**An-Najah National University**
**Faculty of Graduate Studies**

# THE EFFECTIVENESS OF COGNITIVE BEHAVIOURAL GROUP THERAPY PROGRAM IN ENHANCING PSYCHOLOGICAL RESILIENCE OF PARENTS OF CHILDREN WITH CANCER IN JERUSALEM

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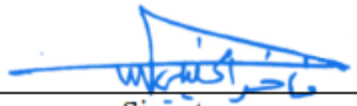
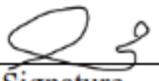
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**2025**

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**By**
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# Dedication

Time and place, old and new, we shall one day be what we desire. Neither has the journey begun, nor has the path ended. My success is only by Allah, *"And the last of their call will be, 'Praise to Allah, Lord of the worlds.'"*

I dedicate my graduation to the teacher of humanity, the light that dispelled the darkness of ignorance, whose radiance illuminated our hearts—our master and prophet, Muhammad (peace and blessings be upon him).

To my beloved homeland, the cradle of my dreams and the compass of my belonging, to its soil that instilled in me the values of dignity and generosity.

To the one whose brow bore the sweat of hard work, teaching me that success comes only through patience and determination. To the light that illuminated my path and the lamp whose flame will never fade from my heart, the one who gave his all and from whom I drew strength and pride—my dear father.

To the one for whom Allah placed paradise beneath her feet, who eased my hardships with her prayers, to the great woman who always dreamed of seeing this day and rejoicing in my success—my beloved mother.

To my soulmate, life companion, and my support in moments of strength and weakness—my dear wife, who bore the burdens of life with me, her presence a source of peace and reassurance in my life.

To my steadfast pillars and the security of my days, to those who strengthened me and were springs from which I drew sustenance, to the best of my days and the purest of them—my precious brothers and sisters.

To everyone who supported and stood by me on this journey.

To the one who made the hardships of travel and study bearable, who was always a source of support during the toughest times, and who showered me with sincere advice—Mahmoud Ali Nasser, my brother and friend.

To those who were teachers, mentors, and friends, who selflessly imparted their knowledge and wisdom, the beacons of learning and sources of inspiration, who taught with dedication and excellence—Dr. Fakher Al-Khalili and Dr. Abdulrahman Khoja.

*"Whoever does not thank people, does not thank Allah."* My heartfelt gratitude to all who were there in times of difficulty.

I dedicate this achievement and the fruit of my success to you all, a dream I longed to realize. Here I stand today, having reaped a new fruit by the grace of Allah Almighty. Praise be to Allah for His blessings, and may He grant me the strength to be a source of goodness wherever I am.

Peace, mercy, and blessings of Allah be upon you

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for their efforts and assistance in ensuring the completion of this thesis in the best possible manner. I also express my heartfelt thanks to the honorable members of the examination committee and to everyone who extended a helping hand along the way.

## Declaration

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

# THE EFFECTIVENESS OF COGNITIVE BEHAVIOURAL GROUP THERAPY PROGRAM IN ENHANCING PSYCHOLOGICAL RESILIENCE OF PARENTS OF CHILDREN WITH CANCER IN JERUSALEM

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

Student's Name Hassan Mohammad Hassan Elyan

Signature: Hassan Elyan

Date: 15/05/2025

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# THE EFFECTIVENESS OF COGNITIVE BEHAVIOURAL GROUP THERAPY PROGRAM IN ENHANCING PSYCHOLOGICAL RESILIENCE OF PARENTS OF CHILDREN WITH CANCER IN JERUSALEM

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## Abstract

Background: The researcher identified a gap in the availability of psychological support specifically tailored to enhance the resilience of parents of children with cancer in Jerusalem. Observing these parents' struggles and recognizing the potential for cognitive behavioral therapy (CBT) to foster resilience, the researcher felt compelled to address this unmet need.

Objectives of the study: this study investigates the effectiveness of a structured CBT program in enhancing the psychological resilience of parents of children with cancer in Jerusalem.

Method: The study population consists of parents of Palestinian children with cancer, whose children are receiving treatment at hospitals in Jerusalem such as Al-Mutlaa Hospital, Al-Maqasid Hospital, and Hadassah Ein Kerem Hospital, a total of 18 participants were randomly and equally assigned to two groups, the experimental group and the control group, each consisting of nine parents, the experimental group comprises six women (66.7 %) and three men (33.3 %), in terms of age a slight majority of the parents are over 35 years old (five participants, 55.6 %) while four participants (44.4 %) are younger than 36 years old.

Findings : The results revealed a moderate level of psychological resilience among the parents of children with cancer, indicating that they generally maintain a reasonable capacity to cope with psychological challenges, the findings also show that the cognitive-behavioral group therapy program was highly effective in enhancing psychological resilience among these parents, this conclusion is supported by the significant improvements observed in various domains of psychological resilience from the pre-test to the post-test, the experimental group, which participated in the program,

demonstrated marked progress in self-confidence, adjustment to changes and stress, perseverance and persistence, coping with problems and stress, and seeking supportive resources.

**Keywords**: CBGTP (Cognitive Behavioral Group Therapy Program), Psychological Resilience, Parents, care in Jerusalem.

# Chapter One

# Introduction and Theoretical Background

## 1.1 Introduction

Such support falls within the range of care, respect, and emotional backing, and relatively speaking, in the proper context, would assist the patient in building his resilience while stimulating the overall well-being during the process of treatment. In the long run, that is why social support stands out as one of the key components in dealing with more general challenges associated with cancer. The psychological, social, and economic burdens of cancer on patients, families, and even societies make it a significant problem for individuals and health systems (Melguizo-Garín, Martos-Méndez, Hombrados-Mendieta, & Ruiz-Rodríguez, 2022; Stenberg, Ruland, & Miaskowski, 2010; Andrykowski, Lykins, & Floyd, 2008; Pedro, Galvão, Rocha, & Nascimento, 2008).

The burden of the disease goes far beyond the control of physical health. Emotional and financial strains it puts on patients and their families are enormous. It, therefore, makes social support a sine qua non in building psychological resistance whose integration is important in the coping process with the disease as well as its broad impacts that cut across health, social, and psychological conditions (Yang, et al., 2024; Dantzer, Cohen, Russo, & Dinan, 2018; Zomerlei, 2015; Janicki-Deverts & Cohen, 2011).

The support of others, especially family and friends, plays a critical role in enhancing psychological well-being by fostering a sense of connection and belonging, which helps counter feelings of loneliness and fear, as highlighted in theoretical research (Kim & Park, 2019; Cal, Sá, Glustak, & Santiago, 2015). With so many problems raised for cancer patients and families-particularly the high levels of distress- psychologists developed different interventions to help. The interventions (as identified by Moorey & Greer, 2011) are intended to increase positive feelings such as pleasure, enjoyment, hope/optimism/confidence and decrease worry/stress/fear/sadness." From these therapeutic modalities, cognitive behavioral therapy (CBT) is predominated in the assistance of psychological-resilience among parents of children with cancer (Khosrobeigi, Hafezi, Naderi, & Ehteshamzadeh, 2022; Chung, et al., 2021; Rosenberg, et al., 2019).

Psychological resilience refers to the ability to effectively cope with stress, maintain both physical and mental health, and prevent stress-related disorders (Sandal, 2018). Resilience plays a vital role in helping individuals navigate and overcome challenges (Masten, 2012).

Several studies have investigated the efficacy of cognitive behavioural therapy (CBT) towards psychological resilience, a recognized method for improving these outcomes, especially in parents of children with cancer (Chung, et al., 2021; Rosenberg, et al., 2019). Nonetheless, due to the particular cultural Palestine and geographical background, few quantitative research has been done in CBT context of the Palestinian community. This literature gap suggests for local evaluations to determine the potential of CBT in this area.

The current study was designed to evaluate the effectiveness of cognitive behavioral therapy (CBT) in promoting psychological resilience among parents of children with cancer in the Jerusalem Governorate, the study implemented a CBT-based group intervention to examine its impact on various dimensions of psychological resilience in this population, the primary objective was to assess the extent to which participation in the CBT group program could help parents cope with the significant psychological and emotional challenges associated with caring for a child with cancer, the study aimed to generate findings that could inform the development of follow-up support systems and targeted interventions for similar groups facing comparable circumstances.

## 1.2 Theoretical Framework and Related Studies

### 1.2.1 Psychological resilience

Psychological resilience, unlike in other parts of the world, is about behaviors, thoughts, beliefs, and actions that can be learned and taught to everyone. This is important because a resilient personality is better equipped to handle various challenges in life, especially emotional distress or significant losses (Kashdan, Disabato, Goodman, Doorley, & McKnight, 2020).

Resilience is also closely tied to a person's internal dynamics, which are strengthened by positive thinking, open communication, and effective interactions with others. As a result, resilient individuals can adapt to changes in their environment and find a balance

between their personal needs and external pressures. This ability allows them to respond constructively and fulfill their responsibilities in life (Rottenberg, 2010).

Moreover, resilient individuals possess the ability to deal with reality in a suitable manner, accepting or changing it as the situation requires and as their capabilities allow. In this context, several related terms are associated with self-strength, such as psychological immunity, emotional stability, emotional composure, and emotional balance (Moran, 2017).

As a result, psychological resilience is thought to be one of the most crucial systems for successful adaptation and constructive coping in the face of psychological stress. It is an essential part of mental health since it allows people to deal with life situations, face challenges, and help avoid negative consequences from the stressors they may encounter. Crucially, it incorporates the person's ability to successfully manage these challenges and preserve their mental health (Wu & Lu, 2020).

### 1.2.2 The concept of psychological resilience

The ability to bounce back from or overcome adversity and still accomplish positive results in spite of trying circumstances or events is a common definition of resilience. The question of whether resilience is better understood as a state or a feature when it is seen as a personal attribute is still up for dispute. Furthermore, resilience is viewed as a process and an outcome in addition to a human attribute (Vella & Pai, 2019).

psychological resilience is the ability to sustain, or recover from, psycho- logical well-being in the face of adversity. Expounding upon this definition, several aspects of well-being are identified and connected to resilience (Ryff, Friedman, Morozink, & Tsenkova, 2012).

According to Sisto, et al. (2019), psychological resilience is a psychosocial and developmental process that allows people who experience protracted hardship or are exposed to potentially traumatic situations to gradually respond psychologically in a good way. As this knowledge grew, psychologists started looking into additional factors that might be present when psychopathology is absent in the 1980s and beyond. They expanded its scope to include social interactions, cultural background, life transitions, and, around the year 2000, neurobiological functions. This broader perspective

emphasized the role that relational, cultural, and communal variables play in creating protective factors. This led to a reinterpretation of teenage resilience as a confluence of individual characteristics, social support networks, and available resources (Masten, et al., 2004). In order to better understand how resilience emerges culturally and identify traits unique to various communities, researchers sought to conduct cross-cultural studies, apply qualitative methodologies, and include marginalized populations (Hamby, 2022).

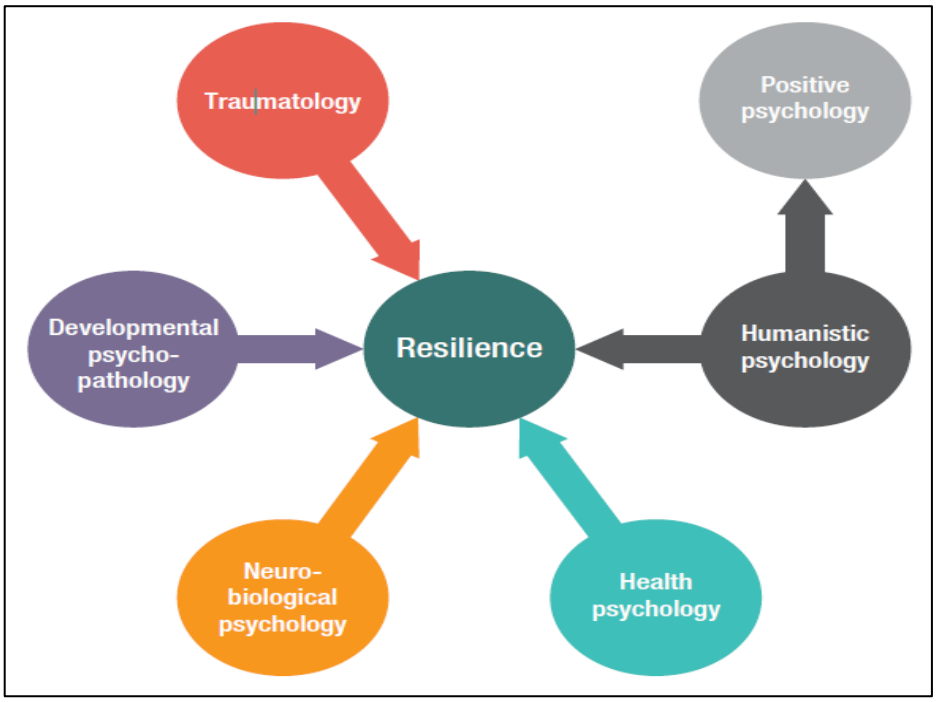
In this framework, it became clear that a person's resilience is intricately linked to their social environment. Innovations in neurobiological methods have deepened our comprehension by offering unique perspectives on resilience at the most fundamental level, potentially influencing pharmacological approaches. Consequently, research on resilience has grown more intricate, mirroring the complexity of the concept itself. (Mawila, 2019).

Furthermore, research on resilience draws from a variety of related disciplines, including developmental psychopathology, which examines how children deal with adversity; positive psychology, which emphasizes human flourishing, positive emotions, and interpersonal relationships; humanistic psychology, which concentrates on meaning-making and personal development; and traumatology, which examines adult responses to trauma (Curtis, 2003).

These fields enhance our understanding of resilience by overlapping with neurobiological psychology and health psychology. Notably, positive psychology and the tenets of resilience research are philosophically grounded in humanistic psychology (Tunariu, Tribe, Frings, & Albery, 2017). Techniques and areas of emphasis have been modified from developmental psychopathology and traumatology (Cicchetti & Toth, 2009).

**Figure 1**

*Illustrate the Visualization of resilience research: intersections with related disciplines in psychology*




Reaching a consensus on defining psychological resilience has been challenging, as various authors have put forth different definitions regarding the structure of psychological resilience. This divergence can be attributed to the scientific perspective from which individuals approach psychological resilience. Some consider psychological resilience as an essential aspect of an individual, while others view it as the competencies or capabilities of individuals. Yet, some describe it as a positive performance in facing challenges (Shean, 2015).

Psychological resilience is defined as the ability to adapt and overcome hardships, shocks, tragedies, threats, and significant pressures. It is an individual's capacity to overcome difficulties and challenges, thereby moving forward in life. Psychological resilience involves individuals achieving relatively good outcomes despite being exposed to serious pressures or hardships. Additionally, it is the ability to maintain stable levels of mental performance in the aftermath of stress and shocks.

Conversely, Jones (2002) defined it as obtaining a natural or developed psychological peak that helps the individual better cope with various needs, such as lifestyle, and become more stable, persevering, focused, self-confident, resistant, and in control under

pressure. Similarly, Bonanno, Romero, & Klein (2015) described psychological resilience as an individual's willingness and acceptance of the environmental psychological changes or pressures they are exposed to. Furthermore, Windle (2011) indicated that psychological resilience is a general belief in one's effectiveness and ability to utilize all available psychological and environmental resources to perceive, interpret, and effectively confront life's stressful events. In addition, Hou, et al. (2017) are described psychological resilience as the individual's ability to deal effectively with psychological stress, adapt to daily challenges and difficulties, handle frustration, mistakes, psychological trauma, and daily problems, and develop specific and realistic goals. Moreover, Fletcher & Sarkar (2013) are pointed out that psychological resilience is a general personality trait shaped by experiences, enabling individuals to face pressures and life events positively. Fletcher, et a highlighted the possession of psychological skills that contribute to facing these pressures and various problems, thereby allowing individuals to deal with them and find solutions.

Vella & Pai (2019) are believes that psychological resilience is a general characteristic of an individual's personality, which is formed and developed to deal with environmental experiences from childhood. Similarly, Tsirigotis & Łuczak (2018) define psychological resilience as a set of skills and competencies that contribute to dealing with stress, shocks, problems, and hardships in life.

In light of the above, psychological resilience can be defined as an individual's capacity to adapt positively to life challenges under difficult social conditions, including familial, emotional, health-related, occupational, and economic stressors.

### 1.2.2 Components of Psychological Resilience

Uribarri & Vassalotti (2020) identified major elements of psychological resilience which enable an individual to cope are as follows. Optimism, one of those elements, is the individual's capacity to visualize the positivity of the future and to remain motivated during hardship. Bringing fear into consciousness and confronting it is also important, for individuals want to overcome the terror that keeps them captive after traumatic experiences. Social support matters as the acceptance of emotional support from a trusted group comprising family, friends, or peers becomes highly useful in times of need. Another is the aspect of role models, who are individuals that have been

successful in overcoming their own adversities, thus providing direction and motivation. The other dimension is the need to remain physically and mentally fit so as to ensure recovery from both physical and psychological stressors; this delineates the definition of psychological resilience. Last but not least, cognitive and emotional resilience refers to the ability to overcome problems, laugh at one's own distress, and cling to hope despite severe problems.

Cherry, Vander Hoeven, Patterson, & Lumley (2010) define the dimensions of psychological resilience as the capacity for improving personal and social characteristics. You are conditioned with up Until October 2023. They encompass a number of essential and psychological qualities, deemed fundamental to any individual. Importantly, these elements are malleable, providing protection from stress and adversity, and facilitating personal growth and increasing one's effectiveness in high stakes contexts. Additionally, they play a role to build up great relationship (Schumacher, 2017).

### 1.2.3 Factors Influencing Resilience

Denckla, et al. (2020) outline several key areas that fall under the domains of psychological resilience. One of the biggest factors is upbringing — psychological resilience is hugely dependent on the construct of the relationships between the individual and those around them. And especially for younger individuals, the way these other people support and motivate the person acts as a difference in the helping and solving the problems in life with a positive mind. As we described you could provide warmth and love, and also contribute a sense of challenge and exploration that is potent in terms of the adult's sense of self-worth and effectiveness.

preventive, counseling, and therapeutic programs are crucial for the appropriate development of psychological resilience, In preventive programs, the personal qualities to be developed mainly cover self-confidence, independence, and emotional regulation. In counseling and therapeutic programs, the focus is on problem-solving skills and coping with life challenges and stressors.

Besides, relationships with others ascertain yet another domain of psychological resilience. It is this domain that connects resilience with other social forces to cushion support against the negative effects an individual undergoes. And in the context of such

an approach, psychological confidence on the one hand and social support on the other play an extremely important role in nurturing resilience

### 1.2.4 Development and Enhancement of Resilience

Psychological resilience is fundamentally a dynamic process in which individuals demonstrate positive adaptive behaviors in response to challenges, problems, and setbacks. Wedding (2022) highlights that psychological resilience is explained as the ability to withstand or resist, without succumbing to despair, an adversarial or negative event, while at the same time including the capability to rebound and adjust flexibility following exposure to some stressors or changes. Again, from this point of view, psychological resilience is a unique, multifaceted perspective that varies from person to person. The individual context may differ when it comes to the mechanisms of adaptation to change or varying degrees of resilience faced during adversities. Therefore, resilience is somewhat complex: that is to say, it refers explicitly to a certain trait of personality of any person and could be affected by a person's upbringing.

