An-Najah National University

Faculty of Graduate Studies

THE EFFECTIVENESS OF A COGNITIVE BEHAVIORAL THERAPY PROGRAM IN REDUCING SYMPTOMS AND IMPROVING SOCIAL SKILLS IN PATIENTS WITH SCHIZOPHRENIA

By

Suhaib Hood Saleh Abu Snineh

Supervisors

Dr. Filasteen Nazzal

Dr. Shadi Abulkebash

This Thesis is Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Clinical Psychology, Faculty of Graduate Studies, An-Najah National University, Nablus, Palestine.

2024

THE EFFECTIVENESS OF A COGNITIVE BEHAVIORAL THERAPY PROGRAM IN REDUCING SYMPTOMS AND IMPROVING SOCIAL SKILLS IN PATIENTS WITH SCHIZOPHRENIA

By
Suhaib Hood Saleh Abu Snineh

This Thesis was Defended Successfully on 02/09/2024 and approved by

Dr. Filasteen Nazzal	
Supervisor	Signature
Dr. Shadi Abulkebash	
Co-Supervisor	Signature
Dr. Eyad Al-Halaq	
External Examiner	Signature
Dr. Ola Hussein	
Internal Examiner	Signature

Dedication

I dedicate this study to the pure spirits of our martyrs, my excellent instructors, my whole family, my coworkers and colleagues who support me, and everyone who assisted me in completing this research.

Acknowledgment

First, I thank God Almighty for his grace upon me until I arrived here.

I would like to thank my professors, Dr. Shadi Abu Al-Kabash and Dr. Filasteen Nazzal, for their support and assistance in finishing the project.

And to my dear colleagues, from whom I learned a lot throughout my academic career.

Finally, to my dear family, who have been a credit to me since my birth until I arrived here, also my wife and children who provide the most beautiful thing in life.

Declaration

I, the undersigned, declare that I submitted the thesis entitled:

THE EFFECTIVENESS OF A COGNITIVE BEHAVIORAL THERAPY PROGRAM IN REDUCING SYMPTOMS AND IMPROVING SOCIAL SKILLS IN PATIENTS WITH SCHIZOPHRENIA

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: لمياء محمد صالح البوسنية

Signature: لمياء ابو سنينة

Date: ٢٠٢٤/٩/٤

List of Contents

List of Tables

List of Figures

List of Appendices

THE EFFECTIVENESS OF A COGNITIVE BEHAVIORAL THERAPY PROGRAM IN REDUCING SYMPTOMS AND IMPROVING SOCIAL SKILLS IN PATIENTS WITH SCHIZOPHRENIA

By
Suhaib Hood Saleh Abu Snineh
Supervisors
Dr. Filasteen Nazzal
Dr. Shadi Abulkebash

Abstract

Background: According to the DSM-5, schizophrenia is a severe mental disorder marked by a disconnect between reality and mind, jumbled thoughts, perceptions, emotions, and behavior. It is a grave psychiatric ailment that hampers normal thinking and behavior, significantly affecting both the individual and those around them.

Previous research has demonstrated that cognitive-behavioral treatment improves social skills and reduces both positive and negative symptoms in patients with schizophrenia. Therefore, this study attempted to explore the role of cognitive behavioral therapy in strengthening social skills and reducing symptoms in people with schizophrenia.

Method: The study follows a quasi-experimental research approach. The study involved 16 individuals diagnosed with schizophrenia, all of whom are Palestinian Arabs residing in occupied Jerusalem and receiving care at the Nathan Center for Mental Health. The researcher utilized the Schizophrenia Social Skills Scale and the Positive and Negative Symptoms Scale to evaluate the enhancement of social skills and reduction of symptoms in these patients.

Results: Among Palestinian patients in Jerusalem diagnosed with schizophrenia, at the Nathan Center for Mental Health, the study revealed a moderate level of schizophrenia symptoms alongside a moderate level of social skills. Despite undergoing Cognitive-Behavioral Therapy Program (CBTP) treatments, the experimental group did not experience significant improvements in social skills or reduction of schizophrenia symptoms. Notably, CBTP did lead to improved emotional control among schizophrenic patients in the experimental group compared to the control group.

Conclusion: The study investigates whether there is an effectiveness of cognitive behavioral treatment in reducing symptoms and enhancing social skills in patients with

schizophrenia. Before starting its implementation, the study emphasizes the importance of educating therapists about treatment techniques and raising general awareness among patients targeted in the treatment program on the importance of psychotherapy in preventing and treating mental health issues.

Keywords: Schizophrenic Disorder, Schizophrenic Patients, Positive Symptoms, NSSegative Symptoms, Cognitive Behavioral Therapy, Social Skills.

Chapter One

Theoretical framework and previous studies

1.1 Introduction

For the past century, schizophrenia has been regarded as a distinct illness entity. It is defined by a combination of positive and negative symptoms and cognitive, emotional, and motor symptoms. Schizophrenia is a chronic and recurring condition that usually has only partial remissions (Kelly et al, 2009).

Schizophrenia is one of the most confusing and costly mental disorders, with symptoms most commonly appearing throughout adolescence and early adulthood. The frequency of the condition, as swell as its symptoms, duration, and responsiveness to therapy, varies substantially among populations and immigrant groups. Scholars have been studying Schizophrenia for a long time. Early work demonstrated that schizophrenia is characterized by structural alterations in the brain as well as changes in dopamine neurotransmission, the latter of which is linked to hallucinations and delusions. Suppressing the dopamine system with drugs helps treat delusions and hallucinations, but it is less effective in addressing severe cognitive and motivational deficiencies. Certain antipsychotic drugs utilized in the context of community case management, as well as certain occupational and psychiatric therapies, have been demonstrated to improve functional outcomes (Van & SKapur, 2009).

According to Palestinian research, Palestinians are more likely to develop mental illness because of their constant exposure to political violence, extended resettlement, and other limited possibilities in the areas of employment, education, finance, and mental health. Schizophrenia is a disabling mental illness that affects approximately 1% of the world's population. According to research, patients with schizophrenia die earlier and have a shorter life expectancy than the general population. The data shows that the lives of people with schizophrenia in Palestine are complex. Obstacles are a lack of knowledge of mental illness, stigma, inconsistent availability of medications, multidisciplinary teamwork, incompetent practitioners, a fragmented mental health system and profession, and other obstacles that prevent these people from improving their quality of life (Maire, Shaabna, & Saleh, 2020).

People with schizophrenia may require much help from healthcare experts, and in most situations, it will take a long time. Conflicting outcomes in research have been yielded on psychotherapy's effects on schizophrenia. Even though medical therapies remain the therapy of choice, the benefits of psychosocial treatments for schizophrenia are significant. According to the findings, present evidence does not support the use of psychodynamic therapies for hospitalized schizophrenia patients (Malmberg et al., 2001).

Psychosocial treatments for people with schizophrenia, when used with medication or psychiatric care, have been shown to reduce psychotic symptoms and relapse, as well as promote long-term outcomes, including recovery, remission, and disease progression (Chein et al., 2013).

CBT, or cognitive behavioral therapy, is a possible treatment for individuals with schizophrenia. CBT helps people change behaviors or beliefs that might be causing them to feel bad. The two basic therapy components are cognitive, which helps the patient alter how they think about a problem, and behavioral, which enables the patient to alter how they behave. Short-term, problem-focused cognitive behavioral therapy teaches individuals with schizophrenia a range of coping mechanisms to help them deal with challenging circumstances (NYU Langone**,** 2024)**.**

Current concerns are the focus of CBT, and solutions are sought. It does not deal with the past in the same way that psychoanalysis does. Cognitive behavioral therapy (CBT) is significantly more focused on addressing present issues. The most essential thing is to assist individuals in helping themselves; they should be able to cope with their life again as soon as possible without using therapy. This is not to say that CBT overlooks the impact of prior experiences entirely. However, it primarily focuses on recognizing and altering present stressful thinking and behavioral patterns. Analytical psychotherapy, which has its roots in Freudian psychoanalysis, employs a variety of techniques. The therapist strives to assist the patient in identifying and comprehending issues and their root causes (IQWIG, 2006).

Aaron Beck developed CBT, sometimes called "cognitive therapy", in the 1960s. Since then, it has been extensively examined and shown to be beneficial for a variety of mental illnesses, including depression, anxiety disorders, eating disorders, substance

misuse, and personality disorders, in several outcome studies. It has also been shown to complement other treatments for major mental illnesses, including bipolar disorder and schizophrenia. This type of treatment has efficacy in treating psychiatric and non-psychiatric illnesses, in addition to the role of the multidisciplinary team in its implementation to enhance patient outcomes (Chand et al., 2023).

Cognitive-behavioral therapy (CBT) is the result of extensive research. This aids in the quest for an effective treatment for a variety of mental illnesses. This treatment is based on a broad movement still developing to confront the patient's obstacles and identify the ambiguous variables that might impact his physical and psychological state (Chibani and Alaka, 2020).

Since the 1990s, CBT has played an increasingly important role in schizophrenia treatment, but it has also run into several theoretical and practical problems. For example, recent methodologically rigorous meta-analyses have indicated shallow overall effect sizes of CBT treatment, raising issues about what and who it truly works for (Skodlar et al., 2013).

CBT has been shown to relieve delusions and hallucinations in many trials, and in-person counseling appears to increase social functioning (Bustillo et al., 2001).

In the 1990s, most of the research that proved the advantages of CBT for schizophrenia was conducted. The bulk of them were aimed at those who were resistant to therapy. The significance of recent studies is increasingly being focused on. Acute effects of CBT on prodromal state negative symptoms, lack of insight, and schizophrenia prevention of recurrence (Rathod et al., 2005).

The importance of CBT in early case studies and uncontrolled trial studies focusing on treating delusions and hallucinations has provided the basis for more recent improvements in CBT for schizophrenia (Xu and Zhang, 2023). An electronic search (MEDLINE and Psych Info) and personal communications resulted in seven randomized controlled trial studies evaluating the efficacy of CBT for schizophrenia. CBT has been shown to have a clinically significant effect on both positive and negative measures of schizophrenia symptoms. Besides the gains achieved through standard care and adjuvant supportive therapy, patients who received routine care and assistance with

CBT saw additional benefits. This data shows that CBT has a promising future (Rector and Beck, 2001).

Patients suffering from acute psychotic episodes have shown an evident influence on positive symptoms and a stronger benefit from CBT. Although medication therapy is useful in the treatment of psychotic diseases, it is ineffective in the treatment of hallucinations and delusions (Zimmermann et al., 2005).

Cognitive behavioral therapy (CBT) is useful in conjunction with antipsychotic medication and remedial methods like social skills training (SST) to address the lingering symptoms of chronic schizophrenia. With a lesser apparent impact on negative symptoms, cognitive behavioral therapy (CBT) seems to be a viable therapeutic strategy for positive symptoms, depression, and general symptoms (Turkington et al., 2004).

SST comprises learning activities that employ behavioral strategies to help people with schizophrenia, and other debilitating mental diseases gain personal illness management and independent living skills to enhance their community functioning. A significant and expanding body of research supports the usefulness and effectiveness of SST for schizophrenia. Patients can learn and maintain various social and independent living skills when the type and frequency of instruction correspond to the condition's stage. When patients are given chances, encouragement, and reinforcement to practice abilities in appropriate contexts, generalization of skills for application in everyday life happens (Kopelowicz et al., 2006).

In a study evaluating its effect on patients with schizophrenia, the SST intervention was shown to be successful in decreasing social dysfunction in psychotic patients. However, applying new skills to patients' everyday functioning is difficult. The intervention was predicted to improve patients' social cognition and performance and transfer acquired responses into daily life. Negative symptoms, psychopathology, and anxiety all improved significantly, according to the statistics. The objective findings of discomfort in social situations, avoidance, and social functioning revealed a learning pattern in emotional perception, assertive actions, and discussion time (Almerie et al., 2015).

Based on the short preview above, the present study will investigate the effectiveness of a CBTP in Reducing symptoms and enhancing social skills in individuals with

schizophrenia in a particular sample of those who visit a Natan treatment center in occupied Jerusalem.

1.2 Schizophrenia Spectrum Disorder

1.2.1 Introduction

Schizophrenia is an illness with diverse phenotypic manifestations and a complicated etiology that includes a significant genetic influence as well as environmental variables interacting with a genetic predisposition. The genetic background is provided by several genes and varied combinations of their polymorphic variations, with a part of the transmitted genotypes remaining clinically unexpressed. Schizophrenia occurs at comparable rates in varied groups, which is compatible with an ancient origin, and its frequency has not altered significantly over the last two centuries, according to records (Jablensky, 2010).

Schizophrenia, a chronic brain illness, affects less than 1% of Americans. Schizophrenia can manifest as delusions, hallucinations, slurred speech, trouble thinking, and a lack of motivation. Most schizophrenia symptoms will improve dramatically with treatment (APA, 2020).

Furthermore, schizophrenia is a prevalent disorder that frequently begins in early adulthood and disrupts core skills, with a lifetime prevalence of 1%. In addition to the typically visible good indicators, the degree of the negative symptoms, notably cognitive impairment, is the essential signal for further diagnosis. Around 20 to 35 percent of patients develop residual illness and become chronic, resulting in impairment in a variety of domains of independent functioning. Diagnostic ideas are fundamental in the management and treatment of schizophrenia patients. Most of the characteristics that define schizophrenia are mostly inferential and based on self-reported subjective experience. No objective diagnostic test or validated biological marker can serve as a solid foundation for clinical decision-making or scientific study (Wobrock et al., 2004).

1.2.2 Definitions

On April 24, 1908, the Swiss psychiatrist Eugen Bleuler (1857–1939) gave a presentation titled "The Prognosis of Dementia Praecox (Schizophrenia Group)" at the annual conference of the German Union for Psychiatry in Berlin (Merriam-Webster Dictionary, 2022).

The term "schizophrenia" refers to the disintegration of mental connections inside the mind and is derived from the Greek terms "chizin" (for division) and "phren" (for the mind) (mind) (Winn, 2000).

Psychiatry, called schizophrenia, "is a severe mental disorder characterized by some, but not necessarily all, of the following features: emotional blunting, intellectual deterioration, social isolation, disorganized speech and behavior, delusions, and hallucinations." (Thesaurus Dictionary, 2022).

There were many different definitions of schizophrenia, but they all had the same substance. The following are some of the most notable literary definitions:

Schizophrenia is a "severe mental condition that has an impact on a person's thoughts, feelings, and actions. Schizophrenia patients may seem to have lost their sense of reality." It may be challenging to engage in typical everyday activities if you have schizophrenia symptoms (NIMH, 2022).

"It is a condition with a varied phenotypic manifestation and a poorly known, complicated etiology that includes a significant genetic component and environmental variables that interact with genetic vulnerability. The genetic background is provided by several genes and various combinations of their polymorphic variations, with a part of the transmitted genotypes remaining clinically unexpressed" (Jablensky, 2010).

Schizophrenia is a "serious mental condition that manifests as psychosis, apathy, social disengagement, and cognitive impairment. Patients with these disorders perform poorly in employment, school, motherhood, self-care, independent living, personal relationships, and leisure time" (Khan et al., 2013).

1.2.3 The Theories explaining schizophrenia

Depending on the theoretical school describing it and the schools from which it is explained, there are several theoretical notions of schizophrenia, such as the following:

1.2.3.1 The Biological Theory

Schizophrenia is one of several diseases classified as complex genetic disorders. It has long been considered that alterations in the DNA sequence are entirely responsible for schizophrenia transmission. However, twin studies suggest that an epigenetic inheritance mechanism may play a role in the transmission of schizophrenia. The idea of epigenetics playing a role—phenotypic alterations that cannot be explained by DNA sequencing—was initially proposed to explain the partial concordance of schizophrenia in monozygotic twins (Gejman et al., 2010).

The new epidemiological data point to factors that raise the likelihood of developing schizophrenia, such as obstetric difficulties other than birth or urban living, famines, immigrant status, and seasonal impacts (by prenatal infection, such as influenza). Further epidemiological research indicates that advanced paternal age, cerebral hypoxia, and other severe pregnancy and neonatal problems are environmental risk factors (Gejman et al., 2010).

1.2.3.2 The Freudian Theory

It is classified as schizophrenia, a weakness in ego functions. In schizophrenia, Hartmann refers to the superego as a faulty structure. It has a low level of structure, integration, distinctiveness, and a lack of stability or consistency. Hartmann connects several aspects to the superego's connection with the weakly developed ego. Freud's explanation of schizophrenia was founded on the libido model. The advent of structural theory, an extensive explication of ego and superego creation and functioning, is a drive theory based on aggressive and libidinal drives and a complete study of early object interactions (Goldstein, 1978).

1.2.3.3 Neurological Theory

Understanding the interconnections between the structural and functional connectomes is more difficult in psychiatric diseases. Schizophrenia is the most researched condition in terms of neuroimaging, and it was the first to use the idea of dysconnectivity to explain the brain foundation of clinical and cognitive symptoms. The dysconnectivity model of schizophrenia is based on evidence of anatomical and functional changes in patients compared to healthy individuals, including widespread reductions in brain volume, cortical thickness, and white matter tract integrity, as well as abnormal connectivity of the major functional networks (Frangou, 2020).

1.2.3.4 Albert Ellis (CBT) Theory

Mental diseases are caused by ideas and beliefs that affect the erratic actions we observe (Emerson & Thomas, 2022).

Currently, numerous research-oriented cognitive models exist in Cognitive Behavioral Therapy (CBT). Nevertheless, Albert Ellis's first cognitive framework was (CBT). Ellis (1957) proposed the inaugural cognitive model of emotional disturbance, known as the ABC model, along with its therapeutic approach. This marked the inception of REBT, the earliest kind of cognitive behavior therapy and a highly influential form of CBT in contemporary practice. According to Ellis' ABC paradigm, unhealthy sentiments (C) are caused by irrational ideas (B), not adversity (A; adverse occurrences). To modify unhealthy feelings, one must first address unreasonable ideas. Albert Ellis' ABC model was founded on two basic concepts distinguishing it from subsequent cognitive models: the identity (or interdependence principle) of cognition, emotion, and behavior, and the biological premise of cognition. These two distinguishing features define Ellis' cognitive model as a grounded cognition model (Tiba, 2024).

1.2.4 The Genesis of Schizophrenia

The actual causes of schizophrenia's inception and progression remain unknown. But one thing is certain: there is no one cause of schizophrenia; instead, a combination of elements must be present (Spittler, 2022).

According to schizophrenia epidemiology, it happens rather frequently, in a range of settings, and conjunction with other disorders, reducing the quality of life and causing premature death. A vast amount of research has gone into the causes of schizophrenia, and we now have a much better understanding of the genetic, environmental, and psychological factors that contribute to the condition. While there are several methods for understanding and conceptualizing schizophrenia, a comprehensive picture of the disorder's biochemistry, structural changes in the brain, and cognitive and social-cognitive deficiencies have yet to emerge. Convulsive therapies and psychosurgery were previously used to treat schizophrenia unsuccessfully, indiscriminately, and without scientific support (Volkan, 2020).

After more than a century of research without a clear explanation of the etiology of schizophrenia, the findings in epidemiology, genetics, antecedents, and psychopathology stand out. Kraepelin and Bleuler's contributions to the concept of sickness are extensive. Schizophrenia is currently regarded as a polygenic disorder that starts in early adulthood and is marked by irregular psychotic episodes and functional impairment; however, it can develop at any age with considerable differences in symptoms and social implications. Men and women encounter similar risks in their lives. Women become unwell after a few years and have fewer severe symptoms than men, but men seldom fall ill later in life (Hafner, 2014).

Based on the evidence, certain individual features might function as susceptibility factors and environmental stresses can induce psychotic episodes in sensitive people. Potential susceptibility variables include information-processing deficiencies, autonomic reactivity abnormalities, and social competence and coping limits. Stressors in the form of discrete life experiences, as well as the current degree of social contextual stress, are viewed as elements that combine with inherent susceptibility features to establish vicious cycles that lead to psychotic episodes (Nuechterlein & Dawson, 1984).

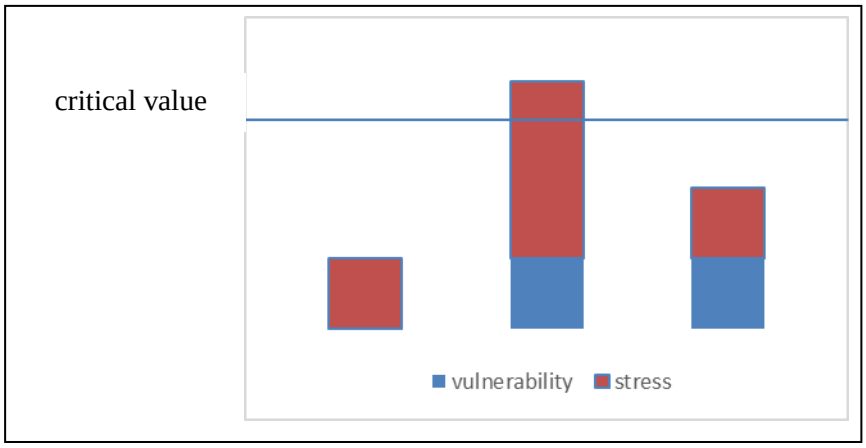
Numerous studies have shown that genetics (G) interacts with unfavorable life events (E) to cause individual variations in sensitivity and resilience to mental diseases such as schizophrenia. The timing of environmental exposure(s) and genetic vulnerability to stress are crucial for these interactions and constitute shared risk factors (Daskalakis and Binder, 2015).

In contemporary psychiatry, the stress-vulnerability model of schizophrenia is a widely accepted explanation regarding the onset and progression of schizophrenia symptoms. Despite some modifications, the concept's basic idea is that an individual's inherited predisposition to the disorder, along with the stress they experience, initiates and advances schizophrenia (Rudnick & Lundberg, 2012).

