AN INVESTIGATION TO DETERMINE IF A MODEL
GROUP COUNSELING PROGRAM CAN AFFECT
THE A-TRAIT AND A-STATE ANXIETY OF
CHILDREN WHO ARE UNDER STRESS

A Dissertation
Presented to
The School of Graduate Studies
Drake University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Molly Claire McCarthy
February 1982
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Molly Claire McCarthy

Approved by Committee:

Chairperson

Edward W. Trapler

James P. Halverson

Mary Haldane

Kenneth J. Miller

Dean of the School of Graduate Studies
AN INVESTIGATION TO DETERMINE IF A MODEL GROUP COUNSELING PROGRAM CAN AFFECT THE A-TRAIT AND A-STATE ANXIETY OF CHILDREN WHO ARE UNDER STRESS

An abstract of a Dissertation by Molly Claire McCarthy
February 1982
Drake University
Advisor: George Lair, Ph.D.

The problem. While growing up, children undergo developmental stress as well as situational stress such as being ill, having an ill or handicapped parent, having divorcing parents or even having a parent who might be dying. How they cope with the stress depends on many factors such as their coping mechanisms to date and how their parents cope. Because of the many stresses the parents have to deal with in their own lives during these times, it is possible their children's needs might go unmet. Intervention, such as counseling, could be helpful to these children. Counseling cancer patients and their families is an emerging field with limited research. The purpose of this study was to determine if a model group counseling program could reduce stress in individual children who have a parent with cancer.

Procedure. This quasi-experimental research project used a single-subject ab design. The study was conducted over a nine-week period. In order to measure the effectiveness of the six-session counseling program, stress was operationally defined as A-State and A-Trait anxiety and was measured during the control and treatment periods by using the State-Trait Anxiety Inventory for Children and the State-Trait Anxiety Inventory. Counseling objectives were to help the children recognize, express, and deal with their own and their parents' emotions constructively; develop communication skills for handling difficult situations; explore their own and others' values and assumptions about cancer and loss; and learn a relaxation technique they could incorporate into their daily life.

Findings. Significant differences were found among the children on A-State and A-Trait anxiety scores. No significant differences were found among the A-State or A-Trait repeated measures. Thus, both null hypotheses were accepted. A-State anxiety was reduced significantly in the first counseling session. The other sessions also showed a trend of reducing A-State anxiety. There was evidence from the children's ratings of the counseling sessions that they were helpful.

Conclusion. This research project was to ascertain if a model-group counseling program could alleviate children's anxiety. Significant reduction of A-State anxiety was found in one of six counseling sessions. Further research with a larger population would help to determine if there is significance or only a trend in reduction.
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Chapter 1

RATIONALE FOR THE STUDY

Children who are in families that have a parent who has cancer undergo stress from many sources. Hans Selye, M.D., father of stress research, reports that, worldwide, the word stress is used to mean a "nonspecific response to any demand."\(^1\) Much of how children respond during this period of illness of their parent is determined by how the parents respond. Children's coping strategies are varied. They run the gamut from acting out, anger, denial, and depression to being helpful and empathetic. Researchers have reported that some adults who develop cancer learned inappropriate coping skills as youths, for example, in dealing with loss.\(^2\)

Families maintain a balance or homeostasis in their interacting. They can do this functionally or dysfunctionally. Coping with a life-threatening illness can bring on the latter type of behavior. Adults have coping skills to deal with their stress. In addition, the patient and the spouse have medical professionals with whom to confer. However, parents are often at a loss when trying to help children cope with their stress and often do not know what to share and when to share.

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According to Elizabeth Kubler-Ross, M.D., the parents in these families who are threatened with losing their lives tend to go through five stages of adapting to the circumstances. She reports these as being: (1) denial and isolation; (2) anger; (3) bargaining; (4) depression; and (5) acceptance. These adaptive states do not follow necessarily any order, and a person may be in more than one stage at a time. Likewise, other family members also experience these stages in accepting the potential loss of their loved one.

The ill parent may have less energy, be unemployed, reverse roles with the spouse, be unable to cope with the children, have pain, and undergo a personality change because of drugs or the disease. Because of the incapacitating illness of the spouse, the partner and family members have to assume more tasks than before. The parents also have the worry of child care during hospital visits, paying the medical bills, as well as the normal day-to-day living.

If the children do not have the proper coping skills, parent models for handling loss, or professional help, they may not resolve the stress in their lives. This could affect their emotional state of mind, their physical body, how they function in school, how they interact with other people, and, later on in their lives, how they react to loss. According to Lewis and Lewis, 85 percent of all illnesses are caused or aggravated by stress. A certain amount of stress is necessary, but when it occurs over a long period of time and without alleviation, the body can suffer permanent or long-term damage.

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When the children's problem-solving techniques and defense mechanisms are not effective to deal with the real or unreal pressures the children perceive, they need some type of positive intervention such as counseling to help them develop better methods of coping. Searches of the literature reveal that counseling of children of cancer patients is limited. Nothing was found on counseling of these children in groups. Just in the last few years, oncologists have been hiring counselors for their patients and their families.¹

Counseling can help children deal with their many concerns. Children handle the known better than the unknown. They need to know about the parent's disease and family plans, aiding them to feel safe. They may need some help in developing appropriate coping skills in the areas of communication and assertiveness. They are affected by their parents' feelings as well as having to deal with their own. They need to learn to identify their own feelings, express them, and realize they are normal. They need to develop empathy for their ill parent and the spouse. They need to feel all right about carrying on their lives as much as possible. They need support in handling the potential loss of their parent. They need to realize that it is the quality, not the quantity, of the ill parent's life that matters. Many of these needs are compounded as the child progresses through developmental stages.

Under stressful conditions, children's anxiety levels rise, making it hard for them to cope cognitively. Two types of anxiety are

distinguished by Charles D. Spielberger: trait (A-Trait) and state (A-State).\footnote{Charles D. Spielberger, "The Measurement of State and Trait Anxiety: Conceptual and Methodological Issues," Emotions--Their Parameters and Measurement, ed. L. Levi (New York: Raven, 1975), pp. 713-25.} Trait anxiety is stable over time and reflects one's personality disposition towards being anxious. State anxiety is characterized by tense and apprehensive feelings and by activation of the autonomic nervous system. State anxiety varies in intensity and changes over time, depending upon the stress one experiences. Trait anxiety refers to one's proneness to respond to psychological stress with elevations in A-State.

The body reacts to stress with the "flight or fight" response. This is appropriate if one's life is threatened. However, it is inappropriate as a response to a parent's illness and the ramifications thereof. A child can learn to turn off his body's stress response by learning a relaxation technique, such as the "Quieting Reflex" developed by Charles F. Stroebel, M.D., Ph.D. Quieting the body will give the child time to act suitably to the stress-producing situation.

Statement of the Problem

The purpose of this study was to determine if a model group counseling program, which included a relaxation component, could reduce stress in children who have a parent with cancer. In order to measure the effectiveness of the counseling program, stress was operationally defined as A-State and A-Trait anxiety.

The following null hypotheses were tested in this study:
Null Hypothesis 1: There will be no statistical difference among the repeated measures of A-State anxiety.

Null Hypothesis 2: There will be no statistical difference among the repeated measures of A-Trait anxiety.

Design of the Investigation

Population; Single Group

The population for this quasi-experimental research project were the children of cancer patients being treated by S. Fred Brunk, M.D., and Thomas R. Buroker, D.O., medical oncologists in private practice in Des Moines, Iowa. The new Des Moines metropolitan area which includes Polk County and Warren County, had an estimated 1976 population of 333,436, according to the U.S. Census Bureau.

Affiliated with these two doctors were two counselors, George S. Lair, Ph.D., and Lawrence E. Fanning, Ed.D. Dr. Lair served as Director of Counseling Services. His office mailed information to patients about offering counseling to their children. (See Appendix A.) From replies to the letter and follow-up calls, parents of seven children agreed to have their children participate in the study, and signed permission forms. (See Appendix B.) The seven children, three boys and four girls, ranged in age from nine through fourteen years of age.

The requirements for Dr. Lair to refer these children were that they be in families with a parent who had been diagnosed at least two weeks as having cancer, be of middle to late latency in age, and not be mentally retarded.
Procedure

This quasi-experimental research project used a single-subject A-B design. The study was conducted over a nine-week period. During the first and third week of the first month, the children responded to two instruments: one measuring A-State anxiety and the other measuring A-Trait anxiety. No treatment was given during the first month. During the first week of the next five weeks, the treatment variable, counseling and the "Quieting Reflex," was introduced. Six one and one-half hour counseling sessions were conducted. Measurement of A-State anxiety was taken before and after each counseling session. A-Trait anxiety was measured only at the beginning of the last session.

Objectives of the model group counseling program of support for these children were to help them recognize, express, and deal with their own and their parents' emotions constructively; develop communication skills for handling difficult situations; explore their own and others' values and assumptions about cancer and loss; and learn a relaxation technique they could incorporate into their daily life. (See Appendix C.) In order to achieve these objectives, the researcher used climate producing, get-acquainted exercises, art and sentence completion to express emotions, communication skills, empathic model of assertiveness training, video-taped vignettes of family problems, and the "Quieting Reflex for Young People."

Each counseling session followed a basic pattern: pretest, conduct business, use techniques such as art or vignettes to arrive at thoughts and feelings and teach skills, employ the QR, and posttest. This researcher was the group’s counselor. She was assisted by an art
technician. A nurse was in attendance when the vignettes were shown. One of the oncologists visited at the children's request.

At the end of the sixth counseling session, the children evaluated the model group counseling program.

Collection and Treatment of Data

During week one of the control period, each child was administered the State-Trait Anxiety Inventory for Children (STAIC), grades four through eight, or the State-Trait Anxiety Inventory (STAI), grades nine through sixteen and adults. The parent(s) were interviewed to collect information about the family life-style, problem-solving techniques, and how the family meets the needs of its members. The referred child also was interviewed to determine the child's perception of the problem, coping mechanisms, how he/she interacts in the family, and how he/she has his/her needs met.

Each child, during week three of the control period, took the STAIC or the STAI. Interviews were conducted to determine if anything unusual was happening in the child's life to raise the A-State score. (See Appendix D.) The doctor was asked to comment on the parent's health. The parent was asked to comment on occurrences in the child's life.

During the six-week treatment period, each child was administered the STAIC or STAI A-State prior to and immediately following counseling. Prior to counseling session six, the STAIC or STAI A-Trait was administered.

The children also completed an evaluation of the counseling after the sixth session.

As data were collected and scored, the raw scores were converted
into normalized T-scores (mean=50; SD=10). (See Appendix E.) To test each hypothesis, a one-way analysis of variance with repeated measures was computed.¹

In order to analyze the effect of each counseling session, the mean change of the pre and post A-State anxiety scores were computed and analyzed in context of the observed events during the counseling sessions. T tests also were computed to ascertain if there were any significant reductions of A-State anxiety in any of the six counseling sessions.

