

Research Article

# Studying the Effectiveness of Schema Therapy on Life Expectancy and Happiness of Depressed Patients

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## Abstract

With the entry into the modern world, humans are rapidly moving towards industrialization, and in the meantime, it can be said that depression is the first characteristic of this technological age, because human relationships are decreasing and human needs are becoming more internalized. Depression is an issue that can seriously affect many life issues. In this study, considering the importance of the lives of depressed patients, the aim was to investigate the effectiveness of schema therapy on the life expectancy and happiness of depressed patients. The research method was semi-experimental. The study population was all patients diagnosed with depression who referred to counseling centers in Sirjan. The sample size in this study was 30 people, which was selected using the available sampling method. The data were obtained using life expectancy and happiness questionnaires. The data obtained were obtained using the statistical method of analysis of covariance. The results of the study showed that schema therapy has an effect on the life expectancy and happiness of depressed patients. From the results of this study, it can be concluded that for depressed patients, third-generation cognitive behavioral therapies such as schema therapy can be emphasized and used, and the main characteristic of depressed patients, namely decreased life expectancy and happiness, can be improved and strengthened.

## Keywords

Depression, Happiness, Life Expectancy, Schema Therapy

## 1. Introduction

According to the World Health Organization (2022), depression is a common disease worldwide, affecting about 3.8% of the population, or about 280 million people. Unfortunately, the prevalence of depression is increasing. In recent studies in the United States, the prevalence of depressive symptoms has been

reported to have more than tripled in 2020 onwards [1]. Depression can be considered a disease and problem that everyone in the world is or has been involved with, even at some point, but at the same time, it is a disease and problem that few people seek serious treatment for. However, depression can affect all aspects

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of a person's life, the most important of which are a sense of happiness and life expectancy [2]. The prevalence of depression in different Iranian populations has varied from 69.5 to 73%. Also, depression in Iran is increasing at a rate of 12.5% annually, in a geometric progression [3]. A depressed person feels more depressed due to successive failures, which can disrupt the order of the person's life and that of those around them [4]. Happiness is said to be the opposite of depression and in contrast to depression. A depressed person experiences a very small amount of happiness. Happiness is one of the basic emotions and one of the most important psychological needs of humans [5]. Psychologists consider joy to be a type of positive emotion that has a profound effect on physical, cognitive, and psychological mechanisms and improves human performance in various fields [6]. It seems that happiness has at least two basic components, emotional and cognitive. The absence of depression is a necessary reason for achieving happiness. Happiness has three basic components: positive emotion, life satisfaction, and the absence of negative emotions, including depression [7]. Happiness is affected by issues such as anxiety and social adjustment [8], couples' psychological resilience and marital conflict [9], and job burnout [10]. Although significant progress has been made in the diagnosis and treatment of depression today, the search for vulnerability factors for this disorder and how these factors relate and interact with each other remains a fundamental issue in mental health [11]. Schema therapy, as a versatile and personalized tool, has the ability to adapt to the needs and characteristics of different individuals. Schema therapy has not only helped to improve mental health, but also to promote feelings of hope and happiness, and has been effective in improving the quality of life of individuals. Schemas are predictors of psychological symptoms, including depression [12]. Research has shown promising results in the schema therapy approach in chronic depression [13]. This study attempts to identify the factors affecting the success of schema therapy and provide solutions for optimizing the use of this method in counseling centers. Based on existing research and findings confirming the use of schema therapy [14, 15], this study confirms the essential role of schema therapy in psychological improvement of depressed patients as an effective treatment suggestion. It is hoped that this research and experience will lead to significant improvements in the lives of people with depression and, based on it, recovery strategies for the development of schema therapy will be proposed. Finally, this study carefully addresses the possible obstacles and challenges in using schema therapy as a treatment method in depressed patients. Therefore, this study answers the question: Does schema therapy affect the level of depression, life expectancy, and happiness in depressed patients referring to counseling centers in Sirjan?