The vulnerability-stress model: Today's popular assumption is that when the "critical value" is surpassed, a vulnerability with unfavorable external variables (stress or medicines) may contribute to the start of illness. This is known as the vulnerability-stress model (Spittler, 2022).

Figure 1

vulnerability-stress model



source: Spittler, 2022.

1.2.5 Symptoms of Schizophrenia

The "schizophrenia group," as it is colloquially known, is phenotypically heterogeneous. Its symptoms cover various psychological aspects, including perception, inferential reasoning, language, attention, social interaction, and thinking and volitional expression. Psychopathology research has simplified this complex group into various study methodologies, including distinguishing between positive and negative symptoms. Schizophrenia symptoms are categorized into three natural dimensions: Positive symptoms are divided into psychotic and disorganized dimensions, with a third negative dimension also present due to the amazing symmetry of these dimensions. Both positive and negative symptoms characterize schizophrenia. Hallucinations, voices speaking to or about the patient, and paranoid delusions are all positive indications.

Negative effects are flat swaying, lack of enjoyment, loss of motivation or drive, and social withdrawal (Schultz et al., 2007).

1.2.5.1 Positive Symptoms

According to (DSM-5) Symptoms are presented as follows:

1. "Delusions".
2. "Hallucinations".
3. "Disorganized speech".
4. "Grossly disorganized or catatonic behavior".

1.2.5.2 Negative Symptoms

Negative symptoms are an essential component of schizophrenia, accounting for a significant amount of long-term damage and poor functional results in patients suffering from this disorder. The term "negative symptoms" refers to the reduction or absence of usual behaviors and functions associated with stimulation, attention, or verbal or emotional expression. The five negative symptoms (a decreased experience of pleasure) are dimpled affect, alogia (a decrease in the number of words said), aphasia (a reduction of goal-directed behavior due to impaired motivation), social connection, and anhedonia. Up to 60% of people may experience clinically significant adverse symptoms requiring treatment. Unfavorable symptoms can appear at any stage of the disease and might be primary symptoms caused by the underlying pathophysiology of schizophrenia, secondary symptoms caused by coexisting psychiatric or medical issues, negative repercussions of therapy, or other environmental factors (Correll & Schooler, 2020).

1.2.6 The Longitudinal Course of Schizophrenia Across the Lifespan

Schizophrenia (SZ), a mental condition characterized by delusions, hallucinations, psychomotor abnormalities, cognitive impairment, or a combination of these symptoms, is a potentially lifelong handicap (Heilbronner et al., 2016).

In historical periods, particularly in the 1970s and 1980s, the diagnosis of schizophrenia was frequently avoided as a stigmatizing label and was thus replaced with alternative diagnostic categories, such as paranoid personality disorder or generic definitions of less compromising psychomotor agitation or anxiety; the diagnosis of schizophrenia

was raised only after several hospitalizations or in extremely severe cases. In a retrospective study of schizophrenia, the first challenge was the exact specification of the sample of cases, which included all patients with the condition while avoiding incorrect diagnoses (Turola et al., 2012).

Spittler (2022) divided schizophrenia into three phases, which are as follows:

First Phase (Starting Stage): Negative symptoms frequently occur at this stage, along with a progressive shift in attitude and behavior, which is referred to as "early warning signals." Many people who have schizophrenia are aware of these early symptoms as indicators of a relapse into the active phase of the disease. Validating treatment at this early stage might help to avoid a dangerous recurrence.

The Acute or Active Phase: Positive symptoms such as delusions, hallucinations, or diverting ideas can be detected during this period, and a crisis might occur. One aspect of the illness is that the patient may be completely unaware that they are ill. During a crisis, the hospital is frequently the safest location for the patient. The patient is examined here, and effective therapy is started.

The Stage that Remains: When the medication begins to work, most patients experience a stabilization of their condition, with acute symptoms gradually disappearing. Some unpleasant symptoms, such as a lack of motivation or social disengagement, might last for a long time, and in some people, they can vanish fast, leaving the patient symptom-free. In other circumstances, undesirable effects may last indefinitely. This stage can endure for years and occasionally relapses into the acute stage. Many patients, however, may keep relapses to a minimum with continuing medication therapy and routine monitoring.

A recent work completed by Spittler (2022) concluded that while diagnosing schizophrenia in its acute form is relatively simple, it is always vital to be cautious since signs of psychosis can coexist with other medical and psychological illnesses. Because the symptoms at the beginning stage are very non-specific, the early stage may not be noticed until later.

1.2.7 Diagnosis of Schizophrenia

People who have psychosis must receive an accurate diagnosis as soon as possible. The earlier schizophrenia is detected, the better the success of therapy. Other disorders, such as bipolar disorder, can, however, exhibit psychotic symptoms like schizophrenia (Soares-Weiser et al., 2015).

The International Classification of Diseases, revision 11 (2022), established diagnostic criteria for schizophrenia, describing it as "distinguished by significant impairments in reality testing and behavioral alterations manifested in positive symptoms such as persistent delusions, persistent hallucinations, disorganized thinking (typically manifested as disorganized speech), grossly disorganized behavior, and experiences of passivity and control, as well as negative symptoms such as blunted or flat effect, avolition, and psychomotor disturbances. The symptoms occur frequently and intensely enough to diverge from expected cultural or subcultural standards. These symptoms are not the result of another mental or behavioral condition (e.g., a mood disorder, delirium, or a disorder due to substance use). The characteristics in this category should not be used to categorize the expression of culturally sanctioned ideas, beliefs, or behaviors".

Schizophrenia and other major psychotic illnesses are classified as primary psychotic diseases because their distinguishing feature is psychotic symptoms. Psychotic symptoms can also arise in the setting of other mental diseases (for example, mood disorders or dementia), but only in conjunction with different aspects of such disorders. Unlike reality, where loss and distortion experiences occur on a continuum and can be found throughout the population, disorders in this category show patterns of symptoms and behaviors that occur with enough frequency and severity to depart from typical cultural or subcultural norms. (The International Classification of Diseases ICD 11, 2022)

Schizophrenia or Other Primary Psychotic Disorders include the following:

- "Schizophrenia (6A20)."
- "Schizoaffective Disorder (6A21)."
- "Schizotypal Disorder (6A22)."
- "Acute and Transient Psychotic Disorder (6A23)."
- "Delusional Disorder (6A24)."
- "Other Specified Schizophrenia or Primary Psychotic Disorders (6A2Y)."

Specifier Scales for Primary Psychotic Disorders' Symptomatic Manifestations.

For the diseases covered in Schizophrenia or Other Primary Psychotic Disorders, ICD-11 (2022) gives the option of specifying the level of severity for six symptom domains. These are the domains:

- "Positive Symptoms (6A25.0)".
- "Negative Symptoms (6A25.1)".
- "Depressive Mood Symptoms (6A25.2)".
- "Manic Mood Symptoms (6A25.3)".
- "Psychomotor Symptoms (6A25.4)".
- "Cognitive Symptoms (6A25.5)".

1.2.8 The Prevalence of Schizophrenia

Schizophrenia is one of the most crippling and economically devastating medical conditions, and it is rated as one of the top ten illnesses contributing to the global disease burden by the World Health Organization (Fischer & Buchanan, 2022).

In a study conducted by Charlson et al. (2018) to examine the prevalence of schizophrenia, the results showed that the worldwide age-standardized point prevalence of schizophrenia was estimated to be 0.28% (95% confidence interval: 0.24-0.31). Schizophrenia manifests itself in adolescence and early adulthood, peaking at 40 years of age and declining in older age groups. There were no gender variations in prevalence.

In summary, researchers observed that the prevalence of schizophrenia varied substantially between locations in the study by Saha, Chant, Welham, and McGrath (2015) (persons, median = 15.2 per 100,000; 10%-90% quantiles = 7.7–43.0). Furthermore, the study discovered:

a. "Males were more likely than females to acquire schizophrenia (median male: female risk ratio = 1.4)".
b. "Migrants were more likely than native-born persons to acquire schizophrenia (median risk ratio = 4.6)".
c. "People who lived in cities were more likely to acquire schizophrenia than those who lived in mixed urban and rural environments".

While the proportion varied from the previous time, according to the study published by Patel, Cherian, Gohil, and Atkinson (2014), the prevalence of schizophrenia in the US population ranges between 0.6% and 1.9%. Furthermore, according to a claims study, the yearly prevalence of diagnosed schizophrenia in the United States is 5.1 per 1,000 people. The condition appears to be equally prevalent in boys and girls, although males have symptoms at a younger age than girls. Males generally have their first episode of schizophrenia in their early twenties, but females typically have their first episode in their late twenties or early thirties.

1.2.9 Social Skills in Patients with Schizophrenia

Forming, establishing, and maintaining social relationships is critical for physical and mental health. According to research, social isolation doubles the risk of sickness and mortality. He added dimensions of Social Skills (Al-Yousef, 2013):

- Verbal communication skills: Social Expression, Social Sensitivity, Social control.
- Nonverbal communication skills: Emotional expression, Emotional sensitivity, Emotional Control.

Poor social skills and abnormal behaviors are central characteristics of schizophrenia and constitute significant elements of social functioning. Prior research indicates that deficits in the social cognitive ability to attribute mental states may forecast inadequate social skills. Deficient social skills appear to correlate with the occurrence of negative symptoms, whereas the relationship with other symptom dimensions remains ambiguous. Deficient social skills appear to correlate with the occurrence of negative symptoms, whereas the relationship with other symptom dimensions remains ambiguous. There is ongoing discussion over the roles that nonsocial cognitions specifically executive functioning—plays in the functional outcome of schizophrenia as well as the connections between social and nonsocial cognition (Brüne, 2011).

SST is a systematic strategy for teaching interpersonal skills that improves functioning and reduces negative symptoms in people with schizophrenia. In SST, complex interpersonal skills are broken down into smaller skills and taught in a structured format through a combination of modeling (clinician demonstration of skills in role plays), behavioral rehearsal (client practicing of skills in multiple role plays), positive and corrective feedback to shape the learning of skills (reinforcement of successive

approximations to the targeted skill), and collaboratively developed home assignments to practice the skill outside of sessions (Browne et al., 2020).

Schizophrenia can manifest as a single episode of illness. Most sufferers, however, have remission and relapses; for up to 41% of people who get schizophrenia, it becomes a chronic and sometimes crippling illness. Antipsychotic medicines are routinely used to control symptoms. Meta-analytical methods suggest that antipsychotic medication should be used in conjunction with family, social, psychological, and psychotherapeutic support, collectively referred to as rehabilitation (Almerie et al., 2015).

SST consists of learning activities that use behavioral strategies to help people with schizophrenia and other burdensome mental diseases develop interpersonal disease management and independent living skills so that they can operate more effectively in their communities. A substantial and expanding amount of evidence confirms the efficacy and effectiveness of SST for schizophrenia. When the type and frequency of training are tailored to the problem phase, patients can learn and retain a variety of social and independent functioning skills. When patients are given opportunities, encouragement, and reinforcement to practice the skills in appropriate contexts, they generalize them for everyday application. SST is crucial in schizophrenia treatment due to its protective factors, which can attenuate the effects of cognitive deficits, neurobiological vulnerability, stressful events, and social maladjustment. These skills provide resilience, interpersonal support, social affiliation, and an improved quality of life. A large sample of over 2000 patients with schizophrenia showed a significant correlation between social competence attributes and subjective life satisfaction. SST helps stabilize illnesses, improve medication and psychosocial treatment adherence, and promote recovery progress. It also helps children and adolescents with schizophrenia develop social skills from an early age, which can be exacerbated by parental overprotectiveness and social withdrawal. SST is essential for patients to become active participants in controlling their illness, overcoming obstacles, and mobilizing social support. It is particularly effective in teaching medication self-management skills, allowing patients to gain greater control over their illness and gain insight into their condition (Kopelowicz et al., 2006).

A meta-analysis by Turner and colleagues confirms the effectiveness of SST in improving social skills and reducing negative symptoms in people with schizophrenia.

The study found that SST has significant effects on social functioning, general psychopathology, and skill content mastery and moderate effects on negative symptoms and community functioning. The findings suggest that SST can improve existing standard services for schizophrenia in addition to pharmacological treatments (Granholm & Harvey, 2018).

1.2.10 Theories of Schizophrenia

1.2.10.1 Neurodevelopmental Theory

Several hypotheses have been proposed to explain the etiology of schizophrenia; one of the most widely accepted is the abnormal neurodevelopmental hypothesis, which is based on the presence of both prenatal and perinatal disorders, differences in IQ, or the presence of genetic abnormalities, all of which result in schizophrenia when they interact. Certain environmental factors can induce schizophrenia in children, and this hypothesis discusses how these factors might disrupt normal development and lead to schizoaffective illness. A smaller but not insignificant number of studies, on the other hand, suggest the presence of a degenerative process in the course of this disease based on factors such as neurotoxicity in the brains of people who have schizophrenia, as well as structural and cerebral abnormalities (Ľupták et al., 2021).

While numerous theories have been proposed regarding the etiology of schizophrenia, most of the evidence points to a neurodevelopmental model in which developmental insults as early as the late first or early second trimester lead to the activation of pathologic neural circuits during adolescence or early adulthood. This results in the emergence of positive or negative symptoms and the following (Fatemi & Folsom, 2009):

a. Brain pathology data include enlargement of the cerebroventricular system, gray and white matter changes, and abnormal laminar organization.
b. Environmental factors include prenatal viral or bacterial infections, an increased frequency of obstetric complications, and increased rates of schizophrenic births.
c. Genetic data include changes in the normal expression of proteins involved in early neuro and glia migration, cell proliferation, axonal outgrowth, synaptogenesis, and apoptosis.

d. Gene-environment interactions are also discussed, as a disproportionate number of schizophrenia candidate genes are regulated by hypoxia, microdel, and gene-environment interactions.

1.2.10.2 Genetics Factor

Heredity is a key risk factor for schizophrenia. Over the last decade, new findings in molecular genetics have raised expectations for the identification of the biological basis of schizophrenia. However, the complexities of the research issue make it almost impossible for experts who are not genetically educated to have a thorough understanding of genetic findings and their limits. The genetic architecture of schizophrenia is extremely complex, varied, and polygenic. Many common genetic variations with minimal individual effects and highly rare genetic variants with considerable implications dictate illness risk (Henriksen et al., 2017).

1.2.10.3 Psychodynamic Theory

According to the psychodynamic interpretation, traumatic childhood experiences cause inner unrest in the patient, resulting in a struggle between the id, ego, and superego (tripartite apparatus). If this conflict is not resolved, it might result in fixation or regress to the early phases of psychosexual development. Schizophrenia is associated with an early stage of the oral stage known as basic narcissism, in which the ego has not yet dissociated from the id. As a result, the individual no longer operates based on the reality principle (Traylor et al., 2022).

In another perspective, Klein (1997) believed that the newborn introduces both good and negative items, with the internalization of positive objects being critical to the formation of healthy ego function. Klein defined depression as "the most developed type of psychological organization," which develops throughout life. The depressed state developed in the second quarter of the first year. Before this, the newborn is in the paranoid-schizoid posture, which is marked by persecutory anxiety and the defense mechanisms of splitting, projection, introjection, and omnipotence—which includes idealizing and denying. Throughout childhood, depressive and paranoid-schizoid patterns of experience coexist (Harris, 2014).

1.2.10.4 Cognitive Theory

A cognitive model-based theoretical approach to schizophrenia integrates the complex interplay of underlying neurobiological, environmental, mental, and behavioral variables with heterogeneous symptomatology. The brain's decreased integrative function and domain-specific cognitive deficiencies make people more vulnerable to negative life events, which lead to dysfunctional beliefs and actions. Disorganization symptoms are caused by specific neurological deficiencies and a relative scarcity of resources available for preserving a set, adhering to communication standards, and limiting the entrance of unsuitable ideas. Delusions regarding the interaction between active cognitive biases like external attributions and resource-saving techniques like leaping to conclusions are examined. Similarly, hallucinations have content and misconceptions about their origin and features (Beck and Rector, 2005).

1.2.11 Treatment Options

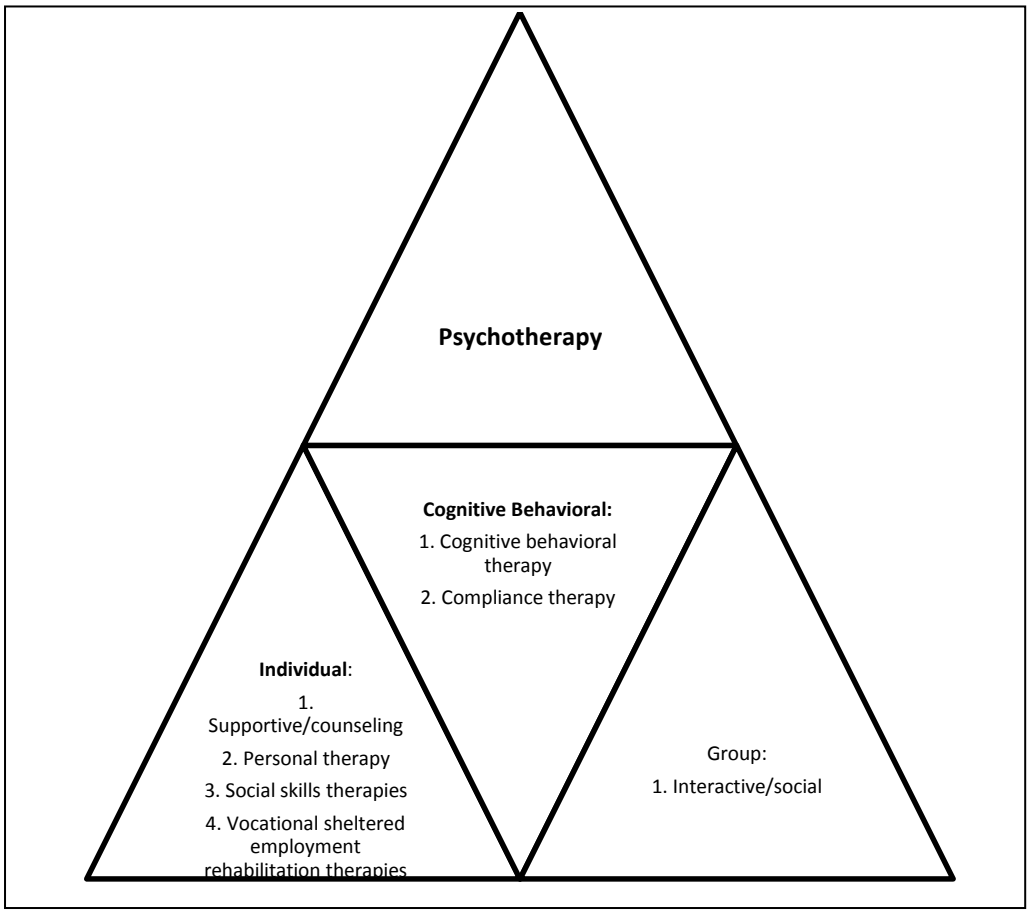
The goals of current schizophrenia therapy are to assist patients in better controlling their symptoms, improving their day-to-day functioning, and accomplishing personal goals, including completing their education, finding employment, and maintaining fulfilling relationships (NIMH, 2022).

1.2.11.1 Nonpharmacological Therapy

The aims of treating schizophrenia include addressing symptoms, avoiding relapse, and developing adaptive functioning so that the patient can be reintegrated into society. Because patients seldom revert to their baseline level of adaptive functioning, nonpharmacological and pharmacological therapies must be employed to optimize long-term results. Individual, group, and cognitive behavioral psychotherapies are the three psychotherapeutic techniques. Psychotherapy is a continually growing therapeutic field. Metacognitive training, narrative treatments, and mindfulness therapy are emerging psychotherapies (Patel et al., 2014)

Figure 2

Psychotherapeutic Approaches



Note: Patel, et al., 2014.

The National Institute for Health and Care Excellence (NICE) suggests the following psychological therapies as some of the most popular (NICE, 2019):

- Cognitive behavioral therapy, or CBT, aims to help you recognize the thought patterns that cause you to feel and act in ways that are not desired and to learn how to replace these beliefs with ones that are more useful and realistic.
- Family counseling: A lot of individuals with schizophrenia depend on their family for support and care. Even though most family members are willing to help, taking care of a family member who has schizophrenia can be difficult. One way to help you and your family deal with your sickness is through family therapy. It involves many informal meetings spaced out across several weeks.
- The goal of art therapy is to encourage artistic expression. You can better express your symptoms of schizophrenia by participating in small group or individual art therapy sessions with an art therapist.

1.2.11.2 Pharmacological Therapy

Antipsychotic prescription patterns vary significantly among nations and even regions due to differences in factors like healthcare regulations, medication availability and cost, psychiatric training, and preferred treatment techniques (BaniOdeh, 2012).

According to the statistics, the most common single antipsychotic medication is risperidone (21,1%), and the most common combination therapy is haloperidol and chlorpromazine (23,2%). The most common type of schizophrenia therapy (41.5%) is antipsychotic medication (Jarut et al., 2013).

1.3 Cognitive Behavior Therapy (CBT)

1.3.1 Introduction

CBT is an experimentally supported psychological treatment with a good evidence foundation in a variety of psychological problems and, more recently, in more serious diseases such as schizophrenia and psychoses (CBTp) (Tarrier, 2010).

CBT is a therapy developed by Beck in 1976, whose basic premise is that human thought patterns are formed through a series of Stimulus-Cognition-Response (SKR) processes that are interconnected and form a kind of network in the human brain, where cognitive processes will become a factor that influences how humans think, feel, and behave (Chand et al., 2023).

CBT tries to incorporate therapeutic strategies to assist patients in changing not just their actual behavior but also their underlying ideas, beliefs, and attitudes. CBT posits that attitudes and beliefs influence behavior and that adjustments in cognition can result in the desired behavioral changes (Goldman, 2022).