### 1.2.5 Resilience and Mental Health

Resilience appears to be one of the important avenues of successful adjustment and healthy coping in situations involving psychological stress. Resilience is the leading concept of mental health; it helps a person survive through conditions which pose challenges, minimizing adverse effects of stressors during the rest of his or her life. Resilience, therefore, is that ability for the person to withstand all these albeit difficult situations while still maintaining soundness of mind. Mental health and resilience are deeply connected in that it builds an individual's capacity to handle challenges and bounce back from adversity and eventually fosters psychological well-being. It helps in controlling reactions to stress and trauma and, thus, enhances mental health outcomes (Wu & Lu, 2020).

### 1.2.6 Types of psychological resilience

Hofgaard, Nes, & Røysamb (2021) classified psychological resilience into three types. Innate psychological resilience develops with the interaction of genetic and environmental factors. The resilience builds up side by side with the individual, slowly becoming second nature to their personality. Psychological resilience can be acquired through learning and experience. This is the second type. Individuals develop this

quality by facing and successfully challenging hard times in their life. This gradually builds up their inner strength and eventually makes them very adaptable. The third type is informed artificially acquired psychological resilience, in which placing individuals into stressful and anxiety-inducing conditions involves them learning to self-regulate their affective experiences and responses and thereby better manage stress.

Yates & Grey (2012) identified two primary dimensions of mental toughness: internal resilience and external resilience. Internal resilience describes an individual's internal resources and personal qualities, such as self-confidence, self-worth, pride, and the openness to learning and growth from difficult experiences. It indicates the capability to retain psychological steadiness and productive adaptation internally. External or outward resilience is determined by social, cultural, and intellectual arenas, as one's achievements interact with the environmental context to give meaning to the individual's capacity for bearing adversity. This dualism was later admitted by Hofgaard and coworkers, as they highlighted the dynamic interplay between internal and external features, suggesting that psychological resilience would be developed through an ongoing interfacing of personal characteristics and environmental influences. Both dimensions, in combination, depict a very intricate yet multifaceted aspect of resilience in facing life's hardships.

**Differences Between Resilience and Related Constructs (Hardiness, Psychological Flexibility, Sumudu, and Mental Toughness)**

It became clear in this environment that a person's social ecology and resilience are intimately related. Our knowledge was further expanded by developments in neurobiological approaches, which offered previously unheard-of insights on resilience at the smallest scale possible, with possible pharmaceutical ramifications. Consequently, resilience research has grown more intricate, mirroring the intricacy of the concept itself (Mawila, 2019).

Developmental psychopathology, which studies how children respond to adversity; positive psychology, which emphasizes positive emotions, interpersonal relationships, and aspects of human flourishing; humanistic psychology, which focuses on meaning-making and personal growth; and traumatology, which studies how adults respond to

trauma, are some other related fields that have an impact on resilience research (Curtis, 2003).

These disciplines contribute to a more thorough understanding of resilience by interacting with neurobiological psychology and health psychology. Positive psychology and the philosophy of resilience research are conceptually supported by humanistic psychology in particular (Tunariu, Tribe, Frings, & Albery, 2017). Techniques and areas of emphasis have been modified from developmental psychopathology and traumatology (Cicchetti & Toth, 2009).

Finally, psychological resilience can be differentiated from related concepts such as hardiness, psychological flexibility, Sumud, and mental toughness, which also focus on coping with adversity but differ in their emphasis and application.

### 1.2.7 Theories of psychological resilience

Several theoretical models have been proposed to explain psychological resilience, each offering a distinct perspective. Below, we explore some of these theories:

Firstly, Kobasa's Theory (1982) posits that exposure to stressful situations is an inevitable part of life, given the inherent obstacles and challenges individuals face. According to Kobasa, individuals cannot avoid failure or frustration, nor can they escape the demands of personal growth throughout life. Her research led to the conclusion that psychological resilience, characterized by the dimensions of commitment, control, and challenge, does more than mitigate the impact of stress. It also acts as a source of resistance and steadfastness, protecting individuals from feeling alienated, weak, or threatened. In this way, resilience helps individuals manage the adverse effects of stressful situations on both their physical and psychological well-being.

Contrastingly, it is Maddi's theory (2004) accentuated by Maddi who puts psychological resilience at the level through which people react differently in the face of stressful life conditions. Maddi (2004) argues further that individuals who are engaged remain somewhat preoccupied with the tasks at hand and try to make their experiences turn into something meaningful and stimulating events. Besides, high controllability people try to

bring about the tough elements of stressful happenings, while high acceptors learn from their experiences finding them useful for their development.

Bartone (2007) proposed a three-fold model on resilience in personality, through which he posited that resilience can be developed and thereafter fortified for better health and performance as well as for the prevention of mental health problems. High-resilient individuals actively and energetically respond to the need of the moment. You show an alert and interested attitude in dealing with new situations and challenges, showing enthusiasm and intrinsic motivation. This proactive engagement would allow them to create personal meanings leading to high resilience.

In a nutshell, whereas Kobasa's theory emphasizes stress resilience as a protective factor, Maddi's theory emphasizes stress resilience as a transformative factor, with Bartone's theory representing something entirely different- building and enhancing resilience, hence greater wellness and performance benefits. Each theory, therefore, gives an important perspective on how psychological resilience works and how to promote mechanisms for individual coping.

Apart from the individual theories of resilience, sociological theories have also emerged. They have relatively provided a broader explanation of the concept; such theories tend to explain how resilience develops and functions in various matters. These theories basically emphasize different perspectives regarding the building and functioning of resilience.

**Psychoanalytic Theory**: The id, ego, and the superego are three aspects of human personality that were postulated by Sigmund Freud with respect to his psychoanalytic theory. According to him, that is the main function of the ego to reconcile the super-ego with the id factored in by the reality principle, as the effectiveness with which a person can surmount hardships is heavily dependent upon the size and strength of his or her ego. It is necessary to keep these factors in equilibrium to manage stress so they may serve to defend the personality, maintain it in homeostasis with the environment, and resolve the conflict that violation of homeostasis has provoked (Malgarim, Macedo, & Freitas, 2018).

Humanistic Theory: According to Carl Rogers' humanistic perspective, individuals are seen as proactive agents that can determine or shape their own destinies. High positive self-regard is developed when a person has much of their self-esteem invested and keeps a favorable attitude toward themselves under conditions of challenge. The development of such character values intrinsic worth and leads humans very effectively toward their goals because they will believe in themselves rather than seek guidance for judgment externally. It creates a drive toward success and the best use of human potential (Saracino, 2020; Shean, 2015).

**Psychosocial Development Theory**: Based on the expansion of Freud's ideas, Erik Erikson traces the evolution of the ego throughout eight stages of life development. In his work, Erikson highlighted the fact that all social, biological, and psychological components interplay to determine how relatively healthy individuals settle crises at a given stage. The trust, autonomy, initiative, and identity forms prove to be significant benchmarks of resilience. Therefore, the theory of Erikson "frames an understanding of resilience as evolving over the life course of an individual" (Meichenbaum, 2007).

**Social Learning Theories**: Social learning theories explain how human beings relate to their environment through a combination of behavioral and cognitive methods. Julian Rotter's cognitive-social learning theory states that future expectations and past experiences influence behavior. In explaining how human beings come to develop behaviors and personalities, it posits that behavior and personality development are a function of the meaning's humans attribute to their experiences (Freda, 2004) This theory accentuates the interaction between cognitive processes and the environment in the formation of resilience.

**Albert Bandura's Theory**: Bandura's theory emphasizes the interplay between environmental conditions, such as external influences, such as environmental conditions, and internal factors, such as cognitive and personal elements. In his presentation, he brings out the value of knowledge acquired through experience and observation. What is more, here comes Bandura with the concept of self-efficacy, which is the belief of one's effectiveness in the fulfillment of tasks; this influences and motivates behavior and is therefore an integral part of resilience (Sools & Mooren, 2012).

**Rank's Theory on Personality**: Developmental roles were grouped under the theory of Otto Rank, where, according to him, people can be categorized into three types: Conformist, Rebel, and Creative Adjuster. According to Rank, the Conformist follows and abides by social norms, the Rebel tries to break away from them, and the Creative Adjuster balances his surroundings and himself. Positive willpower comes after people stop realizing their full potential by comparing themselves with others (Sullivan, 2016; Meichenbaum, 2007).

These theories reveal that different perspectives exist regarding psychological resilience. Kobasa (1982), for example, takes on to articulate the inevitability of extreme stress and the capacity of resilience to mitigate its impact. While Bartone's theory, on the other hand, postulates building up resilience to increase performance and health, Maddi's underscores the effects of resilience on reactions to stress. The Kobasa theory explains psychological resilience extensively and therefore applies to cognitive-behavioral treatment strategies, especially for parents of children with cancer. This approach synthesizes theoretical knowledge and puts it into practice to create and enhance resilience in specific settings.

## 1.3 Cognitive Behavioral Therapy

### 1.3.1 Definition of CBT

Cognitive behavioral therapy (CBT), a well-researched psychological treatment, proves effective against social phobia, panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder, and depression among other mental health conditions (Hofmann, 2012). The National Institute for Health and Care Excellence (NICE) recommends this therapy for the treatment of several conditions (Martin, 2022). Cognitive behavioral therapy (CBT) essentially tries to trace and revamp maladaptive patterns that maintain psychological suffering via an exploration of the interchange between thoughts, emotions, and actions (Jackson, 2009).

Cognitive Behavioral Therapy (CBT) is a modern therapeutic approach that assumes dysfunctional thinking patterns lead to disordered behavior. It aims to modify irrational, unrealistic, and self-defeating beliefs while teaching individuals more rational and positive ways of thinking through philosophical dialogue and persuasive techniques. CBT is one of the contemporary therapeutic interventions designed to address various

psychological disorders and issues faced by individuals by restructuring their cognitive framework. This is achieved by integrating certain cognitive techniques with behavioral techniques (Mohammed, 2024).

### 1.3.2 Development and History of CBT

Over the years, CBT delivery and knowledge diffusion have greatly evolved. Initially, cognitive-behavioral therapy was only utilized by licensed mental health practitioners such as social workers with a master's degree, psychologists, and psychiatrists (Field, 2013). Now, it is also increasingly available through clinical supervision of paraprofessionals administering treatment. Programs like the Improving Access to Psychological Therapies program of the UK have made some contribution to the development of cognitive behavioral therapy by setting down guidelines on how best to deliver it effectively and increasing the availability of psychological therapies based on evidence. This program was launched by the Department of Health in 2007 (Tallon, 2019).

### 1.3.3 Core Principles of CBT

The dynamic formulation in a normal manner might be that thoughts, feelings, and behaviors interrelate with each other. In general terms, according to the British Association for Behavioral and Cognitive Psychotherapies (BABCP) (2019), cognitive behavioral therapy (CBT) will assume the dynamic relationship to be the primary objective is to reduce psychological suffering due to correction in maladaptive thought, and behavior patterns take place. The first generation or original exponents of cognitive behavioral therapy could be spoken of as Aaron Beck and Albert Ellis and are often referred to as the fathers of this relatively new psychotherapy. While the former directed his research into the identification of irrational thought under the background of emotional maladjustment, the latter emphasized the role of rational disputation in the elimination of irrational beliefs.

### 1.3.4 The CBT Techniques

The above-mentioned techniques cover a vast array of structured interventions designed to provoke specified psychological problems while improving emotional and behavioral functioning (Dozois, 2019; Kazantzis, 2018). A major procedure is psychoeducation; it gives clients an understanding of their symptoms and cognitive behavioral therapy

techniques aimed at increasing their participation. The second most important component is establishing progressive relaxation methods, such as deep breathing, meditation, and progressive muscle relaxation, to relieve bodily tension and feel less anxious. Next in importance is experiential exposure, which consists of slowly and systematically presenting situations or stimuli that people fear in order to reduce their avoidance of those stimuli and desensitize their fear response. Behavioral rehearsal enables clients to build and practice social skills, solve problems, and reverse unharmed behavior in a safe setting. Cognitive restructuring involves the identification and challenge of irrational or self-defeating thoughts, replacing them with healthier and more realistic alternatives. Operant procedures finally seek to reinforce adaptive behaviors and diminish maladaptive behaviors by means of rewards and consequences so as to promote enduring behavioral change.

### 1.3.5 Therapeutic Processes in CBT

CBT is provided through delivery offerings of structured sessions Sessions typically take place in hospitals, community centers, homes, and may take place in individual, group, or family formats according to the therapeutic needs of the patient (Bieling, McCabe, & Antony, 2022). For example, the inpatient treatment for social anxiety lasts for about 14 weeks in 90-minute weekly sessions (Leichsenring, 2017). Moderately recent alterations have introduced choices of quick CBT programs which, indeed, may help in some cases, particularly for younger patients or those diagnosed with OCD (Fontenelle, 2018).

CBT therapeutic process should emphasize a responsive flexibility adjustment of the length of the treatment according to the path through which the patient can or cannot recover (Stiles, Barkham, Connell, & Mellor-Clark, 2008). This is in alignment with the NHS approach based on a stepped care model where a patient receives an initial brief intervention and additional sessions if indicated (Cully, 2012).

### 1.3.6 Effectiveness of CBT

CBT, with demonstrated effectiveness across a wide range of psychological disorders, for example, withinфициальпуне IAPT program-the United Kingdom considers it as one of the most evidence based A brmake it an effective treatment option across the spectrum of mental health disorders (Hofmann, 2012). CBT has been proved in several

studies to be effective in treating disorders such as depression, anxiety, and PTSD. On the other hand, even while standard weekly sessions of CBT usually lead to long-term improvement, recent studies indicate that some populations, such as adolescents with obsessive-compulsive disorder, might benefit particularly from intensive CBT (Reuman, 2021). Variable modes of delivery for CBT, including in-person, group-based, or digital approaches, add to its flexibility of application and accessibility; hence, it remains a recognized and effective form of treatment (Curry, 2014).

### 1.7 Related Study

Blumenstein, et al. (2022) conducted an in-depth systematic review and meta-analysis that aimed to explain the effectiveness of cognitive-behavioral therapy (CBT) in improving functional health outcomes among cancer survivors. The current investigation included a comprehensive search across seven electronic databases, 91 review papers previously published, and four credible websites from where all relevant randomized and non-randomized controlled studies focusing on cancer survivors were identified. A total of 95 research pieces, carried out during the period of 1st January 1986 to 18th November 2021, were included after much scrutiny. The studies appeared quite low in bias. The meta-analysis proves that CBT has a statistically significant aggregate impact over functional health outcomes ($d = 0.391$, $p < 0.001$). Most importantly, the nature of the comparison and treatment phase significantly determines whether CBT will be effective or not.

The objective of the study by Zhang et al. (2022) was to evaluate the influence of cognitive behavioral therapy on anxiety and hopelessness among cancer survivors. The study conducted a review of several databases, ranging from the Cochrane Library, PubMed, Embase, and PsycINFO, where only trials focused on the effect of CBT on this particular population were selected. This study incorporates findings from 15 trials, and the standardized mean difference (SMD) is reported at the outcome level. The results indicated a statistically significant improvement of CBT in anxiety and depression symptoms extending up to six months after the intervention. Subgroup analyses by form, duration, and setting did not reveal any differences in outcomes. Thus, the study results would read that CBT improves the mental health of cancer survivors.

The research by Sutanto, Ibrahim, Septiawan, Sudiyanto, & Kurniawan (2021) was designed to assess the benefits of cognitive behavioral therapy (CBT) in the management of anxiety, depression, and quality of life in lung cancer patients. They were 32 participants, divided into two groups; one group which received cognitive-behavioral treatment and the other which made up the control group. The study was carried out in the Regional Public Hospital in Surakarta, namely Dr. Moewardi. In the trial, the CBT group conducted therapy up to six sessions spaced two days apart. Anxiety, depression, and quality of life were quantified respectively through the use of the World Health Organization Quality of Life-Bref (WHOQOL-BREF) and the Hamilton Anxiety Rating Scale (HARS) and Hamilton Depression Rating Scale (HRSD). The outcome was demonstrable improvement in the quality of life of the group receiving CBT therapy when comparably measured with anxiety and depression.

Getu, et al. (2021) performed a systematic review and meta-analysis that examined Cognitive Behavioral Therapy (CBT) interventions and their impacts on patient quality of life (QoL) outcomes for individuals diagnosed with breast cancer. Their analysis comprises eleven RCTs involving 1,690 participants identified through searches of PubMed, Medline, and Web of Science. Overall, the effect of CBT on QoL was medium (0.39, 95% CI 0.12–0.66, $P < 0.00001$, $I^2 = 83\%$). Results in terms of change from baseline in function and symptom scores showed statistical significance for five of the studies. Data extraction was performed by two of the authors according to PRISMA guidelines; a third author cross-verified this information.

The Effectiveness of Cognitive-Behavioral Therapy for Depression in Advanced Cancer: The CanTalk Trial was carried out by Serfaty, et al. (2020) to compare CBT with TAU in patients with advanced cancer and depression. Within the study, 230 patients were randomized; 116 to TAU, and the remainder to a maximum of 12 sessions of CBT. The primary measure of the outcome was BDI-II, while the secondary measures were PHQ-9 and patient care satisfaction. The authors show in this article that this study did not find CBT more effective than TAU on either primary or secondary outcomes. However, an exploratory analysis suggested that certain subgroups— the bereaved and either divorced or separated— might benefit more from CBT (−7.21, 95% CI −11.15 to −3.28).

Abad, Bakhtiar, Kashani, & Habibi (2016) research presented data on the efficacy of Acceptance and Commitment Therapy (ACT) combined with Cognitive-Behavioral Therapy (CBT) in decreasing stress and anxiety levels in female breast cancer patients. The research was aimed at comparing the two modes of treatment for their relative influences on the psychological well-being of female breast cancer patients. Control was taken by another group, and its study has 36 female participants from SHOHADA in Tehran, Iran, assigned randomly either to the ACT or CBT group. Repeated measures of analysis pointed to, at each observation, a significant improvement in manifestations of stress and anxiety due to the use of each of the psychological interventions as described above.

The study was conducted by Goedendorp, Gielissen, Peters, Verhagen, & Bleijenberg (2012) to investigate the long-term effects of Cognitive Behavioral Therapy (CBT) in fatigue management on cancer patients based on a randomized controlled trial. The study involved 210 individuals with different types of cancer. Assessments were carried out at three points in time: baseline, directly post-intervention (at least two months post-treatment), and one year after the intervention. Secondary to these primary assessments, monthly assessments of fatigue were conducted in the period between the second and third assessments. The researchers also checked, using regression analyses, whether the quality of life, functioning, or psychological distress moderated the effectiveness of CBT in reducing fatigue. The results showed that self-reported cognitive functioning effected together with CBT was a significant predictor of reduced fatigue post-treatment. Descriptively, most mean differences at the one-year post-treatment follow-up were not significant. Exploratory analyses indicated a tendency towards lower fatigue up to seven months post-intervention.

Liu, Wang, Li, & Wang (2024) determined the influence of CBPI on social adaptability, psychological resilience, and hope levels in NPC patients under radiation therapy. Patients with NPC were randomly assigned to receive CBPI and standard nursing care in the experimental group or only to conventional specialized nursing care in the control group. Satisfaction, psychological resilience, hope, emotional well-being, and quality of life were measured before and after nursing intervention. It turned out that the living conditions of the patients improved considerably, along with their mental, social, and physical performance, when compared to the control group. In other words, the

experimental group was found to have more improved flexibility, perseverance, sense of control, and goal orientation in comparison to the control group. Also, it was seen that while both groups improved in future orientation as well as social connectedness, the improvements were substantially greater in the experimental group, the effects are stronger for the experimental group.

