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RESEARCH

MOBILIZATION OF THE FAMILIES OF CHILDREN WITH CANCER IN KEY RESILIENCE PROCESSES: A LONGITUDINAL QUALITATIVE STUDY

MOBILIZAÇÃO DA FAMÍLIA DE CRIANÇAS COM CÂNCER NOS PROCESSOS-CHAVE DE RESILIÊNCIA: ESTUDO LONGITUDINAL QUALITATIVO

MOVILIZACIÓN DE LA FAMILIA DE NIÑOS CON CÁNCER EN LOS PROCESOS CLAVE DE RESILIENCIA: UN ESTUDIO LONGITUDINAL CUALITATIVO

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ABSTRACT

Objective: to understand the mobilization of the families of children with cancer in key resilience processes through participation in a family intervention program. **Methods**: a longitudinal qualitative case study was conducted involving two families of children with cancer, who were attended at an expanded clinic for research and family intervention linked to a higher education institution, located in a municipality in the midwest region of Brazil. The theoretical framework used was the resilience model, and the methodological approach employed was qualitative content analysis. Data were collected through semi-structured interviews conducted before and after the families' intervention in the program. **Results**: two main categories were identified, highlighting the mobilization of key family resilience processes: the strengthening of coping capacity and the improvement in communication processes. **Conclusion**: systematized interventions have the potential to mobilize key resilience processes, contributing to alleviating family suffering and enhancing their self-confidence in facing imposed challenges. It is noteworthy that, with interventions, families are able to mobilize key resilience processes, resulting in the mitigation of their suffering and the strengthening of their self-confidence to cope with challenges.

Keywords: Resilience, Psychological; Family; Pediatric Nursing; Neoplasms; Oncology Nursing.

RESUMO

Objetivo: *compreender a mobilização da família de crianças com câncer nos processos-chave de resiliência, por meio da participação em um programa de intervenção familiar.* ***Métodos****: realizou-se um estudo de caso qualitativo longitudinal envolvendo duas famílias de crianças com câncer, atendidas em uma clínica ampliada de pesquisa e intervenção familiar vinculada a uma instituição de ensino superior, situada em um município da região centro-oeste do Brasil. O referencial teórico utilizado foi o Modelo de Resiliência, e, quanto ao aspecto metodológico, empregou-se a análise qualitativa de Conteúdo. Os dados foram coletados por meio de entrevistas semiestruturadas realizadas antes e após a intervenção das famílias no programa.* ***Resultados****: foram identificadas duas categorias principais que evidenciam a mobilização dos processos-chave de resiliência familiar: o fortalecimento da capacidade de enfrentamento e a melhoria nos processos de comunicação.* ***Conclusão****: as intervenções sistematizadas possuem o potencial de mobilizar processos-chave de resiliência, contribuindo para aliviar o sofrimento das famílias e melhorar sua autoconfiança frente aos desafios impostos. Destaca-se que, com as intervenções, as famílias conseguem mobilizar os processos-chave de resiliência, o que resulta na mitigação de seu sofrimento e no fortalecimento de sua autoconfiança para lidar com os desafios.*

Palavras-chave: *Resiliência Psicológica; Família; Enfermagem Pediátrica; Neoplasias; Enfermagem Oncológica.*

RESUMEN

Objetivo*: comprender cómo las familias de niños con cáncer se movilizan en los procesos clave de resiliencia a través de su participación en un programa de intervención familiar.* ***Métodos****: se llevó a cabo un estudio de caso cualitativo longitudinal que involucró a dos familias de niños con cáncer atendidos en una clínica ampliada de investigación e intervención familiar vinculada a una institución de educación superior, ubicada en un municipio de la región centro-oeste de Brasil. Se utilizó el modelo de resiliencia como marco teórico y se empleó el análisis cualitativo de contenido como enfoque metodológico. Los datos se recopilaron a través de entrevistas semiestructuradas realizadas antes y después de la intervención de las familias en el programa.* ***Resultados****: se identificaron dos categorías principales que evidencian la movilización de los procesos clave de resiliencia familiar: fortalecimiento de la capacidad de afrontamiento y mejora en los procesos de comunicación.* ***Conclusión****: las intervenciones sistematizadas tienen el potencial de movilizar procesos clave de resiliencia, contribuyendo a aliviar el sufrimiento de las familias y mejorar su confianza en sí mismas frente a los desafíos impuestos. Se destaca que, mediante estas intervenciones, las familias logran movilizar los procesos clave de resiliencia, lo que resulta en la mitigación de su sufrimiento y en el fortalecimiento de su confianza en sí mismas para enfrentar los desafíos.*

