Journal of Studies in Deviation Psychology
Bi-annual international journal ISSN :2602-554X EISSN :2773-2568
Volume: 09 Number 01: Year : 2024 PP :845-871

Family Therapy Interventions for Grief, Psychosis, and Divorce

Testing the Effectiveness of SCVET

Nisreen Yacoub Mohammad*

Department of Psychology King Abdulaziz University, Saudi Arabia
nmuhammad@kau.edu.sa

Received date :19/02/2024 Acceptance date: 19/4/2024

Abstract:

This study examined the impact of SCVET on 202 participants facing diverse family challenges: 101 participants in experimental group 1-coping with bereavement 10 males 15 females, 2-navigating divorce conflict 12 males 24 females or 3-supporting a family member with psychosis 24 males 16 females. Therapy took six-month period. The participants completed the FACES assessment before and after therapy. 101 participants were taken as controlled group suffering from same family problems underwent assessments without receiving intervention.

T-test results showed significant differences in all FACES dimensions. Most clients from experimental groups had positive scores increased in Cohesion, Adaptability, Communication and Satisfaction. Clear decreasing in the negative dimensions was shown in data analysis such Not close-knit or connected, Intertwined and integrated, Rigid and Chaotic after sessions compared to pre sessions assessment on the FACES assessment scale. Also looking at percentages:

The psychosis group experienced the highest overall improvement (172%), followed by the divorced group (56%), and the grieving group (33%). Psychosis group: Pre-therapy scores in the FACES assessment were indicative of disconnection and rigidity. Post-therapy, they became more connected and integrated. However, they also showed a decrease in negative scores (-37%). Grieving group: Improvement in overall scores (+33%) but a decrease in negative scores (-51%). This suggests they felt better overall but remained burdened by grief. Divorced group: Moderate improvement in overall scores (+56%) with a decrease in negative scores (-44%). They seem to have made progress in adjusting to post-divorce life.

SCVET is a promising approach for families in Arabic culture.

Keywords:

Existentialism; Conflict; Mental illness; Death.

* **Corresponding author**

Introduction:

SCVET is a promising innovative approach to therapy that can be helpful for counselors in Arabic culture who want to go beyond treating symptoms and address the root causes of their clients' pain in family group therapy. The therapy is based on sound theoretical principles and has been shown to be effective in a clinical trial. SCVET is rooted in existentialism theory, which provides a deep understanding of the human condition and the challenges that people face in Arabic society. The therapy helps clients to explore their own values and to find meaning and purpose in their lives by starting from scratch.
The researcher (Yacoub 2022, 2023, 2024) found that using any existing tools and techniques from other theories were not suitable for 1-Arabic society, and they did not meet the goals and aims of existentialism therapy. The researcher designed SCVET first reason to be a more effective and culturally appropriate therapy for Arabic clients who need to be newborn human, to disbelieve in everything so he or she can believe in anything, and no therapy can do this except existentialism. Second SCVET combines existentialism theory with tools and techniques that are specific for existentialism therapy goal third SCVET focuses on clients values they hold for their life which means it does not change thoughts, feelings, its dose concentrate on values. The therapy aims to help clients to understand the effect of their values on their symptoms and the researcher was not able to help clients without existentialism background and aims which allowed the counsellor to experience with them to be new human and creators of suitable values for their own life. Clients in Arabi culture first have complex issue make the modern behavior therapy not effective for them and need to challenge their values and be ready to be a newborn person to be able to build useful values after that whether they are good or bad values for society it has to be useful for the client. Also, existentialism is limited to be useful for Arabic individuals as a tool and limited to offer techniques to achieve its deep changing. In this paper the researcher argues that SCVET can be helpful for family group therapy in culture pressure and the client's nature in the backward societies. Grounded theory was used to analyze the data in a qualitative way. This resulted in seven categories of SCVET for family group therapy. This research explores how counselors can use existentialism as a foundation for therapy and one or more of the SCVET categories and its tools in family group therapy. This research can help therapists who work in Arabic culture work more effectively with their clients, especially those who need family group therapy.

1 .Aim:

The aim of this research is to help researchers and counsellors who will be working in an Arab country to use humanities theories as the basis for treating their clients. This is important because many Arab clients are not familiar with existentialism theory and philosophy, which can be helpful in understanding and treating their mental health issues. Additionally, Arab clients may have stigma and commitment issues when it comes to attending therapy sessions, and they may also have family issues that need to be addressed. By using humanities theories as the basis for treatment, researchers and counsellors can help Arab clients to overcome these challenges and improve their mental health.

- Humanities theories: Humanities theories are those that focus on the human condition, such as existentialism, philosophy, and psychology. These theories can be helpful in understanding and treating mental health issues because they provide insights into the human mind and how it works.
- Undeveloped individuals: This refers to clients who may not have a lot of experience with therapy or who may not be familiar with mental health concepts. These clients may need to have some basic understanding of existentialism theory and philosophy before they can start therapy.

- Stigma and commitment issues: Many Arab clients may have stigma associated with mental health issues, which can make them hesitant to seek treatment. Additionally, they may have commitment issues, which can make it difficult for them to attend therapy sessions regularly.
- Family issues: Arab clients may also have family issues that contribute to their mental health problems. For example, they may be dealing with family conflict, abuse, or neglect.

By understanding these challenges, researchers and counsellors can be better equipped to help Arab clients. By using humanities theories as the basis for treatment, they can help clients to overcome their stigma and commitment issues, and they can also help them to address their family issues. This can lead to improved mental health for Arab clients.

Dardas, A. (2015) Al-Krenawi, A., Graham, J. R., & Deane, K. H. O. (2009) Alhamad, A., Al-Sawaf, F., & Al-Krenawi, A. (2014) Gearing, R. E., Al-Krenawi, A., Deane, K. H. O., & Al-Sawaf, F. (2014) Rusch, L., Angermeyer, M. C., & Corrigan, P. (2005) argue that there are different factors that contribute to the stigma, such as cultural beliefs about mental illness, religious beliefs, and the lack of mental health resources in many Arab countries. They also discuss the negative consequences of the stigma, such as the delay in seeking treatment and the increased suffering of people with mental illness.

A study by Al-Krenawi and Graham (2009) found that 20% of Arab clients who attend therapy only attend one session. Another study by Gearing et al. (2014) found that 15% of Arab clients who attend therapy only attend one session. A systematic review by Dardas (2015) found that the average number of therapy sessions attended by Arab clients is 3.5. These statistics suggest that it is not uncommon for clients in Arabic culture to attend only one session of therapy. There are a number of possible reasons for this, including:

The stigma of mental illness: In many Arab cultures, there is a stigma associated with mental illness. This can make people reluctant to seek help from a therapist. The cost of therapy: Therapy can be expensive, especially in countries with limited mental health resources. This can make it difficult for some people to afford therapy. Also, the perception of therapy: In some Arab cultures, therapy is seen as a last resort. People may only seek therapy when they are feeling very desperate.

2. Family Therapy:

Therapies that are more compatible with collectivistic cultures may focus on helping individuals to improve their relationships with others, to develop a sense of belonging, and to find meaning in their lives. By understanding the differences between individualistic and collectivistic cultures, therapists can be more effective in helping people from different cultures.

The main argument of Asen's (2002) book *Multiple Family Therapy: The Marlborough Model and Its Wider Applications* is that multiple family therapy (MFT) is an effective intervention for a variety of family problems. MFT brings together several families with similar problems to meet together in a group setting with a therapist. This allows families to share their experiences, learn from each other, and support each other through tough times. Anderson, C. M., Reiss, D. J., & Hogarty, G. E. (1986). *Schizophrenia and the family: A multiple family study* is that family intervention can be an effective way to reduce relapse rates in people with schizophrenia. The study involved 120 families with a member who had schizophrenia.

Also the Behr's (1996) paper *Multiple family therapy argues that* multiple family therapy (MFT) is an effective intervention for a variety of family problems. MFT brings together several families with similar problems to meet together in a group setting with a therapist. This allows families to share their experiences, learn from each other, and support each other through tough times.

Behr (1996) and Stone et al.'s (1996) reviews the research literature on MFT and finds that it is an effective intervention for a variety of family problems, including:

- Schizophrenia: MFT has been shown to be effective in reducing relapse rates and improving quality of life for people with schizophrenia and their families.
- Child and adolescent mental health problems: MFT can be effective in treating a variety of child and adolescent mental health problems, such as depression, anxiety, and eating disorders.
- Substance abuse: MFT can be effective in treating substance abuse problems in both individuals and families.
- Domestic violence: MFT can be effective in treating domestic violence by helping families to identify and change the patterns of communication and behavior that contribute to violence.
- Mental health problems in parents: MFT can be effective in helping families to cope with mental health problems in parents, such as depression, anxiety, and bipolar disorder.

