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Perceived Organizational Support and Job Performance: Mediating and Psycholoigical Role of Organizational Citizenship Behavior

Dr. Batani Raghavendra Rao[1], Dr. Prerana Gupta[2], Abhishek Roy[3]

[1]Department of Finance, JAIN (Deemed to-be University), Bangalore, India
[2]Department of Psychitary, Teerthanker Mahaveer University, Moradabad, Uttar Pradesh, India
[3]Department of Allied Health Care, Vivekananda Global University, Jaipur, India

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Abstract

Introduction: The most severe kind of mental disease, schizophrenia is the standard example of a psychotic illness. Approximately 1 in 100 person's worldwide struggle with this issue. A progressive transition away from Psychodynamic therapy and toward biological approaches to treatment has occurred since the creation of the first antipsychotic medications in the 1950s.A global health problem is being created by the aging schizophrenic population and the changing demography. Soon, the proportion of persons with schizophrenia in the world's population who are 55 and older will reach 25% or higher Among those aged 60 and Elders with mental health and substance use issues, schizophrenia ranks third in terms of the most prevalent cause of years lived with a handicap.

Objectives: In this paper we explore the the effects of Psychodynamic therapy in treating Schizophrenia among elder patients.

Methods: A progressive transition away from Psychodynamic therapy and toward biological approaches to treatment has occurred since the creation of the first schizophrenia medications. The effect of older persons with schizophrenia on health care expenses is expected to be larger than other disorders, both physical and mental, resulting in increased patient expenses. Schizophrenia may manifest as incapacitating delusions, extremely disorganized cognition and behavior, and incapacitating hallucinations.

Results: The results of this study suggest that older patients with Schizophrenia who had psychodynamic therapy gradually improved over time.

Conclusions: The current knowledge of schizophrenia in the elderly suggests a different clinical picture from that of younger patients. More research into the neurobiology behind schizophrenia's clinical characteristics and developing of age-appropriate care and therapy are needed to address the disorder's deficiencies in the elderly.

Keywords: Psychodynamic therapy, Schizophrenia, Elderly patients, schizophrenic population

1. Introduction

Schizophrenia is a severe mental illness characterized by perverted perspectives on reality (Gloria et al., 2018). Hallucinations that are incapacitating, delusions, and extremely disorganized cognition and behavior are all potential signs of schizophrenia. Delusions are wild guesses with no basis. The following are examples of when this might be the case: One feels threatened or harassed; one has been the target of threats; It's very skilled or well-known; if someone has fallen in love with them; There will be a catastrophic disaster; etc (Feyaerts et al., 2021). These are the schizophrenia symptoms of delusions.

Experiencing ghostly apparitions or sounds is a typical symptom of hallucinations (Hugdahl et al., 2018). However, for a person with schizophrenia, these events are just as significant and weighty as any other. Despite the prevalence of auditory hallucinations, other senses may be involved as well. Speaking with disorganized Thinking is clear from their illogical speech that there are similar ideas. It's conceivable that inquiries may only get partial responses, which will hinder dialogue. In a typical conversation, it is unusual to utilize word salad,

which is the practice of mixing words with no apparent relationship with one another to create a new meaning (Silva et al., 2021).

Extremely disordered or aberrant motor behavior may take the form of anything from childish babble to uncontrolled anger. Directly related to undirected behavior is the failure to accomplish tasks. Problematic behavior includes odd or inappropriate postures, complete absence of responses, and unneeded or excessive movement. Negative symptoms include impairment or inability to do routine everyday tasks (Shinn et al., 2017). Lacking curiosity in interpersonal care and the use of repetitious words or feelings are some indicators of emotional remoteness. They could also withdraw from friends and family or lose the ability to generally take pleasure in life Strik et al., 2018.

