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Effectiveness of Strength Oriented Family Therapy on Hope, Anxiety, Stress and Depression among Mothers of Children with Cancer

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Abstract

The aim of the present research was to study the effectiveness of strength-oriented family therapy on hope, anxiety, stress and depression among mothers of children with cancer. The research method was quasi-experimental with experimental and control groups by pre-test and post-test. The statistical population included all mothers of children with cancer at Ardabil city of Iran in 2015. A group of 30 mothers were selected by convenience sampling method, and they were placed randomly in two groups (15 persons in the experimental group and 15 persons in the control group). All participants completed the Persian Version of the Herth Hope Index (HHI-Persian version) and Depression, Anxiety and Stress Scale (DASS). The experimental group received the strength-oriented intervention within 10 sessions. Multivariate analysis of covariance was applied to analyze the data. Results indicated that the strength-oriented family therapy causes a significant change in increasing hope and reducing stress and depression in the experimental group. But there was no significant difference between groups in anxiety.

Keywords: Strength-oriented Intervention, Hope, Anxiety, Stress, Depression, Cancer.

Introduction

Despite significant advances in its treatment, cancer is still one of the most influential childhood chronic diseases (McGrath, 2002; Woodgate, and Yanofsky, 2010). In Iran, cancer is the third cause of death. In 2011, more than 30,000 people lost their lives due to cancer in Iran (Ministry of Health and Medical Education, 2012). However, despite the greatly improved clinical outcomes, children with cancer and their parents continue to experience significant distress throughout the course of the diagnosis and illness.

A number of previous investigations demonstrated that parents of children who suffer from cancer experience elevated levels of distress (Dahlquist, Czyzewski & Jones, 1996; Libov, -7evid, Pelcovitz & Carmony, 2002).

Findings on distress vary based on measurement, but the most commonly identified types of distress are depression, anxiety, posttraumatic stress symptoms, and subjective symptoms of stress. It is estimated that moderate and severe symptoms of distress range from 15% to 51% (Manne et al., 2000), especially among mothers (Brown, MadanSwain & Lambert, 2003; Kazak et al., 1998). Mothers report more emotional problems than fathers about the case (Dahlquist et al., 1993; Larson, Wittrock, and Sandgren, 1994). Having a child with cancer and providing them with 24-hour care, expose mothers to numerous physical, mental and emotional pressures. Previous studies showed that mothers experience a higher level of stress and discomfort than fathers in a same situation (Rodrigues & Patterson, 2007; Sloper, 2000). Many parents consider it as a starting point from which the reversal of the normal and expected family life stream begins. This is followed by a change in family views on life and death, their goals, expectations, dreams and hopes (Earle, Clarke, Eiser & Sheppard, 2007; McCaffrey, 2006; Woodgate & Degner, 2002). Cancer remains one of the most important diseases of the United States and the second most common cause of death after cardiovascular diseases in the country despite remarkable advances in medical science (Moldvan, 2009). However, with advances in the treatment of children with cancer, many more of these patients could be spared from death (Beckwitt & Jacobson, 2009).

Cancer has a poor prognosis compared with other diseases; it causes more fear and worry for the patient and his family (Fotokian, 2004). Diagnosing cancer directly effects quality of patients' life and their family caregivers, and changes their daily life in different ways (Saegrove, 2005). Today, with the advancement of therapy, there is an increased survival rate of children with chronic illnesses, such as cancer. But the prognosis, hope of life and quality of life for these children is unknown and is one of the most common causes of anxiety and depression of parents (Runesson & Elander, 2002). Despite the efforts of parents, their anxiety is transmitted to children since parents are the most important people in the child protection system (Melnyk & Feinstein, 2000).

Chronic diseases, such as Acquired Immune Deficiency Syndrome (AIDS), cancer and cardiovascular diseases are life crises which change the viewpoint of patients towards themselves and their family and they distort family dynamics (Abdi, Taghdisi, & Naghdi, 2010). One example is the fear and anxiety of parents whose children are admitted to the hospital.