The Evolution of Psychotherapy with CBT since the advent of psychotherapy, the use of treatment for clients suffering from diverse clinical psychiatric problems has been heavily debated. The famous case of Anna O., which was handled in a Freudian manner, and the case of the rat man are examples of how psychotherapy may be used to treat personality problems. Several specialists have created various versions of CBT (Goldman, 2022).

1.3.2 Definitions

Cognitive behavioral therapy (CBT) is a "dependable and efficacious psychological intervention for a range of mental health conditions. Healthcare professionals need to understand that, to achieve the best outcomes, CBT is commonly used in conjunction with medication therapy. Additionally, it has been shown that CBT yields more benefits or results that are comparable to those of medicine alone. A mental health nurse is the best person to refer patients with psychiatric issues to so they can receive treatment recommendations. It is suggested that primary care physicians work in tandem with behavior therapists to provide and monitor cognitive-behavioral therapy (CBT). A method utilizing an interprofessional team will yield optimal outcomes" (Coffey, Banducci, & Vinci, 2015).

To explain the notion of CBT, the researchers included the following:

1. Rice (2015): "CBT is a combination of behavioral and cognitive therapy. CBT assists clients in challenging their troublesome thinking and changing the behaviors related to such thoughts. This item focuses mostly on CBT, as described by Aaron Beck, one of the early pioneers of the approach."
2. Mcleod (2019): "CBT is a type of talk therapy that can be used to treat a variety of mental health issues. CBT is founded on the concept that the way we think (perceive), feel (emotion), and act (behavior) all interact with each other. Our thoughts influence our mood and actions."
3. Cherry (2022): "CBT included. Behavioral and cognitive therapy is mainly used in the short term. CBT is often regarded as a guiding method for psychotherapy that assists clients in confronting their difficulties. Changes in thoughts and conduct because of such concepts."
4. IQWIG (2013): "CBT is a combination of two treatment modalities known as cognitive therapy and behavioral therapy and is one of the most widely used and researched types of psychotherapy. The basic idea underlying therapy remains constant: what we think, how we feel, and how we act are all closely related".

1.3.3 Cognitive Behavioral Therapy Theory (CBT)

Several psychologists began integrating behavior therapy with cognitive therapies in the 1960s and 1970s to improve clients' unfavorable ways of thinking and processing information. Although several people made crucial contributions to the early development of cognitive therapy, Aaron Beck and Albert Ellis are most credited with its creation. Both were trained as psychoanalysts and identified their discontent with standard psychoanalysis as the impetus for developing innovative techniques to treat depression, anxiety, and associated issues. Ellis called his treatment rational, emotional therapy, and, subsequently, rational emotional behavior therapy, whereas Beck called it cognitive therapy. Both therapies aimed to assist clients in shifting their negative, depressed, anxious, and dysfunctional beliefs, assumptions, and predictions to more realistic, positive, and adaptive ones. As successful behavioral and cognitive therapies became more widely available, researchers in the 1970s and 1980s began to create protocols that included tactics from both types of treatment (Antony and Baugh, 2024).

Because the cognitive mediator would have been lacking in the "first wave" behavioral paradigm, this revolution that led to CBT techniques is also referred to as the "second wave." Ellis' rational-emotional behavior therapy and Beck's cognitive therapy were the "second wave" advocates since they were the first to provide therapeutic parallels to the cognitive revolution. They were followed by less well-known thinkers like Lazarus, Mahoney, Meichenbaum, Goldfried, and Davison, among many others. Later, the "second wave" split into a "rationalist" approach that included both Beck's CT and Ellis' REBT and saw cognition as conscious computational knowledge and a "constructivist" approach that saw cognition as hermeneutical, emotionally laden, and "tacit" knowledge derived from human relationships. Finally, the so-called "third wave" would have gladly brought the tale to a close by including functional processes into the overarching concept of CBT techniques (Ruggiero et al., 2018).

CBT is regarded as one of the most trustworthy and successful approaches for studying and treating psychopathological illnesses. This method proposes a complicated link between emotions, ideas, and behaviors, emphasizing how emotional issues are often the result of dysfunctional beliefs. "CBT seeks to assist patients in identifying repeated beliefs and faulty habits of thinking and reality perception" (Association of Cognitive Psychology and institute, 2020).

Cognitive and behavioral theories of psychopathology and human behavior are combined in CBT. Among the many intervention modalities offered by CBT are extinction, habituation, modeling, cognitive restructuring, problem-solving, and the development of coping skills, mastery, and self-control. CBT covers a wide range of treatment trajectories and uses developmentally directed procedures to address multiple areas of potential vulnerability (e.g., cognitive, behavioral, and emotional). More work is needed to address the ssstreatment of non-responders and enhance the dissemination of effective CBT treatments, even though CBT is commonly considered the "first-line treatment" for many psychiatric diseases among adolescents (Benjamin et al., 2011).

The cognitive-behavioral theoretical framework of human functioning is founded on the idea that thoughts, emotions, and actions are intimately connected and that each component of human functioning affects and influences others. According to CBT, beliefs about oneself, relationships, the world, and the future impact emotions and behaviors. Feelings and behaviors influence ideas and mental processes in a continuous reciprocal feedback loop. Furthermore, CBT holds that cognitive-effective-behavioral processes are comparable and parallel among humans and human experiences. On the other hand, the substance of the cognitive-affective-behavioral processes is unique and personal to the individual (Alford and Beck, 1997).

Researchers and practitioners disagree over the precise extent of CBT. Several modern therapies may be classified as CBT since they all share the idea that thinking (cognition) mediates behavior change and that a change in thinking leads to changes in behavior and mood. The evolution of CBT may be split into three or, as some believe, four stages (Keegan and Holas, 2010):

1. "The independent emergence of behavior therapy in the United States, South Africa, and the United Kingdom from 1950 to 1970 (the first wave of CBT)".
2. "The emergence of cognitive therapy in the United States in the 1960s and 1970s (second wave)".
3. "Further development and merging with behavior therapy into cognitive-behavioral therapy, which gained momentum in the 1980s and continues to achieve remarkable results".
4. "The emergence of the so-called third wave of CBT, with a primary focus on".

1.3.4 Why does Cognitive Behavioral Therapy (CBT) work?

The Association of Cognitive Psychology and Institute (2020) has determined the effectiveness of using CBT, which is concentrated in the following:

1. CBT is supported by research.

The treatment intervention is completely congruent with fundamental psychology research's understanding of mind structures and processes. Furthermore, controlled investigations have proven that CBT is a successful therapy.

2. CBT has a specific purpose in mind.

During the initial visits, the cognitive-behavioral therapist collaborates with the patient to set therapeutic objectives, formulate a diagnosis, and agree on a treatment plan tailored to the patient's specific requirements. He then reviews progress regularly to see if the goals have been met.

3. CBT is hands-on and practical.

The goal of therapy is to resolve specific psychological disorders. Some common aims include reducing depressive symptoms, eliminating panic attacks and any associated agoraphobia, reducing or eliminating compulsive routines or pathological eating patterns, promoting interactions with others, reducing social isolation, and so on.

4. CBT is a team effort.

The patient and therapist collaborate to comprehend and develop ways to help the topic address their challenges. CBT is a type of psychotherapy that relies heavily on collaboration between the patient and the therapist. Both are actively involved in recognizing and challenging the precise patterns of thinking that may produce the patient's emotional and behavioral difficulties.

5. CBT is short-term.

Therapy normally lasts four to twelve months, depending on the circumstances, with a weekly frequency being the most common. More significant psychological issues that need a longer treatment time can still benefit from the combination of cognitive therapy, psychiatric medicines, and other types of treatment".

1.3.5 CBT for Schizophrenia

CBT for schizophrenia is based on drug therapy, targeting positive symptoms (illusions, delusions, etc.), negative symptoms (laziness, withdrawal, etc.), personality and behavioral disorders of schizophrenia, drug compliance, and related psychosocial problems, using unique psychotherapy techniques to change patients' non-adaptive thinking and behavior patterns, reducing the negative impact of symptoms and associated problems on patients' emotions, psychosocial functions, etc., to achieve the purpose of improving function and reducing recur This therapy is practical, focused on the present, highly operable, easy to learn and popularize, and has become the fastest-growing psychotherapy model in the current Anglo-American countries (Zhihua, 2013).

Although medicine is the foundation of therapy and relapse prevention for schizophrenia, 25% to 40% of individuals who take good medication have persistent psychiatric symptoms. CBT for schizophrenia refers to the use of CBT in conjunction with pharmacological treatment to alleviate patients' mental symptoms and produce a therapeutic impact. CBT has become more popular in the treatment of schizophrenia during the last ten years (Suping et al., 2015).

The bulk of the trials with acutely ill individuals were primarily concerned with addressing the chronic and persistent symptoms of schizophrenia. Approximately half of the patients with schizophrenia (47%) have definite psychotic characteristics, whereas the other 22 percent have mild or intermittent psychotic traits. These studies have mostly been conducted in the United Kingdom, where the technique has received widespread diffusion, most likely because of formal support from the National Institute for Clinical Excellence. Tai and Turkington describe the findings of CBT research and reviews of these studies as follows (Morrison, 2009):

1. CBT is helpful in both clinical and research settings.
2. CBT helps with hallucinations and delusions.
3. Negative symptoms improve early and continue to improve during a medium-term follow-up.
4. When people do not believe they have a mental health condition, have delusional systems, or have excessive negative thinking, CBT is less successful.

5. When persons have comorbid problems, such as substance abuse, it is more difficult to engage and treat them. CBT, on the other hand, shows potential even in these more complicated clinical settings.

1.4 Previous Studies

The researcher in this section presents the studies that dealt with the effectiveness of CBT in treating people with schizophrenia, from the most recent studies to the oldest.

Shukla et al. (2021**)** conducted confirmatory pre-post assessment research to investigate the efficacy and durability of CBT in treating hallucinations in patients with schizophrenia. Based on the purposive sampling approach, a sample of 40 patients with schizophrenia who had core symptoms of hallucinations and delusions and were receiving standard therapy was selected and matched on sociodemographic and clinical factors. The Psychotic Symptom Rating Scale and the Scale for the Assessment of Positive Symptoms were used to assess clinical factors. After the baseline assessment, the cognitive-behavioral program was tailored for the experimental group, and patients from both groups were examined after the end of therapy. Follow-up data on the program's durability were collected from all patients in the experimental and control groups. CBT is useful in the treatment of auditory hallucinations in schizophrenia patients. All treatment benefits across all study variables were found to be sustained or improved at follow-up, demonstrating the durability of CBT. This study was carried out at the inpatient department of Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi, a tertiary care psychiatric hospital.

A systematic review and single-group meta-analysis comprised response rates in patients with schizophrenia and positive symptoms receiving CBT in 33 trials, with 1142 people undergoing CBT, according to research done by Bighelli et al. (2018). Subgroup and meta-regression analysis demonstrated a superior overall treatment response in patients who were not treatment-resistant and in studies with the researchers' affiliation. The improved response in studies, including those of experienced therapists and patients who were more critically ill at the start, was marginally significant. The number of sessions, treatment length, and age and gender of the outcome assessor were not significant mediators of response. According to the data, they were integrating CBT with medication which resulted in a minor improvement in

overall symptoms in 44.5% of those who received it. A variety of research and patient factors can influence response rates.

Despite taking their prescribed medications, people with schizophrenia who experienced significant residual symptoms and impaired functioning were treated with cognitive-behavioral interventions in the study by Bradshaw and Roseborough (2016). The study used an aggregated AB single-system research design with 22 participants to assess changes in clinical outcomes. During 18 months of treatment, changes were evaluated using standardized measures of psychosocial functioning, the severity of symptoms, the accomplishment of treatment objectives, and the severity of the impact of the illness on self-concept. A statistically significant improvement in psychosocial functioning was made by 86% of the clients, and a statistically significant decrease in the severity of psychiatric symptoms was made by 82% of the clients. All 22 clients achieved more of their treatment objectives than had been anticipated. In addition, there was a statistically significant increase in the self-esteem of 82% of the clients. These results showed that the therapy had a positive and lasting impact on the client's mental health and well-being, significantly improving their psychosocial functioning, decreasing the severity of psychiatric symptoms, and increasing their self-esteem.

Morrison (2009**)** in his research emphasizes the widespread use of cognitive-behavioral therapy in rehabilitation settings that leads to improvements in general function in Cognitive behavioral therapy for people with schizophrenia, which has received notice and recognition in the United States as a treatment for people with schizophrenia. Despite several new treatment regimens for people with schizophrenia, this has not occurred.

A study by Lysaker et al. (2009) found that using weekly CBT group and individual sessions instead of traditional vocational support improved patients with schizophrenia spectrum disorders employment outcomes. In this study, 100 people with schizophrenia or schizoaffective disorder were offered a six-month job placement and randomized to receive support services (50) or IVIP (a program of cognitive-behavioral group and individual interventions). Weekly hours were recorded, and job performers Were evaluated biweekly using the weekly behavior inventory by raters unaware of the condition being assessed. Participants in the IVIP group worked significantly more weeks than those in the support condition, according to t-test results. Additionally,

repeated measures ANOVA showed that the IVIP group put in more hours overall. Results suggest a connection between cognitive-behavioral interventions and higher levels of work performance in people with schizophrenia.

1.5 Trends Emerge from Previous Studies

This section began with a short review of the literature regarding theory. It is clear from the presentation of previous studies that the topic of CBT for Schizophrenia disorder has gotten much attention from researchers in their later stages of life.

The current study is like earlier studies in that it seeks to determine the effectiveness of CBT in the treatment of schizophrenia and in reducing the positive and negative symptoms of the disorder.

1.6 Definitions of Terms

Cognitive Behavior Therapy (CBT): "is one of the most widely used and researched types of psychotherapy. It combines two treatment approaches: cognitive therapy and behavioral therapy. The therapy methods used are determined by the sickness or problem being addressed. The essential concept behind treatment remains consistent: what we think, how we feel, and how we conduct ourselves are all inextricably linked - all these elements dramatically affect our well-being" (Cherry, 2023).

It is defined procedurally: This is a sort of psychological treatment that has been proven to be effective for a wide range of conditions, including depression, anxiety disorders, alcohol and drug misuse, marital problems, eating disorders, and serious mental illness. It combines the basic components of a person: feelings, thoughts, and behavior. This study represents a CBT program that focuses on restoring the patient's cognitive structure and modifying his behavior to reduce symptoms and improve social skills.

Schizophrenia: "is a chronic and burdensome condition with a wide range of positive and negative symptom combinations. The difference between positive and negative symptoms was developed in neurology and later accepted in psychiatry; in schizophrenia, this division correlates to clinical findings and allows the condition to be characterized in terms of symptom domains. While positive symptoms show an excess or distortion of normal function (e.g., delusions, hallucinations, disordered behavior),

negative symptoms refer to a reduction or lack of normal motivation and interest-related activities" (Correll & Schooler, 2020)"

Procedurally, it is defined as a tough brain illness that makes it difficult to tell what is real and what is not, to think effectively, control emotions, relate to people, and operate normally. It influences how a person behaves, thinks, and perceives the world. It also impairs a person's capacity to detect indications of this disorder, such as hallucinations and delusions.

1.7 Statement of the Problem

Psychotherapists treat a wide range of illnesses using a variety of psychological schools, including behavioral, analytical, and cognitive approaches. In the third wave of psychotherapy, CBT was proposed to treat a variety of diseases successfully, and it is now being studied for its beneficial impact and comparison with other therapeutic approaches.

The researcher concluded that many schizophrenic patients while working with them for a long period, did not receive any form of non-pharmacological psychological treatment, which increases their chances of being hospitalized due to their failure to improve the symptoms of the disease and weak social skills. Using a CBT approach may help them improve their symptoms and social abilities to some extent.

The researcher is investigating its effectiveness with schizophrenia and strengthening the social skills of a schizophrenic patient in a therapy sample who attends a mental health clinic in occupied Jerusalem in this study.

The situation raises the following major question: "What is the efficacy of the cognitive behavioral treatment program in reducing symptoms and improving social skills among schizophrenic patients?"

1.8 Sub Questions

The following sub-questions emerge from the main question:

1. Are there statistically significant differences in the effectiveness of cognitive behavioral therapy in reducing symptoms and improving social skills among schizophrenic patients according to severity?

2. Are there statistically significant differences in the effectiveness of cognitive behavioral therapy in reducing symptoms and improving social skills among schizophrenic patients according to age?
3. Are there statistically significant differences in the effectiveness of cognitive behavioral therapy in reducing symptoms and improving social skills among schizophrenic patients according to educational level?
4. Are there statistically significant differences in the effectiveness of cognitive behavioral therapy in reducing symptoms and improving social skills among schizophrenic patients according to social status?

1.9 Study Significance

1.9.1 Theoretical Importance

1. This study adds to other studies that show the importance of CBT in reducing symptoms and improving social skills in patients with schizophrenia.
2. The attention of researchers to the possibility of developing preventive programs to improve the symptoms and social abilities of schizophrenic patients while improving their health and quality of life drew the attention of researchers.

1.9.2 Practical importance

1. Contribute to the development of treatment programs based on cognitive behavioral approaches appropriate for use with patient groups that give psychotherapists strategies for current cognitive therapy applications.

2. The treatment program is predicted to aid in reducing positive symptoms, particularly delusions, since it is expected to coincide with improving those positive symptoms.

1.10 Study hypotheses

1. There are no statistically significant differences (α =.05) between schizophrenic symptoms and social skills means among Palestinian schizophrenic patients in occupied Jerusalem and the cut point of (3).
2. There are no statistically significant differences (α =.05) between the pre-test and post-test in schizophrenic symptoms and social skills means in the experimental group among Palestinian schizophrenic patients in occupied Jerusalem.

3. There are no statistically significant differences (α =.05) in schizophrenic symptoms and social skills means in the post-test due to group type, age, duration of schizophrenia, parent education, and marital status among Palestinian schizophrenic patients in occupied Jerusalem.

Chapter Two

Research Methodology

2.1 Introduction

This chapter comprises the method, study design, procedures utilized in the current study, and the population and sampling technique. Furthermore, this chapter contains a description of the study data collection tools that were used and their psychometric properties. Additionally, a summary of the group therapeutic program sessions, the statistical analysis methods, and variable categories were presented in this chapter.

2.2 Study Design

The current study aimed to reduce schizophrenic symptoms and improve social skills among patients with schizophrenia in the occupied East Jerusalem area and its suburbs. To achieve this objective, a cognitive behavioral therapy program (CBTP) was utilized. Thus, the quasi-experimental design with a pretest-post-test control and experimental group was utilized in the current study. The study evaluated the differences in schizophrenic symptoms and social skills' means among patients with schizophrenia before and after intervention by using a CBTP. Accordingly, the independent variable was the CBTP, and the dependent variables were schizophrenic symptoms and social skills. The design of two equivalent groups was used; control and experimental groups, whereas the CBTP program was applied to the experimental group. Meanwhile, the control group did not receive any intervention. Pretest and post-test were conducted for the two groups to assess schizophrenic symptoms and social skills before and after applying the therapeutic program, and scores were compared and analyzed. The study design with symbols is illustrated by the following.

$$\begin{array}{llll} G_{exp} & O_{pre\text{-}exp} & X & O_{post\text{-}exp} \\ G_{con} & O_{pre\text{-}con} & \text{----} & O_{post\text{-}con} \end{array} \quad \ldots\ldots\ldots\ldots \text{ Equation (1)}$$

Where the symbols refer to:

G_{exp}: Experimental group that received a CBTP program.

G_{con}: The control group that did not receive any intervention.

$O_{pre\text{-}exp}$: Pre-test of the dependent variable of schizophrenic symptoms and social skills for the experimental group members.

$O_{pre\text{-}con}$: Pre-test of the dependent variable of schizophrenic symptoms and social skills for the control group members.

X: The experimental intervention represented by a CBTP program that the experimental group received.

$O_{post\text{-}exp}$: Post-test of the dependent variable of schizophrenic symptoms and social skills for the experimental group members.

$O_{post\text{-}con}$: Post-test of the dependent variable of schizophrenic symptoms and social skills for the control group members.

2.3 Study Population

The population of this study consisted of all Palestinian schizophrenic patients from the occupied East Jerusalem area and its suburbs, whom specialized psychiatrists or psychologists previously diagnosed in the past years. According to the Palestinian Central Bureau of Statistics (PCBS, 2023), the population of occupied East Jerusalem and its suburbs is about (430.000). The incidence of schizophrenia in Palestine is (91) cases per (100,000) people (The Palestinian Center for Policy Research and Strategic Studies [MASARAT], 2023). Accordingly, the number of cases of schizophrenia in occupied East Jerusalem and its suburbs can be estimated at (391) cases. In addition, the incidence of schizophrenia among males is (56.2%) compared to (43.8%) among females.

2.4 Sampling and Sample Size

More than half of schizophrenic patients in the occupied East Jerusalem area and its suburbs are males. This is in line with the global prevalence rate of schizophrenia by gender; males are more frequently diagnosed with schizophrenia than females, and the prevalence ratio is often cited as about 1.4 males for every 1 female diagnosed with schizophrenia. Therefore, the study sample consisted of males. It was a purposive sample of 16 male schizophrenic adults (8 for an experimental group and 8 for a control group), and their ages ranged between 20 and 50 years. The researcher conducted individual interviews with each patient to collect data (Marie et al., 2020).

All participants were selected from the Nathan Center for Psychotherapy in occupied Jerusalem. The inclusion criteria for selecting participants were:

- Adults who were already diagnosed with schizophrenia (295.90 or F20.9) according to DSM-5 criteria.
- Adults who were diagnosed with schizophrenia for at least one year.
- Adults who are at least (20) years old.
- Adults whose families have agreed to consent.
- The following table shows the description of participants considering some categorical variables.