Ding, et al. (2024) reported the network meta-analysis and systematic review of randomized controlled trials testing various interventions that improve resilience in patients with cancer. The investigators searched for trials in major English and Chinese databases up to November 13, 2023. Only twelve interventions were included in the analysis. Results showed that in comparison with usual care, cognitive therapy, expressive therapy, attention and interpretation therapy, cyclic adjustment training, positive psychological interventions, social support, and work-environment therapy significantly improved resilience. At the same time, attention and interpretation therapy, cognitive interventions, and positive psychological interventions were found to be three most effective therapies due to their statistical power, probability of ranking, and overall effect.

A quasi-experimental design was employed by Sheykhangafshe, Doost, Niri, Mojez, & Bourbour (2023) to ascertain the effect of cognitive-behavioral group therapy on psychological well-being and resilience in students having a depressive syndrome. It was conducted upon 30 high school students of the first grade during the 2021-2022 academic year in Rasht. Subjects were randomly assigned to an experimental group that received eight sessions of therapy for 90 min each or to a control group. The control group did not receive any intervention. The data were collected through a Depression Inventory and a questionnaire of Psychological Well-being and Resilience. This data set, when analyzed with multivariate covariance, reveals that the improvements achieved by the experimental group are significant. The findings of the study explicitly denote that in students with a depressive syndrome, cognitive-behavioral therapy can enhance both psychological well-being and resilience.

Cham, et al. (2023) conducted a systematic review and meta-analysis, and meta-regression analysis to evaluate the effects of resilience interventions on resilience and posttraumatic growth in patients with cancer, incorporating aggregated data from 23 randomized controlled trials involving 3,287 patients with cancer. Their results

indicated that indeed, resilience treatments improved quality of life, anxiety, depressive symptoms, resilience, and posttraumatic growth, although to various degrees of statistical significance. Theory-based interventions delivered synchronously performed better. Cognitive flexibility, self-efficacy, self-esteem, self-regulation, and coping strategies are found to be central in the outcomes. Results from meta-regression analysis show that sample size is a factor that can partly explain variability in posttraumatic growth. The study concluded that more well-designed research is needed to confirm these results.

Luo, et al. (2021) examined the effect of a mobile resilience training program on reducing depressive symptoms and increasing resilience and quality of life (QOL) in parents of pediatric cancer patients. Participants were recruited from the pediatric oncology departments of three Chinese hospitals and randomized to either an eight-week resilience training program (experimental group) or an informational program with placebo (control group). Resilience, depressive symptoms, and CV were assessed at baseline, two months, and six months; after six months, the experimental group showed a marked increase in resilience and a decrease in depressive symptoms, but no significant change in CV. The study concluded that resilience training programs are effective in increasing resilience and helping to reduce depressive symptoms in parents of pediatric cancer patients. Şahin & Türk (2021). The effects of a group psychoeducational cognitive behavioral program on resilience, irrational beliefs, and well-being in high school students were studied. was examined. Twenty-nine participants participated in the study, and instruments such as the Resilience Scale, Irrational Beliefs Scale (for youth), and Subjective Well-Being Scale (for high school students) were used. The experimental group underwent a 10-week program, while the control group received no intervention; a 2 × 3 experimental design was used, with a post-test after the end of the program and a follow-up assessment five months later. The results showed that students in the experimental group had significantly improved resilience scores and decreased irrational beliefs, indicating that the program had a beneficial effect on their psychological well-being.

Tang, Liu, Wu, & Shi (2020) evaluated the effectiveness of a cognitive-behavioral counseling program for reducing emotional distress in breast cancer patients. The study involved 14 participants from the oncology department of Kafr Al-Sheikh Al-Ober

Hospital, divided into experimental and control groups with seven female patients in each group. The researchers used instruments such as the Patient Psychological Distress Scale and the Behavioral and Cognitive Counseling Program. The results showed significant differences in psychological distress levels between the experimental and control groups, with improvements being greater in the experimental group. The authors of the study concluded that cognitive-behavioral counseling is effective in alleviating psychological distress in breast cancer patients.

The aim of Grim's (2016) study was to determine cancer patients' perceptions of psychological and social factors affecting their mental health and their impact on quality of life, social support and changes in medical practice. The sample consisted of 292 cancer patients. One of the most important findings was that cancer patients with low levels of resilience and a negative view of their illness tended to have worse quality of life and psychological impact.

This study determined levels of resilience in newly diagnosed patients with head and neck cancer, The purpose of the study was to predict the likelihood of developing depression, anxiety, and decreased quality of life. The sample consisted of 200 patients with head and neck cancer. One of the main findings from the resilience scale was that as resilience increased, depression and anxiety decreased in patients with head and neck cancer.

Breitbart, et al. (2015) found that the effectiveness of meaning centered group psychotherapy (MCGP) in promoting mental health in patients with advanced cancer. The study examined the effectiveness of MCGP. A total of 253 patients were randomized to receive eight sessions of MCGP or supportive group psychotherapy (SGP). Mental health and quality of life, as well as secondary measures such as depression, hopelessness, anxiety, and somatic symptoms, were assessed before, immediately after, and two months after treatment. The results showed that MCGP significantly improved mental health and quality of life and reduced depression, hopelessness and physical distress compared to SGP. However, there were no significant differences in anxiety levels; intention-to-treat analysis confirmed the higher efficacy of MCGP on quality of life, depression, and hopelessness.

### 1.7.1 Commenting on previous studies

A review of the literature revealed a continued focus on evaluating the impact of cognitive behavioral therapy (CBT) on the psychological well-being of cancer patients and their families Blumenstein et al. (2022) evaluated the effectiveness of CPT in improving functional health outcomes in cancer survivors. They conducted a systematic review and meta-analysis. Their analysis was based on 95 studies and found a significant treatment effect, with factors such as treatment stage acting as major adjustment factors. Similarly, Zhang et al. (2022) examined the effects of CBT on anxiety and depression in cancer survivors and found that CBT produced sustained reductions in both symptoms at 6 months post-treatment, highlighting its potential for long-term psychological effects in cancer treatment; Sutanto, Ibrahim, Septiawan, Sudiyanto, & Kurniawan (2021) also demonstrated the efficacy of CBT in reducing anxiety and depression while improving quality of life in patients with lung cancer, further supporting the therapeutic value of CBT in addressing cancer-related mental health issues. Further extending the impact on quality of life, Getu et al. (2021) found that breast cancer patients treated with CBT reported moderate improvements in patients' quality of life, further supporting the growing body of research on the benefits of CBT in cancer treatment.

In contrast, Serfaty et al. (2020) presented a different perspective and showed that the effect of CBT on reducing depression in advanced cancer patients was limited. However, subgroup analysis showed that CBT may be more effective for certain groups such as widows, divorced and separated patients, indicating that the effects of CBT vary according to cancer stage and patient characteristics. Abad, Bakhtiar, Kashani, & Habibi (2016) found that reducing stress and anxiety in breast cancer patients. Abad, Bakhtiar, Kashani, & Habibi (2016) compared CBT with acceptance and commitment therapy (ACT) and found that both therapies were effective, albeit with slightly different approaches; Goedendorp, Gielissen, Peters, Verhagen, & Bleijenberg (2012) focused on fatigue in cancer patients and found that CBT helps reduce moderate fatigue, but its effects diminish over time. A study by Liu, Wang, Li, & Wang (2024) further contributed to this area by demonstrating a positive effect of CBT on psychological resilience in adolescents and patients with nasopharyngeal cancer, respectively. These

studies demonstrated improvements in resilience, emotional flexibility, and hope, and showed the broad applicability of CBT to overcome various psychological problems.

### 1.7.2 The distinction of the current study from previous studies

The current study aims to enhance the psychological resilience of parents of children with cancer in Jerusalem, distinguishing itself from previous studies by focusing specifically on parents, who face unique emotional strains distinct from the cancer patients themselves. By targeting resilience, this study fills a gap as most prior research centers on reducing symptoms of anxiety, depression, or improving functional health in cancer patients rather than boosting resilience in caregivers. Moreover, while CBT has been widely studied among patients, its application to parental resilience amidst a child's cancer journey is relatively underexplored, offering an opportunity to extend CBT's known benefits to a crucial support network within oncology contexts. Therefore, this study stands out by addressing not only the unique demographic of parents but also by measuring changes in resilience—an outcome that supports sustained psychological well-being amidst ongoing adversity.

## 1.9 Problem Statement

Parents of pediatric cancer patients often face psychological challenges that undermine their resilience and mental health. Unlike the patient, these parents have to contend with their own emotional reactions of worry, anxiety, and helplessness while at the same time caring for their child in need. The prolonged grief caused by such intense emotional strain can undermine their ability to provide their children with the help they need. The psychological resilience of these parents is necessary to control stress, cope with prolonged uncertainty, and maintain emotional stability. Unfortunately, many parents lose their resilience when coping with the daily demands of caring for and monitoring their children's physical condition.

In Jerusalem, it has been observed that there are almost no psychological support services available to parents of children with cancer, specifically regarding building their psychological resilience. In view of the concerning conditions under which these parents liverends, this study closes a gap in the literature using strong research-based evidence that CBT is effective in fortifying such resilience. Accordingly, this study aims to examine the efficacy of a group cognitive behavioral therapy program in

improving psychological resilience and coping styles among Jerusalem's parents with children with cancer in Jerusalem.

Thus, this study investigates the effectiveness of a structured CBT program in enhancing the psychological resilience of parents of children with cancer in Jerusalem. The study's central question is:

**What is the effectiveness of cognitive behavioral therapy in enhancing the psychological resilience of parents of children with cancer in Jerusalem?**

### 1.9 Research Questions

In light of the presentation of the statement of the problem, The following sub-questions branch out from the main question as follow:

1. What is the level of psychological resilience among parents of children with cancer who are visitors and residents in hospitals in Jerusalem?
2. Are there significant differences between the medians of psychological resilience in the pre-test and post-test in the experimental group among parents of children with cancer?
3. Are there significant differences between the medians of psychological resilience in the post-test according to group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer?

### 1.10 Study Hypotheses

1. The psychological resilience scores among parents of children with cancer, who are either visitors or residents in hospitals in Jerusalem, significantly differ from the hypothesized median value of 3.00
2. There are insignificant differences between the medians of psychological resilience in the pre-test and post-test in the experimental group among parents of children with cancer
3. There are insignificant differences in the median psychological resilience scores in the post-test based on group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer

### 1.11 Importance of the study

The importance of the research is evident in the following:

1. The research dealt with one of the modern topics, which is the psychological resilience of an important social group (the parents of children with cancer).
2. Attempting to contribute to presenting a theoretical framework on the concept of psychological resilience and the theories associated with it.
3. The results of the study may benefit psychologists and social workers in designing therapeutic programs that work to increase the level of psychological resilience in parents of children with cancer.
4. The results of the research contribute to directing cancer treatment centers and families in which an individual suffers from cancer to the role of social support and psychological resilience in raising the level of mental health among cancer patients.
5. This research draws attention to the role of the psychological aspect in achieving physical and biological health.

### 1.12 Research Objectives

This study aims to explore the effect of cognitive behavioral resilience on enhancing the psychological resilience of parents of children with cancer in Jerusalem. More specifically, the study also aims to achieve the following objectives:

1. To build and assess a treatment program based on cognitive behavioral group therapy program to increase the level of psychological resilience among the parents of children with cancer, which can be used by specialists and practitioners in this field.
2. To measure the effectiveness of a treatment program based on cognitive behavioral group therapy program to increase psychological resilience parents of children with cancer.

### 1.13 Limitation of the Study

The researcher clarifies the limitation of the study into four: locative, temporal, human and topical limitations.

1. Locative limitation: The study covers Jerusalem city.

2. Temporal limitation: The researcher carried out this study in the scholastic year 2023/2024.
3. Human limitation: The sample of the study was the Parents of Children with Cancer in Jerusalem.
4. Topical limitation: The study was conducted to examine the effectiveness of cognitive behavioral group therapy program enhancing/increasing psychological resilience.

# Chapter Two

# Research Methodology

## 2.1 Introduction

This chapter outlines the methodology, study design, and procedures employed in the current study, including details about the population and sampling techniques. It also provides an overview of the data collection tool used and its psychometric properties. Additionally, this chapter summarizes the therapeutic program sessions, statistical analysis methods, and categories of variables.

## 2.2 Study Design

The aim of this study was to improve the psychological resilience of parents of children with cancer in Jerusalem. To achieve this goal, a cognitive behavioral therapy program (CBTP) was used. Therefore, this study used a quasi-experimental design with a pre-test-post-test control group and an experimental group. The study examined the differences in the psychological resilience of parents before and after the use of CBTP intervention. Therefore, the independent variable was CBTP and the dependent variable was psychological resilience. Two equivalent groups were used in the design: a control group and an experimental group, and CBTP was applied to the experimental group. However, the control group did not receive any intervention. The psychological resilience of both groups was assessed before and after the application of the treatment program, and the results were compared and analyzed. The symbolized study design is as follows:

1. $G_{exp}$ $O_{pre\text{-}exp}$ X $O_{post\text{-}exp}$
2. $G_{con}$ $O_{pre\text{-}con}$ ---- $O_{post\text{-}con}$

Where the symbols refer to:

$G_{exp}$: The experimental group that participated in the CBTP program.

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

$O_{pre\text{-}exp}$: Pre-test measuring psychological resilience for the experimental group participants.

$O_{pre\text{-}con}$: Pre-test measuring psychological resilience for the control group participants.

X: The CBTP program intervention administered to the experimental group.

$O_{post\text{-}exp}$: Post-test measuring psychological resilience for the experimental group participants.

$O_{post\text{-}con}$: Post-test measuring psychological resilience for the control group participants.

### 2.3 Study Population

The study population consists of parents of Palestinian children with cancer, whose children are receiving treatment at hospitals in Jerusalem such as Al-Mutlaa Hospital, Al-Maqasid Hospital, and Hadassah Ein Kerem Hospital. These children are accompanied by their parents and are admitted to these hospitals through medical referrals from hospitals in the West Bank and Gaza Strip, with some also being residents of Jerusalem.

The cancer incidence rate is 84 per 100,000 people Al-Ayyam (2017), and the total Palestinian population in the West Bank, Jerusalem, and Gaza Strip is approximately 6 million (Palestinian Central Bureau of Statistics, 2024). This means the number of cancer patients is 5,040. Approximately 8% of the total cancer patients are children, which means the number of children with cancer is 403. Among these children, 59% are males, and 41% are females. Additionally, 31.7% of child cancer cases in Palestine are recorded in the age group under five years. The percentage of child deaths from cancer out of the total reported cancer deaths in Palestine is 3.8%, while the percentage of Palestinian children under five years old who died from cancer is 26.8% (Al-Ayyam, 2017).

### 2.4 Sampling and Sample Size

The type of sample in this study appears to be a convenience sample. Convenience sampling is a non-probability sampling technique in which participants are selected based on their availability and willingness to participate in the study. This method is not a random selection, which means that not everyone in the population has an equal chance of being included in the sample. Instead, participants are selected because they are easily accessible to the researcher (Fink, 2015).

A total of 18 participants were divided evenly into two groups: the experimental group and the control group, each consisting of 9 participants. The experimental group

comprises nine parents. Within this group, the majority of the parents are female, with 6 out of 9 participants 66.7% being women, while the remaining 3 participants 33.3% are men. In terms of age, a slight majority of the parents are over 35 years old, with 5 participants 55.6% falling into this category, and 4 participants 44.4% being younger than 36 years.

In terms of children, there were slightly more boys, with five 55.6% children being boys compared to four 44.4% girls. Similarly, five 55.6% children were under 10 years of age and the remaining four 44.4% were nine years of age or older. In terms of cancer stage, the experimental group had a slightly higher proportion of children in the early stages of the disease, with six 66.7 % children in stage one or two and three 33.3% in stage three or four. The control group also consists of nine parents. Five 55.6% were female and four 44.4% were male. There is a high proportion of parents aged 35 years or older, with six 66.7% aged 35 years or older and three 33.3% aged 36 years or younger.

The gender distribution of children was the same as in the experimental group: five boys 55.6% and four girls 44.4%. The age distribution was also the same: five 55.6% children younger than 10 years and four 44.4% older than 9 years. Regarding the stage of the cancer, most children were in the early stages of the disease: seven 77.8 % were in the first or second stage and only two 22.2 % were in the third or fourth stage.

Demographic variables in both groups are fairly balanced with only minor differences. Both groups have slightly more female parents and a higher proportion of parents aged 35 and older. Children are evenly distributed by gender and age, with a slightly higher proportion of boys under the age of 10. Most children in both groups are in the early stages of cancer, with a slightly higher proportion in the control group than in the experimental group.

This balanced demographic distribution supports the validity of the experimental design, ensuring that any observed effects are less likely to be influenced by these variables. The following table shows the description of participants in light of some categorical variables.

**Table 1**

*Participants' description (n = 18)*

| Demographic Variables | Variables Level | Group Type | | | |
|---|---|---|---|---|---|
| | | Experimental Group | | control Group | |
| | | Frequency | Percentage | Frequency | Percentage |
| Parent gender | Male | 3 | 33.3% | 4 | 44.4% |
| | Female | 6 | 66.7% | 5 | 55.6% |
| | Total | 9 | 100% | 9 | 100% |
| Parent age | 35 years or less | 4 | 44.4% | 3 | 33.3% |
| | More than 35 | 5 | 55.6% | 6 | 66.7% |
| | Total | 9 | 100% | 9 | 100% |
| Child gender | Male | 5 | 55.6% | 5 | 55.6% |
| | Female | 4 | 44.4% | 4 | 44.4% |
| | Total | 9 | 100% | 9 | 100% |
| Child age | 9 years or less | 5 | 55.6% | 5 | 55.6% |
| | More than 9 years | 4 | 44.4% | 4 | 44.4% |
| | Total | 9 | 100% | 9 | 100% |
| Cancer stage | First or second | 6 | 66.7% | 7 | 77.8% |
| | Third or fourth | 3 | 33.3% | 2 | 22.2% |
| | Total | 9 | 100% | 9 | 100% |

## 2.5 Instrumentation

The researchers aimed to create a scale specifically for parents of children with cancer by combining elements from existing scales such as the Connor-Davidson Resilience Scale (CD-RISC) developed by Davidson & Conner (2003) and the Resilience Rating Scale (RES) developed by (Van Der Meer, et al., 2018). Existing resilience scales often struggle to clearly differentiate between hardness, resilience, flexibility, and malleability. 'Toughness' metaphorically refers to emotional resilience, or the ability to withstand difficult situations without being easily overwhelmed, and implies emotional endurance or resilience (Maddi, 2004). In contrast, resilience refers to the ability to bounce back quickly from setbacks and difficulties, adapt well in stressful situations, and maintain psychological well-being (Masten, 2001).

Psychological resilience involves adapting to changing circumstances by adjusting thoughts, emotions, and behaviors, thus overcoming challenges through the ability to adapt (Kashdan & Rottenberg, 2010). SMOD encompasses fortitude, resilience and endurance in the face of adversity and reflects mental toughness and perseverance in

maintaining determination and purpose (Marie, Hannigan, & Jones, 2018). Based on an extensive literature review, this study developed a psychological resilience scale (PRS) specifically for parents of children with cancer; the PRS consists of 35 items distributed across five domains, each addressing a different aspect of psychological resilience. Participants rate items on a five-point Likert scale (strongly agree = 5, agree = 4, neutral = 3, disagree = 2, strongly disagree = 1), with reverse-scored items adjusted accordingly (strongly agree = 1, agree = 2, neutral = 3, disagree = 4, strongly disagree = 5).The PRS domains are: Self-confidence (SC), Adjustment to changes and stress (ACS), Perseverance and persistence (PP), Dealing with problems and stress (DPS), Seeking resources (SR) Scores across all items are summed to obtain an overall resilience score, with higher scores indicating greater psychological resilience.

