer & Davis, 2008; Roe et al, 2003). For example, Holding, Tarrier, Gregg and Barrowclough (2013) observed that the level of self-esteem related to the amount of time that the patients were without relapses. In their study, in which they found a relapse rate of 92% in a 5-year follow-up period, patients with low self-esteem relapsed earlier than those with high self-esteem. Thus, they concluded that favorable self-esteem can act as a protective factor. Research, such as that of Kao et al. (2017) link self-esteem with resistance to stigma, which in turn is related to the patient's quality of life and empowerment. Lastly, Jones, Hansen, Moskvina, Kingson and Turkington (2010) have observed that patients with high self-esteem express feelings of confidence and optimism, show a greater ability to adapt and are more likely to succeed in a job. However, patients with low self-esteem report feelings of loneliness, take a defensive attitude in their relationships with others, experience greater anxiety and underestimate their own abilities.

Likewise, different studies have assessed the link between self-esteem and positive-type symptoms, proposing two explanations in general about the connection between both variables. On one side, Bentall's team argues that paranoid delusions are the result of a psychological defense mechanism that protects patients from feelings of low self-esteem (Bentall et al., 2008; Kinderman & Bentall, 1996). In support of this

idea, a loss in the level of self-esteem, as well as greater instability in the evaluation of oneself, have been observed as being associated with an increase of paranoid ideas (Erikson & Lysaker, 2012; Jongeneel, Pot-Kolder, Counotte, van der Gaag & Veling, 2018; Thewissen, Bentall, Lecomte, van Os & Myin-Germeys, 2008). On the other hand, Garety's team defends that self-esteem contributes to the formation and persistence of delusions and hallucinations, which are coherent with the self-esteem level that patients display, regardless of the presence of a defensive mechanism in the symptoms (Freeman et al, 1998; Freeman & Garety, 2003; Garety, Kuipers, Fowler, Freeman & Bebbington, 2001). In this respect, research as carried out by Smith et. Al. (2006) has found that low self-esteem is associated to a more acute degree of auditive hallucinations with negative content and delusions of persecution, while high self-esteem is associated to a more acute level of delusions of grandeur. Besides these theories, low self-esteem has also been associated with more symptoms of disorganization and higher levels of psychopathology in general (Justo, Risso, Moskowitz & Gonzalez, 2018).

Due to all of these reasons, several authors consider that self-esteem training should be included in schizophrenia treatment protocols (Benavides, Brucato & Kimhy, 2018; Costa et al., 2018), since good self-esteem can act as a protection factor in the progression of the disease (Benavides et al., 2018; Jongeneel et al., 2018).

The research has also compared the self-esteem level in patients with schizophrenia, with that of the non-clinical population. The results obtained were not conclusive. Some authors state that patients have low self-esteem (Freeman et al, 1998; Hall & Tarrier, 2003; Lecomte, Corbière & Laisné, 2006; Lincoln, Mehl, Kesting & Rief, 2011; Romm et al, 2011), due, among other factors, to the fact of having a mental disease or the need for psychiatric hospitalization (Birchwood & Iqbal, 1998; Iqbal, Birchwood, Chadwick & Trower, 2000). However, other authors haven't found significant differences when comparing it with the normalized population, or the scale of the control subjects (Berge & Ranney, 2005; Costa et al., 2018; Justo et al., 2018; Kao et al., 2017; Ringer, Buchanan, Olesek & Lysaker, 2014). The differences between the results might be due to the patients' clinical status while the study was being carried out, given that, as stated earlier, different authors have found that patients with an active symptomatology have higher self-esteem (Lyon et al, 1994; Smith et al, 2006). Cella, Swan, Medin, Reeder and Wykes (2013). They also associate self-esteem with consciousness about one's own cognitive deficiencies, by which patients that are aware of their symptoms display lower self-esteem. These authors suggest that this should be taken into account in those interventions working with metacognition abilities, since an improvement in these abilities could negatively affect self-esteem.