Throughout therapy, changes in symptom kind and intensity, as well as phases of deterioration and improvement, are possible. It's conceivable that certain symptoms may last indefinitely. Schizophrenia seems to strike men more often between the ages of 18 and 30 (Holm et al., 2021). The majority of the time, symptoms don't appear until a woman is in her late twenties. Before the early age of 18, schizophrenia is very rare, but it becomes considerably less prevalent beyond the age of 45. In this paper, we explore the effects of Psychodynamic therapy in treating Schizophrenia among elder patients.

2. Literature Review

The following paragraphs examines the available studies on perceived organizational support (POS), Nucifora et al., 2019 focused on the psychological profile, brain imaging, neuroscience, therapies, and guidelines for defining TRS, to provide neurobiologists with a review of the major results in TRS compared with patients who respond to antipsychotic treatment, also referred to as untreated schizophrenia. Lally et al., 2016 determined the percentage of patients with Treatment-Resistant Schizophrenia (TRS) who respond to clozapine plus electroconvulsive therapy (C + ECT). From 1980 through July 2015, they searched numerous electronic databases. Jung et al., 2015 objective was to determine the pertinent therapist traits that CBTp's early therapeutic alliance predictors should have.

Li et al., 2015 compared the effectiveness of supportive therapy (ST) and cognitive behavioral therapy (CBT) for individuals with schizophrenia in China. The research has the potential to inform future studies with bigger sample sizes that compare the predictive power of psychobiological processes to those of standard clinical indicators (Mason et al., 2017). Jones et al., 2018 established a connection between the individual's distressing emotions and thought processes. The National Institute for Health and Care Excellence (NICE) now suggests CBT as an adjunctive treatment for patients diagnosed with schizophrenia. There is a family of Cochrane CBT reviews for patients with schizophrenia, of which this is one member.

Stępnickiet et al., 2018 explored existing hypotheses about schizophrenia, which involve many neurotransmitter systems, offer innovative notions in schizophrenia and its treatment, mostly involving novel mechanisms of GPCRs signaling, and conclude with some recommendations for future research. Henriksen et al., 2017 measured to aid in this comprehension by presenting a synopsis of the major approaches and findings in schizophrenia genetics from its inception to the present day, as well as by discussing the constraints and obstacles that this area of study faces. Iglay et al., 2017 was to evaluate the differences in time between breast cancer diagnosis and therapy between elderly individuals with and without a history of mental disorder. The study was performed out in response to concerns over the findings of observations, early research, and reports concerning the frequency of therapy failures for Schizophrenic patients brought on by communication mistakes during treatment.

The purpose of this study was to ascertain how nurses communicate therapeutically with patients Siregar et al., 2021. Müller (2018) reviewed the available research on animals and humans that points to inflammation as a key factor in schizophrenia. It has been shown in animal models, and comparable results have been observed in people, that inducing an immunological response during pregnancy or the neonatal period may enhance immune reactivity later in life. Hsieh et al., 2022 employed a serial multiple mediation model including therapy alliance and medication attitude to investigate the connection between insight and medication adherence in people with community-dwelling schizophrenia. Shattock et al., 2018 was to identify the factors that contribute to a

successful therapeutic alliance between schizophrenic patients and their therapists, as well as to evaluate if such an alliance is predictive of therapeutic results.

3. The Various Schizophrenias

Schizophrenia comes in a variety of forms:

Paranoid: This type of schizophrenia affects the majority of those who have it. Possibly onset later in life than other forms. Even if one experiences illusions and/or delusions, one may still be able to converse and/or feel emotions.
Hebephrenic: The symptoms of this type of schizophrenia, often known as "disorganized schizophrenia," typically appear between the ages of 15 and 25. Temporary hallucinations and delusions are common symptoms, as well as disorders in behavior and cognition. Due to their chaotic speaking patterns, the patient could be hard to understand. lack of ability to communicate emotions in looks, speech, and behavior is a hallmark of people with disorganized schizophrenia.
Catatonic: Movement becomes slowed and jerky in the most severe cases of schizophrenia. The patient's activity level may swing wildly between extremes. Perhaps this individual doesn't say much and instead conforms to the norms of society in both speech and behavior.
Undifferentiated: Despite having symptoms in common with paranoid, hebephrenic, and catatonic schizophrenia, this diagnosis may not be easily classified into any one of these subtypes.
Residual: It is possible to diagnose a patient with residual schizophrenia if they have a history of psychosis but are only showing negative symptoms at present.
Simple: A diagnosis of schizophrenia without any other symptoms is extremely unusual. Positive symptoms, such as hallucinations and disorganized thinking, are rarely noticed, whereas negative symptoms, such as slow mobility, poor memory, loss of focus, and poor hygiene, are more noticeable early on and worsen with time.
Cenesthopathic: Symptoms of cenesthopathic schizophrenia include unusual bodily sensations.
Unspecified: The diagnostic criteria have been met, yet the symptoms do not fit into any of the above categories.