### 2.6 The Psychological Resilience Scale validity

The present study evaluated the validity of the PRS assessed by judges. The scale underwent review by six experts from the Departments of Psychology at An-Najah National University, Quds University, and Hebron University. These judges recommended rephrasing unclear items and paraphrasing text to enhance comprehension for parents of children with cancer. Furthermore, two items were removed based on their suggestions. Consequently, the PRS comprised 33 items in this phase.

In the current study, construct validity was evaluated using a method based on corrected item-total correlations (CITCs). The scale was distributed to an exploratory sample consisting of parents of children diagnosed with cancer. Participants were visitors and residents of the Pediatric Oncology Department at An-Najah National University Hospital, representing various regions of the West Bank and Gaza Strip. Distribution occurred over two weeks, involving 35 parents (both mothers and fathers).

Pearson correlation coefficients were computed between each item and its corresponding subscale, as well as with the total score. All items showed significant correlations with both the total score and their respective subscales. Correlation coefficients between items and the total score ranged from 0.36 to 0.84, and with their corresponding subscales ranged from .45 to .88. Additionally, the Pearson correlation

coefficients between subscales and the PRS were 0.67 (SC), 0.74 (ACS), 0.81 (PP), 0.68 (DPS), and 0.79 (SR).

Based on these findings, the PRS retained all scale items, indicating sufficient construct validity and demonstrating its ability to effectively assess the intended underlying construct. The CITCs results of the PRS are presented in the table below.

**Table 2**

*The construct validity of the PRS (n = 35)*

| # | C.O. with SC | C.O. with PRS | # | C.O. with ACS | C.O. with PRS | # | C.O. with PP | C.O. with PRS | # | C.O. with DPS | C.O. with PRS | # | C.O. with SR | C.O. with PRS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | 0.61** | 0.55** | 2. | 0.61** | 0.55** | 3. | 0.74** | 0.68** | 6. | 0.44** | 0.39** | 12. | 0.68** | 0.65** |
| 7. | 0.52** | 0.47** | 5. | 0.54** | 0.62** | 4. | 0.82** | 0.79** | 8. | 0.52** | 0.48** | 13. | 0.45** | 0.43** |
| 9. | 0.75** | 0.71** | 11. | 0.66** | 0.64** | 10. | 0.56** | 0.48** | 14. | 0.67** | 0.53** | 16. | 0.44** | 0.40** |
| 15. | 0.45** | 0.36* | 27. | 0.69** | 0.56** | 20. | 0.88** | 0.84** | 24. | 0.59** | 0.55** | 17. | 0.61** | 0.58** |
| 21. | 0.80** | 0.74** | 30. | 0.44** | | 22. | 0.61** | 0.58** | 25. | 0.77** | 0.74** | 18. | 0.55** | 0.47** |
| 29. | 0.58** | 0.51** | | ACS | 0.74** | 26. | 0.70** | 0.66** | 28. | 0.66** | 0.62** | 19. | 0.68** | 0.63** |
| 31. | 0.44** | 0.38* | | | | 27. | 0.57** | 0.62** | | DPS | 0.68** | 23. | 0.77** | 0.72** |
| 33. | 0.70** | 0.64** | | | | 28. | 0.83** | 0.81** | | | | | SR | 0.79** |
| | SC | 0.67** | | | | | PP | 0.81** | | | | | | |

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

## 2.7 The Psychological Resilience Scale reliability

The current study evaluated the internal consistency reliability of the PRS and its subscales using the Cronbach's Alpha equation, resulting in a coefficient of 0.924 for the total score, which indicates good reliability. The coefficients for the subscales were 0.847 (SC), 0.888 (ACS), 0.901 (PP), 0.758 (DPS), and 0.798 (SR), respectively.

In light of the validity and reliability results, the scale retained 33 items that demonstrate suitability and are distributed across the following subscales:

- Self-confidence (SC): Items 1, 7, 9, 15, 21, 29, 31, 33.
- Adjustment to changes and stress (ACS): Items 2, 5, 11, 27, 30 (reversed item).
- Perseverance and persistence (PP): Items 3, 4, 10, 20, 22, 26, 32.
- Dealing with problems and stress (DPS): Items 6, 8, 14, 24, 25, 28.
- Seeking resources (SR): Items 12, 13, 16, 17, 18, 19, 23.

**A therapeutic program based on CBTP to enhance the psychological resilience of parents of children with cancer**

**a. CBTP Description:**

The CBTP (Cognitive-Behavioral Therapeutic Program) is designed to bolster the psychological resilience of parents whose children are battling cancer. The program integrates a range of therapeutic techniques based on established cognitive and behavioral theories to help parents cope with the stress, trauma and emotional burden associated with their child's illness. The key components of the program include:

1. Cognitive Restructuring: Helping parents identify and challenge negative thought patterns, replacing them with more constructive and positive ones.
2. Behavioral Activation: Encouraging parents to engage in meaningful and enjoyable activities that can improve their mood and overall well-being.
3. Stress Management: Teaching effective strategies for coping with stress, such as mindfulness, relaxation techniques, and problem-solving skills.
4. Emotional Regulation: Providing tools to help parents better manage their emotions, reducing feelings of anxiety, depression, and helplessness.
5. Social Support Enhancement: Facilitating the development of a strong support network, both within the family and the broader community.

**b. Objectives of the CBTP:**

The CBTP aimed to enhance psychological resilience among parents of children with cancer. The following sub- objective branch out from the main objective:

1. Understanding the psychological challenges faced by parents of children with cancer.
2. Developing emotional regulation skills.
3. Enhancing cognitive flexibility.
4. Building social support networks.
5. Cultivating positive thinking skills.
6. Promoting effective communication within the family.

7. Managing stress and anxiety.
8. Fostering optimistic thinking and hope.
9. Coping with anger and resentment.
10. Promoting self-care.

**c. The importance of the CBTP:**

Cognitive-behavioral therapy (CBT)-based treatment programs for parents of pediatric cancer patients improve their psychological resilience by addressing negative thought patterns and promoting emotional regulation. This reduces anxiety and depression, enhancing family dynamics and fostering communication skills. The program also enhances emotional regulation skills, allowing parents to manage emotions more effectively, reducing emotional outbursts and creating a more stable home environment.

The program focuses on addressing anger and resentment, promoting cognitive flexibility and problem-solving skills. It encourages adaptive thinking and different perspectives on challenges, enabling parents to find realistic solutions. Social support is also crucial, providing emotional and practical support through strong networks within families and the community.

The program promotes self-care, reducing caregiver burden, and promoting optimism and hope. It helps parents maintain their health and well-being, prevent burnout, and focus on positive outcomes. Access to local resources and support groups also contributes to this process.

The program enhances stress management by teaching techniques like mindfulness and relaxation exercises, and teaches problem-solving skills to parents with childhood cancer. It boosts psychological resilience, enabling parents to support their children effectively and protect their well-being in difficult situations, ultimately improving family outcomes.

**d. CBTP stages:**

The CBTP to enhance the psychological resilience of parents of children with cancer is structured in three main phases: early phase, mid-treatment phase and end-of-treatment phase.

**Initial Stage: Assessment, Orientation, and Psychoeducation**

1. Initial Assessment: The researcher conducted an assessment of the psychological resilience of respective groups before intervention for a comprehensive analysis of all participants.
2. Orientation Session: The researcher elaborated on the program's goals, structure, school of treatment, including the commitment needed and audience expectations set out for the program to the parents.
3. Psychoeducation: The researcher gave a module on the psychological problems of parents of cancer patients, allowing them to be aware of the emotional processing and stressors that are commonly involved.
4. Introduction to CBT Principles: Parental education on core principles regarding the CBT itself and the link between thoughts, feelings, and behavior was given by the researcher.

**Middle Treatment Stage:**

This stage included:

1. Cognitive Restructuring: The researcher assisted parents in recognizing negative or unhelpful thoughts that contribute to their distress and guided them in challenging these thoughts and replacing them with more constructive and positive ones.
2. Emotional Regulation: The researcher tried to help parents become more aware of their emotional triggers and responses, and provided tools for managing emotions, such as mindfulness, deep breathing, and relaxation techniques.
3. Behavioral Activation: The researcher motivated parents to engage in activities that they find meaningful and enjoyable to improve their mood and well-being, and supported them in creating a balanced routine that includes self-care and leisure activities.

**Stress Management:**

1. Identifying stressors: The researcher tried to help parents pinpoint specific stressors related to their child’s illness and caregiving role.

2. Implementing stress reduction techniques: The researcher taught parents effective strategies for managing stress, including mindfulness, relaxation techniques, and problem-solving skills.

**Enhancing Cognitive Flexibility:**

1. Promoting adaptive thinking: The researcher encouraged flexible thinking and adaptive problem-solving to handle changing situations more effectively.
2. Exercises and role-playing: The researcher used practical exercises and role-playing scenarios to reinforce adaptive thinking and cognitive flexibility.

**Promoting Positive Thinking and Optimism:**

1. Cultivating positivity: The researcher taught parents strategies for maintaining a positive outlook and fostering hope.
2. Fostering hope: The researcher encouraged future-oriented thinking and the maintenance of hope despite challenging circumstances.

**Managing Anger and Resentment:**

1. Recognizing and understanding anger: The researcher tried to help parents identify feelings of anger and resentment and understand their sources.
2. Anger management techniques: The researcher provided techniques for managing anger constructively, such as assertive communication.

**Promoting Self-Care:**

1. Importance of self-care: The researcher educated parents on the importance of self-care for maintaining their mental and physical health.
2. Incorporating self-care into daily routine: The researcher assisted parents in integrating self-care practices into their daily routine to prevent burnout.

**End Stage of Treatment:**

The researcher assessed the psychological resilience of all participants after the intervention for both groups.

**e. The CBTP timeframe**:

This program consists of 12 sessions, scheduled every five days over a period of two months, with each session lasting approximately two hours.

**f. Place and Tools**

The CBTP program was conducted at "Wardeh Society" in Wadi al-Joz, Jerusalem. It is located near the hospitals where the study sample is situated. The sessions utilized LCD screen, laptops, pens, pencils, coloring pens, CBTP cards, and some gifts to facilitate the program activities.

**g. Content of the CBTP program:**

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

**Table 3**

*The content of the twelve-session CBTP*

| Session number | Session objectives | Session duration by |
|---|---|---|
| The first session | - Initial assessment (pre-test).<br>- Orientation, and psychoeducation.<br>- Introductions, icebreaking, and participant expectations disclosure. | 2 hours |
| The second session | - Understanding the psychological challenges faced by parents of children with cancer. | 2 hours |
| The third session | - Developing emotional regulation skills. | 2 hours |
| The fourth session | - Enhancing cognitive flexibility. | 2 hours |
| The fifth session | - Building social support networks. | 2 hours |
| The sixth session | - Cultivating positive thinking skills. | 2 hours |
| The seventh session | - Cultivating positive thinking skills. | 2 hours |
| The eighth session | - Promoting effective communication within the family. | 2 hours |
| The ninth session | - Managing stress and anxiety. | 2 hours |
| The tenth session | - Fostering optimistic thinking and hope. | 2 hours |
| The eleventh session | - Coping with anger and resentment | 2 hours |
| The twelfth session | - Promoting self-care.<br>- Assessing psychological resilience as post-test. | 2 hours |

## 2.8 The Study Procedures

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

1. Review and development of the theoretical framework, along with presenting previous studies related to the study topics: psychological resilience, parents of children with cancer, and Cognitive Behavioral Therapy Program (CBTP).
2. Preparation of the study instrument and the therapeutic program based on CBT.
3. Testing the validity and reliability of the Psychological Resilience Scale (PRS) by applying it to an exploratory sample of 35 parents of children with cancer.
4. Determining the study's sampling technique (convenience sample) and conducting pre-tests to assess the level of psychological resilience among parents of children with cancer.
5. Presenting informed consent to parents of children with cancer to obtain permission for administering the CBTP. All participants agreed to participate, resulting in a final sample of 18 parents.
6. Distributing participants into two study groups (9 in the experimental group and 9 in the control group) using an equivalent group design, matching participants based on their psychological resilience level and cancer stage.
7. Administering the CBTP to the experimental group, while the control group received no intervention.
8. Conducting a post-test for both groups after implementing the CBTP.
9. Entering data into a computer for statistical analysis using SPSS.
10. Analyzing the results, discussing findings, and providing recommendations based on the outcomes.

## 2.9 The Statistical Analysis

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

1. Frequencies, Percentages, Means, and Standard Deviations to summarize the study variables.

2. Pearson Product-Moment Correlation Coefficient to assess the validity of the Psychological Resilience Scale.
3. Cronbach's Alpha to measure the reliability of the Psychological Resilience Scale.
4. Shapiro-Wilk Test to test the normality of the study variables, particularly for small sample sizes (less than 30 participants).
5. Mann–Whitney U Test to assess the significance of differences between two independent medians.
6. Wilcoxon Signed Rank Test for one sample to evaluate the psychological resilience levels among parents of children with cancer in Jerusalem.
7. Wilcoxon Signed Ranks Test for paired samples.
8. Nonparametric Multivariate Analysis of Covariance (NPMANCOVA) to examine the significance of post-test mean differences considering pre-test scores, group type, parent gender, parent age, child gender, child age, and cancer stage.

### 2.10 Study Variables

**a.** Independent variables: represented by the CBTP, where the experimental group received the intervention while the control group received nothing. In addition, the independent variables included parent gender, parent age, child gender, child age, and cancer stage.

**b.** Dependent variables: The dependent variable was the psychological resilience and its domains.

### 2.11 The Equivalence of the Two Study Groups

The equivalence for the level of psychological resilience was verified in the pre-test for the two groups and the results of this study were obtained. In addition, to conduct appropriate statistical test, the researcher examined psychological resilience's normal distribution among both groups for the pretest. Parametric tests are the most powerful statistical tests when the data follows normal distributions. While non-parametric tests become an appropriate option when data are not normally distributed (Verma & Abdel-Salam, 2019). Additionally, when the sample size is less than 30 individuals, the appropriate test for normality is the Shapiro-Wilk test (Field, 2013). The following table shows the results of the Shapiro-Wilk test.

**Table 4**

*Testing the normality of the responses in psychological for both groups in the pre-test by the Shapiro-Wilk test*

| Group type | Dependent variable | Shapiro-Wilk test | | |
|---|---|---|---|---|
| | | Statistic | df | Sig. |
| Control ($n$ = 9) | PRS | 0.722 | 8 | 0.003** |
| Experimental ($n$ = 9) | PRS | 0.826 | 8 | 0.040* |

**(p < .01), *(p < .05).

However, as table tells, normality was not granted for psychological resilience in the pre-tests on both groups. Because all statistic values of the Shapiro-Wilk test were significant, it should be applied in this case non-parametric statistical methods. In order to assess the equivalence of both groups in psychological resilience and its domains at the pre-test, medians were tested for differences using the Mann–Whitney U test. Here are the results:

**Table 5**

*Results of the Mann–Whitney U test for psychological resilience and its dimensions for parents of children with cancer (n = 18)*

| Dependent Variables | Exp. Group (n=9) | | Con. Group (n=9) | | U | Z | P-value |
|---|---|---|---|---|---|---|---|
| | Mean Ranks | Sum of Ranks | Mean Ranks | Sum of Ranks | | | |
| SC | 10.44 | 94.00 | 8.56 | 77.00 | 32.00 | -0.760 | .447 |
| ACS | 10.11 | 91.00 | 8.89 | 80.00 | 35.00 | -0.494 | .621 |
| PP | 8.67 | 78.00 | 10.33 | 93.00 | 33.00 | -0.668 | .504 |
| DPS | 9.56 | 86.00 | 9.44 | 85.00 | 40.00 | -0.045 | .964 |
| SR | 9.44 | 85.00 | 9.56 | 86.00 | 40.00 | -0.049 | .961 |
| PRS | 9.56 | 86.00 | 9.44 | 85.00 | 40.00 | -0.044 | .965 |

The results in the previous table show that the Mann–Whitney test value for the total score of psychological resilience was (U = 40.00), with a statistical value of (Z = -0.044, $\alpha > 0.05$). This indicates no statistically significant differences between the medians of the control and experimental groups for the total score of psychological resilience in the pre-test, suggesting that the two groups were equivalent in this measure.

For the dimension of self-confidence (SC), the Mann–Whitney test value was (U = 32.00), with a statistical value of (Z = -0.760, $\alpha > 0.05$). This indicates no statistically

significant differences between the medians of the two groups in self-confidence in the pre-test, showing equivalence between the groups.

Regarding the dimension of adjustment to changes and stress (ACS), the Mann–Whitney test value was (U = 35.00), with a statistical value of (Z = -0.494, $\alpha > 0.05$). This indicates no statistically significant differences between the medians of the two groups in this dimension in the pre-test, meaning the groups were equivalent.

For the dimension of perseverance and persistence (PP), the Mann–Whitney test value was (U = 33.00), with a statistical value of (Z = -0.668, $\alpha > 0.05$). This indicates no statistically significant differences between the medians of the two groups in this dimension in the pre-test, confirming equivalence.

The Mann–Whitney test value for the dimension of dealing with problems and stress (DPS) was (U = 40.00), with a statistical value of (Z = -0.045, $\alpha > 0.05$). This indicates no statistically significant differences between the medians of the two groups in this dimension in the pre-test, demonstrating equivalence.

Lastly, the Mann–Whitney test value for the dimension of seeking resources was (U = 40.00), with a statistical value of (Z = -0.049, $\alpha > 0.05$). This indicates no statistically significant differences between the medians of the two groups in this dimension in the pre-test, meaning the groups were equivalent.

Overall, these results confirm the equivalence of the two groups before the intervention.

# Chapter Three

# The Results

The main goal of this study was to investigate the effectiveness of the CBTP in enhancing psychological resilience among parents of children with cancer in hospitals in Jerusalem. Furthermore, this study aimed to examine the differences in psychological resilience based on parent gender, parent age, child gender, child age, and cancer stage. Accordingly, this chapter addresses questions related to these objectives:

## 3.1 The Results of the First Question

What is the level of psychological resilience among parents of children with cancer who are visitors and residents in hospitals in Jerusalem?

Based on this question the researcher hypothesized that: "The psychological resilience scores among parents of children with cancer, who are either visitors or residents in hospitals in Jerusalem, significantly differ from the hypothesized median value of 3.00"

To evaluate the level of psychological resilience among parents of children with cancer visiting or residing in hospitals in Jerusalem, this study compared resilience scores and its domains using predefined cut-off value. This value was determined based on the midpoint between the minimum and maximum scores. The Wilcoxon Signed Rank test for one sample was employed to assess whether the sample scores significantly differed from this cut-off value, which were treated as hypothetical means. A cut-off value of 3.00 was used as the hypothesized median. The table below summarizes the findings of the analysis.

**Table 6**

*Results of Wilcoxon Signed Rank test for one sample for the difference between the psychological resilience sample median and the hypothetical median (n = 18)*

| Variables | Sample median | Z-value | Sig. |
|---|---|---|---|
| SC | 3.13 | 1.203 | .229 |
| ACS | 2.50 | -2.042 | .041* |
| PP | 2.79 | -1.525 | .127 |
| DPS | 2.36 | -2.70 | .007** |
| SR | 3.00 | 1.489 | .137 |
| PRS | 2.80 | -1.547 | .122 |

**($p < .01$), *($p < .05$).

As illustrated in the table above, the result indicates that there is a negative insignificant difference ($z = -1.547$, $p > 0.05$) between the PRS sample median 2.80 and the hypothetical median (cut point = 3.00). In other words, there is a moderate level of psychological resilience among parents of children with cancer.