Palabras clave: *Resiliencia Psicológica; Familia; Enfermería Pediátrica; Neoplasias; Enfermería Oncológica.*

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INTRODUCTION

Cancer is one of the diseases that most significantly disrupt the family system and routine. Its diagnosis in a child directly impacts family interactions, potentially compromising its structure and functioning, with the potential to cause changes in organizational patterns, a need for adaptations, and profound suffering[1-2]. However, there is evidence of positive emotions experienced by the family, including resilience, hope, and improvements in relationships[3-4].

Among treatment options, chemotherapy stands out as a systemic therapy consisting of chemical agents administered at intervals, varying according to the prescribed therapeutic protocols[5]. However, although considered a hope for cure by the family, chemotherapy is also feared for its side effects and the possibility of weakening the child[6].

The demands of caring for and treating the child cause a disruption in family interactions and routine, both for the child and the family. To cope with this situation, the family resorts to coping processes such as resilience[3]. Family Resilience is a construct that seeks to identify and strengthen interactional and coping processes that enable the family to withstand the disorganizing challenges imposed by illness and to emerge from them[7].

Key resilience processes are classified into three domains: belief system, organizational patterns, and communication processes. The belief system is the core of family functioning, from which the meaning of adversity is derived from a positive perspective; in other words, it represents the lens through which the family views and perceives the world. Organizational patterns support the integration of the family system by regulating behaviors, connections, and bonds. These patterns are maintained by internal and external norms, specific to each family, reinforced by family beliefs and culture. Communication Processes involve the exchange of information, problem--solving, and the family's creativity to overcome difficult times[7].

Resilience involves behaviors, thoughts, and actions that allow the family to understand the reasons for the events they face, as well as to develop the skills necessary for reorganizing family life[8]. The success in the adaptation process and the way the family interprets the child's illness directly influence how the family will manage adversity[9].

The approach to family resilience enables health professionals to alter the family's perspective from viewing suffering as a form of imperfection to seeing it as a challenge, reaffirming the family's potential for growth and self-repair[7]. To care for the family of a child with cancer, it is essential that the nurse understands the family's experience regarding the child's illness, as well as the elements of family resilience that help family members cope with and manage the situations they face. It is also important to propose interventions that promote, among other actions, active listening to the families' experience narratives, identification of support networks, and exploration of their beliefs about the illness[10].

Studies[11-13] highlight the importance of programs that offer personalized interventions for families in challenging situations, addressing their caregiving potential, experiences, and coping and resilience processes in the face of illness.

The Family Intervention Program (PIF)[14] emerges as support for the nurse by proposing systematized interventions for families of children with chronic health conditions, with the aim of strengthening their resilience. The care provided in the PIF is based on the Calgary Family Intervention Model, which includes interventions in the cognitive, affective, and behavioral domains, helping the family discover new ways to manage the situation and alleviate their suffering[15]. Families attending the PIF are referred by services for children with cancer and other chronic health conditions.

Initially, the program was created to serve families of children with disabilities. Subsequently, the authors expanded its scope to include other health and illness contexts, also receiving families of children with cancer, sickle cell anemia, and renal diseases.

Thus, the study questions how key resilience processes are mobilized in families of children with cancer attending an intervention program. This study aimed to understand the mobilization of the family of a child with cancer in key resilience processes through participation in a family intervention program.

METHOD

This study is a longitudinal qualitative case study, anchored in the theoretical framework of froma Walsh's family resilience model[7], which addresses the coping and adaptation processes of the family as a functional unit.