Finally, means for the children's program evaluation instrument were computed.

The data are presented in tables and figures, accompanied by a discussion of the same.

Chapter 2

REVIEW OF THE LITERATURE

Introduction

The literature related to children and stress is selectively reviewed and presented in this chapter as it pertains to the study. Because of the magnitude of this task, only selected contributions are offered. A comprehensive review is not feasible in light of the voluminous contributions of the authors in some of the related areas.

This study has to do with normal children in the middle and late latency period of development, how they react to stress, how they cope with loss, and how to intervene with them in their crises.

Stress

"Biologic stress is the nonspecific response of the body to any demand made upon it."\(^1\) Children are bombarded daily with stressors, and they react with a stress response. Sometimes their response is adequate, sometimes not. Such normal stressful situations as interacting with school, peers, parents, siblings, family concerns, animals, traffic, neighbors, and church impinge upon children. Up to a point, stress serves as an energizer for children.

Two natural responses children are born with are the relaxation

and "flight or fight" responses. When their bodies are relaxed, children can think clearly to make a decision in a stressful situation. During the "flight or fight" alarm response, their bodies prepare to flee or fight their way out of dangerous situations. This latter response is appropriate to use during danger but inappropriate otherwise. After the children determine a situation is not harmful, they can turn the response off. Some children in some situations, depending upon their perception of the stress, do not totally turn off their alarm, remaining in high gear. This is debilitating to children when it is consistent and over a long period of time.\textsuperscript{1} Childhood ulcers are a sign of this.

Psychologist John Connolly states that both children and adults respond to stress in the same way, and these responses can be measured objectively. Under stress, he said, people show changes in cardiovascular or psychobiological patterns and biochemically. He states that people have individual responses to stress, e.g., some respond with changes in blood pressure while others respond with elevation in heart rate. (See Appendix F.)

Connolly said the real question appears to lie in the reason people become different types of responders; the correlation of response patterns and personality types; and early influences on establishing patterns of coping.\textsuperscript{2}


\textsuperscript{2}Based on personal correspondence between John A. Connolly, Senior Clinical Psychologist, Psychosomatic Unit, The Irish Foundation for Human Development, Dublin, Ireland, and the writer, October 31, 1979. See Appendix F.
Crises

Caplan defines crisis as occurring "when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made."\(^1\)

Individuals are thought of as trying to maintain internal homeostasis or equilibrium. Normally an individual has problem-solving techniques to handle daily problems. However, if the problems are not adequately solved, the individual feels internal disharmony. Either the individual finds a solution to the problem or adapts to not finding one. In either case, the individual will arrive at homeostasis. However, his/her mental health may be affected as the methods used for coping may have been inadequate. With a crisis, the individual has a rise in inner tension, feels anxious, and becomes disorganized and emotionally upset. Whether the crisis is resolved positively depends upon the individual and how he interacts with the significant others in his emotional environment.\(^2\)

Two types of crises can cause stress to children. These are stressful event\(^3\) crises that can affect individuals no matter what their economic or cultural social status and those of a developmental


\(^3\)Ibid., p. 73.
nature\textsuperscript{1} that normally occur during an individual's life. The children can experience these stresses directly or because they are in families that are having the crises and become symptom bearers.

\textit{Situational.} Unexpected stressful events are those such as prematurity, status and role change, rape, physical illness, divorce, suicide, death, and the grief process. Other sources are losses, moves, separations, additions to the family, illness, accidents, legal suits, and shifts in roles. Pregnancy in a family, marriage of an older child or a widowed grandparent, birth of a grandchild, "loss" of a young child entering school or of an older child entering the armed forces, change in residence which sometimes results in a transfer in schools and the loss of friends (both for the children and the parents), and additional financial burdens in a move to a better neighborhood can be stressful situations. Additional stresses are changes in employment of either parent which disrupt patterns of family interaction, changes in the number of people living in the home, and the impending return of family members.\textsuperscript{2} Baldwin also states that the nature and dates of all losses and anniversaries are important because they might be reactivating unresolved feelings.

\textit{Developmental.} Crises of normal maturation would be birth, puberty, young adulthood, marriage, illness, or death of a family member, climacteric, and old age. The latter crises usually take place

\textsuperscript{1}Ibid., p. 132.

over a longer period of time and make more permanent changes in the individual's character.

Children in the Middle and Late Latency Period of Development

Three age groups make up the stage of latency: early latency, ages 7 and 8; middle latency, ages 9 and 10; and late latency, ages 11 and 12, ending with pubescence, from ages 11 to 14. The tasks of latency-aged children as described by Humphrey are to: solidify personal and sexual identity; develop social skills; learn how to interact with peers; attain academic skills; control self; and work independently. ¹

Children in middle latency, stated Humphrey, are in the period of greatest stability. Most are concentrating on school and friends and are interested in joining group activities such as clubs and sports.

Late latency children in contrast, he said, are less stable. As they approach their teens, they become less predictable, silly, volatile and immature. Peers, primarily of the same sex, are very important to them.

Erikson perceived the latency period as one of industry vs. inferiority and its developmental tasks as learning and producing in school and elsewhere, helping children feel confident, independent,

accepted, and respected.  

Erikson's theory attempts to explain an individual's psychosocial development as a result of his/her encounters with his/her social environment.  

Erikson built his theory on that of Freud who described the latency period, ages 6 to around 11, as a period of repressed sexual desires. During this period, children identify with their parents and peers of their own sex. When children mature genitaly, they are termed puberal, and their sexuality begins. Latency is a period when defenses are formed, when the super-ego is consolidated, and when the concept of loss can be understood.  

Cognitive development plays an important part in children's problem solving. Piaget describes the period of cognitive development as concrete operations (about 7 to 11 years) and formal operations (about 11 to 15 years). The 7 to 11 year old can think concretely in systematic ways. He/she can order, count, and classify. In terms of problem solving, he/she can think of cause and effect. He/she can take other people's points of view even though their's do not match his. However, he/she begins to feel that his/her opinions should. The 11 to 15 year old can think in purely abstract terms as well as  

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complex deductive reasoning. To solve a problem, he/she thoroughly can think about it—all the factors and all the possibilities. He/she can make hypotheses and test them.¹

**Family Influence**

Families have a great deal to do with how children experience stress. Parad and Caplan study families in crisis in relation to their lifestyle's values, roles, and communication.² A family's values give meaning to certain critical situations and how to react to them. Roles have to do with the pattern of what is to be done in the family, who is to do it, and who is to decide on the allocation of tasks. Communication has to do with internal communication, both verbal and nonverbal, of feelings, ideas, messages, and information and external communication, between the family and community.

They also look at their intermediate problem solving techniques to maintain equilibrium. These may be effective or not. Those that are not have to do with lack of leadership, emotional exploitation of a family member by either passively not meeting his/her emotional needs, or actively, by emotional exploitation.³

The third area that Parad and Caplan assess a family crisis situation is its need-response pattern. They state that an individual has basic needs to maintain mental health, such as: (1) love for one's own sake; (2) a balance between support and independence with respect

¹Smart and Smart, p. 652.


³Ibid., p. 7.
to tasks; (3) a balance between freedom and control with respect to instinctual expression; and (4) the availability of suitable role models.¹

They look at these needs in terms of perception by family members and by the culture of the family, by the respect of them being attended to and the satisfaction of them to the extent the family's resources can meet them.² They state that these vary depending upon culture and economic class of the family. Crises periods bring on a shift in need-response patterns. Some frustration is not damaging, but over time and in particular critical developmental periods, it can be conducive to poor mental health. Also, individuals could cover up signs of frustrated need by adaptive reactions.³

Sometimes a child experiences being made the family scapegoat or symptom bearer when its family is under stress.⁴ Because the parents are using inadequate problem-solving techniques, they displace their anxiety and guilt often on a child. The parents then release their tensions on him/her.

In other situations, the parents have a lack of affect because they are not ready to deal with their stress. They displace all their anxiety on the child.⁵ In these instances, the child being helped frees up the parents eventually to look at the real causes of stress of the child and themselves and at what they are experiencing.

¹Ibid.                                    ²Ibid., pp. 7-8.
³Ibid., p. 8.                              ⁴Baldwin, p. 31.
⁵Ibid., p. 33.
Stress Reactions

Children maintain equilibrium both internally and externally. When stress is overwhelming, children might experience transitional situational disturbances. Symptoms disappear as the stress decreases. For example, when children begin a new grade in school, some new coping mechanisms such as bed wetting or fingernail biting might appear. However, their behaviors can extinguish as they feel assured they can achieve in the new classroom situation. Authors describe some of the other reactions to stressful situations that children might have not only psychologically but physically and behaviorally.

Psychological. Depression can be a reaction to stress. Humphrey states that depression is of a recent cause and usually precipitated by an event such as losing a parent through death or divorce or as a reflection of marriage problems. Childhood depression may be expressed as an adult would with psychomotor retardation, despondency, sadness, and possible leanings toward suicide.¹

Philips believes that childhood depression is similar to adult depression of the children's caretakers. He states that depressed children are overly sensitive and overly hurt. They become self-deprecatory. They want relationships yet are afraid to try for fear of being abandoned. They criticize themselves or put blame on others. Unhappiness marks their appearance. They chronically complain of physical or psychological hurts. In the classroom, they could be the day dreamers or the class clowns. Scolding or punishment only

¹Humphrey, pp. 108-116.
reinforces their negative feelings of themselves. Unfortunately, the teachers do not recognize they just need consolation.\(^1\)

Children in latency have problems if they lose hope of the completion of their industry, feeling inadequate, inferior, in despair, and mediocre. Their self-esteem may be hampered if their appearance is different for some reason, such as color of skin, because of their being in such a socialization stage.\(^2\)

School phobia can be caused by performance anxiety or by fears of being separated from parents, especially the mother, or even by a fear of open spaces such as agoraphobia.\(^3\)

Coping mechanisms are what an individual uses in everyday life to help him/her solve stressful situations, handling anxiety, and reducing tension. Individuals develop a style of coping to maintain internal equilibrium and call upon it when they again face stress. Aguilera states that mechanisms can be covert or overt and consciously or unconsciously activated and fall in the categories of aggression, regression, withdrawal, and repression.\(^4\) Examples of coping mechanisms might be to talk the problem over with a friend, to think it out by oneself, to cry, to swear, to get into a verbal fight, or to slam doors. When coping mechanisms are not effective to handle a novel stressful event, an individual becomes uncomfortable on the conscious level and becomes intent on reducing the stress to the detriment of other happenings in his life.

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\(^1\) Philips, p. 514.  \(^2\) Erikson, p. 260.