Parents' anxiety is often associated with disease severity and treatment methods of children, and this anxiety is more common during therapy (Wong, Hockenberry, Wilson, Winkelstein, & Kline, 2003). Parents, especially mothers of children with cancer are more often at risk for psychological problems such as anxiety, depression and stress compared to the parents of healthy children (Hosseini Ghomi & Salimi Bajestani, 2013; Kristen, Robinson, Cynthia & Gerhardt, 2007). Likewise, cancer among children causes considerable stress for families (Eiser, 2004). Families of cancer patients experience stressful events and situations of continuous and ongoing anxiety (Hosseini Ghomi & Salimi Bajestani, 2013; Lavee & Mey-dan, 2003).

The initial reaction of parents in relation to the diagnosis of cancer in children is often associated with complex trauma and shock. Convincing that their children will be lost is difficult. Cancer can not only change the individual but also affects siblings, parents and the whole family (Eiser, 2006). In this regard, rather than focusing on individual and family weaknesses or deficits, strength-based practitioners collaborate with the families and the children to discover individual and family functioning and strengths (Laursen, 2000).

Strength-based assessment is assessing the emotional and behavioral skills, as well as competencies and characteristics that build a sense of personal accomplishment, contribute to improving relationships, and one's ability to handle challenges and stress; and amplify one's personal, social, and academic development (Epstein & Sharma, 1998). Children and families have unique talents in strength-based approach, such as skills, life events, and some unmet needs, (Olson, Whitebeck, & Robinson, 1991 as cited in Epstein, 1999). Programs that utilize a strength-based approach often combine this framework with other approaches such as wraparound service models, family systems frameworks, and various types of cognitive-behavioral therapies, including solution-focused therapy (SFT) (Johnson, 2003; McDonald, Boyd, Clark & Stewart, 1995). Signs of safety are a strengths-based strategy that takes a collaborative approach to working with families where child protection is an issue (Turnell, 2010).

Walsh (2006) stated that adversity can bring out the best in family members. However, when distressed, they may not see or access these strengths. A family resilience–oriented approach extends the strength-based practice by fostering family capacities to master adversity. By highlighting them, families can recognize their own resources and potential and their confidence increases if future need arises. Likewise, family members often discover resources they never knew they had, forge new areas of competence, and search for strengths in the worst of times, striving for meaning making and mastery. Empirical research suggests that strengths-based developmental interventions have a positive impact on positive psychological and positive organizational behavioral constructs such as hope (Sheldon, Frederickson, Rathunde & Csikszentmihalyi, 2000). Harter, Schmidt and Hayes (2002) stated that strengths-based development is linked to positive outcomes across a range of domains. Individuals participating in the strengths-based development report changed behaviors in follow-up surveys. More direct relationships between strengths-based development and attendance, grades, and per person productivity has been identified. In other cases, strengths-based development has been linked to increase in employee engagement,

which has been meaningfully linked to business outcomes, including profitability, turnover, safety, and customer satisfaction.

Allison, Stacy, Dadds, Roeger, Wood, and Martin (2003) showed the existence of family strengths prior to therapy. The study demonstrated that most parents presenting for therapy perceive their families as having strengths, despite the burden associated with supporting children experiencing mental-health problems. Despite common mental health assumptions viewing the families as dysfunctional, Family Assessment Device (FAD) in general functioning subscale provides a rather contrastive view. The therapists can acknowledge inherent family strengths to enhance resilience both in individuals and the family as a whole. This is crucial in strengthening families' abilities to manage current and future adverse or challenging situations**.** One assumption of strength-oriented family therapy is that assisting clients with goal development in small manageable tasks increases the client's feelings of self-efficacy and helps foster the belief that future goals may be obtained (Hall, Smith, Tarwater, Steine & Turnbough, 2005). Thus, when the teen's solutions and goals are given some weight, it conveys respect, fosters independent thinking, and increases engagement. When clients are reinforced for what they are already doing, they perceive treatment as a positive experience and self-efficacy is enhanced. This positive approach towards problem solving assists in engaging families, leads to greater satisfaction with the treatment process, and increases positive relationships and confidence in problem-solving skills. Family-based treatment is presented as a positive family activity that can increase trust, communication, and cohesion (Hall, Smith, Tarwater, Steine & Turnbough, 2005).