The qualitative case study[16] involves in-depth investigation of contemporary phenomena, allowing the researcher to capture significant and holistic characteristics of

real-life events. This study followed the steps of the qualitative case study[16]: I. definition of the study question (how do key resilience processes change in families of children with cancer attending the Family Intervention Program?);II. formulation of study propositions (describe the changes in key resilience processes in families of children with cancer attending the Family Intervention Program); III. establishment of the unit of analysis (key resilience processes); IV. data linkage; V. selection of criteria for interpreting the findings the qualitative content analysis method was chosen to guide the data analysis[17].

The study was conducted at the expanded clinic for research and family intervention, linked to a Higher Education Institution in a municipality in the midwest region of Brazil, from December 2017 to January 2019. The cases for this study were selected through convenience sampling and refer to two families of children with a cancer diagnosis undergoing chemotherapy treatment, who had completed their follow-up in the PIF.

The PIF is conducted through therapeutic meetings, characterized by attentive listening to the family, during which they present their demands and challenges, allowing exploration of interactional processes, identification of family suffering hypotheses, and guidance of the intervention plan[14]. The frequency and number of meetings are based on the family's needs and availability. In this program, the process of concluding the family's participation is decided jointly with each family, taking into account their perceptions of their ability to better manage the uncertainties and challenges faced due to the child's clinical condition. Since its implementation in 2017, the PIF has served approximately 150 families experiencing the illness of one of their members. At the time of the study, four families of children with cancer were participating in the PIF meetings at the clinic.

The care model underlying the program is based on the theoretical integration of Symbolic Interactionism, the family vulnerability model, and the resilience model[7].

Inclusion criteria for participating in the research were: being a family of a child with cancer who participated from the beginning to discharge in the PIF. Families who did not reside in the municipality or who did not complete their participation in the PIF in time to be included in the research were excluded.

Data were collected through semi-structured interviews conducted with each family individually, before and after their participation in the PIF. The interviews were conducted by the principal researcher with the assistance of a research faculty member with experience in family nursing and conducting the PIF (author of the PIF).

Pre-participation interviews were conducted with the families at the Expanded Clinic for Research and Family Intervention in a dedicated room, with an average duration of 60 minutes, with mothers being the primary participants. The interviews began with the guiding question: "Could you tell me how your family has been coping with the child's cancer situation of _____?" Following this, supporting questions were asked, such as: "How are the challenges being faced? Do you feel capable of adapting to the changes caused by the illness? How do you share the challenges faced within the family?"

Despite the effort to involve as many family members as possible, not all could attend the PIF meetings due to work, distance, and preferences. As a result, only the mothers were available and agreed to participate in all program meetings and interviews.

After participating in the program, interviews were conducted at the same location, with an average duration of 120 minutes. The questions followed the same previous script, adding questions related to participation in the program, such as: "How has the family been coping with the child's cancer situation following participation in the meetings?". These questions were designed considering the domains of the belief system, organizational patterns, and communication processes of family resilience[4] and the family's management of the child's cancer experience.

Data collected from family records stored in the clinic, along with information from the genogram, ecomap, number of meetings held, family members present at each meeting, hypotheses of suffering, interventions offered, and the family's progress in the program, were used. Data related to minor participants were excluded. Although they participated in the PIF, their statements and interactions were not included in the analyzed data. Examples of interventions offered to families include: listening to families about their experience and management of the illness; encouraging families to make decisions; and providing relevant information. All interviews were digitally recorded and fully transcribed by the principal researcher.

To identify the key resilience processes of each family, before and after participation in the PIF, interviews and family records were read and analyzed deductively according to the theoretical resilience framework. To understand the mobilization of family resilience key processes, researchers conducted the analysis inductively and independently. After the reading, the steps prescribed for the identification, coding, and categorization of data were followed. Subsequently, subcategories were grouped into analysis categories representative of the manifestation of key processes in each domain of resilience[17].

For this study, the principles of credibility, transferability, adequacy, and confirmability were upheld by presenting the sociodemographic data of the participants and providing a detailed description of the method, following the Consolidated Criteria for Reporting Qualitative Research (COREQ)[18].