Table 1

Participants' description (n = 16)

Group Type	Demographic Variables		Frequency	Percentage
Control	Age	20-25 years old	2	25%
		26-30 years old	3	37.5%
		31 years old and above	3	37.5%
		Total	8	100%
	Duration of the disorder	1-5 years	3	37.5%
		6-10 years	5	62.5%
		Total	8	100%
	Mother education	Illiterate	1	12.5%
		Basic school	3	37.5%
		Secondary school	3	37.5%
		University	1	12.5%
		Total	8	100%
	Father education	Illiterate	0	0%
		Basic school	2	25%
		Secondary school	6	27%
		University	0	0%
		Total	8	100%
	Marital status	Single	4	50%
		Married	3	37.5%
		Divorced	1	12.5%
		Total	8	100%
Experimental	Age	20-25 years old	1	12.5%
		26-30 years old	3	37.5%
		31 years old and above	4	50%
		Total	8	100%
	Duration of the disorder	1-5 years	3	37.5%
		6-10 years	5	62.5%
		Total	8	100%
	Mother education	Illiterate	3	37.5%
		Basic school	4	50%
		Secondary school	1	12.5%
		University	0	0%
		Total	8	100%
	Father education	Illiterate	5	62.5%
		Basic school	2	25%
		Secondary school	1	12.5%
		University	0	0%
		Total	8	100%
	Marital status	Single	1	12.5%
		Married	3	37.5%
		Divorced	4	50%
		Total	8	100%

2.5 Instrument

Two self-report scales were used for collecting data. The first was the schizophrenic symptoms [SCHS] scale, and the second was the social skills scale [SCSS]. The following describes each scale:

- **The Schizophrenic Symptoms Scale (SCHS)**

The SCHS was constructed and validated by Abdullah (2017) for Sudani schizophrenic patients. The SCHS was constructed to assess the positive and negative schizophrenic symptoms. Positive symptoms [PS] refer to changes in behavior or thoughts, such as hallucinations or delusions (Murray et al., 2002). On the other hand, Negative Symptoms [NS] refer to withdrawing from the world around, taking no interest in everyday social interactions, and often appearing emotionless and flat (Murray et al., 2002).

The scale consisted of (35) two-point Likert scale items (for positive symptoms [PS],(Yes = 1 and No = 0, for negative symptoms [NS], Yes = 0 and No = 1). Items 1 to 14 reflect PS, and items 15 to 35 reflect NS.

According to Abdullah (2017), the SCHS has good psychometric properties. PS and NS correlated significantly with SCHS total scores with coefficients of.647 and.701, respectively. The internal consistency by Cronbach's alpha was.754 for the total score, and for PS and NS, they were.607 and.784, respectively.

1. The Schizophrenic Symptoms Scale [SCHS] validity

The current study assessed the SCHS by judges' validity. The scale was reviewed by seven experts in the Department of Psychology and Counseling at An-Najah National University, Quds University, and Hebron University. The judges suggested rephrasing some unclear items and paraphrasing some text to be more understandable for schizophrenic patients. In addition, no item was eliminated based on the judges' recommendations; therefore, the Schizophrenic Symptoms Scale [SCHS] has kept all the scale items.

Furthermore, the validity of the Schizophrenic Symptoms Scale [SCHS] in the current study was evaluated using a construct validity method. The corrected item-total correlations (CITCs) were calculated by applying the Schizophrenic Symptoms Scale

[SCHS] to an exploratory sample of (34) schizophrenic male patients who receive mental health services at the Mental Health Community Center in Al Izareya/ occupied Jerusalem and the Palestinian Counseling Center in Beit Hanina/ occupied Jerusalem.

The Pearson correlation coefficients were calculated between each item, its corresponding subscale, and the total score. All items significantly correlated with the total score and their corresponding subscales. The correlation coefficients of items with the total score ranged from (.34 to.66) and with their corresponding subscales ranged from (.44 to.76). The Pearson correlation coefficients of subscale with the SCHS were.66, and.75 for PS and NS, respectively. Accordingly, the Schizophrenic Symptoms Scale [SCHS] has kept all the scale items, indicating sufficient construct validity and adequately assessing the underlying construct that it is supposed to measure. The table below shows the CITCs results of the Schizophrenic Symptoms Scale [SCHS].

Table 2

The construct validity of the SCHS (n = 34)

#	C.O. with PS	C.O. with SCHS	#	C.O. with NS	C.O. with SCHS
1.	0.549**	0.583**	15.	0.622**	0.592**
2.	0.561**	0.347*	16.	0.609**	0.439**
3.	0.548**	0.479**	17.	0.643**	0.428**
4.	0.634**	0.381*	18.	0.741**	0.592**
5.	0.452**	0.544**	19.	0.582**	0.540**
6.	0.604**	0.341*	20.	0.619**	0.584**
7.	0.509**	0.447**	21.	0.651**	0.409*
8.	0.532**	0.497**	22.	0.635**	0.514**
9.	0.704**	0.572**	23.	0.632**	0.515**
10.	0.498**	0.528**	24.	0.456**	0.530**
11.	0.719**	0.653**	25.	0.503**	0.398*
12.	0.629**	0.625**	26.	0.721**	0.391*
13.	0.541**	0.422**	27.	0.675**	0.485**
14.	0.660**	0.632**	28.	0.541**	0.485**
PS with SCHS		0.663**	29.	0.520**	0.606**
			30.	0.466**	0.503**
			31.	0.660**	0.518**
			32.	0.716**	0.661**
			33.	0.737**	0.583**
			34.	0.602**	0.473**
			35.	0.556**	0.568**
			NS with SCHS		0.752**

*(p <.05), **(p <.01), C.O.: Correlation Coefficient

2. The Schizophrenic Symptoms Scale [SCHS] reliability

The current study checked the internal consistency reliability of the SCHS and its subscales using the Cronbach Alpha equation, resulting in a coefficient of (.787) for the total score, indicating good reliability. The coefficients for the PS and NS were.634 and.792, respectively.

3. The Social Skills Inventory [SCSI]

The SCSI was constructed by Riggio (2014). Mammaria (2021) adapted and validated SCSI for the non-clinical population in Algeria. The SCSI was constructed to assess six verbal and non-verbal social skills. The inventory consisted of (90) four-point Likert scale items (much = 3, moderate = 2, little = 1, no = 0), and no reversed items included in the SCSI.

The verbal social skills subscales are (Mammaria, 2021; Riggio, 2014):

1. Social Expressivity [SE]: It refers to general verbal speaking skill and an ability to engage others in social interaction.
2. Social Sensitivity [SS]: It refers to the ability to decode and understand verbal communication and general knowledge of the norms governing appropriate social behavior.
3. Social Control [SC]: It refers to a general skill in social self-presentation. Individuals high in SC are tactful، socially adept, and self-confident.

The non-verbal social skills subscales are (Mammaria, 2021; Riggio, 2014):

1. Emotional Expressivity (EE): This is the broad ability to communicate nonverbally. It represents people's capacity to accurately and spontaneously convey their felt emotional states as well as their nonverbal attitudes and interpersonal orientation cues.
2. Emotional Sensitivity [ES]: This is the overall ability to read and interpret nonverbal cues from others. People with high ES are perceptive of others' nonverbal emotional cues and are worried about them.
3. Emotional Control [EC]: The all-around capacity to manage and regulate unspoken and emotional expressions. When someone is high on emotional compounds (ECs), they are probably skilled emotional actors who can pose emotions on cue and utilize

opposing emotional cues to conceal their true feelings (e.g., laughing suitably at a joke, putting on a bright smile to cover melancholy).

4. The Social Skills Inventory [SCSI] validity

The current study assessed the validity of the SCSI by Supervisor Dr. Shadi Abu Al-Kabash. The supervisor, Dr. Shadi Abu Al-Kabash, suggested rephrasing some unclear items and paraphrasing some text to make it more understandable for schizophrenic patients. In addition, four items (9, 10, 11, and 49) were eliminated based on the judges' recommendations; therefore, the SCSI consisted of (86) after the judges' validity.

The social skills scale developed by Ronald E. Riggio in 1989 was used. Bashir Maamria, an Algerian researcher, authorized it for patients who have schizophrenia in 2011. Based on a sample of 400 schizophrenia patients.

Furthermore, the current study's SCSI validity was evaluated using a construct validity method. The CITCs were calculated by applying the SCSI to an exploratory sample of (34) schizophrenic male patients who receive mental health services at the Mental Health Community Center in Al Izareya/ occupied Jerusalem and the Palestinian Counseling Center in Beit Hanina/ occupied Jerusalem.

The Pearson correlation coefficients were calculated between each item, its corresponding subscale, and the total score. Out of (86) items, (10), items were eliminated since they did not correlate significantly with the total score of the SCSI, and those items were (13, 20, 29, 34, 35, 41, 50, 55, 58, and 79). Accordingly, (76) items stayed on the scale because they significantly correlated with the total score and their corresponding subscales.

The correlation coefficients of items with the total score ranged from (.30 to.70), and with their corresponding subscales ranged from (.35 to.73). The Pearson correlation coefficients of subscales with the SCSI were.90,.95,.86,.90,.85, and.92, for EE, ES, EC, SE, SS, and SC respectively. Accordingly, the current study's final version of the SCSI consisted of (76) items indicating sufficient construct validity of the inventory and adequately assessing the underlying construct that it is supposed to measure. The table below shows the CITCs' SCSI results.

Table 3

The construct validity of the SCSI (n = 34)

#	C.O. with EE	C.O. with SCSI	#	C.O. with ES	C.O. with SCSI	#	C.O. with EC	C.O. with SCSI
1.	0.444**	0.342*	2.	0.444**	0.420*	3.	0.621**	0.572**
7.	0.487**	0.399*	8.	0.498**	0.433**	15.	0.536**	0.493**
13.	0.289	0.242	14.	0.601**	0.592**	21.	0.347*	0.301*
19.	0.524**	0.507**	20.	0.222	0.191	27.	0.355*	0.302*
25.	0.589**	0.552**	26.	0.666**	0.636**	33.	0.547**	0.499**
31.	0.452**	0.389*	32.	0.617**	0.604**	39.	0.584**	0.527**
37.	0.498**	0.440**	38.	0.387*	0.311*	45.	0.386*	0.354*
43.	0.721**	0.627**	44.	0.588**	0.544**	51.	0.374*	0.346*
55.	0.288	0.242	50.	0.257	0.227	57.	0.495**	0.459**
61.	0.504**	0.495**	56.	0.635**	0.597**	63.	0.381*	0.356*
67.	0.725**	0.696**	62.	0.524**	0.487**	69.	0.554**	0.515**
73.	0.547**	0.499**	68.	0.476**	0.442**	75.	0.405*	0.390*
79.	0.247	0.195	74.	0.687**	0.635**	81.	0.399*	0.387*
85.	0.457**	0.349*	80.	0.492**	0.463**	87.	0.624**	0.596**
EE with SCSI		0.897**	86.	0.347*	0.312*	EC with SCSI		0.860**
			ES with SCSI		0.951**			

#	C.O. with SE	C.O. with SCSI	#	C.O. with SS	C.O. with SCSI	#	C.O. with SC	C.O. with SCSI
4.	0.586**	0.564**	5.	0.532**	0.493**	6.	0.487**	0.424*
16.	0.588**	0.511**	17.	0.588**	0.570**	12.	0.441*	0.360*
22.	0.472**	0.423**	23.	0.358*	0.308*	18.	0.658**	0.612**
28.	0.598**	0.572**	29.	0.257	0.200	24.	0.486**	0.414*
34.	0.247	0.202	35.	0.214	0.191	30.	0.364*	0.309*
40.	0.587**	0.569**	41.	0.279	0.261	36.	0.643**	0.591**
46.	0.405*	0.389*	47.	0.555**	0.501**	42.	0.386*	0.326*
52.	0.623**	0.573**	53.	0.695**	0.647**	48.	0.487**	0.436**
58.	0.248	0.227	59.	0.486**	0.444**	54.	0.347*	0.327*
64.	0.524**	0.496**	65.	0.469**	0.454**	60.	0.388*	0.347*
70.	0.388*	0.347*	71.	0.682**	0.621**	66.	0.601**	0.548**
76.	0.466**	0.439**	77.	0.597**	0.554**	72.	0.574**	0.454**
82.	0.657**	0.619**	83.	0.402*	0.361*	78.	0.347*	0.327*
88.	0.607**	0.576**	89.	0.555**	0.527**	84.	0.507**	0.445*
SE with SCSI		0.898**	SS with SCSI		0.854**	90.	0.627**	0.590**
						SC with SCSI		0.921**

*(p <.05), **(p <.01), C.O.: Correlation Coefficient

- **The SCSI reliability**

The current study checked the internal consistency reliability of the SCSI and its subscales by using the Cronbach Alpha equation, which resulted in a coefficient of (.945) for the total score, which indicates excellent reliability. The coefficients for the subscale sssare shown in the table below.

Table 4

The reliability of the Social Skills Inventory [SCSI] and its subscales

Subscale	Number of Items	The Items	Cronbach Alpha
EE	11	1, 7, 19, 25, 31, 37, 43, 61, 67, 73, and 85.	.689
ES	13	2, 8, 14, 26, 32, 38, 44, 56, 62, 68, 74, 80, and 86.	.799
EC	14	3, 15, 21, 27, 33, 39, 45, 51, 57, 63, 69, 75, 81, and 87.	.633
SE	12	4, 16, 22, 28, 40, 46, 52, 64, 70, 76, 82, and 88.	.730
SS	11	5, 17, 23, 47, 53, 59, 65, 71, 77, 83, and 89.	.849
SC	15	6, 12, 18, 24, 30, 36, 36, 42, 48, 54, 60, 66, 72, 84, and 90.	.836
SCSI		76	.945

5. A therapeutic program based on CBTP to reduce schizophrenic symptoms and improve social skills for schizophrenic adult patients.

a. CBTP Description

The CBTP consists of several skills created within the framework of several cognitive and behavioral theories that have previously been utilized with patients with schizophrenia and shown to be successful in lowering the severity of the condition and social handicap. The researcher also believes that implementing this method for the first time at the Arab and local levels will successfully alleviate symptoms in schizophrenia patients.

The program was created with numerous factors in mind, the most essential of which are:

- Behavioral symptoms in the form of disorders, such as introversion, isolation, and neglect of self, are distant from the character of the individual.
- Confusion over the substance, trajectory, and mode of presentation of one's thoughts.
- The emotion has evolved from what it formerly was.
- The patient's lack of understanding of his ailment.
- Perceptual disturbance characterized by delusions and hallucinations.

b. Objectives of the CBTP

The CBTP aimed to reduce schizophrenic symptoms and improve social skills among schizophrenic adult patients. The following sub-objective branch out from the main objective:

1. Establishing a collaborative therapeutic connection between the patient and the therapist to identify the patient's difficulties, the elements leading to their persistence, and their link to the disorder's occurrences.
2. Identifying appropriate explanations for the patient's psychotic ideas, which a disruption in his biological functioning may cause.
3. Developing the capacity to build successful social and personal interactions, such as self-care, interest in social engagement, entering positive partnerships, and improving communication skills.
4. Reducing the patient's anxiety, sorrow, and despair because of psychotic symptoms.
5. Increasing the patient's sentiments of discipline and control while decreasing feelings of despair and hopelessness.
6. Provide guidance on cognitive behavioral treatment techniques.
7. Assisting the patient in developing a specific treatment plan adds to the absence of recurrence.
8. Develop measures to assist the patient in overcoming social handicaps in the future, whether in the short or long term.

c. The importance of the CBTP

1. This study adds to other studies that show the importance of CBT in reducing symptoms and improving social skills in patients with schizophrenia.
2. The attention of researchers to the possibility of developing preventive programs to improve the symptoms and social abilities of schizophrenic patients while improving their health and quality of life drew the attention of researchers.
3. Contribute to the development of treatment programs based on cognitive behavioral approaches appropriate for use with patient groups that give psychotherapists strategies for current cognitive therapy applications.
4. The treatment program is predicted to aid in the reduction of positive symptoms, particularly delusions, since it is expected to coincide with the improvement of those positive symptoms.

d. CBTP stages

The program consists of three main phases:

The initial stage

1. Assessing schizophrenic symptoms and social skills as a pre-test (2 sessions).
2. A group discussion on the patient's psychotic disease. definition, causes, treatment techniques, and prevalence (two sessions).
3. Psychotic symptoms, delusions, and hallucinations: Using cognitive-behavioral coping methods (two sessions).

Middle treatment stage

1. Applying cognitive-behavioral methods to delusional and hallucinatory beliefs (Two Sessions).
2. Using cognitive-behavioral coping methods to address behavioral aspects like introversion and isolation (two sessions).

The end stage of treatment

1. Using skills to deal with social disabilities and setbacks (two sessions).
2. Assessing schizophrenic symptoms and social skills as post-test.

e. The CBTP contents

1. The first session

- Establishing a therapeutic relationship with the patient.
- Identify the patient's problems.
- Case study application.

Duration: 45 to 60 minutes.

2. The second session

- Describe the elements that make these issues more persistent.
- Discover the patient's perspective on his issues.
- The schizophrenia scale's application.

Duration: 45 to 60 minutes.

3. The third session

- Using cognitive-behavioral coping mechanisms to treat symptoms of psychosis.
- Increasing the patient's sense of control and discipline, instilling hope in him, and limiting the general dejection and hopelessness
- A method of psychological instruction.

Techniques applied throughout the session: Training approach to combat depression, employing a variety of methods, and model for teaching students to solve problems.

Duration: 45 to 60 minutes.

4. The fourth session

Teaching the patient how to relax during 15 minutes of relaxation practice as homework.

Techniques applied during the session Coping methods for anxiety: Through applying several approaches that fall under this strategy, anxiety is reduced. These methods include self-monitoring, daily diaries, exposure, anxiety arousal, structured desensitization, relaxation training, and homework.

Duration: 45 to 60 minutes.

5. The fifth session

Group discussion of the illness model for people with psychotic disorders

There are five steps in the session:

- Describe the logic behind the treatment concept.
- Identify a particular circumstance of concern.
- Practice relaxation techniques.
- Anxiety is triggered, and then relief is experienced.
- Homework.

Techniques applied throughout the session: The patient is taught to practice relaxation while picturing embarrassing events that might otherwise make them feel depressed to eliminate those sensations.

Duration: 45 to 60 minutes.

6. The sixth session

It incorporates two new fundamental elements: recognizing some psychotic symptoms, a particular circumstance in which the degree of anxiety increases, and how to deal with that intensity. With the patient bearing a greater degree of responsibility for recovering control over himself, this is what we may refer to as defining a hierarchy of anxiety that is exploited through what is known as a loss of controlled sensitivity. Two sorts of self-monitoring are utilized after causing anxiety in this stage:

Techniques applied throughout the session:

During time monitoring: the patient evaluates any symptoms of psychological stress, such as those that appear in the morning or at other times. Monitoring is carried out every two hours in the case of stress-related headaches to prevent the onset of any muscle tension.

Keeping an eye on various scenarios: It is up to the patient to gauge the level of psychological stress that he feels when engaging in any activity that is known to cause anxiety or stress. Training in relaxation techniques is used to lessen the severity of anxiety in both cases. Then, the information mentioned above is presented in class as homework. The patient recognizes the circumstances. Relaxation techniques are used when psychological stress levels rise; this process is known as anxiety management training.

Duration: 45 to 60 minutes.

7. The seventh session

- Applying cognitive behavioral techniques to the assumptions underlying hallucinations and delusions.
- This stage focuses on certain beliefs associated with prevailing delusions, the schizophrenia patient's misinterpretation of events, or the patient's perceptions of the voices he hears.
- Identifying plausible explanations for the patient's psychotic feelings and beliefs brought on by an imbalance in his biological functioning.

- Relieving the patient's anxiety, agony, and despair brought on by their psychotic symptoms.

Targeted psychotic symptoms

- Hallucinations.
- Interpretations.
- Impulses.
- A rush of thoughts.
- Feelings of helplessness and self-defeat.

Techniques applied

Modification techniques for sensory input include employing headphones to listen to music, especially when experiencing auditory hallucinations.

Duration: 45 to 60 minutes.

8. The eighth session

Encouraging the patient to look for alternate answers and relevant justifications for various circumstances. As a result, many therapy methods are employed.

Techniques applied

- Cognitive techniques like attentional diversion or shift.

- Behavior-modifying techniques, such as altering activity levels.

For instance, we might ask the patient to hum, read, or repeat something aloud. Additionally, we may utilize calming the patient's mind and boosting his spirits and confidence. Asking the patient questions will help you engage him in a Socratic dialogue. Does he believe that people may have opinions about him? This is an attempt by the therapist to make the patient feel bad about himself, which would naturally lead him to question the veracity of those voices and beliefs and start looking for alternatives to those notions.

The important goal of treatment, as with treating these symptoms, is to assist the patient in learning methods for overcoming these delusions, enhance motivation, assist him in creating meaningful goals and working toward them, normalize the fictitious pressures and tensions, and effect change in the delusional interpretations that are related to the delusions.

Duration: 45 to 60 minutes.

9. The ninth session

- Applying cognitive-behavioral coping techniques to assumptions with distinct functional underpinnings. The focus at this point is on functional distinctions and associated beliefs and presumptions about oneself and other people, including these beliefs.
- To convince the patient that he is not valuable.
- To convince the patient that he is bad and dangerous.
- Or that he shouldn't believe or trust people because they don't deserve it, that they're attempting to hurt him, and that it puts him at risk.

Techniques applied

The problem-solving approach aids the patient in getting over his emotional issues. The following eight steps will help patients understand the connection between their thoughts and feelings. To achieve this, they must recognize the issue. The therapist lines up the patient at the start of the session. His desire to discuss his issue with him first will give him the notion that they will collaborate. To assist him in overcoming his emotional issues, deciding on objectives, and determining their relevance to the issue at hand. Analyzing the problems triggering or creating occurrences. Determine and assess any problems with secondary efficacy. Teaching the client to recognize the relationship between beliefs and outcomes. Remove some irrational thoughts and beliefs and replace them with rational ones and homework.