Still in use today, the classical stages of problem solving were proposed by John Dewey in 1910: (1) a difficulty is felt; (2) the difficulty is located and defined; (3) possible solutions are suggested; (4) consequences are considered; and (5) a solution is accepted.¹

Biehler notes that not all children have effective problem-solving techniques. They differ for numerous reasons, some of which are differences in styles of conceptualization, intelligence, intellectual maturity, and kind of parenting received.²

Another stress reaction is anxiety. Horney believes that normal anxiety is a realistic fear of concrete events such as death while neurotic anxiety reflects fear of a world thought of as hostile and confusing.³

The Smarts define anxiety as "a stirred-up, unpleasant, tense feeling, focused only vaguely or generally. Fear indicates the same type of feeling state but with accompanying attention focused on a specific situation or problem."⁴ Erikson feels that it is hard to distinguish fear from anxiety in childhood.⁵ Anxiety affects how children approach and handle learning and producing. The Smarts feel:

It seems reasonable that a very mild degree of fear or anxiety would help a child in problem solving, as long as the

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¹Ibid., p. 64.
⁴Smart and Smart, p. 424.
⁵Erikson, p. 408.
resulting tense feeling served to focus his attention squarely on the task at hand. A greater degree of fear would immobilize his resources, freezing them instead of energizing them. Repeated experiences with failure would lead to expectations of more failure, a feeling of worthlessness, inferiority, and inadequacy, all of which constitute the negative of a sense of industry.¹

Physiological. Remaining in high gear as a reaction to stress can be damaging to the body. Physicians Whatmore and Kohli have been researching for many years at the Pacific Northwest Research Foundation, in Seattle, Washington, on the causes and treatment of physiopathology or functional disorders.

Physiopathology is damage to the body brought about by incorrect signals to the body parts, causing damage such as cardiovascular and gastrointestinal malfunctions, headache, backache, depression, anxiety states, insomnia, and other conditions. These are problems that are caused by altered physiology and not by underlying structural pathology such as caused by tumors or infections.²

These researchers believe that through extensive case assessment and remediation, they can reduce communications in the nervous and endocrine systems that send out information to and from the body that wear it down. Their treatment utilizes specially designed electronic instruments, biofeedback equipment, sometimes medicine, exercise, and physical medicine, such as massage, to reprogram their patients' bodies and lives. They call it "effort training" or orthoponetics. Ortho means straight, correct, or right; ponos means effort,

¹ Smart and Smart, pp. 425-6.
work, or toil.\textsuperscript{1} This training, to some degree, originates from early work by Jacobson who wrote \textit{Progressive Relaxation} in 1938.\textsuperscript{2} An individual's inner effort responses to life experiences, to his/her memory, and to the anticipation of future experiences are made more right working or orthoponetic vs. dysponetic. The authors feel psychotherapy, hypnosis, and medicine are ineffective to counteract dysponesis. Psychotherapy and drugs can be used with orthoponetic training, however.\textsuperscript{3} They report a 60 percent long term improvement in patients using orthoponetic training.\textsuperscript{4}

Silverman, based largely on psychoanalytic investigations, states that the more of the following characteristics that occur together in an individual, the somatic disease is apt to occur:

1. The exposure to critical psychologic stress inadequately compensated for by other environmental factors of a favorable nature; 2. some degree of physical dysfunction (ranging up to major illness) as part of a general style of adaptation to psychologic stress in the past, with previously sensitized body areas representing potential current target organs; 3. evidence of increasing instability and regressive shifts in psychologic equilibrium; 4. blocking of affects from adequate emotional expression or insufficient awareness of their significance if they are being so discharged; 5. presence of denial as a prominent psychological defense; 6. existence of a high degree of ego-superego tensions despite lessening psychologic manifestations of their presence; 7. build-up of unmodified aggressiveness which is internalized; 8. a persisting increase in awareness of physical sensations and perceptions compared with previous levels; 9. recurrent dreams (and parapraxis) whose latent content contains prominent physical references especially to some form of dysfunction; and 10. verbal references to somatic identification with an emotionally significant object, reinforced by actual

\textsuperscript{1} Ibid., p. 136. \hspace{1cm} \textsuperscript{2} Ibid., p. 137.\hspace{1cm} \textsuperscript{3} Ibid., pp. 138-39. \hspace{1cm} \textsuperscript{4} Ibid., p. xxi.
occurrence of similar or related organ dysfunction in that person.¹

Whatmore and Kohli call these stress-caused disorders functional and believe that calling them neurotic or psychosomatic are misnomers.²

**Behavioral.** Children can manifest their stress through their behavior. As stated previously, depression can be stress induced and be similar to an adult's reaction. On the other hand, it can be expressed by hyperactivity, defiance, and aggressive behavior, appearing to be an unsocialized aggressive reaction. However, the child who manifests the latter has typically reflected this behavior since early childhood.³

Learning disorders can cause not only present but future problems for children if they are not caught and remediated. Children become discouraged and turn off school, becoming behavior problems of a defiant, acting out nature.⁴

Having a hard time attending is one of the indicators of hyperkinetic behavior. Also, being easily distracted and constantly in motion are manifested here. Teachers and parents may attribute this behavior, if the problem is not diagnosed, to a child's lack of being able to control himself.⁵


²Whatmore and Kohli, p. 1.


⁴Ibid.

⁵Ibid.
Children's Coping with Situational Crises of Loss

This research project predominantly deals with children's situational stress of loss. Examples are life-threatening illnesses, disabilities, death, and divorce.

Life-Threatening Illnesses

Children sometimes have to cope with their own life-threatening illnesses. They have to cope with the stress of each of its phases—diagnosis, remission, exacerbation, and terminal state.¹ The first reaction is one of grief, sadness, and crying and the child flows in and out of a period of mourning, realizing goals may not be reached now or ever. Or they may be protected by parents denying the situation and keeping it from them. The parents might take opposing stances in their coping, possibly providing different information to their children and lowering the trust level. In a case of children dying with cystic fibrosis, the children experienced not only physical pain but fear, imprisonment by their oxygen tent, dislike of diet, and insomnia.²

Hickey writes of the stresses that impact children who have kidney diseases. She says that teens who receive a transplant experience absences from school, loss of friends, and problems with sex and dating and bodily image and identity. She says that children's lack of maturity and information about the medical process causes them to be


frightened. Frequent and lengthy hospitalizations, the parents' anxieties and effects of the illness impact the children's developmental process while the children are forming their personalities. Children have to put up with overprotection of parents, competition and resentment of siblings, and possibly even the problems of the parents' marriages. When children who have had successful transplants are dismissed from treatment, with no restrictions, they might have to deal with parents' or their own fears keeping them from participating in extra-curricular school activities.¹

Furman and her colleagues counseled with children who lost parts of their bodies or body functions such as through amputation or bodily functions through polio. Her study found that the patients go through a slow and painful longing and renunciation (hypercathexis and decathexis). She said identification could not occur because a limb or function cannot "love you back." The self-love was directed at other body parts or functions and patients self-images changed likewise.² When latency children resolved their oedipal conflict, Furman said, they found themselves less threatened by decathexis and even more so of the adolescent.³

Life-threatening illnesses of a parent are stressful for children and involve anticipatory mourning. Elizabeth Kubler-Ross, M.D., has found five stages that the afflicted themselves as well as their


³Ibid., p. 53.
family members experience in adapting to the circumstances. They are: (1) denial and isolation; (2) anger; (3) bargaining; (4) depression; and (5) acceptance. The individuals may not follow the order listed and may be in more than one stage at any one time.¹

Lebow states that the family grieves the daily sufferings, changes, separations, and relationship distances.² She states the family also suffers much anxiety and quotes Paul Tillich, "Time runs from beginning to end but our awareness goes in the opposite direction, that is it starts with anxious anticipation of end."³

Children have to give up plans and dreams for the patient. They may feel cheated and anxious about what lies ahead. They wonder about final separation, changes in life style if any, coping with changes in roles, what might happen daily with the patient, how long he/she might live, and feel stress in decisions for his/her care and treatment. Lebow states that uncertainty makes for ambivalence with increased negativity. She said that it reactivates old and unresolved ambivalent issues within each of the family members. Children feel anger and guilt due to feelings of desertion and abandonment. The children might wish for the patient's death or prolongation of life, really feeling that their thoughts could affect the patient. Anxiety mounts as the defenses do not seem adequate as conflicts are suppressed or repressed and as children fear their own emotions and behavior.

¹Kubler-Ross, p. 235.
³Ibid.
Disability

Children who must experience a parental disability find a stressful situation. Children might experience loneliness, changes in home management, be deprived of both parents, and be disappointed when expectations are not met. The children might experience anxiety about their own frailty, about their causing the disability by their angry wishes or inattention about physical damage as punishment or trying to replace the absent parent. The children might also feel helpless. On the other hand, they might try to replace the disabled parent in the household. Suppression of feelings by the parents probably will cause the children to suppress their feelings, too.¹

Death

Erna Furman, in her book, A Child's Parent Dies, stated that, "when a child's parent dies, he faces an incomparable stress which threatens the further development of his personality."² There are many studies of adults to show how their parent's death affected them. In 1974, Beck, controlling for socioeconomic variables, reviewed the literature, relating orphanhood and adult depression. From his study, he found that approximately 30 percent of severely depressed adults experienced loss of a parent in childhood.³

¹Mary D. Romano, "Preparing Children for Parental Disability," Social Work in Health Care, I (Spring, 1976), 310-11.
²Furman, p. 11.
Furman and her colleagues found children to have various reactions to the stress of death of their parents. Children have trouble distancing themselves from their deceased loved one yet being close enough to allow empathy and sympathy. They sometimes felt their death wish killed their parent. Because the children were developmentally dependent on the deceased, Furman and her colleagues saw children having problems with the death of their parent if their needs went unfulfilled and if the children felt they had lost parts of themselves, identifying so closely with their parents.  

At the funeral, children may feel insecure and anxious. Furman stated that children become frightened and confused by seeing the dead parent's body or even being asked to touch or kiss it.

During the first weeks of the loss, said Furman, children sometimes resort to defenses or become overwhelmed with despair. They hold on to mementos and possessions such as clothes and pictures.  

Furman found that if children had never been prepared for parental separation, they could become overwhelmed with their feelings and use defensive measures to deny them. She said at this point children's feelings during separation will be temporarily or permanently affected.

The reaction to bereavement, states Brown, in older children usually involves anxiety and depression. They also may feel guilty.

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1 Furman, p. 248.
2 Ibid., p. 21.
3 Ibid., p. 23.
4 Ibid., p. 15.
However, he stated, the deprivation that is a consequence, rather than the loss itself, may be the main problem of bereavement.¹

**Divorce**

Everly found that in 1977 one of every six children under eighteen in the United States was in a single parent home. That is eleven million out of sixty-six million children.² Children living through the stresses of divorce are not a small problem.