The project was approved by the research ethics Committee of a public higher education institution. The participants signed the Informed Consent Form, and to ensure anonymity, the extracts from the reports are identified by the letter F (family), followed by the number indicating the order of the interviews.

RESULTS

The study involved two families of children with cancer who were attended to in the PIF. Pre and post participation interviews in the program were conducted with the mothers, considering their availability. However, the questions referred to the family's experience as a whole. Below, we present the characterization of the families and a summary of each case.

Family 1 (F1): this family resides in the study city and consists of the father, 34 years old, a merchant; the mother, 29 years old, a hairdresser who stopped working to accompany the child during chemotherapy treatment; and two children: the patient, an 11-year-old girl diagnosed with osteosarcoma, and the brother, a healthy six-year-old boy. Both attend school. The father was informally adopted during childhood and does not maintain contact with his extended biological family. The father, mother, and the two children live together and receive financial support from the grandparents and siblings.

Initial contact with the family occurred in December 2017. The child was hospitalized for chemotherapy treatment and would subsequently undergo a surgical procedure for the amputation of the left upper limb. In December 2018, the meetings at the PIF concluded, coinciding with the end of the child's chemotherapy treatment. The conclusion of the program occurs collaboratively with the families, and the meetings end when families effectively promote changes to overcome their situation, with renewed strength and diminished suffering.

Six therapeutic meetings were conducted with F1 at the PIF, with the mother and patient participating in all of them, the brother in two meetings, and a 20-year-old maternal cousin in one meeting. Table 1 below describes the resilience elements of family F1, manifested before and after their participation in the Program.

Family 2 (F2): composed of a 38-year-old father, whose profession is unknown; a 34-year-old mother, a municipal early childhood teacher; and a three-year-old son diagnosed with grade II astrocytoma. The parents are judicially separated. The father and extended paternal family had sporadic contact with the child and the mother.

In December 2016, the child began to show symptoms of the disease. After the diagnosis was confirmed, a surgery was performed to partially remove the tumor, followed by chemotherapy and motor rehabilitation. The family's approach occurred in January 2018, at the hospital where the child was undergoing chemotherapy.

Six therapeutic meetings were held with the family, with the mother and occasionally the child participating. During their involvement in the PIF, the child continued to attend scheduled health services at reference facilities. In Table 2, are described the elements of resilience for Family F1, manifested before and after participation in the Program.

In this study, the interventions proposed during the meetings with each family included: encouraging internal family dialogue; intervention questions aimed at narrating the family's experience in the situation; providing information and guidance about the child's treatment, expected side effects, prognosis, the importance of play in childhood, and respect for the child as a subject; validating the emotional responses of family members; and praising the family's strengths and competencies in caring for the child and other family members. During the follow-up in the PIF, the therapeutic bond with the family was maintained through the sending of therapeutic letters, phone calls, and messages via apps, documenting the family's achievements and changes during the sessions. This process aimed to strengthen the family's self-confidence in their ability to mobilize the key processes of resilience.

From the analysis of the pre- and post-participation interviews in the PIF, observations, and records in each family's files, it was possible to identify that, in experiencing the child's cancer, the family was challenged in its resilience processes. Participation in the program strengthened the family's resilience, helping them reflect on their feelings, perceptions, and actions in the situation, enabling the mobilization of strengths to meet emotional demands and the needs of the child and family members, and supporting the management of the child's care and coping with cancer. The analytical categories representing

Table 1. Elements of family resilience manifested before and after participation in the program.

Elements of resilience for family F1	Before participation in PIF	After participation in PIF
Belief system	The family believes that chemotherapy harms the child's health; the mother sees herself as the only competent caregiver; there is a distancing from spiritual beliefs.	The family redefined the treatment (chemotherapy and amputation), understanding that these procedures were essential for the child's recovery. The mother developed her ability to share care with other family members, believing that everyone's participation makes them more capable of handling the child's care demands. Additionally, the family reconnects with religious faith.
Organizational patterns	The mother assumed responsibility for care and decisions, not accepting the participation of the father, other family members, or the healthcare team. Family's overprotective attitudes led to behavioral conflicts in the child.	Decision-making began to be done jointly with the child and family, acknowledging the child's right to participate and be heard regarding their needs. The child became more active and developed better relational skills.
Communication processes	There was some difficulty in discussing the situation within the family, leading to a tendency towards isolation among members. Additionally, there was ineffective communication between the family and the multidisciplinary team.	The family improved its communication pattern, successfully expressing feelings and discussing various treatment options with the multidisciplinary team.