Another explanation could be found in the use of different self-esteem assessment tools. Rosenberg's Self-Esteem Scale (RSES; Rosenberg, 1965), is one of the most used tests, offering a global and stable measure of this variable. However, some authors consider that it is better to differentiate between a positive and a negative dimension of self-esteem within the clinical population, which is why they discourage the use of RSES for clinical use (Barrowclough et al, 2003; Lecomte et al, 1999; Lecomte et al, 2006; Torrey, Mueser, McHugo & Drake, 2000). The Self-Esteem Rating Scale is found among the scales that value the two dimensions of self-esteem (SERS; Nugent & Thomas, 1993). The SERS is composed of 40 items, 20 for the positive dimension and 20 for the negative dimension. Lecomte et al. (2006) developed a reduced version of 20 items (SERS-SF), 10 for each dimension.

The main objective of this study is to adapt and validate the SERS-SF into Spanish. It is also aimed at analyzing the relationship between symptoms and self-esteem and compare the level of the self-esteem of those patients with schizophrenia against the control subjects.

Methodology

Participants

A total of 370 subjects participated in the study: 328 were selected from the general population and the rest (n=42) were patients diagnosed with schizophrenia or schizoaffective disorder as diagnosed by their psychiatrist from the Cantabrian Health Service. The inclusion criteria for both samples required subjects to be between the ages of 18-65 years old and not present a diagnosis for an organic disorder or intellectual disability. In the case of those subjects from the general population, they should not have a mental disorder diagnosis either.

A freely accessible web page was designed, which was disseminated through social networks and email to collect information from the control subjects. From the 328 subjects that participated in the study, 72.26% were women, between the ages of 30 and 39 years (33.23%) with university education (80.18%). In the case of the patients, the test was made in person in paper and pencil format. The 42 participants were outpatients who attended the Padre Menni Psychosocial Rehabilitation Center in Santander, Spain. They were all under treatment with antipsychotic medication, with training in social skills, psychoeducation, cognitive training and activities in daily living. Most of the sample was characterized as being female (52.38%), between the ages of 30 and 39 years (54.70%) with higher education (69.03%). The characteristics of the two samples are specified in Table 1.

Table 1
Socio-demographic and Clinical Characteristics

	Controls (n = 328)	Patients (n = 42)	X ²
Sex			
Male	91 (27.74%)	20 (47.62%)	
Female	237 (72.26%)	22 (52.38%)	5.14*
Age			
18-29	87 (26.52%)	3 (7.14%)	
30-39	109 (33.23%)	23 (54.76%)	12.51*
40-49	88 (26.83%)	9 (21.43%)	
50-64	44 (13.41%)	7 (16.67%)	
Studies			
Primary	8 (2.44%)	8 (19.05%)	
Secondary	57 (17.38%)	29 (69.05%)	82.92**
University	263 (80.18%)	5 (11.90%)	
		Media ± d.t	
Age first diagnosed			
Evolution years			
PANSS			

Positive Scale	12.10 ± 5.03
Negative Scale	14.30 ± 4.85
General Psychopathology	26.07 ± 8.03
Total Score	51.96 ± 13.10

Note: *p<.05, **p<.01

Both groups completed the test on two occasions, with a difference of 15 days between administrations. A total of 204 control subjects and 40 patients participated in the retest administration.

Instruments

Self-esteem

Two self-esteem tests were used: SERS-SF and RSES. The SERS-SF (Lecomte et al., 2016) is a 20-item test consisting of two subscales: positive self-esteem and negative self-esteem, each composed of 10 items scored on a Likert scale of 7 choices (never, rarely, seldom, sometimes, quite a few times, almost always, always). The two scales have a score of 10 to 70 and -10 to -70 respectively, and in both cases, the higher the score the higher the self-esteem, either negative or positive. Consequently, good self-esteem would be characterized by a high score on the positive scale and a low score on the negative scale. The positive and negative scales have an internal consistency of .91 and .87 respectively, and a test-retest reliability of .90 and .91.

The RSES (Rosenberg, 1965) consists of 10 items that value the degree of agreement with respect to a series of affirmations in a Likert scale of 4 choices (strongly agree, agree, disagree, strongly disagree). The score ranges from 10 to 40, with 25 being the cut-off score indicating good or bad self-esteem. Although it includes 5 positive and 5 negative phrases, the test is considered an overall measure of self-esteem. The RSES has shown good psychometric properties in the Spanish population, with an internal consistency of .87 and a test-retest reliability of .72 (Vázquez-Morejón, Jiménez García-Bóveda & Vázquez-Morejón Jiménez, 2004). The RSES was used to assess the criterion's validity.

