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Faculty of Graduate Studies

The Effectiveness of a Group Therapy Program Based on Cognitive Behavioral Therapy in Reducing Anxiety among Parents of Children with Autism Spectrum Disorder

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

2019

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Dedication

I dedicate this work to the people who always have inspired me starting with my father who always urged for more work and to my mother whose prayers were with me all the way to success. To my wife Joanna who stood next to me and was always a source of motivation. To my brothers, sisters, cousins and aunt.

Acknowledgement

I'd like to start my acknowledgment by my gratefulness to Allah for guiding my way through this important stage of life and making it possible all the way through all obstacles I faced.

This study is a result of support and help of great people who were there next to me when I needed them. Every part of the study has its own fingerprints after special teachers who took my hands to achieve it. Beginning with my supervisor Dr. Fayez Mahamid whom without none of this would come out. I truly appreciate your help and guidance, not only you showed me the way through difficulties, but also created the ideas and thought-generators to get this work done.

I also would like to address a deep gratefulness to my co-supervisors, who were wonderful teachers and supervisory committee members.

My appreciation is also to be sent to Sanad Association for their awesome assistance and facilitation over different steps of my research from the beginning to the time of the posttest and evaluation.

I send my gratitude to every group or individual for their help to make this study come out in the form it is now. I might have missed some names, but please know that every effort was done is deeply appreciated.

The researcher

Asim Eshtaya

الإقرار

أنا الموقع أدناه، مقدم الرسالة التي تحمل العنوان:

فاعلية برنامج علاجي سلوكي معرفي جمعي في خفض مستوى القلق المعمم لدى والدي الأطفال من ذوي اضطراب طيف التوحد

The Effectiveness of a Group Therapy Program Based on Cognitive Behavioral Therapy in Reducing Anxiety among Parents of Children with Autism Spectrum Disorder

اقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وان هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

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

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The Effectiveness of a Group Therapy Program Based on Cognitive Behavioral Therapy in Reducing Anxiety Among Parents of Children with Autism Spectrum Disorder

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Abstract

The study aimed to testing the effectiveness a Group Therapy Program based on Cognitive Behavioral Therapy in reducing anxiety among parents of children with Autism Spectrum Disorder. The sample that the study was conducted on was a group of 20 participants of parents of children with Autism Spectrum Disorder that attend therapy sessions at Sanad Association for children with special needs in Nablus.

The group of participating parents was randomly distributed into two groups: The experimental group that had 10 parents and received a group counseling program for 13 sessions; the control group that had 10 parents and didn't receive the CBT counseling program. The two groups had the level of anxiety checked before and after the intervention.

After the statistical analysis was conducted, the results emphasized that the group counselling program was effective in reducing the level of generalized anxiety in the favor of the experimental group.

The researcher recommends to conclude parents with parallel counseling programs side by side with their child therapy. That will lead

into a better mental health and resilience within the family members and with that being done, it can help improving the therapeutic process.

Keywords: **Group therapy program, cognitive behavioral therapy, autism spectrum disorder.**

Chapter One

Introduction:

For a long period of time, direct interference with the clients was the only therapy to be applied with mental disorders. But now, this seems to be changing since any positive change would be done in the surrounding environment of people with a disorder can also enhance the healing process and accelerate the progress among the clients. This includes all disorder categories and classifications, specially childhood disorders and neurodevelopmental disorders in particular. It's not only this category needs special skills to work with, but also because children are the least fortunate to have coping strategies and experience dealing with any sort of difficulty. Considering parent empowerment as an important component of early intervention programs for children with autism, some therapists emphasis that if you help parents, that can help the child himself (Harris, 1994).

Moreover, parents who live with a child with a certain disorder usually encounter a second phase of struggle as they watch and deal with their child. And because they face daily stress which might develop into anxiety and depression in many cases. Fingerman believes that an important, overlooked factor contributing to stress levels in parents of children with autism spectrum disorder (ASD) is the degree to which they feel their child suffers, per the old maxim (Fingerman, 2011).

Neurodevelopmental disorders usually manifest during the early stage of child-hood, within the first five years after the baby is born (APA, 2013). It's the age that the child needs the most essential help from parents that is possible. It's weak and can't live on its own. Then, symptoms start to appear and things get even more complicated and new difficulties make it even harder for both child and parents. ASD is one of these disorders can be noticed or diagnosed at early ages. Then, parents put their full effort on the treatment. While a child might go through a special long therapy, parents start to sink into levels of stress and anxiety, and their Well-being construction is hurt as the ongoing process of child-treatment continues. Parents often loose resilience under the stress that frequently leads into anxiety. As anxiety takes place, parents start suffering hidden pain. Their concerns are usually based on the fear of unknown regarding their child and other types of anxiety. In this stage, Parents skip or even lose a lot of important social and communicational skills under the effect of anxiety. These foundational strategies - parents are in need for to help their kid-disappear if they don't get the right interference to get their well-being back so they can be part of therapy-process (APA, 2013).

ASD is a critical disorder that requires a high involvement of parents. As the child lacks the communication and the social interaction, the mother and the father might be taken away by a high level of anxiety as Autism Spectrum Disorder is usually associated with burden and stress for parents (Howlin et al., 2004). Considerable research findings suggest that parents of children with autism experience higher levels of stress,

depression, anxiety, and reduced marital satisfaction than parents of typically developing children or children with other types of disabilities do(Sharpley, Bitsika, & Efremidis,1997).

In this case, the child would struggle more while recovering ASD because of not being able to practice communication and social interaction in the house of anxious parents. Therefore, I find it really important to interfere with parents of ASD children side to side with the child treatment. It is necessary that the parallel intervention with parents takes place with any therapy to conducted with children. Eventually, that would help parents to develop an essential insight which will assist in creating a positive atmosphere in the house where the child lives. Stressful anxiety among parents associated with ASD child in the house isn’t going to be an easy thing for both parties. As a result, anxiety has to be dealt with as a source of difficulties facing the ASD treatment and since it usually affects the insight and the self-awareness of parents, there has to be a suitable intervention. CBT is one of the good approaches that works well with anxiety. The irrational thoughts which is a foundational concept in the CBT and it can be a major source of generalized anxiety. Therefore, I find CBT program targeting anxiety among a group of adult parents suitable to help parents deal with their cognition and the thoughts that might transform frustration into anxiety.

Statement of the problem:

Parents of Autism Spectrum Disorder children suffer from a hidden pain. As the child lacks the communication and the social interaction, the mother and the father might be taken away by a high level of anxiety as Autism Spectrum Disorder is usually associated with burden and stress for parents (Howlin et al., 2004) They watch their kids helplessly and encounter stressful obligations. That leads to different levels of anxiety as treatments usually takes a long time. So, they also need an intervention helps them regain their wellbeing. Moreover, this study is trying to answer the following question:

Importance of research:

The research is not only essential for parents themselves, but also for the benefit of the helpless child who needs resilient parents next to him or her. Basically, that's what makes this research important. Moreover, this study is foundational for additional reasons:

1. It presents CBT as an important intervention and a method in supporting the ASD treatment within children by helping their parents.

2. The study investigates the effect of an important approach in a Palestinian context, which is the CBT.

3. In addition, it aims to help the parents reduce the anxiety which indirectly affects their ASD child recovery.

Definitions of key terms:

Autism Spectrum Disorder (ASD): The American Psychiatric Association (APA) defines ASD in the DSM 5 as persistent deficits in social communication and social interaction across multiple contexts associated with restricted, repetitive patterns of behavior, interests, or activities. These Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life). Also, the symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level. (APA, 2013:50-51)

Anxiety (Generalized Anxiety): According to DSM5, generalized anxiety is an excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). The individual finds it difficult to control the worry, and the anxiety and worry are associated with

three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months); 1. Restlessness or feeling keyed up or on edge. 2. Being easily fatigued. 3. Difficulty concentrating or mind going blank. 4. Irritability. 5. Muscle tension. 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism). The disturbance is not better explained by another mental disorder (APA, 2013:222). From the procedural pointed view, it's defined as the score a parent receives on anxiety scale which was used in this study.

Cognitive Behavioral Therapy(CBT): Which Aaron Beck described as a structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional (inaccurate and/or unhelpful) thinking and behavior (Beck, 1964). The treatment is based on a cognitive formulation, the beliefs and behavioral strategies that characterize a specific disorder (Alford & Beck, 1997). Treatment is also based on a conceptualization, or understanding, of individual patients (their specific beliefs and patterns of behavior). The therapist seeks in a variety of ways to produce cognitive change - modification in the patient's thinking and belief system - to bring about enduring emotional and behavioral change (Beck, 2011). From the

procedural pointed view, it’s defined as a group counseling session constructed and used in this research. This includes many exercises and techniques based on CBT and conducted along 10 sessions.

Group Therapy: Springer Link website emphasizes that GT refers to a format of several individuals taking part in a psychological intervention aimed at helping them change or deal with a long-lasting problem they are encountering, guided by a therapist or counselor. Group therapies have important advantages and are thus suitable for several types of problems, mainly those involving interpersonal issues. These include, for example, stress management, a common medical problem (cancer, heart disease), or addictions. The advantages of group over individual interventions include vicarious learning from others, knowing and being comforted by the fact that others share one’s difficulties, and practicing in a safe environment constructive solution for interpersonal problems. In behavior medicine, studies have used such a format to treat cancer patients (e.g., Andersen et al., 2008), cardiac patients (e.g., Gidron, Davidson, & Bata, 1999), and many other patient samples. In cardiac patients, one review .

Limitations of the study:

The primary limitations of this research are:

1. The Sample: Parents of ASD children at Sanad Center for Special Care in the city of Nablus.

2. Study instruments: CBT group program and generalized anxiety scale. All sessions followed CBT specific methodology.

3. Research time: It’s going to be conducted during the year 2017.

Chapter Two

Theoretical Background and Literature Review

Background of the study:

Autism Spectrum Disorder:

As one of the neurodevelopmental disorders that manifests during the early childhood. ASD is a life-long developmental disorder characterized by qualitative impairments in social and communication behavior and a restricted range of activities and interests. ASD is estimated to affect 1 in 150 persons; thus, it is no longer considered a rare disorder (Kuehn, 2007). Although the American Psychiatric Association (APA) agrees with the social and communicational impairments with restricted, repetitive patterns of behavior as major features of ASD, a study was published by the APA in 2015 says that 1 in every 68 children in the United States is diagnosed with ASD and shows that the number has raised due either an increasing rate of the disorder or the development of diagnosis methodology (Kuehn, 2007).