## 2. Method

The present research is of the quasi-experimental type. Quasi-experimental research has one or more control groups, but the arrangement of the subjects is not done randomly. In

this type of research method, the goal is to approach true experimental research. However, because the conditions of the experiment and research are such that it is not possible to control or manipulate all the research variables, it is called quasi-experimental. The statistical population was all patients with depression in Sirjan County, and based on the collection in 10 counseling centers in Sirjan County who were willing to cooperate, about 78 patients were introduced to the researcher. It is a group or group of individuals or persons who have been selected and the results of the study are generalized to the entire population. Based on the research method, a sample of 30 people was selected through available sampling, which was randomly replaced in two groups of 15 experimental and 15 control.

## 3. Measurement Tools

In this study, the following questionnaires were used to collect data, analyze and test the research hypotheses:

**Miller Life Expectancy Questionnaire:** The Miller Life Expectancy Questionnaire or Miller Hope Questionnaire was developed in 1988 by Miller and Powers. The initial questionnaire had 40 questions, which were increased to 48 questions in subsequent versions. This questionnaire is scored on a Likert scale from strongly disagree (score 1) to strongly agree (score 5). The scoring of the Miller Life Expectancy Questionnaire is as follows: first, you must give each item a score of strongly disagree 1, disagree 2, indifferent 3, agree 4, and strongly agree 5. 14 items are also scored in reverse. Reverse scoring: Questions 11- 13- 16- 18- 25- 27- 28- 31- 33- 34- 38- 39- 47- 48 are scored in reverse. Since this questionnaire does not have subscales, at the end we add up all the items and get the total score. Each person's score will be between 48 and 240. This questionnaire also does not have a cut-off score, and the higher the person's score, the more hope they have for life. Based on this method of analysis, add up the scores obtained and then judge based on the table below. Note that the following scores are for a questionnaire if the number of questions in the questionnaire \* 1 = the lower limit of the score. The lower limit of the score is 48, the average score is 144, and the upper limit of the scores is 240. Add up the individual's scores from the above 48 statements. The minimum possible score is 48 and the maximum will be 240. A score between 48 and 96: the person's hope is low. A score between 96 and 144: the person's hope is medium. A score higher than 144: the person's hope is high. This questionnaire is translated from an English tool that has not been implemented in Iran so far and requires validation (validity and reliability testing). However, Miller reported the validity of this questionnaire as desirable and its reliability according to Cronbach's alpha was above 80. The test options are scored on a 5-point scale from 1 very disagree to 5 very agree, but 12 items of Miller's questionnaire consist of negative items that are scored in reverse in the scoring of these items and are: (11 \_ 13 \_ 16 \_ 18 \_ 25 \_ 27 \_ 28 \_ 31 \_ 33 \_ 34 \_ 38 \_ 39) and questions 41 to 48 are

specific to chronic patients. Question 49: "Indicate your level of hope currently by choosing one of the following numbers." The subject must determine the level of hope by choosing one of the numbers 1 to 10, where 1 indicates the least hope and 10 indicates the most hope. Kiani et al. (2019) obtained a Cronbach's alpha of 89%. [16]. Nedai and Einali Hermoshi (2019) obtained a Cronbach's alpha of 87% for the questionnaire [17].

#### 4. Oxford Happiness Inventory (OHI)

This instrument was developed by Argyle, Martin, and Crossland (1989) based on the Beck Depression Inventory (1976) at the University of Oxford, England. The 21 items in this questionnaire were taken from the Beck Depression Inventory and reversed, and 11 items were added to cover other aspects of mental health. Like the Beck Depression Inventory (BDI), each item in the Happiness Inventory has four options from which the subject must choose one according to his or her current situation [18]. This questionnaire has 29 statements and is scored on a Likert scale between A (not at all = 0), B (a little = 1), C (a lot = 2), and D (very much = 3); thus, the

lowest and highest score that a subject can obtain on this scale is 87, which indicates the highest level of happiness, and the lowest score on this questionnaire is zero, which indicates the subject's dissatisfaction with life and depression. The normal score for this test is between 40 and 42 [18]. This inventory (questionnaire) has 6 subscales: life satisfaction (3, 5, 6, 8, 9, 14, 17, 24), pleasure (1, 2, 19, 21, 22, 23, 26, 29), self-confidence (7, 13, 16, 25, 28), composure (12, 15, 18), control (4, 10, 11, 27), and self-efficacy [20]. Argyle, Lowe, and Martin (1989) obtained an alpha coefficient of 0.90 with 347 subjects, Farnham and Breen (1990) [19] obtained an alpha of 0.87 with 101 subjects, and Noor (1993) [20] obtained an alpha of 0.84 with 180 subjects with a shorter form of this questionnaire. In a study by Francis and Robbins (2003), the reliability of this questionnaire was found to be 0.92 using Cronbach's alpha [21].

