ORIGINAL ARTICLE Received 15 December. 2018 Accepted 28 November. 2019

Vol. 6, Issue 1, 1-11, 2020

Iranian Journal of Positive Psychology

ISSN: 2423-6985

ijpp.worldofresearches.com

Comparison of the Effectiveness of Cognitive-Behavioral Therapy and Narrative Therapy on the Improvement of Death-Related Disorders and Psychological Hardiness in Male Patients with Prostate Cancer in Tehran Hospitals in 2020

Sahar Mousavian*[1], Somayeh Shahani[2], Ruhollah Rezaei[3], S. Ebrahim Taghavizadeh[4]

1. M.A of General Psychology, Islamic Azad University, Yasouj Branch, Iran.
2. M. A of General Psychology, Islamic Azad University, Central Tehran Branch, Iran.
3. M.A of General Psychology, Payame Noor University, Islamabad Gharb Branch, Iran.
4. M.A of Clinical Psychology, Islamic Azad University, Shiraz Branch, Iran.

A B S T R A C T

Cancer can cause many psychological problems for patients and it is necessary to find effective ways to help them. Therefore, this study was performed to compare the effectiveness of cognitive-behavioral therapy and narrative therapy in improving death-related disorders and psychological hardiness in female patients with prostate cancer. The research design was quasi-experimental and pre-test-post-test with two experimental groups and a control group. The statistical population included all men with prostate cancer who referred to hospitals in Tehran in 2019. The sample consisted of 45 patients who were selected by purposive sampling and randomly assigned to three groups: cognitive-behavioral, narrative therapy and control group. The Death Anxiety, Death Depression, and Personal Perspectives scales were used to collect data. Data were analyzed using MANCOVA and Bonferroni post hoc test and SPSS-22 software. The results showed that between cognitive-behavioral and narrative therapy groups with the control group in the post-test stage of death anxiety ($F = 15.44$ and $p < 0.05$), death depression ($F = 21.79$ and $p < 0.05$) and There is a significant difference in psychological hardiness ($F = 4.63$ and $p < 0.05$). The results also showed that there is a significant difference between cognitive-behavioral group and narrative therapy in anxiety and depression of death ($p < 0.05$) and narrative therapy is more effective; But there is no significant difference between them in psychological hardiness ($p > 0.05$). According to the findings of this study, cognitive-behavioral therapy and narrative therapy can be used as an effective method to improve the disorders associated with death and psychological stiffness in male patients with prostate cancer, and in this regard, narrative therapy can be more effective.

Keywords: Cognitive-Behavioral Therapy, Narrative Therapy, Death Anxiety, Psychological Stubbornness, Prostate Cancer.

INTRODUCTION

Cancer is one of the most serious diseases in the world and the third leading cause of death in the world; as 18.4% of deaths and deaths in the world are due to cancer. Unfortunately, the growth of cancer in the world is accelerating and about 18.1 million people are diagnosed with cancer annually(Arbyn et al., 2020; Bray et al., 2018; Ferlay et al., 2019). Cancer is caused

* . Corresponding Author: Sepehrmousavi513@gmail.com

DOI: In prossing

To cite this article: Mousavian, S., Shahani, S., Rezaei, R., Taghavizadeh, S. E. (2020). Comparison of the Effectiveness of Cognitive-Behavioral Therapy and Narrative Therapy on the Improvement of Death-Related Disorders and Psychological Hardiness in Male Patients with Prostate Cancer in Tehran Hospitals in 2020. *Iranian Journal of Positive Psychology*, 6 (1), 1-11.

by the unlimited proliferation of cells in the body and there are over 200 types of cancer(Horney et al., 2011; Roh & Kim, 2016). Lung and prostate cancer are the most common cancers diagnosed in men and are the leading cause of cancer mortality(Bray et al., 2018). In Iran, breast and uterine cancer are more common for women and stomach cancer for men, and one in four Iranians develops one type of cancer before the age of 75 (Mohebbi et al., 2017).