Table 2. Elements of family resilience manifested before and after participation in the program.

Elementos de resiliência da família F2	Antes da participação no PIF	Após participação no PIF
Belief system	Definition of illness as a stigma of death; fear for the child's future.	The reframing of the illness involves cultivating hope for the child's future, developing an optimistic perspective regarding their prognosis, as well as accepting what cannot be changed.
Organizational	Maternal overload with the child's care and treatment routine; maternal overprotection; distancing of the child from social interaction.	The mother developed the ability to share the child's care with the maternal grandmother, resumed her professional life, and enrolled the child in school. Additionally, there was an improvement in the mother's self-esteem and a reconciliation in the relationship with the child's father.
Communication processes	Lack of internal family dialogue and communication with the healthcare team, hindering the externalization of doubts.	The mother managed to reframe the concept of the child, encouraging the child's development and respecting his autonomy. The family, in turn, has opened up space for dialogue and sharing of feelings among its members. Additionally, the mother established a trusting relationship with the team, which contributed to improved communication.

the family's mobilization and the repercussions on the key processes of family resilience are: the strengthening of the family's coping ability and the improvement in family communication processes, as described below.

Strengthening of the family's coping ability

From the meetings in the PIF, the family has the opportunity to acquire knowledge and mobilize their internal strengths, feeling empowered in their coping ability. As they participate in the PIF, the family changes how they perceive themselves in the situation, no longer viewing themselves as incapable of caring for their child but adopting a perspective of capability and overcoming their limitations. With this strengthening, the family seeks what they need to cope with the child's illness and modifies their management strategies.

> *We manage to overcome things more easily nowadays. There are days that (..) daily struggles, but nothing compared to what we went through in the past year and two months. Today we have more firmness, more grounding to pursue things.* (F1)

> *It's difficult, but we managed. If something new comes up, I don't know, but we'll keep trying. Always looking to adapt. We try to overcome in every way possible. And if it doesn't work, it's a bit frustrating, but we move forward.* (F2)

The family recognizes and learns that the child herself has the capacity to face the experience of cancer, which encourages her to mobilize her strengths.

> *Actually, I thought it would be a huge challenge for her, but it turned out to be more of a challenge for us. For her, it's been fine because M. overcomes everything !(F1)*

The interventions of the PIF created space for the family to change their beliefs about the child's illness and encouraged them to learn about similar experiences.

> *Today we are much more open to this (..) you see that your problem is nothing compared to others; today I am more centered and less anxious. (F1)*

> *Then you see that you are not the only one going through this. Because sometimes you feel alone and think it's only happening to you. But then you realize how big it is, how many children are sick, and how many children have cancer. It was good to go there (to the PIF) for that reason, to understand this reality and change our thinking (F2)*

It is noticeable that the family changes its restrictive beliefs, starts to view the situation in a more positive light, and maintains optimism and hope. They recognize the difficulties and challenges they need to face but are more confident in dealing with reality.

> *But now we manage to overcome things. Sometimes with difficulty, other times it takes time, but it always works out! We always manage to get through some situation well. There is always something that serves as a lesson, and we no longer see it as negative, but as positive.(F1)*

Spiritual values, faith, and religious rituals were mobilized by the family since the child's cancer diagnosis. After participating in the PIF, the family reconnected with religious faith and strengthening beliefs, which became a source of strength, enabling them to persevere with hope.

> *We try to always be in the presence of God, always at church; we returned to church, and we pray the rosary every day. God only gives us what we can bear, right? So, I think that today it was a challenge completed. It's dialogue and faith. God shows us what we need to overcome. (F1)*

> *Being strong, seeking God, that's how we overcome. Living one day at a time.(F2)*

The feelings triggered by the diagnosis and the changes imposed on the family caused conflicts in family relationships, intensified by differing opinions, the burden on one member, and the anxieties and uncertainties surrounding this episode. Interactions and bonds were strengthened as the family reorganized its routine and expressed its feelings. Mutual support and the unity of all members enhanced the family's strength and coping ability.