Sorosky lists the following factors as influential to a child's adjustment to divorce:

a. The psycho-dynamics of the family prior to the divorce, including the severity of marital discord; b. the nature of the marital breakup; c. the post-divorce relationship of the parents; d. the age or stage of development of the youngster at the time of divorce; and e. the personality strengths and coping skills of the child.³

The divorce period evolves over three major stressful periods as described by Anthony which are predivorce, actual divorce and post-divorce.⁴ Predivorce is when the parents emotionally divorce each other. Marriage and life are turbulent. The children are aggressive, restless, irritable, difficult, or devitalized, generally flat and lacking in zest. The actual divorce crisis depends on the child's

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³A. D. Sorosky, "The Psychological Effects of Divorce on Adolescents," Adolescence, XII, No. 45 (1977), 133.

predivorce coping. The post-divorce period is marked by the stresses accumulated over the previous stages. Factors affecting the child's reactions are: legal contest; feelings of the cause by the child; parents' reactions; developmental stage of the child; separation anxiety; feelings of loss; community stigma; visitation; changes in income; and working mother.

Dlugokinski discusses the theory of separation as it relates to children's divorce reaction. He feels there is a three-stage pattern of coping with the divorce crisis that evolves with children experiencing the feelings of rejection, helplessness, and anxiety. The first stage is orientation. Children suffer from shock and block out their feelings and other reactions until they are able to cope. They may use denial, become depressed. They may become excessively dependent on another. They may have a sudden shift in peer relations or in school performance. They may disown anxiety or sadness that they suffer.

The second stage described by Dlugokinski is integration which begins a few weeks or months following the divorce. Children begin to work through the divorce. They might feel angry, sad, excited, or sometimes disoriented. When they do reorient themselves, it might be with feelings of anxiety or insecurity. They can face or master these reactions or use denial and escape. They may also be involved in self-denial by fusing identity with their parent, developing an adult role, becoming depressed, or becoming dependent.

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Consolidation is the third phase of coping with the divorce crisis. At this point children have a feeling of functioning effectively and regaining living.

Another author, Gardner, describes children coping with the stress of divorce. He says children initially use repression and suppression to cope with divorce. They ask when the absent parent will return or go through daily routines as if the parent were still there. For several weeks, the children typically might become depressed with accompanying insomnia, anorexia, apathy, and withdrawal. Children might compensate for loss through regression to an earlier developmental stage. Almost all the children react in anger at the parent for leaving and in fear at expressing this emotion. Anger is repressed and displaced through antisocial behavior or into neurotic behavior such as obsession, compulsion, and phobia. The children often believe they are to be blamed for the divorce or for problems related to the divorce. Children can persist for years with wishes for their parents to be reunited.

Every child has an individual reaction to the divorcing situation feel Wallerstein and Kelly. Their divorce counseling philosophy is based on three beliefs. The first is that stressed children intermingle defense and adaptive mechanisms to cope. One determines the reaction a child is using and for what reason by looking at the

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behavior payoff. The second belief is that one should judge the coping response to divorce stress over time because divorce as well as the development of the child proceeds in stages. The third belief about children involved in divorce stress is that one should consider their normal developmental tasks for their age group.

Wallerstein and Kelly describe the coping mechanisms of children of divorce. They seek coherence, use denial, bravado, courage, activity, seek support from others, and use conscious avoidance and activity. They react with shame. They have conscious and intense anger that is organized and directed at specific objects. Oftentimes the children do not feel that divorce is justified and take a moral stance. The children are dependent on the family for identification, nurturing, protection, and control. Divorce can cause them confusion and broken identity. External controls are also important for the superego formation. The more mature children are at this age and the more they expect support from their parents, the more they feel sad, lonely, powerless, and peripheral in the divorce process in realizing that divorce is a battle between their parents with them often pressured to take sides.

Crisis Intervention Counseling

Definition

Crisis intervention counseling is a specialty counseling. The need for it is precipitated by what the client perceives as a novel situation with which he/she cannot cope. A new approach is needed. Thus, the need for intervention by a trained professional in counseling. One aim of crisis counseling is to help the client return to
the precrisis state of homeostasis or at an even higher level of functioning. The counselor mainly deals with the client's present state. The goal is to resolve the immediate crisis. The counselor does not deal much with the past, is active verbally in the sessions, and is directive. Among other areas, the counselor works to help the client understand his situation, express his feelings, look at the past and present coping mechanisms, find and use a support system, and plan for the future to reduce possible similar situations. Average length of treatment runs from one to six sessions.¹

Crisis intervention counseling for children can be with individuals, groups, families, and the child and his parent. Some medical facilities hire counselors. Other sources are schools, mental health centers, and private agencies.

_Counseling in the Area of_  
_Children and Loss_

**Life Threatening Illness**

Medical doctors hiring counselors to work with the psychological, emotional, and behavioral needs of patients who have life threatening illnesses is a recent phenomena.² Prior to this and still occurring, medical staffs handled or ignored their patients' and their families' nonmedical needs, depending on the medical professional's time and skills. Now, recognizing that providing for the good mental health of the entire patient's family is important, counseling is becoming a part of the total treatment plan in more and more clinics

across the United States. Patients even can use their medical insurance for psychological services. In the area of oncology, hospitals also support patient information and counseling through training nurses to counsel patients and by sponsoring such patient groups as "I Can Cope" and "Make Today Count." A nationwide support group for parents of children with leukemia is "Candlelighters."

A recent study by Rosenheim and Ichilov in crisis intervention with a group of children who were about to lose their parent to cancer illustrated to them the need for preventative counseling of children. This was the only study found by this researcher of single or group counseling of children of cancer patients. Goals of the counseling were: "1. perception of the illness and their reactions to it; 2. the factual life situation at home (present as compared to the past and also as projected to the anticipated future); and 3. feelings towards the parents and self-concept."\(^1\)

Partial loss is suffered by children who have intermittent contact with their parents. It is different than mourning for a parent who has died as the contact with the lost parent results in repeated cycles of renewed hope, partial gratification and renewed frustration.\(^2\) On the other hand, the children of parents who have life threatening illnesses face the threat of losing their parent through death.

As stated previously, children are dependent on their parents for their teaching them and modeling appropriate behavior. White


\(^2\) Furman, p. 47.
writes of three stages of adaptation which provide a framework for
looking at coping with stress. The three strategies of adaptation
are: (1) obtaining information on an on-going basis to adapt to and
influence the environment; (2) sustaining an internal condition satisfac-
tory to be able to act as well as process information; and (3) feel-
ing free to have flexibility of action as well as retaining some auton-
omy of direction.¹

Children need information from the parents about the ill
parent's disease. Without adequate information, children might feel
isolated at school and set apart from their peers because of misunder-
standings of the illness. When the parents can transfer information
about the disease and treatment to children, it will help reduce their
children's anxiety and provide them with new ways of coping. To help
the children who are so dependent on the ill parent to not have feel-
ings of abandonment during hospital stays, the parents need to tell
the children where the ill parent is and find ways of communicating
with them during the expected and unexpected absences. Parents and
children can be anxious about whether the disease might be inherited
by the children. Adequate medical information can reduce this worry.²

Maintaining an internal balance in order to cope with stress
is necessary for children. Both parents having to spend time at the
hospital threaten children with feelings of abandonment and being un-
cared for. Children also might experience a personality change of the

¹Robert W. White, "Strategies of Adaptation: An Attempt at
Systematic Description," Coping with Adaptation, ed. George V. Coelho

²Lillian Pike Cain and Nancy Staver, "Helping Children Adapt
to Parental Illness," Social Casework, LVII, No. 9 (1976), 575.
ill parent, for example, expressing a temper or being in depression. Anthony calls it a disconnecting aspect of an illness when children have problems comparing the parent they now have with the one they once knew.\(^1\) Children might have to put up with their parents' use of denial which helps reduce anxiety and guilt but which can cause the parents to ignore their children's affects. For example, not taking the children to the hospital because of the parents' inability to handle their own feelings. The children may blame themselves for their parent's illness. Parents may feel they are to blame for their spouse's illness and project their guilt onto the medical team by angrily finding fault with it. Children then have no one to listen to them and may not be as trusting of the parents.\(^2\)

Families need to provide freedom of movement is White's third strategy of adaptation. Children can feel helpless and lack action when their parents are troubled. Some parents also involve their children in more of the parent's illness and caretaking than is appropriate for their age.\(^3\)

Furman noted that if children's parents are ill before they die, they have a chance to integrate what is happening not only with each parent but with the children, too. The children have a chance to ask questions and feel assured for their safety, physically and emotionally. To the extent they are assured, they will cope better. The

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\(^2\)Cain and Staver, pp. 578-9.

\(^3\)Ibid., p. 579.
well parents sometimes have to withdraw to some degree from parenting. But if they do not withdraw emotionally, the children will feel more secure. Children can feel helpless, left out, angry, and guilty at this time. The children need to physically be in the presence of the ill parent as long as possible. The hospital visits should be appropriate in length and amount to the age and development of the children.\(^1\)

If the families have someone in the home to carry on the routine as before, the children will feel more secure. Life-threatening illnesses over a long period of time seem like never-ending anxious anticipation whereas a sudden death is very shocking. Sometimes children witness sudden death or are even injured at the same time. The children are best helped when the surviving parents can discuss the children's experience and clarify any puzzling parts of the story. If the parents try to cover up the experience, it will harm the parent-child relationship. If the parents learn about death first, it is better for them to tell the children and not to wait until they are composed or have all the details.\(^2\)

Lebow states the casework goals for working with family members during the patient's pre-death period are: (1) "remaining involved with the patient" through maintenance of open family communication; (2) "remaining separate from the patient," each family member needs to feel a sense of self and direction apart from the patient; (3) "adapting suitably to role changes"; (4) "bearing the affects of grief"

\(^1\)Furman, pp. 18-19.

\(^2\)Ibid., pp. 19-20.
(anticipatory grieving); (5) "coming to some terms with the reality of impending loss"; and (6) "saying goodbye."\(^1\)

Weisberg supports understanding Kubler-Ross' emotional stages the critically ill go through in order to define the tasks and goals of counseling with them.\(^2\) When a family has the advantage of preparing for a member's death, mourning lasts longer but is less intense. When it is precipitated by a sudden loss, mourning may not last as long but is more intense.\(^3\)

**Disability**

Counselors who prepare children for a parental disability are suggested by Romano to help them with four tasks.\(^4\) The first is to help them prepare for the disabled parent's absence from the household. The second task is to help the child to handle the threat of loss of him/herself. This could be based on the absence of the parent that the child most depends upon for emotional or physical survival. Or it could be based upon the child identifying with the absent parent. Helping the child reestablish contact with the disabled parent is the third task. The last task is to help the disabled parent reintegrate into the family. Older children or teens should be encouraged to talk about their concerns, questions, and feelings. To help them not feel

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\(^1\)Lebow, p. 460.

\(^2\)Lillian Miro Weisberg, "Casework with the Terminally Ill," *Social Casework*, LV, No. 6 (1974), 337-42.

\(^3\)Stanley B. Goldberg, "Family Tasks and Reactions in the Crisis of Death," *Social Casework*, LIII, No. 7 (1973), 404.

\(^4\)Romano, p. 311.
helpless, they can become involved with the parents rehabilitation
process and learning about the equipment.