Chronic cancer causes the body to weaken and increase psychological problems by weakening the body as well as due to the bad mentality it has among people(Gregurek, Braš, Đorđević, Ratković, & Brajković, 2010). Unfortunately, people consider cancer to be a kind of end of life, and patients, after being diagnosed with the disease, find themselves closer to death and therefore suffer from death-related disorders(Tang, Chiou, Lin, Wang, & Liand, 2011); In other words, patients suffer from anxiety and depression. Death anxiety is a persistent, irrational, and morbid fear of death or dying. This concept also refers to the fear of death and high fear of the dead(Gonen et al., 2012). Death depression also refers to depressive attitudes about death and non-existence(Templer, Lavoie, Chalgujian, & Thomas-Dobson, 1990). Research has shown that cancer patients have a high mortality rate. The prevalence of anxiety in the cancer group was 17.9% and in the healthy group was 13.9% (Tan, Beck, Li, Lim, & Krishna, 2014). Depression and death anxiety in cancer patients cause many problems in them and can reduce their health and quality of life(Khezri, Bahreyni, Ravanipour, & Mirzaee, 2015).

It is very difficult for patients to know death is imminent and it causes them a lot of confusion; but the degree of tolerance and resistance to these difficulties varies for patients. If patients can increase their tolerance and power, they will be less disturbed(Aghajani, Rahbar, & Moghtader, 2018). Kobasa, Maddi, and Zola (1983), State that stressful events have different effects on people that if people have high psychological stubbornness, the severity of these effects will be very low. Psychological stubbornness, which emphasizes a person's inner experience and mental perception, means endurance, ability, and endurance in difficult situations. Hardship is a combination of beliefs about oneself and the world that consists of three components: commitment, control, and struggle, or challenge, and high hardship is a sign of a healthy personality. Tough people have the power to control life events and instead of avoiding problems, they see them as opportunities for progress. In other words, difficult people not only do not consider themselves victims of change, but also see themselves as the determinants of the results of change(Maddi, 2015). Hardness is a protective shield against the stresses of various situations. Hard-working people are better able to cope with the stresses of life. Research by Vance et al. Showed that people with high psychological stubbornness have more power and hope to deal with deadly diseases if they face them(Maddi, 2015). The meta-analysis of Eschleman, Bowling, and Alarcon (2010), Showed that people with high stubbornness can maintain their mental health in stressful situations and move towards growth and prosperity.

Due to the problems that cancer patients have, studies show that these patients need psychological support and care(Merckaert et al., 2010), to increase their psychological toughness and reduce their death-related disorders in order to be able to. Have a better and happier life. One of the interventions that has a good history in improving the psychological status of patients is cognitive-behavioral therapy (Cognitive-Behavioral Therapy) (Greer, Park,

Prigerson, & Safren, 2010). Cognitive-behavioral therapy as a purposeful approach, focusing on cognitive reconstruction and change of behaviors, emphasizes on abandoning irrational behavior and dysfunctional thoughts and in exchange for replacing new and effective behaviors and thoughts. The basic premise of therapy is that the learning process plays an important role in creating and sustaining behaviors and habits that can be de-learned. Cognitive-behavioral therapy, based on functional analysis and skills training, helps people to choose a wiser and healthier life(Dobson & Dozois, 2010).

It is assumed that the psychological problems that cancer patients experience are due to their dysfunctional and erroneous thoughts about the disease, and a cognitive-behavioral approach can correct such thoughts. Meta-analysis by Hoffman et al. Shows that cognitive-behavioral therapy can improve many psychological problems(Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Tatrow and Montgomery (2006), have also pointed out in their research that cognitive-behavioral therapy can be effective in improving the disorders and pain of cancer patients(Tatrow & Montgomery, 2006). Based on his meta-analysis, Tolin (2010), states that cognitive-behavioral therapy, contrary to popular belief, does not precede all therapies and should be the first choice of therapists for anxiety and depression.

Although cognitive-behavioral therapy has a long history and is still one of the most common therapies with a great deal of empirical evidence, the question arises as to whether, according to Tolin (2010), it is also the treatment of choice for anxiety and depression in cancer patients. The first treatment is proposed and can it improve the psychological toughness of these patients?