3.1 Reasons, Dangers, and Consequences

However, research suggests that schizophrenia might be caused by a combination of genetics, brain chemistry, and environmental factors. Disturbances in the levels of neurotransmitters like Schizophrenia may be influenced by naturally occurring brain chemicals dopamine and glutamate. Nero imaging studies have shown that people with schizophrenia have atypical brain and central nervous systems. Although the significance of these changes is still up for debate, they do provide further evidence that schizophrenia is a neurological condition. It is not known for sure what triggers schizophrenia, but several recognized risk factors exist that seem to have a significant role:

i. The existence of a family history of schizophrenia

ii. A baby's brain development may be impacted by a variety of issues, including hunger and chemical or viral infection during pregnancy or delivery, to name just two.

iii. Using psychoactive or psychotropic drugs while an adolescent or young adult. These drugs alter one's mental state.

If schizophrenia is not adequately controlled, it can have disastrous implications on a person's life. The following issues are related to schizophrenia or could result from it:

- Suicidal conduct, suicidal thoughts, and suicide
- Disorders of mood and anxiety, such as OCD.
- Depressive illness
- misuse of alcohol, drugs, or tobacco products

- unable to attend a meeting or a class
- Money problems and homelessness
- Nonsocial behavior
- Health problems and illnesses
- victimization isolation
- Although uncommon, aggression does occasionally happen.

The risk of symptom recurrence or worsening is lower for individuals who follow their treatment plan, even though there is presently no known approach to Schizophrenia Prevention. Additionally, scientists are optimistic that a deeper comprehension of the etiology of schizophrenia would enable earlier recognition and treatment.

The term "older patients with schizophrenia" encompasses both early-onset and late-onset cases. The "old-old" are those aged 75 and more, while the "young-old" are those aged 55 to 74 and comprise the current population of people with schizophrenia. People with schizophrenia are living longer than they did a generation ago, although their life expectancy lags behind that of the overall population. The death rate among people with schizophrenia is two to three times that of the general population, and it has been steadily rising over the past few decades. In comparison to their healthy peers, people of the same age who have schizophrenia have a higher mortality rate.Older persons with schizophrenia are more likely to get congestive heart failure, chronic lung disease, and hypothyroidism. This is exacerbated by antipsychotic medication and other lifestyle factors including poor diet and smoking. Due to our limited understanding of the mechanisms underlying the rising morbidity and mortality in the elderly with schizophrenia, further research is needed to pinpoint preventable health and socioeconomic determinants0073.

3.2 The Positive and Negative Symptoms of Schizophrenia

The good symptoms of schizophrenia tend to fade away as people become older, while the negative ones tend to become more pronounced. Multiple studies' findings, however, have disproved this idea. Based on an analysis of 18 global cohorts, with patients ranging in age from 15 to 25 years, 77% of those diagnosed with schizophrenia in the International Study of Schizophrenia (ISoS) did not have any significant negative symptoms throughout their illness. In a long-term study of institutionalized elderly people, negative schizophrenia symptoms did not improve considerably over time. Patients of all ages often exhibit the same degree of severity when it comes to the negative symptoms of schizophrenia.