Historical highlights of ASD:

The term Autism spectrum Disorder wasn't the first to describe the case. The words "autism" and "autistic" come from the Greek word autos, meaning "self," or "is the same". This term autism was first used by Eugen Bleuler, a swiss psychiatrist, to describe a symptom of schizophrenia that

refers to lack of relationships with the surrounding environment except yourself. Then, Leo Kanner, a German-American physician, was the first to describe Autism scientifically in 1943 in the article “Autistic Disturbances of Affective Contact” published in The Nervous Child. He described the children in refer to isolation “self-sufficient”, “happy if left alone”, “as in a shell” and not reactive when it comes to relations (Paucheri and Pfanner 1999).Hans Asperger, an Austrian pediatrician in Vienna, wrote in his published doctoral thesis using the term autistic in his study of four boys. He again described children who developed special interests, but also had deficits in the areas of communication and social interaction. Asperger was more likely to describe more able children, and he felt there can be some positive features to autism which could lead to great achievements as an adult. However, for thirty years, Kanner’s description became the most widely recognized. “Asperger’s syndrome” was first used by Lorna Wing in 1981, and she described children much like the more able boys Asperger had described years before that. Asperger died in 1980, but he didn’t know that a few years later a condition named after him would become well known worldwide.

Causes of Autism:

There are different theories and scientists tried to explain ASD based on various approaches. However, none of these could give the perfect answer to the question: WHAT CAUSES ASD? In this part, we’ll try to present some of the common theories attempted to answer that question.

Starting with the man who used the term in a scientific way, Kanner identified the parents of the ASD children that all of them being “cold and intellectual” and later, Bettelheim emphasized that the refusal of the part of the parents is a key element in the genesis of each case of autism, that’s of course from his theory of psychoanalysis’s perspective (Bettelheim, 1967). That opened way to the explanation of the onset autistic disorder and came under the name of the “refrigerator mother’’ that neglects the role of the organic background and the type of parenting. Autism was described as a defense against anxiety, a rising from a failure of the first object relations.

However, that perspective wasn’t very popular and since the psychoanalytic hypotheses were not so acceptable in Anglo-Saxon countries, Psychologists like Bernard Rimland who was a father of an Autistic child, triggered the approach to this disorder clamming that parents were not to be blamed, but it’s the organic cause. That was the beginning of new start up for theories: the socio-affective theory of mind and the executive function theory.

The Socio-Affective Theory was the beginning of the neurobiological research in the field of ASD and mainly targeted the characteristics of mental functioning of the autistic that behaviors define the clinical description (Hobson, 1993). This theory says that the ASD child has an innate inability, biologically determined to interact with others emotionally, and the absence of this empathy is not referential or primary inter-subjective (Hobson and Lee, 1989). It also can be due to a kind of

cascade reaction that results an inability to learn and/or recognize the mental states of other people, dysfunctional symbolization and difficulties in language and social interaction (Trevarthen and Aitken, 2001).

Another explanation of autism is the limited executive function and central coherence which refers to the ability to synthesize into coherent whole the different experiences that affect senses in a fragmented way (Frith and Happé, 1994). The lack of that ability would therefore be to remain at parceled experiential data, and the meaning of the stimulus is not understandable for the case of autism. Some of these previous skills are foundational in the process of organization and planning the behavior for problem solving, but they also refer to the ability to activate an area of mental work or in other words, to mentally formulate a plan of action, not to be rigidly anchored in the perceptual data, to inhibit impulsive responses and to be aware of the reflected feedback information in order to turn attention to the various aspects of the context. In conclusion, any disturbance of these aspects can cause events like impulsiveness, inability to inhibit appropriate responses (turns the face when receiving greetings), hyper-selectivity (plays with the same object for long time), remaining anchored to details and perseverance (watches the very small parts of toys): all these aspects are peculiarly close to autism (Bennetto et al. 1996).

One of the theories that gave a different point of view about ASD is call The Theory of Mind, this theory came out in the eighties of the last century; it’s based on the assumption that the child at the age of 4 years

begins to acquire the ability to respond on emotions, desires and beliefs about self and others. It assumes that the child doesn't gain the ability to predict the behavior of others if the first ability doesn't show up or happen. And furthermore, the child won't reach the level of "meta-representations" which means he doesn't know how to think that other people think and what they think. The result is hyper-selectivity, repetitiveness, rigidity and perseveration and will probably affect social interaction and communication (Baron-Cohen et al. 2000). The mirror system discovery suggests a "physiological'' explanation to this theory. The MS is neural system present in human and non-human primates explains the way we understand imitation and the intentions of others. The research investigated the organization of intentional motor chains in children with typical development and with ASD by means of electromyography (EMG); the intentional chains are altered in ASD children and the high-functioning ASD children understand the intentions of others cognitively. Although, they lack a mechanism allowing direct and immediate experiential of the action (Cattaneo et al. 2007).

The causes behind ASD is still unknown, yet, there are other hypotheses that involve genetics, obstetric complications and toxic exposures. However, none of these has been established as a definite etiological factor (Constantino et al. 2010). If the child is born for a family that already have an ASD child, the rate is as high as 18.7 to have another ASD child. And the risk as twice higher in the family of two ASD children.

If a girl is born to a family of ASD child, she will have 2.8 more times risk to have ASD children (Ozonoff et al. 2011).

ASD diagnoses between DSM4 and DSM 5:

ASDs, in the DSM-IV:

According to the American Psychiatric Association, ASD is significantly abnormal or deficient social interaction, impaired communication and language abilities and a considerably narrow pattern of activities and interests are the mainstays of the ASD diagnosis. ASDs, in the DSM-IV, are defined within two categories: “persistent impairment in reciprocal social communication and social interactions” and “restricted and repetitive patterns of behavior,” both present since early childhood. In the DSM-IV diagnosis must meet the following criteria A, B, C and D:

A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifested by all three of the following:

1. Deficits in social–emotional reciprocity; ranging from abnormal social approach and failure of normal back-and-forth conversation, through reduced sharing of interests, emotions, and affect and response, to total lack of initiation of social interaction.

2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated verbal and nonverbal

communication, through abnormalities in eye contact and body language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.

3. Deficits in developing and maintaining relationships appropriate to the level of development (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts, through difficulties in sharing imaginative play and in making friends, to an apparent absence of interest in people.

B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:

1. Stereotyped or repetitive speech, motor movements, or use of objects; (e.g. simple motor stereotypes, echolalia, repetitive use of objects or idiosyncratic phrases).

2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (e.g. motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).

3. Highly restricted, fixated interests that are abnormal in intensity or focus; (e.g. strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment; (e.g. apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)

D. Symptoms together limit and impair everyday functioning.

The diagnosis also requires the specification of the presence or absence of related intellectual disability, alterations of language as well as medical conditions or associated genetics.

ASD in DSM5:

The disorder affects social and communicational skills which is associated with the restricted activities and/or interests in different levels. That's also obvious in the three out-come severity levels that's explained in the ASD's DSM5 chart that indicates the impacts severity has on the social communication and restricted, repetitive behaviors as following:

Table (1): Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

(APA, 2013; 52)

Between DSM IV And DSM 5, the main characteristics of ASD remained close, yet, DSM5 focused on the themes of the deficits according to the level of severity (APA, 1994).

Generalized Anxiety Disorder:

According to DSM5, generalized anxiety is an excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). The individual finds it difficult to control the worry, and the anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months); 1. Restlessness or feeling keyed up or on edge. 2. Being easily fatigued. 3. Difficulty concentrating or mind going blank. 4. Irritability. 5. Muscle tension. 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism). The disturbance is not better explained by another mental disorder (APA, 2013:222).

It’s common to find the generalized anxiety referred to as GAD. GAD is a topic of heated debate in the mental health field. Many believe that it’s highly misunderstood, commonly occurring, chronic, disabling,

diagnostically independent, and severe condition. It was once considered a mild disorder of the “worried well,” but then, GAD has proven to be much more complex and elusive in nature (Kasper, 2004).

In 2008, and according to representative epidemiologic surveys, the estimated prevalence of generalized anxiety disorder in the general population of the United States is 3.1% in the previous year and 5.7% over a patient’s lifetime; the prevalence is approximately two times higher among women than among men. No certain age was more to have the GDA; some cases begin in childhood, most begin in early adulthood, and another peak of new-onset cases occurs in older adulthood, and it’s more likely to occur when having chronic physical health conditions. Generalized anxiety disorder is, by definition, a chronic disorder; 6 months is the minimum duration of anxiety for diagnosis, and most patients have had the disorder for years before seeking treatment (Kessler & Wang, 2008).

Understanding GAD:

A high rate of primary care seekers tells how GAD occurs more frequently that what we used to think. 7 to 8% of patients in primary care settings show some of GDA characteristics. However, they rarely report the symptom of worry (Kroenke et al, 2007). Most reported symptoms at the primary care units are the physical ones (headaches or gastrointestinal distress) and for children it usually manifests as recurrent abdominal pain and other somatic symptoms (Stein et al, 2005).

GAD manifests as an underlying waxing-and-waning condition in my people who suffer the disorder, and it's common to be associated with episodic bouts of major depression emerging through stressful life circumstances. This case of association between GAD and major depression is sometimes referred to as "anxious depression" and it's a specific common clinical presentation in primary care settings (Zbozinek, Rose, Wolitzky-Taylor et al, 2012).

Sometimes it's difficult to distinguish between GAD and major depression as it is common to be a coexisting condition and thanks to the fact that many symptoms of GAD are somehow similar to those of major depression like fatigue and insomnia. Anhedonia (inability to have pleasure) is not a symptom of GAD as it is characterized of major depression. It's often that people who suffer GAD report a sense of helplessness, but those have major depression can feel hopeless. Suicidal tendencies are at a higher rate in people with GAD as they are at increased risk for deliberate self-harm more than of those with major depression (Chartrand, Sareen, Toews & Bolton, 2012).

GAD is a mental disorder that has impacts on different aspects in people's life, so when diagnosed with GAD, patients usually have higher risk to have the GAD associated with other mental and physical health difficulties (e.g., chronic pain syndromes, asthma or chronic obstructive pulmonary disease, and inflammatory bowel disease). Therefore, the diagnostic factor here can be multi-sided and distinctive features should be

taken in consideration when therapy plans are prescribed (Sareen, Jacobi et al, 2006). People with GAD are often to try different ways to overcome or even reduce the GAD symptoms. Drugs and alcohol are usually used for that purpose and here the consequences may bring out more complications and risks among those persons. Drugs and alcohol tend to have their negative effects on regular people, and the results are expected to be worse when having the GAD associated with drugs and/or alcohol addiction (Robinson, Sareen Cox & Bolton, 2011).