Psychopathology

To assess psychopathology, the Positive And Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opler, 1987) was used in the Spanish version by Peralta and Cuesta (1994). It consists of a 30-item test that evaluates the positive and negative symptomatology and psychopathology in general. All the symptoms are assessed regarding a Linkert-based scale that ranges from 1 (missing) to 7 (extreme). The positive and negative scales consist of 7 items each, so the scoring range is from 7 to 49 for both. For its part, general psychopathology is valued by 16 items, so the score ranges between 16 and 112. The internal consistency for each of the scales (positive, negative and general psychopathology) is .62, .92 and .55, while the interjudge reliability shows values of .71, .80 and .56 respectively.

PANNS was only applied to the patient sample.

Procedure

To carry out the adaptation and validation for the SERS-SF the first step was to translate the original test from English into Spanish. The translation was done

independently by three mental health professionals. Each translation was compared, and a version of the test was selected (see Annex 1), of which a retro-translation was carried out by a person with a degree in English philology from outside the first group of translators. Both the Spanish version and the retro-translated version were supervised and approved by one of the authors from the reduced version of the SERS, Dr. Lecomte. The SERS-SF was translated into Spanish as *Escala de Valoración de la Autoestima (EVA)*.

Once the translation process was completed, the psychometric properties for the EVA were assessed, both with the control subjects and with the patients. The first assessment was whether the Spanish version also maintained the two dimensions from the original test. Internal consistency, test-retest reliability and criterion validity were also analyzed. Likewise, the EVA relationship with the socio-demographic variables (sex, age and educational level) were also evaluated in both samples, as was the case for the patients with the symptoms.

Statistics Analysis

A confirmatory factorial analysis with varimax rotation was used to see if two dimensions for self-esteem were confirmed. Internal consistency was assessed using Cronbach's alpha, and test-retest reliability and criterion validity with Pearson's correlation coefficient.

The relationship with sex was analyzed using chi-square, while a one-way ANOVA test was used to assess the relationship with the age and educational level variables. Lastly, the relationship between psychopathology and self-esteem was analyzed using the Pearson correlation coefficient.

Differences in the level of self-esteem between the two samples were assessed with the mean difference *t* test for independent samples.

Statistical analyses were carried out with the SPSS, version 22.0

Ethical issues

Every patient was given an information sheet that explained the study objectives, and where they signed an informed consent document to participate in the study. Likewise, this document and the study's design itself were approved by the Ethics Committee from the Hospitalario Padre Menni Center in Santander.

Results

Control Subject Sample

In the control subject sample, the factorial analysis confirmed the existence of two factors, which explained 46.09% and 10% of the variance. The first factor was composed of those items that value the negative aspects of self-esteem, while the second factor was composed of those items that value the positive ones (see Table 2). The rest of the statistical analyses were carried out with each factor separate, referred to as a positive and a negative scale respectively.

Cronbach's alpha coefficient was .91 in both the positive and negative scales. Both scales showed a good test-retest reliability (positive scale): $r=.86$, $p<.001$; negative

scale: $r=.92$, $p<.001$), as well as a statistically significant relationship with RSES (positive scale): $r=.50$, $p<.001$; negative scale: $r=.67$, $p<.001$).

Regarding the relationship with the socio-demographic variables, neither the positive nor the negative scale was significantly related to any of the analyzed variables (sex, age and educational level). Since there were no significant differences in terms of any of the socio-demographic variables, comparative scales were calculated for the sample total (see Table 3)

Schizophrenia Patient Sample

The factor analysis resulted in the existence of 6 main factors, although Factors 5 and 6 were composed of only two items each and only explained 5.34% and 4.88% of the variance. Because of this, it was decided to force a factorial analysis of two-factors. The distribution of the items in each factor coincided with the two factors obtained in the control subject sample (see Table 2), although in this case, Factor 1 grouped the positive items and Factor 2 the negative items. Each factor explained the 40.80% and the 14.41% of the variance. Validity and reliability analyses were also carried out for each factor separately with the schizophrenia patient sample.