Duration: 45 to 60 minutes.

10. The tenth session

Continue the ninth session.

Duration: 45 to 60 minutes.

11. The eleventh session:

- Addressing social incapacity and avoiding future relapse. This stage, which is the final one in the treatment process, focuses on developing a new understanding of the issues that the person has that have emerged during the treatment program.
- Assistance with the patient's self-regulation, which aids in coping.
- Training in social skills to avoid relapse.

Techniques applied

After the treatment program is through, coping techniques can be employed to decrease the likelihood of relapse.

- Self-monitoring.
- Self-reinforcement.

Duration: 45 to 60 minutes.

12. The twelve sessions

Assist the patient in creating a unique treatment strategy that helps to prevent relapse. Creating measures to assist the patient in the future, whether in the short or long term, in overcoming his social impairment

Techniques applied

Social skill development People with schizophrenia have poor social skills, so they need to be coached to improve these skills to engage in complicated social relationships. Three methods are used to do this.

- Instructions.
- Roleplay.
- Reinforcement and feedback.

Technical information

The person assumes a certain position and represents the circumstances, allowing the researcher to decide on the appropriate course of action and spot any flaws. The researcher provided the group members with detailed instructions on how to complete the assignment. The person reenacts the part. The researcher praises the person for making little effort and offers suggestions.

Duration: 45 to 60 minutes.

f. The CBTP timeframe

This program comprises 12 sessions, one per week, each lasting 45 minutes to an hour, depending on the patient's responses and the nature and substance of the session. At the end of each session, 5–10 minutes will be set aside to go over what was covered.

g. Place and Tools

The CBTP program was conducted at Nathan Center for Psychotherapy in occupied Jerusalem. In addition, LCD, laptop, pens, pencils, coloring pens, CBTP cards, and some gifts.

h. Content of the CBTP program

The following table shows the content of the twelve-session CBTP program that was applied to the experimental group:

Table 5

The content of the twelve-session CBTP

Session number	Session objectives	Session duration by
The first session	– Assessment and Diagnosis (pre-test).	45 to 60
The second session	– Assessment and Diagnosis (pre-test).	45 to 60
The third session	– A group discussion on the patient's psychotic disease. definition, causes, treatment techniques, and prevalence	45 to 60
The fourth session	– A group discussion on the patient's psychotic disease. definition, causes, treatment techniques, and prevalence	45 to 60
The fifth session	– Psychotic symptoms, delusions, and hallucinations: Using cognitive-behavioral coping methods	45 to 60
The sixth session	– Psychotic symptoms, delusions, and hallucinations: Using cognitive-behavioral coping methods	45 to 60
The seventh session	– Applying cognitive-behavioral methods to delusional and hallucinatory beliefs	45 to 60
The eighth session	– Applying cognitive-behavioral methods to delusional and hallucinatory beliefs	45 to 60
The ninth session	– Using cognitive-behavioral coping methods to address behavioral aspects like introversion and isolation	45 to 60
The tenth session	– Using cognitive-behavioral coping methods to address behavioral aspects like introversion and isolation	45 to 60
The eleventh session	– Using skills to deal with social disabilities and setbacks	45 to 60
The twelfth session	– Using skills to deal with social disabilities and setbacks. – Assessing schizophrenic symptoms and social skills as post-test.	45 to 60

6. The Study Procedures

The following procedures were followed to achieve the objectives of the study:

- Reviewing and preparing the theoretical framework and presenting the previous studies that addressed the current study subjects: schizophrenic symptoms, social skills, and CBTP.
- Preparing the study instruments in terms of SCHS, SCSI, and the therapeutic program based on CBT.

- Testing validity and reliability of SCHS and SCSI by applying it to schizophrenic patients (exploratory sample, $n = 34$).
- Identifying the study sampling technique (purposive sample) and establishing the inclusion criteria for selecting schizophrenic patients. In addition, the pre-tests to assess the levels of schizophrenic symptoms and social skills among schizophrenic adult male patients.
- The informed consent was presented to schizophrenic patients' families to get permission to apply CBTP. All the families agreed and welcomed to let the schizophrenic patients participate in the study. Resulting in a sample of (16) schizophrenic adult male patients.
- Distributing the participants to the two study groups (8 in the experimental group and 8 in the control group) by using an equivalent group design through matching, where the participants were matched based on the duration of the schizophrenia disorder, symptoms severity, and social skills variables in both groups.
- The CBTP was applied to the schizophrenic patients in the experimental group, while the participants in the control group did not receive any therapeutic intervention.
- After implementing the CBTP, post-tests were conducted on the schizophrenic patients in the experimental and control groups.
- The data is entered into the computer to perform the statistical analysis using the Statistical Analysis Program (SPSS).
- Coming up with the results, discussing them, and presenting recommendations in light of the findings.

7. The Statistical Analysis

After collecting the data and entering them into SPSS software, the following statistical methods were used:

- Frequencies, percentages, means, and standard deviations of the study variables.
- The Pearson Product-Moment Correlation Coefficient was used to reveal the validity of the study variables.
- Cronbach Alpha equation was used to reveal the reliability of the study variables.
- The Shapiro-Wilk Test was used to check the normality of the study variables, where this test was used in small samples (less than 30 individuals).

- An independent samples t-test was used to check the mean difference in schizophrenic symptoms and social skills scores between both groups in the pre-tests.
- A paired Samples t-test was used to check the mean difference of schizophrenic symptoms and social skills in the total scores and sub-scores between the pre-test and post-test for the experimental group.
- Seven-way MANCOVA was used to examine the differences in schizophrenic symptoms and social skills in the post-test according to the pre-test, group type, age, duration of schizophrenia, parent education, and marital status.
- The effect size of Rosenthal et al. (1994) was used to examine the effectiveness of CBTP in reducing schizophrenic symptoms and improving social skills.

8. Study Variables

- Independent variables: represented by the CBTP, where the experimental group received the intervention meanwhile the control group received nothing. In addition, independent variables included age, duration of schizophrenia, parent education, and marital status.
- Dependent variables: The dependent variables were schizophrenic symptoms, social skills, and their domains.

9. The Equivalence of the Two Study Groups

Before getting the results of the study, the equivalence of the two groups was verified in the pre-tests in the levels of schizophrenic symptoms and social skills. Furthermore, the researcher checked the normality of schizophrenic symptoms and social skills and their domains for both groups in the pre-tests to perform appropriate statistical tests. "When data follows the normal distribution, parametric tests are the most powerful statistical tests. Meanwhile, non-parametric tests are suitable when data do not follow the normal distribution" (Verma and Abdel-Salam, 2019).

Furthermore, in the case of a sample size of less than (30) individuals, "the appropriate test for normality is the Shapiro-Wilk test" (Field, 2013), and the following table shows the results of the Shapiro-Wilk test.

Table 6

Testing the normality of the responses in schizophrenic symptoms and social skills and its domains for both groups in the pre-tests by the Shapiro-Wilk test

Group type	Dependent variables	Shapiro-Wilk test		
		Statistic	df	Sig.
Control (*n* = 8)	SCHS	.853	7	.109
	SCSI	.861	7	.123
	EE	.847	7	.089
	ES	.898	7	.277
	EC	.948	7	.691
	SE	.857	7	.111
	SS	.915	7	.388
	SC	.953	7	.740
Experimental (*n* = 8)	SCHS	.967	7	.873
	SCSI	.905	7	.362
	EE	.856	7	.138
	ES	.880	7	.226
	EC	.906	7	.370
	SE	.864	7	.163
	SS	.964	7	.848
	SC	.902	7	.340

As shown in the previous table, the responses were normally distributed in the schizophrenic symptoms and social skills and their domains for both groups in the pre-tests. All statistic values of the Shapiro-Wilk test were insignificant (p (.05); consequently, parametric statistical methods can be used in this case. To examine the equivalence of the two groups in the schizophrenic symptoms and social skills and their domains in the pre-tests, differences between means were tested using the independent samples t-test, and the following table presents the results.

Table 7

Means, standard deviations, and the results of the independent sample t-test of the schizophrenic symptoms and social skills and its domains for both groups in the pre-tests

Dependent variables	Con. group (n = 8)		Exp. group (n = 8)		df	T-value	Sig.
	Mean	S.D.	Mean	S.D.			
SCHS	0.54	0.06	0.50	0.04	14	1.56	0.140
SCSI	1.37	0.40	1.30	0.60	14	0.288	0.778
EE	1.36	0.43	1.19	0.60	14	0.654	0.524
ES	1.42	0.41	1.25	0.67	14	0.623	0.544
EC	1.28	0.43	1.29	0.65	14	-0.065	0.949
SE	1.14	0.47	1.15	0.55	14	-0.074	0.942
SS	1.72	0.70	1.58	0.72	14	0.384	0.707
SC	1.37	0.39	1.41	0.73	14	-0.114	0.911

Table 7 shows that the mean of SCHS in the pre-test in the control group was (0.54) with a standard deviation of (0.06), whereas it was (0.50) with a standard deviation of (0.04) in the experimental group. The difference between the two means was insignificant (t = 1.56, p >.05), indicating no difference between the two groups in SCHS in the pre-test.

The mean of SCSI in the pre-test in the control group was (1.37) with a standard deviation of (0.40), whereas it was (1.30) with a standard deviation of (0.60) in the experimental group. The difference between the two means was insignificant (t = 0.288, p >.05), indicating no difference between the two groups in SCSI in the pre-test.

In addition, the mean of EE in the pre-test in the control group was (1.36) with a standard deviation of (0.43), whereas it was (1.19) with a standard deviation of (0.60) in the experimental group. The difference between the two means was insignificant (t = 0.654, p >.05), indicating no difference between the two groups in EE in the pre-test. The mean of ES in the pre-test in the control group was (1.42) with a standard deviation of (0.41), whereas it was (1.25) with a standard deviation of (0.67) in the experimental group. The difference between the two means was insignificant (t = 0.623, p >.05), which indicated no difference between the two groups in ES in the pre-test.

The mean of EC in the pre-test in the control group was (1.28) with a standard deviation of (0.43), whereas it was (1.29) with a standard deviation of (0.65) in the experimental group. The difference between the two means was insignificant (t = -0.065, p >.05),

indicating no difference between the two groups in EC in the pre-test. The mean of SE in the pre-test in the control group was (1.14) with a standard deviation of (0.47), whereas it was (1.15) with a standard deviation of (0.55) in the experimental group. The difference between the two means was insignificant ($t = -0.074$, $p > .05$), indicating no difference between the two groups in SE in the pre-test.

The mean of SS in the pre-test in the control group was (1.72) with a standard deviation of (0.70), whereas it was (1.58) with a standard deviation of (0.72) in the experimental group. The difference between the two means was insignificant ($t = 0.384$, $p > .05$), which indicated that there was no difference between the two groups in SS in the pre-test. Finally, the mean of SC in the pre-test in the control group was (1.37) with a standard deviation of (0.39), whereas it was (1.41) with a standard deviation of (0.73) in the experimental group. The difference between the two means was insignificant ($t = -0.114$, $p > .05$), which indicated that there was no difference between the two groups in SC in the pre-test.

All results indicate the availability of the equivalence of the two groups before the intervention.

Chapter Three

The Results

The main goal of this study was to investigate the effectiveness of the CBTP in reducing schizophrenic symptoms and improving social skills among schizophrenic patients at Nathan Center for Psychotherapy in occupied Jerusalem. Furthermore, this study tried to test the differences in schizophrenic symptoms and social skills considering age, duration of schizophrenia, parent education, and marital status. Accordingly, this chapter answered questions related to the above objectives.

3.1 The Results of the First Question

"What are the levels of schizophrenic symptoms and social skills among Palestinian schizophrenic patients in occupied Jerusalem?"

To answer this question and to discover the position of Palestinian schizophrenic patients in the disorder symptoms and social skills on the pre-test for both groups, the researcher compared the schizophrenic symptoms and social skills and their domains with appropriate cut-point value, based on the mid-point between the minimum and the maximum values. To test the difference between the sample score and its cut point value, which represents the hypothetical mean, the researcher used a one-sample t-test with a cut point value of (0.50) for the schizophrenic symptoms and a cut point value of (1.50) for the social skills. The table below shows the result.

Table 8

Results of one sample t-test for the difference between the schizophrenic symptoms and social skills sample mean and the hypothetical means

Variables	Sample mean	Standard deviation	Hypothetical mean	T value	d.f.	Sig.
SCHS	0.52	0.05	0.50	1.23	15	.237
SCSI	1.34	0.50	1.50	-1.30	15	.213
EE	1.28	0.51	1.50	-1.73	15	.104
ES	1.34	0.54	1.50	-1.20	15	.248
EC	1.29	0.53	1.50	-1.62	15	.126
SE	1.14	0.49	1.50	-2.83	15	.013*
SS	1.65	0.69	1.50	0.857	15	.405
SC	1.39	0.56	1.50	-0.768	15	.455

*(p <.05).

As illustrated in the table above, the result indicates that there is a positive insignificant difference (t = 1.23, p >.05) between the SCHS sample mean (0.52 ± 0.05) and the hypothetical mean (cut point = 0.5). In other words, there is a moderate level of schizophrenic symptoms among Palestinian schizophrenic patients in occupied Jerusalem. Also, there is a negative insignificant difference (t = 1.23, p >.05) between the SCSI sample mean (1.34 ± 0.50) and the hypothetical mean, which indicated a moderate level of social skills among the participants. Accordingly, there is a need to reduce schizophrenic symptoms and improve social skills among the participants, specifically social expressivity skill (SE), which refers to a general verbal speaking skill and an ability to engage others in social interaction. Where, there is a negative significant difference (t = -2.83, p <.05) between the SE sample mean (1.14 ± 0.49) and the hypothetical mean (cut point = 1.5) in favor of the hypothetical mean. In other words, there is a low level of social expressivity among Palestinian schizophrenic patients in occupied Jerusalem.

3.2 The Results of the Second Question

This question states, "Are there significant differences between the means of schizophrenic symptoms and social skills in the pre-test and post-test in the experimental group among schizophrenic patients?"

Before answering this question, and to determine the statistical test that should be used since the study sample is small (*n*= 8 and less than 30). Based on what Field (2013) reported, the normality of responses in schizophrenic symptoms and social skills and their domains in the pre-test and post-test for the experimental group was examined to choose the appropriate statistical methods. The Table below shows the results.

Table 9

The normality of the responses in schizophrenic symptoms and social skills was tested in the pre-test and post-test for the experimental group using the Shapiro-Wilk test (n = 8)

Test type	Dependent variables	Shapiro-Wilk test		
		Statistic	df	Sig.
Pre-test (*n* = 8)	SCHS	.967	7	.873
	SCSI	.905	7	.362
	EE	.856	7	.138
	ES	.880	7	.226
	EC	.906	7	.370
	SE	.864	7	.163
	SS	.964	7	.848
	SC	.902	7	.340
Post-test (*n+9*5\27* = 8)	SCHS	.914	7	.423
	SCSI	.913	7	.419
	EE	.832	7	.083
	ES	.970	7	.900
	EC	.964	7	.850
	SE	.892	7	.288
	SS	.970	7	.900
	SC	.923	7	.492

As shown in the previous table, responses were normally distributed in terms of schizophrenic symptoms and social skills and their domains for the experimental group in the pre-test and post-test. All statistic values of the Shapiro-Wilk test were insignificant (p (.05); consequently, parametric statistical methods can be used in this case.

Means and standard deviations were calculated to examine the differences between schizophrenic symptoms and social skills in the pre-test and post-test of the experimental group, and the following table presents the results.

Table 10

Means and standard deviations of schizophrenic symptoms and social skills for the pre-test and post-test of the experimental group (n = 8)

Dependent variables	Pre-test (*n* = 8)		Post-test (*n* = 8)	
	Mean	S.D.	Mean	S.D.
SCHS	0.50	0.04	0.48	0.05
SCSI	1.30	0.60	1.61	0.38
EE	1.19	0.60	1.63	0.51
ES	1.25	0.67	1.53	0.36
EC	1.29	0.65	1.83	0.40
SE	1.15	0.55	1.44	0.62
SS	1.58	0.72	1.72	0.44
SC	1.41	0.73	1.46	0.48

As shown in the table above, there were apparent differences between schizophrenic symptoms and social skills and their domains according to measuring type in the experimental group. Where the mean of SCHS in the pre-test was (0.50) with a standard deviation of (0.04), then it became (0.48) with a standard deviation of (0.05) in the post-test. On the other hand, the means and standard deviations of the social skills and their domains in the pre-test in the experimental group were (1.30 ± 0.60, 1.19 ± 0.60, 1.25 ± 0.67, 1.29 ± 0.65, 1.15 ± 0.55, 1.58 ± 0.72, and 1.41 ± 0.73) for SCSI, EE, ES, EC, SE, SS, and SC respectively. Then they became (1.61 ± 0.38, 1.63 ± 0.51, 1.53 ± 0.36, 1.83 ± 0.40, 1.44 ± 0.62, 1.72 ± 0.44, and 1.46 ± 0.48) for SCSI, EE, ES, EC, SE, SS, and SC respectively in the post-test.

To test the differences between these means according to measuring type (pre-test and post-test), the researcher used paired samples t-test. The following table presents the results.

As shown in Table (11) in Appendix D, all the differences in means were insignificant between the schizophrenic symptoms and social skills and their subscales in the pre-test and post-test for the experimental group, which indicated that the CBTP intervention was Ineffective in reducing schizophrenic symptoms and enhancing social skills among the experimental group members.

In more detail, the difference between the two means of SCHS in the experimental group was insignificant ($t = 1.11$, $p > .05$), which indicated that the schizophrenic

symptoms did not decrease among the experimental group members. The difference between the two means of SCSI in the experimental group was insignificant (t = -1.03, p >.05), which indicated that social skills did not increase among the experimental group members.

For social skills subscales, the difference between the two means of EE in the experimental group was insignificant (t = -1.31, p >.05), which indicated that emotional expressivity did not increase among the experimental group members. The difference between the two means of ES in the experimental group was insignificant (t = -1.31, p >.05), which indicated that the emotional sensitivity did not increase among the experimental group members. The difference between the two means of EC in the experimental group was insignificant (t = -2.03, p >.05), which indicated that the emotional control did not increase among the experimental group members.

Furthermore, the difference between the two means of SE in the experimental group was insignificant (t = -0.67, p >.05), which indicated that the social expressivity did not increase among the experimental group members. The difference between the two means of SS in the experimental group was insignificant (t = -0.46, p >.05), which indicated that the social sensitivity did not increase among the experimental group members. The difference between the two means of SC in the experimental group was insignificant (t = -0.13, p >.05), which indicated that the social control did not increase among the experimental group members.

3.3 The Results of the Third Question

This question states, "Are there significant differences between the means of schizophrenic symptoms and social skills in the post-test according to group type, age, duration of schizophrenia, parent education, and marital status among schizophrenic patients?"

Before answering this question, and determine the statistical test that should be used since the study sample is small (*n* = 8 and less than 30). In addition, based on what Field (2013) reported, the normality of responses in schizophrenic symptoms and social skills and their domains in the post-test for both groups were examined to choose the appropriate statistical methods. The table below shows the results.

Table (12) in Appendix D shows that responses were normally distributed in schizophrenic symptoms and social skills and their domains for the post-test in both groups. All statistic values of the Shapiro-Wilk test were insignificant (p (.05); consequently, parametric statistical methods can be used. To examine the differences between schizophrenic symptoms and social skills and their domains in the post-test according to group type, age, duration of schizophrenia, parent education, and marital status among schizophrenic patients, means and standard deviations were calculated. The following Table presents the results.

As in Table (13) in Appendix D, there were apparent differences between schizophrenic symptoms and social skills and their domains according to group type, age, duration of schizophrenia, parent education, and marital status in the post-test. To test the differences between these means according to group type, age, duration of schizophrenia, parent education, and marital status in the post-test, the researcher used a six-way MANCOVA test to control the effect of the pre-test in the post-test. Moreover, the effect sizes of independent variables were calculated. The following table shows the results.

As illustrated in table (14) in Appendix D, there are significant differences in EC, means according to group type in the post-test in favor of the experimental group ($F = 22.60$, $p < .05$) with effect size (η^2) of (0.88), which are considered big effect size according to Klappa (2019) which in turn indicated to the effectiveness of the CBTP in improving emotional control among the schizophrenic patients in the experimental group comparing with a control group (see Table 13).

On the other hand, there are insignificant differences in SCHS, SCSI, EE, ES, SE, and SS according to group type, age, duration of schizophrenia, parent education, and marital status in the post-test. In other words, CBTP and categorical factors did not affect schizophrenic symptoms and social skills in the post-test among the schizophrenic patients in both groups.

Regarding the effect of covariate (pre-test scores of SCHS) on the post-test scores of all dependent variables, results showed that pre-test scores of SCHS had no significant impact on post-test scores ($F = 1.64$, $p > .05$, $F = 7.46$, $p > .05$, $F = 1.64$, $p > .05$, $F = 1.02$, $p > .05$, $F = 0.29$, $p > .05$, and $F = 8.83$, $p > .05$) for SCHS, SCSI, EC, SS, and SC

respectively. On the other hand, the effect of covariate (pre-test scores of SCHS) on the post-test scores of EE, ES, and SE results showed that pre-test scores of SCHS had a significant impact on post-test scores ($F = 10.95$, $p < .05$, $\eta^2 = 0.78$, $F = 16.50$, $p < .05$, $\eta^2 = 0.85$, and $F = 11.25$, $p < .05$, $\eta^2 = 0.79$) for EE, ES, and SE respectively which means the changing in emotional expressivity, emotional sensitivity, and social expressivity levels in post-test caused by the pre-test scores of SCHS.