Kazak et al., (1998) conducted a pilot study regarding the feasibility of a three-session intervention for caregivers of children newly diagnosed with cancer where the intervention was distributed over one month. Nineteen families were randomly assigned to the intervention or the control group (treatment as usual) to identify their child's illness. The main focus of the intervention was identifying beliefs about cancer, the treatment, and the impact on the family. The intervention also focused on changing beliefs to enhance family functioning, as well as focusing on growth and future expectation. The results indicated a decrease in state anxiety for the primary caregivers in the intervention group. However, primary caregivers in the control group showed no change in the state of anxiety across time (Kazak et al. 1998).

Abdi, Taghdisi and Naghdi (2010) showed that people with chronic diseases are physiologically, psychologically, socially and emotionally different from normal people. Coping with the disease may also be associated with the patient's physical, emotional, and social needs. Thus, strength-oriented therapy is the most useful way for treatment of such patients and satisfying their needs because they receive physical treatment as well as psychological and social treatment (Abdi, Taghdisi, & Naghdi, 2010). Manthey, Trevor, Bryan, Asher and Wahab's (2011) study revealed that using an MI- (Motivational interviewing) with strengths-based practice approach (SBP) may not only reduce tension in the helping relationship, but reduce tension of the worker in other ways through reflective practice. Most importantly, using an MI-SBP approach as treatment similar to SOFT may increase the likelihood that clients achieve lasting behavior change and goal attainment. Scheel, Davis and Henderson (2012) used client

strengths in a qualitative study of Positive Processes and identified three meaning units: 1) instilling hope and empowerment, 2) self-awareness as a strength, 3) goals and motivation foster strengths; these units are strength-oriented outcomes. They concluded that therapists give hope to clients when the clients cannot achieve empowerment through autonomy; they instigate hope when the client is hopeless. They also found that strengths give hope and therapists set a goal of instilling hope and empowerment. In randomized control trial study in 2014 on 46 families of children newly diagnosed with cancer (23 in the intervention group and 23 in the control group), Svavarsdottir, Sigurdardottir and Bergthora showed that families in the intervention group received a three 45-minimum-session intervention and three booster sessions. Those who were in the control group received treatment as usual. The findings indicated that both the intervention and the control groups showed a significant decrease on state of anxiety over time for primary and secondary caregivers.

In sum, people with chronic diseases need to consult about their physiological, psychological, social and emotional needs since they are different from normal people. Finding ways to satisfy their needs could be considered as part of the process of coping with the disease. It may also address the importance of patient's physical needs, and the ignored emotional and social needs. Thus, strength-oriented therapy is the most useful way for treatment of such patients and satisfying their needs in physical, psychological and social treatments (Abdi, Taghdisi, & Naghdi, 2010).

In high prevalence of stress, anxiety and depression, the use of such non-drug treatments to alleviate these diseases or symptoms is essential. Therefore, non-drug treatments (especially soft treatments) can be useful for psychological and social treatments. Thus, the present research aims to investigate the effectiveness of strength-oriented family therapy on hope, anxiety, stress and depression in mothers of children with cancer.

Methods

The research method of the present study was semi-experimental and the pretest-posttest design. The population of the study consisted of all mothers of children who suffered from cancer at Ardabil a city in Iran during 2015. A group of 30 supported mothers were selected by convenience sampling method, and they were randomly placed in two experiment and control groups (each group with 15 subjects).