#### 5. Schema Therapy Sessions

Schema therapy sessions were used and structured using the article by Nosrat Abadi and Afzali Group (2010) [22] and were taught in 8 45-minute sessions.

*Table 1. Schema therapy summary.*

Topic	Session
First,	establishing communication and empathy, initial assessment of the group, familiarization and understanding of the concepts of schema therapy and its application
Second,	accurate and scientific learning of the concepts of early maladaptive schemas
Third,	complete familiarity with the areas of early maladaptive schemas and their recognition
Fourth,	recognizing and adapting cognitive coordination and ineffective coping responses to personal experiences
Fifth:	Identifying and diagnosing early maladaptive schemas
Sixth:	Modifying ineffective schemas and coping styles
Seventh:	Changing and improving the emotional and affective level of maladaptive schemas
Eighth:	Replacing coping and maladaptive behaviors with healthy and effective behaviors

At the inferential level, tests to examine assumptions (Kolmogorov-Smirnov and Levine test for normal distribution of scores) and analysis of covariance with repeated measures were used.

#### 6. Findings

In this study, univariate analysis of covariance (ANCOVA) was used for inferential analysis of the results. Therefore, preliminary studies were conducted to ensure that the assumptions of these statistical methods were not violated, and the results of these studies are as follows.

##### 1. Assumption of interval scale of dependent variables

The dependent variables in this study, which include depression, life expectancy, and happiness, are obtained using the scores obtained from the questionnaires mentioned in the third chapter. These variables have small values according to the scores, and their interval scale is confirmed.

##### 2. Assumption of normal distribution of dependent variables

In order to examine this assumption, the Shapiro-Wilk test was used.

**Table 2.** Results of the Shapiro-Wilk test.

Variable	Group	Shapiro Wilk	
		Statistics	Meaningfulness
Life expectancy	Test	0.88	0.063
	Control	0.91	0.17
Satisfaction with life	Test	0.95	0.63
	Control	0.94	0.41
Pleasure	Test	0.94	0.48
	Control	0.94	0.48
Self-confidence	Test	0.92	0.21
	Control	0.89	0.08
Calmness	Test	0.91	0.17
	Control	0.9	0.97
Control	Test	0.96	0.82
	Control	0.95	0.6

Variable	Group	Shapiro Wilk	
		Statistics	Meaningfulness
Self-efficacy	Test	0.88	0.63
	Control	0.88	0.051
Happiness	Test	0.95	0.57
	Control	0.93	0.33

**Table 2** presents the results of this test. The significant results (with a significance value greater than 0.05) indicate that the distribution of scores across the groups is normal. As demonstrated in this table, all significance levels are below the assumed threshold (0.05). Given the scores and their normality, the findings are reliable and can be referenced. Homogeneity assumption The error variance of the dependent variables in the studied groups was examined by referring to the results of the Levene test in order to examine this assumption.

**Table 3.** Results of Levene's test for examining the homogeneity of error variance of dependent variables.

Variable	First degree of freedom	Second degree of freedom	F- value	Significance level
Life expectancy	1	28	0.016	0.89
Satisfaction with life	1	28	2.87	0.101
Pleasure	1	28	1.005	0.32
Self-confidence	1	28	0.77	0.38
Calmness	1	28	0.001	0.99
Control	1	28	1.99	0.16
Self-efficacy	1	28	2.09	0.15
Happiness	1	28	0.001	0.99

According to **Table 3**, the significance level (p-value) of the obtained scores is greater than 0.05. Therefore, this significance level indicates that the assumption of homogeneity of

variances has been met, and the results are reliable.