Table 2
Confirmatory Factorial Analysis SERS-SF

Items	Controls (n = 328)		Patients (n = 42)	
	Factor 1	Factor 2	Factor 1	Factor 2
Positive Scale				
2. I believe in my ability to deal with people		.80	1.16	
4. I think that people like talking with me		.81	1.90	
5. I believe I am a very competent person		.69	.91	
6. When I am with other people, I have the impression that they enjoy my presence		.71	.87	
7. I think I create a good impression upon others		.75	.84	
8. I believe I can begin new relationships if I want		.90	.90	
11. I think my friends find me interesting		.87	1.15	
12. I believe I have a good sense of humor		.68	.80	
14. My friends value me very much		.68	1.17	
19. I believe people enjoy them self with me		.82	.99	
Negative Scale				
1. I think other people do things better than me	.64			.52
3. I feel that I am likely to fail the things I do	.73			.73
9. I am ashamed of myself	.98			.98
10. I feel inferior to others	1.01			.93
13. I am angry at my own way of being	.94			1.04
15. I am afraid of appearing stupid to others	1.16			1.01
16. I wish I could disappear when I am surrounded by other people	.76			1.05
17. I think I would be happier with myself if I could be like other people	.96			1.54
18. I think I let myself be stepped over more than other people	.87			.83
20. I wish I could be someone else	.85			1.17

Cronbach's alpha coefficient was .92 for both for the positive and negative scales. Good test-retest reliability values were also obtained for both scales (positive scale): $r=.92, p<.001$; negative scale: $r=.91, p<.001$), and both of them showed a statistically significant relationship with the RSES (positive scale): $r=.50, p=.001$; negative scale: $r=.47, p=.002$). As in the case of the control subjects, no significant differences were found between the patients in terms of any of the socio-demographic variables analyzed.

Regarding the relationship with symptomatology, the only statistically significant relationship found was between the positive EVA scale and PANSS item G12 on absence of judgment and introspection ($r=.40, p=.027$). To carry out a more detailed analysis between self-esteem and symptomatology, the first step was to dichotomize the sample of patients according to the level of self-esteem they presented, taking as cut-off value the direct score equivalent to the 15th and 85th percentiles of the scales developed with the control subjects (Ardila y Ostrosky, p.25). Therefore, a low self-esteem was equivalent to scores equal to or lower than 44 on the positive scale, and equal to or higher than -36 on the negative scale (see Table 3). In this way, the aim was to analyze if there were differences in symptoms between patients with good and bad self-esteem. The correlation with the symptoms was assessed through the t test for the mean difference for the independent samples. There were only significant correlations between the positive scale and the depression item (G6) on the PANSS. In this case, patients with low self-esteem on the positive scale had a significantly higher mean score on the depression item than patients with normal self-esteem on the positive scale ($t(28)=2.912, p=.007, d=1.21$). There were no significant differences on PANSS items between patients with high self-esteem and patients with normal self-esteem on the EVA negative scale.

Table 3
Comparative Table of the Control Subjects ($n = 328$)

Positive Scale ^a		Negative Scale ^b	
Direct Score	Percentil	Direct Score	Percentil
69-70	99	≥ -55	99
64	95	-43	95
62	90	-40	90
61	85	-36	85
60	80	-33	80
59	75	-31	75
58	70	-29	70
57	65	-27	65
56	60	-26	60
55	55	-25	55
54	50	-24	50
53	45	-23	45
52	40	-22	40
51	35	-21	35
50	30	-20	30
48	25	-19	25
47	20	-18	20
44	15	-17	15
42	10	-16	10
38	5	-14	5
≤ 29	1	≤ -11	1

Note: ^a A higher score corresponds to a more positive self-esteem; ^b A higher score corresponds to a lower self-esteem

Secondly, the reverse was done, assessing if there were differences in self-esteem levels depending on the presence or the absence of symptoms. For said purpose, the sample was divided into two groups: absence of the symptom (direct scores from 0 to 2 on the PANSS) and presence of the symptom (direct scores from 3 to 7). In this case, there were significant differences on the EVA positive scale according to the PANSS items that assess grandiosity (P5) and the lack of judgement and insight (G12). In the P5 item case, patients with grandiose delusions presented better self-esteem than those who did not have this symptom ($t(28)=-2.216$, $p=.048$, $d=.80$). In the G12 item case, patients with lack of judgement and insight had higher scores than those with good judgement and insight ($t(28)=-2.384$, $p=.024$, $d=.80$).