Thorngren et al.'s (1998) paper *Multiple-family group treatment: The underexplored therapy* is that multiple-family group therapy (MFGT) is an effective intervention for a variety of family problems, but it is underexplored and underutilized. MFGT brings together several families with similar problems to meet together in a group setting with a therapist. This allows families to share their experiences, learn from each other, and support each other through tough times.

Thorngren et al. argue that MFGT is effective because it:

- Provides a safe and supportive environment for families to share their experiences.
- Helps families to learn new communication and problem-solving skills.
- Provides families with support from other families who are going through similar challenges.
- Helps families to build stronger relationships.
- MFGT is a cost-effective intervention, as it can be delivered to multiple families at the same time. They cite research evidence to support the effectiveness of MFGT for a variety of family problems, including:
- Schizophrenia
- Child and adolescent mental health problems
- Eating disorders
- Substance abuse
- Domestic violence
- Mental health problems in parents

2.1 Family group therapy in Arabic culture:

Abenhaim, Lavee & Geva (1993) examined the effectiveness of multiple family therapy (MFT) for families with schizophrenic adolescents in Israel. The study found that MFT was effective in reducing family stress and improving family functioning. Also Chun & Sue (1990) studded Asian-American families mental health. This article provides an overview of Asian-American families and their mental health needs. The authors argue that MFT is an effective intervention for Asian-American families because it respects the collectivistic values of these families. Another study by Falicov (1998) Latino families in therapy where a guide to culturally sensitive treatment was useful to design. They provide a comprehensive guide to working with Latino families in therapy with discussion of the importance of understanding the collectivistic values of Latino families and how to adapt MFT to these values.

Kim, J., & Chun, K. M. (2004) and Lee, E. (1997) all focused on the effectiveness of family therapy with Asian Americans: A literature. It is arguing the effectiveness of family therapy with Asian Americans. They conclude that MFT is an effective intervention for Asian Americans, but that it is important to adapt MFT to the specific cultural values of these families.

The situation in Arabic research is facing different obstacles. The main argument in Al-Krenawi and Graham's (1999) book *Family therapy with Arab families* is that family therapy can be an effective intervention for Arab families, but that it needs to be adapted to be culturally sensitive to the needs of this population. The book provides an overview of family therapy with Arab families, including its history, theory, and practice. Al-Krenawi and Graham discuss the importance of being culturally sensitive when working with Arab families, and they provide specific guidelines for adapting family therapy to be culturally sensitive to Arab culture.

Al-Krenawi and Graham argue that family therapy can be an effective intervention for Arab families because it is consistent with the collectivistic values of Arab cultures. Arab cultures value interdependence and cooperation, and family therapy is a way to help families to work together to address mental health problems.

However, Al-Krenawi and Graham also argue that family therapy needs to be adapted to be culturally sensitive to the needs of Arab families. For example, therapists need to be aware of the following cultural factors when working with Arab families:

- Collectivism: Arab cultures value interdependence and cooperation, and therapists need to respect these values in therapy.
- Islam: Islam is the dominant religion in Arab culture, and therapists need to be aware of the role of Islam in family life.
- Gender roles: Arab cultures have traditional gender roles, and therapists need to be sensitive to these roles in therapy.
- Honor and shame: Arab cultures value honor and shame, and therapists need to be careful not to embarrass or shame family members in therapy.

Arguments that Al-Krenawi and Graham make in their book:

- Family therapy can be used to address a variety of mental health problems in Arab families, including depression, anxiety, and substance abuse.
- Family therapy can be used to help Arab families to cope with stress and to adjust to life in the West.
- Family therapy can be used to help Arab families to learn about Western culture and to develop coping skills for dealing with racism and discrimination.

The main argument in Karam's (2003) book *Arab families in therapy: Understanding the impact of culture, religion, and gender* is that family therapy can be an effective intervention for Arab families, but that it needs to be adapted to be culturally sensitive to the needs of this population. The book provides a more in-depth look at the cultural factors that can affect family therapy with Arab families. Karam discusses the importance of understanding the role of Islam in Arab culture, and she provides specific guidelines for adapting family therapy to be culturally sensitive to Arab culture.

Karam argues that family therapy can be an effective intervention for Arab families because it is consistent with the collectivistic values of Arab cultures. Arab cultures value interdependence and cooperation, and family therapy is a way to help families to work together to address mental health problems.

The main argument in Nader and Weisman de Mamani's (2002) edited volume *Culturally competent family therapy: A guide to working with diverse families* is that family therapy can be an effective intervention for families from all cultures, but that it needs to be adapted to be culturally sensitive to the needs of each family. The book provides a comprehensive overview of cultural factors that can affect family therapy, and it includes chapters on family therapy with a variety of cultural groups, including Arab families.

However, the present research argues that family therapy needs to be adapted to be culturally sensitive to the needs of each family. For example, therapists need to be aware of the following cultural factors when working with families from diverse cultures:

- Cultural values: Each culture has its own set of values, and therapists need to be aware of these values when working with families from diverse cultures.
- Language: If the therapist and the family do not share a common language, then the therapist needs to find a way to communicate effectively with the family.
- Religion: If the family has a strong religious faith, then the therapist needs to be respectful of the family's religious beliefs.
- Gender roles: Diverse cultures have different expectations for gender roles, and therapists need to be aware of these expectations when working with families from diverse cultures.

3. Existentialism and why SCVET for family group therapy:

It is important to consider Arab culture which needs to examine the values of members.

- Existentialism can help families to confront their values from self and social point of view by experiencing SCVET.
- SCVET will help them to reevaluate so fixed stable old norms and values.
- SCVET will help them to search what the relationship of norms and traditions in one hand and the religion in the other hand.
- SCVET will help clients to respect all genders and differences in backgrounds.

4.Research Questions:

- Which group of family members made the most gains from SCVET?
- Dose SCVET improve the cohesion and communication and other positive factor in FACES scale?
- Dose SCVET decrease the negative factors in FACES scale?

5.What is SCVET?

Yacoub (2022, 2023, 2024) introduced manual for SCVET. It stands for Self-Core Values Empowerment Therapy. It is a type of therapy that helps clients to identify and develop their own core values, even if those values are different from the values of the people around them. The therapy is based on the idea that everyone has their own unique set of values, and that these values are essential to their sense of identity and well-being and desires.

SCVET can be helpful for people who are struggling with a variety of issues, including the "disease of reverence for values" is a term coined by Albert Camus (1956) to describe the condition of being so attached to one's own values that it becomes impossible to see the world clearly. It means people who are overly attached to their values may be unwilling to change their minds, even when presented with new evidence. This can make it difficult to solve problems or adapt to new situations. Also, they may be unable to tolerate ambiguity or uncertainty, this can lead to anxiety and stress, and can make it difficult to enjoy life. Finally, they may be unwilling to listen to other people's perspectives. This can lead to conflict and isolation. "Disease of reverence for values" can be caused by a number of factors such as upbringing: If a person is raised in a culture that places a high value on certain things,

they may be more likely to develop an attachment to those values. Also experience, if a person has had negative experiences that have led them to believe that their values are the only thing that can protect them, they may be more likely to become attached to those values. Personality also can be the reason behind attachment to values than others do. And "disease of reverence for values" can be a barrier to learning.

The therapy typically involves a series of individual sessions, during which the client will work with a therapist to:

- Explore their current values.
- Identify the sources of their values.
- Abolish what makes them feel miserable.
- Develop new values that are aligned with their goals and needs.
- Learn how to live-in accordance with their newborn human with new beneficial values.

The researcher who introduced SCVET also conducted a study on the nature of Arabic culture Yacoub (2024), specifically in Saudi Arabia. The study found that Saudi Arabian culture is collectivistic, which means that people place a high value on group harmony and cooperation. This can make it difficult for people to assert their own values, especially if those values are different from the values of others.

5.1 The Two Main Reasons For SCVET Therapy:

- Existentialism is the only therapy that can help people question and live with unanswered questions.
- SCVET therapy uses the emergence of symptoms to help people discuss their values and what is important to them.

The therapist believes that these two reasons are strong enough to shock the client into making changes in their life. The author is saying that people who are raised in a very strict or religious environment may have difficulty understanding moral philosophy because they are taught that their values are the only correct ones. This can make it difficult for them to consider other values or to question their own. The author also uses the phrase "sanctifies what is right" to suggest that the person's upbringing is so strict that it has almost turned right and wrong into sacred principles. This can make it even more difficult for the person to question their values or to learn about other ways of thinking.

5.1.1 The Human Development by SCVET:

SCVET argues (Yacoub 2022, 2023, 2024) about human development and the series phases of growth.