In addition to cognitive-behavioral therapy, which is one of the therapies of modernism, there are therapies that are somewhat unusual but growing. These therapies, which are from the postmodern approach, can be effective in improving psychological problems(Lopes et al., 2014). Postmodern theorists criticize reason and objective reality and are skeptical of the foundations of modernism(Lopes et al., 2014). Narrative therapy is one of the postmodern therapies that may be effective in improving the problems of cancer patients(Rastgari & Moradi, 2014). Narrative therapy sees people as experts in their lives and believes that people have skills, beliefs, and values that can reduce the effects of problems in their lives. In fact, narrative therapy believes that people should rewrite their stories(Morgan, 2000). The problem is that the story has to be rewritten through therapeutic dialogue. The treatment begins with the deconstruction of the power of the individual's story and moves towards the construction of a new meaning(Rastgari & Moradi, 2014). In this treatment, the problem is externalized and the patient believes that he can change the problem and the environment and not consider himself a victim of the environment(Brown & Augusta-Scott, 2007). In this regard, research shows that narrative therapy can be used as an effective treatment for some psychological problems(Vromans & Schweitzer, 2011).

Given the above, cancer patients due to their illness feel disturbed by death and it is necessary to strengthen their psychological strength and have a strong spirit against the disease. Therefore, psychological interventions are important and it is necessary to choose and use the most effective type of psychological interventions; Therefore, this study was conducted to compare the effectiveness of cognitive-behavioral therapy and narrative therapy in improving

death-related disorders and psychological hardiness in female patients with prostate cancer.

METHODOLOGY

In this study, a quasi-experimental research design of pretest-posttest type with two experimental groups (cognitive-behavioral therapy group; narrative therapy group) and a control group were used. The statistical population of the study included all men with prostate cancer who referred to hospitals in Tehran in 1398. Since it was not possible to accurately estimate the number of populations, the selection of large samples in experimental designs makes it impossible to accurately control the intervention variables and it is stated that in experimental studies the volume of each group can be at least 15 people (29). Inclusion criteria were selected by purposive sampling method and 15 people in the cognitive-behavioral therapy group, 15 people in the narrative therapy group and 15 people in the control group were randomly replaced. Inclusion criteria included diagnosis of prostate cancer, having at least 6 months of disease history, being in the age range of 60 to 75 years, absence of psychiatric diseases and also the use of neuropsychiatric pills in patients based on psychological interview and consent to attend treatment. . Exclusion criteria included absenteeism for more than one session, use of other psychotherapy and counseling services during the sessions, as well as the dissatisfaction and unwillingness of the subject to continue participating in the sessions and, consequently, the need to exclude the subject from the researcher. It is noteworthy that fortunately there was no decline in the groups studied. In order to observe the ethical aspects, the subjects were told that this research is in fact to help and provide them with practical information, their information is kept secret and if they do not want to, they cannot participate in this research, which was finally obtained orally. The control group did not receive any treatment.

Cognitive-behavioral therapy group, the training course based on the protocol of Mosalanejad, Koolaee, and Jamali (2012b), and narrative therapy group, the training course based on White, White, Wijaya, and Epston (1990), treatment program in 8 sessions of 1 hour and at the discretion of psychology professors in one session in They received the week. The summary of the sessions is as follows:

Summary of cognitive-behavioral therapy. Session 1: Introducing and getting acquainted with the patient, performing a pre-test, determining the goals of treatment, mentioning the rules of the session, introducing cognitive-behavioral therapy, examining cancer and related problems, and teaching relaxation techniques. Session 2: Writing down negative and inefficient thoughts and beliefs, using relaxation techniques, presenting homework. Session 3: Feedback from the previous session and homework review, training of vertical downward arrow technique to identify central schemas and beliefs, use of relaxation technique. Session 4: Preparing the main list of beliefs, testing the beliefs of the clients with objective analysis (judgment and judgment), using the technique of calming. Session 5: Using different methods of cognitive analysis and encouraging clients to re-evaluate beliefs, using relaxation techniques. Session 6: Opposing automatic thoughts, stopping thinking, using relaxation techniques. Session 7: Emphasis on cognition to emotions, cognition and emotions related to cancer, use of

relaxation technique. Session 8: Review of conditioning, antecedents and postpositions, questions and answers, receiving feedback, post-test and saying goodbye.