Schizophrenia is characterized by a chronic lack of clarity of thought that severely limits a person's capacity to operate. Functional impairment, which increases rapidly in later life, accounts for over half of the cost of treating schizophrenia. Adults with schizophrenia have been demonstrated to have significant cognitive deficits, especially as they age. These include difficulties with the speed of processing, Administrative Procedures, Attention, Language learning, Visual learning, Mind over matter, Problem-solving, and logical thinking.

Researchers have found that a person's living situation is a strong indicator of how their cognitive deterioration would progress among the elderly with schizophrenia. Until they reach their late 60s and early 70s, community-dwelling patients with schizophrenia do not exhibit any greater cognitive decline than the common population. Schizophrenia patients above the age of 70 may have sudden cognitive decline. People over the age of 65 with schizophrenia are particularly vulnerable to cognitive decline due to long-term hospitalization.

In a large-scale study, schizophrenia patients were assigned to one of four cognitive trajectories of functions throughout the study's duration. There was little to no change in cognitive capacity for 50% of the group, a moderate decline for 40%, and a rapid fall for 10%. Cognitive decline in the general population mirrors that seen in people with stable schizophrenia. In most studies, older people with schizophrenia do not demonstrate cognitive decline with age, leading researchers to conclude that the condition causes premature aging.

Preserving and improving cognitive function in elderly people with schizophrenia has significant individual and societal benefits.

3.3 Pharmacologic therapy

The elderly have a higher incidence of adverse responses to antipsychotics than younger generations. Both pharmacokinetic changes that cause antipsychotic drug sensibility weight to rise and half-life to decrease with age and psychodynamic changes that reduce the total amount of dopamine and D2 receptor-containing neurons in the brain contribute to this phenomenon. In elderly patients with schizophrenia, extrapyramidal symptoms are associated with reduced occupancies of D2 receptors. Antipsychotics are associated with an increased risk of Parkinson's disease, tardive dyskinesia falls, and metabolic syndrome in the elderly. These adverse consequences may have a devastating effect on the cognitive and behavioral functioning of elderly adults with schizophrenia. Even though there is a dearth of data and some challenges connected with using antipsychotics, they are effective in controlling psychotic symptoms in older people with schizophrenia. Due to the potential for major adverse effects, antipsychotic medicines should be suggested with caution and only at the smallest effective dosage. A longitudinal PET study found that more than 80% of people with stable late-life schizoaffective disorder could securely reduce their antipsychotic dose.11 Inhibiting D2/3 receptors improved clinical symptoms, lowered hyperprolactinemia, and reduced side effects. D2 receptor accessibility in the striatum was found to improve when antipsychotic doses were reduced by as much as 40%, according to a separate study. This enhancement allows D2 receptors in the striatum to contribute more significantly to cognitive function and may be a target of interventions to improve cognitive ability in older adults with schizophrenia. A person with schizophrenia will likely require lifelong treatment. If symptoms are treated early, before serious complications develop, the prognosis may improve.