The sample median for self-confidence (SC) is 3.13. The z-value of (1.203, $p > 0.05$) indicates that the difference from the hypothetical median (cut point = 3.00) is not statistically significant. Therefore, there is no indication of a noteworthy difference in self-confidence observed among parents of children with cancer when compared to the hypothetical median. In other words, there is a moderate level of self-confidence among parents of children with cancer.

The sample median for adjustment to changes and stress (ACS) is 2.50. The z-value of (-2.042, $p < 0.05$) indicated a statistically significant difference. This suggests that parents of children with cancer generally exhibit lower adjustment to changes and stress compared to the hypothetical median. In other words, there is a low level of adjustment to changes and stress among parents of children with cancer.

The sample median for perseverance and persistence (PP) is 2.79. The z-value of (-1.525, $p > 0.05$) indicated no statistically significant difference. Thus, parents' perseverance and persistence are not significantly different from the hypothetical median. In other words, there is a moderate level of perseverance and persistence among parents of children with cancer.

The sample median for dealing with problems and stress (DPS) is 2.36. The z-value of (-2.700, $p < 0.05$) indicated a statistically significant difference. This suggests that parents have a lower ability to deal with problems and stress compared to the hypothetical median. In other words, there is a low level of dealing with problems and stress among parents of children with cancer.

The sample median for seeking resources (SR) is 3.00. The z-value of (1.489, $p > 0.05$) indicated no statistically significant difference. Therefore, the tendency to seek resources among parents is similar to the hypothetical median. In other words, there is a moderate level of seeking resources among parents of children with cancer.

In conclusion, while there is a moderate level of psychological resilience among parents of children with cancer, specific areas such as adjustment to changes and stress, and dealing with problems and stress, could benefit from targeted interventions like a therapeutic CBT group program. Such a program could provide valuable tools and support to help enhance their resilience and better cope with the challenges associated with their situation.

### 3.2 The Results of the Second Question

This question states, "Are there significant differences between the medians of psychological resilience in the pre-test and post-test in the experimental group among parents of children with cancer?

Based on this question, the researcher hypothesized that: “There are insignificant differences between the medians of psychological resilience in the pre-test and post-test in the experimental group among parents of children with cancer”.

Before answering this question and to determine the appropriate statistical test to use since the study sample is small (less than 30), it is essential to assess the normality of the responses. Based on what was reported by Field (2013), the normality of the psychological resilience responses in the pre-test and post-test for the experimental group was examined in order to choose the appropriate statistical methods. The Table below shows the results.

**Table 7**

*Testing the normality of the responses in psychological resilience in the pre-test and post-test for the experimental group by the Shapiro-Wilk test (n = 9)*

| Test type | Dependent variables | Shapiro-Wilk test | | |
|---|---|---|---|---|
| | | Statistic | df | Sig. |
| Pre-test ($n$ = 9) | PRS | 0.826 | 8 | 0.040* |
| Post-test ($n$ = 9) | PRS | 0.795 | 8 | 0.021* |

*($p < 0.05$).

As shown in the previous table, the responses were not normally distributed in psychological resilience for the experimental group in the pre-test and post-test, as the Shapiro-Wilk test statistic was significant ($p < 0.05$). Consequently, nonparametric statistical methods should be used in this case.

To examine the differences in psychological resilience between the pre-test and post-test of the experimental group, the medians of PRS and its domains were calculated. Additionally, the Wilcoxon Signed Ranks Test, a nonparametric test, to determine the significance of the difference between the medians of two related groups. Moreover, the effect size (r) was calculated using the Tomczak & Tomczak (2014) equation, which is specifically designed for calculating effect size with nonparametric tests. The equation is as follows:

$$r = \frac{Z}{\sqrt{n}} \quad \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots \quad (1)$$

And the following table presents the results.

**Table 8**

*The results of paired samples t-Test of the differences between pre-test and post-test of psychological resilience in the experimental group*

| Dependent variables | Median | | Negative (n=0) | | Positive (n=9) | | Z | P-value | Effect Size |
|---|---|---|---|---|---|---|---|---|---|
| | Pre-test | Post-test | Mean Ranks | Sum of Ranks | Mean Ranks | Sum of Ranks | | | |
| SC | 3.06 | 4.37 | 0.00 | 0.00 | 4.50 | 36.00 | -2.54 | 0.011* | 0.90 |
| ACS | 2.38 | 3.75 | 2.50 | 2.50 | 5.31 | 42.50 | -2.38 | 0.017* | 0.84 |
| PP | 2.79 | 4.36 | 0.00 | 0.00 | 5.00 | 45.00 | -2.67 | 0.008** | 0.94 |
| DPS | 2.36 | 4.14 | 0.00 | 0.00 | 5.00 | 45.00 | -2.68 | 0.007** | 0.95 |
| SR | 3.00 | 4.00 | 0.00 | 0.00 | 5.00 | 45.00 | -2.70 | 0.007** | 0.95 |
| PRS | 2.77 | 4.17 | 0.00 | 0.00 | 5.00 | 45.00 | -2.67 | 0.008** | 0.94 |

**(p < .01), *(p < .05).

The results from the previous table show that the median of psychological resilience (PRS) increased from 2.77 to 4.17 with a significant z-value ($z = -2.67$, $p < 0.01$) for the overall score of psychological resilience among parents of children with cancer was statistically significant in favor of the post-test, with an effect size of ($r = 0.94$). This effect is considered very strong, indicating that the cognitive-behavioral group counseling program was effective in enhancing the psychological resilience of the experimental group members. It is noteworthy that the number of positive ranks was (9), meaning that the psychological resilience of all (9) participants in the experimental group improved, representing the entire experimental group.

The median self-confidence (SC) score increased from 3.06 to 4.37, with a significant z-value of -2.54 and an effect size of 0.90. This indicates a strong improvement in self-confidence among the participants. Similarly, the median score for adjustment to changes and stress (ACS) increased from 2.38 to 3.75, with a significant z-value of -2.38 and an effect size of 0.84. This effect is considered strong and suggests a substantial enhancement in how participants adjust to changes and stress.

The median of perseverance and persistence (PP) rose from (2.79 to 4.36), with a significant z-value of ($z = -2.67$, $p < 0.01$) and an effect size of .94. This effect is considered very strong indicating marked improvements in perseverance and persistence.

The median score for dealing with problems and stress (DPS) increased from 2.36 to 4.14, with a significant z-value of -2.68 ($p < 0.01$) and an effect size of .95. This indicates a very strong improvement in the ability to handle problems and stress. Similarly, the median score for seeking resources (SR) rose from 3.00 to 4.00, with a significant z-value of -2.70 ($p < 0.01$) and an effect size of .95, indicating a strong improvement in seeking resources.

The cognitive-behavioral group therapeutic program proved highly effective in enhancing various aspects of psychological resilience among parents of children with cancer. The strong effect sizes and significant improvements across all measured domains underscore the program's impact and suggest that such interventions can substantially benefit this population.

### 3.3 The Results of the Third Question

This question states, "Are there significant differences between the medians of psychological resilience in the post-test according to group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer?

Based on this question, the researcher hypothesized that: “There are insignificant differences in the median psychological resilience scores in the post-test based on group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer.

Before answering this question, and to determine the statistical test that should be used since the study sample is small (less than 30). In addition, based on what was reported by Field (2013); the normality of responses in psychological resilience in the post-test for both groups were examined in order to choose the appropriate statistical methods. Table below shows the results.

**Table 9**

*Testing the normality of the responses in psychological resilience in the post-test a by the Shapiro-Wilk test (n = 9)*

| Group type | Dependent variables | Shapiro-Wilk test | | |
|---|---|---|---|---|
| | | Statistic | Df | Sig. |
| Control (n = 9) | PRS | 0.777 | 8 | 0.014* |
| Experimental (*n* = 9) | PRS | 0.795 | 8 | 0.021* |

*($p < 0.05$).

As shown in the previous table responses were not normally distributed in psychological resilience for the post-test in both groups. Where, all statistic values of the Shapiro-Wilk test were significant ($p > 0.05$), consequently nonparametric statistical methods can be used in this case. To examine the differences between psychological resilience and their domains in the post-test according to group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer. The researcher used the Non-Parametric Six-Way MANCOVA, which, according to Dunn (1972), is the non-parametric alternative to the Parametric Multiple Analysis of Covariance (MANCOVA). This test involves converting responses into ranks, and then testing the differences in these ranks using Parametric MANCOVA. The results of this analysis are presented in the following table.

**Table 10**

*Results of the Non-Parametric Six-Way MANCOVA test for the significance of differences between the mean ranks of the post-test for psychological resilience and its dimensions according to the independent variables among parents of children with cancer (n = 18)*

| Independent Variables | Dependent Variables | Sum of Squares | DF | Mean Squares | F-Value | P-Value | Eta Squared / Effect Size |
|---|---|---|---|---|---|---|---|
| Group Type | SC | 306.804 | 1 | 306.804 | 44.080 | 0.000** | 0.830 |
| | ACS | 229.438 | 1 | 229.438 | 10.238 | 0.011* | 0.532 |
| | PP | 337.842 | 1 | 337.842 | 42.819 | 0.000** | 0.826 |
| | DPS | 349.296 | 1 | 349.296 | 43.058 | 0.000** | 0.827 |
| | SR | 336.866 | 1 | 336.866 | 35.332 | 0.000** | 0.797 |
| | PRS | 385.391 | 1 | 385.391 | 49.634 | 0.000** | 0.847 |
| Parent Gender | SC | 0.185 | 1 | 0.185 | 0.027 | 0.874 | 0.003 |
| | ACS | 6.680 | 1 | 6.680 | 0.298 | 0.598 | 0.032 |
| | PP | 11.557 | 1 | 11.557 | 1.465 | 0.257 | 0.140 |
| | DPS | 0.086 | 1 | 0.086 | 0.011 | 0.920 | 0.001 |
| | SR | 0.224 | 1 | 0.224 | 0.024 | 0.881 | 0.003 |
| | PRS | 0.010 | 1 | 0.010 | 0.001 | 0.973 | 0.000 |
| Parent Age | SC | 0.371 | 1 | 0.371 | 0.053 | 0.822 | 0.006 |
| | ACS | 24.715 | 1 | 24.715 | 1.103 | 0.321 | 0.109 |
| | PP | 8.223 | 1 | 8.223 | 1.042 | 0.334 | 0.104 |
| | DPS | 2.478 | 1 | 2.478 | 0.305 | 0.594 | 0.033 |
| | SR | 3.195 | 1 | 3.195 | 0.335 | 0.577 | 0.036 |
| | PRS | 2.908 | 1 | 2.908 | 0.374 | 0.556 | 0.040 |
| Child Gender | SC | 0.100 | 1 | 0.100 | 0.014 | 0.907 | 0.002 |
| | ACS | 13.289 | 1 | 13.289 | 0.593 | 0.461 | 0.062 |
| | PP | 0.025 | 1 | 0.025 | 0.003 | 0.956 | 0.000 |
| | DPS | 7.203 | 1 | 7.203 | 0.888 | 0.371 | 0.090 |
| | SR | 1.009 | 1 | 1.009 | 0.106 | 0.752 | 0.012 |
| | PRS | 0.283 | 1 | 0.283 | 0.036 | 0.853 | 0.004 |
| Child Age | SC | 6.578 | 1 | 6.578 | 0.945 | 0.356 | 0.095 |
| | ACS | 5.717 | 1 | 5.717 | 0.255 | 0.626 | 0.028 |
| | PP | 11.795 | 1 | 11.795 | 1.495 | 0.253 | 0.142 |
| | DPS | 0.119 | 1 | 0.119 | 0.015 | 0.906 | 0.002 |
| | SR | 2.819 | 1 | 2.819 | 0.296 | 0.600 | 0.032 |
| | PRS | 1.169 | 1 | 1.169 | 0.151 | 0.707 | 0.016 |
| Cancer Stage | SC | 17.379 | 1 | 17.379 | 2.497 | 0.149 | 0.217 |
| | ACS | 12.926 | 1 | 12.926 | 0.577 | 0.467 | 0.060 |
| | PP | 9.608 | 1 | 9.608 | 1.218 | 0.298 | 0.119 |
| | DPS | 18.251 | 1 | 18.251 | 2.250 | 0.168 | 0.200 |
| | SR | 1.804 | 1 | 1.804 | 0.189 | 0.674 | 0.021 |
| | PRS | 5.689 | 1 | 5.689 | 0.733 | 0.414 | 0.075 |
| Pre-Test of PRS | SC | 1.675 | 1 | 1.675 | 0.241 | 0.636 | 0.026 |
| | ACS | 6.011 | 1 | 6.011 | 0.268 | 0.617 | 0.029 |
| | PP | 4.791 | 1 | 4.791 | 0.607 | 0.456 | 0.063 |
| | DPS | 4.580 | 1 | 4.580 | 0.565 | 0.472 | 0.059 |
| | SR | 0.486 | 1 | 0.486 | 0.051 | 0.826 | 0.006 |
| | PRS | 6.312 | 1 | 6.312 | 0.813 | 0.391 | 0.083 |

**($p < .01$).

The results of the previous table show that there are statistically significant differences between the mean ranks of the post-test for the control and experimental groups in psychological resilience and its dimensions for parents of children with cancer, in favor of the experimental group. The value of ($F = 49.63$, $p < 0.01$) for the total psychological resilience score, indicating the effectiveness of the cognitive-behavioral group therapeutic program in enhancing the level of psychological resilience among members of the experimental group compared to the control group. The effect size for the experimental treatment was 0.85, which is considered strong according to (Thalheimer & Cook, 2022).

There is a statistically significant difference in the mean ranks of the post-test scores for self-confidence (SC) across different group types (experimental vs. control). The experimental group shows significantly higher scores ($F = 44.080$, $p < 0.01$), indicating that the cognitive-behavioral group therapeutic program is effective in enhancing psychological resilience compared to the control group (effect size = 0.83). Similar to SC, adjustment to changes and stress (ACS) shows significant improvement in the experimental group ($F = 10.238$, $p < 0.05$), with effect size of (0.53) which considered moderate.

Regarding perseverance and persistence (PP) also demonstrates significant improvement in the experimental group ($F = 42.819$, $p < 0.01$), with effect size of 0.83 which considered strong. In addition, dealing with problems and stress (DPS) scores indicate significant improvement in the experimental group ($F = 43.058$, $p < 0.01$), with effect size of (0.83) which considered strong. Furthermore, seeking resources (SR) shows significant improvement in the experimental group ($F = 35.332$, $p < 0.01$), with effect size of (0.80) which considered strong.

On the other hand, there are no statistically significant differences found in the mean ranks of the post-test scores for psychological resilience and its domains (PRS, SC, ACS, PP, DPS, and SR) due to parent gender and age, child gender and age, cancer stage, and the pre-test of psychological resilience. This suggests that these factors do not significantly influence the psychological resilience scores in the post-test.

Overall, the findings indicate that the cognitive-behavioral group therapeutic program is highly effective in enhancing psychological resilience among parents of children with cancer. The effect sizes (Eta squared values) are consistently high across different dimensions of psychological resilience, indicating strong practical significance.

# Chapter Four

# Discussion, Conclusions, Recommendations

This chapter includes a discussion of the research questions and hypotheses. Finally, recommendations for the study are provided based on the findings.

## 4.1 Discussion

### 4.1.1 Discussion of the Results Related to the First Question

What is the level of psychological resilience among parents of children with cancer who are visitors and residents in hospitals in Jerusalem?.

The findings show that parents of children with cancer who visit or stay in hospitals in Jerusalem have a modest level of overall psychological resilience (PRS), with a sample median of 2.80 that does not significantly differ from the hypothetical median of 3.00. Adjustment to changes and stress (ACS) and coping with difficulties and stress (DPS) are much below the hypothetical median, even though other categories like self-confidence (SC), perseverance and persistence (PP), and seeking resources (SR) all show moderate levels. These results demonstrate the need for focused interventions, including cognitive-behavioral therapy (CBT) courses, to improve resilience in areas where parents face more challenges.

The study emphasizes the need for focused therapies to improve specific aspects of resilience, including cognitive behavioral group therapy, these therapy programs can give parents the skills and strategies they need to deal with stress more skillfully, adjust to changes, and solve problems more skillfully, these interventions can help parents feel less alone and receive more emotional support by creating a supportive group setting that promotes a sense of community and understanding.

In fact, mothers and fathers having diagnosed cancer patients in Jerusalem are generally associated with moderate psychological resilience levels, despite the many marked challenges by which changes had to be adapted, stress managed, and needed resources acquired. These aspects point to the significance of very strong support systems. Healthcare providers can contribute act in developing such resilience, coping skills, and parenting in parents by putting into operation such focused and targeted interventions.

These results are consistent with earlier studies on the value of cognitive-behavioral therapies in enhancing psychological resilience, especially for caregivers and cancer survivors. For example, studies by (Zhang et al., 2022; Blumenstein et al., 2022) demonstrated how well cognitive-behavioral therapy (CBT) works to improve functional health outcomes and lower anxiety and depression in cancer survivors. Similar to this, Sutanto, Ibrahim, Septiawan, Sudiyanto, & Kurniawan (2021) discovered that CBT considerably decreased depression and anxiety, reflecting the necessity for focused interventions for parents who are under a lot of stress. Additionally, (Getu et al., 2021; Serfaty et al., 2020) highlighted the potential advantages of cognitive behavioral therapy (CBT) in enhancing cancer patients' quality of life and managing their mental health.

### 4.1.2 Discussion of the Results Related to the Second Question

The answers to the second question show how well the cognitive-behavioral group therapy program worked to help parents of cancer patients become more psychologically resilient. With a very substantial effect size (r =.94) and a median increase from 2.77 (pre-test) to 4.17 (post-test), statistical analysis using the Wilcoxon Signed Ranks Test showed significant improvements in the total psychological resilience score. With impact sizes ranging from.84 to.95, improvements were seen in all areas, including self-confidence, adjusting to changes and stress, tenacity and persistence, handling issues and stress, and seeking resources. These results demonstrate the program's significant benefits and its potential as a useful intervention for helping this demographic.

The noteworthy enhancements noted in every area of psychological resilience imply that the cognitive-behavioral group therapy program was quite successful. The program's overall effectiveness is demonstrated by the strong effect sizes and steady gains in many resilience-related domains. According to these findings, parents of children with cancer can greatly benefit from such therapy treatments, which will help them deal with the practical and emotional difficulties they encounter. Larger sample sizes in future research could confirm these results and examine the long-term advantages of these initiatives.

The study's findings unequivocally show how well the cognitive-behavioral group treatment program works to improve psychological resilience in parents of cancer patients. The findings showed significant gains in all assessed aspects of psychological resilience, such as self-assurance, adaptability to stress and change, tenacity and persistence, handling stress and challenges, and resource seeking. The fact that the effect sizes (r) were continuously large suggests that the intervention significantly improved the participants' capacity to manage the difficulties associated with their children's illness.

Notably, every participant showed improvements in psychological resilience, demonstrating the program's wide range of applications. Psychological resilience This consistent improvement highlights the program's potential as a broadly applicable intervention for this demographic and indicates that it was successful for a varied set of parents.