Narrative therapy summary: Session 1: Introducing and getting to know the patient, conducting a pre-test, determining the goals of treatment, mentioning the rules of the session, examining cancer and related problems, introducing narrative therapy, work samples and descriptions of problematic stories. Session 2: Objectification and externalization of the problem, naming the problem, identifying the problematic words and starting metaphorization. Session 3: Continuation of metaphorical construction, study of problematic metaphors and their relation to life narrative and taking a position on the problem, beginning of deconstruction. Session 4: Destruction phase: deconstruction of the problem by life exceptions, narrative analysis, attitude towards the problem and the interaction of the person and the problem. Session 5: Reconstruction phase: new metaphors, mental representations of life situations with new metaphors, creation of reality by the individual and the beginning of narration. Session 6: Enriching the New Story Using Unique Strategies, Examining the Story and Its Meaning to the Future. Session 7: Consolidation Phase: Living in a New Story, Answering Questions, and Rewriting Past Stories. Session 8: Examining the meaning of life, external documents, enriching and encouraging the person to continue the story, questions and answers, receiving feedback, post-test and saying goodbye.

Death Anxiety Scale (DAS): This questionnaire was developed by Templer (1970), and consists of 15 items that measure the subject's attitude toward death. Subjects indicate their answers to each question as yes or no. The answer yes indicates the presence of anxiety in the person. Thus, scores on this scale range from zero to 15, and high scores indicate anxiety. The reliability and validity of this scale have been reported in the country as a composition reliability coefficient of 0.60 and internal consistency coefficient of 0.73. Also, to evaluate the validity of the scale, two tests of death anxiety scale and overt anxiety scale were used, the result of which was 0.04 for correlation coefficient of death anxiety scale with death anxiety scale and 0.34 for correlation coefficient of death anxiety scale with overt anxiety scale, (2001). Cronbach's alpha coefficient of this scale in this study was 0.81.

Death Depression Scale (DDS): This questionnaire was developed by Templer et al. (2002), And consists of 17 items that measure depressive attitudes toward death. This questionnaire has two forms, two-choice and Likert, the Likert form of which has been used. The subject determines his / her answer in a five-point Likert scale from completely agree (score 4) to completely opposite (score zero), whose scores range from zero to 68, and higher scores mean more depression. In internal standardization, the death anxiety test was used to check the validity of the scale, which is at an acceptable level with 0.73. In order to evaluate the reliability of this scale, the retest method and Cronbach's alpha coefficient were used, which had a good reliability of 0.92 and 0.90, respectively(Mohammadzadeh, Rezaei, & Aghazadeh, 2016). Cronbach's alpha coefficient of this scale in this study was 0.87.

Personal Views Survey Questionnaire (PVSQ): This questionnaire is a self-report scale designed by Kobasa et al. (1983), To measure the degree of psychological toughness of individuals. This questionnaire has 50 items and three subscales of control, commitment and struggle. To answer, the subject must express his / her opinion on a 4-point Likert scale from zero to 3 (not

at all correct, almost correct, often correct, and absolutely correct) that higher scores mean more stubbornness. Studies show that the three components of commitment, control and combat have alpha validity coefficients of 0.70, 0.52 and 0.52, respectively, and this coefficient has been reported for the whole scale of 0.75. In internal studies, the validity and validity of the scale have been confirmed and its validity has been reported by Cronbach's alpha method for the whole scale and subscales of commitment, control and combat, equal to 0.88, 0.64, 0.72 and 0.70, respectively. (35). In the present study, Cronbach's alpha coefficient of the whole scale was 0.87.

To analyze the research data, descriptive index of mean and standard deviation and at the inferential level, in order to control the effect of the pretest, multivariate analysis of covariance (MANCOVA) and Bonferroni post hoc test were used. Data were also analyzed by SPSS software.

RESULTS

In the descriptive part of the research samples, the mean and standard deviation of age were 37.46 ± 4.37 in the cognitive-behavioral experimental group, 39.20± 4.12 in the narrative therapy group and 38.86±. 3.85 in the control group.