3.4 Psychosocial Treatment Alternatives

Both pharmacologic and no pharmacologic therapy is effective in the treatment of psychosis. Cognitive remediation is a behavioral intervention aimed at addressing cognitive deficits through the practice of tasks repeatedly and/or the acquisition of new techniques. Even though cognitive remediation is most effective for those in the pre-symptomatic and early-symptomatic stages of schizophrenia, existing programs might be adapted to match the cognitive demands of elderly people with schizophrenia. Cognitive behavioral treatment is another common non-pharmacologic technique for assisting elder people with schizophrenia with their general mood, social relationships, and positive and negative symptoms. Physical activity programs have been demonstrated to delay the decline of cognitive abilities and ADLs in this population, while Therapy for social skills has been utilized to tackle problems with social communication. Potentially more people in need of these psychosocial treatments could be reached if they were delivered with the help of portable gadgets. Multiple factors contribute to senior psychosis. Both pharmaceutical and non-pharmaceutical methods for treating these symptoms in patients with schizophrenia and neurodegenerative disorders are discussed in this article. Treatment of psychotic symptoms with antipsychotic medication has been the gold standard for many years. It is well-established that atypical antipsychotics are superior to conventional antipsychotics for the treatment of older patients because they provide less of a threat of side effects, and this holds for both chronic and late-onset forms of the disease. There have been growing concerns about their usefulness in treating Psychopathic dementia in recent years. It has highlighted the need to adopt and develop non-pharmacological treatments, even while the debate continues about the necessity of a complete prohibition on their use. Psychosis manifests itself in distorted perceptions of reality, the formation of false beliefs, and the creation of incoherent speech and behavior patterns. Delusions and hallucinations are hallmarks of psychosis, a dangerous mental disease often utilized as a stand-in in professional settings. In the elderly, psychotic symptoms can be caused by a wide range of medical conditions. Symptoms and their manifestations in the clinic are often specific to the ailment being treated. Sudden onset psychosis can be caused by delirium brought on by disease, alcohol, or drug use. Prolonged psychotic symptoms may originate from caused by a neurodegenerative condition like vascular dementia, Alzheimer's disease with Lewy bodies, or Parkinson's, or an elementary psychotic disorder like schizophrenia or bipolar disorder.

4. Result and discussion

Fifty patients with schizophrenia participated in the clinical study. According to Table 1, the majority of patients (90%) were between the ages of 60 and 65. 44 percent of the patients were single, 34 percent were married, and the other patients were neither widowed nor divorced. According to Table 2, 52% of patients did not know their ailment, compared to 48% of patients who were aware of it.

Table 1: Patients' Sociodemographics and Preferences

Parameter	Percentage	No. of Patients
Education Level		
Masters	4%	2
Graduation	12%	6
Middle	8%	4
Illiterate	32%	16
Intermediate	10%	5
Secondary	18%	9
Primary	16%	8
Age Range (years)		
71 - 75	0%	0
81 - 85	2%	1
66 - 70	6%	3
76 - 80	2%	1
60 - 65	90%	45
Marital Status		
Unmarried	44%	22
Married	34%	17
Widowed	4%	2
Divorced	18%	9

Table 2: Understanding of the Disease

Insight	Percentage	No. of Patients
Absent	52%	26
Present	48%	24

According to Figure 1 and Table 3, 28% of patients' current hospitalizations lasted up to six months. 20% of the patients had been in hospitals for the previous five to ten years after that.

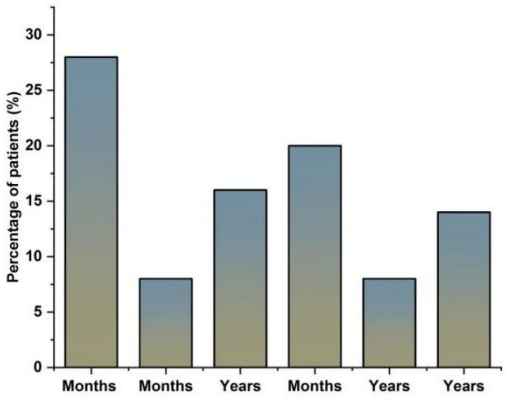

Figure 1: Duration of Current Hospitalization of Patients (n=50)

Table 3: Patients' current hospital stay duration

Duration	Percentage of patients (%)
Months	28
Months	8
Years	16
Months	20
Years	8
Years	14

Figure 2 and Table 4 show that 18% of patients had a history of psychiatric illness spanning six to ten years. 12% of the patients in this category were men, and 6% were women. Another 18% of Patients' Past Mental Health Conditions disease dates back 26 to 30 years, however, in this group, males (14%) outnumbered girls (4%), who were more prevalent.