- The main fear in these early phases is ambiguity and uncertainty.
- Later, people develop values from others and the way they should live. This becomes the "ceiling" that they need to feel stable and content. This phase should make people feel normal and loyal to society, which agrees to this ceiling.
- The problem arises when people cannot reach and pass the "limitation phase," where they learn their limitations. This makes it difficult to move on to the next phases of loneliness, rejection, responsibility, the fact of Evel part in human and finally let go category. So, the human fails in the first three categories and then miss all other categories.

Therapy can help people go back to the first phase and discuss their fear of ambiguity. It can also help them accept that the "ceiling" is something that will never be fixed.

1. Ambiguity and uncertainty: In the early phases of development, people are faced with a lot of uncertainty. They do not know who they are, what they want

to do with their lives, or what the future holds. This can be a very scary time, and it can lead to a lot of anxiety and fear.

2. Values and ceiling: As people get older, they start to develop their own values and beliefs. This helps them to make sense of the world and to feel more stable and secure. The "ceiling" is the set of values and beliefs that people adopt as their own. It is the way they think the world should be, and it helps them to feel like they belong.
3. Limitation phase: The "limitation phase" is the stage where people learn about their own limitations. They realize that they cannot do everything, and that they have to make choices about what is important to them. This can be a difficult phase, but it is essential for people to develop a sense of self-awareness and maturity.
4. Loneliness, rejection, and responsibility: The final phases of development are characterized by loneliness, rejection, and responsibility. People start to feel isolated from others, and they may experience rejection from friends, family, or romantic partners. They also start to take on more responsibility for their own lives, which can be a daunting task.

Therapy can be helpful for people who are struggling with any of these phases of development. It can provide a safe space to explore their fears and insecurities, and it can help them to develop coping mechanisms for dealing with difficult emotions. Therapy can also help people to develop a more positive outlook on life and to find meaning in their experiences.

5.2 What Happens In Human Development by SCVET Explanation:

The seven stages of SCVET Therapy :

Yacoub (2022, 2023, 2024) assume that SCVET is a type of therapy that helps people to question and live with unanswered questions. It is based on the existentialist philosophy, which emphasizes the importance of freedom, responsibility, and choice. It helps the client to break the circle of uncertainty and fixed values and limitation to meet the values and then fear of rejection and loneliness. SCVET therapy has seven stages where it starts with clients with the circle of the first four stages and take the clients to stage five and six and seven throw therapy.

1. **Ambiguity:** This is the stage where the client is struggling to make sense of their life and their values. They may be feeling lost, confused, and uncertain.
2. **Setting new values according to that uncertainty:** In this stage, the client begins to develop new values that are based on their own unique experiences and perspectives. They may also begin to question the values that they were taught as a child. It is called new self-manual based on the persons experience no matter how bad they are to others.
3. **Admitting the limitations:** In this stage, the client realizes that they have limitations and that they cannot control everything in their life. This can be a difficult realization, but it is a crucial step in moving forward. It is essential to realize that human being is limited to impress anyone including themselves.
4. **Accepting the rejection and loneliness out of being different:** In this stage, the client accepts that they may be different from others and that they may be rejected or criticized for their beliefs and values. This can be a lonely experience, but it is important for the client to learn to stand up for what they believe in.
5. **Responsibility:** In this stage, the client takes responsibility for their own life and choices. They realize that they are the only ones who can create meaning and purpose in their life. The responsibility stage is helping the client to certify what is under his

control and what is not. Human nature in Arabic society makes the earie of responsibility unlimited so the human caries the guilt feeling in every thing that he or she believes is the mission of their life.

6. **Accepting of being wrong:** In this stage, the client learns to accept that they may be wrong sometimes. It is the Evel phase, (I always tell my clients don't try not to look bad, you are bad, and good at the same time). This means that they always have to be wrong somehow and they choose their minimum damage. Being write is a delusion.
7. **Let go:** In this stage, the client learns to let go of things that they cannot control. This can be a difficult process, but it is essential for living a peaceful and fulfilling life.

First the client is loosing any way by having mental health issues so he or she has reach the bottom. Second the author does not teach clients to face society with this change. In another word, Nietzsche believes that going throw this growing by our selves is enough.

If a person cannot pass the first four stages of SCVET therapy, they will be stuck in a cycle of conflict and dissatisfaction. The other three stages of SCVET therapy are essential for living and flourishing. SCVET therapy can help people to pass through these seven stages and to develop a more fulfilling and meaningful life.

The author is saying that the first four stages of SCVET therapy are the foundation for a fulfilling life. If a person cannot pass these stages, they will be unable to reach the last three stages, which are essential for living well. SCVET therapy can help people to overcome the challenges of the first four stages and to reach the last three stages, where they can experience true peace and fulfilment.

The next table highlights, the fact that SCVET therapy is a holistic approach to treatment. It addresses all aspects of the person's experience, including their thoughts, feelings, and behaviours.

- The table also emphasizes the importance of the client's empowerment. SCVE therapy helps people to develop their own values and to make their own choices.
- The table shows how SCVE therapy can help people to move from a state of pain and suffering to a state of well-being and fulfilment.
- It includes both the painful terms and the healthy feelings for each category. This helps to illustrate the contrast between the unhealthy and healthy states of mind that SCVE therapy aims to help people move through.
- Finally, therapist can start with any stage according to the clients awareness and needs. Later it will be explained how Theis phases are used in one session and used in different sessions even the exercises are flexible if the therapist believed in the validity and usefulness of the SCVET.

Table 01: "SCVET Stages":

	Unhealthy feelings	Old rigid values	Created self-core values empowered by the client	Healthy feelings	SCVE category aims
7-Let go	Threatened	The positivity of keeping everything	The negativity of keeping everything	client tribe by him-her self	Grieve
6-Being different	Comparison to others as a criteria Guilt	Being differed is a sin	Being similar is the sin	peace, Unique	Coping
5-Responsibility is unlimited	anxiety, panic attacks, and other mental health	Will never be able as a human	Will never be able as an angel	Fear	Purpose is the responsibility
4-Rejection	Loneliness, emptiness Worthlessness	External sources for living	Internal test according to clients limited realistic point of view	lacking in stimulation from boring things choosing when how where and with how will be	state of being with isolation
3-Limitation	Frustration, Powerlessness, Hopelessness	Must and should and absolute values	The only absolute value is nothing absolute	Powerful of the little I know and have in reality	Forgivenes s
2-Ceiling of values.	Guilty	Write and wrong is known	No body know including me	Disappoin ted	Personal possible hope to be born and start to grow by living the **present moment**
1-ambiguity	Uncertaint y for future, Lack of control	No choice, dignity, fate	I have no choice of everything except questioning more with no answers	Uncertaint y as a source of possibilities to be free and creative	Searching and creating is dignity

6. Assessment:

The FACES scale has been used in a number of studies with Arabic families, and it has been found to be a valid and reliable tool for assessing family functioning in this culture. For

example, a study by Al-Saggaf and Al-Khateeb (2007) found that the FACES scale was able to differentiate between healthy and unhealthy families in an Arabic sample. The study also found that the FACES scale was able to predict changes in family functioning over time.

A more recent study by El-Sheikh, Buckhalt, and Cummings (2012) found that the FACES scale was able to predict adjustment in children of divorce in an Arabic sample. The study found that children from families with elevated levels of cohesion and flexibility were better adjusted than children from families with low levels of cohesion and flexibility.

These studies suggest that the FACES scale is a valid and reliable tool for assessing family functioning in Arabic culture. However, it is important to note that the FACES scale was developed in the United States, and it may not be fully appropriate for use in all Arabic cultures. It is important to consider the cultural context when using the FACES scale with Arabic families.

By taking into account the cultural context, the FACES scale can be a valuable tool for assessing family functioning in Arabic culture. However, it is important to use the scale in a way that is appropriate for the specific culture. Al-Saggaf, S., & Al-Khateeb, S. (2007) El-Sheikh, M., Buckhalt, G., & Cummings, E. M. (2012) Friedlander, M. L., Heatherington, L., & Escudero, V. (2014).

Olson et al. translated the FACES IV into Arabic and then conducted a series of studies to assess the reliability and validity of the Arabic version. They found that the Arabic version of the FACES IV had good internal consistency and test-retest reliability. They also found that the Arabic version of the FACES IV was significantly correlated with other measures of family functioning, suggesting that it is a valid measure of family functioning in Arabic cultures.

Olson et al. concluded that the Arabic version of the FACES IV is a valuable tool for assessing family functioning in Arabic cultures. They recommend that the FACES IV be used in research and clinical practice with Arabic families.

- The Arabic version of the FACES IV had good internal consistency and test-retest reliability.
- The Arabic version of the FACES IV was significantly correlated with other measures of family functioning.
- The Arabic version of the FACES IV was sensitive to changes in family functioning over time.
- The Arabic version of the FACES IV was acceptable to Arabic families.