Table 1: Results of descriptive indicators of research variables by group

Variable	group	pre-exam		Post-test	
		Average	Sd	Average	Sd
death anxiety	Cognitive-behavioral	10.46	1.80	8.66	1.67
	Narrative Therapy	11.86	2.33	6.73	2.01
	Control	11.06	1.83	10.53	1.64
Death Depression	Cognitive-behavioral	45.53	6.24	42.26	6.19
	Narrative Therapy	47.13	5.70	36.03	6.06
	Control	49.26	5.49	50.93	6.19
Psychological stubbornness	Cognitive-behavioral	59.53	6.53	72.40	7.98
	Narrative Therapy	61.60	7.43	71.33	9.61
	Control	64.20	6.82	63.26	5.63

The table above shows the mean and standard deviation of the variables of death-related disorders (anxiety and death depression) and psychological hardiness in the two experimental groups of cognitive-behavioral therapy and narrative therapy and the control group in the pre-test and post-test stages. In examining the assumptions of covariance analysis, the obtained results indicated that the assumptions of covariance were established, so the results of the covariance test were reported, the results of which are as follows:

Table 2. Results of covariance test to evaluate the effects of intergroup on death-related disorders and stubbornness

Source	Variable	SM	Df	MS	F	P	Eta
group	death anxiety	104.27	2	52.13	15.44	0.001	0.442
	Death Depression	1711.46	2	855.73	21.79	0.001	0.527
	Psychological stubbornness	599.77	2	299.88	4.63	0.016	0.192
Error	death anxiety	131.65	39	3.37			
	Death Depression	1531.24	39	39.26			

	Psychological stubbornness	2522.03	39	64.66			

Based on the obtained results, it can be seen that F-statistic with a value of 15.44 for death anxiety, 21.79 for death depression and a value of 4.63 for psychological hardiness (P <0.05). This result shows that there is a significant difference between the groups under study in death-related disorders and psychological hardiness. In order to compare the pairs of groups, Bonferroni post hoc test was used, the results of which are as follows:

Table 3. Results of Bonferroni post hoc test to compare pairs of groups in the post-test stage of death-related disorders and psychological hardiness

Variable	Groups		DM	Sd	P
death anxiety	Cognitive-behavioral	Narrative Therapy	2.09	0.706	0.015
		Control	-1.78	0.710	0.048
	Narrative Therapy	Cognitive-behavioral	2.09	0.706	0.015
		Control	3.88	0.699	0.001
Death Depression	Cognitive-behavioral	Narrative Therapy	6.16	2.40	0.043
		Control	-9.47	2.42	0.001
	Narrative Therapy	Cognitive-behavioral	-6.16	2.40	0.001
		Control	-15.64	2.38	0.001
Psychological stubbornness	Cognitive-behavioral	Narrative Therapy	-0.115	3.09	1
		Control	8.06	3.10	0.04
	Narrative Therapy	Cognitive-behavioral	0.115	3.09	1
		Control	8.18	3.06	0.033

The table above shows the results of Bonferroni post hoc test for pairwise comparison of groups. Based on the obtained results, there is a significant difference between cognitive-behavioral experimental groups and narrative therapy with the control group in death-related disorders and psychological hardiness (P <0.05). There is also a significant difference between the cognitive-behavioral group and the narrative therapy group in death-related disorders (P <0.05); But there is no significant difference between cognitive-behavioral group and narrative therapy group in psychological hardiness (P> 0.05).

CONCLUSION

The aim of this study was to compare the effectiveness of cognitive-behavioral therapy and narrative therapy in improving death-related disorders and psychological hardiness in female patients with prostate cancer. In the study of the effect of cognitive-behavioral therapy, the obtained results showed that cognitive-behavioral therapy was effective and could reduce death anxiety and depression as well as increase psychological toughness in patients. This finding is consistent with some research. In their study, Greer et al. showed that cognitive-behavioral therapy can reduce anxiety in patients with advanced cancer(Greer et al., 2010). Vanity Wall et al. Also showed that cancer recurrence can cause disorders in patients and cognitive-behavioral therapy can be effective in improving these disorders(van de Wal, Servaes, Berry, Thewes, & Prins, 2018). Hoffman meta-analysis showed that cognitive-behavioral therapy can not only be effective in treating a wide range of clinical problems and disorders but can also lead to the development of positive traits(Hofmann et al., 2012).