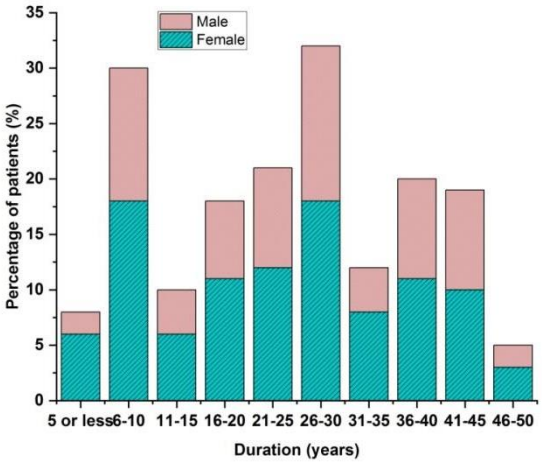

Figure 2: Patients' Past Psychiatric Conditions

Table 4: Previous psychiatric illnesses of the patients

Duration (years)	Percentage of patients (%)	
	Female	Male
5 or less	6	2
6-10	18	12
11-15	6	4
16-20	11	7
21-25	12	9
26-30	18	14
31-35	8	4

36-40	11	9
41-45	10	9
46-50	3	2

Figure 3 and Table 5 indicate that comorbid illnesses were present in 56% of patients. The majority of patients' antipsychotic medicines (50%) were exclusively atypical antipsychotics.

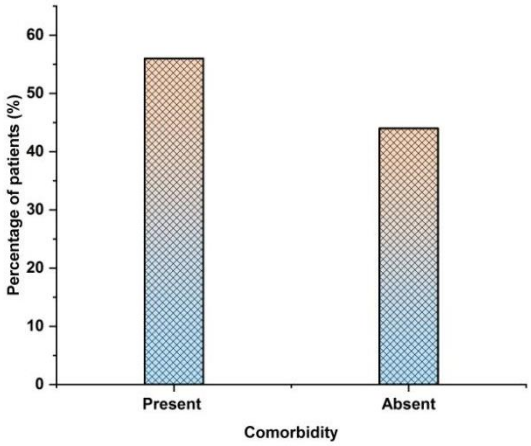

Table 5: Prevalence of Comorbidity in Patients

Comorbidity	**Percentage of patients (%)**
Present	56
Absent	44

Figure 4 and Table 6 show that 22% of patients received both typical and atypical antipsychotics, 14% received only typical antipsychotics, and 14% received no antipsychotic medication at all.

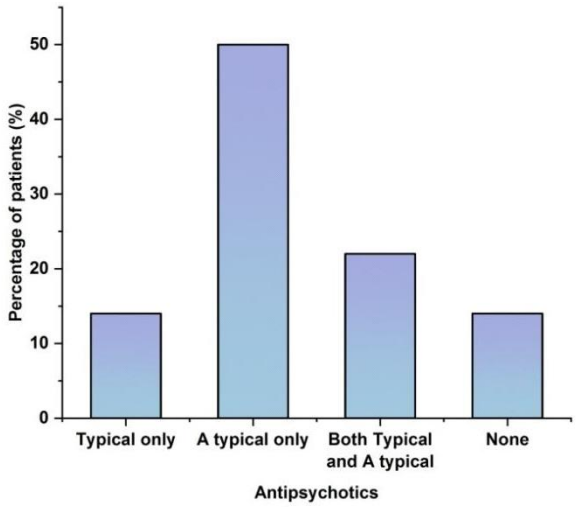

Figure 4: Antipsychotics Used in Current Therapy

Table 6: Currently Administered Antipsychotics

Antipsychotics	Percentage of patients (%)
Typical only	14
A typical only	50
Both Typical and Atypical	22
None	14

One common misconception about schizophrenia is that it only affects young people. However, research shows that the condition can present itself both early in life and later in life, after the age of 40. Patients who were above 40 when they were first diagnosed with schizophrenia were included in the current study, along with individuals whose psychosis manifested earlier in life but who are now elderly. The elderly schizophrenia patients of dual psychiatric centers were used as a sample, and their experiences were analyzed from multiple angles. Individuals at both mental hospitals were over the age of 65, and it was discovered that schizophrenia was the most common psychiatric disorder for which these individuals were admitted. Nine in ten patients admitted are between the ages of 60 and 65, while only 4% are older than 70 years.