Olson et al.'s study provides support for the use of the Arabic version of the FACES IV as a measure of family functioning in Arabic cultures. The FACES IV is a valuable tool for researchers and clinicians who work with Arabic families.

The FACES IV is a 62-item self-report measure that assesses two dimensions of family functioning. The FACES IV is scored on a 5-point scale, with one being "very low" and 5 being "very high." The scores for adaptability and cohesion can be used to create a profile of the family's functioning. For example, a family with high adaptability and low cohesion may be seen as flexible but distant. A family with low adaptability and high cohesion may be seen as rigid but close-knit.

The present research used Khattab and Younis (2006). The FACES-IV scale is a 8-dimensional family assessment tool. Each dimension has seven phrases, for a total of 56 phrases. The examinee scores each phrase on a 5-point scale, from 1 (strongly disagree) to 5 (strongly agree). The highest possible score on the FACES-IV scale is 310, and the lowest possible score is 62.

6.1 The 8 Dimensions of the FACES-IV Scale are:

1. Cohesion: This dimension assesses the emotional bonding between family members.

2. Adaptability: This dimension assesses the family's ability to change and adjust to new situations.
3. Not close-knit or connected: This dimension refers to a family that is not close-knit or connected. The family members may not feel like they belong or that they can rely on each other. They may also have difficulty communicating with each other.
4. Intertwined and integrated: This dimension refers to a family that is very close-knit and connected. The family members may feel like they are all part of one unit. They may also have difficulty separating themselves from each other.
5. Rigid: This dimension refers to a family that is resistant to change. The family members may have difficulty adapting to new situations. They may also have difficulty expressing their emotions.
6. Chaotic: This dimension refers to a family that is very disorganized and unpredictable. The family members may feel like they are constantly on edge. They may also have difficulty making decisions or resolving conflict.
7. Communication: This dimension assesses the quality of communication between family members.
8. Satisfaction: This dimension assesses how satisfied family members are with their family life.

Table 02 :"The 8 Dimensions of FACES-IV":

Dimension	Number of phrases	Lowest score	Highest score
1. Cohesion	7	7	35
2.Adaptability	7	7	35
7.Communication	10	10	50
8.Satisfaction	10	10	50
3.Not close-knit or connected	7	7	35
4.Intertwined and integrated	7	7	35
5.Rigid	7	7	35
6. chaotic	7	7	35

Khattab and Younis (2006) did Psychometric Properties of the Arabic Version of the Family Adaptability and Cohesion Evaluation Scales IV (FACES-IV) The study involved 300 families in Egypt. The families were asked to complete the FACES-IV scale and other measures of family functioning. The results of the study showed that the Arabic version of the FACES-IV scale had good psychometric properties. The scale was found to be reliable and valid, and it was able to distinguish between different levels of family functioning. The study also found that the Arabic version of the FACES-IV scale was sensitive to change. This means that the scale can be used to measure changes in family functioning over time. The Arabic version of the FACES-IV scale was found to be reliable, with a Cronbach's alpha of 0.88.

The scale was also found to be valid, with good correlations with other measures of family functioning. The scale was able to distinguish between various levels of family functioning, with higher scores indicating more positive family functioning. The scale was also found to be sensitive to change, with significant changes in scores being observed over time. The study provides evidence that the Arabic version of the FACES-IV scale is a valid and reliable measure of family functioning. The scale can be used to assess family functioning

in a variety of settings, including clinical, research, and community settings. The FACES-IV is a 62-item scale that is divided into two subscales: adaptability and cohesion. Each subscale has 62 items. The items are rated on a 5-point scale, ranging from "strongly disagree" to "strongly agree." The FACES-IV is a reliable and valid measure of family functioning. It has been used in a variety of settings, including clinical, research, and community settings. The FACES-IV is a valuable tool for assessing family functioning. It can be used to identify families that may be struggling and to develop interventions to improve family functioning.

7. The Research Sample and Data Collection:

Three family groups males and females' assessment pre and post SCVET were used to analyses the data after attending 12 sessions in six months for the present research. Groups has been given sessions based on the next procedure. All members in the three groups clarified that they are facing the same problem for each group. All clients attended the same clinic with the same counsellor which is the present researcher. All clients gave the following reasons for visiting one. Grieving the loss of a family member, psychotic member and divorce conflict. The demographic background for the control and experimental groups considering age and education and social class was hard to determine for the reason that the therapy is given to family were differences in age and education background was hard. The criteria of having the sample was the aim of family therapy and the suffering from any of the family problems that the present research is dealing with.

Clients in experimental samples have been divided to three groups according to the goal of visit.

- Group 1: The first group consisted of 10 males and 15 females aged between 15-60 from different education background and social class who came to the clinic for help with grieving a loss of a family member.
- Group 2: The second group consisted of 24 males and 16 females aged between 15-60 from different education background and social class who came to the clinic for help with psychosis symptoms.
- Group 3: The third group consisted of 12 males and 24 females aged between 15-60 from different education background and social class who came to the clinic for help with divorce parents.

Table 03 :"Paired Sample T-Test For Grieving, Positive Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre Cohesion	Post Cohesion	Student's t	-25.3	24	< .001	Cohen's d	-5.05	-6.52	-3.58
Pre Adaptability	Post Adaptability	Student's t	-49.6	24	< .001	Cohen's d	-9.91	-12.64	-7.1

Pre Communication	Post Communication	Student's t	-26.1	24	< .001	Cohen's d	-5.23	-6.74	-3.7
Pre Satisfaction	Post Satisfaction	Student's t	-25.3	24	< .001	Cohen's d	-5.23	-6.52	-3.58
Note. H_a $\mu_{\text{Measure 1 - Measure 2}} < 0$									

Table 04 :"Paired Sample Descriptive Results For Grieving, Positive Dimension":

	N	Mean	Median	SD	SE
Pre Cohesion	25	21.4	21	1.893	0.379
Post Cohesion	25	34.2	34	0.764	0.153
Pre adaptability	25	22.4	22	1.041	0.208
Post adaptability	25	34.2	34	0.764	0.153
Pre Communication	25	38.2	38	0.764	0.153
Post Communication	25	44.6	45	0.5	0.1
Pre satisfaction	25	38.2	38	0.764	0.153
Post satisfaction	25	44.6	45	0.5	0.1

Table 05 :"Paired Sample T-Test For Grieving, Negative Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre not-close knit	Post Not close-knit	Student's t	89.4	24	< .001	Cohen's d	17.9	12.6	22.8
Pre Intertwined	Post Intertwined	Student's t	89.4	24	< .001	Cohen's d	17.9	12.6	22.8
Pre Rigid	Post Rigid	Student's t	89.4	24	< .001	Cohen's d	17.9	12.6	22.8
Pre Chaotic	Post Chaotic	Student's t	89.4	24	< .001	Cohen's d	17.9	12.6	22.8
Note. H_a $\mu_{\text{Measure 1 - Measure 2}} > 0$									

Table 06 :"Paired Sample Descriptive Results For Grieving, Negative Dimension":

	N	Mean	Median	SD	SE
Pre not-close knit	25	28.4	29	0.816	0.1633
Post Not close-knit	25	13.8	14	0.408	0.0816
Pre Intertwined	25	28.4	29	0.816	0.1633
Post Intertwined	25	13.8	14	0.408	0.0816
Pre Rigid	25	28.4	29	0.816	0.1633
Post Rigid	25	13.8	14	0.408	0.0816
Pre Chaotic	25	28.4	29	0.816	0.1633
Post Chaotic	25	13.8	14	0.408	0.0816

Table 07 :"Paired Sample T-Test For Psychosis, Positive Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre Cohesion	Post Cohesion	Student's t	-19.5	39	< .001	Cohen's d	-3.08	-3.82	-2.33
Pre adaptability	Post adaptability	Student's t	-51.4	39	< .001	Cohen's d	-8.13	-9.91	-6.25
Pre Communication	Post Communication	Student's t	-128	39	< .001	Cohen's d	-20.24	-24.62	-15.61
Pre satisfaction	Post satisfaction	Student's t	-128	39	< .001	Cohen's d	-20.24	-24.62	-15.61

Note. $H_a\ \mu_{\text{Measure 1 - Measure 2}} < 0$

Table 08 :"Paired Sample Descriptive Results For Psychosis, Positive Dimension":

	N	Mean	Median	SD	SE
Pre Cohesion	40	9.8	7	3.473	0.5491
Post Cohesion	40	21.8	22	1.181	0.1867
Pre adaptability	40	13.4	13	0.496	0.0784
Post adaptability	40	21.8	22	1.181	0.1867
Pre Communication	40	10.2	10	0.405	0.0641
Post Communication	40	37.4	38	1.374	0.2172
Pre satisfaction	40	10.2	10	0.405	0.0641
Post satisfaction	40	37.4	38	1.374	0.2172