Death

Furman wrote that if children have a realistic concept of
deeh, it helped their understanding of the situation. Children can
concretely understand death at about the age of two. Because their ab-
stract thinking is not developed, an introduction of religious and
philosophical concepts of death confused and frightened young children
but could be added to the concrete idea of death of latency aged chil-
dren and older.\(^1\) Parents can help their children by being in touch
with their own concept of death.\(^2\)

Customs surrounding the funeral, ethnic, religious, personal,
give the family some security therefore helping the children to feel
less anxious. To help them feel emotionally secure, it is best,
stated Furman, if the surviving parents are physically and emotionally
in touch with the children. Older children need to be included in the
funeral to confirm their relationship with the living parent and to
see the concreteness of death. If the parents are not defensively
overly busy, they can be helpful to the children's understanding of
death, how the families deal with the decisions and funerals, and why
everything is done.\(^3\) At an opportune point, the children need to
visit the grave, said Furman.

\(^1\)Furman, p. 11.
\(^2\)Ibid., pp. 13-14.
\(^3\)Ibid., pp. 21-23.
Erich Lindemann stated that grief consists of three phases:
"emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing and the formation of new relationships.¹ Siggins speaks of mourning which is part of the grief process having two basic steps which one progresses through: introjection and the loosening of ties to the deceased. She states that when an individual has gone through the following, he/she has finished his grief work:

Under the influence of the reality that the object no longer exists, the ego gives up its libidinal ties to the object. This is a slow, piecemeal process in order that the ego will not be overwhelmed by a flood of feeling. The mourner pursues this task by introjecting the relationship with the lost object, and then loosening each tie to the now internalized object. . . . Thus introjection acts as a buffer by helping to preserve the relationship with the object while the gradual process of relinquishing is going on. . . . In this process, of course, the relationship to the lost person is not abandoned, but the libidinal ties are so modified that a new relationship can be established.²

Furman and colleagues helped children in mourning by helping them with their ability to handle and express feelings, understand the reality of their situation, and better their relationship with their significant others. They found by their helping the children grow they were better able to stand later stressful problems including object loss.³


³Furman, p. 183.
The more children could tolerate and express longing, found Furman, consisting of sad and angry feelings for their parents, the better able they were to deal with the loss of their parent. This depended upon the children's maturation and whether they had ever experienced longing before.¹

At the time of the parent's death, the children are best helped by the other parent even though he/she is faced with his/her own anxieties. The children need the surviving parent to help them objectively look at the deceased's positive and negative aspects and memories. The children need information about their deceased parent as they progress through the developmental stages, so that they can integrate the parent into their personality as well as separate from him/her. The parents' understanding of the children's different needs in mourning helped children to understand the parents'.²

The end of mourning brings seeking a new love object, stated Furman. A new parent on the scene can bring conflicts. The children have to incorporate the new parent with the remaining cathexis of the dead parent. The children may not be ready for a new parent or possibly have been ready for a long time. Both situations causing frustrations. Parents need to consider the children's feelings. A new parent could mean change in homes, routines, new siblings, adoptions, etc. The children compare the new parent with the deceased, bringing up painful memories and conflicts of loyalty. The children need to adapt to the relationship of two adults again.³

The counselor needs to help the family individuals through the following tasks after the death of a family member, according to Goldberg: (1) allowing mourning to happen; (2) letting go the memory of the dead family member; (3) realigning of roles in the family; and (4) realigning the family's roles with outside relationships such as memberships in clubs and sports. Goldberg also feels that the counselor needs to realize that the family unit makes changes, too, as a result of a family member's death. They are: (1) family members' roles being reorganized; (2) increased solidarity for two reasons, emotional support and successful functioning and/or death of a member who caused problems in the family; (3) object replacement of the family's emotions on another family member or person; and (4) scapegoating the family members' guilt and anger on another family member.¹

Divorce

Toomim and Hozman and Froiland work with children of divorce through a loss model. Toomim feels children have to cope with the loss of:

1. The faith and trust she/he had that parental care would be everlasting; 2. the predivorce mother/father/child relationship/s; 3. the mother as she was prior to her divorce; 4. the father as he was prior to the divorce; 5. familiar environmental support; and, finally, 6. even the child him/herself who is inevitably changed by the experience.²

Using Kubler-Ross' model of anticipatory mourning, Hozman and Froiland designed a counseling model for latency-aged children of

¹Goldberg, pp. 398-405.

divorce.¹ During stage one, denial, the counselor works with the parents and the children to change their denial behaviors. Direct confrontation is used with the children. Feelings are accepted and allowed to be ventilated through role playing. Play therapy techniques are recommended. Anger is stage two, and strategies recommended are: (1) allow the children to express anger unconditionally; (2) help to channel the anger; and (3) assist in directing the anger on safe objects. Bargaining for the parents' reconciliation is stage three. The counselor helps children to see that they have no control nor responsibility for parents' behavior. This is done through problem-solving activities. Depression is the fourth stage where children behaviorally mourn the loss. This is done by helping the children who have the same problem and encouraging the children that this state is only temporary. Acceptance is the final stage when the children see the situation realistically and realize that they have lived through the crisis with self-esteem and self-confidence intact.

At the Divorce Counseling Service of Marin County, California, Kelly and Wallerstein provide short-term preventative counseling for children at their developmental stage. They begin by assessing the children's understanding of the divorce, affective responses, defenses being employed, new symptoms and behaviors, and evaluation of the support systems--parent/child relationships, siblings, relatives, school, peers, and other activities.² From this information, they plan an

²Wallerstein and Kelly, p. 25.
intervention strategy. Kelly and Wallerstein believe the children's responses to divorce "are more tied to their developmental stages, their environment, and parents/children relationship vicissitudes, including accessibility to the non-custodial parent" rather than Kubler-Ross' response stages.1

Their crisis intervention counseling goals for older children are:

1. Reduction in suffering, where suffering was defined as intense anxiety, fearfulness, depression, anger, longing or other symptoms causing distress; 2. reduction in cognitive confusion in relation to the divorce and its sequelae; 3. increase in psychological distance between the divorce situation and the child, or a divorcing parent and his child, where the child has become directly involved in the parental conflict; and 4. successful resolution of various idiosyncratic issues, for example, dealing more comfortably with a mentally disturbed non-custodial parent, or working through the dilemma of having to chose between parents.2

Kelly and Wallerstein feel their direct intervention rather than through parents was more successful with late latency children and adolescents whom they found to realize their divorce-related problems and to be motivated to work on them.3

As mentioned by Rice, Cesare-Murphy and Moore describe a preventative therapy group for latency-aged children.4 Their time-limited group used the Magic Circle techniques which focused on awareness

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1 Wallerstein and Kelly, p. 29.
2 Ibid., p. 30.
3 Ibid., p. 31.
(feelings, thoughts and behaviors), self-concept and social relations.\(^1\)

Play therapy was also used with various media and children role played.

An all-day workshop format is used by Kessler and Bostwick.

Their counseling model is for older latency and adolescents but could be adapted to use with children aged 6 to 10 or even 11 to 17 years old felt the counselors. They like to work with groups of ten children with co-counselors. Their goals for the children are: "1. to explore their own and others' values/assumptions about marriage/divorce; 2. to recognize, express and cope with their own and their parents' emotions constructively; and 3. to develop communication skills for handling difficult situations." They use the American Personnel and Guidance Film: "Divorce Part II," introductory group building exercises, sentence completion exercises, empathic assertiveness training model, and values clarification exercises.\(^2\)

Summary

Suffering loss can affect children throughout their lifetime. Children are more susceptible to this situational stress than adults, as their personalities are less formed, their self-concepts less firm, and their world experience less. They can act out of proportion to the incident, but they also can recover faster than adults. What seems

\(^1\)L. Fearn and R. E. McCabe, Magic Circle Human Development Program: Supplementary Idea Guide (La Mesa, California: Human Development Training Institute, 1975), p. 4.

like a large emotional problem in children may not last long due to
ready response to treatment.¹

As the country's number one asset, children need to have
healthy mental states. Guilt, shame, anger, fear, anxiety in a crisis
situation throw the child into a state of confusion. Helping a child
express and handle these feelings can promote growth and change.²

Growth and change are needed to affect good mental health.³

¹Newcomer, p. 66.
²G. Caplan, "Opportunities for School Psychologists in the
³Parad and Caplan, p. 5.
Chapter 3

DESIGN OF THE STUDY

The primary purpose of this research was to determine if group counseling could reduce significantly over time the A-State anxiety of children who are in families that have a parent who has cancer. The sample, instruments, group counseling program, analyses, and treatment of the data and a summary of the research project are contained in this chapter.

Description of the Sample

The population of this study were the children of cancer patients being treated by S. Fred Brunk, M.D., and Thomas R. Buroker, D.O., medical oncologists in private practice in Des Moines, Iowa. Affiliated with these two doctors were two counselors, George S. Lair, Ph.D., and Lawrence E. Fanning, Ed.D. Dr. Lair served as Director of Counseling Services.

In order to arrive at a sample to counsel, Dr. Lair's office mailed information to patients about offering counseling to their children. (See Appendix A.) The requirements for Dr. Lair to refer children were as follows:

1. They be in families with a parent who had cancer, had been diagnosed at least two weeks, and was still living;
2. They not be diagnosed mentally retarded; and
3. They range in age from 9 to 14 years.
From replies to Dr. Lair's letter and follow-up calls, parents of seven children agreed to have their children participate in the study and signed permission forms. (See Appendix B.)

The group counseling program was designed for normal middle and late latency-aged children. Humphrey described these ages as middle latency, ages 9 and 10, through late latency, ages 11 and 12, ending with pubescence, from ages 11 to 14.\(^1\) Determining the lower limit of the study was the measuring instrument, the State-Trait Anxiety Inventory for Children, which was normed on fourth grade children who are approximately 9 years of age. Determining the upper age limit was the age of late latency of approximately age 14.

These ages are a five-year spread. However, the children are motivated to work and enjoy socializing with their peers. They can understand the concept of loss and problem solving, at least, in terms of cause and effect.\(^2\) The older latency children can help the younger with their budding abstract thinking.

**Individual Group Members**

Subject One was a 13-year-old female who was an above-average student in school. Her mother was diagnosed as having breast cancer in November of 1978. She reported their family problems started when they found out their mother had cancer and that their moods swung as their mother's did. She said she knew cancer was dangerous.

Subject Two was a 14-year-old male whose mother had ovarian cancer, diagnosed in January of 1979. An average student, he said he

wanted to receive more information about cancer. His mother said he
had reacted with a lot of anger and, in the past school year, was in-
volved in fights at school. She felt this was due to her having can-
cer. She said she wanted both her children, Subjects Two and Three,
to not deny the cancer as she felt they had been. She felt the denial
was keeping them from fully functioning.

Subject Three was a 13-year-old female and a below average
student in school. She openly admitted, that as much as possible, she
denied her mother's illness because she did not want to think of the
possibility of losing her. However, she did want to come to counseling
to receive more information and to receive help in coping.