Genetic factor was examined by some studies that involved twins and the results have shown evidence of a moderated risk of GAD with heritability estimated at between 15 and 20%. GAD and other anxiety can be genetically associated according to some candidate and genome associated studies conducted on persons with these disorders. However, these findings yet to be widely replicated (Hettema, Prescot et al, 2005).

Some studies went further and used the functional the neuroimaging when examined the brains of patients with GAD and they have suggested increasing activation within parts of the limbic system (e.g., the amygdala) and reductive activation in the prefrontal cortex. In addition, the studies also have shown an additional evidence of diminished functional connectivity between these regions. As a results, it is suggested that effective treatments of GAD can remediate the functional abnormalities in the brain. One of the successful methods used for this purpose is the functional magnetic resonances imaging through which patients with GAD

has shown increased activation of the amygdala while they are looking at pictures of faces that express emotion. The functional magnetic resonances imaging for activation is conducted side by side with CBT (Robinson, Krimsky et al, 2014. Hilbert, lueken & Beesdo-Baum, 2014).

Cognitive Behavioral Therapy:

Cognitive-behavioral therapy has clearly been introduced with strong evidences as a powerful intervention for mental health problems in adults. Many publications have been shown in the field of cognitive-behavioral therapy, both from research and practical perspectives. Cognitive-behavioral treatments have an empirical base and the majority of practitioners all around the world. Cognitive-behavioral approach endorses a general philosophical perspective termed the realist assumption. The perspective beyond the general idea of the realist assumption is that a "real-world" or an objective reality exists independently of our awareness of it. That makes the CBT closer to the factual world of people. As such, people can come to know the world more accurately and operate within its principles since they can be still cognitively aware of their life. Generally speaking, it's simply can be approached as a more accurate appraisal of the world, and a closer adaptation to its demands, is one of the indicators of good mental health (Dobson & Dozois, 2001; Held, 1995).

For group therapy, cognitive behavioral approaches are becoming increasingly popular for many client groups and work settings. It's also described as an efficient form of treatment for a wide range of specific

mental cases for diverse client populations (Bieling, McCabe, & Antony, 2006; White & Freeman, 2000). The formula of a group appeals to many who facilitate psychoeducational groups. Practitioners of cognitive behavioral therapy use a brief, active, directive, collaborative, present-focused, didactic, psychoeducational model of therapy that relies on empirical validation of its concepts and techniques. The thing makes the approach not complicated and a step-to-step planed program (Reinecke & Freeman, 2003).

The CBT has developed during the last ten years, and behavior therapy has evolved and expanded in the cognitive and behavioral dimensions. A new generation of behavior therapies emphasize mindfulness, acceptance, the therapeutic relationship, spirituality, values, meaning and purpose in one's life, meditation, being in the present moment, and emotional expression (Hayes, Follette, & Linehan, 2004). With the new changes and developments, these newer approaches are making an impact on behavior therapy, especially in treating complicated clinical problems (Spiegler & Guevremont, 2010).

Not only behavior therapy has changed significantly, but also it continues to evolve and adjust with the new needs in the world of mental disorders. The foundations of behavior therapy theory have broadened, and treatment strategies have become more diverse. The CBT adopts well in the modern psychotherapy field and as behavior therapy continues to expand, it

increasingly overlaps with other theoretical approaches to therapy (Wilson, 2011).

The basic criteria of CBT therapy for the groups is that the cognitive behavioral groups have a detailed, concrete, problem-oriented structure. It's often described as brief therapy and the groups tend to utilize short-term interventions. Therapists need to be skilled in drawing on a wide variety of brief techniques aimed at efficiently and effectively solving problems and assisting clients in developing new skills. Therefore, cognitive behavioral groups are most effective when goals are limited and specific. And because the time limitation can be a major factor for members to make the best use of group time to achieve their goals.

Leaders of the group in CBT assume the role of teacher and encourage members to learn and practice social skills within the group before they take them to their life. The group creates a safe environment for the rehearsal. Counselors/therapists are expected to assume an active, directive, and supportive role in the group and to apply their knowledge of behavioral principles and skills to the resolution of problems. While conducting in a group, counselors/therapists model active participation and collaboration by their involvement with members in creating an agenda, generating adaptive responses, designing homework, and teaching skills (White, 2000). Counselors/therapists observe and assess behavior to determine the conditions that are related to certain problems and the conditions that will facilitate change. Clients in cognitive behavioral

therapy groups specify skills that they lack or would like to improve. They also proceed through training sessions that require active role and involve interventions such as modeling the skill, behavioral rehearsal and coaching, feedback, practicing skills both in the group sessions and through homework, and self-monitoring.

Cognitive Behavioral Therapy: Treatment Mechanisms:

It's foundational that CBT is based on the beliefs of different types, such as the client expectations, evaluations and attributions of causality or responsibility. When client is aware of content of his or her cognitive responses, he or she is more able to see it as a hypothesis more than a fact (Hollon & Kriss, 1984). The idea of framing a belief in the sort of a hypothesis is called "distancing" indicating the way a person can dissociate oneself from a belief to allow an objective evaluation. Putting the belief under a careful consideration, the client then can reach a different view. If it's possible to make the change in the belief, it's common to have the change in the emotional reactions afterwards (Hollon, 1999).

Repeating attempts to identify and question the content of people's reactions to different life events come with several effects. A, concern over troubling events is commonly reduced since the person is no longer under the initially troubling aspect of the belief. B, the emotional reaction is controlled and understandable. The cognitive model gives the feeling of hopefulness and comfort. The adoption of the CBT organizing principles, the client realizes that there's a "light at the end of the tunnel" (Frank,

1973). C, Once the client experiences the success of the implementation of the CBT, he or she tends to use it with day-to-day difficulties.

Clients are to invest the CBT skills on his or her own tackling the life problems and some of them continue to use the CBT methods to encounter difficult circumstances even when therapy is done. Thinking skills that are taught in CBT are life skills that can be used even after the process of treating a problem, and some of these skills are common used by people who never have mental health issues. Moreover, although there's a risk of relapse in most mental disorder, the learnt skills that can be applied after the therapy are to resist and reduce the risk of relapse (Nisbett & Ross, 1980).

Cognitive Methods:

Most of the CBT procedures target the change in cognition and it's known for CBT therapist and service providers that any change within thoughts can lead into change of behavior and emotions as a result. The techniques are various, but most of the procedures are based on the following CBT therapeutic strategies.

Daily Record of Dysfunctional Thoughts:

One of the foundational devices of CBT is what's called the Daily Record of Dysfunctional Thoughts. The idea of this procedure is to follow the cognitive model of emotions by monitoring one's emotion based on (situation, belief, emotional consequence) then the patients are to find the

fourth goal which is the counter-responses to the beliefs that can be more rational and/or functional. Through the therapy process, patients are trained to use the DRDT and they usually write their notes about the times they encounter the stressful situations. In addition, they are to understand that the terms feelings and emotions can indicate different meaning. Moreover, the patients are to write notes on the situation and the thoughts associated its occurrence. It's typical that patients highlight the negative impact on their emotions while noting thoughts, so CBT therapist is to teach patients to attend to these thoughts, although it's common to face automatic thoughts.

This technique was a keystone while building the therapeutic program of this study. The cognitive restructuring methodology used in the therapy of the study aimed at finding the most disturbing thoughts that cause anxiety among the parents of ASD children and it was helpful to use the DRDT to create good therapy. The first part of the therapy program was to identify the irrational disturbing thoughts through means and homework that DRDT helped build.

Cognitive Errors:

Falling into any categories of cognitive errors is major consequence of thoughts dysfunction. As a result, one alternative approach here is the questions involve the therapist teaching the patient to be aware when his or her thinking if turns into these errors. Then, patient can discount the improbable or illogical inference by reframing it.

Socratic Questioning and Guided Discovery:

It might be one of the most difficult features of CBT for therapists, yet, the Socratic method of questioning or what's also known as "guided discovery" is probably the most distinctive stylistic method of CBT. The idea of using leading but open-end question is aiming at helping the patient to reach a perspective that encounter his or faulty beliefs. The strategy of these questions that the therapist ask is to lead the patient to where he wants him to go considering not to be in a hurry and to be certain of the goal he wants to achieve with the patient through the guiding questions. Unlike the purpose of the Greek Socrates, the questions here with the CBT are open-ended. It's recommended that therapists listen to recordings of therapy sessions in order to avoid declarative statements or ask closed-ended questions. That can help asking Socratic questions in more therapeutic and fruitful way. Moreover, that kind of questions are helpful for both therapist and patient, because it requires a high level of engagement from the patient through the questions and it also gives the chance to talk more about the error thoughts (Dobson, 2010)

The Downward Arrow:

This technique is based on a series of questions to be asked to the patient, and each answer usually generates the next question highlighting the personal meaning of the inference to the patient to the point of exposing the rational cognition. These questions are usually in the term of assuming situation like (what if it is true that….), but the meanings are sometimes

unpredictable. This method is good to use when the patient presents the irrational thoughts during the sessions to go deep and see the foundational routs where the error thoughts come from in order to start a successful cognition restructure. In this research, the researcher used this technique during the therapy sessions and it was very helpful to show the impacts of the irrational thoughts the group members had.

Identifying Schemas:

This stage of therapy usually comes after several sessions through which both sides of therapy prosses (patient and therapist) will realize the beliefs that are behind the emotional disturbance. It's really important to classify and define these schemas before the beginning of the cognition error reformation. Furthermore, knowing the targeted schemas well help building the rest of therapy plan based on factual evidences referring to the schemas and that was essential to accomplish the reset of the therapy program of this research. Judith Beck called the tool to identify the cognitive errors as the Cognitive Conceptualization Diagram in which it was suitable to approach this inquiry (Beck, 1995).

At the end of reviewing the major methods of CBT therapy, the researcher found them very helpful to build up a therapeutic program that can achieve the goal of this study. The sessions were based on these techniques taking in consideration the cultural context of the therapy group participants.

Summary:

In this part of chapter II, we find that the three variables that the study focused on are some of the top concerning topics of the modern mental health research. Autism Spectrum Disorder, Generalized Anxiety and Cognitive Behavioral Therapy separately took and still taking a lot of the research effort, not only because they are important to study, but also to the fact they impact the lives of a wide range of age groups. Therefore, this study tried to put them together and check the effect of CBT as one of leading approaches in helping families of ASD children to overcome one of the major causes of mental health instability causes which is the GAD. This part introduced each of the three topics and we could see how important each one was through that previous theoretical data.