The outcomes also show that the program successfully covered important facets of psychological resilience, including self-assurance and the capacity to cope with stress and change. The notable progress in these areas indicates that the training gave parents useful resources and techniques to better handle their situation. This is a significant result since these resilience-related traits are essential for overcoming the psychological and emotional difficulties of raising a kid with cancer.

These resilience components were greatly enhanced by the program's content and approaches. Cognitive-behavioral therapy is well-known for its emphasis on recognizing and altering negative thought patterns as well as creating coping mechanisms to deal with stress. The program promoted more resilience by giving parents useful coping mechanisms to deal with their kids' illnesses and related pressures. In a circumstance as daunting as caring for a kid with cancer, the therapeutic practices probably gave parents a sense of empowerment and control over their emotional reactions.

To sum up, the cognitive-behavioral group therapy program was a very successful intervention for raising the psychological fortitude of parents of cancer patients. Given the notable gains in a number of resilience domains, this strategy need to be regarded as an important part of support programs for parents dealing with comparable difficulties.

To validate these results and investigate the long-term advantages of such therapies, more studies with bigger sample sizes and longitudinal designs are required. Further understanding of how particular aspects of the therapy contribute to the noted gains may also help to improve these programs.

The findings of this study are consistent with earlier investigations into how well cognitive-behavioral treatment (CBT) might improve psychological resilience. For example, Hassanein's (2021) study demonstrated the beneficial effects of cognitive-behavioral interventions on stress management and emotional regulation, which is consistent with the gains seen in this study regarding parents' capacity to manage stress and adapt to changing conditions. The results of this study, which demonstrate changes in parents' psychological flexibility and their capacity to endure hardship, are in line with Jaberat's (2021) emphasis on the role of cognitive behavioral therapy (CBT) in boosting emotional resilience by altering negative thought patterns.

Furthermore, the results of this study are consistent with those of Abdel-Aal (2022) and Nsheekat (2022), who investigated the role of cognitive behavioral therapy (CBT) in promoting coping strategies for people facing health-related stress. Both studies discovered that CBT enhanced participants' capacity to control stress and preserve emotional stability, which is similar to what the parents in this study reported after completing the group therapy program.

### 4.1.3 Discussion of the Results Related to the Third Question

Are there significant differences between the medians of psychological resilience in the post-test according to group type, parent gender, parent age, child gender, child age, and cancer stage among parents of children with cancer?

The findings reveal statistically significant differences in psychological resilience scores in the post-test between the experimental and control groups of parents of children with cancer, favoring the experimental group. This demonstrates the effectiveness of the cognitive-behavioral group therapeutic program in enhancing psychological resilience, with strong effect sizes across its dimensions: self-confidence, adjustment to changes and stress, perseverance and persistence, dealing with problems and stress, and seeking resources. However, no significant variations were found according to the pre-test scores, cancer stage, kid age, parent gender, or parent age, indicating that these factors

do not significantly affect psychological resilience results. Overall, the experimental group's resilience levels were greatly increased by the therapy program. The program's efficacy is demonstrated by the noticeable improvement in every aspect of resilience. This implies that in addition to enhancing general resilience, the cognitive-behavioral approach focuses on particular psychological domains that are essential for parents coping with the trying time of raising a child with cancer.

For example, parents may be better able to manage their mental health and successfully handle the many difficulties that come with caring for a kid with a serious disease if they experience gains in their self-confidence and perseverance. The program's potential to give parents useful tools for stress management and enhancing their general coping mechanisms is also demonstrated by the rise in the capacity to manage stress and seek resources.

Demographic factors such parent gender, age, child gender, child age, cancer stage, and pre-test psychological resilience scores did not substantially affect the post-test resilience scores, according to another important analysis conclusion. This is especially significant since it implies that a wide range of demographic groups can benefit from the cognitive-behavioral group therapy approach. The absence of substantial variations according to these variables suggests that the program's influence is not limited to particular sample groups.

This discovery is significant because it shows that the program's advantages are broadly applicable, making it a suitable intervention for a variety of families dealing with the psychological and emotional strain of raising children with cancer. The nature of the cognitive-behavioral therapy itself, which focuses on teaching people particular coping mechanisms and ways to reframe their ideas and emotions in response to stress, may account for the non-significant impact of these demographic characteristics.

Regardless of the demographics of the participants, the program seems to provide skills that are universally valuable by focusing on cognitive processes and behavioral patterns. It's likely that all participants, regardless of their past or unique situation, can benefit from the program's therapeutic approaches, which include cognitive restructuring, relaxation techniques, and problem-solving skills.

The study's overall conclusions provide compelling evidence of the cognitive-behavioral group therapy program's ability to improve psychological resilience in parents of cancer patients. Together with the lack of demographic effects, the notable increases in psychological

## 4.2 Conclusions

According to the study, parents of children with cancer in Jerusalem can improve their psychological resilience by participating in a cognitive-behavioral group therapy program. Numerous aspects of psychological resilience, such as self-confidence, adaptability to changes and stress, tenacity and persistence, handling issues and stress, and resource seeking, saw notable increases as a result of the training.

These parents' psychological resilience was initially moderate overall, suggesting a good ability to deal with their child's condition while also pointing out areas that could use development. In particular, the training successfully addressed issues with stress management and change adaptation, which are crucial for these parents who deal with ongoing practical and emotional demands.

Significant improvements in median scores for all resilience characteristics, with strong effect sizes ranging from 0.84 to 0.95, demonstrate the program's effectiveness. These enhancements imply that the program strengthens particular areas essential for handling the continuous stress of caring for a child's condition in addition to improving psychological resilience generally.

The results highlight the effectiveness of cognitive-behavioral group therapy in offering this susceptible group focused support. Larger sample sizes and longitudinal studies should be the main focus of future research in order to confirm these findings and investigate the intervention's long-term advantages. Furthermore, analyzing the precise elements of the treatment that are most responsible for the noted gains may offer more profound understanding of how to best implement such treatments.

Parents of children with cancer have shown significant improvements in psychological resilience as a result of the cognitive-behavioral group treatment program. The program's potential as a useful part of support services for families dealing with comparable issues is shown by its capacity to generate notable gains across a number of resilience categories.

### 4.3 Recommendations

#### 4.3.1 Based on the study's findings, the researcher recommends the following

1. Expand the availability of CBT programs for parents of children with cancer to strengthen psychological resilience in key areas such as self-confidence, stress management, adaptability, perseverance, and problem-solving skills.
2. Customize CBT interventions to target areas where parents exhibit lower resilience, particularly in coping with stress and adapting to changes, by integrating evidence-based strategies.
3. Schedule CBT sessions at flexible times and offer them in various locations, including online platforms, while providing ongoing support and supplementary resources to sustain progress.
4. Foster a sense of community among parents through peer support mechanisms within CBT programs, enhancing emotional support and improving coping strategies.
5. Conduct future studies with larger sample sizes and longitudinal designs to assess the sustained impact of CBT on parental resilience and identify specific elements contributing to psychological well-being.
6. Regularly assess the effectiveness of CBT programs and use participant feedback to refine and adapt interventions based on evolving parental needs.
7. Provide comprehensive training for therapists on managing group dynamics and addressing unique psychological challenges faced by parents of children with cancer.
8. Establish partnerships between healthcare providers and CBT programs to create a holistic support system that integrates psychological interventions with medical care for families navigating childhood cancer.

### 4.4 Suggestions

1. Establish structured peer-led support groups after CBT programs to provide ongoing guidance and emotional reinforcement, allowing experienced parents to mentor new participants.
2. Integrate general parenting skills training into future CBT programs, focusing on resilience-building techniques for both managing a child's illness and handling everyday parenting challenges.
3. Adapt CBT interventions to cultural and social contexts to ensure inclusivity and effectiveness across diverse family structures.
4. Collaborate with schools to provide additional psychological and academic support for children, reinforcing resilience both at home and in the educational environment.

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# Appendixes

## Appendix A

## The Initial Version of The Psychological Resilience Scale

يقوم الباحث بإجراء دراسة استكمالاً للحصول على درجة الماجستير في علم النفس الإكلينيكي من جامعة النجاح الوطنية، والدراسة بعنوان " **فعالية برنامج العلاج السلوكي المعرفي الجماعي في تحسين المرونة النفسية لأولياء أمور الأطفال المصابين بالسرطان في القدس**".

ولتحقيق أهداف الدراسة قام الباحث بتطوير استبانة والتي يرجى قراءة كل فقرة منها والإجابة عليها وذلك بتحديد الاجابة المناسبة، علماً بأنه لا توجد إجابة صحيحة وأخرى خاطئة، فالإجابة الصحيحة هي التي تعبر عن رأيك بصدق وصراحة، وستُحاط إجابتك بالسرية التامة ولا تُستخدم إلا لأغراض البحث العلمي فقط، لذا أرجوا منكم الإجابة عليها بكل موضوعية ودقة.

شاكراً لكم حُسن تعاونكم.

الطالب/ حسن عليان

**أولاً: المعلومات الأساسية:**

- **جنس ولي الامر:**

ذكر ( )  انثى ( )

- **عمر ولي الامر:**

35 عاماً أو أقل ( )  أكثر من 35 عاماً ( )

- **جنس الابن المصاب بالسرطان:**

ذكر ( )  انثى ( )

- **عمر الابن المصاب بالسرطان:**

اقل من 6 سنوات ( )  من 6 –9 سنوات ( )

من 13–10 سنة ( )  اكثر من 13 سنة ( )

- **التحصيل العلمي لولي الامر:**

ثانوية عامة او أقل ( )  بكالوريوس ( )  دراسات عليا ( )

- **الدخل الشهري للأسرة بالشيكل:**

أقل من 3000 شيكل شهرياً ( )  من 3000 إلى أقل من 6000 ( )

من 6000 إلى أقل من 9000 ( )  9000 وأكثر ( )

- **حجم الأسرة:**

أقل من 4 أفراد ( )  من 4 إلى 7 أفراد ( )  أكثر من 7 أفراد ( )

- **نوع السرطان المصاب به الأبن:** .....

- **درجة السرطان المصاب به الأبن:** الدرجة الأولى، الدرجة الثانية، الدرجة الثالثة، الدرجة الرابعة.

- **فترة إصابة الابن بالسرطان:** أقل من عام ( )  أكثر من عام **( )**

- **مدة الإقامة في المستشفى:**

أقل من 3 شهور ( )  من 3 إلى أقل من 6 شهور ( )

- من 6 إلى أقل من 9 شهور ( )  9 شهور وأكثر( )

**ثانياً: المقياس:**

**أمامك عدد من العبارات التي يمكن ان تصف أي شخص، اقرأ كل عباره، وحدد مدى انطباقها عليك بشكل عام، وذلك بوضع إشارة صح في الخانة الصحيحة.**

| الرقم | الفقرة | موافق بشدة | موافق | محايد | معارض | معارض بشدة |
|---|---|---|---|---|---|---|
| .1 | لدي ثقة في نفسي | | | | | |
| .2 | يمكنني التكيف بسهولة في المواقف الصعبة | | | | | |
| .3 | أنا قادر على المثابرة | | | | | |
| .4 | بعد الانتكاسات، يمكنني بسهولة أن أكمل من حيث توقفت | | | | | |
| .5 | أنا مرن | | | | | |
| .6 | يمكنني التعامل بشكل جيد مع المشاكل غير المتوقعة | | | | | |
| .7 | أقدر نفسي | | | | | |
| .8 | يمكنني التعامل مع الكثير في نفس الوقت | | | | | |
| .9 | أنا أؤمن بنفسي | | | | | |
| .10 | لا أشعر بالإحباط بسهولة | | | | | |
| .11 | أنا قادر على التكيف عندما تحدث التغييرات | | | | | |
| .12 | لدي علاقات مع الأهل والأصداقاء وثيقة وآمنة | | | | | |
| .13 | يعينني الله على تحمل الأمور | | | | | |
| .14 | يمكنني التعامل مع كل ما يأتي في طريقي | | | | | |
| .15 | النجاحات السابقة تمنحني الثقة | | | | | |
| .16 | أحاول أن أرى الجانب الإيجابي للأشياء عندما أواجه مشاكل | | | | | |
| .17 | الاضطرار إلى التعامل مع التوتر يمكن أن يجعلني أقوى | | | | | |
| .18 | أميل إلى التعافي بعد المرض أو الإصابة أو المصاعب الأخرى | | | | | |
| .19 | أعتقد أن معظم الأشياء تحدث لسبب ما | | | | | |
| .20 | أبذل قصارى جهدي، مهما كان الأمر | | | | | |
| .21 | أعتقد أنني أستطيع تحقيق أهدافي، حتى لو كانت هناك عقبات | | | | | |
| .22 | حتى عندما لا يوجد أمل، لا أستسلم | | | | | |
| .23 | في أوقات الشدة، أعرف أين أجد المساعدة | | | | | |

| الرقم | الفقرة | موافق بشدة | موافق | محايد | معارض | معارض بشدة |
|---|---|---|---|---|---|---|
| .24 | تحت الضغط، أظل مركزاً وأفكر بوضوح | | | | | |
| .25 | أفضل أن أتولى زمام المبادرة في حل المشكلات | | | | | |
| .26 | لا يعيقني الفشل بسهولة | | | | | |
| .27 | أرى نفسي كشخص قوي عند التعامل مع تحديات الحياة وصعوباتها | | | | | |
| .28 | أتخذ قرارات غير واضحة أو صعبة | | | | | |
| .29 | أنا قادر على التعامل مع المشاعر غير السارة أو المؤلمة مثل الحزن والخوف والغضب | | | | | |
| .30 | اعتمد في تصرفاتي وقراراتي على الحدس | | | | | |
| .31 | لدي هدف قوي في الحياة أرغب بتحقيقه | | | | | |
| .32 | أشعر وكأنني تحت سيطرة الأحداث | | | | | |
| .33 | أنا أحب التحديات | | | | | |
| .34 | اعمل على تحقيق أهدافي دون ملل | | | | | |
| .35 | أنا فخور بإنجازاتي | | | | | |

## Appendix B

## The Final Version of The Psychological Resilience Scale

| الرقم | الفقرة | موافق بشدة | موافق | محايد | معارض | معارض بشدة |
|---|---|---|---|---|---|---|
| .1 | لدي ثقة في نفسي | | | | | |
| .2 | يمكنني التكيف بسهولة في المواقف الصعبة | | | | | |
| .3 | أنا قادر على المثابرة | | | | | |
| .4 | بعد الانتكاسات، يمكنني بسهولة أن أكمل من حيث توقفت | | | | | |
| .5 | أنا مرن | | | | | |
| .6 | يمكنني التعامل بشكل جيد مع المشاكل غير المتوقعة | | | | | |
| .7 | أقدر نفسي | | | | | |
| .8 | يمكنني التعامل مع الكثير في نفس الوقت | | | | | |
| .9 | أنا أؤمن بنفسي | | | | | |
| .10 | لا أشعر بالإحباط بسهولة | | | | | |
| .11 | أنا قادر على التكيف عندما تحدث التغييرات | | | | | |
| .12 | لدي علاقات مع الأهل والأصداقاء وثيقة وآمنة | | | | | |
| .13 | يعينني الله على تحمل الأمور | | | | | |
| .14 | يمكنني التعامل مع كل ما يأتي في طريقي | | | | | |
| .15 | النجاحات السابقة تمنحني الثقة | | | | | |
| .16 | أحاول أن أرى الجانب الإيجابي للأشياء عندما أواجه مشاكل | | | | | |
| .17 | الاضطرار إلى التعامل مع التوتر يمكن أن يجعلني أقوى | | | | | |
| .18 | أميل إلى التعافي بعد المرض أو الإصابة أو المصاعب الأخرى | | | | | |
| .19 | أعتقد أن معظم الأشياء تحدث لسبب ما | | | | | |
| .20 | أبذل قصارى جهدي، مهما كان الأمر | | | | | |
| .21 | أعتقد أنني أستطيع تحقيق أهدافي، حتى لو كانت هناك عقبات | | | | | |
| .22 | حتى عندما لا يوجد أمل، لا أستسلم | | | | | |
| .23 | في أوقات الشدة، أعرف أين أجد المساعدة | | | | | |

| الرقم | الفقرة | موافـق بشدة | موافق | محايد | معارض | معــارض بشدة |
|---|---|---|---|---|---|---|
| .24 | تحت الضغط، أظل مركزاً وأفكر بوضوح | | | | | |
| .25 | أفضــل أن أتــولى زمــام المبــادرة فــي حــل المشكلات | | | | | |
| .26 | لا يعيقني الفشل بسهولة | | | | | |
| .27 | أرى نفســي كشــخص قــوي عنــد التعامــل مــع تحديات الحياة وصعوباتها | | | | | |
| .28 | أنا قادر على التعامل مع المشاعر غير السارة أو المؤلمة مثل الحزن والخوف والغضب | | | | | |
| .29 | لدي هدف قوي في الحياة أرغب بتحقيقه | | | | | |
| .30 | أشعر وكأنني تحت سيطرة الأحداث | | | | | |
| .31 | أنا أحب التحديات | | | | | |
| .32 | اعمل على تحقيق أهدافي دون ملل | | | | | |
| .33 | أنا فخور بإنجازاتي | | | | | |

# Appendix C

## Training Program

**Introduction to the Training Program:** This program aims to provide a group-based cognitive behavioral therapy (CBT) system designed to clarify and improve psychological resilience in parents of children with cancer.

**Primary Objective:**

To enhance the psychological resilience of parents facing the challenges associated with their children's cancer diagnosis.

**Number of Sessions:** 12 training sessions

**Program Duration:**

Each session lasts 2 hours, totaling 12 hours of training over a span of 12 days.

**Number of Participants:** 12 individuals

**Session 1:**

**Session Title:**

Introduction and Team Building

**Session Duration:**

2 hours

**Session Objectives:**

1. Introduce the program, its objectives, and anticipated benefits.
2. Explain the concept of psychological resilience.
3. Highlight the importance of psychological resilience.
4. Create a supportive and cohesive team environment.
5. Build a team spirit and establish connections among participants.

**Tools Used in the Session:**

1. Presentation about the program and its objectives.
2. Icebreaker activities to help parents get to know each other.

**Session Activities:** The session begins with an introduction to the participants, a presentation on the program's title, objectives, and importance (15 minutes). The following activities are then conducted:

1. **Introduction Activity:** (Duration: 30 minutes)
   - Provide each participant with personalized name cards that include personal information and hobbies.
   - Conduct a brief session for participants to exchange name cards and learn more about each other.
2. **Goal-Setting Activity:** (Duration: 30 minutes)
   - Invite participants to identify their personal and family-related goals for the program.
   - Discuss each participant's goals and how they hope to enhance their psychological resilience.
   - Create a collective goal board to foster motivation.
3. **Challenge Game Activity:** (Duration: 40 minutes)
   - Divide participants into four groups, each consisting of three individuals.
   - Assign each team a small challenge related to teamwork and problem-solving.
   - Discuss the experiences afterward and draw lessons learned from the activity.

**Conclusion:** (Duration: 5 minutes)

Thank the participants for attending the session, gather their feedback on the session's clarity, and encourage active participation in the next session.

**Session 2:**

**Title:** Understanding Psychological Challenges

**Duration:** 2 hours

**Objectives:**

1. Identify the psychological challenges parents may face.
2. Encourage parents to share their experiences.
3. Discuss the psychological challenges parents encounter.
4. Understand the psychological impact of a cancer diagnosis on children and their parents.

**Tools Used:**

1. A table listing the psychological challenges that parents might face.
2. Group discussions on challenges and coping strategies.