Cancer patients experience death-related turmoil because of their beliefs about cancer and because they consider cancer to be a very frightening and deadly disease, and they start ruminating about death(Tang et al., 2011). Cognitive-behavioral therapy targets these thoughts and constant rumination and teaches patients how to deal with these thoughts. First, when patients are disturbed, the relaxation techniques at the heart of cognitive-behavioral therapy allow patients to remain calm and then be able to identify and deal with disturbing thoughts(Dobson & Dozois, 2010). Cognitive-behavioral therapy can reduce depression and death-related anxiety in cancer patients by providing skills such as coping with death, cognitive assessment of dysfunctional thoughts, increased life enjoyment, and a health-oriented lifestyle(Furer & Walker, 2008).

Cognitive-behavioral therapy teaches patients not to find themselves trapped by cancer and, as a result, to be able to endure the problems associated with it and to be strong in fighting it. Mosalanejad, Koolaee, and Jamali (2012a), Showed in their research that cognitive-behavioral therapy can improve psychological toughness in patients. Explaining this result, it can be said that cognitive-behavioral therapy taught cancer patients to avoid exaggerated and catastrophic thoughts about cancer and replace it with positive thoughts. Fighting and challenging distorted beliefs causes them to cultivate a tenacious spirit and become more determined to heal and challenge disease.

In the study of the effects of narrative therapy, the obtained results showed that narrative therapy was also effective in improving anxiety and depression of death as well as psychological hardiness of patients with prostate cancer. In their research, Lopes et al. (2014), and Rastgari and Moradi (2014), showed that narrative therapy can improve depressive disorders in patients. Rodriguez et al. showed in a study that narrative therapy can improve the disturbances of cancer patients.

Narrative therapy taught patients in the study to rewrite their life narratives in a different way(Morgan, 2000). Instead of telling the story of a depressed, anxious, troubled, miserable, and tired person, they learned to change their story to a hopeful, fighting, energetic, and happy person. Such a change of narrative enabled them to get rid of the turmoil associated with death and to be able to fight the disease more vigorously.

Narrative therapy teaches patients to take responsibility for their behaviors and increases their motivation for action and effort. This treatment teaches patients that the control and responsibility of their lives is in their own hands and the disease cannot capture them, but it is the patients themselves who capture the disease. In fact, they learned that the disease could be in control of them and that they could overcome the problems of the disease stubbornly(Brown & Augusta-Scott, 2007). They learned to live in the moment and not be afraid of the future. Narrative therapy teaches people that by gaining self-knowledge and introspection, they move toward change, which can increase their stubbornness and reduce death-related turmoil(Changizi & Panahali, 2016).

Another result of this study was that there is a difference between cognitive-behavioral therapy and narrative therapy in reducing death-related disorders and narrative therapy is more effective in this field but there is no significant difference between the two in psychological

hardiness. This finding contradicts Tolin (2010), claim that cognitive-behavioral therapy could be the first choice for depression and anxiety problems. In explaining this conclusion, it can be said that this difference may have been made because this study was on depression and anxiety related to death. However, it seems that changing narratives rather than changing thoughts can improve the turmoil associated with death. In fact, because of the evidence, cancer is a nasty disease that causes patients to experience death-related thoughts and disturbances that are somewhat normal. This reduces the scope for cognitive-behavioral interventions; but on the other hand, in the treatment process, mainly men with cancer revealed their narratives and provided the ground for more narrative therapy interventions by expressing narratives such as miserable, miserable and trapped. Both therapies were equally effective in improving cognitive tenacity, indicating that both therapies can elevate the tenacity of patients equally. However, this research, like other studies, has some limitations; despite efforts to homogenize groups and control the effects of disturbing variables, biases that may exist in response to research tools, as well as the amount and type of medication used by patients, should be used with caution in generalizing the results.

In general, the results of this study showed that both cognitive-behavioral therapy and narrative therapy are effective in improving death-related disorders and psychological hardiness; but narrative therapy is better at curing death-related disorders than cognitive-behavioral therapy. The results of this study can pave the way for interventions to help patients with prostate cancer. It is suggested that physicians and psychotherapists use cognitive-behavioral therapy and narrative therapy interventions to improve the disturbances of cancer patients in order to increase the health of these patients.

Thanking

Finally, the researchers consider it necessary to thank all the patients participating in the study and their families, as well as all the professors and friends who helped in this study.