> *There used to be a lot of conflict in the family, but now we don't have that anymore, always trying to help each other. We support and talk more. (F1)*

> *Talking, helping each other, supporting each other. That's how we managed to get through this phase that has ended. (F2)*

Improvement in family communication processes

The family's participation in the PIF resulted in significant changes in the way family members communicate, changes that were even noticed by people outside the family. The family took on a leading role, managing situations with more calm and tranquility, and talking more about the situation and the child's illness. It is observed that the family feels more empowered and recognizes improvements in communication among all its members.

> *(..) even the psychologist here (at the hospital) mentioned it, saw a change, that it helped us a lot (participating in the PIF). And everything that was said there somehow served me, served her (daughter), it was very good! Today I talk more about the subject. (F1)*

> *Even L (the nurse) commented on how different I am, that I'm calmer, more centered (...). (F2)*

The therapeutic conversations in the PIF help the family to shift the focus from the illness to seeing the child as a whole. The family reports that the meetings in the program brought comfort, information, and relief from suffering. They describe the PIF as a space to ask questions, dialogue, receive support, and feel heard and understood.

> *I used to go to the meetings sometimes, even though I didn't want to, because I had a lot to solve, but it was only half an hour. When I realized, it was already an hour, an hour and*

a little, and it passed because it was a good thing. It was a positive thing in our lives. It was very good! I felt heard. (F1)

It helped me a lot, cleared up many doubts, helped me strengthen myself, and provided a lot of guidance. They (researchers) have a different perspective, I felt comforted and supported. I felt heard. It was very significant for me. With the conversations, which don't just talk about illness but look at the person, what you're feeling, look at the self, the human being. It's very good, special, and important. (F2)

Having a dialogic space where it's possible to express feelings openly strengthens the family and encourages them to make decisions regarding the health and well--being of the child with cancer. This environment creates conditions for safe communication with the medical team, allowing the family to question or express their opinions.

And today I say everything. If I don't like something, that's it; the children are mine, and I'm the mother. And always remembering A (the nurse from PIF), there are things we don't like and need to speak up about, we can't just keep it inside. So (PIF) helped a lot! (F1)

I've learned to express myself more, to talk more. You should continue (with the PIF sessions) because it supports the family a lot. It makes families feel more strengthened. (F2)

Open communication among family members promotes unity, respect, patience, and mutual tolerance. Additionally, the family feels more capable of handling family conflicts that arise during daily life. Family members change the way they relate to each other, adopting a more positive perspective on stressful situations and changes in communication processes. Thus, the family creates spaces for listening and dialogue, respecting each member's individuality.

Today we are more united, we talk more, everyone has more patience with each other. We have problems, but they are easier to overcome now. So, at home, in terms of listening more, dialogue, each one has a different personality, and we have to respect that. (F1)

Oh, I have my opinion and I share it with the family, the closest ones, each one says what they think and I see if it's reasonable or not. Because you might think one way, but sometimes someone else's perspective is better, so I always consider it. (F2)

In this sense, the family becomes more adept at recognizing when one of its members has difficulty expressing their feelings and engaging in dialogue. This happens because mutual sensitivity to the feelings of other family members is heightened, allowing the family to act to reconcile and strengthen lost or weakened bonds.

We become more sensitive to certain things. But I still speak up, he (husband), on the other hand, does not. And there are things, like I say he should have participated in the Program, because there are things you need to talk about; otherwise, you'll just be feeding illness within yourself. (F1)

DISCUSSION

The study allowed for an understanding that the mobilization of key processes of Family Resilience in the experience of childhood cancer is a natural way of coping and adapting to the situation, aiming at the family's survival in the face of adversity. However, although the family accesses these key resilience processes and strives to manage and face the situation as best as it can, it experiences deep suffering due to the uncertainties and vulnerabilities that the context of childhood cancer generates for all family members. Often, the family fails to establish an effective connection with the professional team to clarify their doubts.