In addition, the effect of the covariate (pre-test scores of SCSI) on the post-test scores of all dependent variables, results showed that pre-test scores of SCSI had a not significant impact on post-test scores ($F = 0.03$, $p > .05$, $F = 0.20$, $p > .05$, $F = 2.27$, $p > .05$, $F = 0.68$, $p > .05$, $F = 0.000$, $p > .05$, $F = 0.002$, $p > .05$, $F = 0.20$, $p > .05$, and $F = 0.70$, $p > .05$) for SCHS, SCSI, EE, ES, EC, SE, SS, and SC respectively

Chapter Four

Discussions and Conclusions

4.1 Introduction

The current study aimed to assess the effectiveness of the CBTP in reducing schizophrenic symptoms and increasing social skills among patients with schizophrenia at the Natan Center in occupied Jerusalem.

The present study yielded several key findings, outlined as follows:

- Among Palestinian patients in occupied Jerusalem diagnosed with schizophrenia, the study revealed a moderate level of schizophrenia symptoms alongside a moderate level of social skills.
- Despite undergoing Cognitive-Behavioral Therapy Program (CBTP) treatments, the experimental group did not experience significant improvements in social skills or reduction of schizophrenia symptoms.
- Notably, the CBTP did lead to improved emotional control among schizophrenic patients in the experimental group compared to the control group. However, neither social skills nor schizophrenia symptom outcomes were influenced by the CBTP intervention.

4.2 Discussing the results of the study questions:

The first question: "What are the levels of schizophrenic symptoms and social skills among Palestinian schizophrenic patients in occupied Jerusalem?"

The findings suggest that Palestinian schizophrenic patients in Jerusalem exhibit a moderate level of schizophrenic symptoms and social skills, as indicated by insignificant differences between sample means and hypothetical means. However, there is a need to address and improve social skills, particularly social expressivity, among participants, as there is a significant negative difference between the sample mean and the hypothetical mean for social expressivity. This suggests a low level of social expressivity among Palestinian schizophrenic patients in Jerusalem.

The significant negative difference between the sample mean and the hypothetical mean for social expressivity indicates that this aspect is lacking among the participants. Social

expressivity refers to the ability to effectively convey emotions, thoughts, and intentions through verbal and non-verbal communication. The finding suggests that Palestinian schizophrenic patients in Jerusalem may struggle with expressing themselves socially.

Schizophrenic patients often face challenges in expressing themselves socially due to a combination of psychological, cognitive, and social factors (Kurtz and Mueser, 2008). Schizophrenia can lead to cognitive deficits, affecting memory, attention, and executive functions (Dickinson et al., 2007). These impairments make it difficult for patients to process social cues, understand context, and respond appropriately in conversations. As a result, they may struggle with maintaining coherent and meaningful interactions (Kurtz and Mueser, 2008).

In addition, negative symptoms of schizophrenia, such as apathy, social withdrawal, and anhedonia (loss of interest or pleasure), impact social engagement (Dziwota et al., 2018). Therefore, patients may lack motivation to initiate conversations or participate in social activities (Dickinson et al., 2007). Accordingly, reduced emotional expressivity can hinder their ability to convey feelings effectively. On the other hand, positive symptoms (hallucinations, delusions) can distort perception and disrupt communication. Therefore, patients may experience auditory hallucinations, making it hard to focus on external conversations (Robertson et al., 2014).

Furthermore, delusional beliefs can lead to social mistrust or paranoia, affecting their interactions.

Moreover, schizophrenia often coexists with social anxiety disorder. Patients may fear judgment, rejection, or embarrassment in social situations (Nemoto et al., 2019). Thus, anxiety can inhibit self-expression and increase withdrawal. On the other hand, the stigma associated with mental illness can lead to self-stigma (Robertson et al., 2014). So, patients may internalize negative stereotypes, affecting their self-esteem and willingness to engage socially, and the fear of being labeled as “crazy” or “different” can discourage open communication (Nemoto et al., 2019).

Some schizophrenic patients use antipsychotic medications to manage symptoms that may cause sedation, cognitive blunting, or movement-related side effects. These can

impact verbal fluency, facial expressions, and overall social functioning (Kucharska-Pietura and Mortimer, 2013).

In summary, a combination of cognitive deficits, symptoms, anxiety, stigma, and social skill deficits contribute to the challenges schizophrenic patients face in expressing themselves socially (Tamminga, 2022).

Second Question: "Are there significant differences between the means of schizophrenic symptoms and social skills in the pre-test and post-test in the experimental group among schizophrenic patients?"

The results indicate that the CBTP intervention was ineffective in achieving its intended outcomes. Specifically, there were insignificant differences in means between the pre-test and post-test measurements for both schizophrenic symptoms and social skills among the experimental group members. SCHS (Schizophrenic Symptoms): The difference in means for schizophrenic symptoms (SCHS) within the experimental group was insignificant ($t = 1.11$, $p > .05$). This implies that the intervention did not lead to a decrease in schizophrenic symptoms among the experimental group members. On the other hand, the difference in means for social skills (SCSI) within the experimental group was also insignificant ($t = -1.03$, $p > .05$). Thus, social skills did not significantly increase after the intervention.

In the current study, the CBTP intervention with schizophrenic patients faces challenges, may the reasons behind:

CBTP intervention with schizophrenic patients may initially improve patients' ability to function, but this benefit tends to be short-lived. CBTP does not alleviate the distress associated with psychosis symptoms in schizophrenia and may fail to enhance the quality of life in terms of self-perception, hope, well-being, and relationships. In addition, CBTP intervention with schizophrenic patients is unable to cope with positive symptoms (hallucinations and delusions) and negative symptoms. Furthermore, combining CBTP with antipsychotic drugs is more effective than CBT alone.

The current findings challenge prior research on the efficacy of cognitive behavioral therapy (CBT) for individuals with schizophrenia, as demonstrated by studies conducted by (Bighelli et al. (2018), Radshaw and Roseborough (2016), Shukla et al. (2021)).

These results are in contrast to the studies completed by Lysaker et al. (2009) and Morison (2009).

The researcher notes that individuals with schizophrenia often miss their scheduled therapy sessions and frequently reschedule them, potentially impacting treatment adherence and outcomes. This variability in attendance and commitment may influence treatment efficacy in the long term, especially considering that some patients temporarily discontinue treatment before resuming it.

Furthermore, social pressures experienced by patients during therapy sessions may restrict their ability to engage with treatment fully. Michelle et al. (2018) corroborated that CBT can yield positive results when patients are receptive to treatment and do not resist it.

In a study by Algahtani et al. (2019) on the cultural adaptation of CBT for depression and anxiety in Saudi Arabia and Bahrain, it was suggested that psychotherapy should be tailored differently in Arab cultures due to factors like social stigma and limited social education about psychotherapy's significance. This contrasts with Western societies, which have robust psychotherapy education networks.

Additionally, some patients attribute their symptoms and poor health to a perceived disconnection between themselves and their God, which they view as the primary cause of their illness. Munawar et al. (2023) found that incorporating religious or Islamic elements into CBT may be beneficial for religious Muslims with mental health issues. Addressing religious motivations directly, as Munawar et al. (2023) suggested, could yield similar positive outcomes in therapy.

Third Question: "Are there significant differences between the means of schizophrenic symptoms and social skills in the post-test according to (group type, age, duration of schizophrenia, parent education, and marital status) among schizophrenic patients?"

The findings revealed that there were significant differences in means according to group type in the post-test, favoring the experimental group ($F = 22.60$, $p < .05$). The effect size (η^2) of 0.88 is considered substantial, indicating that the CBTP intervention effectively improved emotional control among schizophrenic patients in the experimental group compared to a control group.

However, other factors did not significantly impact schizophrenic symptoms and social skills in the post-test. Where, schizophrenic symptoms (SCHS), social skills (SCSI), emotional expressivity (EE), emotional sensitivity (ES), social expressivity (SE), and social sensitivity (SS) showed insignificant differences according to group type, age, duration of schizophrenia, parent education, and marital status in the post-test. In other words, the CBTP intervention and categorical factors did not significantly affect these aspects among schizophrenic patients in both groups.

Pre-test Scores of SCHS did not signi proproblficantly impact post-test scores for SCHS, SCSI, EC, SS, and SC. However, pre-test scores of SCHS significantly influenced post-test scores for emotional expressivity (EE), emotional sensitivity (ES), and social expressivity (SE). This suggests that changes in emotional expressivity, sensitivity, and social expressivity levels in the post-test were not influenced by the pre-test scores of SCHS. Pre-test Scores of SCSI had no significant impact on post-test scores for the dependent variables.

Al-Tijani Al-Mahi Hospital in Khartoum State treated patients with residual schizophrenia, as reported by Abdullah (2017), the principal researcher of the program. Interestingly, the research focused on patients with schizophrenia (295.90–F 20.9), and the research found no statistically significant evidence of improvement resulting from the CBTP.

Abdullah's study revealed that dependent variables, including group type, age, duration of schizophrenia, parents' education, and marital status, did not exhibit any statistically significant effect. However, there was a significant difference in mothers' education levels. Similarly, the current findings of the present study align with a study by Bighelli et al. (2018), which also found no significant impact on age or duration of treatment.

Notably, the program is specifically designed for residual schizophrenia, characterized by prominent negative symptoms (such as reduced emotional expression). Patients at the Nathan Center demonstrated improved emotional control over time. Initially, these patients were emotionally subdued, but as therapy sessions progressed, their enthusiasm for treatment grew, and they developed better emotional regulation skills in everyday situations.

4.3 Limitations

The current research is limited to a sample of individuals with schizophrenia, consisting of 8 patients selected from the Natan Center.

These limits can be detailed as follows:

Geographical boundaries: The geographical boundaries of the current study were set at the Natan Health Center in occupied Jerusalem.

Temporal limits: Implementation of the current study program begins from the beginning of the first semester of the academic year 2023 until the end of the first semester of the academic year 2023.

Human limits of the study: The human limits of the current study are 8 patients diagnosed with schizophrenia.

Institutional limits of the study: The study was limited to individuals with schizophrenia at the Natan Center in occupied Jerusalem.

Objective limits of the study: Implementing a program based on the use of CBT to reduce positive and negative symptoms and improve social skills among patients with schizophrenia.

4.4 Conclusion

This study confirms other research that examines the effectiveness of the CBTP to improve social skills and lessen both positive and negative symptoms in individuals with schizophrenia. The current study used an experimental approach and showed that CBTP improves emotional regulation in people with schizophrenia. The paper outlines the foundational principles of CBT. Kanas (2006) stressed that group treatment is superior to individual treatment in comparison studies. The present study is based on individual treatment, and the researcher believes that if group treatment were relied upon in the CBTP, the program's effect on patients might differ favorably. According to Burlingame et al. (2020), group therapy results in a 44% improvement in general functioning. Raising the level of knowledge among psychotherapists working in mental health facilities and sanitariums regarding the history of conventional therapy and the application of contemporary methods to treatment is crucial. Workshops and training

programs based on CBT can accomplish this. In addition to receiving training, therapists should educate the public about the value of psychotherapy in preventing potential mental diseases and encouraging people to seek help when necessary.

4.5 Recommendations

After reviewing the results of the study, there are several recommendations, which are:

1. Creating cognitive-behavioral therapy-based treatment plans for individuals with schizophrenia that encompass the three phases of the illness's progression to investigate its effectiveness.
2. Emphasizing the value of getting psychological care when necessary and lessening the stigma attached to people who seek treatment for psychological diseases under different names.
3. Encourage the public to participate in psychotherapy-related workshops or courses in psychological education.

4.6 Suggestions

There are several suggestions for the researchers, which are:

1. Evaluating the impact of CBT on a wider range of schizophrenia development stages in a more diversified sample.
2. Extend the program's duration.
3. Utilizing group therapy to assess the program's efficacy on patients with schizophrenia.
4. Evaluating the program's efficacy in helping schizophrenia patients gain better emotional regulation on a larger sample size than the one utilized in this investigation.

References

Abdullah, Y., D., J. (2017). *The efficiency of the rehabilitation cognitive behavior therapy program to advance residual schizophrenia symptoms in loanee Almahy hospital, Khartoum state*. (Unpublished Doctoral Dissertation), Al Neelain University, Khartoum, Sudan.

Alford, B. A., Beck, A. T., & Jones, J. V. (1997, January). The Integrative Power of Cognitive Therapy. *Journal of Cognitive Psychotherapy*, *11*(4), 309–312. https://doi.org/10.1891/0889-8391.11.4.309

Algahtani, H. M., Almulhim, A., AlNajjar, F. A., Ali, M. K., Irfan, M., Ayub, M., & Naeem, F. (2019, January 1). *Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: a qualitative study exploring views of patients, carers, and mental health professionals*. The Cognitive Behaviour Therapist. https://doi.org/10.1017/s1754470x1900028x

Almerie, M. Q., Okba Al Marhi, M., Jawoosh, M., Alsabbagh, M., Matar, H. E., Maayan, N., & Bergman, H. (2015). Social skills programmes for schizophrenia. *The Cochrane database of systematic reviews*, *2015*(6), CD009006. https://doi.org/10.1002/14651858.CD009006.pub2

Almerie, M. Q., Okba Al Marhi, M., Jawoosh, M., Alsabbagh, M., Matar, H. E., Maayan, N., & Bergman, H. (2015). Social skills programmes for schizophrenia. *The Cochrane database of systematic reviews*, *2015*(6), CD009006. https://doi.org/10.1002/14651858.CD009006.pub2

Al-Youssef, Rami Mahmoud (2013). *Social skills and their relationship to perceived self-efficacy and general academic achievement among a sample of intermediate school students in Hail, Kingdom of Saudi Arabia, in light of a number of variables.* Journal of the Islamic University for Educational and Psychological Studies, Issue 1, Page 327-365, Department of Psychology, University of Hail, Kingdom of Saudi Arabia. file:///C:/Users/HITECH/Downloads/550-1594-1-PB.pdf

Andreasen, N. C., Nopoulos, P., Schultz, S. K., Miller, D. D., Gupta, S., Swayze, V. W., & Flaum, M. (1994, November 1). *Positive and negative symptoms of schizophrenia: past, present, and future*. Acta Psychiatrica Scandinavica. https://doi.org/10.1111/j.1600-0447.1994.tb05891.x

Antony, M. M., & Baugh, L. S. (2024, March 28). *Cognitive behaviour therapy (CBT) | Definition, History, Techniques, & Facts*. Encyclopedia Britannica. https://www.britannica.com/science/cognitive-behaviour-therapy

APA, (2020). *Schizophrenia*. https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

Association of Cognitive Psychology and institute. (2020, September 4). *La terapia cognitivo comportamentale (CBT) - APC*. Associazione Di Psicologia Cognitiva.

https://apc.it/chi-siamo/la-psicoterapia-cognitiva/terapia-cognitivo-comportamentale/

Beck, A. T., & Rector, N. A. (2005). Cognitive approaches to schizophrenia: theory and therapy. *Annual review of clinical psychology*, *1*, 577–606. https://doi.org/10.1146/annurev.clinpsy.1.102803.144205

Beck, A. T., & Rector, N. A. (2005, April 1). Cognitive Approaches to Schizophrenia: Theory and Therapy. *Annual Review of Clinical Psychology*, *1*(1), 577–606. https://doi.org/10.1146/annurev.clinpsy.1.102803.144205

Benjamin, C. L., Puleo, C. M., Settipani, C. A., Brodman, D. M., Edmunds, J. M., Cummings, C. M., & Kendall, P. C. (2011, April). History of Cognitive-Behavioral Therapy in Youth. *Child and Adolescent Psychiatric Clinics of North America*, *20*(2), 179–189. https://doi.org/10.1016/j.chc.2011.01.011

Berzoff, J., Flanagan, L. M., & Hertz, P. (2008). *From Theory to Practice. Inside Out and Outside In: Psychodynamic Clinical Theory and Psychopathology in Contemporary Multicultural Contexts*. Jason Aronson. 271 https://www.google.ps/books/edition/Inside_Out_and_Outside_in/m457T81-toUC?hl=ar&gbpv=0

Bhugra, D. (2005, May 31). *The Global Prevalence of Schizophrenia*. PLOS Medicine. https://doi.org/10.1371/journal.pmed.0020151

Bighelli, I., Huhn, M., Schneider-Thoma, J., Krause, M., Reitmeir, C., Wallis, S., Schwermann, F., Pitschel-Walz, G., Barbui, C., Furukawa, T. A., & Leucht, S. (2018, December 1). *Response rates in patients with schizophrenia and positive symptoms receiving cognitive behavioural therapy: a systematic review and single-group meta-analysis*. BMC Psychiatry. https://doi.org/10.1186/s12888-018-1964-8

Bradshaw, W., & Roseborough, D. J. (2004, March 1). *Evaluating the Effectiveness of Cognitive-Behavioral Treatment of Residual Symptoms and Impairment in Schizophrenia*. Research on Social Work Practice. 14(2), 112–120. https://doi.org/10.1177/1049731503257872

Browne, J., Mueser, K. T., & Pratt, S. I. (2020, January 1). *Social skills training for persons with schizophrenia*. Elsevier eBooks. https://doi.org/10.1016/b978-0-12-817752-5.00017-2

Brüne, M., Schaub, D., Juckel, G., & Langdon, R. (2011). Social skills and behavioral problems in schizophrenia: the role of mental state attribution, neurocognition and clinical symptomatology. *Psychiatry research*, *190*(1), 9–17. https://doi.org/10.1016/j.psychres.2010.03.015

Burlingame, G. M., Svien, H., Hoppe, L., Hunt, I., & Rosendahl, J. (2020). Group therapy for schizophrenia: A meta-analysis. *Psychotherapy*, *57*(2), 219–236. https://doi.org/10.1037/pst0000293

Bustillo, J., Lauriello, J., Horan, W., & Keith, S. (2001). The psychosocial treatment of schizophrenia: an update. *The American journal of psychiatry*, *158*(2), 163–175. https://doi.org/10.1176/appi.ajp.158.2.163

Chand, S. P., Kuckel, D. P., & Huecker, M. R. (2023, May 23). *Cognitive Behavior Therapy*. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK470241/#_NBK470241_pubdet_

Charlson, F. J., Ferrari, A. J., Santomauro, D., Diminic, S., Stockings, E., Scott, J. G., McGrath, J. J., & Whiteford, H. (2018, May 12). *Global Epidemiology and Burden of Schizophrenia: Findings From the Global Burden of Disease Study 2016*. Schizophrenia Bulletin., 44(6), 1195–1203 https://doi.org/10.1093/schbul/sby058

Cherry, K. (2023, November 2). *What Is Cognitive Behavioral Therapy (CBT)?* Verywell Mind. https://www.verywellmind.com/what-is-cognitive-behavior-therapy-2795747

Chibani, L. and Alaka, S. 2020. The foundations of CBT in psychotherapy in general and clinical psychology in particular. *Social Sciences Journal*. 14, 2Add (Sep. 2020), 93-101. DOI: https://doi.org/10.34118/ssj.v14i2Add.874.

Chien, W. T., Leung, S. F., Yeung, F. K., & Wong, W. K. (2013). Current approaches to treatments for schizophrenia spectrum disorders, part II: psychosocial interventions and patient-focused perspectives in psychiatric care. *Neuropsychiatric disease and treatment*, *9*, 1463–1481. https://doi.org/10.2147/NDT.S49263

Coffey, S. F., Banducci, A. N., & Vinci, C. (2015). Common Questions About Cognitive Behavior Therapy for Psychiatric Disorders. *American family physician*, *92*(9), 807–812. https://pubmed.ncbi.nlm.nih.gov/26554473/

Correll, C. U., & Schooler, N. R. (2020, February 1). *Negative Symptoms in Schizophrenia: A Review and Clinical Guide for Recognition, Assessment, and Treatment.* Neuropsychiatric Disease and Treatment. 21;16:519-534. https://doi.org/10.2147/ndt.s225643

Daskalakis, N. P., & Binder, E. B. (2015, January 14). *Schizophrenia in the Spectrum of Gene-Stress Interactions: The FKBP5 Example*. Schizophrenia Bulletin. Volume 41, Issue 2, March 2015, Pages 323–329 https://doi.org/10.1093/schbul/sbu189

Dickinson, D., Bellack, A. S., & Gold, J. M. (2007). Social/communication skills, cognition, and vocational functioning in schizophrenia. *Schizophrenia bulletin*, *33*(5), 1213–1220. https://doi.org/10.1093/schbul/sbl067

Dziwota, E., Stepulak, M. Z., Włoszczak-Szubzda, A., & Olajossy, M. (2018). Social functioning and the quality of life of patients diagnosed with schizophrenia. *Annals of Agricultural and Environmental Medicine: AAEM*, *25*(1), 50–55. https://doi.org/10.5604/12321966.1233566

Emerson, A., & Thomas, S. (2022, 3 14). Albert Ellis Theory | History, Model & Applications. Retrieved from https://study.com/learn/lesson/albert-ellis-theory-model.html

Fatemi, S. H., & Folsom, T. D. (2009, March 30). *The Neurodevelopmental Hypothesis of Schizophrenia, Revisited*. Schizophrenia Bulletin. Volume 35, Issue 3, May 2009, 528–548, https://doi.org/10.1093/schbul/sbn187

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Sage.