Review of the literature:

Autism Spectrum disorder and its effects on parents:

Parents are engaged with almost every activity their children do, and with an ASD child, that involvement in the child's life is expected to be with a higher intensity. Under the pressure of care, love and concern, both mother and father find themselves face to face with a second episode of stressors. In 2015, Lai, Goh and Oei did a research and examined psychological well-being and coping in parents of children with ASD and parents of typically developing children. 73 parents of children with ASD and 63 parents of typically developing children completed a survey. Parents

of children with ASD reported significantly more parenting stress symptoms (i.e., negative parental self-views, lower satisfaction with parent-child bond, and experiences of difficult child behaviors), more depression symptoms, and more frequent use of Active Avoidance coping, than parents of typically developing children. Parents of children with ASD did not differ significantly in psychological well-being and coping when compared as according to child's diagnosis. Study results reinforced the importance of addressing well-being and coping needs of parents of children with ASD (Lai, Wei Wei; Goh, Tze Jui; Oei, Tian, 2015).

Another study was conducted in 2014 by Xu Yangmu. The research has proved again that Parents of children with autism spectrum disorders (ASD) have higher rates of depressive symptoms than parents of typically developing children and parents of children with other developmental disorders. Parental depressive symptoms are strongly associated with problem behaviors in children; however, the mechanisms through which parental depression influences child behavior in families of children with ASD are unclear. The purpose of this study was to examine the relationship between parental depression and child behavior problems among families of children with ASD, more specifically to investigate the mediating variables that may explain the processes through which parental depression and child behavior problems are associated. The sample consisted of 33 parents of children with ASD (ages 2 to 5 years old). Findings suggested that authoritative parenting style significantly mediated the relationship between parental depression and behavior problems. This study highlights

the importance of considering parental mental health and its impact on parenting behavior in interventions targeting child behavior problems. (Xu, Yangmu; Neece, Cameron L.; Parker, Kathleen H, 2014)

Anxiety is highly expected within different parts of age for different reasons. Sometimes it’s common to show up at late age stages and it is one of the most commonly occurring mental health disorders in late-life (Byers, Yaffe, Covinskey, Friedman, & Bruce, 2010). Therefore, therapists and mental health care providers tend to say that life experience and difficulties are to have their role in shaping our ability to overcome our late-life obstacles.

In the study of investigating social support impact for parents of children with ASD has been shown to significantly influence the self-reported levels of stress experienced by mothers (Konstantareas & Homotidis, 1989). That shows how mothers are aware of the stress that affects their lives.

Researches and studies have targeted different aspects of ASD impacts on parents, but most of them have shown significant indications of negative outcomes among the family members of ASD child, and parents in particular. Stress, anxiety and depression are some of the effects are to be expected within anxious parents. One of the studies that tried investigate the effects of ASD on parents in 1997 was conducted by Sharpley, Bitsika, & Efremidis and it showed elevated levels of anxiety and depression compared with the normal population. Parents with access to other family

members for assistance in childcare had generally lower stress than parents who did not have such access, there were significantly lower levels of anxiety and depression among parents who considered that their family members who gave them assistance had a ‘clear understanding of the child’s difficulties and needs’ than among parents who considered that their family supporters did not have such expertise, and finally that parents with an illness or disability reported significantly higher anxiety, depression and stress than parents who were healthy and/or did not have a disability. There were no significant effects according to the age of diagnosis or the age of the child during the survey (Sharpley, Bitsika, & Efremidis, 1997).

Later in 2004, a second research was conducted by Sharplely and Bitsika and in this study, a sample of 107 parents completed a questionnaire that assessed their demographic backgrounds, anxiety and depression scores on standardized inventories, and also tapped several aspects of those factors that may have contributed to their wellbeing. Over 90% of parents reported that they were sometimes unable to deal effectively with their child’s behavior. Nearly half of the participants were severely anxious and nearly two thirds were clinically depressed. Factors that emerged as significant in differentiating between parents with high versus low levels of anxiety and depression included access to family support, parents’ estimation of family caregivers’ expertise in dealing with the behavioral difficulties of a child with ASD, and parental health. Parents’ suggestions for personal support services are reported, and some comparisons across the data from the two states are made, with suggestions

for further research into parent support mechanisms. (Vicki Bitsika and Christopher F. Sharpley, 2004).

In this study on ASD parents in 2001, Dunn and others suggest that parents of Autism spectrum Disorder children are at higher risks and the demands placed on the parents caring for a child with autism contribute to a higher overall incidence of parental stress, depression, and anxiety and that all affects family functioning and marital relationships compared with parents of children with other intellectual, developmental, or physical disabilities. The same almost was confirmed in Yim's study and others (Dunn et al., 2001; Yim et al., 1996).

When mothers are described to be closer to the child, that leaves them in the face of more impact than fathers. That's shown in Yirmiya and Shaked's (2005) Study where they see mothers of children with autism are more likely to have depression than mothers of children with intellectual disability (ID) without autism and mothers with typically developing children.

Considering parent empowerment as an important component of early intervention programs for children with autism, Harris emphasis that parents training can help the child himself (Harris, 1994).

In some studies, the results have shown clearly that interventions with parents can lead to good outcomes with the child treatment. There is empirical evidence that parent training contributes to the effectiveness of

behavioral treatments (Schreibman, 2000; Schreibman and Anderson, 2001) and, as an example of that is what Moes and Frea prove in their study that enhances functional communication in young children with autism (Moes and Frea, 2002) and may result in improved parent-child interactions after pivotal response training (Koegel et al., 1996).

Although most researches have focused on child outcomes, there are some studies of the effect on parental adjustment of parent counseling programs for parents of children with autism spectrum disorder. The Early Bird Program (Shields, 2001), offers a 3-month program of parent support groups, behavior management training, and individual early intervention for the child with autism.

In his study with others in 2002, Salt's pilot study of Early Bird Program showed that parents reported a drop-in stress after 3- and 6-month follow-up. A small, nonrandomized controlled study (treatment n = 12; control n = 5) of The Scottish Centre for Autism program (therapist-supervised parent-child sessions, behavior management parent training groups) found a nonsignificant reduction of parental stress (Salt et al., 2002).

However, there are studies that suggest that effects can be insignificant sometimes. In a randomized controlled trial of a parent intervention that focused on the development of joint attention skills and joint action routines in 12 children with autism compared with 12 children

receiving local services only found no treatment effect at 12-month follow-up (Drew et al., 2002).

Studies of CBT effects on Anxiety:

Although it's an approach that usually takes some time, brief CBT intervention can also help anxious adults. In the research was led by Ravikant G Pinjarkar, Paulomi M Sudhir1, Suresh Bada Math2 in 2015 examined the effectiveness of a brief CBT of six sessions in patients with social anxiety disorder. The results showed that brief CBT was effective in reducing social anxiety in all patients. Brief CBT was also effective in reducing social avoidance and self-consciousness. However, brief CBT was not effective in reducing fear of negative evaluation in all patients, suggesting the need for longer duration for cognitive changes in some dysfunctional beliefs. Conclusions: This preliminary case series indicates that brief CBT may be a promising and a cost and time effective approach to managing for social anxiety.

In a qualitative study by using CBT to reduce symptoms of social anxiety disorder in an adolescent, Kendall Delfini (2013) found that CBT individualized treatment of social anxiety as helpful as group intervention. Findings revealed that anxiety was lowered in about 50% of the participant's anxiety provoking situations, and that the daily monitoring logs were the most helpful form of treatment for the participant. That shows also a positive significant impact of the CBT on anxiety under the individual treatment as well as it's with groups. Delfini (2013).

Group CBT is used more and more with mental disorders and with Generalized Anxiety Disorder in particular. Both individual and group CBT is used and it's proved that group CBT is as effective as individual CBT (Dugas et al., 2003) for GAD. An individual GAD protocols with focus on positive beliefs about worry, problem-solving training, and

exposure to uncertainty was adapted to a group setting. Although higher dropout rates in the group (10%) compared to none for those having individual CBT, these clinician researchers found that many persons found the group helped them feel less isolated and provided opportunities to learn from others.

Clinicians are keen to use Cognitive Behavioral Group Therapy for GAD and many report success, although they also recognize that outcomes could be better. This may in part have to do with how the CBT style is conducted in a group setting. It is not easy for therapists to do problem solving, and especially worry exposure, in a group. Some of them believe that these traditional CBT interventions may not suffice, and they seek to augment CBGT for GAD with a mindfulness training component (Orsillo, Roemer, & Barlow, 2003).

Summary:

The studies shown up indicated that Cognitive Behavior Therapy is effective in treating anxiety and other problems with different back grounds. We can report here after viewing these studies that CBT can be

used in another aspect and conducted with parents who suffer the anxiety impacts for having a child with Autism Spectrum Disorder. We also can tell after viewing the previous studies that parents of children with Autism Spectrum Disorder face a higher risk of encountering anxiety and stressful life more than parents of children without such deficits.

That again supports the justification of conducting this study and evaluates how a Cognitive Behavioral Therapy program can help parents get their resilience and be part of the therapy program targeting their child instead of being an obstacle. The studies showed the justifications that this study was based and gave a strong platform to carry on.

Chapter Three

Methodology

This chapter presents the research design, variables, setting, assignment of participants, and the procedures for testing the effectiveness of a Group Therapy Program based on Cognitive Behavioral Therapy in reducing anxiety among parents of children with Autism Spectrum Disorder. The research criterion instruments, research hypotheses, and statistical analysis that were used in this study are also presented.

The intervention used was a thirteen-session Cognitive Behavioral Therapy Program with the ASD parents group. The study used two groups consisting of eight parents of ASD children in each group. Experimental group A received the thirteen-CBT sessions within three months' time. Control Group B which didn't receive any therapy. A pretest was used to establish baseline information for the two groups using Taylor Test for General Anxiety. A posttest was used to determine the effectiveness of the therapeutic program on variable of the level Anxiety scored.

Study Design:

The study was a quasi-experimental one treatment design. The outcomes for the therapeutic program were tested in terms of the level of anxiety among the parents of the ASD children after they finished the thirteen-sessions CBT program which was followed by the posttest. The parents were randomly assigned to Group A who received the CBT

program and Group B who was a control Group. All Parents of ASD children at Sanad Society for Children with Special needs were asked to do Taylor Test for General Anxiety. The highest scores on the scale were divided into two groups: A Group the experimental and B Group the Control.

After the experimental group had the therapy program of 13 sessions, a posttest was conducted on both experimental and control groups. This study yielded pre-and-post therapy data to be compared between the two groups (E & C) as well as the differences in the scores within the group itself on the pre and posttests. Figure 1 details the research design.