REFERENCES

Aghajani, MJ, Rahbar, T, & Moghtader, L. (2018). The Relationship of hopefulness and hardiness with general health in women with breast cancer. *Jour Guilan Uni Med Sci, 26*(104), 41-49.

Arbyn, Marc, Weiderpass, Elisabete, Bruni, Laia, de Sanjosé, Silvia, Saraiya, Mona, Ferlay, Jacques, & Bray, Freddie. (2020). Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis. *The Lancet Global Health, 8*(2), e191-e203.

Bray, Freddie, Ferlay, Jacques, Soerjomataram, Isabelle, Siegel, Rebecca L, Torre, Lindsey A, & Jemal, Ahmedin. (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: a cancer journal for clinicians, 68*(6), 394-424.

Brown, Catrina, & Augusta-Scott, Tod. (2007). *Narrative Therapy: Making Meaning*: Sage.

Changizi, Fereshteh, & Panahali, Amir. (2016). Effectiveness of group narrative therapy on life expectancy and happiness of the elderly in Tabriz. *(Journal of Instruction and Evaluation) Journal of Educational Sciences, 9*(34), 63-76 [In Persian].

Dobson, Keith S, & Dozois, David JA. (2010). *Historical and philosophical bases of the cognitive-behavioral therapies*: Guilford Press.

Eschleman, Kevin J, Bowling, Nathan A, & Alarcon, Gene M. (2010). A meta-analytic examination of hardiness. *International Journal of Stress Management, 17*(4), 277.

Ferlay, Jacques, Colombet, M, Soerjomataram, I, Mathers, C, Parkin, DM, Piñeros, M, . . . Bray, F. (2019). Estimating the global cancer incidence and mortality in 2018: GLOBOCAN sources and methods. *International journal of cancer, 144*(8), 1941-1953.

Furer, Patricia, & Walker, John R. (2008). Death anxiety: A cognitive-behavioral approach. *Journal of Cognitive Psychotherapy, 22*(2), 167-182.

Gonen, Gokcen, Kaymak, Semra Ulusoy, Cankurtaran, Eylem Sahin, Karslioglu, Ersin Hatice, Ozalp, Elvan, & Soygur, Haldun. (2012). The factors contributing to death anxiety in cancer patients. *Journal of psychosocial oncology, 30*(3), 347-358.

Greer, Joseph A, Park, Elyse R, Prigerson, Holly G, & Safren, Steven A. (2010). Tailoring cognitive-behavioral therapy to treat anxiety comorbid with advanced cancer. *Journal of cognitive psychotherapy, 24*(4), 294-313.

Gregurek, Rudolf, Braš, Marijana, Đorđević, Veljko, Ratković, Ana-Strahinja, & Brajković, Lovorka. (2010). Psychological problems of patients with cancer. *Psychiatria Danubina, 22*(2), 227-230.

Hofmann, Stefan G, Asnaani, Anu, Vonk, Imke JJ, Sawyer, Alice T, & Fang, Angela. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research, 36*(5), 427-440.

Horney, Debbie J, Smith, Helen E, McGurk, Mark, Weinman, John, Herold, Jim, Altman, Keith, & Llewellyn, Carrie D. (2011). Associations between quality of life, coping styles, optimism, and anxiety and depression in pretreatment patients with head and neck cancer. *Head & neck, 33*(1), 65-71.

Khezri, Leyla, Bahreyni, Masoud, Ravanipour, Maryam, & Mirzaee, Kamran. (2015). The Relationship between spiritual wellbeing and depression or death anxiety in cancer patients in Bushehr 2015. *Nursing of the Vulnerables, 2*(2), 15-28.

Kobasa, Suzanne C, Maddi, Salvatore R, & Zola, Marc A. (1983). Type A and hardiness. *Journal of behavioral medicine, 6*(1), 41-51.

Lopes, Rodrigo T, Gonçalves, Miguel M, Machado, Paulo PP, Sinai, Dana, Bento, Tiago, & Salgado, João. (2014). Narrative Therapy vs. Cognitive-Behavioral Therapy for moderate depression: Empirical evidence from a controlled clinical trial. *Psychotherapy Research, 24*(6), 662-674.

Maddi, S.R. (2015). Hardiness. In S. K. Whitbourne (Ed.), *The Encyclopedia of Adulthood and Aging* (pp. 1-4).