Subject Four was a sister to Subject One and was 12 years old.
She was an average student. She said the most frustrating part of her
parent's illness was not knowing what would happen.

Subject Five was a 10-year-old above-average student. His
mother had cancer of the breast in 1977 which reoccurred in the origi-
nal site in 1978. In 1979, it occurred in her liver. This Subject
was being troubled with nightmares which he thought were due to his
mother's condition. He reported that he wanted his mother to stop
smoking and drinking.

Subject Six was 9 years old and an average student. He was
the brother of Subjects One and Four. He said it hurt him to see his
mother sick and that he did not understand cancer.

Subject Seven's mother was diagnosed as having fibrosarcoma in
1979. Her cancer began in the leg and spread to her brain. Her son
was the only child who was physically deformed, having Treacher Collins
Syndrome. The mother reported her son denied her illness. He said he
had questions about cancer he would like answered. He was a below average student and the most immature and youngest of the group.

Families of the Group Members

All four families had both parents living in the home. The mothers were undergoing chemotherapy at the time of their children being involved in this study. The children knew their parent had cancer. The children reported believing in God and attending church. None of the children had been involved in counseling related to their parent's cancer. All the children were from multiple sibling homes. The fathers were employed as were two of the mothers. Two of the families owned their own business. No low-income families were involved in the study.

Subjects One, Four, and Six reported they missed their father because he was away from home so much because of the family business. The mother also was involved in it during the day. Communication was open to a degree in this family. The mother did most of the parenting. The father was reported to be understanding. The older girl was the model child, the middle girl, the social belle, and the youngest, the most happy-go-lucky, the boy. All had jobs in the home and consequences for not doing them were grounding, isolation, or taking away a privilege. The mother reported hollering and nagging at the children.

Communication with the father of Subjects Two and Three was reported by them as being hampered. They felt closer to their mother. The mother reported sometimes hollering at the children to do their chores. If they did not, they would lose privileges. The oldest of
these two had a part-time job in the father's business. He also was the only one to have a girl friend.

Subject Five's family had problems with internal communications, role reversals, and with the mother's coping with the cancer. Late in 1980, the mother went through an alcoholic treatment program. Subject Five was fourth out of five children. The youngest child went to the art therapy technician for counseling. Subject Five had chores at home and reported if he did not do them, his older brother yelled at him.

The mother of Subject Seven coped with the paralysis of her left arm and leg, necessitating role reversals in their family. The father worked nights. This Subject was the middle of three children, however, functioned as the oldest child. That child was away at an institution for the retarded. The mother became emotional during the parents' initial interview. Among other problems, she felt she expected too much of her son. Of all the mothers, this mother had the most serious case of cancer. Her son knew she may die. (She did in January, 1981.)

Review of the Instruments Used

The amount of state anxiety indicated perceived stress by the children. State anxiety, as described in the Manual for the State-Trait Anxiety Inventory (STAI) "is conceptualized as a transitory emotional state or condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension, and heightened autonomic nervous system activity." Spielberger terms state anxiety A-State anxiety.
State is to be differentiated from trait anxiety (A-Trait according to Spielberger) which refers to, stated the manual, "relatively stable individual differences in anxiety proneness, that is, to differences between people in the tendency to respond to situations perceived as threatening with elevations in A-State intensity."

The four youngest children were given the State-Trait Anxiety Inventory for Children (STAIC) which was normed on fourth, fifth, and sixth grade children. The older children were given the STAI. Both are self-report measures composed of twenty items each for the A-Trait (how you generally feel) and the A-State (how you feel right now). There is no time limit.

Norman S. Endler, Professor of Psychology and Chairman of the Department, York University, Toronto, Ontario, Canada, wrote in Buros' The Eighth Mental Measurements Yearbook, that the STAIC "is probably the best scale available for assessing anxiety in children." He said he "would recommend it over the CMAS and GASC, primarily on the basis of the care and precision with which it has been developed. I would, however, recommend it primarily as a research instrument; it is probably premature to use it in applied clinical work." He said, "It has a good theoretical basis, adequate norms, adequate reliability, and moderate validity."1

Two reviewers in Buros recommended the STAI very highly. They were Ralph Mason Dreger, professor of psychology, Louisiana State University, Baton Rouge, Louisiana, and Edward S. Katkin, professor of

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Psychology, State University of New York at Buffalo, Buffalo, New York.

Dregor stated that:

The revised STAI is one of the best standardized of anxiety measures, if not the best. Its faults are suggested in the previous paragraphs. From the many references in the literature to the STAI it appears that it is a popular test. For instruments of its type it appears to be deservedly popular, in that the reliabilities are nearly as high as one would expect for intelligence scales; it demonstrates expected differences among groups of persons; and its state form generates nonrandom factor structures when used over time. The only major reservation this reviewer has to recommending the STAI for both research and applied uses is its openness to faking.\(^1\)

Katkin stated that:

It appears that the STAI is an excellent choice for the clinical psychologist or personality researcher looking for an easy-to-administer, easy-to-score, reliable, and valid index of either individual differences in proneness to anxiety or individual differences in transitory experience of anxiety. The test is carefully described in the manual, there is a voluminous research literature attesting to its reliability and validity in a variety of contexts, and the test is grounded well in psychological theory.\(^2\)

The STAIC was begun in 1969. The manual, accompanying the test, was copyrighted in 1973. Developers were Charles D. Spielberger in collaboration with C. Drew Edwards, Robert E. Lushene, Joseph Montuori, and Denna Platzek. Test-retest reliability coefficients for the STAIC for fourth, fifth, and sixth grade school children over a six-week interval were males: .65 A-Trait and .31 A-State, and females: .71 A-Trait and .47 A-State. The manual states that test-retest correlations for the A-Trait scale were only moderate, probably reflecting both a limitation in the psychometric properties of the scale and the instability of personality structure in children of this

\(^1\)Ibid., p. 1095.

\(^2\)Ibid., p. 1096.
age. The alpha reliability coefficients for A-Trait and A-State were computed for a Leon County sample, cited in the manual, using the Kuder-Richardson formula 20 as modified by Cronbach (1950). For the A-Trait scale, the alpha coefficients were .78 for males and .81 for females. The A-State alpha coefficients were .82 for males and .87 for females. Alpha coefficients for the A-State are better indicators of reliability than test-retest because A-State is influenced by the child's emotional feelings at the time of testing and is expected to fluctuate, thus having a low test-retest correlation. The test maker feels the internal consistency of the STAIC scales is reasonably good and the test-retest reliability of the A-Trait scale is moderate.¹

The STAI was begun in 1964. The manual, which includes a copy of Form X, was copyrighted in 1970. Developers were Charles D. Spielberger, Richard L. Gorsuch, and Robert E. Lushene. After testing a group of college undergraduates, the test-retest correlations for the A-Trait scale ranged from .75 to .86, for males, and .76 to .77, for females. Those for the A-State scale ranged from .33 to .54, for males, and .16 to .31, for females. The test maker felt the A-Trait correlations were "reasonably high" and those for the A-State, although low, were anticipated because of the reflection of the test conditions manipulated by the testers. The alpha reliability coefficients for the STAI scale were computed by formula K-R 20 as modified by Cronbach (1950) for the above normative samples. The A-Trait alpha reliabilities ranged from .86 to .90, for males, and from .86 to .92, for females, while the

A-State ranged from .83 to .89, for males, and from .86 to .92, for females.¹

Cronbach states that the better inventories show reliabilities of .80 and above in parallel-form, internal-consistency or correlations between inventories having similar scales of self-report measures.² His definition of the alpha coefficient is that it relates how well scores obtained by testing under just one condition represent universe scores, the mean.³

To serve as a contrast to Spielberger's STAI and STAIC, Anastasi wrote about the reliabilities of several self-report measures. She said the test-retest reliabilities on normal and abnormal adult samples for the Minnesota Multiphasic Personality Inventory are reported in the manual and range from the .50s to the low .90s. The intervals varied from a few days to over a year.⁴

The California Psychological Inventory retest reliabilities, she reported, yielded a median coefficient of .80 over intervals of one to three weeks in an adult group. The median reliabilities were .65 for males and .68 for females with a one-year interval in high school groups.⁵


³Ibid., p. 160.


⁵Ibid., p. 448.
She found that the Edwards Personal Preference Schedule manual reported retest reliabilities range from .74 to .88 over a one-week time period.\(^1\) Of the Myers-Briggs Type Indicator, she found the manual stated that, with some exceptions, split-half reliabilities computed in samples of high school and college students (N=26 to 100) are in the upper .70s and .80s.\(^2\)

STAI Trait score validities were estimated by correlating the scores with the IPAT Anxiety Scale, the Manifest Anxiety Scale, and the Affect Adjective Check List. For 126 college women, coefficients were .75, .80, and .52 respectively. For 80 college males, they were .76, .79, and .58. To determine the validity of the A-State, subjects were given the A-State scale under two different sets of instructions, one being a normal set and the other to imagine oneself in a stressful situation. To indicate this are the following scores for college students. The 332 males scored 40.02 under normal conditions and 54.99 under stressful conditions. The critical ratio was 24.14 and point-biserial correlation was .60. The 645 college females scored 39.36 under normal conditions and 60.51 under stressful conditions. The critical ratio was 42.13 and the point-biserial was .73.\(^3\)

Validity of the STAIC is not as far advanced as for the STAI. The Manual reported that the concurrent validity of the STAIC A-Trait scale is shown by its correlation with the Children's Manifest Anxiety Scale (CMAS) and the General Anxiety Scale for Children (GASC). The STAIC A-Trait scale correlated .75 with the CMAS and .63 with the GASC

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\(^1\)Ibid., p. 454.  
\(^2\)Ibid., p. 455.  
\(^3\)Spielberger and others, pp. 9-10.
in a sample of 75 children. The construct validity of the A-State scale for a sample of 913 children, fourth, fifth, and sixth grade students (456 males and 457 females) is as follows: under normal conditions, males 31.10 and females 31.03; under stress conditions, males 41.76 and females 43.79.¹ There were no critical ratios nor point-biserial correlations for the entire scale.

Administration

To aid test-retest reliability, the following directions preceded the instructions printed on each test form:

Your scores on this test are important. This is a special project to help other children like you. Thus, your scores on this test will help them.
You have been assigned a number on your test answer sheet. Your name will not be used. Someone other than the counselors will score your answer sheet. Your parents will not see it.
Thank you for helping us by telling us exactly how you feel.

The STAI and STAIC are self-administering and have no time limit. Young children might need to have the STAIC read to them. That was the case for the two youngest children in the sample studied. As recommended, the A-State was presented first when both A-State and A-Trait scales were given because A-State scores are influenced by the immediate environment.

Testing time is from 8 to 12 minutes to complete one scale and up to 20 minutes to complete both. Repeated test taking required about 5 minutes or less.