Table (2): Research Design

Research Groups	Pretest	Treatment	Post Test
Random Experimental Group	O1	X	O2
Random Control Group	O1	--	O2

Study variables:

Independent variable. The independent variable for this study was an assignment to a Cognitive Behavioral Therapy group therapy program.

Dependent variables. Level of anxiety scored in the post test of anxiety. The outcomes were measured by the scores on Tylor Scale for Generalized Anxiety.

Settings:

The community of parents of children with mental disorders is the target of this study. And the sample is chosen from the parents of children with Autism Spectrum Disorder to assess the effectiveness of CBT on the level of anxiety among the parents at Sand Society for Children with Special Needs in Nablus city in Palestine. This organization is based in Nablus and specialized in providing the professional treatment and rehabilitation for the less fortunate children in Nablus district who can't afford the high costs of treatment. Children come the center with Autism Spectrum Disorder, Speech Disorder, Down Syndrome and other mental and neurodevelopmental disorder. The facility is located in Rafedya and it contains Speech therapy rooms with equipment, Sensory Room and other specialized play-therapy corners. There are psychologists, speech-therapists, social workers and special educationists in the place who work under the supervision and involvement of professional care providers in the region.

Parents who come to Sanad Society are from Nablus city and nearby villages, towns and refugee camps. Ahmad Salous, the director the organization, told how stressed parents feel every time they come along with their children. Some even try not to be seen by people around saying they don't feel comfortable when people know about their child who comes for therapy. Stigma is one major cause of parents' concern while coming to the center. That leaves parents under the unexpected, painful side effect of

their child treatment and here comes the importance of the need to a parent-supporting plan, says Mr. Salous. The group therapy program was conducted at Sanad Society with the experimental group of parents. The sessions took place in one of the rooms which was equipped with all requirements. Then, a meeting with the experimental group was done and parents signed the therapy contract. It was agreed in the meeting that the sessions will be once a week. The general outline of the program and the members rights and obligations were discussed.

Participants:

The participants in this study were parents of children with Autism Spectrum Disorder who agreed to voluntarily participate in the study and were enrolled in the Cognitive Behavioral Therapy program. Eight parents obligatorily decided to join the group after they did the pretest of Generalized Anxiety. Both experimental and control group from the bigger group of parents who did the pretest. The two groups had the highest score on Taylor test, and their scores were also higher when compared to the bigger base-line score of the random group to check the validity.

Cognitive Behavioral Therapy (CBT) Program:

This Cognitive Behavioral Therapy program was prepared based one the cognitive restructuring and readopting the rationality thoughts. Also using the cognitive narrative model and thought desensitization. All was designed to strengthen rational thinking and resilience in the face of anxiety

among the ASD parents. Appendix 2 provides a complete description of this module.

Criterion Instruments

All parents completed a therapy contract form during the pretesting session. Parents also did Taylor pretest to provide baseline measures of the dependent variable of generalized anxiety. This instrument was repeated following the end of the therapy program in order to check changes on the GAD score on Taylor pre and posttests.

Validity of Taylor Test for Generalized Anxiety:

Taylor scale for anxiety was adjusted to be used in a middle-eastern context by Dr. Mustafa Fahmi, a professor and director of mental health department at Ain Shams University and Dr. Muhammad Ahmad Ghali, the professor of psychology at Alazhar University. For more validity and reliability, the researcher conducted the following procedures.

Validity of the Scale:

Different methods and procedures were used to test the validity of Taylor scale and that included:

First: Content Validity: Content validity and comprehensiveness of Taylor scale required a committee of experts in the field of therapy and counseling to review all 50 items of the scale. That committee included experts working in the field of therapy and counseling as shown in

appendix 4. The committee members had to have 80% of agreement on every item to be confirmed on the final version of the scale. The committee members agreed that all item can remain on the scale with some adjustment to the language of some items.

Second: Construct Validity: To test the construct validity, a correlation test between the items and the total score of Taylor scale for anxiety that was applied on a sample of 40 parents outside Sanad Institution and the results are as shown in the table:

Table (3): Spearman correlation coefficients between total score and all items of Tylor scale for generalized anxiety

Item	correlation	Item	correlation	Item	correlation
1	0.57**	19	0.77**	37	0.59**
2	0.65**	20	0.63**	38	0.56**
3	0.65**	21	0.44**	39	0.49**
4	0.52**	22	0.62**	40	0.81**
5	0.56**	23	0.49**	41	0.43**
6	0.70**	24	0.80**	42	0.33*
7	0.60**	25	0.56**	43	0.54**
8	0.52**	26	0.68**	44	0.61**
9	0.55**	27	0.51**	45	0.57**
10	0.58**	28	0.58**	46	0.64**
11	0.50**	29	0.65**	47	0.47**
12	0.49**	30	0.46**	48	0.57**
13	0.54**	31	0.70**	49	0.33*
14	0.73**	32	0.48**	50	0.36*
15	0.57**	33	0.61**		
16	0.61**	34	0.50**		
17	0.67**	35	0.75**		
18	0.65**	36	0.62**		

**** Correlation is significant at the 0.01 level (2-tailed).**

*** Correlation is significant at the 0.05 level (2-tailed).**

The Spearman correlation coefficients results shown in table number (2) indicate that all correlations between total score of Tylor for GAD scale and its items are significant.As a result of spearman correlation test targeting the construct validity, Taylor scale for GAD still contains (50) items that can be applied in order to test the GAD.

Reliability of the Scale:

In order to test reliability of the scale, the researcher used Cronbach's alpha formula to test the reliability and the test was done among a sample of (40) parents independent of the sample of the study (reliability sample) to assess internal consistency for Taylor scale in table number (4).

Table (4): Results of Cronbach's Alpha for Taylor scale for GAD

Score	Values of Cronbach's alpha
Total score	**0.96**

Scale Scoring:

Taylor Scale is a two-point rating scale and usually presented as a YES/NO option for each item on the scale. In order to have more reliability and accuracy, the scale was readjusted into a five-point rating scale (always, often, sometimes, rarely and never) always receives four points and then down to zero point for never. So, the scale ranged between (0) the min point to (200) the max point which indicates the high level of anxiety. Having 50 items multiplied by 4 which is the to score for each item on the always makes it 200 points to the max score.

Group CBT Counseling Program (Appendix III):

A CBT counseling program was set and developed by the researcher. The program was basically built refereeing to the theory and practices of Cognitive Behavioral Therapy approach and its techniques. The program focused on the CBT approach of cognitive restructuring which the researcher called “thought reformation’’ to resist the negative and irrational thoughts. The CBT program was of (13) sessions and it continued for three months and a half. The purpose of the program was to reduce the level of generalized anxiety among the parents of children with ASD. Homework, cognitive role-playing and thoughts-exposure were some of the techniques used in the sessions. Before the program was conducted, a committee of counselors and therapists reviewed the program and gave their ideas and edits which later the researcher used to have the program at its final formulation. Here is a brief description of the 13 sessions:

Session 1: Learn about anxiety

Session 2: Learning to recognize when you’re anxious and what that feels like in the body.

Session 3: Identifying your negative thoughts.

Session 4: Learning relaxation skills.

Session 5: Coping skills and relaxation techniques to counteract anxiety and panic.

Session 6: Confronting your fears (either in your imagination or in real life)

Session 7: Challenging your negative thoughts.

Session 8: Cultivate your connections with other people.

Session 9: Adopt healthy lifestyle habits.

Session 10: Reduce stress in your life.

Session 11: Replacing negative thoughts with realistic thoughts.

Session 12: Creating a step-by-step list.

Session 13: Working through the steps.

Research Questions and Hypotheses:

The two problems addressed in this study were: 1- Are there significant differences at ($\alpha = 0.05$) in the level of anxiety between the two groups (control and experimental) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups? 2- What is the effect of the group counseling program based on CBT approach in reducing level of anxiety among the parents of ASD children?

The first research question was: Is there a significant difference at ($\alpha=0.05$) in the level of generalized anxiety between the two groups (control and experimental) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups?

H1: There will be no significance in the level of generalized anxiety between the two groups (control and experimental groups of parents) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups.

Null Hypothesis $\mu 1 = \mu 2$

Alternative Hypothesis $\mu 1 \neq \mu 2$

Instruments: Tylor test for generalized anxiety.

The second research question was: Will the Cognitive Behavioral Therapy program be effective in reducing the level of generalized anxiety among parents of ASD children?

H2: There will be no significant difference in the level of generalized anxiety among the parents of ASD children who participated in a CBT program.

Null Hypothesis $\mu 1 = \mu 2$

Alternative Hypothesis $\mu 1 \neq \mu 2$

The instrument: Tylor test for generalized anxiety.

Data Analysis:

Data was examined to determine the effectiveness of joining a Cognitive Behavioral Therapy program in reducing the level of generalized anxiety among the parents of the children who received the CBT program

and to compare their scores with the scores of the control group on Taylor scale. The data analysis was conducted utilizing SPSS for Windows (SPSS 22., Win 10) computer program, and tested at alpha of .05. Descriptive statistics including frequency distributions for the nominally scaled demographic variables to provide a profile of the sample were employed. Cross-tabulations to determine the assumption of approximate normal distribution, measures of central tendency (mean, median, and mode), measures of variability (variance and standard deviation), and correlation of the dependent variables were performed.

Prior to testing the research hypotheses, t-tests for independent samples were used to determine if the two groups were statistically equivalent prior to beginning the training intervention as shown in the table below.

Table (5): Independent Samples t-test on generalized anxiety according to Group

Variable	Mean	SD	T. Value	DF	Sig
Exp.	1.89	0.32	0.28	14	0.77
Con.	1.84	0.33			

The t-tests for independent samples showed the groups were not statistically different prior to treatment. The criteria for rejecting the null hypothesis was all measures for each dependent variable show statistical significance. The statistical analysis for each hypothesis is shown in Table 5.

Table (6): Statistical Analysis Chart

Research Question/ Hypothesis	Variables	Statistical Analysis
1. Will there be a significant difference at ($\alpha = 0.05$) in the level of generalized anxiety between the two groups (control and experimental) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups? H1: There will be no significance in the level of generalized anxiety between the two groups (control and experimental) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups.	Independent Variable: Cognitive Behavioral Therapy program. Dependent Variable: Posttest scores on Tylor scale for generalized anxiety for both groups (control and experimental).	The mean scores of posttest were compared to determine whether there was a significant difference between the groups occurred on the level of anxiety following treatment.
2.Will the Cognitive Behavioral Therapy program effective in reducing the level of generalized anxiety among parents of ASD children? H2: There will be no significant difference in the level of generalized anxiety among the parents of ASD children who participated in a CBT program.	Independent Variable: Cognitive Behavioral Therapy program. Dependent Variable: Posttest scores on Tylor scale for generalized anxiety.	The mean scores of the pre and posttest were compared to determine whether there was a significant difference occurred on the level of anxiety following treatment.