Fischer, B. A., & Buchanan, R. W. (2022, Jul 13). Schizophrenia in adults: Epidemiology and pathogenesis. (S. Marder, & M. Friedman, Eds.) *Up To Date*. Retrieved from https://www.uptodate.com/contents/schizophrenia-in-adults-epidemiology-and-pathogenesis#H31673348https://www.uptodate.com/contents/schizophrenia-in-adults-epidemiology-and-pathogenesis#H31673348

Frangou S. (2020). The Enduring Allure of Explanatory Reductionism in Schizophrenia. *Biological psychiatry*, *87*(8), 690–691. https://doi.org/10.1016/j.biopsych.2020.01.008

Gejman, P. V., Sanders, A. R., & Duan, J. (2010). The role of genetics in the etiology of schizophrenia. *The Psychiatric clinics of North America*, *33*(1), 35–66. https://doi.org/10.1016/j.psc.2009.12.003

Goldman, R. (2022, Aug 10). What Is Cognitive Behavioral Therapy (CBT)? *verywellmind*. Retrieved from https://www.verywellmind.com/what-is-cognitive-behavior-therapy-2795747

Goldstein, W. N. (1978, January 1). *Toward an Integrated Theory of Schizophrenia**. Schizophrenia Bulletin,3, 426–435. https://doi.org/10.1093/schbul/4.3.426

Granholm, E., & Harvey, P. D. (2018, January 5). Social Skills Training for Negative Symptoms of Schizophrenia. *Schizophrenia Bulletin*, Volume 44, Issue 3, Pages 472–474, https://doi.org/10.1093/schbul/sbx184

Häfner, H. (2014, September 15). *The Concept of Schizophrenia: From Unity to Diversity*. Advances in Psychiatry. https://doi.org/10.1155/2014/929434

Häfner, H., & an der Heiden, W. (1997). Epidemiology of schizophrenia. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *42*(2), 139–151. https://doi.org/10.1177/070674379704200204

Harris, P. (2014). An analysis of Melanie Klein's "The Psychoanalysis of Children." ResearchGate. https://www.researchgate.net/publication/272999920_An_analysis_of_Melanie_Klein's_The_Psychoanalysis_of_Children

Heilbronner, U., Samara, M., Leucht, S., Falkai, P., & Schulze, T. G. (2016, March 1). *The Longitudinal Course of Schizophrenia Across the Lifespan*. Harvard Review of Psychiatry. *24*(2), 118–128. https://doi.org/10.1097/hrp.0000000000000092

Henriksen, M. G., Nordgaard, J., & Jansson, L. B. (2017). Genetics of Schizophrenia: Overview of Methods, Findings and Limitations. *Frontiers in human neuroscience*, *11*, 322. https://doi.org/10.3389/fnhum.2017.00322

Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. Cognitive behavioral therapy. Cologne, Germany. HYPERLINK https://www.ncbi.nlm.nih.gov/books/NBK279297/?report=reader

IQWIG. (2013, Aug 7). *cognitive behavioral therapy*. Germany. HYPERLINK "https://www.ncbi.nlm.nih.gov/books/NBK279297/" Cognitive behavioral therapy - InformedHealth.org - NCBI Bookshelf (nih.gov)

Jablensky A. (2010). The diagnostic concept of schizophrenia: its history, evolution, and future prospects. *Dialogues in clinical neuroscience*, *12*(3), 271–287. https://doi.org/10.31887/DCNS.2010.12.3/ajablensky

Jarut, Y. M., Fatimawali, F., & Wiyono, W. I. (2013, August 1). *TINJAUAN PENGGUNAAN ANTIPSIKOTIK PADA PENGOBATAN SKIZOFRENIA DI RUMAH SAKIT PROF. DR. V. L. RATUMBUYSANG MANADO PERIODE JANUARI 2013-MARET 2013 | PHARMACON*. ejournal.unsrat.ac.id. https://doi.org/10.35799/pha.2.2013.2378

KANAS, N. (2006). Group Therapy With Schizophrenia Patients. *THE AMERICAN JOURNAL OF PSYCHIATRY*, 937-938. Retrieved from https://ajp.psychiatryonline.org/doi/full/10.1176/ajp.2006.163.5.937b

Keegan, E., & Holas, P. (2010). Cognitive-behavioral therapy: Theory and practice. In R. A. Carlstedt (Ed.), *Handbook of integrative clinical psychology, psychiatry, and behavioral medicine: Perspectives, practices, and research* (605–629). Springer Publishing Company.

Kelly, D. L., Weiner, E., Ball, M. P., McMahon, R. P., Carpenter, W. T., & Buchanan, R. W. (2009). Remission in schizophrenia: the relationship to baseline symptoms and changes in symptom domains during a one-year study. *Journal of psychopharmacology (Oxford, England)*, *23*(4), 436–441. https://doi.org/10.1177/0269881108093883

Keshavan, M. S., Nasrallah, H. A., & Tandon, R. (2011, April 1). *Schizophrenia, "Just the Facts" 6. Moving ahead with the schizophrenia concept: From the elephant to the mouse*. Schizophrenia Research.127(1-3), 3–13. https://doi.org/10.1016/j.schres.2011.01.011

Khan, Z., Martin-Montañez, E., & Muly, E. (2013, September). Schizophrenia: Causes and Treatments. *Current Pharmaceutical Design*, *19*(36), 6451–6461. https://doi.org/10.2174/1381612811319360006

Klappa, P. (2023, December 10). *Cohen's d effect size paired t-test [Video file]*. Retrieved from https://www.youtube.com/watch?v=K6GRHelAOYw

Klein, M. (1933). *The Psycho-Analysis of Children*. The Sociological Review, a25(3), 296–298. HYPERLINK "https://doi.org/10.1111/j.1467-954X.1933.tb01887.x" https://doi.org/10.1111/j.1467-954X.1933.tb01887.x

Kopelowicz, A., Liberman, R. P., & Zarate, R. (2006). Recent advances in social skills training for schizophrenia. *Schizophrenia bulletin*, *32 Suppl 1*(Suppl 1), S12–S23. https://doi.org/10.1093/schbul/sbl023

Kopelowicz, A., Liberman, R. P., & Zarate, R. (2006). Recent advances in social skills training for schizophrenia. *Schizophrenia bulletin*, *32 Suppl 1*(Suppl 1), S12–S23. https://doi.org/10.1093/schbul/sbl023

Kucharska-Pietura, K., & Mortimer, A. (2013). Can antipsychotics improve social cognition in patients with schizophrenia?. *CNS drugs*, *27*(5), 335–343. https://doi.org/10.1007/s40263-013-0047-0

Kurtz, M. M., & Mueser, K. T. (2008). A meta-analysis of controlled research on social skills training for schizophrenia. *Journal of consulting and clinical psychology*, *76*(3), 491.

Li, X., Zhou, W., & Yi, Z. (2022). A glimpse of gender differences in schizophrenia. *General Psychiatry*, *35*(4).

Ľupták, M., Michaličková, D., Fišar, Z., Kitzlerová, E., & Hroudová, J. (2021). Novel approaches in schizophrenia-from risk factors and hypotheses to novel drug targets. *World journal of psychiatry*, *11*(7), 277–296. https://doi.org/10.5498/wjp.v11.i7.277

Lysaker, P. H., Davis, L. W., Bryson, G. J., & Bell, M. D. (2009). *Effects of cognitive behavioral therapy on work outcomes in vocational rehabilitation for participants with schizophrenia spectrum disorders.* Schizophrenia Research, *107*(2-3), 186–191. HYPERLINK https://doi.org/10.1016/j.schres.2008.10.018

Malmberg, L., Fenton, M., & Rathbone, J. (2001). *Individual psychodynamic psychotherapy and psychoanalysis for schizophrenia and severe mental illness*. Cochrane Database of Systematic Reviews, (3). HYPERLINK https://doi.org/10.1002/14651858.CD001360

Mammaria, B. (2021). Adaptation of the social skills scale in Algerian society. *Nafssaniat*, *17*(71), 1-20.

Marie, M., Shaabna, Z. & Saleh, M. (2020). Schizophrenia in the context of mental health services in Palestine: a literature review. *Int J Ment Health Syst* **14**, 44 (2020). https://doi.org/10.1186/s13033-020-00375-6

McLeod, S. A. (2019, January 11). *Cognitive behavioral therapy*. Simply Psychology. HYPERLINK www.simplypsychology.org/cognitive-therapy.html

Merriam-Webster Dictionary. (2022). schizophrenia. Retrieved from https://www.merriam-webster.com/dictionary/schizophrenia#medicalDictionary

Morrison A. K. (2009). Cognitive behavior therapy for people with schizophrenia. *Psychiatry (Edgmont (Pa.: Township))*, *6*(12), 32–39. HYPERLINK https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2811142/

Munawar, K., Ravi, T., Jones, D., & Choudhry, F. R. (2023). Islamically modified cognitive behavioral therapy for Muslims with mental illness: A systematic review. *Spirituality in Clinical Practice.* Advanced online publication. HYPERLINK https://doi.org/10.1037/scp0000338

Murray, R. M., Jones, P. B., Susser, E., Van Os, J., & Cannon, M. (Eds.). (2002). *The epidemiology of schizophrenia*. Cambridge University Press.

Najas-García, A., Rufián, S., & Rojo, E. (2014). *Neurodesarrollo o neurodegeneración: Revisión sobre las teorías de la esquizofrenia*. Actas Esp Psiquiatr, 42(4), 185-95.

Nemoto, T., Uchino, T., Aikawa, S., Saito, J., Matsumoto, H., Funatogawa, T.,... & Mizuno, M. (2019). Social anxiety and negative symptoms as the characteristics of patients with schizophrenia who show competence–performance discrepancy in social functioning. *Psychiatry and Clinical Neurosciences*, *73*(7), 394-399.

NICE. (2019). *Treatment - Schizophrenia*.

NIMH. (2022). *Schizophrenia*. https://www.nimh.nih.gov/health/topics/schizophrenia#part_2275

Nuechterlein, K. H., & Dawson, M. E. (1984). A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophr Bull*, 300-12. Retrieved 2022, from https://pubmed.ncbi.nlm.nih.gov/6729414/

NYU Langone (2024). Cognitive Behavioral Therapy for Schizophrenia. https://nyulangone.org/conditions/schizophrenia/treatments/cognitive-behavioral-therapy-for-schizophrenia ss

Odeh, J. M. B. (2012). *Prescription Pattern of Antipsychotics in Patients with Schizophrenia in North West-Bank.* https://repository.najah.edu/handle/20.500.11888/6817?show=full

Patel, K. R., Cherian, J., Gohil, K., & Atkinson, D. (2014). Schizophrenia: overview and treatment options. *P & T: a peer-reviewed journal for formulary management*, *39*(9), 638–645. HYPERLINK https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4159061/#

Rathod, S., Kingdon, D., Smith, P., & Turkington, D. (2005). Insight into schizophrenia: the effects of cognitive behavioural therapy on the components of insight and association with sociodemographics--data on a previously published randomised controlled trial. *Schizophrenia research*, *74*(2-3), 211–219. https://doi.org/10.1016/j.schres.2004.07.003

Rector, N. A., & Beck, A. T. (2001). Cognitive behavioral therapy for schizophrenia: an empirical review. *The Journal of nervous and mental disease*, *189*(5), 278–287. https://doi.org/10.1097/00005053-200105000-00002

Rice, R. H. (2015). *Cognitive-behavioral therapy*. The Sage encyclopedia of theory in counseling and psychotherapy, 1, 194. http://dx.doi.org/10.4135/9781483346502.n77

Riggio, R. E. (2014). The Social Skills Inventory (SSI): measuring nonverbal and social skills. *The sourcebook of nonverbal measures*, 25-33.

Robertson, B. R., Prestia, D., Twamley, E. W., Patterson, T. L., Bowie, C. R., & Harvey, P. D. (2014). Social competence versus negative symptoms as predictors of real-world social functioning in schizophrenia. *Schizophrenia Research*, *160*(1-3), 136-141.

Rosenthal, R., Cooper, H., & Hedges, L. (1994). Parametric measures of effect size. *The handbook of research synthesis*, *621*(2), 231-244.

Rudnick, A., & Lundberg, E. (2012). The Stress-Vulnerability Model of Schizophrenia: A Conceptual Analysis and Selective Review. *Current Psychiatry Reviews*, 337 - 341. Retrieved from https://www.eurekaselect.com/article/46492

Ruggiero, G. M., Spada, M. M., Caselli, G., & Sassaroli, S. (2018, Apr 13). A Historical and Theoretical Review of Cognitive Behavioral Therapies: From Structural Self-Knowledge to Functional Processes. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 378–403. Retrieved from https://link.springer.com/article/10.1007/s10942-018-0292-8#Abs1

Saha, S., Chant, D., Welham, J., & McGrath, J. (2005). A systematic review of the prevalence of schizophrenia. *PLoS medicine*, *2*(5), e141https://doi.org/10.1371/journal.pmed.0020141

Schultz SH, North SW, Shields CG. *Schizophrenia: a review*. Am Fam Physician. 2007 Jun 15;75(12):1821-9. PMID: 17619525.

Shukla, P., Padhi, D., Sengar, K. S., Singh, A., & Chaudhury, S. (2021). Efficacy and durability of cognitive behavior therapy in managing hallucination in patients with schizophrenia. *Industrial psychiatry journal*, *30*(2), 255–264. https://doi.org/10.4103/ipj.ipj_94_20

Skodlar, B., Henriksen, M. G., Sass, L. A., Nelson, B., & Parnas, J. (2013). Cognitive-behavioral therapy for schizophrenia: a critical evaluation of its theoretical framework from a clinical-phenomenological perspective. *Psychopathology*, *46*(4), 249–265. https://doi.org/10.1159/000342536

Soares-Weiser, K., Maayan, N., Bergman, H., Davenport, C., Kirkham, A. J., Grabowski, S., & Adams, C. E. (2015). First rank symptoms for schizophrenia. *The Cochrane database of systematic reviews*, *1*(1), CD010653https://doi.org/10.1002/14651858.CD010653.pub2

Soares-Weiser, K., Maayan, N., Bergman, H., Davenport, C., Kirkham, A. J., Grabowski, S., & Adams, C. E. (2015). First rank symptoms for schizophrenia. *The Cochrane database of systematic reviews*, *1*(1), CD010653. https://doi.org/10.1002/14651858.CD010653.pub2

Spittler, S. (2022). Schizophrenia, Information for patients and their relatives. OTSUKA. Retrieved from https://www.lundbeck.com/content/dam/lundbeck-com/europe/germany/06-downloads/patietenbrosch%C3%BCren/Patientenbrosch%C3%BCre_Schizo_arabisch.pdf.coredownload.pdf

Suping, Y., Ling, H., Chow, L., & Hong, D. (2015). Research progress of cognitive behavioral therapy in the treatment of schizophrenia. *Chinese Journal of Psychiatry*, 249-251. Retrieved from https://rs.yiigle.com/CN113661201504/638682.htm

Tamminga, C. (2022). SCHIZOPHRENIA AND SIMILAR DISORDERS. *SCHIZOPHRENIA*. Retrieved from https://www.msdmanuals.com/de-de/heim/psychische-gesundheitsst%C3%B6rungen/schizophrenie-und-%C3%A4hnliche-st%C3%B6rungen/schizophrenie

Tarrier N. (2010) *Cognitive behavior therapy for schizophrenia and psychosis: current status and future directions*. Clin Schizophr Relat Psychoses. 2010 Oct;4(3):176-84. doi: 10.3371/CSRP.4.3.4. PMID: 20880828.

The International Classification of Diseases, revision 11 (2022). Schizophrenia or other primary psychotic disorders. https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f405565289

The Palestinian Center for Policy Research and Strategic Studies [MASARAT] (2023). *Policy paper: Policies for developing mental health services for Palestinian youth.* Retrieved from (Access Date: 2/12/2023): https://t.ly/SxNqh.

The Palestinian Central Bureau of Statistics [PCBS] (2023). *Estimated mid-year population of Jerusalem Governorate by locality 2017-2026.* Retrieved from (Access Date: 2/12/2023): https://t.ly/5C_Hu

Thesaurus Dictionary. (2022). schizophrenia. Retrieved from https://www.dictionary.com/browse/schizophrenia

Tiba A. I. (2024). The grounded cognition foundation of the first cognitive model in cognitive behavior therapy: implications for practice. *Frontiers in psychology*, *15*, 1364458. https://doi.org/10.3389/fpsyg.2024.1364458

Traylor, J., Overstreet, L., & Lang, D. (2022, August 1). *Psychodynamic Theory: Freud*. Pressbooks. https://iastate.pressbooks.pub/individualfamilydevelopment/chapter/freuds-psychodynamic-theory/

Turkington, D., Dudley, R., Warman, D. M., & Beck, A. T. (2004). Cognitive-behavioral therapy for schizophrenia: a review. *Journal of Psychiatric Practice*, *10*(1), 5–16. https://doi.org/10.1097/00131746-200401000-00002

Turola, M. C., Comellini, G., Galuppi, A., Nanni, M. G., Carantoni, E., & Scapoli, C. (2012). Schizophrenia in real life: courses, symptoms and functioning in an Italian

population. *International journal of mental health systems*, *6*(1), 22. https://doi.org/10.1186/1752-4458-6-22

Van Os, J., & Kapur, S. (2009). Schizophrenia. *Lancet (London, England)*, *374*(9690), 635–645. https://doi.org/10.1016/S0140-6736(09)60995-8

Verma, J. P., & Abdel-Salam, A. S. G. (2019). *Testing statistical assumptions in research*. John Wiley & Sons.

Verma, J. P., & Abdel-Salam, A. S. G. (2019). *Testing statistical assumptions in research*. John Wiley & Sons.

Volkan, K. (2020). *Schizophrenia: epidemiology, causes, neurobiology, pathophysiology, and treatment*. Journal of Health and Medical Sciences, 3(4), 487-521.

Winn, P. (2000). *The biological basis of schizophrenia*. Principles of Medical Biology, 14, 233-261. https://doi.org/10.1016/S1569-2582(00)80014-8

Wobrock, T., Pajonk, F. G., & Falkai, P. (2004). Schizophrenie. Teil I. Epidemiologie, Atiopathogenese, Symptomatologie [Schizophrenia]. *Fortschritte der Neurologie-Psychiatrie*, *72*(2), 98–113.

Xu, F., & Zhang, H. (2023). The application of cognitive behavioral therapy in patients with schizophrenia: A review. *Medicine*, *102*(32), e34827. https://doi.org/10.1097/MD.0000000000034827

Zhihua, G. (2013). Cognitive behavioral therapy (CBT) for schizophrenia. *Chinese Journal of Mental Health*, 602-606.

Zimmermann, G., Favrod, J., Trieu, V. H., & Pomini, V. (2005). The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: a meta-analysis. *Schizophrenia research*, *77*(1), 1–9. https://doi.org/10.1016/j.schres.2005.02.018

Appendices

Appendix A

Social skills inventory

إعداد Roland E. Riggio1989

العمر:..... الجنس.....

المهنة:.....

المستوى التعليمي:.....

التخصص التعليمي:.....

التعليمات:

فيما يلي عدد من العبارات التي تصف اتجاهك وتصرفاتك في الحياة ومع الاخرين. اقرأها وأجب عنها بوضـــع علامة × تحت كل درجة من العبارات التي تصفك فيما يلي:

الرقم	العبارات	لا	قليلا	متوسطا	كثيرا
1	يسهل على الآخرين أن يعرفوا متى أشعر بالحزن أو الكآبة				
2	عندما يتحدث إلي شخص فإني أراقب تحركاته وتصرفاته بقـــدر استماعي لما يقوله				
3	يصعب على الناس معرفة مشاعري إذا عملت على إخفائها				
4	أستمتع بوجودي في الحفلات				
5	أظهر شعوري بالضيق من النقد أو التوبيخ				
6	أستطيع التوافق مع كل الناس صـــغيرهم أو كبيـــرهم، غنـــيهم أو فقيرهم				
7	أتحدث بسرعة تفوق معظم الأشخاص				
8	الكثير من الناس حساسون ومتفاهمون مثلي				
9	يسهل علي أن أمنع نفسي من الضحك عند سماعي لنكتة أو قصة مضحكة				
10	يستغرق الآخرون وقتا قصيرا ليتعرفوا علي جيدا				
11	يعد الناس أكبر مصدر لسعادتي وأحزاني				
12	عندما أكون مع مجموعة من أصدقائي أكون غالبا أنـــا الشـــخص المتحدث إليهم				

الرقم	العبارات	لا	قليلا	متوسطا	كثيرا
13	عندما أشعر بالحزن أحاول أن أجعل الآخرين يشعرون بـــالحزن أيضا				
14	أثناء وجودي في حفلة أستطيع معرفة الشخص الذي يهتم بي				
15	يصعب على الناس معرفة ما إذا كنت متــوترا إذا نظــروا إلـــى تعبيرات وجهي				
16	أحب المشاركة في الأنشطة الاجتماعية				
17	أتجنب المشاركة في المناقشات السياسية وأفضل ملاحظة وتحليل ما يقوله الآخرون				
18	يمكنني بسهولة أن أنظر إلى وجوه وعيون الآخرين عندما أتحدث إليهم				
19	يمكن للآخرين معرفة مشاعري من خلال النظر إلى عيني				
20	أهتم بمعرفة كل ما يجذب انتباه الناس من إشارات وعلامات				
21	أستطيع ضبط انفعالاتي أو التحكم بدقة في مشاعري				
22	أفضل الأعمال التي تحتاج إلى عدد كبير من الأفراد للقيام بها				
23	أتأثر بدرجة كبيرة بالحالة النفسية للمحيطين بي				
24	أنا ماهر في إجراء حوار حتى ولو لم يتم الإعداد له				
25	أتظاهر بعدم الضيق عندما أجرح مشاعر الآخرين				
26	أستطيع بسهولة فهم طبيعة أي شخص من خـــلال تعاملـــه مـــع الآخرين				
27	أستطيع أن أخفي مشاعري الحقيقية نحو أي شخص				
28	أختلط عادة بالآخرين أثناء الحفلات والاجتماعات				
29	أشعر بالقلق إزاء صحة ما أقوله أو أفعله في بعض المواقف				
30	يسهل علي التحدث أمام مجموعة كبيرة من الناس				
31	أضحك عادة بصوت مرتفع				
32	يمكنني معرفة المشاعر الحقيقية للناس مهما بذلوا جهدا لإخفائها				
33	أستطيع أن أمنع نفسي من الضحك أو الابتسامة حتـــى إذا حـــاول أصدقائي إضحاكي				
34	أبادر عادة بتقديم وتعريف نفسي للغرباء				
35	آخذ أحيانا ما يقوله الآخرون لي بشكل شخصي على أنه يمسني				
36	عندما أكون مع مجموعة من الناس ينفتح تفكيـــري إزاء الأشـــياء التي يجب أن أتحدث فيها				
37	أكون هادئا لدرجة أن أصدقائي يشعرون أني مرتـــاح لوجـــودي معهم.				