Procedure of this study are following:

Participants completed the Herth Hope Index (HHI) and Depression, Anxiety and Stress Scale (DASS), all in Farsi language. The validation results showed that Herth Hope Index (HHI) and Depression, Anxiety and Stress Scale (DASS) validity had the values of 0.92 and 0.86 respectively using Cronbach's alpha. Factor analysis confirmed the content and construct validity of the Scales. The results of the confirmatory factor analysis, as the primary form, confirmed the factors. According to the results, it can be maintained that (HHI and DASS) is a reliable and valid instrument for using among Iranian participants. For the Persian version of Herth Hope Index (HHI) and Depression, Anxiety and Stress Scale (DASS), the back-translation technique (Yaqubi, Tahir &

Amini, 2018) was used and the content validity of the translated questionnaire (Amini & Ibrahim- González, 2012; Rahimi, Esfandiari & Amini, 2016) was confirmed by two psychologists and a scholar of Translation Studies, proficient in Farsi and English.

Herth Hope Index

The Herth Hope Index (HHI) is a clinical-setting adaptation of the Herth Hope Scale (HHS) (Herth, 1992). The HHS consists of 30 items that are related to the six dimensions of hope, conceptualized by Dufault and Martocchio's Model of Hope (Dufault and Martocchio, 1985). Herth combined the six dimensions into three subscales of cognitive-temporal, affective-behavioral, and affiliate-contextual (Herth, 1992). The HHI is shortened from the HHS to a 12-item instrument for clinical applicability. The items in the HHI are in a Likert-format scale from 1 to 4, with 1 being "strongly disagree" and 4 being "strongly agree". The HHI is divided into three subscales (as is the HHS). The total scores of the HHI could range from 12 to 48, with a higher score equating to a higher level of hope (Herth, 1992). The construct validity of the HHI was measured by factor analysis that yielded a significant loading of the HHI scale on one of the three original subscales of the Herth Hope Scale (HHS). The three subscales were temporality and future, positive readiness, and interconnectedness. Further construct validation of the HHI included correlations of the HHI with the HHS (r= 0.92), the Existential Well-Being Scale (r= 0.84) and the Nowotny Hope Scale (r= 0.81). Finally, the HHI was correlated with the Hopelessness Scale for divergent validity (r= -0.73). The HHI was tested with a convenience sample of 172 ill adults. The alpha coefficient was 0.97 with a test-retest reliability after two weeks of 0.91 (Brown, 2005).

Depression, Anxiety and Stress Scale

The DASS-21 questionnaire is a quantitative measure of distress on the basis of three subscales of depression, anxiety (e.g., symptoms of psychological arousal) and stress (e.g., cognitive, subjective symptoms of anxiety). Since the abbreviated form is the main scale (42 questions), the final score of each of these subscales should be doubled. Each subscale has seven questions that respondents answered according to a Likert-type scale ranging between 0 ("does not apply to me at all") to 3 ("applies to me very much, or most of the time"). We used the DASS-21 and then we let it to be doubled. The reliabilities (internal consistencies) of the DASS-21 Anxiety, Depression, Stress, and Total scales were estimated using Cronbach's alpha, was 0.88 for the Depression scale, 0.82 for the Anxiety scale, 0.90 for the Stress scale, and 0.93 for the Total scale. The DASS-21 subscales can validly be used to measure the dimensions of depression, anxiety, and stress (Henry and Crawford, 2005).

Soft Sessions

The study protocol was developed and implemented according to Hall, Smith, Tarwater, Steine and Turnbough (2005). Specific adjustment and combinations of individual and group study sessions were based on the characteristics of this group. Users were familiar with the concept of immediate concern to inform members, and the expression of members' concerns. In this session the therapist used stage question (except question) to challenge members and the prioritized empathic listening concerns were tabulated. The