Summary:

Chapter III described the methods of preparing the sample to treatment conditions, independent raters' duties, research setting, treatment method and procedures, and criterion instruments used in this study. Also described in this chapter were the research design, research questions and hypotheses, and statistical analysis used. Chapter IV presents the results of the statistical analyses performed and a description of the findings from the data collected for this research.

Chapter Four

Results

This chapter presents the results of the data analyses used to describe the sample and test the hypotheses created for the study. The chapter is also showing the results related to the two questions of the study

Results related to the first question of the study:

Are there significant differences at (α=0.05) in respect to generalized anxiety due to treatment: Experimental and control?

To answer this question the following steps were followed:

First: Independent samples t-test was calculated on pretest, to test the differences between experimental and control groups in respect to generalized anxiety as shown in table (5).

Result of table number (5) show no significant differences between experimental and control group on generalized anxiety scale before the interference. Comparing the means on the pretest and considering the significance (0.77) both show that the two groups had similar scores.

To answer the first research question that was: Will there be a significant difference at (α=0.05) in the level of generalized anxiety between the two groups (control and experimental) after conducting the CBT program with experimental group and comparing the Pre and Posttests scores for both groups?

The two groups were considered equivalent prior to starting treatment, and the table below shows how they got divided.

Table (7): Means and standard deviations for study variable on pre and post tests for Tylor scale of GAD

Group	Pre test			Post test	
	No.	M	S.D	M	S.D
Experimental	8	1.89	0.33	1.43	0.31
Control	8	1.85	0.33	1.97	0.33
Total	**16**	**1.87**	**0.33**	**1.70**	**0.42**

To answer the first question and to investigate the difference between the scores of the two groups after the CBT program was conducted, the means of two groups were compared in the posttest finding that there is a significant difference between the two groups scores indicating an obvious difference between the score and showing how the experimental groups score mean (1.43) was significantly less than the mean of the control group (1.97). Here we can refer the significant difference between the two groups to the effectiveness of the CBT program that the experimental groups received. And when comparing the mean of the control groups mean in pre and posttests, we realize that the control group mean even went higher and that can probably be thanks to the main justification of this research that parents sink into deeper level of struggle if they do not get the right help.

As a result, the second hypothesis is to be rejected and the alternative hypothesis is true.

In order to answer the second research question which was: Will the Cognitive Behavioral Therapy program effective in reducing the level of generalized anxiety among parents of ASD children? The Paired Sample t-test was conducted and the results in chart (8) showed a clear difference between the pre-mean and the post mean indicating that the Cognitive Behavioral Therapy Program was effective in reducing the level of anxiety scored on the posttest with (0.000 sig) significance below 0.05.

The Paired Sample T-test clearly indicated the difference shown in the table between the two groups after the Cognitive Behavioral Therapy program was applied. Table presents the descriptive statistics for the dependent variable examined in the study. The results of the analyses for the dependent variable showed a mean score of (1.43) in the post test dropping down in compare with the pretest that had a mean score of (1.89) showing a significant difference between the two score before the and after the CBT program was conducted and indicating that the program was significantly affective in reducing the level of anxiety among the parents of ASD children.

Table (8): Means, standard deviations and paired samples t- Test for Tylor scale on pretest and posttest from the control group

Test	M	S.D	T .value	DF	Sig
Pretest	1.89	0.33	16.39	7	0.000*
Posttest	1.43	0.31			

Therefore, the hypothesis 2 is rejected and the alternative hypothesis is accepted.

H2: There will be no significant difference in the level of generalized anxiety among the parents of ASD children who participated in a CBT program.

Null Hypothesis $\mu 1 = \mu 2$

Chapter Five

Discussion and Recommendations

The study's purpose was to examine the effectiveness of a group therapy program based on the Cognitive Behavioral Therapy in reducing the level of generalized anxiety among parents of children with Autism Spectrum Disorder at Sanad Center for children with mental health disorders in Nablus. The findings showed the significant effectiveness of the therapeutic CBT program to help parents dealing with their anxiety. In the first part of this chapter, we're going to discuss the results based on the questions of the study.

The two questions:

Are there significant differences at (α=0.05) in respect to generalized anxiety due to treatment: Experimental and control? And will the Cognitive Behavioral Therapy program be effective in reducing the level of generalized anxiety among parents of ASD children?

The results of the data analysis showed the therapeutic program was significantly affective in reducing the level of the anxiety among the parents of the Autism Spectrum Disorder children and that goes with the justification of the study. Also, the outcomes indicated that parents need the help to improve their lives and regain the resilience they need to help their children during any interference, and parents showed a better willingness to

cooperate with the therapists working with their children and a higher capacity of tolerance to future stressors and irrationality.

The study results emphasized that parents can learn life skills through cognitive approach easily when they have the CBT based on their need. It was clear that parents not only needed that help, but also were welling to bring up their potentials once they had some guidance.

The generalized anxiety had its own impact on whole family members, therefore, the results indicated that parents had an opportunity to make some changes within their families and increase sense of hope everyone needed. That was one foundational justification of the study which is to help regaining balance in the family and then with therapy.

Although, therapeutic interference usually examines how efficient a plan can be with a direct client, this study aimed at a further purpose that can enhance a new approach in the future by including parents with therapy programs and involving them more and more with the essential process. This idea might increase the chances of recovery and make family more capable of improvement.

The findings of the study agree with other studies that examined the effectiveness of Cognitive Behavioral Therapy. In this qualitative study by using CBT to reduce symptoms of social anxiety disorder in an adolescent, Kendall Delfini (2013) found that CBT individualized treatment of social anxiety as helpful as group intervention. That agrees with the study's

outcomes and findings revealed that anxiety was lowered in about 50% of the participant's anxiety provoking situations, and that the daily monitoring logs were the most helpful form of treatment for the participant. That shows also a positive significant impact of the CBT on anxiety under the individual treatment as well as it's with groups. Delfini (2013)

The study also agree with another research was led by Ravikant G Pinjarkar, Paulomi M Sudhir1, Suresh Bada Math2 the study examined the effectiveness of a brief CBT of six sessions in patients with social anxiety disorder. The results showed that brief CBT was effective in reducing social anxiety in all patients. Brief CBT was also effective in reducing social avoidance and self-consciousness and that all shows similar effects of CBT in both studies. (Pinjarkar et al, 2015).

The results here also agreed with studies aimed at checking the effect on parents of children with Autism Spectrum Disorder. One of these studies is The Early Bird Program (Shields, 2001), the pilot study of Early Bird Program showed that parents reported a drop-in anxiety and stress after 3- and 6-month follow-up. Both studies agreed on the importance of parents' enclosure to assist the ASD child treatment.

The findings suggested that the support the ASD child family receives can have positive influence on parents' awareness of stress. These findings agreed with the study of investigated social support impact for parents of children with ASD has been shown to significantly influence the self-reported levels of stress experienced by mothers (Konstantareas &

Homotidis, 1989). That shows how mothers are aware of the stress that affects their lives.

Not only the study agreed with studies investigated the impact of CBT, but also with studies tried behavioral methods. It agreed with the results of this study that suggested there was empirical evidence that parent training contributes to the effectiveness of behavioral treatments (Schreibman, 2000; Schreibman and Anderson, 2001) and, as an example of that is what Moes and Frea prove in their study that enhances functional communication in young children with autism (Moes and Frea, 2002) and may result in improved parent-child interactions after pivotal response training (Koegel et al., 1996).

ASD Parents showed a significant drop in the level of anxiety and the outcomes. Here is another study that approved the same findings. In his study with others in 2002, Salt's pilot study of Early Bird Program showed that parents reported a drop-in stress after 3- and 6-month follow-up. A small, nonrandomized controlled study (treatment n = 12; control n = 5) of The Scottish Centre for Autism program (therapist-supervised parent-child sessions, behavior management parent training groups) found a nonsignificant reduction of parental stress (Salt et al., 2002).

Conclusions:

The findings of the study here agree with what most studies came up with either the efficiency of the CBT with GAD or good outcomes when including parents of ASD children with special programs such as the one in this study and how that enhances their role with their child treatment. It's also clear now that parents of ASD children in Palestinian context are similar to most parents with a child has developmental disorder. Palestinian mothers and fathers here showed they face the same obstacles, so their need for support is essential as it is anywhere else around the world.

Recommendations:

Throughout these results and program demonstration, the researcher recommends the following:

1- Parents to be included in any further treatments of Autism Spectrum Disorder the thing that enhances and improves the process of therapy.
2- Awareness and family role education should be spread out through private and public therapeutic facilities aiming at therapeutic environment improvement.
3- The researcher recommends that ASD therapist and parents anxiety therapist to coordinate throughout the program. That would give both sides ideas on how the therapy is working and let them work on certain issues involving the family.

4- Family therapy sessions that include more family members are suggested by the researcher in order to include more people in a more efficient therapy that requires the top family support of ASD child.

5- Since the child is very dependent, the researcher suggests that ASD therapy would be more efficient if teachers and care providers and take part in CBT programs.

6- The researcher indicates that further studies in this field can include two parallel therapy programs with ASD child. One with child himself, and the other with parents. Then, an experimental comparable study to be conducted to see the impact of the parents' therapy on the child progress.

Suggestions and further researches:

Working with parents of children with Autism Spectrum Disorder is beneficial as the study showed, and children are expected to improve faster when their parents can earn resilience. As a result, this study is proposing some ideas for further studies in the following manner: While the child with Autism Spectrum Disorder is involved in a therapeutic program, parents can have their own empowering Cognitive Behavioral Therapy program parallel to the child program. That idea can then be transformed into a research that include the two programs with one group of parent-child pairs, and compare that with another group of parent-child pairs as a control group to find out the effectiveness of the CBT for parents on the progress that a therapy program does for the children with ASD.