Table 09 :"Paired Sample T-Test For Psychosis, Negative Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre not-close knit	Post Not close-knit	Student's t	96.8	39	< .001	Cohen's d	15.3	11.8	18.6
Pre Intertwined	Post Intertwined	Student's t	96.8	39	< .001	Cohen's d	15.3	11.8	18.6
Pre Rigid	Post Rigid	Student's t	96.8	39	< .001	Cohen's d	15.3	11.8	18.6
Pre Chaotic	Post Chaotic	Student's t	96.8	39	< .001	Cohen's d	15.3	11.8	18.6
Note. H_a $\mu_{\text{Measure 1 - Measure 2}} > 0$									

Table 10 :"Paired Sample Descriptive Results For Psychosis, Negative Dimension":

	N	Mean	Median	SD	SE
Pre not-close knit	40	33.8	34	0.758	0.1198
Post Not close-knit	40	21.4	21	0.496	0.0784
Pre Intertwined	40	33.8	34	0.758	0.1198
Post Interwined	40	21.4	21	0.496	0.0784
Pre Rigid	40	33.8	34	0.758	0.1198
Post Rigid	40	21.4	21	0.496	0.0784
Pre Choatic	40	33.8	34	0.758	0.1198
Post Choatic	40	21.4	21	0.496	0.0784

Table 11 :"Paired Sample T-Test For Divorce, Positive Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre Cohesion	Post Cohesion	Student's t	-19.5	39	< .001	Cohen's d	-3.08	-3.82	-2.33

Pre adaptability	Post adaptability	Student's t	-51.4	39	< .001	Cohen's d	-8.13	-9.91	-6.25
Pre Communication	Post Communication	Student's t	-128	39	< .001	Cohen's d	-20.24	-24.62	-15.61
Pre satisfaction	Post satisfaction	Student's t	-128	39	< .001	Cohen's d	-20.24	-24.62	-15.61
Note. H_a $\mu_{\text{Measure 1 - Measure 2}} < 0$									

Table 12 :"Paired Sample Descriptive Results For Divorce, Positive Dimension":

Descriptives					
	N	Mean	Median	SD	SE
Pre Cohesion	40	9.8	7	3.473	0.5491
Post Cohesion	40	21.8	22	1.181	0.1867
Pre adaptability	40	13.4	13	0.496	0.0784
Post adaptability	40	21.8	22	1.181	0.1867
Pre Communication	40	10.2	10	0.405	0.0641
Post Communication	40	37.4	38	1.374	0.2172
Pre satisfaction	40	10.2	10	0.405	0.0641
Post satisfaction	40	37.4	38	1.374	0.2172

Table 13 :"Paired Sample T-Test For Divorce, Negative Dimension":

								95% Confidence Interval	
			Statistics	Df	P		Effect Size	Lower	Upper
Pre not-close knit	Post Not close-knit	Student's t	46.4	35	< .001	Cohen's d	7.73	5.9	9.52
Pre Intertwined	Post Intertwined	Student's t	46.4	35	< .001	Cohen's d	7.73	5.9	9.52
Pre Rigid	Post Rigid	Student's t	46.4	35	< .001	Cohen's d	7.73	5.9	9.52

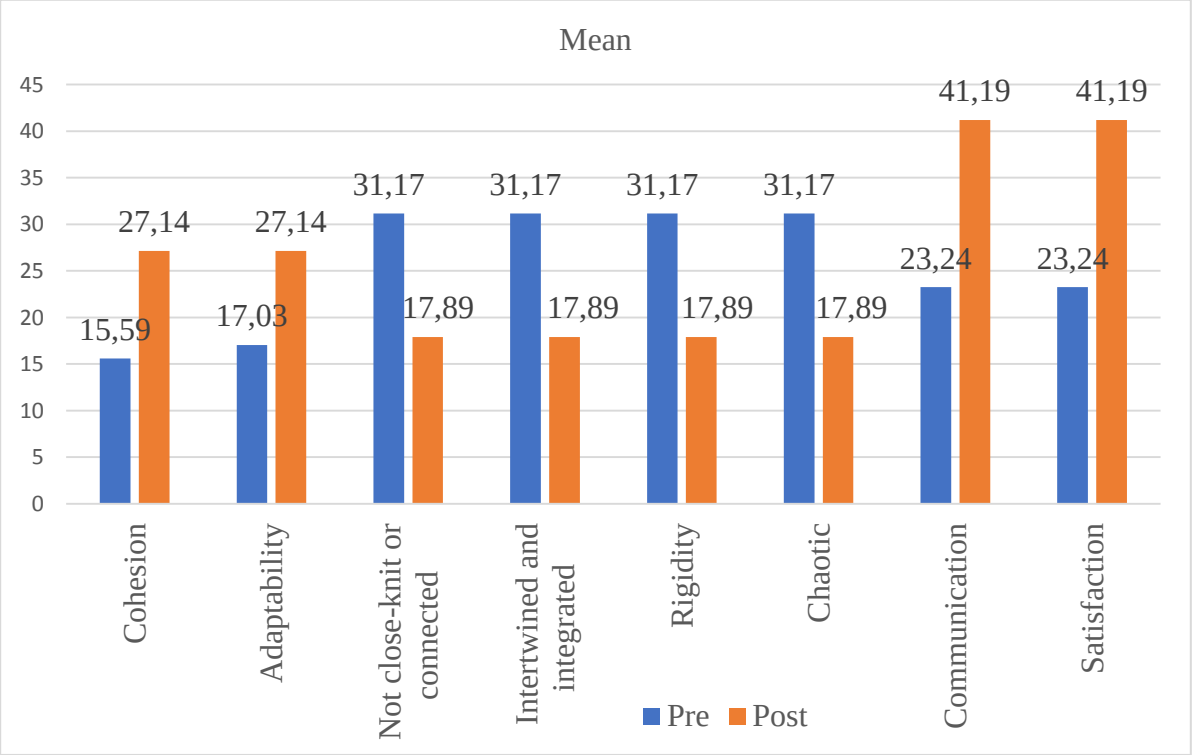
Pre Chaotic	Post Chaotic	Student's t	46.4	35	< .001	Cohen's d	7.73	5.9	9.52

Note. H_a $\mu_{\text{Measure 1 - Measure 2}} > 0$

Table 14 :"Paired Sample Descriptive Results For Divorce, Negative Dimension":

Descriptives					
	N	Mean	Median	SD	SE
Pre not-close knit	36	30.2	29	2.44	0.407
Post Not close-knit	36	16.8	14.5	3.77	0.628
Pre Intertwined	36	30.2	29	2.44	0.407
Post Intertwined	36	16.8	14.5	3.77	0.628
Pre Rigid	36	30.2	29	2.44	0.407
Post Rigid	36	16.8	14.5	3.77	0.628
Pre Chaotic	36	30.2	29	2.44	0.407
Post Chaotic	36	16.8	14.5	3.77	0.628

Shape 01 :"Mean between all 8 dimensions pre & post":



Shape 02 :"Percentage of Reason for Visit":

Table 15 :"Improvement Percentage in Grieving in Positive Dimension":

	Pre-Cohesion	Pre-Adaptability	Pre-Communication	Pre-Satisfaction	Avg	Improvement %
Pre	21.12	21.96	37.08	37.08	29.31	33%
Post	33.64	33.64	44.2	44.2	38.92	

Shape 03 :"Mean Improvement in Grieving in Positive Dimension Pre vs Post":

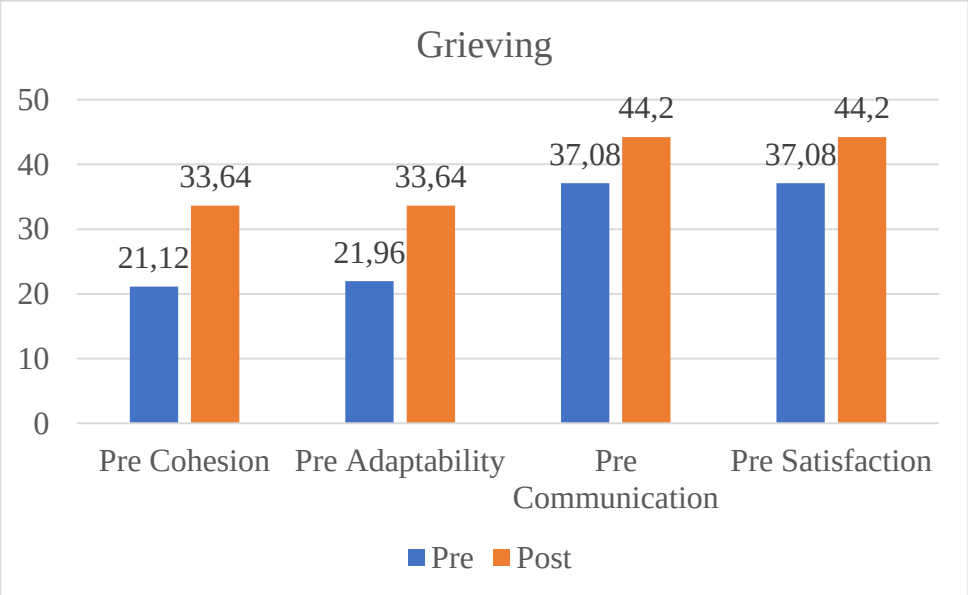


Table 16 :"Improvement Percentage in Psychosis in Positive Dimension":