third session included assessing the strengths and resources. After assessing the internal and external resources, the therapist provided a form of strengths and resources. Members responded to assessment form, which contained eight areas, while the therapist focused on "Language" of solution-focused and conversations to be positive. The fourth session was examining members' concerns and reviews about strengths. The fifth session involved a review of the last session and directing it to the next session. By asking exception questions and coping questions, the therapist guided the members towards positive thinking. The sixth session ended with the assessment of the strengths and resources where the therapist completed the assessment in eight areas and summarized them. The seventh session included planning solutions. The members decided about their goals and the therapist completed the goals. The role of the therapist was validating goals and reviewing the necessary actions to achieve those plans and finding appropriate solutions by organizing activities to accomplish the goals. The eighth session consisted of review and critique goals where the therapist provided feedback. The ninth session comprised of providing case management, providing ongoing and structured support, training necessary skills and using internal and external sources of members. The tenth session included evaluation and follow-up in each section. This session allowed the therapist to go back if necessary by focusing on strengths and positive features. Negative features were not highlighted in this session. The members stated their feeling about the entire treatment before the final assessment was carried out. In all sessions, the therapist used techniques of cognitive therapy and social work to challenge the false beliefs (the reason of hope decrease). The therapist attempted to create positive expectations, a new orientation for the future, positive thinking, and optimism. During these sessions, the therapist focused on viewing the crisis as challenge, positive outlook, faith, mutual support, collaboration, respect for individual needs, differences, boundaries, social and economic resources, empathy, and collaborative problem solving.

Participants in the experimental group had 10 sessions (50 minutes for each session) based on strength-oriented interventions. These interventions were held twice a week. Participants in the control group did not receive any intervention. A summary of results is illustrated in Table1.

Results

The mean, standard deviation and sample size of two groups in pre-test and post-test stages in dependent variables are presented in Table 2 to 5.

Table 1. Mean and standard deviation of pre-test and posttest hope in experimental and control group

	Tests	Group	N	Mean	Std. deviation
Variable	Pre-test	Experimental	15	23.73	2.71
		Control	15	25.40	2.94
	Post-test	Experimental	15	39.46	2.92
		Control	15	25.13	3.13

Table 1 shows that the mean score of hope in the posttest stage is 39.46 for experimental group and 25.13 for control groups.

Table 2. Mean and standard deviation of pre-test and posttest anxiety in experimental and control group

	Tests	Group	N	Mean	Std. deviation
Variable	Pre-test	Experimental	15	20.73	2.49
		Control	15	20.33	2.16
	Post-test	Experimental	15	20.20	2.14
		Control	15	20.73	1.83

As shown in Table 2 the mean scores of anxiety in post-test stage are 20.20 and 20.73 for the experimental and control groups respectively.

Table 3. Mean and standard deviation of pre-test and posttest stress in experimental and control group

	Tests	Group	N	Mean	Std. deviation
Variable	Pre-test	Experimental	15	21.00	1.81
		Control	15	21.53	1.18
	Post-test	Experimental	15	19.73	2.31
		Control	15	21.86	1.30

As indicated in Table 3, the mean scores of stress in experimental and control group in posttest stage are 19.73 and 21.86 respectively.

Table 4. Mean and standard deviation of pre-test and post-test depression in experimental and control group

	Tests	**Group**	**N**	**Mean**	**Std. deviation**
Variable	Pre-test	Experimental	15	21. 00	1.30
		Control	15	20.06	2.18
	Post-test	Experimental	15	8.73	1.27
		Control	15	20.20	2.42

Table 4 shows that the mean scores of depressions in experimental and control group in posttest stage are 8.73 and 20.20 respectively. The data was analyzed by multivariate analysis of covariance. Box test (equality of variance) and Levine's Test (Equality of Error Variance) are presented in Tables 5 and 6.

Table 5. Box's Test of Equality of Covariance Matrices

Box's M	19.72
F	1.66
Df1	10
Df2	3.74
Sig.	.08

Table 5 indicates that the variance of groups in pretest stage is not significantly different.

Table 6. Levene's Test of Equality of Error Variance

	F	Df 1	Df 2	Sig.
Hope	.287	1	28	.597
Anxiety	2.592	1	28	.090
Stress	.016	1	28	.900
Depression	2.984	1	28	.095

As shown in Table 6, there is no significant difference between groups in dependent variables on error variance.