6-1 Assumption of homogeneity of interaction effects and slopes Regression

**Table 4.** Results of the test to examine the assumption of homogeneity of the interactive effects of the research variables of the two groups in the population.

Variable	Source of changes	F- value	Significance level
Life expectancy	Pre-test*Group	0.017	0.89
Satisfaction with life	Pre-test*Group	2.79	0.107
Pleasure	Pre-test*Group	0.17	0.68

Variable	Source of changes	F- value	Significance level
Self-confidence	Pre-test*Group	1.76	0.19
Calmness	Pre-test*Group	0.89	0.35
Control	Pre-test*Group	0.27	0.6
Self-efficacy	Pre-test*Group	0.23	0.63
Happiness	Pre-test*Group	0.9	0.76

As can be seen in Table 4, the F value of the interaction for all research variables is insignificant (significance value greater than 0.05). Therefore, the assumption of homogeneity of interaction effects is also confirmed.

Assumption of homogeneity of two groups in the pre-test of

variables

To examine this assumption, the means of the pre-test variables of the two groups are compared with each other using an independent t-test. The results are as follows:

**Table 5.** Results of independent t-test to examine the homogeneity of pre-test scores of the two control and experimental groups.

Variables	Group	Average	Statistics t	Degree of freedom	Meaningful value
Life expectancy	Test	118.13	-1.39	28	0.174
	Control	127.8			
Satisfaction with life	Test	4.53	-1.46	28	0.155
	Control	6.13			
Pleasure	Test	6.66	-0.63	28	0.528
	Control	7.04			
Self-confidence	Test	3.02	-1.002	28	0.325
	Control	4.13			
Calmness	Test	3.26	-1.03	28	0.312
	Control	3.93			
Control	Test	2.93	-1.39	28	0.173
	Control	4.33			
Self-efficacy	Test	1.6	0.209	28	0.836
	Control	1.53			
Happiness	Test	22.2	-1.18	28	0.245
	Control	27.46			

According to Table 5, the significance value of the t-test for the pre-test of all variables is greater than 0.05. Therefore, this significance level shows that the assumption of homogeneity of pre-test scores in the two groups has not been violated.

#### Hypothesis testing

After ensuring that the assumptions of the analysis of covariance were not violated, the research hypotheses were examined using the ANCOVA analysis of covariance method.

Hypothesis 1: Schema therapy has a significant effect on life expectancy in depressed patients referring to counseling centers in Sirjan.

H0: Schema therapy has no effect on improving life expectancy.

H1: Schema therapy has an effect on improving life expectancy.

To test this hypothesis on life expectancy in depressed pa-

tients referring to counseling centers in Sirjan, one-way covariance analysis was used, and the results of this analysis are

presented in Table 6.

**Table 6.** Results of one-way analysis of covariance.

Variable	Source of change	Sum of squares	Degrees of freedom	Mean squares	F	Significance level	Eta squared
Life expectancy	Pre-test	1507.1	1	1507.1	6.1	0.02	0.184
	Group	14034.69	1	14034.69	56.86	0.001	0.678
	Error	6664.36	27	246.82			

As shown in Table 6, by controlling the effect of the auxiliary variable (pre-test) on the dependent variable, there is a significant difference between the two groups in terms of life expectancy (significant value less than 0.05), or in other words, schema therapy has an effect on the life expectancy of depressed patients. Table 6 shows the mean values of post-test and pre-test life expectancy in the control and experimental groups (schema therapy). This indicates that schema therapy has been able to improve the life expectancy of depressed patients and has significantly increased the life expectancy of these individuals in the experimental group. On the other hand, since the eta squared value for the group is equal to 0.678, it can be said that 67 percent of the total variance and dispersion of the life expectancy variable is explained by the group effects.

Hypothesis 2: Schema therapy has a significant effect on the level of happiness in depressed patients.

H0: Schema therapy does not affect the improvement of happiness.

H1: Schema therapy has an effect on the improvement of happiness.

To investigate this hypothesis on the level of happiness in depressed patients referring to counseling centers in Sirjan, one-way analysis of covariance was used, and the results of this analysis are presented in Table 7. Table 7 Results of one-way analysis of covariance in the ANCOVA text on the mean happiness scores of the experimental group (therapeutic schema) and the control with pre-test control.