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Appendixes

Appendix (1)

Taylor Scale for Generalized Anxiety

The Sentence	Always	Often	Sometimes	Rarely	Never
1- My sleeping is disturbed					
2- I have a lot of fears in compare with my friends.					
3- Some nights I can't sleep because of anxiety.					
4- I think I'm more nervous than others.					
5- I have nightmares.					
6- I get stomachache.					
7- I notice my hands shaking every time I do something.					
8- I get diarrhea.					
9- Money and career make me worried.					
10- I have nausea attacks.					
11- I get concerned about blushing of shyness.					
12- I feel hungry					
13- I don't have confidence in myself.					
14- I easily get tired.					
15- Waiting makes me very angry.					
16- I feel nervous to the point I can't sleep.					
17- I'm not usually a calm person.					
18- I usually feel nervous so I can't sit for long.					
19- I'm not happy all the time.					
20- I hardly can focus while working.					
21- I feel worried without a reason.					
22- Whenever I see a fight, I get a way.					
23- I wish I'm happy like others.					
24- I get concerned about mysterious things.					
25- I feel worthless.					
26- I feel that I'm going to collapse because of boredom.					

The Sentence	Always	Often	Sometimes	Rarely	Never
27- I sweat a lot even when it's cold.					
28- To me, life is just fatigue and disturbance.					
29- I'm always busy and I fear the unknown.					
30- I usually feel ashamed of myself.					
31- My heart beats fast.					
32- I cry a lot.					
33- I feared people and things that weren't harmful.					
34- Events and news affect me.					
35- I get headache a lot.					
36- Some worthless things make me worried.					
37- I can't focus on one thing.					
38- I easily get confused and make mistakes when I do something.					
39- I feel that I'm not worthy of doing anything.					
40- I'm a very nervous person.					
41- When I get confused, I sweat a lot and that annoys me.					
42- I blush when I talk to others.					
43- I'm more sensitive than others.					
44- I difficult experiences that I couldn't deal with.					
45- I feel nervous when I do some work.					
46- My hands and feet are cold.					
47- I usually have dreams that I don't like to talk about.					
48- I lack confidence.					
49- I experience disturbing constipation.					
50- Shyness makes me blush.					

Appendix (2)

The Cognitive Behavioral Therapy Program

The session planner:

Session 1: Learn about anxiety

Orientation: Explaining the sessions and time setup. Checking the individuals' needs regarding their children during the session.

Check in: ABC model and the effects of our thoughts. The thought-feeling round and every one to share what he wants to tell the group.

Parents are to understand the foundations of CBT model and how the feelings and reactions we have are based on the beliefs and thoughts are in our minds. Some of the feelings and reactions that are resulted of the thoughts and beliefs can manifest in different forms: Physical forms like high heartbeats and motional forms, like the tension.

Agenda: What is anxiety and how does it impact our life (physically, cognitively and emotionally)

Today, we're going to talk about how anxiety impacts our life in different aspects. When we're anxious, our bodies, emotions and thoughts are all affected. That leads to more social complications and bonds with people in our surroundings will get shaken. Among those people are our children who need us the most, our son or daughter with ASD. That's why we are

learning how to deal with anxiety. First, we need to learn more about it and where it comes from and leads to.

ABC is an easy modal to understand how our anxiety grows out of the thoughts we have. And when a feeling is usually what we sense the most, we find that there's a thought or a group of thoughts trigger that feeling out before it turns into actions.

Homework: Watch your anxiety and find out the thought beneath it!

Summarization and feedback: What did you learn today and what are you taking with you?

Session 2: Learning to recognize when you're anxious and what that feels like in the body.

Orientation: Welcoming the group and doing the startup round! Thoughts and Feelings.

The participants are to talk about their thoughts that brought into the session today and share it with the group.

Check in: Home work experience and concluding the connection between thought and anxiety. The members will talk about their self-observation regarding thought-feeling orientation. Sharing their findings about how thoughts create the foundation of the way we feel and react.

Agenda: The group is to learn how to find out if they're anxious or not and how that feeling is like!

Today, the session is highlighting the ways anxiety manifests in different forms and when are we able to tell if we're anxious or not and what level anxiety is controlling things in our lives.

The members are to draw them selves and to show and talk about where and how they feel anxiety in their bodies. Then, they talk about the feelings associate with anxiety. Are their typical thoughts generate your anxiety? Do you think about the same ideas that make you anxious? What do you usually do when you feel that you're at the top of anxiety mountain?

Concluding the session making the connection between the way we think and the way we feel and how that creates a circle when generates the negative thoughts and feelings leading towards the lack of control.

Homework: Make a time table of the moments you feel anxious and what other thoughts and feelings it is associated with!

Time	Thought	Feeling	My reaction

Summarization and feedback: What knowledge did you learn today?

Session 3: Identifying your negative thoughts.

Orientation: Some thoughts are good, and some are bad. However, both generate feelings.

Check in: Share your time table experience with the group, and how often did you feel anxious?

When did the worst feeling occur? What thought was behind that feeling? How long did it last?

What was your reaction to that feeling? How did you deal with your anxiety?

These questions are to be asked through presentation of the homework.

Agenda: What is a positive and a negative thought? Frame out the negative thoughts.

Are all our thoughts negative? Are there any good thoughts associated to anxiety?

Some of our thoughts are protective and necessary for our self-defense mechanisms. So what thoughts are to fight and resist? And how to tell if the thoughts are good or bad? Can my negative ideas be positive for someone else?

This discussion is to show that not every thought trigger in our mind is negative and some of them are good and can produce great ideas and resilience strategies.

When you think of real threat, you protect yourself. When you think of your needs, you put out plans. These are some examples of how our thoughts can help us. So, what is the negative thought?

The group is to discus how to know which thought bad or good and what factors make a thought irrational.

Homework: Make a list of your most disturbing negative thoughts that make you anxious!

Summarization and feedback: How is your experience for today?

Session 4: Learning relaxation skills.

Orientation: Body-Thought-Feelings-Reactions. The participants are to listen to quite music and feel the reaction in their bodies as they listen to music and think of anything comes to their minds.

Check in: Homework round and share some the negative thoughts! Which thoughts were the most powerful? And what was the resulting reaction of these thoughts?

Agenda: Have the members learn a relaxing technique to have more body-thought control.

The idea of relating is to let the body and thoughts get calmed by lowering the tension and the deep breathing during the music and the instructions as they imagine themselves follow the words and the music.

Homework: Practice relaxing twice a day and make a self-observation of your own thought-anxiety combination before and after relaxing!

Summarization and feedback: Anxiety-negative thoughts and control.

Session 5: coping skills and relaxation techniques to counteract anxiety and panic.

Orientation: Story: listen to the story of two friends who installed security alarms for their offices (the lesson: it's ok to not to care a lot sometimes).

Check in: A group-sharing experience about the effect of practicing relaxation while observing the thoughts.

Agenda: Today, we are learning a coping skill and putting it with the relaxing technique. The coping skill is called "adopting SO WHAT" idea in some stressing situations. Based on the story, the group members are to discus the impact of adopting the first man model of life and being worried about everything in his life to the point he buys an expensive and very sensitive alarm for his office. And the second man who cares about his office but doesn't worry so much.

At the end, parents will start to figure out what the SO WHAT is about, and how important to have at in some social settings.

They conclude the session by having a relaxation and listening to some stressing comments at the same time. They are to respond either verbally or in their minds saying: SO WHAT.

Homework: Go home and try to encounter some of the simple stressors with a SO WHAT response and record your reaction afterwards.

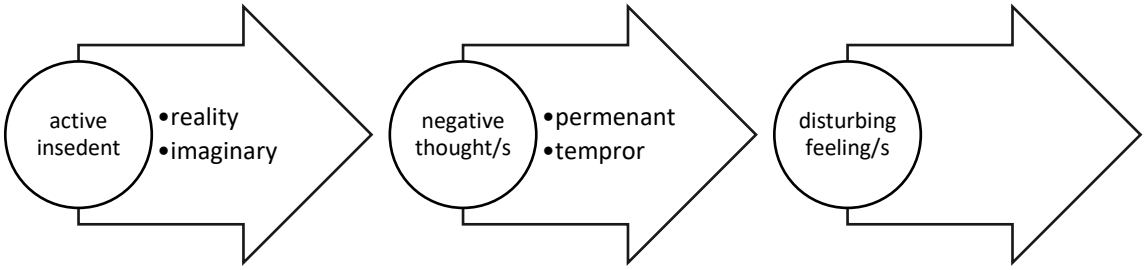
Summarization and feedback: sometimes, we need to let go things that are not so important in our lives and leave our energy for the priorities.

Session 6: Confronting your fears (either in your imagination or in real life)

Orientation: Story: Here's the story of the king and fatal-drawing challenge (the lesson: sometimes we see things different than they really are)

Check in: Sharing reactions on the SO WHAT homework experience and exchanging thoughts and feedback around the circle.

Agenda: On this day, we are learning the first step on how to tackle our fears through understanding the thought-foundational route of what scares us:



It's important to know that some fears are reasonable as well as the thoughts that generate them, so were don't have to fight all thoughts and feeling. Here, we want to see and talk about how our biggest fears are created and how we can get in control if we can understand and differentiate between the level of rationality of our thoughts. Then to practice to put our feelings back to their cognitive foundation before we try to get rid of any of them.

Homework: Watch your feelings, write them down and put every feeling you get to the idea that generated it.

Summarization and feedback: Our feelings are important because they decide a lot about our relation with things and people around us. However, there are these negative feelings that are not based on rationality that we can learn how to deal with if we understand how thoughts push them up to the surface.

Session 7: Challenging your negative thoughts

Orientation: Story: The river with one way of flow (the lesson: sometimes there as an alternative way if we could look around)

Check in: Let's talk about the homework. What thoughts were common behind your feelings?

Agenda: Today, we are going to see how thoughts also are controllable if we could manage our feelings through thoughts. To challenge and change the negative thoughts, we have to review how thoughts become powerful and result the feeling we suffer. Check this chart as an example:

The incident	The irrational thought	The resulting feeling	The clue supporting the thought
I slept of the stairs.	My life is miserable.	Frustrated.	It happens to me a lot.

Have the group talk about similar situations when they have negative feelings as a result of such thoughts. What if there are other clues resist the irrational thought?

The incident	The irrational thought	The resulting feeling	The clue supporting the thought	Other clues resisting the thought.
I slept of the stairs.	My life is miserable.	Frustrated.	It happens a lot to me.	There are days I don't slip.

Have each person in the group find a resisting clue to the irrational thought and talk about to the group. Discussing the feelings resulting after the alternative clues.

Homework: on a similar chart, track a negative thought causing negative feeling you usually have and try to find the supporting and counter clues for that thought.

Summarization and feedback: If an irrational thought is based on fragile clues, it's easier to break it down. And then. we can find resisting clues that can help us destructing the irrational thought faster.

Session 8: Restructure your own brand-new rational thought.

Orientation: A game: I say something, you tell true or not (the idea: you can measure external influence)

Check in: Share your experience with the resisting clue homework and tell the group what was easy or difficult to do it.