	Pre-Cohesion	Pre-Adaptability	Pre-Communication	Pre-Satisfaction	Avg	Improvement %
Pre	9.80	13.43	10.20	10.20	10.91	172%
Post	21.80	21.80	37.50	37.50	29.65	

Shape 04 :"Mean Improvement in Psychosis in Positive Dimension Pre vs Post":

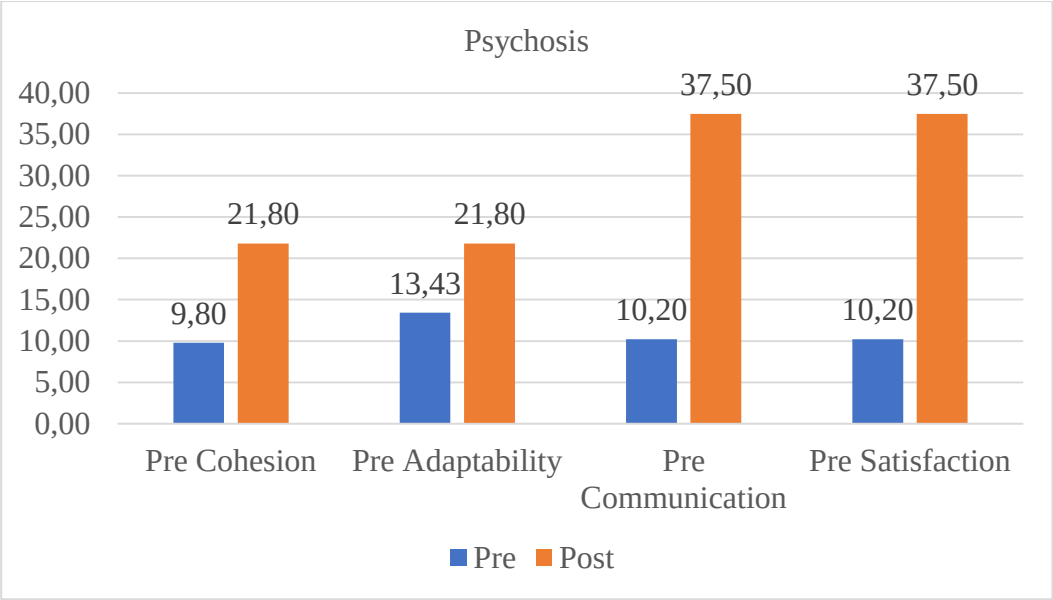


Table 17 :"Improvement Percentage in Psychosis in Positive Dimension":

	Pre-Cohesion	Pre-Adaptability	Pre-Communication	Pre-Satisfaction	Avg	Improvement %
Pre	18.11	17.43	27.83	27.83	22.80	56%
Post	28.37	28.37	42.94	42.94	35.66	

Shape 05 :"Mean Improvement in Psychosis in Positive Dimension Pre vs Post":

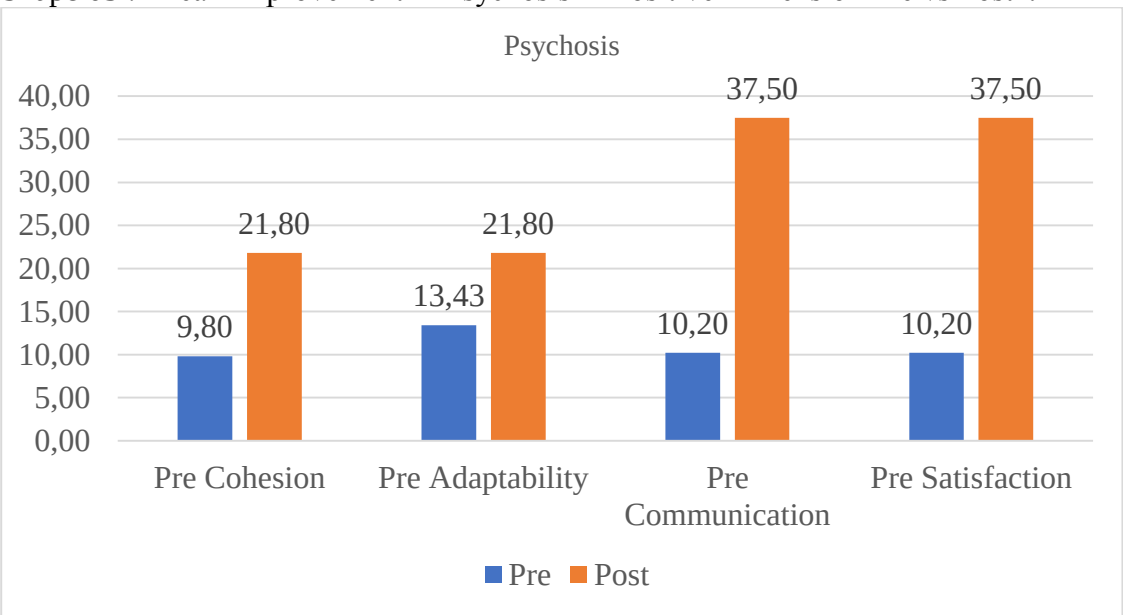
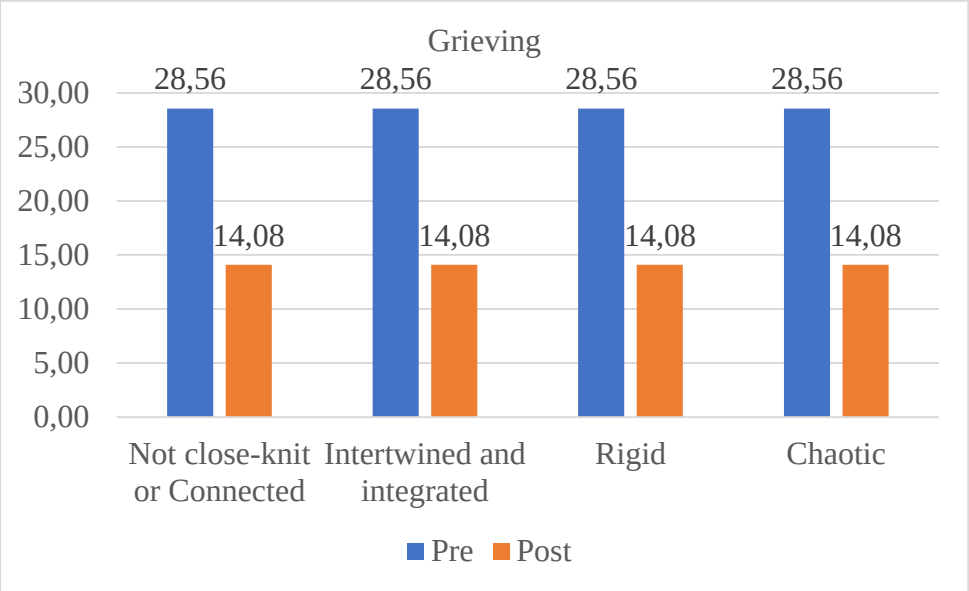


Table 18 :"Improvement Percentage in Grieving in Negative Dimension":

	Not close-knit or connected	Intertwined and integrated	Rigid	Chaotic	Avg	Improvement %
Pre	28.56	28.56	28.56	28.56	28.56	-51%
Post	14.08	14.08	14.08	14.08	14.08	

Shape 06 :"Mean Improvement in Grieving in Negative Dimension Pre vs Post":