الرقم	العبارات	لا	قليلا	متوسطا	كثيرا
38	يمكنني فهم طبيعة أي شخص من مجرد مقابلته لأول مرة				
39	يسهل علي جدا التحكم في انفعالاتي				
40	أكون عادة الشخص الذي يبدأ الحوار في المناقشة مع الآخرين				
41	يؤثر علي ما يتوقعه الآخرون مني من تصرفات				
42	أكون عادة ماهرا في إدارة المناقشات الجماعية				
43	تكون تعبيرات وجهي عادية				
44	من أعظم الأمور التي تسعدني وجودي مع الناس				
45	يمكنني أن أحتفظ بمظهري هادئا حتى ولو كنت مضطربا أو متوترا				
46	عندما أحكي قصة لشخص ما استعمل الكثير من الإشارات والإيماءات لتوضيح ما أقوله				
47	أكون غالبا قلقا من أن يسيء الآخرون فهمهم لما أقوله لهم				
48	أكون هادئا عادة عندما أجلس مع أشخاص يختلفون عني في المكانة الاجتماعية				
49	من طبيعتي أن أظهر غضبي أحيانا				
50	أستطيع أن أكتشف الشخص المحتال منذ اللحظة الأولى من مقابلته				
51	عندما ألتقي مع مجموعة من الناس بالصدفة يمكنني التكيف معهم بسهولة				
52	عندما أكون في مناقشة جماعية فإني أشارك بنصيب كبير في الحديث				
53	يركز والداي منذ صغري على أهمية السلوك الحسن عند مخاطبة الناس والتعامل معهم				
54	أنا ماهر في الاختلاط بالناس والتعامل معهم				
55	أقترب من أصدقائي غالبا عندما أتحدث معهم				
56	أكون هادئا ومصغيا عندما يحكي لي الآخرون عن مشاكلهم				
57	بالرغم من أنه في بعض الأحيان أكون في حالة غضب شديد إلا أنه يمكنني أن أخفي ذلك عن الآخرين				
58	أستمتع بالحديث مع الآخرين في الحفلات				
59	أتأثر بشدة بأي شخص يبتسم لي أو يغضب في وجهي				
60	أكون هادئا ومرتاحا في الحفلات التي يحضرها بعض الأشخاص المهمين جدا				
61	أستطيع تحويل حفلة مملة إلى حفلة مرحة وممتعة				
62	أبكي أحيانا عندما أشاهد أفلاما حزينة				

الرقم	العبارات	لا	قليلا	متوسطا	كثيرا
63	أستطيع التظاهر بأني سعيد جدا في المواقف الاجتماعية حتى ولو كنت غير ذلك في حقيقة الأمر				
64	أنا شخص اجتماعي				
65	أنا شخص حساس جدا للنقد				
66	حتى الأشخاص الأقل مني في المكانة الاجتماعية يشعرون بالارتياح عندما يجلسون معي				
67	أحب أن أكون موضع اهتمام الآخرين				
68	يسهل علي أن أضحك أي شخص لديه مشكلة للتخفيف عنه				
69	يمكنني أن أخفي مشاعري القوية				
70	أستمتع بالذهاب إلى الحفلات الكبيرة ومقابلة أشخاص جدد				
71	يهمني جدا حب الناس لي				
72	أكون ماهرا في حديثي مع أشخاص غرباء				
73	أظهر عادة مشاعري وانفعالاتي				
74	أقضي فترة طويلة لمجرد مراقبة الناس				
75	يسهل علي أن أتظاهر بالغضب والحزن، حتى لو كنت أشعر فعلا بالسعادة				
76	يسهل علي أن أبدأ الحديث مع الغرباء				
77	أكون عصبيا ومتوترا إذا عرفت أن شخصا ما يراقبني				
78	أرغب كثيرا في أن أكون قائد جماعة				
79	أنا كثير الكلام				
80	يعتبرني الآخرون بأني شخص حساس وعاطفي				
81	يصعب على الناس معرفة مشاعري عندما أخفيها عنهم				
82	أحب جو السهرات والحفلات				
83	أهتم بما أكونه عن الآخرين من انطباعات				
84	أضع نفسي غالبا في مواقف اجتماعية مريحة				
85	أعبر عن غضبي أحيانا بالصراخ				
86	عندما يكون أصدقائي متضايقين يبحثون عني لكي أخفف عنهم الضيق				
87	أستطيع بسهولة أن أبدو سعيدا في لحظة ما وحزينا في اللحظة التالية				
88	يمكنني أن أتحدث عدة ساعات في أي موضوع				
89	اهتم بانطباعات الآخرين عني				
90	أستطيع أن أتكيف بسهولة في أي موقف اجتماعي				

Appendix B

Residual Schizophrenia Test (SC)

العمر:

( ) 19– 25 سنة ( ) 26 – 30 سنة

( ) 31 سنة فما فوق

النوع:

( ) ذكر ( ) أنثى

فترة الإصابة:

( ) أقل من سنة ( ) 1–5 سنوات

( ) 6–10 سنوات

تعليم الام:

( ) أمي ( ) أساسي

( ) ثانوي ( ) جامعي

تعليم الاب:

( ) أمي ( ) أساسي

( ) ثانوي ( ) جامعي

الحالة الزواجية

( ) متزوج ( ) عازب

( ) مطاق ( ) أرمل

الرقم	العبارة	نعم	لا
1	افكر دائما في أشياء قبيحة لا يمكن التحدث عنها		
2	لا شك في إنني مظلوم في هذه الحياة.		
3	في بعض الأحيان تنتابني نوبات من الضحك والبكاء لا استطيع التحكم فيها		
4	لو ان الناس لم تضمر اشياء ضدي لكنت اكثر نجاحا مما أنا عليه		
5	اشعر بحرارة فجأة في كل جسمي مرة أو أكثر في الأسبوع بدون سبب حقًا		
6	كل شيء في نظري سواء		
7	اشعر بالحزن والانقباض في معظم الأوقات		
8	يبدوا إنني مستهدف لمؤامرة ضدي		
9	قمت بسرقة بعض الأشياء عندما كنت صغيراً		
10	مرت بي فترات كنت أقوم فيها بأفعال دون ان اعرف بعد الك ماذا كنت افعل		
11	اشعر باننني تعاقبت كثيرا من دون سبب		
12	دائما ما اشعر بان عقلي مختل		
13	الأمور الجنسية تثير عندي القلق دائما		
14	اشعر بان الحياة سوداء أمامي		
15	أهلي يعاملونني كطفل اكثر مما يعاملونني كراشد		
16	تصيبني نوبات يتوقف فيها نشاطي ولا اشعر فيها بما يدور حولي		
17	اجد صعوبة في بداء أي عمل من الأعمال.		
18	افقد الإحساس في منطقة أو أكثر من جلدي.		
19	اشعر أحيانا بكراهية نحو أفراد أسرتي التي احبها في العادة.		
20	لا تضايقني الأفكار الجنسية.		
21	الحياة صعبة لي في معظم الأوقات.		
22	اشعر بالوحدة حتي وانا مع الأخرين.		
23	الكثير من أحلامي تتعلق بالأمور الجنسية.		
24	اشعر بان صوتي محبوس أحياننا.		
25	يصبح سمعي أحياننا مرهفا لدرجة تضايقني.		
26	اشعر أحياننا بان الأشياء ليست واقعية		
27	أنا شرير في بعض الأحيان.		
28	احب والدي		
29	لا اشكوا تقلصات في العضلات وان شكوة فنادرا		

الرقم	العبارة	نعم	لا
30	أنا احب والدتي.		
31	حياتي اليومية بمليئة بما يثير اهتمامي.		
32	اجد متعة كبيره مع الأطفال.		
33	لا اشعر غالبا بطنين في الأذنين		
34	إنني احصل علي كل ما استحقه من عطف.		
35	دائما ما أكون صداقاتي بصورة سريعة.		

Appendix C

Facilitate the student's task

An-Najah
National University
Department of Psychology
and Counseling

جامعة
النجاح الوطنية
قسم علم النفس والإرشاد

26/02/2022

السادة : **NATHAN for Nursing and Rehabilitation.** المحترمين

تحية طيبة وبعد؛

الموضوع: عقد جلسات علاجية

ارجو من حضرتكم الموافقة على السماح للطالب صهيب هود صالح أبوسنينة علما انه احد طلبة برنامج ماجستير علم النفس الاكلينيكي، وضمن مرحلة اعداد الاطروحة، اذ يحتاج الطالب تطبيق برنامج بعنوان: فعالية برنامج علاجي سلوكي معرفي في تقليل الاعراض وتحسين المهارات الاجتماعية لدى مرضى الفصام، في مؤسستكم وبواقع 10-12 جلسة كحد اقصى، علما ان الباحث ملزم باخلاقيات المهنة في التعامل مع الحالات والمنتفعين بشكل كلي.

مع فائق الإحترام والتقدير

المشرف الاكاديمي

د. شادي خليل ابو الكباش

Shadi.k@najah.edu

0568351821

Appendix D

Tables

Table 11

The results of the paired samples t-test of the differences between the pre-test and post-test of schizophrenic symptoms and social skills in the experimental group

Dependent variables	$Mean_D$	SD_D	T-value	df	Sig.
SCHS	0.02	0.05	1.11	7	.305
SCSI	-0.31	0.86	-1.03	7	.339
EE	-0.43	0.94	-1.31	7	.233
ES	-0.27	0.88	-0.822	7	.443
EC	-0.54	0.75	-2.03	7	.082
SE	-0.27	1.08	-0.67	7	.529
SS	-0.14	0.83	-0.46	7	.657
SC	-0.05	1.10	-0.13	7	.901

**(p <.01).

Table 12

The normality of the responses in schizophrenic symptoms and social skills was tested in the post-test using the Shapiro-Wilk test (n = 8)

Group type	Dependent variables	Shapiro-Wilk test		
		Statistic	df	Sig.
Control (n = 8)	SCHS	.931	7	.527
	SCSI	.902	7	.235
	EE	.911	7	.207
	ES	.888	7	.117
	EC	.864	7	.108
	SE	.955	7	.758
	SS	.830	7	.094
	SC	.872	7	.128
Experimental (*n* = 8)	SCHS	.914	7	.423
	SCSI	.913	7	.419
	EE	.832	7	.083
	ES	.970	7	.900
	EC	.964	7	.850
	SE	.892	7	.288
	SS	.970	7	.900
	SC	.923	7	.492

Table 13

Means and standard deviations of schizophrenic symptoms and social skills in the post-test according to group type, age, duration of schizophrenia, parent education, and marital status

Independent variable		Dependent variables							
		SCHS	SCSI	EE	ES	EC	SE	SS	SC
Group type	Control	0.52±0.06	1.16±0.43	1.10±0.48	1.13±0.45	1.13±0.44	1.18±0.53	1.33±0.61	1.14±0.29
	Experimental	0.49±0.05	1.61±0.38	1.63±0.51	1.53±0.36	1.83±0.40	1.44±0.62	1.72±0.44	1.46±0.48
Age	20-25	0.53±0.02	1.16±0.23	1.18±0.09	1.10±0.19	0.97±0.23	1.17±0.44	1.36±0.55	1.20±0.31
	26-30	0.47±0.07	1.47±0.49	1.47±0.58	1.45±0.53	1.65±0.54	1.43±0.55	1.61±0.62	1.24±0.44
	≥ 31	0.51±0.05	1.42±0.51	1.34±0.67	1.29±0.47	1.54±0.57	1.26±0.69	1.52±0.55	1.39±0.47
Duration of the disorder	1-5 years	0.50±0.07	1.32±0.39	1.35±0.43	1.24±0.42	1.30±0.54	1.38±0.45	1.42±0.48	1.29±0.38
	6-10 years	0.50±0.06	1.43±0.51	1.36±0.64	1.37±0.48	1.59±0.55	1.27±0.66	1.58±0.60	1.31±0.45
Mother education	Illiterate	0.45±0.05	1.72±0.44	1.72±0.63	1.59±0.42	1.96±0.0.48	1.67±0.76	1.80±0.57	1.48±0.44
	Basic school	0.52±0.03	1.26±0.28	1.22±0.34	1.31±0.34	1.28±0.41	1.13±0.34	1.38±0.40	1.24±0.39
	Secondary school	0.49±0.05	1.42±0.62	1.39±0.72	1.27±0.64	1.50±0.63	1.46±60	1.61±0.79	1.31±0.49
	University	0.63±0.80	0.80+0.00	0.72±0.00	0.77±0.00	0.86±0.00	0.50±0.00	1.10±0.00	0.87±0.00
Father education	Illiterate	0.49±0.04	1.62±0.49	1.76±0.53	1.37±0.38	1.76±0.41	1.55±0.70	1.67±0.49	1.49±0.62
	Basic school	0.49±0.08	1.25±0.42	1.14±0.52	1.37±0.54	1.36±0.50	1.21±0.45	1.23±0.32	1.20±0.36
	Secondary school	0.51±0.06	1.30±0.45	1.19±0.49	1.26±0.49	1.35±0.64	1.19±0.57	1.58±0.70	1.22±0.26
	University	---	---	---	---	---	---	---	---
Marital status	Single	0.48±0.08	1.45±0.49	1.44±0.58	1.48±0.57	1.37±0.65	1.53±0.47	1.60±0.67	1.32±0.28
	Married	0.50±0.03	1.39±0.53	1.26±0.66	1.23±0.38	1.56±0.59	1.26±0.71	1.51±0.63	1.33±0.46
	Divorced	0.52±0.07	1.32±0.42	1.40±0.48	1.25±0.42	1.49±0.48	1.13±0.53	1.45±0.40	1.24±0.54

Table 14

Six-way MANCOVA results of differences in schizophrenic symptoms and social skills in the post-test according to group type, age, duration of schizophrenia, parent education, and marital status

Source	Dependent Variable	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared (η2)
Group type	SCHS	0.001	1	0.001	0.473	0.541	0.14
	SCSI	0.169	1	0.169	3.164	0.173	0.51
	EE	0.018	1	0.018	0.298	0.623	0.09
	ES	0.234	1	0.234	10.025	0.051	0.77
	EC	0.942	1	0.942	22.603	0.018*	0.88
	SE	0.074	1	0.074	0.785	0.441	0.21
	SS	1.116	1	1.116	3.453	0.160	0.54
	SC	0.011	1	0.011	0.140	0.734	0.04
Age	SCHS	0.005	2	0.002	1.502	0.353	0.50
	SCSI	0.306	2	0.153	2.856	0.202	0.66
	EE	0.199	2	0.100	1.678	0.324	0.53
	ES	0.174	2	0.087	3.714	0.154	0.71
	EC	0.401	2	0.201	4.814	0.116	0.76
	SE	0.659	2	0.329	3.485	0.165	0.70
	SS	0.607	2	0.304	0.939	0.482	0.38
	SC	0.824	2	0.412	5.148	0.107	0.77
Duration of schizophrenia	SCHS	0.001	1	0.001	0.542	0.515	0.15
	SCSI	0.159	1	0.159	2.963	0.184	0.50
	EE	0.120	1	0.120	2.022	0.250	0.40
	ES	0.040	1	0.040	1.694	0.284	0.36
	EC	0.002	1	0.002	0.040	0.855	0.01
	SE	0.643	1	0.643	6.802	0.080	0.69
	SS	0.024	1	0.024	0.075	0.802	0.02
	SC	0.763	1	0.763	9.536	0.054	0.76
Mother education	SCHS	0.005	2	0.003	1.658	0.327	0.53
	SCSI	0.314	2	0.157	2.937	0.197	0.66
	EE	0.639	2	0.319	5.379	0.102	0.78
	ES	0.369	2	0.185	7.905	0.064	0.84
	EC	0.058	2	0.029	0.691	0.566	0.32
	SE	0.951	2	0.476	5.031	0.110	0.77
	SS	0.059	2	0.030	0.092	0.915	0.06
	SC	0.692	2	0.346	4.321	0.131	0.74

Source	Dependent Variable	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared (η2)
Father education	SCHS	0.002	1	0.002	1.201	0.353	0.29
	SCSI	0.297	1	0.297	5.547	0.100	0.65
	EE	0.130	1	0.130	2.188	0.236	0.42
	ES	0.115	1	0.115	4.909	0.114	0.62
	EC	0.178	1	0.178	4.282	0.130	0.59
	SE	0.348	1	0.348	3.683	0.151	0.55
	SS	0.685	1	0.685	2.120	0.241	0.41
	SC	0.533	1	0.533	6.659	0.082	0.69
Marital status	SCHS	0.00005	1	0.00005	0.023	0.889	0.01
	SCSI	0.005	1	0.005	0.093	0.780	0.03
	EE	0.001	1	0.001	0.025	0.885	0.01
	ES	0.036	1	0.036	1.544	0.302	0.34
	EC	0.001	1	0.001	0.036	0.862	0.01
	SE	0.046	1	0.046	0.482	0.537	0.14
	SS	0.002	1	0.002	0.005	0.946	0.00
	SC	0.149	1	0.149	1.859	0.266	0.38
Pre-test of SCHS	SCHS	0.003	1	0.003	1.638	0.291	0.35
	SCSI	0.399	1	0.399	7.460	0.072	0.71
	EE	0.629	1	0.629	10.592	0.047*	0.78
	ES	0.386	1	0.386	16.504	0.027*	0.85
	EC	0.042	1	0.042	1.016	0.388	0.25
	SE	1.063	1	1.063	11.247	0.044*	0.79
	SS	0.094	1	0.094	0.290	0.628	0.09
	SC	0.707	1	0.707	8.832	0.059	0.75
Pre-test of SCSI	SCHS	0.00006	1	0.00006	0.028	0.878	0.01
	SCSI	0.034	1	0.034	0.197	0.688	0.06
	EE	0.347	1	0.347	2.268	0.229	0.43
	ES	0.084	1	0.084	0.677	0.471	0.18
	EC	0.00000008	1	0.00000008	0.000	0.991	0.00
	SE	0.001	1	0.001	0.002	0.965	0.00
	SS	0.066	1	0.066	0.199	0.686	0.06
	SC	0.179	1	0.179	0.697	0.465	0.19

*(p <.05).

جامعة النجاح الوطنية
كلية الدراسات العليا

فعالية برنامج العلاج السلوكي المعرفي في تقليل الأعراض وتحسين المهارات الاجتماعية لدى مرضى الفصام

إعداد
صهيب هود صالح أبو سنينة

إشراف
د. فلسطين نزال
د. شادي أبو الكباش

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في علم النفس الاكلينيكي،
من كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس – فلسطين.

2024

فعالية برنامج العلاج السلوكي المعرفي في تقليل الأعراض وتحسين المهارات الاجتماعية لدى مرضى الفصام

إعداد

صهيب هود صالح أبو سنينة

إشراف

د. فلسطين نزال

د. شادي أبو الكباش

الملخص

الخلفية: وفقا للدليل التشخيصي والإحصائي للاضطرابات العقلية (DSM-5)، فإن الفصام هو اضطراب عقلي حاد يتميز بالانفصال بين الواقع والعقل، والأفكار المختلطة، والتصورات، والعواطف، والسلوك. وهو مرض نفسي خطير يعيق التفكير والسلوك الطبيعي، ويؤثر بشكل كبير على الفرد ومن حوله.

وقد أظهرت الأبحاث السابقة أن العلاج السلوكي المعرفي يحسن المهارات الاجتماعية ويقلل من الأعراض الإيجابية والسلبية لدى مرضى الفصام. ولذلك حاولت هذه الدراسة استكشاف دور العلاج السلوكي المعرفي في تقوية المهارات الاجتماعية وتقليل الأعراض لدى المصابين بالفصام.

طريقة الدراسة: شملت الدراسة 16 فرداً مصابين بالفصام، جميعهم من العرب الفلسطينيين المقيمين في القدس المحتلة ويتلقون الرعاية في مركز ناثان للصحة النفسية. استخدم الباحث مقياس المهارات الاجتماعية للفصام ومقياس الأعراض الإيجابية والسلبية لتقييم تعزيز المهارات الاجتماعية وتقليل الأعراض لدى هؤلاء المرضى.

النتائج: بين المرضى الفلسطينيين في القدس الذين تم تشخيص إصابتهم بالفصام، كشفت الدراسة عن مستوى متوسط من أعراض الفصام إلى جانب مستوى معتدل في المهارات الاجتماعية. على الرغم من خضوعهم لعلاجات برنامج العلاج السلوكي المعرفي (CBTP)، لم تشهد المجموعة التجريبية تحسينات كبيرة في المهارات الاجتماعية أو الحد من أعراض الفصام. والجدير بالذكر أن برنامج CBTP أدى إلى تحسين التحكم العاطفي بين مرضى الفصام في المجموعة التجريبية مقارنة بالمجموعة الضابطة. ومع ذلك، لم تتأثر المهارات الاجتماعية ولا نتائج أعراض الفصام بتدخل CBTP.

الاستنتاج: تبحث الدراسة فيما إذا كان هناك فعالية للعلاج السلوكي المعرفي في خفض الأعراض وتعزيز المهارات الاجتماعية لدى مرضى الفصام، وتؤكد على أهمية تثقيف المعالجين حول تقنيات العلاج ورفع الوعي العام حول أهمية العلاج النفسي في الوقاية والعلاج النفسي. مشاكل صحية.

الكلمات المفتاحية: الاضطراب الفصامي، مرضى الفصام، الأعراض الإيجابية، الأعراض السلبية، العلاج السلوكي المعرفي، المهارات الاجتماعية.