Scoring

The STAI scores on each scale ranged from 20 to 80 and on the STAIC, from 20 to 60. To have them both on the same scale, they

¹Spielberger, Gorsuch, and Lushene, pp. 10-14.
were converted to normalized T-scores (mean=50; SD=10). ¹ (See Appendix E.)

**Counseling Goals and Expectations**

The group counseling model program served as the treatment of the seven children. It consisted of six 1½ hour sessions preceded and followed by the STAI or STAIC self-report anxiety measures. The sessions followed a typical format of business, a method to arrive at feelings and processing of those feelings or skills teaching, and culminated with utilization of a relaxation technique entitled the Quieting Reflex (QR) for Young People by Margaret Holland, Charles Stroebel, and Elizabeth Stroebel. This researcher, who is a counselor and an art therapy technician, led the group.

The goals of the group counseling program for the children were:

1. To recognize, express, and deal with emotions constructively;
2. To develop communication skills for handling difficult situations;
3. To explore their own and others' values; and
4. To learn a relaxation technique they can incorporate into their daily lives. (See Appendix C.)

The following rules were introduced to the group at the beginning of the first session and followed throughout:

1. Speak for yourself—not for anyone else;
2. Listen to others—then they'll listen to you;
3. Avoid putdowns—who needs them;

¹Based on personal correspondence between Lynne G. Westberry, M.A., Graduate Assistant to Charles D. Spielberger, Ph.D., Professor of Psychology, Director, Center for Research in Community Psychology, University of South Florida, College of Social and Behavioral Sciences, Human Resources Institute, Tampa, Florida, and the author, February 25, 1981.
4. Take charge of yourself—you are responsible for you; and
5. Show respect—every person is important.

**Techniques Used in Counseling**

Composing the counseling sessions were various techniques used to arrive at the counseling goals. They were: music; art; handouts; video-taped vignettes; empathic assertiveness training; Quietening Reflex (QR) for Young People; and medical consultants.

**Music**

Easy listening music from a local FM radio station was played quietly during each counseling session. The radio was turned off if it interfered with discussion or when the relaxation tapes were played.

**Art**

Art techniques were used to facilitate the expression of affects. Because there was such a short time of meetings, it was felt using art would speed up the process. The children expressed themselves through various art mediums and then each member processed his/her own. This process was facilitated by the adult leaders.

Rubin states that stressful periods frequently coincide with increased productivity and that regression is associated with stress. For growth to take place, she stated, previous blocks must be in some way dissolved.¹ She said:

For many children, both hyperactive and inhibited, experimenting with a freer, more honest form of creating may be

essential to convince them that, in this symbolic mode, they can indeed let go, express strong feelings with free movements, and remain in control of impulses which turn out neither to be as destructive nor as disorganizing as anticipated. It is only after such a symbolic "letting loose" that familiarity with the feared experience permits them to freely grow.¹

Peckham stated that, "Only in protected situations, characterized by high walls of psychic insulation" can a child allow himself/herself to "experience disparities, tensions, etc. . . . art offers precisely this kind of experience."²

Approximately one hour and twenty minutes were allocated for art projects and processing in the first three sessions. Art also was used in the last session for about one hour.

Handouts

Several handouts were given to the children. They were: a sentence completion form; a form with a list of words on which the children drew a line description; and an evaluation form on which the children were to indicate their positive and negative feelings on a likert scale about the counseling session components, the group, and themselves.

Empathic Assertiveness Communication Training

Children need to develop the skills to communicate their needs. Sometimes in stressful situations, their needs go unmet. Not because parents want to slight their children but because their attention might

¹Ibid., p. 24.

be elsewhere. Kessler and Bostwick teach a process of communication entitled empathic assertiveness training to the children they counsel who are involved in divorcing families.¹ This researcher adapted this process for this group. It involved an introduction of assertiveness training and the empathic assertiveness communication model which is a sentence containing three parts. They are: (1) empathy—showing an understanding of what the parent felt; (2) content—presenting what the speaker felt; and (3) action—calling for a response. The children practiced this model following the video-taped vignette processing.

**Vignettes**

Six short video-taped vignettes were developed for the counseling sessions in order to stimulate discussion, support for group members, and reasons for learning empathic assertiveness communication skills.

Through reading in the literature and discussions with staff at Oncology P.C. Clinic, and P. J. McDonald, M.S.W., Human Service Associates, both of Des Moines, Iowa, it seemed as if there were several themes that might lead to disfunctional families. Video-taped vignettes were made of these themes which are presented and discussed in counseling sessions four, five, and six further on in this chapter.

**Medical Consultants**

During the vignettes, a nurse was in attendance to answer any questions of a medical nature. During the last session, a doctor visited with the children at their request.

¹Kessler and Bostwick, pp. 39-40.
Quieting Reflex for Young People

Another component of the group counseling program was teaching the children a relaxation technique. Thus, when they felt stressed, they could automatically calm their bodies so their minds could function. The Quieting Reflex (QR) for Young People was the technique taught to the children.

The QR for Young People is based on the Quieting Reflex invented by Charles Stroebel in 1974.\(^1\) It is a six-second relaxation technique that involves the mind and body. The technique is as follows:

1. The children sense fear, worry, or anger and decide if they should flee or fight (the emergency response) or quiet themselves;
2. They then do a QR by:
   a. Smiling and thinking to themselves, "I can keep my body calm."
   b. Breathing in through imaginary holes in the bottom of their feet and taking the breath up to their shoulders;
   c. Allowing their tongues to lie flat on the floor of their mouths;
   d. Dropping their shoulders; and
   e. Taking the breath down and out through the holes in the bottom of their feet.

The technique is learned gradually on a series of six tapes distributed by the QR Institute. The tapes also teach other relaxation exercises that children could use. The children also had a QR log they completed between sessions. The log was only for their personal use and not shared.

At the end of each session, the children were asked if they

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\(^1\) Margaret Holland, Charles Stroebel and Elizabeth Stroebel, QR for Young People Manual (Wethersfield, Connecticut: QR Institute, 1979), pp. 7-10.
had questions about their QR logs. They then listened and responded to a QR tape.

Outline of the Counseling Sessions

The treatment in this study consisted of six 1\frac{1}{2} hour group counseling sessions. In addition, approximately ten minutes were added to each session to administer the anxiety measures which preceded and followed each session. Each session will be outlined in the following discussion. Easy listening music on a local FM radio station was played in the background of each session unless it conflicted with discussion. The music was not played when the relaxation tapes were played.

Session One

The purposes of session one were to become acquainted and to build group cohesiveness. Following the State-Trait Anxiety Inventory for Children (STAIC) and the State-Trait Anxiety Inventory (STAI) A-State anxiety measures, various business items were handled. They were: each of the facilitators and members introduced himself/herself; each member told what he/she wanted to receive from the group; an overview of the counseling sessions was presented; and the behavior expectations were given.

As part of the becoming-acquainted process, the group members, including one counselor, formed diads. Each diad had an 18 x 24 sheet of white paper. Four packages of felt-tipped markers were available for drawing. Instructions were to converse nonverbally with their
partner through drawing.\footnote{Elinor Ulman and Penny Dochinger, \textit{Art Therapy} (New York: Schocken, 1977), p. 137.} Following this, children were helped to express their feelings about their drawing and their partner's.

Then, a sentence completion form was handed out to each of the children. The purposes were to focus on why the children were in the group, on the fact that they had a parent with cancer, and on helping them become acquainted. The children shared their feelings they expressed on this form. This sharing facilitated their knitting into a group as they discovered their commonalities of experiences about having a parent who had cancer.

The counseling session was closed with an introduction of the Quieting Reflex (QR) for Young People, an adaptation of the QR invented by Charles Stroebel. Each child was given a QR log to complete between sessions. The log was for their own personal use and not shared. The exercises in the log helped to raise the children's awareness of stress. Tape one of the QR for Young People was played.

The STAIC and STAI A-State anxiety measures were given.

Session Two

For the children in the group to understand their feelings and themselves in relationship to their family was the goal for session two. To begin with, the STAIC and STAI A-State anxiety measures were given, and business was conducted.

To introduce how the children can express feelings and words through art, the children then were given a handout entitled "Seeing by Drawing" with a series of words on it and asked to draw in a line
what it might mean to them. Examples of the words were: dance, sleep, anger, happy, illness, lonely, fear, depressed, patience, sad, love, etc. Children shared their line drawings if they wished. Next the children draw with felt-tipped markers on 5 x 8 index cards a picture of something they feared. They took turns and shared their fear.

This led into a planned discussion of feelings, how children think about a feeling, physically feel it in their body, and express feelings verbally and nonverbally in safe and unsafe ways.

Finally, the children made a family and self collage. Materials needed were 18 x 24 sheets of white paper divided into three sections marked mother, father, and self, and vari-colored construction paper. The purpose was to understand how individuals are affected by their parents and acquire some of their traits. Instructions were to tear out shapes to represent three positive and three negative attributes of each of their parents and themselves. After that, the collage was processed as to content and feelings.

The session was ended with any needed help on the QR log, tape two of the QR and the STAIC and STAI A-State anxiety measures.

Session Three

The purpose of session three was to help the children understand themselves. Following the administration of the STAIC and STAI A-State anxiety measures, business was conducted.

The purposes of this session's exercise for the children were

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1 Jeannette Wright, Art Therapy Practitioner, Iowa Methodist Medical Center, Des Moines, Iowa, Collection of Techniques Used in Art Therapy (Mimeoographed), 1979, Technique "Seeing by Drawing."
to rate their feelings of themselves and another in relationship to a number and communicate angry feelings with that person. Materials needed were 5 x 8 index cards, pencils, and children's blocks. Instructions were to write from one to ten on the 5 x 8 index card and to draw a circle around the number that best describes himself/herself. Following that, the children were to think of someone each of them had been angry with recently or in the past. They then were to circle a number for that person. Using the blocks, each of the children were to depict the angry event. Afterwards, the children took turns explaining their angry event and told about why they identified with a certain number and likewise why they ascribed a certain number to the person at whom they were angry.¹

The second art exercise to help the children understand themselves was with bodily sensations. Materials needed were 5 x 8 index cards, felt-tipped markers, non-hardening clay, and newspapers. The children were asked to think of a pain they might have in their body, localize it, and draw how it appears. After that they were to mold it in clay. Children processed their pictures and their clay project. Following that they were asked to change the clay shape until it was without pain. Then, the children were asked if they felt better physically.²

Providing help on the QR log if needed, playing tape three of the QR, and administering the A-State anxiety measures of the STAIC and STAI concluded the session.

¹Ibid., Technique "Reconstructing Anger."

²Ibid., Technique "Physical Pain Image."
Session Four

Session four's purpose was to give the children a skill they could use with significant others in order to show understanding of others while still having their needs met. To begin the session, the STAIC and STAI A-State anxiety measures were given. Any business was conducted.

The skill taught was empathic assertiveness communication training. First the children were introduced to assertive behavior. The children were taught to tell the difference between nonassertion, aggression, and assertion. They also were taught the difference between "I" and "you" statements. A discussion was held, and the children gave examples of the different ways of communicating.