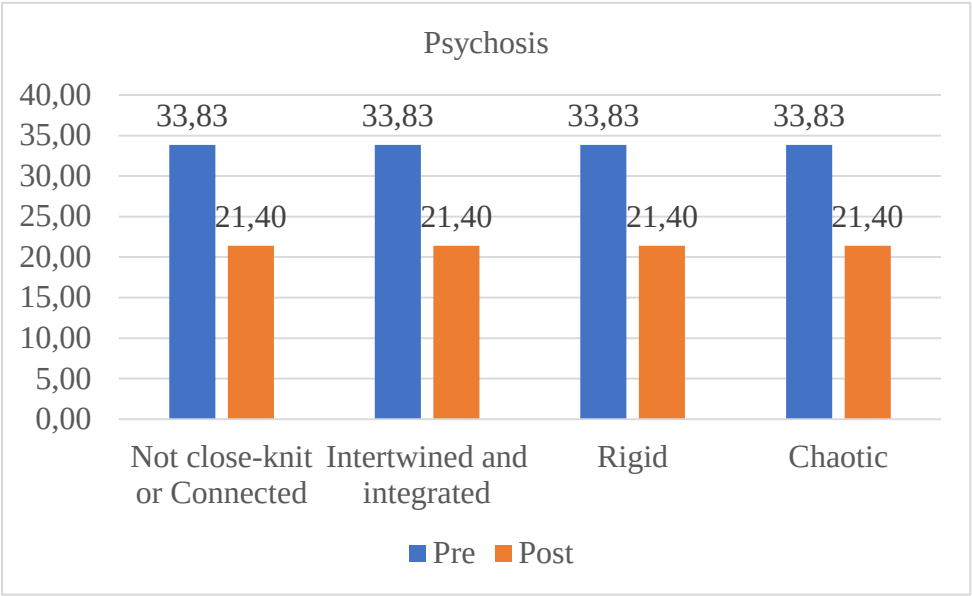


Table

19 :"Improvement Percentage in Psychosis in Negative Dimension":

	Not close-knit or connected	Intertwined and integrated	Rigid	Chaotic	Avg	Improvement %
Pre	33.83	33.83	33.83	33.83	33.83	-37%
Post	21.40	21.40	21.40	21.40	21.40	

Shape 07 :"Mean Improvement in Pshycosis in Negative Dimension Pre vs Post":



Table

20 :"Improvement Percentage in Divorce in Negative Dimension":

	Not close-knit or connected	Intertwined and integrated	Rigid	Chaotic	Avg	Improvement %
Pre	30.06	30.06	30.06	30.06	30.06	-44%
Post	16.71	16.71	16.71	16.71	16.71	

Shape 08 :"Mean Improvement in Psychosis in Negative Dimension Pre vs Post":

	Pre-Not close-knit or Connected	Pre-Intertwined and integrated	Pre-Rigid	Pre-Chaotic	Post Not close-knit or connected	Post Intertwined and integrated	Post Rigid	Post Chaotic
Grieving	28.40	28.40	28.40	28.40	28.40	28.40	28.40	28.40
Psychosis	33.80	33.80	33.80	33.80	33.80	33.80	33.80	33.80
Divorce	30.17	30.17	30.17	30.17	30.17	30.17	30.17	30.17

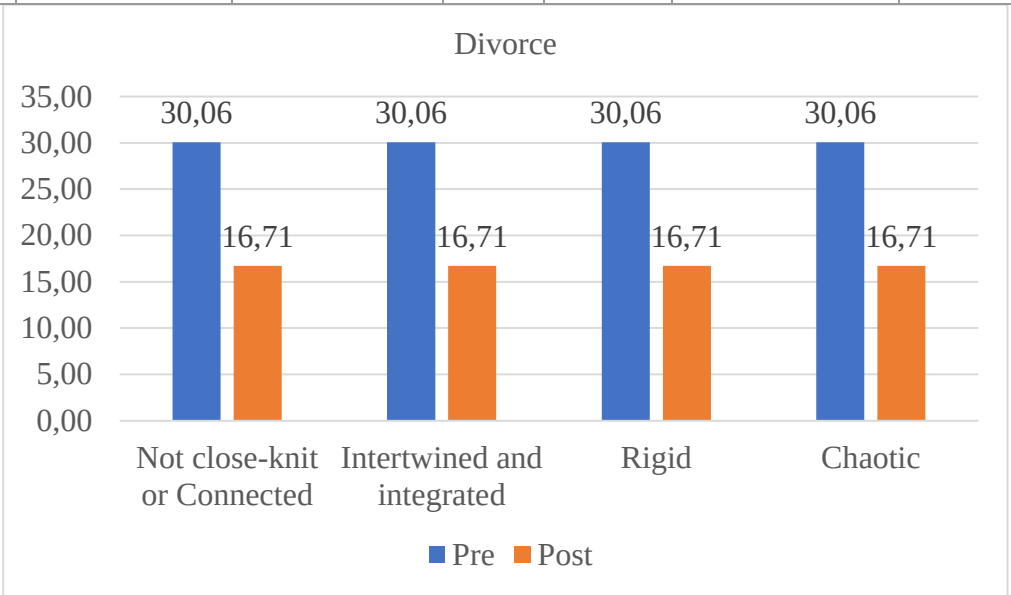


Table 21 :"Mean of Faces Data for Controlled Group":

8. Result Analysis:

T test results show the significant differences between pre and post results for the benefits of the post results after the SCVET experiments on all positive and negative dimensions for the FACES assessment. Each group has taken different level of improvement. Psychosis group has 172 % improvement in all Cohesion, Adaptability , Communication and Satisfaction the positive dimensions. In Pre study the number was 10.9% while the average for post 29.6 %. Second best was divorced group with 56 % improvement as pre was 22.8 % and the post was 35.6 %. In grieving group the improvement was 33 %. The pre was 29.3% while post 38.9%.

In the negative dimensions such as Not close-knit or connected, Intertwined and integrated, Rigid and Chaotic Grieving group was the best group which decreased in all dimensions, we found a decrease in the post versus the pre with – 51% . The pre was 28.5 % and post 14 %.

Psychosis group improvement was -37%. In their case the pre was 33.8 % while post 21.4 %. Finally Divorce group improvement -44 % percent. The pre was 30% while the post was 16.7%. Psychosis group experienced the highest overall improvement (172%), followed by the divorced group (56%), and the grieving group (33%). Psychosis group: Pre-therapy scores in the FACES assessment were indicative of disconnection and

rigidity. Post-therapy, they became more connected and integrated. However, they also showed a decrease in negative scores (-37%).

Grieving group: Improvement in overall scores (+33%) but a decrease in negative scores (-51%). This suggests they felt better overall but remained burdened by grief. Divorced group: Moderate improvement in overall scores (+56%) with a decrease in negative scores (-44%). They seem to have made progress in adjusting to post-divorce life.

9. Conclusion:

Results shows that SCVET was most effective in increasing positive dimensions such as communications and cohesion with families who suffers from having a psychotic member. They suffer from understanding the symptoms and accepting the mental illness and the member himself after SCVET. Families who suffered from grieving were the best group who was able to decrease the negative dimensions in FACES. They were suffering before SCVET from rigidity , Intertwined and integrated, and Chaotic situations. After SCVET they became better in these dimensions and less conflicts.

Arabic culture as it has been discussed before in this research have stigma and inferiority feelings towards problems and traumas. They use the tradition of hiding weaknesses and mental illness and unfortunately even loss. SCVET focuses on values have been made as main references to human being and why, how human needs to rebuild them according to their circumstances. Going throw the stages in SCVET with family members was effective in accepting uncertainty and limitations so each member can take the responsibility of any possible duties they can offer. Even rejection was very helpful in helping them to accept that they would feel it but they need to learn how to accept it and respect it. As it has been argued before Yacoub (2022, 2023, 2024) stages of SCVET helps the client to grow and live existentially the full roll of his or her life in a culture that neglect individuality.

10. Recommendations:

Recommendations will be extremely helpful in using SCVET:

1-Issues like communication patterns, relational conflicts, or shared histories that impact the entire family unit can be solved and respected the way it is reall and realistic with less expectations.

2-concrete tools have been designed by the researcher in (2022, 2023, 2024) in using SCVET which offers specific techniques or strategies for conflict resolution, communication improvement, or behavior change with full respect for the culture and the background of the clients.

3- acceptance from the therapist and full convinced mentality of the SCVET is particularly important before using it.

11. Limitations:

SCVET therapy has strength in rebuilding members values for their specific situations with specific tools, however, it is: focuses on individual responsibility and meaning-making, which can overshadow the family system's dynamics and interconnectedness if the counsellor is not experienced in moderating the therapy and considering their needs. The categories in SCVET such as being Evel or accept rejection and limitations and ambiguity, responsibility can be challenging for families to grasp collectively. Some members might find it overly intellectual or distant from their immediate concerns, leading to a disconnect with the therapy process. It is hard and needs motivation from each family members so Holding each family member accountable for their individual choices and anxieties can be helpful. Furthermore, **r**eligious incompatibility for families with strong religious beliefs, the SCVET emphasis on existential freedom and creating meaning outside of any predetermined structures might clash with their existing worldview.

References

Abenhaim, L., Lavee, Y., & Geva, N. (1993). Multiple family therapy as an intervention for families with schizophrenic adolescents in Israel. Family Process, 32(3), 373-387.