**Activities:** Welcome participants and proceed with the following activities:

1. **Sharing Session:** (Duration: 30 minutes)
   - Invite some parents to share their personal challenges and how their daily lives have been impacted.
   - Facilitate a discussion on these shared experiences and encourage the exchange of insights.
2. **Case Analysis:** (Duration: 20 minutes)
   - Provide case studies and invite participants to analyze how to address specific challenges.
3. **Dialogue Workshop:** (Duration: 30 minutes)
   - Pose open-ended questions about the challenges participants face.
   - Encourage open discussion and active listening among participants.
4. **Problem-Solving Game:** (Duration: 30 minutes)
   - Present participants with a specific challenge their children might face (e.g., hair loss during treatment).
   - Encourage them to brainstorm flexible solutions and share their ideas.
5. **Conclusion:** (Duration: 10 minutes)

Thank participants, seek feedback on the session, and motivate them to attend the next session with even more engagement.

**Session 3:**

**Title:** Developing Emotional Control Skills

**Duration:** 2 hours

**Objectives:**

1. Explain effective strategies for emotional control.
2. Learn emotional control strategies.
3. Practice managing psychological pressures appropriately.
4. Apply these strategies in real-life situations.

**Tools Used:**

1. Interactive activities for emotional control training.
2. Audio or recorded guidance for learning control techniques.

**Activities:** Welcome participants and proceed with the following activities:

1. **Breathing and Relaxation Exercises:** (Duration: 20 minutes)
   - Teach deep breathing and relaxation techniques.
   - Conduct a practical session for participants to try out these techniques.
2. **Experience Sharing:** (Duration: 30 minutes)
   - Invite participants to share their experiences in emotional control during challenging situations.
   - Encourage a group exchange of effective strategies.
3. **Emotional Art Workshop:** (Duration: 30 minutes)
   - Provide paper and drawing tools.
   - Invite participants to draw their emotions and share their experiences.
4. **Balloon Control Game:** (Duration: 30 minutes)
   - Give each participant a balloon.
   - Have them write challenges on the balloon, then gently pop it to symbolize managing the challenges.
5. **Conclusion:** (Duration: 10 minutes)

Thank participants, seek feedback, and encourage them to write down their thoughts and suggestions on a card to bring to the next session.

**Session 4:**

**Title:** Enhancing Flexible Thinking

**Duration:** 2 hours

**Objectives:**

- Understand the importance of flexible thinking and its impact on dealing with challenges.
- Practice shifting negative thoughts to positive ones.
- Discuss specific events that parents encountered during their child's illness and treatment.

**Tools Used:**

1. Worksheets for flexible thinking exercises.
2. Interactive exercises for analyzing and changing thoughts.

**Activities:** Welcome participants, collect feedback cards, and proceed with the following activities:

1. **Positive Analysis Exercises:** (Duration: 20 minutes)
   - Invite participants to analyze situations positively.
   - Use written exercises to record positive thoughts.
2. **Role-Playing:** (Duration: 30 minutes)
   - Present scenarios and invite participants to think of flexible ways to handle them.
3. **Film Analysis:** (Duration: 30 minutes)
   - Show a short motivational film.
   - Discuss how flexible thinking can be applied in everyday life.
4. **Reframing Workshop:** (Duration: 30 minutes)
   - Present a negative situation and invite participants to shift their perspective positively.
5. **Conclusion:** (Duration: 10 minutes)

Thank participants, gather feedback, and encourage them to write their opinions and suggestions on a card to bring to the next session.

**Session 5:**

**Title:** Building a Support Network

**Duration:** 2 hours

**Objectives:**

1. Increase parents' understanding of the importance of mutual support.
2. Guide them in building a strong support network.

**Tools Used:**

1. Group discussions on the value of social support.
2. Interactive exercises for building a support network.

**Activities:** Welcome participants, collect feedback cards, and proceed with the following activities:

1. **Trust-Building Workshop:** (Duration: 20 minutes)
   - Organize a workshop on building trust among parents.
   - Conduct exercises on effective communication and active listening.

2. **Success Story Sharing:** (Duration: 30 minutes)
   - Invite parents to share similar stories they've heard about overcoming challenges.
3. **Active Race Game:** (Duration: 30 minutes)
   - Conduct a team-building game that promotes collaboration.
   - Discuss how these lessons can be applied in daily life.
4. **Motivational Stories Workshop:** (Duration: 30 minutes)
   - Invite a guest speaker with a successful experience to share their story on overcoming challenges.
5. **Conclusion:** (Duration: 10 minutes)

Thank participants, seek feedback, and encourage them to write their thoughts on a card to bring to the next session.

**Session 6: Developing Positive Thinking Skills**

**Session Title:** Developing Positive Thinking Skills

**Duration:** Two hours

**Session Objectives:**

1. Enhance parents' understanding of the importance of positive thinking.
2. Strengthen parents' awareness of the impact of positive thinking.
3. Practice transforming negative thoughts into positive ones.

**Materials Used in the Session:**

1. A set of papers and pens for writing.
2. Cards containing positive and negative thoughts.
3. Workshop on analyzing and changing negative thoughts.

**Session Activities:**

The session begins by welcoming participants and collecting the cards they prepared from the previous session for review and evaluation. Then, the following activities are implemented:

1. **Educational Session on the Impact of Positive Thinking on Mood (30 minutes)**
   - Use papers and pens for participants to write down positive and negative thoughts that come to mind.
   - Discuss the thoughts shared by participants, allowing each participant to read what they wrote while others provide feedback.

2. **Positive Thinking Exercises (40 minutes)**

- Encourage participants to record their negative thoughts and transform them into positive ones.
- Discuss the resulting shift and its effect on their mood.

3. **Workshop: Building a Positivity List (40 minutes)**

- Ask participants to create a list of positive things in their lives.
- Exchange lists and discuss the positive impact of these aspects.

4. **Conclusion (10 minutes)**

- Thank participants for attending and ask for feedback on the clarity of the session.
- Inquire if there are any activities they would like added to the program.
- Encourage participants to attend the next session with greater enthusiasm.

**Session 7: Strengthening Effective Family Communication**

**Session Title:** Strengthening Effective Family Communication

**Duration:** Two hours

**Session Objectives:**

1. Enhance family members' communication skills.
2. Provide tools for effective communication with children dealing with illness.

**Materials Used in the Session:**

1. Communication games to strengthen family bonds.
2. Effective communication models to guide parents.

**Session Activities:**

The session begins by welcoming participants, checking in on their well-being, and motivating them to start the session positively. The following activities are then implemented:

1. **Workshop on Nonviolent Communication Skills (30 minutes)**

- Ask participants about their understanding of effective family communication.
- Hold a brief discussion on the importance of communication skills.
- Train on active listening and expressing emotions correctly.

2. **Effective Communication Exercises (40 minutes)**

- Session on learning nonviolent communication skills with children.

- Practice exercises for effective communication in simulated scenarios.

3. **Game: Building Bridges (40 minutes)**

- Divide participants into pairs.
- Discuss scenarios parents face and work on enhancing understanding skills.

4. **Conclusion (10 minutes)**

- Thank participants for attending, ask for feedback on the session, and encourage them to attend the next session with even more enthusiasm.

**Session 8: Coping with Stress and Anxiety**

**Session Title:** Coping with Stress and Anxiety

**Duration:** Two hours

**Session Objectives:**

1. Understand the psychological impact of stress and anxiety.
2. Learn strategies for managing stress and anxiety.

**Materials Used in the Session:**

1. Cards explaining stress, its symptoms, and how to manage it.
2. Relaxation and meditation techniques.
3. Deep breathing exercises for stress relief.

**Session Activities:**

The session begins by welcoming participants, followed by the implementation of the following activities:

1. **Educational Session on Stress Management (30 minutes)**

- Ask participants to write down their thoughts on stress and how to cope with it.
- Briefly exchange views, with participants sharing and discussing their thoughts while offering advice.

2. **Workshop: Breathing and Relaxation Exercises (40 minutes)**

- Train on deep breathing and relaxation exercises.
- Conduct a trial session to observe its effect on stress.

3. **Session: Problem-Solving Strategies (40 minutes)**

- Invite participants to identify solutions for stressful situations.
- Encourage them to seek positive resolutions to challenges.

4. **Conclusion (10 minutes)**

- Thank participants for attending and ask for feedback on the session.
- Request participants to write their feedback on the activities and bring it to the next session.
- Motivate participants to attend the next session with greater enthusiasm.

**Session 9: Promoting Optimistic Thinking**

**Session Title:** Promoting Optimistic Thinking

**Duration:** Two hours

**Session Objectives:**

1. Develop skills in optimistic thinking.
2. Foster hope and optimism among parents.

**Materials Used in the Session:**

1. Daily positive thinking activity for participants.
2. Workshop on transforming negative thoughts into positive ones.

**Session Activities:**

The session starts by welcoming participants, collecting the cards prepared from the previous session for review and evaluation, followed by the implementation of the following activities:

1. **Workshop on Future-Oriented and Optimistic Thinking (30 minutes)**

- Present ideas on how to develop forward-thinking.
- Ask participants to provide examples of optimism and relevant scenarios.
- Hold a brief discussion to share thoughts and ideas presented during the session.

2. **Game: Positives of the Day (40 minutes)**

- Ask participants to record positive events from the day.
- Discuss how these positive experiences can affect their thinking.
- Talk about how they can apply positivity when interacting with their children.

3. **Workshop: Building the Future (40 minutes)**

- Guide participants to set positive future goals.
- Share steps that can be taken to achieve these goals.

4. **Conclusion (10 minutes)**

- Thank participants for attending, ask for feedback on the session, and encourage them to attend the next session with more enthusiasm.
- Request participants to prepare a written card about their opinion on the program, activities, or any suggestions, and bring it to the next session.

**Session 10: Managing Anger and Resentment**

**Session Title:** Managing Anger and Resentment

**Duration:** Two hours

**Session Objectives:**

1. Understand anger and learn effective management techniques.
2. Develop strategies for controlling anger.

**Materials Used in the Session:**

1. Workshop on understanding the causes of anger.
2. Anger management exercises.

**Session Activities:**

The session begins with a welcome, collecting the prepared cards from the previous session for review and evaluation, followed by the implementation of the following activities:

1. **Anger Management Exercises (40 minutes)**

- Learn techniques for controlling anger.
- Practical exercises to apply these techniques in simulated scenarios.

2. **Practice Exercises for Improving Anger Management Strategies (40 minutes)**

- Ask participants to share experiences where they faced anger and how they managed those situations.
- Discuss the situations and provide suggestions to help parents handle similar situations with their children.

3. **Game: Rebound Ball (30 minutes)**

- Session to redirect anger positively by clarifying thoughts and reactions.
- Use a ball to express anger and share ways to transform it into positivity.

4. **Conclusion (10 minutes)**

- Request participants to prepare a written card with their feedback on the program, activities, or any suggestions, and bring it to the next session.

- Thank participants for attending, ask for feedback on the session, and encourage them to attend the next session with more enthusiasm.

**Session 11: Enhancing Self-Care**

**Session Duration:** 2 hours

**Objectives:**

1. Encourage parents to take care of themselves.
2. Provide strategies for self-care under pressure.

**Tools Used:**

1. Educational session on the importance of self-care.
2. Workshop on applying self-care techniques.

**Session Activities:**

- **Welcome Participants**: Collect cards from the previous session to review and assess them, then proceed with the following activities:

1. **Self-Care Strategies Workshop** (Activity Duration: 30 minutes)
   - Discuss key points on the importance of self-care.
   - Present examples of self-care strategies and discuss them collectively with participants.
   - Hold a brief discussion on situations where participants practiced self-care and its impact on their children's treatment and their own health.
2. **"Creating a Self-Care List" Workshop** (Activity Duration: 40 minutes)
   - Invite participants to identify their preferred self-care methods.
   - Create a list they can refer to when needed.
3. **"Quiet Moments" Game** (Activity Duration: 40 minutes)
   - Guide participants to find quiet moments in their day.
   - Share experiences and discuss ways to include more of these moments in their routine.
4. **Conclusion** (Activity Duration: 10 minutes)
   - Thank participants for attending, inquire about the clarity of the session, and motivate them to actively participate in the next one.

**Session 12: Evaluation and Review**

**Session Duration:** 2 hours

**Objectives:**

1. Review progress and improvement.
2. Strengthen parents' understanding of how to continue applying acquired techniques.

**Tools Used:**

1. Use of questionnaires to assess participants' improvement.
2. Individual follow-up sessions with parents.

**Session Activities:**

- **Welcome Participants**: Collect cards from the previous session to review and assess, then proceed with the following activities:

1. **Progress Evaluation** (Activity Duration: 20 minutes)
   - Use self-assessment questionnaires.
   - Hold individual follow-up sessions to discuss progress achieved.
2. **Group Evaluation Session** (Activity Duration: 20 minutes)
   - Discuss improvements and changes observed by participants.
   - Encourage sharing ideas on how to maintain progress.
3. **"Personal Strength Assessment" Workshop** (Activity Duration: 30 minutes)
   - Use tools to assess personal strengths with participants.
   - Discuss results and how to apply them in the future.
4. **"Future Challenges" Game** (Activity Duration: 30 minutes)
   - Invite participants to think about future challenges and how to approach them positively.
5. **Conclusion** (Activity Duration: 20 minutes)
   - Thank participants for attending, inquire about session clarity, and provide a final assessment of all previous session cards.

**Additional Activities Usable Across All Sessions:**

- Provide extra resources such as articles, books, or exercises to practice at home.
- Host interactive sessions and encourage parents to share experiences.

**Monitoring and Evaluation Tools:**

- Use questionnaires to assess participants' improvement.
- Hold individual follow-up sessions with parents.

**Future Recommendations:**

- Consider regularly repeating the program.
- Add additional sessions for in-depth exploration of specific areas.

# Appendix D

## Training Program in Arabic

**مقدمة عن البرنامج التدريبي:**

يهدف البرنامج الى تقديم نظام علاجي سلوكي معرفي جماعي يعتمد على توضيح مفهوم المرونة النفسية وتحسينها لدى أولياء امور الأطفال المصابين بالسرطان.

**الهدف الرئيسي:**تعزيز المرونة النفسية لأولياء الأمور الذين يواجهون تحديات السرطان لأطفالهم.

**عدد الجلسات:**12جلسة تدريبية.

**مدة البرنامج:** ساعتان لكل جلسة أي يمعدل 12 ساعة تدريبية، موزعة على 12يوم.

**عدد المشاركين في البرنامج:** 12 شخص.

**الجلسة 1:**

**عنوان الجلسة: التعريف وإنشاء روح الفريق**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. التعريف بالبرنامج وأهدافه والفوائد المتوقعة منه.
2. توضيح تعريف المرونة النفسية.
3. توضيح أهمية المرونة النفسية
4. تكوين فريق متكامل وداعم.
5. بناء روح الفريق والتعارف بين المشاركين

**الأدوات المستخدمة من خلال الجلسة:**

1. عرض تقديمي للبرنامج وأهدافه.
2. أنشطة تعارف وتقديم الأهل لبعضهم البعض.

**أنشطة الجلسة:**

بالبداية يتم التعريف بالمشاركين وبعنوان البرنامج وتقديم مقدمة حول اهدافه وأهميته (مدة العرض 15 دقيقة)، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **نشاط التعارف: (مدة النشاط= 30 دقيقة)**

- جلب كروت تعريف شخصية لكل مشارك، تحتوي على معلومات شخصية وهوايات.
- جلسة قصيرة لتبادل الكروت ومعرفة المزيد عن بعضهم البعض.

2. **نشاط تحديد الأهداف: (مدة النشاط = 30 دقيقة)**

- دعوة المشاركين لتحديد أهدافهم الشخصية والعائلية من البرنامج.
- مناقشة أهداف كل فرد في المشاركة في البرنامج وكيف يأملون في تحسين مرونتهم النفسية.
- إنشاء لوحة أهداف جماعية لتعزيز التحفيز.

3. **نشاط لعبة التحدي: (مدة النشاط = 40 دقيقة)**

- تقسيم المشاركين إلى فرق صغيرة كل فريق يتكون من 3 أشخاص اي 4 مجموعات مختلفة.
- إعطاء كل فريق تحدياً صغيراً يتعلق بالتعاون وحل المشكلات.
- مناقشة التجربة بعد الانتهاء واستخراج الدروس المستفادة.

**الخاتمة: (المدة 5 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 2:**

**عنوان الجلسة: فهم التحديات النفسية**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تحديد التحديات النفسية التي يمكن أن تواجهها الأهالي.
2. تشجيع الأهالي على مشاركة الخبرات.

3. مناقشة التحديات النفسية التي يمكن أن يواجهها الأهل.

4. فهم التأثير النفسي لتشخيص السرطان على الأطفال وأولياء الأمور.

**الأدوات المستخدمة في الجلسة:**

1. جدول للتحديثات النفسية التي قد يواجهها الأهل.

2. مناقشات جماعية حول التحديات وكيفية التعامل معها

**أنشطة الجلسة:**

الترحيب بالمشاركين ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **جلسة مشاركة: (مدة الجلسة= 30 دقيقة)**

- دعوة بعض الأهالي لمشاركة تحدياتهم وكيف تأثرت حياتهم اليومية.
- جلسة مناقشة للتفاعل مع التحديات المشاركة وتبادل الخبرات.

2. **تحليل الحالة: (مدة الجلسة = 20 دقيقة)**

- توفير حالات دراسية ودعوة المشاركين لتحليل كيف يمكن التعامل مع تحديات محددة.

3. **ورشة الحوار: (مدة الجلسة = 30 دقيقة)**

- توجيه أسئلة مفتوحة للمشاركين حول تحدياتهم.
- تشجيعهم على الحوار المفتوح والاستماع الفعّال لبعضهم البعض.

4. **لعبة "حل المشكلات": (مدة الجلسة = 30 دقيقة).**

- إعطاء المشاركين مشكلة محددة قد تواجه أبناءهم (مثل مشكلة تساقط الشعر أثناء العلاج).
- تشجيعهم على التفكير في حلول مرونة ومشاركتها.

5. **الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 3:**

**عنوان الجلسة: تطوير مهارات التحكم العاطفي**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. شرح مجموعة من الاستراتيجيات الفعالة للتحكم في العواطف.
2. تعلم استراتيجيات التحكم في العواطف.
3. تمرين على التعامل مع الضغوط النفسية بشكل صحيح.
4. تمرين على تطبيق هذه الاستراتيجيات.

**الأدوات المستخدمة في الجلسة:**

1. أنشطة تفاعلية لتدريب التحكم العاطفي.
2. توجيهات صوتية أو تسجيلات للمساعدة في تعلم تقنيات التحكم.

**أنشطة الجلسة:**

الترحيب بالمشاركين ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **تمارين التنفس والاسترخاء: (مدة الجلسة 20 دقيقة)**

- تعليم تقنيات التنفس العميق وتمارين الاسترخاء.
- جلسة تطبيقية لتجربة هذه التقنيات.

2. **مشاركة التجارب: (مدة الجلسة= 30 دقيقة)**

- دعوة المشاركين لمشاركة تجاربهم في التحكم بالعواطف في مواقف صعبة.
- تحفيز التبادل بين الأهالي حول الاستراتيجيات الفعّالة.

3. **ورشة "الرسم العاطفي:" (مدة الجلسة = 30 دقيقة)**

- توفير أوراق وأدوات للرسم.

- دعوة المشاركين لرسم مشاعرهم ومشاركة تجاربهم.

**4. لعبة "التحكم بالبالونات:" (مدة الجلسة= 30 دقيقة)**

- إعطاء كل مشارك بالونة.
- كتابة عبارات تمثل تحدياتهم على البالونة ومن ثم فرم البالونة برفق.