The majority of the patients analyzed were male (74%). In contrast to the majority of female patients who were married, the majority of male patients were single. Most patients in the study (32% overall) were found to have low literacy levels. An individual's capacity for self-care and awareness of their condition is greatly influenced by their level of education. Patients treated for 5-10 years made up the largest group, at 28%, followed by those admitted for 1-6 months.

The majority of patients (80%) did not report having a history of mental illness in their family. Figure 2 shows that 64% of patients had previously had inpatient treatment for mental illness. Patients' medication was mostly antipsychotics (86%). As the first-line medicines for the treatment of schizophrenia, atypical antipsychotics are being used by the vast majority of patients (50%) today (figure 4). More than half of the patients (56%) were diagnosed with more than one ailment, according to the research.

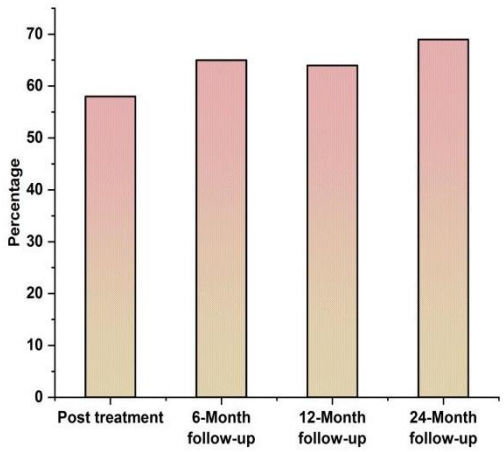

Figure 5: Response Rates to Psychodynamic Therapy in Schizophrenia Patients

Table 7: Rates of Improvement after Psychodynamic Treatment for Schizophrenia

Duration	Percentage (%)
Post-treatment	58

6-Month follow-up	65
12-Month follow-up	64
24-Month follow-up	69

Figure 5 and Table 7 show the percentage of older adults with schizophrenia who respond well to psychodynamic therapy.

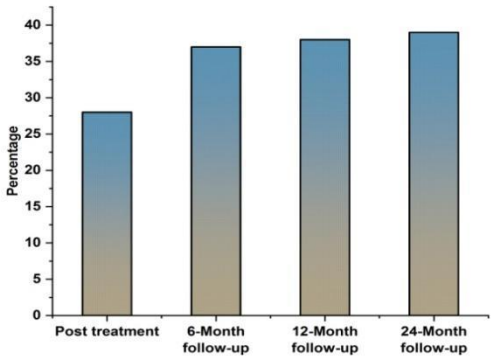

Figure 6: Psychodynamic Therapy Remission Rates in Schizophrenia Patients

Table 8: Recovery from Schizophrenia with Psychodynamic Treatment

Duration	**Percentage (%)**
Post-treatment	28
6-Month follow-up	37
12-Month follow-up	38
24-Month follow-up	39

Remission Rates of Psychodynamic Therapy for Patients with Schizophrenia are shown in Figure 6 and Table 8. As a result, response and remission rates appear to be rather constant under the present conditions of treatment. The results of this study suggest that older patients with Schizophrenia who had psychodynamic therapy gradually improved over time.

5. Conclusion and Implications

Schizophrenia is one of the most prevalent mental illnesses seen in elder adults. There are opportunities for research because of the major gaps in our knowledge of schizophrenia in the elderly. Understanding the neuroscience behind the clinical variability of early-onset schizophrenia may help with therapy selection, diagnosis, and the creation of innovative therapies. More study is needed to determine what triggers late-onset schizophrenia, and why females are disproportionately affected. Finally, research into the biological processes that contribute to cognitive impairment in schizophrenia and the development of drugs to treat cognitive deficits in the elderly should both be given high priority. Current knowledge of schizophrenia in the elderly suggests a different clinical picture from that of younger patients. More research into the neurobiology behind schizophrenia's clinical characteristics and the development of age-appropriate care and therapy are needed to address the disorder's deficiencies in the elderly.

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