Comparison between Samples

With the data taken all together, significant differences were found between those subjects from the general population and patients with schizophrenia in the two self-esteem tests used for the study, RSES and EVA, both on the positive and the negative scale. The results are shown in Table 4.

However, as it can be seen in Table 4, the patient mean score in the RSES is higher than the cut-off value, indicating low self-esteem. In this same way, using the 15 and 85 percentiles from the positive and negative EVA scales as a reference, only 43.8% of patients scored within the normalized values in the positive scale (direct score over 44), percentage which increases to 68.8% in the negative scale (direct score below -36).

Table 4
Self-esteem Differences between the Control Population and the Patients

	Controls (n = 328)	Patients (n = 42)	<i>t</i>	<i>d</i>
	(media ± dt)			
RSES	32.35 ± 4.47	27.25 ± 7.13	4.90**	.85
EVA				
Positive Scale	52.97 ± 8.22	42.91 ± 11.31	6.37**	1.01
Negative Scale	-25.81 ± 9.55	-31.63 ± 10.60	3.25**	-.57

Note: ** $p<.01$

Discussion and Conclusions

The main goal of the present study consisted in validating the abbreviated form of the Self-Esteem Rating Scale in Spanish, which was translated as *Escala de Valoración de la Autoestima* (EVA). The EVA has demonstrated as having good psychometric properties, both in the control subject sample and in the clinical group. The factorial analysis agrees with the results obtained in the English and French versions of the trial (Lecomte et al., 2006) and confirmed that it is a suitable trial for assessing the positive and negative dimensions of self-esteem through two different sub-scales. Both sub-scales, the positive and the negative ones, showed good internal consistency and test-retest reliability values, as well as acceptable validity criteria values.

As it was pointed out in the introduction, one of the most used tests to assess self-esteem, both nationally and internationally, was the RSES. However, in some

authors' opinion, (Barrowclough et al., 2003; Lecomte et al., 1999; Lecomte et al., 2006; Torrey et al., 2000;), this trial provides a global and stable measure of self-esteem which is unhelpful for its use with patient populations, especially for collecting possible changes from therapeutic procedures aimed at improving this variable. In its place, they propose the use of such scales as the EVA, which provides a differentiated assessment of the positive and negative self-esteem characteristics. As support for this approach, Barrowclough et al. (2003) observed that schizophrenic patients can present simultaneous high scores in scales that assess both the positive self-esteem and the negative one; in other words, they can have a high positive self-esteem and a negative one at the same time. This data could be taken as evidence of the fact that schizophrenic patients do not carry an overall and uniform assessment of their self-esteem (a uniform assessment would be understood as having a high score in positive self-esteem characteristics and a low score in negative characteristics, or rather the contrary. The data obtained in the present study would support this conclusion, due to 43.75% of schizophrenic patients carrying out a non-uniform assessment of their self-esteem against only 15.54% of the control subjects. As shown in Figure 1, the main difference between the controls and the patients is provided in the low-low column, which indicates that low scores have been obtained both in the positive scale and in the negative scale. Remember that in the positive scale, a low score reflects bad self-esteem; however, in the negative scale, this is equivalent to a self-esteem within normal values.

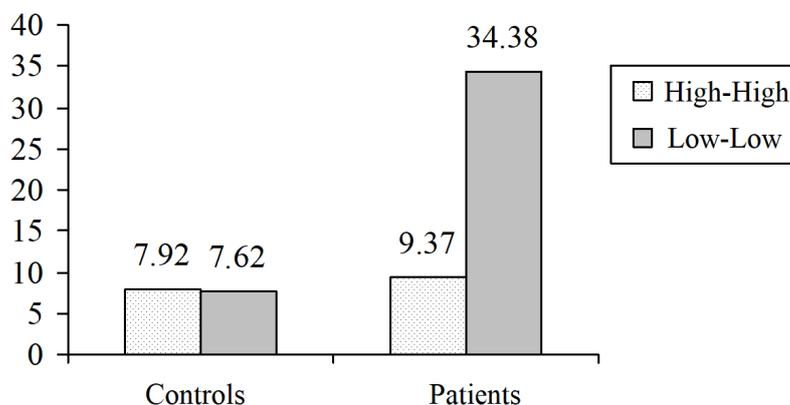


Figure 1. Percentage of patients and control subjects who carried out a non-uniform assessment of their self-esteem