**5. الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

الطلب من المشاركين اعداد بطاقة مكتوبة حول رأيهم بالبرنامج وأنشطة واي مقترحات لديهم، واحضارها في اللقاء القادم.

**الجلسة 4:**

**عنوان الجلسة: تعزيز التفكير المرن**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

- فهم أهمية التفكير المرن وكيف يؤثر على التحديات السلبية.
- تدريب على تغيير الأفكار السلبية إلى إيجابية.
- مناقشة بعض الأحداث التي تعرض لها اولياء الأمور خلال مرحلة اصابة ابنائهم وعلاجهم.

**الأدوات المستخدمة في الجلسة:**

1. أوراق عمل لتمارين التفكير المرون.
2. تمارين تفاعلية لتحليل وتغيير الأفكار.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **تمارين التحليل الإيجابي: (مدة الجلسة= 20 دقيقة)**

- دعوة المشاركين لتحليل الوضع بطريقة إيجابية.
- استخدام تمارين كتابة لتسجيل الأفكار الإيجابية.

2. **لعب دور:(مدة الجلسة= 30 دقيقة)**

- تقديم سيناريوهات ودعوة المشاركين للتفكير بطرق مرونة في التعامل مع المواقف.

3. **تحليل الأفلام: (مدة الجلسة= 30 دقيقة)**

- عرض فيلم قصير يتناول موضوعًا محفزًا.
- مناقشة كيف يمكن تطبيق التفكير المرون على الحياة اليومية.

4. **ورشة "إعادة الإطار:" (مدة الجلسة= 30 دقيقة)**

- تقديم موقف سلبي ودعوة المشاركين لتغيير إطار تفكيرهم بشكل إيجابي.

5. **الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

الطلب من المشاركين اعداد بطاقة مكتوبة حول رأيهم بالبرنامج وأنشطة واي مقترحات لديهم، واحضارها في اللقاء القادم.

**الجلسة 5:**

**عنوان الجلسة: بناء شبكة الدعم**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تعزيز فهم الأهالي لأهمية دعم بعضهم البعض.
2. توجيههم في بناء شبكة دعم قوية.

**الأدوات المستخدمة خلال الجلسة:**

1. مناقشات جماعية حول أهمية الدعم الاجتماعي.
2. تمارين تفاعلية لبناء شبكة الدعم.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **ورشة بناء الثقة: (مدة الجلسة= 20 دقيقة)**

- تنظيم ورشة عمل حول بناء الثقة بين الأهالي.
- تمارين التواصل الفعّال والاستماع الفعّال.

2. **مناقشة قصص النجاح:(مدة الجلسة= 30 دقيقة)**

- دعوة أولياء الامور للحديث حول قصص قد سمعوا عنها تعرضت لمواقف مشابهة.

3. **لعبة "السباق الفعّال:" (مدة الجلسة= 30 دقيقة)**

- تنظيم لعبة تعاونية تشجع على العمل الجماعي.
- مناقشة كيف يمكن تطبيق تلك الآفات في الحياة اليومية.

4. **ورشة "قصص التحفيز:" (مدة الجلسة= 30 دقيقة)**

- دعوة متحدث ذو تجارب ناجحة لمشاركة قصته وكيف تغلب على التحديات.

**5. الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

الطلب من المشاركين اعداد بطاقة مكتوبة حول رأيهم بالبرنامج وأنشطة واي مقترحات لديهم، واحضارها في اللقاء القادم.

**الجلسة 6:**

**عنوان الجلسة: تنمية مهارات التفكير الإيجابي**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تعزيز فهم الأهالي لأهمية التفكير الإيجابي.
2. تعزيز فهم الأهالي حول أثر التفكير الإيجابي
3. تدريب على تحويل الأفكار السلبية إلى إيجابية.

**الأدوات المستخدمة من خلال الجلسة:**

1. مجموعة من الأوراق والأقلام للكتابة.
2. بطاقات تحتوي افكار ايجابية وأخرى سلبية.
3. ورشة عمل حول تحليل الأفكار السلبية وتغييرها.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

**1. جلسة تعليمية حول أثر التفكير الإيجابي على المزاج: (مدة النشاط= 30 دقيقة)**

- استخدام مجموعة الأوراق والارقام لتدوين ليقوم المشاركين بتدوين ما يخطر ببالهم من أفكار ايجابية وسلبية.
- مناقشة الأفكار التي طرحها المشاركين، بحيث يقوم كل مشارك بقراءة ما كتب ويقدم الأخرين ملاحظاتهم حولها.

**2. تمارين التفكير الإيجابي: (مدة النشاط = 40 دقيقة)**

- دعوة المشاركين لتسجيل أفكارهم السلبية وتحويلها إلى أفكار إيجابية.
- مناقشة التحول الناتج وتأثيره على المزاج.

**3. ورشة "بناء قائمة الإيجابيات": (مدة النشاط = 40 دقيقة)**

- طلب من المشاركين كتابة قائمة بالأشياء الإيجابية في حياتهم.
- تبادل القوائم ومناقشة التأثير الإيجابي لهذه الأشياء.

**4. الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء.

سؤال المشاركين اذا كانت هناك اي انشطة يرغبون باضافتها للبرنامج.

تحفيز المشاركين لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 7:**

**عنوان الجلسة: تعزيز التواصل الفعال في الأسرة**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تعزيز مهارات التواصل بين أفراد الأسرة.
2. تقديم أدوات للتواصل الفعّال مع الأطفال المصابين بالمرض.

**الأدوات المستخدمة من خلال الجلسة:**

1. ألعاب تواصلية لتعزيز العلاقات الأسرية.
2. نماذج تواصل فعّال لتوجيه الأهالي.

**أنشطة الجلسة:**

بدأ اللقاء بالترحيب بالمشاركين وسؤالهم عن أحوالهمواعطاءهم دفعة ايجابية للبدأ باللقاء، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **ورشة تعلم مهارات التواصل غير العنفي: (مدة النشاط= 30 دقيقة)**

- سؤال المشاركين حول معلوماتهم عن التواصل الفعال في الاسرة.
- جلسة قصيرة لتبادل أراء المشاركين حول مهارات التواصل واهميتها.
- تدريب على الاستماع الفعّال والتعبير عن المشاعر بشكل صحيح.

2. **تمارين التواصل الفعّال: (مدة النشاط = 40 دقيقة)**

- جلسة لتعلم مهارات التواصل غير العنفي مع الأطفال.
- تمارين تطبيقية للتواصل بشكل فعّال في مواقف محاكاة.

3. **لعبة "بناء الجسور": (مدة النشاط = 40 دقيقة)**

- تقسيم المشاركين إلى مجموعات تحتوي كل منها شخصان.
- مناقشة مواقف تواجه الأهالي وتحسين مهارات التفاهم.

4. **الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 8:**

**عنوان الجلسة: التعامل مع التوتر والقلق**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. فهم التأثير النفسي للتوتر والقلق.
2. تعلم استراتيجيات التحكم في التوتر والقلق.

**الأدوات المستخدمة من خلال الجلسة:**

1. بطاقات تعريفة حول التوتر ومظاهره وكيفية التعامل معه.
2. تقديم تقنيات الاسترخاء والتأمل.
3. تمارين التنفس العميق لتخفيف التوتر.

**أنشطة الجلسة:**

الترحيب بالمشاركينومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **جلسة تعليمية حول تأثير التوتر وكيفية التعامل معه: (مدة النشاط= 30 دقيقة)**

- الطلب من المشاركين كتابة أرائهم حول التوتر وكيفية التعامل معه.
- جلسة قصيرة لتبادل الأراء ومناقشة ما قام المشاركين الأخرين بكتابته أمام الأخرين وتقديم النصائح لهم.

2. **ورشة "تمارين التنفس والاسترخاء": (مدة النشاط = 40 دقيقة)**

- تدريب على تقنيات التنفس العميق وتمارين الاسترخاء.
- جلسة تجريبية لتجربة التأثير على التوتر.

3. **جلسة "التفكير في الحلول": (مدة النشاط = 40 دقيقة)**

- دعوة المشاركين لتحديد حلول لمواقف تسبب لهم التوتر.

- تشجيعهم على البحث عن حلاً إيجابياً للتحديات.

**4. الخاتمة: (المدة 10 دقائق)**

- شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء
- الطلب من المشاركين كتابة ملاحظاتهم حول الأنشطة والقيام باحضارها في الجلسة القادمة.
- تحفيز المشاركين لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 9:**

**عنوان الجلسة: تعزيز التفكير التفاؤلي**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تطوير مهارات التفكير التفاؤلي.
2. تعزيز الأمل والتفاؤل لدى أولياء الأمور.

**الأدوات المستخدمة من خلال الجلسة:**

1. نشاط تفكير إيجابي يومي للمشاركين.
2. ورشة عمل حول تحويل الأفكار السلبية إلى إيجابية.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

**1. ورشة عمل حول تطوير التفكير المستقبلي والتفاؤل: (مدة النشاط= 30 دقيقة)**

- طرح مجموعة من الأفكار تتعلق بطرق تطوير التفكير المستقبلي.
- الطلب من المشاركين اعطاء امثلة حول التفاؤل وتقديم مواقف تتعلق به.
- جلسة قصيرة لتبادل الآراء والأفكار التي طرحها الجميع خلال الجلسة.

2. **لعبة "إيجابيات اليوم": (مدة النشاط = 40 دقيقة)**

- طلب من المشاركين تسجيل أحداث إيجابية خلال اليوم.
- مناقشة كيف يمكن أن تؤثر هذه التجارب الإيجابية على تفكيرهم.
- مناقشة كيف يمكنهم التعامل مع أطفالهم بإيجابية.

3. **ورشة "بناء المستقبل": (مدة النشاط = 40 دقيقة)**

- توجيه المشاركين لتحديد أهداف إيجابية للمستقبل.
- مشاركة الخطوات التي يمكن اتخاذها لتحقيق هذه الأهداف.

4. **الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

الطلب من المشاركين اعداد بطاقة مكتوبة حول رأيهم بالبرنامج وأنشطة واي مقترحات لديهم، واحضارها في اللقاء القادم.

**الجلسة 10:**

**عنوان الجلسة: التعامل مع الغضب والاستياء**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. فهم الغضب وكيفية التعامل معه بشكل فعّال.
2. تطوير استراتيجيات تحكم في الغضب.

**الأدوات المستخدمة من خلال الجلسة:**

1. ورشة عمل حول فهم أسباب الغضب.
2. تقديم تمارين تحكم في الغضب.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **تمارين تحكم في الغضب: (مدة النشاط= 40 دقيقة)**

- جلسة تعلم تقنيات تحكم في الغضب.
- تمارين عملية لتطبيق تلك التقنيات في سيناريوهات محاكاة.

2. **تمارين عملية لتجربة وتحسين استراتيجيات التحكم في الغضب:(مدة النشاط= 40 دقيقة)**

- الطلب من المشاركين تقديم أمثلة حول تجاربهم في مواقف تعرضوا للغضب وكيف تعاملوا مع هذه المواقف.
- مناقشة المواقف وتقديم مقترحات للاستفادة منها في المستقبل من خلال تعامل الأهالي مع أطفالهم.

3. **لعبة "الكرة الارتدادية:"(مدة النشاط= 30 دقيقة)**

- جلسة لتوجيه الغضب بشكل إيجابي من خلال توضيح الأفكار وردود الفعل عليها.
- استخدام الكرة للتعبير عن الغضب ومشاركة كيفية التحول إلى إيجابية.

4. **الخاتمة: (المدة 10 دقائق)**

الطلب من المشاركين اعداد بطاقة مكتوبة حول رأيهم بالبرنامج وأنشطة واي مقترحات لديهم، واحضارها في اللقاء القادم.

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 11:**

**عنوان الجلسة: تعزيز الرعاية الذاتية**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. تشجيع أولياء الأمور على رعاية أنفسهم.
2. تقديم استراتيجيات للرعاية الذاتية في ظل الضغوط.

**الأدوات المستخدمة من خلال الجلسة:**

1. جلسة تعليمية حول أهمية الاهتمام بالنفس.
2. ورشة عمل عن تطبيق تقنيات الرعاية الذاتية.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

1. **ورشة تعلم استراتيجيات الرعاية الذاتية: (مدة النشاط= 30 دقيقة)**

- مناقشة النقاط الرئيسية حول أهمية الاهتمام بالنفس.
- تقديم أمثلة حول استراتيجيات الرعاية الذاتية ومناقشتها بصورة جماعية مع المشاركين.
- جلسة قصيرة لمناقشة بعض المواقف التي وقع به المشاركين حول الاهتمام بالنفس وبيان أثر ذلك على علاج أطفالهم وصحتهم.

2. **ورشة "صناعة قائمة الرعاية الذاتية": (مدة النشاط = 40 دقيقة)**

- دعوة المشاركين لتحديد أفضل طرق الرعاية الذاتية لهم.
- إنشاء قائمة يمكنهم الرجوع إليها عند الحاجة.

3. **لعبة "اللحظات الهادئة": (مدة النشاط = 40 دقيقة)**

- توجيه المشاركين للبحث عن لحظات هادئة في يومهم.
- مشاركة تجاربهم وكيف يمكنهم تضمين المزيد من هذه اللحظات في روتينهم.

**4. الخاتمة: (المدة 10 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء وتحفيزهم لحضور اللقاء القادم بفعالية أكبر.

**الجلسة 12:**

**عنوان الجلسة: التقييم والمراجعة**

**مدة الجلسة: ساعتان**

**أهداف الجلسة:**

1. مراجعة التقدم والتحسين.
2. تعزيز فهم الأهالي لكيفية استمرار تطبيق التقنيات المكتسبة.

**الأدوات المستخدمة في الجلسة:**

1. استخدام استبيانات لتقييم تحسن المشاركين.
2. جلسات فردية للمتابعة مع الأهالي.

**أنشطة الجلسة:**

الترحيب بالمشاركين، وجمع البطاقات التي قاموا باعدادها من الجلسة الماضية ليتم مراجعتها وتقييمها، ومن ثم البدأ بتنفيذ الأنشطة التالية:

**1. تقييم التقدم: (مدة النشاط = 20 دقيقة)**

- استخدام استبيانات للتقييم الذاتي.
- جلسات فردية للمتابعة والتحدث عن التقدم المحقق.

**2. جلسة تقييم جماعية: (مدة الجلسة= 20 دقيقة)**

- مناقشة التحسينات والتغييرات التي لاحظها المشاركون.
- تشجيع على مشاركة الأفكار حول كيفية استمرار التقدم.

3. **ورشة "تقييم القوة الشخصية:" (مدة الجلسة= 30 دقيقة)**

- استخدام أدوات تقييم القوة الشخصية مع المشاركين.
- مناقشة النتائج وكيفية تطبيقها في المستقبل.

4. **لعبة "التحديات المستقبلية:" (مدة الجلسة= 30 دقيقة)**

- دعوة المشاركين للتفكير في التحديات المستقبلية وكيف يمكن التعامل معها بشكل إيجابي.

5. **الخاتمة: (المدة 20 دقائق)**

شكر المشاركين في البرنامج والاستفسار منهم عن وضوح اللقاء.

تحليل جميع البطاقات خلال الجلسات الماضية وتقديم التقييم النهائي لهم.

**الأنشطة الإضافية يمكن استخدامها خلال الجلسات جميعها.**

- تقديم موارد إضافية مثل مقالات، كتب، أو تمارين يمكن ممارستها في المنزل.
- إقامة جلسات تفاعلية ومشاركة الخبرات بين الأهالي.

**أدوات استخدمت للمراقبة والتقييم:**

- استخدام استبيانات لتقييم تحسن المشاركين.
- جلسات فردية للمتابعة مع الأهالي.

**الاقتراحات للمستقبل:**

- إمكانية تكرار البرنامج بانتظام.
- إضافة جلسات إضافية للتعمق في مجالات معينة.

جامعة النجاح الوطنية

كلية الدراسات العليا

# فعالية برنامج العلاج السلوكي المعرفي الجمعي في تحسين المرونة النفسية لأولياء أمور الأطفال المصابين بالسرطان في القدس

إعداد

حسن محمد حسن عليان

إشراف

د. فاخر الخليلي

د. محمد مرشود

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجه الماجستير في علم النفس الإكلينيكي من كلية الدراسات العليا في جامعة النجاح الوطنية، نابلس- فلسطين.

2025

# فعالية برنامج العلاج السلوكي المعرفي الجمعي في تحسين المرونة النفسية لأولياء أمور الأطفال المصابين بالسرطان في القدس

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**حسن محمد حسن عليان**

**إشراف**

**د. فاخر الخليلي**

**د. محمود مرشود**

## الملخص

الخلفية: حدد الباحث فجوة في الدراسات المتعلقة بتوفر الدعم النفسي المصمم خصيصًا لتعزيز مرونة الآباء والأمهات الذين لديهم أطفال مصابون بالسرطان في القدس، ومن خلال ملاحظة معاناة هؤلاء الآباء والأمهات والتعرف على الإمكانية التي توفرها العلاج السلوكي المعرفي (CBT) في تعزيز المرونة، شعر الباحث بالحاجة الماسة لمعالجة هذا الفراغ.

أهداف الدراسة: تهدف هذه الدراسة إلى التحقيق في فعالية برنامج علاج سلوكي معرفي منظم في تعزيز المرونة النفسية لآباء وأمهات الأطفال المصابين بالسرطان في القدس.

الطريقة: يتكون مجتمع الدراسة من آباء وأمهات الأطفال الفلسطينيين المصابين بالسرطان الذين يتلقون العلاج في مستشفيات القدس مثل مستشفى المطلع، مستشفى المقاصد، ومستشفى هداسا عين كارم. تم تقسيم 18 مشاركًا إلى مجموعتين بالتساوي: المجموعة التجريبية والمجموعة الضابطة، حيث تتكون كل مجموعة من 9 مشاركين. تتكون المجموعة التجريبية من تسعة آباء وأمهات، حيث أن غالبية المشاركين في هذه المجموعة هم من النساء، حيث أن 6 من 9 مشاركين (66.7%) هن نساء، بينما 3 مشاركين (33.3%) هم رجال. فيما يتعلق بالعمر، فإن الغالبية الطفيفة من الآباء والأمهات يتجاوزون 35 عامًا، حيث أن 5 مشاركين (55.6%) ينتمون إلى هذه الفئة العمرية، و4 مشاركين (44.4%) أصغر من 36 عامًا.

النتائج: أظهرت النتائج بشكل عام مرونة نفسية معتدلة، حيث حافظ هؤلاء الآباء والأمهات على مستوى معقول من المرونة النفسية. وتشير النتائج إلى أن برنامج العلاج السلوكي المعرفي الجماعي كان فعالًا للغاية في تعزيز المرونة النفسية بين الآباء والأمهات الذين لديهم أطفال مصابين بالسرطان. يدعم هذا الاستنتاج الزيادات الملحوظة في المرونة النفسية عبر مجالات مختلفة من الاختبار القبلي إلى الاختبار البعدي، حيث أظهرت المجموعة التجريبية التي شاركت في البرنامج تحسنًا كبيرًا في أبعاد متنوعة من المرونة النفسية، بما في ذلك الثقة بالنفس، التكيف مع التغيرات والضغوط، المثابرة، التعامل مع المشاكل والضغوط، والبحث عن الموارد.

**الكلمات المفتاحية:** العلاج السلوكي المعرفي الجماعي، المرونة النفسية، الآباء والأمهات، دور الرعاية في القدس.