Agenda: In this session, we're learning how to rebuild a thought into a rational form after we managed to destruct the old irrational thought by resisting clues. Creating the new thought is basically a contrast of the old-irrational thought nature, so it's going to be a continuum of the chart we

used in the previous sessions adding a new column for the newly-structed thought.

The incident.	The irrational thought.	The resulting feeling.	The clue supporting the thought.	Other clues resisting the thought.	A new substitute thought.	A new resulting feeling.
I slept of the stairs.	My life is miserable.	Frustrate.	It happens a lot to me.	There are days I don't slip.	There's a good day and a bad day.	Optimistic

The parents to continue on the chart and find the new thought as an alternative and to talk about the feeling resulted after adopting the new and more rational thought.

Homework: During the next week, track your negative feeling and scroll the steps all the way reaching a new positive feeling after replacing the old irrational thought with one new rational thought.

Summarization and feedback: If you can put your hand on the foundations of any disturbing thought and feeling, you can learn how to break it down into their fundamentals and regain your rationality.

Session 9: Use the Cognitive Systematic Desensitization.

Orientation: Story: The duck nest on the high way (lesson: we can learn to do difficult things, if we start from the simple step)

Check in: Present your chart of rational thought restructure. Talk about obstacles and give feedback and supportive words as members talk about their experience.

Agenda: Today, we'll learn the steps of cognitive reformulation through the systematic desensitization. The idea is to list situations that cause negative thoughts. Then put these situations in an ascending style from the simple to the most complicating. Find the thoughts that you get for each situation. Using the relaxation and thought-restructuring techniques to systematically face the thoughts. It's a kind of thought-exposure method that trains the parents to practice and live stressing thoughts even before they encounter them.

Homework: Practice going through your obstacles and their thoughts, from the easier to the most difficult.

Summarization and feedback: If you train your self on facing thoughts while not stressed, you can do better when they come to reality.

Session 10: Reduce stress in your life.

Orientation: Planning: it's a magic that works everywhere (the idea: don't wait for the difficult situation, have your tools ready)

Check in: Check the home work and how the practice of CSD worked with the parents.

Agenda: In this session, we're going to see how facing the problem functionally by problem solving technique can help one control the problems efficiently.

Parents will take part in framing out problems they usually have and then conduct the problem-solving technique (identifying the problem-setting the goal-putting out solutions-studying the solutions-choosing and applying the most suitable one)

Homework: Apply the PST to face stressful problems and write notes about the process.

Summarization and feedback: If you solve your daily problem, you will be able to reduce your stress.

Session 11: Replacing negative thoughts with realistic thoughts.

Orientation: If you can change your negative thought, you can change a lot in your life to the better.

Check in: Discus the homework of PST and share your feelings and experience with other parents.

Agenda: Today, we are learning to put skills we learnt together leading towards replacing the negative thoughts with realistic thoughts. Parents are to have different stories and situations and then presenting solutions to these situations using CBT techniques.

Homework: Write a successful attempt where you could conquer a negative thought until it’s replaced with a realistic one.

Summarization and feedback: realistic life-style is part of the resilience we aim at. So, work on it.

Session 12: Creating a step-by-step list

Orientation: Being cognitively alert means that you are able comprehend the circumstances around you and sort them in the way you make it through successfully.

Check in: Start with sharing the written stories about the realistic challenges and members to listen and give supportive comments.

Agenda: Here, It's the session of concluding the work by giving parents more time of practicing the organized CBT steps to face negative thoughts and feelings in a step-by-step manner where they use role-playing and the loud-thinking techniques in order to learn how to act on real-life stressing events.

Homework: Put a plan on how to deal with a situation using the step-by-step starting from stating the situation, naming the rational and irrational thoughts you may have, and then the way you're going to deal with that situation.

Summarization and feedback: CBT program can help you help your self and others around you, so use the best of it to improve your life and your beloved ones.

Session 13: Conclude the work.

Orientation: What you learnt is your own, so keep it with you and ready to use it whenever you feel the bad thoughts and feelings.

Check in: Present your plan and share the ideas that you found useful to and might help others face their difficulties.

Agenda: Today, we will finish the sessions by concluding the work and giving everyone the chance to talk about their experience and its impact on his or her life through the past 3 months. Parents are expected to handle life stressors better using the techniques they learned.

The group of parents do the post test of generalized anxiety for the sake of research and statistical analyses.

Appendix (3)

Tylor Scale for Generalized Anxiety (Arabic Version)

الرقم	العبارة	دائما	غالبا	احيانا	نادرا	ابدا
1	نومي مضطرب ومتقطع.					
2	مخاوفي كثيرة بالمقارنة مع اصدقائي.					
3	يمر علي أيام لا أنام بسبب القلق.					
4	أعتقد انني أكثر عصبية من الاخرين.					
5	أعاني كل عدة ليالي من الكوابيس المزعجة.					
6	أعاني من الالام بالمعدة في كثير من الاحيان.					
7	ألحظ أن يدي ترتجف عندما أقوم بأي عمل.					
8	أعاني من الاسهال.					
9	تثير قلقي أمور العمل والمال.					
10	تصيبني نوبات من الغثيان.					
11	أخشى ان يحمر وجهي خجلا.					
12	أشعر بالجوع.					
13	أنا لا أثق في نفسي.					
14	أتعب بسهولة.					
15	ألانتظار يجعلني عصبي جدا.					
16	أشعر بالتوتر لدرجة أعجز عن النوم.					
17	عادة لا اكون هادئا وأي شيء يستثيرني.					
18	تمر بي فترات من التوتر لا أستطيع الجلوس طويلا.					
19	أنا غير سعيد في كل وقت.					
20	من الصعب علي التركيز أثناء أداء العمل.					
21	اشعر بالقلق دون مبرر.					
22	عندما أشاهد مشاجرة أبتعد عنها.					
23	أتمنى أن أكون سعيدا مثل ألاخرين.					
24	ينتابني شعور بالقلق على اشياء غامضة.					
25	أشعر بأني عديم الفائدة.					
26	أشعر بأني سوف أنفجر من الضيق والضجر.					
27	أعرق بسهولة حتى في الأيام الباردة.					

الرقم	العبارة	دائما	غالبا	احيانا	نادرا	ابدا
28	الحياة بالنسبة لي تعب ومضايقات.					
29	أنا مشغول واخاف من امجهول.					
30	انا اشعر بالخجل من نفسي.					
31	أشعر ان قلبي يخفق بسرعة.					
32	أبكي بسهولة.					
33	خشيت أشياء وأشخاص لا يمكنهم ايذائي.					
34	أتأثر بالأحداث.					
35	أعاني من الصداع.					
36	أشعر بالقلق على امور وأشياء لا قيمة لها.					
37	لا أستطيع التركز في شيء واحد.					
38	من السهل جدا ان ارتبك وأخطئ عند عمل شيء ما.					
39	أشعر بأني عديم الفائدة ولا أصلح لشيء.					
40	أنا شخص متوتر جدا.					
41	عندما ارتبك، احيانا اعرق ويسقط العرق مني بصورة تضايقني.					
42	يحمر وجهي خجلا عندما أتحدث للاخرين.					
43	أنا حساس أكثر من الاخرين.					
44	مرت بي أوقات عصبية لم استطيع التغلب عليها.					
45	اشعر بالتوتر أثناء قيامي بعمل ما.					
46	يداي وقدماي باردتان في العادة.					
47	أنا احلم بحاجات من الافضل ألا اخبر أحد بها.					
48	تنقصني الثقة بالنفس.					
49	يحصل لي حالات امساك تضايقني.					
50	يحمر وجهي من الخجل.					

Appendix 4

Validity Committee Experts List

Name	Institution	Profession
Muath Zeyod	Medcan de Mond/ France	Counselor/Therapist
Ahmad Mansour	National Security/Palestine	Counselor
Arwa Khamis	Ministry of Education	School Counselor
Lina Habash	The Palestinian Institution for Children	Family Therapist
Fathi Qabour	The Palestinian Counseling Center	CBT Counselor
Mustafa Wazeer	Ministry of Education	School Counselor
Arabeya Abu Zant	Ministry of Education	School Counselor
Dr. Mahmoud Obaid	Alquds Open University	Special Education lecturer and Trainer
Dr. Bashar Anabousi	Ministry of Education	Head of Counseling Special Education Depatment
Fawzy Habash	Ministry of Education	Counselor/Special Education

جامعة النجاح الوطنية
كلية الدراسات العليا

فاعلية برنامج علاجي سلوكي معرفي جمعي في خفض مستوى القلق المعمم لدى والدي الأطفال من ذوي اضطراب طيف التوحد

إعداد
عاصم جميل محمود إبراهيم

إشراف
د. فايز عزيز محاميد

قدمت هذه الأطروحة استكمالاً لمتطلبات الحصول على درجة الماجستير في الإرشاد النفسي والتربوي بكلية الدراسات العليا في جامعة النجاح الوطنية في نابلس، فلسطين.
2019

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الملخص

هدفت الدراسة الى اختبار فاعلية برنامج علاجي سلوكي جمعي مبني على العلاج السلوكي المعرفي في خفض القلق لدى اولياء الاطفال من ذوي اضطراب طيف التوحد. تتكون العينة التي اجريت عليها الدراسة من عشرين من اولياء الاطفال ذوي اضطراب طيف التوحد والذين يتلقون الخدمة العلاجية التأهيلية في جمعية سند للأطفال ذوي الاحتياجات الخاصة في مدينة نابلس.

تم اختيار مجموعة الاولياء المشاركين بشكل عشوائي ومن ثم وزعوا الى مجموعتين: المجموعة التجريبية والتي ضمت عشرة اولياء لأطفال ذوي طيف التوحد وقد تلقوا البرنامج الارشادي السلوكي المعرفي في فترة ثلاثة عشر اسبوعا. والمجموعة الضابطة والتي ضمت عشرة اولياء للأطفال ذوي طيف التوحد ولم تتلقى البرنامج الارشادي. كلا المجموعتين اجي لها اختبار فحص مستوى القلق قبل وبعد تنفيذ التدخل. بعد اجراء عملية التحليل الاحصائي، بينت النتائج بان البرنامج الارشادي كان فاعلا في خفض مستوى القلق المعم وذلك لصالح المجموعة التجريبية.

يوصي الباحث باشراك اهالي الاطفال من ذوي طيف التوحد في برامج علاجيبة تمكينية بالتوازي مع برامج علاج وتأهيل اطفالهم الامر الذي يساعد في تحسين البيئة الاسرية لما لذلك من انعكاس على العملية العلاجية للطفل.