Regarding the relationship between self-esteem and psychopathology, the results obtained offer isolated relationships between positive self-esteem and specific symptoms such as delusions of grandeur, level of depression and disease awareness (items P5, G6 and G12 of the PANSS). As for delusions of grandeur, patients with this symptom were those who had a higher score on the EVA positive scale. This data is in line with the previous results (Smith et al., 2006) and would partially support the hypothesis from Garety's team (Freeman and Garety, 2003, Garety et al., 2001) on the congruence between the content of delirious ideas and the level of self-esteem. The fact that the entire sample of patients has a low symptom profile (see Table 1), and that it is a cross-sectional study, means that this conclusion should be taken with caution. The

results regarding the relationship between the level of depression and the EVA positive scale support the data found by Karatzias, Gumley, Power and O'Grady (2007), which conclude that low self-esteem can be related to the development and maintenance of anxious and affective type symptoms. In this case, patients with lower positive self-esteem showed higher levels of depression.

Lastly, and in line with the previous research (Aghababian, Auguier, Baumstarck-Barrau & Lançon, 2011, Lysaker et al., 2013), the association observed between the EVA positive scale and the absence of judgment and introspection item, indicates that patients with good awareness of their disease carry out a worse evaluation of positive aspects of themselves. Based on what was said in the introduction about the relationship between self-esteem and success in rehabilitation processes, this data would highlight the importance of taking into account the possible impact of self-esteem programs aimed at increasing disease awareness. While the importance of patients accepting and acknowledging that they have a disease and the consequences derived from it is undoubtedly important, it would also be important to accompany this type of intervention with programs that reinforce or improve self-esteem. Some of these programs have already their effectiveness for increasing the levels of self-esteem from those patients suffering schizophrenia (Borras et al., 2009; Hall & Tarrier, 2003; Lecomte et al., 1999). Unlike the results obtained by other authors (Barrowclough et al., 2003), significant relationships between positive self-esteem and negative symptoms have not been observed.

On the other hand, the data from the following study would support the concept that patients with schizophrenia have low self-esteem than those from the control group, since they have significantly lower scores in both the RSES, as well as in the positive and negative EVA sub-scales. However, in the RSES case, more than 70% of the patients had a score higher than the cut-off score (25), by which if they do have worst self-esteem than the control subjects, it cannot be concluded that they do have lower self-esteem. This data changes when the EVA is used as a reference. In this case, more than half of the patients had scores indicative of low self-esteem within the positive sub-scale, something that occurred in less than 30% of the negative sub-scale sample. If we combine the data from the two, we may conclude that the patients with schizophrenia carried out a good assessment of themselves when evaluating their overall self-esteem, but the use of the tests that differentiate between the self-esteem's positive dimension and negative dimension allows for a more precise assessment. In this case, we can see that the self-esteem problems appear above all within the positive dimension, and no so much in the negative dimension. This is to say, patients in general do not carry out a negative assessment of themselves ("I feel inferior to everyone else", for example), but rather, consider themselves to lack positive abilities or competencies. The difference between the results obtained through RSES or through the EVA, would reinforce the convenience of using scales that separately assess the two self-esteem dimensions.

Lastly, based on the results from the present study, sex, age or educational level do not appear to be variables significantly related with self-esteem, neither in the control subjects or patients with schizophrenia. However, it is important to consider this data with caution in the case of the patient sample, for as can be seen in Table 1, only 3 of the subjects were between the ages of 18-29 years, or only 5 subjects had a university education.

In a future research, it would be convenient to analyze with more detail the possible differences between those patients that maintain normal levels of self-esteem

and those that have low positive self-esteem or high negative self-esteem. It would also be of interest to assess why patients with schizophrenia have an unequal valuation before their self-esteem in comparison with subjects from the control group, whom have a more uniform valuation of their self-esteem levels.

The main limits for the study is the sample size of those patients with schizophrenia, as well as the low profile of the present symptoms and the fact that all patients were interned in a Psychosocial Rehabilitation Center. Because of this, the data obtained cannot be generalized before other samples with other characteristics, such as hospitalized patients or those with greater symptomatic levels. In addition, by being a cross study, we must have caution with the relationships found with the specified.

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