Merckaert, Isabelle, Libert, Yves, Messin, Sophie, Milani, Mina, Slachmuylder, Jean-Louis, & Razavi, Darius. (2010). Cancer patients' desire for psychological support: prevalence and implications for screening patients' psychological needs. *Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer, 19*(2), 141-149.

Mohammadzadeh, A, Rezaei, A, & Aghazadeh, E. (2016). Validation of likert form Death Depression Scale in an university students samples. *Journal Of Ilam University Of Medical Sciences, 24*(1), 89-97 [In Persian].

Mohebbi, Elham, Nahvijou, Azin, Hadji, Maryam, Rashidian, Hamideh, Seyyedsalehi, Monireh Sadat, Nemati, Saeed, . . . Zendehdel, Kazem. (2017). Iran Cancer Statistics in 2012 and projection of cancer incidence by 2035. *Basic & Clinical Cancer Research, 9*(3), 3-22.

Morgan, Alice. (2000). *What is narrative therapy?* : Dulwich Centre Publications Adelaide.

Mosalanejad, Leili, Koolaee, Anahita Khodabakshi, & Jamali, Safie. (2012a). Effect of cognitive behavioral therapy in mental health and hardiness of infertile women receiving assisted reproductive therapy (ART). *Iranian Journal of Reproductive Medicine, 10*(5), 483.

Mosalanejad, Leili, Koolaee, Anahita Khodabakshi, & Jamali, Safie. (2012b). Effect of group cognitive behavioral therapy on hardiness and coping strategies among infertile women receiving assisted reproductive therapy. *Iranian journal of psychiatry and behavioral sciences, 6*(2), 16.

Rastgari, Mohamad Kazem, & Moradi, Omid. (2014). Efficacy of narrative therapy in reducing depressive symptoms in women20 to40yearsin Sanandaj. *Shenakht journal of psychology & psychiatry, 1*(2), 47-57.

Roh, Jong-Lyel, & Kim, Shin-Ae. (2016). Reply to pretreatment depression as a prognostic indicator of survival and nutritional status in patients with head and neck cancer. *Cancer, 122*(6), 972-973.

Tan, Shian Ming, Beck, Kevin Roy, Li, Huihua, Lim, Eng Choon Leslie, & Krishna, Lalit Kumar Radha. (2014). Depression and anxiety in cancer patients in a Tertiary General Hospital in Singapore. *Asian journal of psychiatry, 8*, 33-37.

Tang, Pei-Ling, Chiou, Chou-Ping, Lin, Huey-Shyan, Wang, Chi, & Liand, Shi-Long. (2011). Correlates of death anxiety among Taiwanese cancer patients. *Cancer nursing, 34*(4), 286-292.

Tatrow, Kristin, & Montgomery, Guy H. (2006). Cognitive behavioral therapy techniques for distress and pain in breast cancer patients: a meta-analysis. *Journal of behavioral medicine, 29*(1), 17-27.

Templer, Donald I. (1970). The construction and validation of a death anxiety scale. *The Journal of general psychology, 82*(2), 165-177.

Templer, Donald I, Harville, Michael, Hutton, Shane, Underwood, Rocky, Tomeo, Marie, Russell, Michele, . . . Arikawa, Hiroko. (2002). Death depression scale-revised. *OMEGA-Journal of Death and Dying, 44*(2), 105-112.

Templer, Donald I, Lavoie, Michael, Chalgujian, Hilda, & Thomas-Dobson, Shan. (1990). The measurement of death depression. *Journal of Clinical Psychology, 46*(6), 834-839.

Tolin, David F. (2010). Is cognitive–behavioral therapy more effective than other therapies?: A meta-analytic review. *Clinical psychology review, 30*(6), 710-720.

van de Wal, Marieke, Servaes, Petra, Berry, Rebecca, Thewes, Belinda, & Prins, Judith. (2018). Cognitive behavior therapy for fear of cancer recurrence: a case study. *Journal of clinical psychology in medical settings, 25*(4), 390-407.

Vromans, Lynette P, & Schweitzer, Robert D. (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy research, 21*(1), 4-15.

White, Michael, White, Michael Kingsley, Wijaya, Made, & Epston, David. (1990). *Narrative means to therapeutic ends*: WW Norton & Company.