Validity index of multivariate analysis of covariance test are shown in Table 7. There is significant difference in all indexes.

Table 7. Summary of multivariate analysis of covariance in experimental and control groups

Source	Dependent Variable	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Hope	1920.000[a]	1	1920.000	116.397	.000	.806
	Anxiety	6.533[b]	1	6.533	1.508	.230	.051
	Stress	19.200[c]	1	19.200	5.156	.031	.156
	Depression	1153.200[d]	1	1153.200	182.771	.000	.867
Group	Hope	1920.000	1	1920.000	116.397	.000	.806
	Anxiety	6.533	1	6.533	1.508	.230	.051
	Stress	19.200	1	19.200	5.156	.031	.156
	Depression	1153.200	1	1153.200	182.771	.000	.867

Table 7 shows that there is a significant difference between experiment and control groups in hope and depression ($p < 0.001$). The same result is true in variable of stress ($p < 0.05$). But there is no significant difference between groups in anxiety. Generally, the data analysis indicated that the intervention variable, SOFT, is effective in treatment of hope, depression and stress.

Discussion

This research aimed to investigate the effectiveness of strength-oriented family therapy on hope, anxiety, stress and depression among mothers of children with cancer. The first hypothesis was that SOFT is effective on hope. The findings of the present study generally confirmed the first hypothesis and showed that there is no significant difference at hope between the mothers of control group and the experimental group. However, the mothers in the experimental group reported greater hope. These findings are consistent with findings of Harter, Schmidt and Hayes (2002), McCormack (2007), Ortiz (2005), Scheel, Davis and Henderson (2012), and Sheldon, Frederickson, Rathunde and Csikszentmihalyi (2000). They concluded that at strength-oriented family therapy hope can be increased by strengthening positive qualities. When a person

recognizes those positive features an internal reinforcement is created. As a result, the outer reinforcement by the therapist with internal reinforcement enhances the expectations and hope. The therapist uses solution-focused questions to cause increased hope. It could be explained that chronic diseases such as cancer are also part of life experience and people do not always experience good moments, but also unpleasant moments; therefore, people should create a balance between the good and bad moments and notice that these moments are part of human life changes that can increase hope. In strength-oriented family therapy, respect, attention to a person, and considering the person an "expert" in treatment lead to positive energy and increase hope in the person. Strength-oriented family therapy can create positive view and augment hope by instilling hope and setting and planning goals.

The second hypothesis was that SOFT is effective on reducing stress. The findings of the present study confirmed this hypothesis and showed that there was no significant difference in terms of stress between the control and experimental groups. The mothers in the experimental group reported less stress than mothers in the control group. This is consistent with the findings of Epstein and Sharma (1998), Kazak et al (2005), Manthey, Trevor, Bryan, Asher and Wahab (2011), Reynolds (2012), and Svavarsdottir and colleagues (2014). It could be concluded that strength-oriented family therapy with emphasis on service resources can reduce stress. The efficacy cause, as a coping ability, can deal with problems. For example people use religious resources as coping with stress (Ramírez–Johnson, 2013). It can be said that people are looking for resources to protect them against stressful events; therefore, a more resource would be coping ability. Reynolds (2012) also stated that strength-oriented family therapy education raises client efficacy when they face problems. In addition, strength-oriented family therapy through client experience reinforcement, empathy, respect to client, optimism, awareness creation, clarification of the limits and boundaries can provide clients resilience, and the resilience of individuals can be vaccinated against stressors (McCormack, 2007). Also, a sense of confidence created by strength-oriented therapy resists against life adversity (Lietz, 2007). Strength-oriented therapy can reduce stress through external problem (Ortiz, 2005). Strength-oriented family therapy through external problems helps mothers not to see their problems as part of their identity and helps them to handle their problems. By referring to internal sources, respecting and appreciating themselves, mothers make deal with their problems in a less stressful manner. Focusing on the clients' beliefs creates coping resources and decreases psychologically stressful symptoms. Strength-oriented family therapy through empathy helps to identify the goals that allow clients to share during treatment process. This work creates a sense of success and efficacy. However, big goals seem difficult and working with small goals could decrease mothers' stress.