Studies support these findings and lead to the reflection that the family faces a disease with a devastating potential for family interactions, causing profound changes in its structure, and bringing anguish, uncertainties, and suffering[19-20].

This study emphasizes the importance of providing systematic interventions focused on strengthening Family Resilience to alleviate suffering and promote coping with the situation. The approach to family resilience requires a dynamic view of the challenges and the family's reactions throughout their experience in managing a child with cancer. To help families cope with the demands of different stages of adaptation to this experience, it is necessary for nurses to assist them in drawing on the various potentials needed to handle the situation, adapt to the future, and reorganize family life.

Participation in the PIF contributed to creative and positive transformations within families, strengthening relationships, balancing family interactions, and re-signifying the illness, bringing a bit of normalcy to daily life. This process also facilitated the development of more open communication among family members, allowing the expression of feelings and frustrations and establishing

dialogue with the professional team. The family feels stronger and more capable of facing the challenges imposed by childhood cancer, which alleviates family suffering. Additionally, they are able to express emotions and promote a space for communication within the family and with healthcare professionals. With interventions that strengthen the cognitive domain of family functioning, families start to focus on their potential and recognize the child's strength in facing cancer, which sparks hope and confidence that they can overcome adversity together.

In the bravery and determination of the child, families in this study find their own strength and source of support, making this strength a motivator for optimism and better understanding and re-signification of life priorities. Moreover, encouragement received from individuals outside the family context is also crucial for the family to continue its efforts to overcome adversities.

Another fundamental element evidenced by the families participating in the PIF is the reconnection with faith and religiosity, as well as the mobilization of resources from the religious community. Spirituality and faith are seen as cornerstones for the family, considered intrinsic to the human being. These beliefs create a sense of support, resilience, and optimism, re-signifying the experience of the child's illness and seeking answers to the suffering and issues arising from this situation[21].

We observe that the key processes of Family Resilience were also mobilized with regard to the family's ability to unite during times of stress and crisis, and to rely on each other for support and encouragement. A holistic assessment of the family allows for the identification of challenges and resources among its members, helping them draw on the necessary potentials to cope with crises, reorganize their lives, and adapt to the immediate future[22-27].

Authors state that during adverse situations, families are capable of seeking balance, adjusting, and adapting to changes, overcoming challenges faced; and the extended family becomes a factor that helps minimize this impact or burden, enhancing resilience[24].

The improvement in family communication processes led to more effective functioning. Openness to dialogue and clarity in communication were valuable for families in the study to understand facts and opinions from their members, which allowed for better organization of interactions and expression of each person's behavioral expectations. Families in the study also established a more open dialogue with healthcare professionals, expressing themselves regarding cancer treatment practices and protocols, positioning themselves, and making decisions. This stance helped them feel supported in establishing dialogues both among their members and with professionals and services required.

The interventions provided in the PIF strengthened the family's ability to face the challenges of childhood cancer. In professional practice, utilizing resilience-promoting interventions has the potential to strengthen communication processes between the professional and the family. Interventions guide nurses in identifying the challenges faced by families and help them mobilize the key processes of family resilience, contributing to the management of the disease and coping with childhood cancer.

As a limitation of the study, the scarcity of research on the resilience of families with children with cancer is highlighted, which makes it difficult to compare the results obtained with other studies. Further research with different designs and populations is needed to investigate other outcomes related to family resilience and childhood cancer.

CONCLUSION

The study provided insight into how families of children with cancer mobilize key processes of resilience, stimulated by participation in an intervention program, with a focus on changes in the Belief System. Families derive meaning from the adversity experienced, develop a positive perspective on the situation, and reconnect with spirituality. In Organizational Patterns, family members perceive themselves as competent to change and reorganize family life, supporting each other and mobilizing resources for the care demands of the child and other family members. In Communication Processes, the family begins to express emotions clearly and openly and seeks to solve problems collaboratively.

The interest in resilience in studies with families helps redirect health professionals' focus, previously concentrated on the family's deficit and negative aspects, now highlighting the strength and potential of the family unit.

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