**Table 7.** Results of one-way analysis of covariance.

Variable	Source of change	Sum of squares	Degrees of freedom	Mean squares	F	Significance level	Eta squared
Happiness	Pre-test	632.58	1	632.58	9.65	0.004	0.263
	Group	5254.99	1	5254.99	80.23	0.001	0.748
	Error	1768.35	27	65.49			

As shown in Table 7, by controlling the effect of the auxiliary variable (pre-test) on the dependent variable, there is a significant difference between the two groups in terms of happiness (significant value less than 0.05), or in other words, schema therapy has an effect on the happiness of depressed patients. Table 3 shows the mean values of post-test and pre-test happiness in the control and experimental groups (schema therapy). This indicates that schema therapy has been able to improve the level of happiness in depressed patients and has significantly increased the happiness of these people in the experimental group. On the other hand, since the eta squared value for the group is equal to 0.748, it can be said

that 74 percent of the total variance and dispersion of the happiness variable is explained by the effects of the group.

## 7. Discussion and Conclusion

Hypothesis 1: Schema therapy has a significant effect on life expectancy in depressed patients.

The results of the study indicate that schema therapy has been able to improve life expectancy in depressed patients and has significantly increased the life expectancy of these individuals in the experimental group. On the other hand, because



the value of the eta square for the group is equal to 0.678, it can be said that 67 percent of the total variance and dispersion of the life expectancy variable is explained by group effects.

The results of the study are consistent with the results of Gholizadeh Alkami (2022) [23], Ghaderi et al. (2022) [24], and Orang et al. (2017) [2]

In explaining these results, it can be said that schema therapy causes people to achieve better self-efficacy beliefs during training sessions by changing negative beliefs about themselves, and due to this, their ability to cope with increased problems and their perseverance and intellectual and practical ability to overcome problems and problems in life have improved. Therefore, by increasing this characteristic in people, the adverse effects of an environment that is not socially and economically supportive are neutralized to some extent. Also, people with a strong perception of self-efficacy experience less anxiety when facing potential dangers and can cope with anxiety-provoking events, experience less distress, and by focusing on what they can do to adapt to that situation, they no longer focus their attention on failure and inability to adapt to that situation. In addition, group members help each other during treatment sessions, that is, they support each other during treatment, reassure each other, make suggestions, and provide insight; And these interactions facilitate the therapeutic process of the sessions and change their negative thoughts and increase life expectancy.

Hypothesis 2: Schema therapy has a significant effect on the level of happiness in depressed patients.

The results of the study indicate that schema therapy has been able to improve the level of happiness in depressed patients and has significantly increased the happiness of these people in the experimental group. On the other hand, because the value of the eta square for the group is equal to 0.748, it can be said that 74 percent of the total variance and dispersion of the happiness variable is explained by the effects of the group.

The results of the study are consistent with the results of Mahzoun Ghorbanipour et al. (2017) [25], Hosseini et al. (2021) [26] and Peters et al. (2024) [27].

In explaining these results, it can be said that the schema therapy approach, by combining four cognitive, experiential, behavioral, and relational techniques in depressed individuals and by affecting maladaptive schemas, which are the main cause of the formation of ineffective and irrational thoughts, and also focusing on the ineffective coping styles of patients that have been formed since childhood and continued into adulthood, has been able to affect the change of maladaptive schemas and lead to increased happiness in depressed patients. On the other hand, schema therapy training, in addition to questioning maladaptive schemas emotionally, causes the discharge of buried negative emotions and feelings, such as anger resulting from the failure to satisfy the needs for spontaneity and secure attachment to others in childhood. On the other hand, schema therapy has the ability to break behavioral patterns. This strategy helps clients plan and implement behavioral tasks to replace adaptive behavioral patterns instead

of maladaptive and ineffective coping responses, and increases happiness in patients.

## Author Contributions

**Farzaneh Javanbakhsh:** Project administration

**Fezeh Fathi Livari:** Conceptualization

**Maryam Mahmoudabadi:** Data curation

**Sedighe Abedini:** Software

## Conflicts of Interest

The authors declare no conflicts of interest.

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