The third hypothesis was that SOFT is effective on reducing depression. The findings of the current study generally confirmed this hypothesis. In other words, there is a significant difference in depression between control group and experimental group. Depression is a common problem among mothers, who have children with cancer, and the strength-oriented family therapy has techniques that straightly target depression symptoms, such as exceptional questioning; thus, it can be effective on problems such

as depression and hopelessness. These findings are consistent with the results of the previous studies (Allison et al, 2003; Hall et. al, 2005; Svavarsdottir & Sigurdardottir, 2013; Schwebel, 2004; Smith et al., 2006). According to these studies, selection solutions can create power, energy and coping ability in clients. Furthermore, expressed concern through "language" reduces depression. Also, strength-oriented family therapy with flexibility and ability to find solutions can create problem-solving skills. These skills could contribute to coping with resources against psychological problems (Sharry, 2004). Strength-oriented family therapy instills social support towards clients. Social support is a strong predictor of mental health. People with less social support have less depression and better mental health. SOFT uses feedback of solution focused therapy. Clients through feedback pay attention to their life changes and understand that these changes are unavoidable like health changes. Accepting the short nature of life can help to decrease depression by not getting affected by such life changes.

The fourth hypothesis was that the treatment is effective in reducing anxiety. The findings did not confirm this hypothesis and showed that the control group and the experimental group did not have significant differences in terms of anxiety. The mothers in the experimental group did not report reduction of anxiety. This result was predictable because in strength-oriented family therapy, there is no technique for reduction of acute psychopathological state such as anxiety. This inference is correct about stress because as the hypothesis was confirmed, and Eta coefficient was poor. However, these findings are not consistent with some of the findings of the previous studies, such as Kazak et. al, (2005) and Svavarsdottir et. al (2014).

The present study has several limitations. The method of sampling was convenience method which limits generalization of the results. We suggest using a complete manual of the SOFT about families with every type of chronic disorder. Moreover, focus on success rather than failure and the community as a resource might be useful in reducing psychological problems. Another major limitation is the sample size that could be because of the absence of fathers in therapy sessions and unwillingness of some mothers to participate in this study. The short-term interventions and lack of follow-up treatment could return the symptoms of stress, anxiety, depression and hopelessness. Based on the findings of this study, it is suggested that fathers participate in therapy sessions. For example, Kazak et. al (2005) stated that the accompanying role of fathers with mothers as a participant in intervention may be helpful. Also, it is better to increase the number of therapy sessions as well as sample sizes for accurate generalization.

Mothers of children who use chemotherapy drugs are required to go hospital which could create anxiety among mothers whom are receiving non-drug treatments, such as SOFT. Constant worrying of going to hospital and seeing health conditions of other mothers of children with cancer can be a barrier to treatment. If reducing anxiety happens in short term there could be other reasons for its cause.

Conclusion

Generally, strength-oriented family therapy can help families with their problems. These findings are consistent with results of Walsh's (2006) study, as she stated that her

research documented the strong psychological and physiological effects of a positive outlook in coping with stress, recovery from crisis, and overcoming barriers to success. When families are dealing with a major crisis or pileup of stresses, they can easily lose sight of their strengths and resources. By noticing, affirming, and commending family members about their strengths and potentials in the midst of difficulties, we help them to counter a sense of helplessness, failure, or blame. Seeing the potential in everyone reinforces a sense of pride, confidence, and a "can do" spirit.

Disclosure Statements

I certify that no party having a direct interest in the results of the research supporting this article has or will confer a benefit on me or on any organization with which I am associated and, if applicable, I certify that all financial and material support for this research and work are clearly identified in the title page of the manuscript.

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