Alhamad, A., Al-Sawaf, F., & Al-Krenawi, A. (2014). Stigma associated with mental illness and its treatment in the Arab culture: A systematic review. Disease and Treatment, 10, 2031-2037.

Al-Krenawi, A., & Graham, J. R. (1999). Family therapy with Arab families. London, UK: Sage Publications.

Al-Krenawi, A., & Graham, J. R. (2000). An existential-humanistic approach to family therapy with Arab families. Journal of Family Therapy, 22(4), 325-345.

Al-Krenawi, A., & Graham, J. R. (2000). The Arabic version of the McMaster Family Assessment Device (FAD). Journal of Family Therapy, 22(4), 347-362.

Al-Krenawi, A., Graham, J. R., & Deane, K. H. O. (2009). Cross-national comparison of Middle Eastern university students: Help-seeking behaviors, attitudes toward helping professionals, and cultural beliefs about mental health problems. Community Mental Health Journal, 45(1), 26-36.

Al-Saggaf, S., & Al-Khateeb, S. (2007). The validity and reliability of the FACES III with Arabic families. American Journal of Family Therapy, 35(3), 177-188.

Anderson, C. M., Reiss, D. J., & Hogarty, G. E. (1986). Schizophrenia and the family: A multiple family study. New York, NY: Guilford Press.

Asen, K. E. (2002). Multiple family therapy: The Marlborough model and its wider applications. London, UK: Karnac Books.

Behr, M. (1996). Multiple family therapy: A review of the literature. Journal of Marital and Family Therapy, 22(3), 339-359.

Chun, M. J., & Sue, S. (1990). Asian-American families: Assessment of mental health and service needs. Journal of Community Psychology, 18(3), 281-295.

Cohen, L., Manion, L., & Morrison, K. (2000). *Research Methods in Education*. (5th ed.). London and New York: Routledge Falmer.

Dardas, A. (2015). The stigma of mental illness in Arab families: a concept analysis. Journal of Psychiatric and Mental Health Nursing, 22(1), 61-67.

El-Sheikh, M., Buckhalt, G., & Cummings, E. M. (2012). Family functioning and adjustment in children of divorce: A meta-analytic review. Journal of Family Psychology, 26(4), 530-541.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (2019). The McMaster Family Assessment Device (FAD). Boston, MA: Allyn & Bacon.

Falicov, C. J. (1998). Latino families in therapy: A guide to culturally sensitive treatment. New York, NY: Guilford Press. .

Falicov, C. J. (2002). Latino families in therapy: A systemic approach. New York, NY: Guilford Press. This book discusses how to apply existentialist concepts to family therapy with Latino families.

Friedlander, M. L., Heatherington, L., & Escudero, V. (2014). Family therapy: Past, present, and future. Family Process, 53(1), 5-26.

Fukunishi, I., Ichikawa, M., Ichikawa, M., & Matsuzawa, T. (1994). Multiple family therapy for families with alcoholic members. International Journal of Family Psychology, 8(1), 1-16.

Gearing, R. E., Al-Krenawi, A., Deane, K. H. O., & Al-Sawaf, F. (2014). Stigma associated with mental illness in the Arab world: A systematic review. International Journal of Social Psychiatry, 60(4), 367-380.

Gearing, R. E., Al-Krenawi, A., Deane, K. H. O., & Al-Sawaf, F. (2014). The stigma of mental illness in the Arab world: A systematic review. International Journal of Social Psychiatry, 60(4), 367-380.

Goldenberg, I., & Goldenberg, H. (2008). Family therapy: An overview (7th ed.). Belmont, CA: Brooks/Cole.

James F. T. Bugental 1976 Existential Counseling: The Process of Finding Meaning Holt, Rinehart and Winston ISBN: 003052025X

Karam, A. (2003). Arab families in therapy: Understanding the impact of culture, religion, and gender. New York, NY: Guilford Press.

Karam, A. (2007). Existential therapy with Arab families. In F. Walsh (Ed.), Spiritual resources in family therapy (2nd ed., pp. 231-246). New York, NY: Guilford Press.

Khattab, M., & Younis, A. (2006). Psychometric Properties of the Arabic Version of the Family Adaptability and Cohesion Evaluation Scales IV (FACES-IV). The Egyptian Journal of Psychiatry, 37(2), 105-112. Ain Shams University. Egypt

Kim, J., & Chun, K. M. (2004). The effectiveness of family therapy with Asian Americans: A literature review. Journal of Family Therapy, 26(1), 95-110.

Kim, M. E. (2005). Existential therapy in a collectivistic culture: A case study. Journal of Counseling and Development, 83(2), 177-184.

Kim, M. E. (2007). Individualism and collectivism: Implications for counseling and psychotherapy. Journal of Counseling and Development, 85(3), 242-251.

Laqueur, H. P. (1972). Mechanisms of change in multiple family therapy. In C. J. Sager & H. S. Kaplan (Eds.), Progress in group and family therapy (pp. 245-274). New York, NY: Bruner/Mazel.

Lee, E. (1997). Family therapy with Asian Americans: A clinical guide. New York, NY: Guilford Press.

McFarlane, W. R., Link, B., Dushay, R., Marchal, G., & Crilly, J. (1995). Multiple family groups and psychoeducation in the treatment of schizophrenia. Archives of General Psychiatry, 52(5), 360-366.

Moos, R. H. (1994). Family Environment Scale (FES). Palo Alto, CA: Consulting Psychologists Press.

Moos, R. H. (1994). The Arabic version of the Family Environment Scale (FES). Palo Alto, CA: Consulting Psychologists Press.

Nader, K., & Weisman de Mamani, M. (Eds.). (2002). Culturally competent family therapy: A guide to working with diverse families (pp. 163-180). New York, NY: Guilford Press.

Nader, K., & Weisman de Mamani, M. (Eds.). (2002). Culturally competent family therapy: A guide to working with diverse families. New York, NY: Guilford Press.

Nagata, F. (2007). Culture and psychotherapy: A critical analysis. American Psychologist, 62(4), 289-297.

Nagata, F. (2007). Narrative therapy in a collectivistic culture: A case study. American Journal of Psychotherapy, 61(4), 477-491.

Olson, D. H., Gorall, D. M., Lebow, J. L., & Amols, M. D. (2011). The Arabic version of FACES IV: Family Adaptability and Cohesion Scales. Minneapolis, MN: Life Innovations.

Pedersen, P. B. (2002). The impact of culture on psychotherapy: A critical review of cross-cultural research. Psychotherapy, 39(3), 376-388.

Pedersen, P. B. (2008). Therapy for people from collectivistic cultures: A guide for therapists. New York, NY: Sage Publications.

Rusch, L., Angermeyer, M. C., & Corrigan, P. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. European Psychiatry, 20(8), 445-450.

Stone, G. L., McKay, M. M., & Stoops, M. (1996). Multiple family therapy: A guide for practitioners. New York, NY: Guilford Press.

Thorngren, J., Christensen, T., & Kleist, D. (1998). Multiple-family group treatment: The underexplored therapy. The Family Journal, 6(2), 125-131.

Walsh, F. (2016). Spiritual resources in family therapy (3rd ed.). New York, NY: Guilford Press.

Yacoub, N. (2000) the challenges Faced by a counsellor running person-cent therapy for first time in Saudi Arabia. Newcastle University, Counselling department. UK. Master degree research.

Yacoub, N. (2006) Culture and gender differences in IWM of attachment and autobiographical memory and self esteem. Durham University. Psychology Department. UK. PhD theses.

Yacoub, N. (2018). *ثلاثين خطوة نحوك[Thirty Steps Towards You]*. Saudi Arabia, Jeddah:

Yacoub, N. (2021). *على خطأ [Mistaken]*. Saudi Arabia, Jeddah: كنوز المعرفة.

Yacoub, N. (2022) The challenges of applying humanity therapy in Saudi Arabia from perspective of psychological counsellor. Qualitative study of the emerge of SCVET. Postgraduate Studies and research Sector Fayoum University. International Journal of Learning Management. Egypt. ISSN 2090-8466 (print) ISSN 2090-8474 (Online)

Yacoub, N. (2022). *المعجزة [The Miracle]*. Saudi Arabia, Jeddah: كنوز المعرفة.

Yacoub, N. (2023) *quantitative and qualitative analysis of the influence of SCVET in one session. جامعة طنطا إكتوبر, مجلد 2. مجلة العلوم المتقدمة للصحة النفسيةو التربية الخاصة بكلية التربية جامعة طنطا. ISSN 2974-346X on line ISSN 2682-3926.*

Yacoub, N. (2024) SCVET Method Manual 4547-2974 national number for print, 4520-2974 electronic national number. Journal of education college in Tefha AL-AZHZR UNIVERSITY Vol 4 Jun. Egypt.
دار الطاووس للنشر.