The children were talked to as to their responsibility in making their needs known while at the same time respecting their parents' needs. That was the crux of the empathic assertiveness communication model which is a sentence containing three parts: (1) empathy--showing an understanding of what the parent felt; (2) content--presenting what the speaker felt; and (3) action--calling for a response. After hearing the counselor give some examples of these sentences, the children broke into two groups, each with an adult, and practiced these responses. An example was: "Dad, I realize you are working late to earn extra money and tired when you come home (empathy), however, I get lonely at home by myself (content), so I'd like you to save me two hours this weekend so we can go to a movie (action). This communication model preceded the introduction of the video-taped vignettes.

---

1 Kessler and Bostwick, pp. 39-40.
Two vignettes were presented in session four:

1. The scene implied a trip to and stay in the hospital. The mother was shown packing her suitcase. The parents excluded the children from being involved with the preparations.

2. The scene was at home, and the parent was suffering treatment effects which could include weight loss, sick more than well, lack of energy, and personality change. The children were worrying about her. She told them to go outside and play.

Questions asked of the children to generate discussion were:

1. What are the parents assuming?
2. How do they feel?
3. What are the children trying to do?
4. How do they feel?
5. Did this happen to you?
6. What would appropriate empathic assertiveness responses be?

During the vignette showing and discussion, a nurse from Oncology P.C. was present to answer questions and provide any needed information or insight.

The session was concluded with help on the QR log if needed, presentation of tape four of the QR, and the administration of the STAIC and STAI A-State anxiety measures.

Session Five

Skill building was also the purpose of session five. Following the administration of the STAIC and STAI A-State anxiety measures and the business session, three video-taped vignettes were shown. After each vignette, the children processed (see questions in session four) and practiced the empathic assertiveness communication model.

The third vignette theme was:

3. The scene depicts the daughter at her mother's knee, plaintively wondering who was going to take care of her, etc., if the mother died. Possible loss of the parent brought up such issues as safety, money, bereavement, and child care.
Kubler-Ross' stages of anticipatory grieving were included in the discussion following this vignette. They are: (1) denial and isolation; (2) anger; (3) bargaining; (4) depression; and (5) acceptance.

Vignettes four and five were:

4. The scene showed a kitchen with the mother and children around the kitchen table. The father walked in after work to dinner not ready, hungry children, an ailing wife, and a P.T.A. meeting to attend that night. Problems of parenting, role changes, rules, and who attends functions were the concerns.

5. The scene demonstrates lack of home management, giving the children either too much or too little responsibility. The ill mother was shown overloading the children with work. She said for them to stay nearby and be quiet as she had to take a nap.

Again, an Oncology P.C. nurse was present during the vignettes.

The session was concluded by providing any needed help on the QR log, presentation of tape five of the QR for Young People, and giving the A-State anxiety measures of the STAIC and STAI.

Session Six

Building skills, wrapping up the group counseling program, and evaluating it on the part of the children were the goals of session six. Administering the STAIC and STAI A-State and A-Trait anxiety measures and handling any business began the session.

Vignette six was shown and processed (see questions in session four) followed by the children practicing the empathic assertiveness communication model. The theme of the vignette was:

6. The scene illustrated the reactions of peers such as their being negative, shy and confused, and having inaccurate information about the illness. The children were shown talking about how their peers felt about their mother having cancer.

To culminate the program and to have the children evaluate
their growth, the children were directed to paint a mural. They were requested to paint what they learned about themselves. Then they processed their painting—what they had learned and how they had grown. Materials needed for the mural were: four-foot by six-foot white poster board with a hard finish, water color paints, brushes, and newspapers. Photographs were taken of the children and their mural. The facilitators also reviewed with the children the intentions of the program, the components, and their continued use by the children.

An evaluation form was handed out at the conclusion of the last session for the children's completion. They were to indicate their positive or negative feelings on a likert scale about the counseling session components, the group, and themselves. (See Appendix G.)

The QR log was discussed, and the sixth tape of the QR was presented. The final administration of the A-State anxiety measure of the STAIC and STAI was completed.

Treatment of the Data

The data pertaining to this study was obtained from the administration of the State-Trait Anxiety Inventory for Children (STAIC), grades four through six, and the State-Trait Anxiety Inventory (STAI), older children and adults.

During week one of the control period, each child was administered the STAIC or STAI, both A-State and A-Trait. The parent(s) were interviewed to collect information about the family life-style, problem-solving techniques, and how the family meets the needs of its members. The referred child also was interviewed to determine the child's
perception of the problem, coping mechanisms, how he/she interacts in the family, and how he/she has his/her needs met.

Interview forms were designed by the researcher for the children and their parents first and second interviews during the control period. ¹,²,³ (See Appendix D.) Interviewing served several purposes: for the researcher to meet the children and their parents; to establish rapport with the family; to motivate both the children and the parents; to secure the support of the parents; to inform both the parents and the children of the goals and content of the sessions; to glean information that might be helpful to cover in the sessions; and to firm up times and dates for the six counseling sessions.

Each child, during week three of the control period, was administered the STAIC or STAI, both A-State and A-Trait. Each child was interviewed to determine if anything unusual was happening in the child's life to raise the A-State score. (See Appendix D.) The doctor was asked to comment on the parent's health. The parent was asked to comment on the child's life.

During the treatment period, each child was administered the STAIC or STAI A-State prior to and immediately following counseling. Prior to counseling session six, the STAIC or STAI A-Trait was administered.

¹Information from Marilee Fredericks, Ph.D., Director, Child Guidance Center, Des Moines, Iowa, by telephone, May 20, 1979.

²"Outline for Writing Social Assessment and Final Assessment and Recommendations," Mitchellville Training School (Mimeographed and Undated), Mitchellville, Iowa, pp. 1-12.

³Parad and Caplan, pp. 3-15.
The A-Trait test measured the children's personality disposition towards being anxious, while the A-State test measured their tense and apprehensive feelings which are of a transient nature, depending upon the stress the child is experiencing at the time.

The children also completed an evaluation of the counseling after the sixth session. (See Appendix G.)

Analysis of the Data

The examination of the literature related to this study suggested to the researcher the possibility of utilizing group counseling to reduce the stress of children who are in families who have a parent with cancer. With this thought in mind, the researcher stated the following null hypotheses:

1. There will be no statistical difference among the repeated measures of A-State anxiety; and
2. There will be no statistical difference among the repeated measures of A-Trait anxiety.

STAIC and STAI scores assessed the children's A-State and A-Trait anxiety. The raw scores were converted to normalized state and trait T-scores (mean 50; SD 10). (See Appendix E.)

Because of the variation in the children's backgrounds and experience, they might respond differently to the experimental treatment. Separating this variability from treatment effects and experimental error increased the sensitivity of the experiment. If it cannot be estimated, the subject variability can become part of the uncontrolled sources of variability and a part of the experimental error.\footnote{Winer, pp. 261-2.} To
control for this, a one-way analysis of variance with repeated measures was figured. Alpha level was .05.

If any unusual scores occurred during the control period, the information collected from interviewing was examined to ascertain whether there was a logical explanation for it. The mean change of the pre and post A-State anxiety scores also were analyzed for each counseling session. Finally, the children's evaluation of the counseling was looked at. The data is presented in Chapter 4.

Summary

The investigation was designed to ascertain if a group counseling program could make a statistically significant reduction over time on the anxiety level of children who were in families who had a parent with cancer.

The sample was a group of seven children, aged nine through fourteen, who had a parent who was a patient of S. Fred Brunk, M.D., and Thomas R. Buroker, D.O., oncologists in Des Moines, Iowa.

The total study lasted nine weeks; four weeks when the group was only tested and interviewed and five weeks over which the counseling took place. Two counseling sessions each were held weeks five, six, and nine. Summer schedules of the parents partly determined the spacing of the sessions. The study was during the summer of 1980.

The treatment was a model group counseling program of six sessions. It contained such components as self-exploration using art, video-taped vignettes, empathic assertiveness communication training, and a relaxation technique entitled the Quietting Reflex for Young People.
For collection of data, the State-Trait Anxiety Inventory for Children and the State-Trait Anxiety Inventory measures were used. Each test measured A-State and A-Trait anxiety. The A-Trait measure was administered weeks one, three, and nine. A-State measurements were taken weeks one and three during the control period and pre and post every counseling session during the treatment period. A one-way analysis of variance with repeated measures was figured. Other data examined were information collected during the control period interviewing, mean changes of the pre and post A-State anxiety scores for each counseling session, and the children's evaluation of the group counseling.
Chapter 4

PRESENTATION OF THE DATA

This chapter presents data from this study and the researcher's analysis of that data. Results from the State-Trait Anxiety Inventory for Children (STAIC) and the State-Trait Anxiety Inventory (STAI) A-State and A-Trait anxiety will be evaluated for the children. Also presented are the counseling session goals, the counseling session results, and an evaluation by the children. A summary concludes the chapter.

Report of the Findings

Data collected to test the hypotheses were from the scores on the STAIC and STAI, measures of A-State and A-Trait anxiety. The A-State test measured the children's tense and apprehensive feelings which are of a transient nature, depending upon the stress the child is experiencing at the time. The A-Trait test measured the children's personality disposition towards being anxious.

Significant differences were found (p<.01) among the children on A-State anxiety scores. (See Table 1.) No significant differences were found among the A-State repeated measures at the .05 or .01 level. However, they were significant at the .10 level. These findings are reported in Table 2 and illustrated in Figure 1.

In terms of the A-Trait anxiety scores, it was found there were significant differences (p<.01) among the children. (See Table 4.)
Table 1
A-State Anxiety T-Scores

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| Mean    | 55.14| 50.43| 49.0 | 44.14 | 45.70 | 44.70 | 52.0 | 45.86 | 47.14 | 43.57 | 50.43 | 49.57 | 49.71 | 47.86 |
### Table 2

Single Factor Repeated Measures Analysis of Variance
For the Children's A-State Anxiety Measures

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*p < .01

### Table 3

A-Trait Anxiety T-Scores

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<td>Total</td>
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Mean 47.0 46.29 46.14
Figure 1

Mean Change of the Children's
A-State Anxiety Scores
Table 4
Single Factor Repeated Measures Analysis of Variance For the Children's A-Trait Anxiety Measures

<table>
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*p < .01

Figure 2
Mean Change of the Children's A-Trait Anxiety Scores
Also, there were no significant differences in the A-Trait repeated measures at any probability level, illustrating that A-Trait anxiety was consistent throughout counseling. This information is included in Table 5 and shown in Figure 2.

Thus, both hypotheses were accepted which were:

1. There will be no statistical difference among the repeated measures of A-State anxiety; and
2. There will be no statistical difference among the repeated measures of A-Trait anxiety.

Information was collected from interviewing the parents, children, and the doctors to help explain any unusual stress on the part of the children. It was found there was no unusual stress of a significant nature to affect the children other than what they were experiencing already.

Presentation of the Counseling Session Goals

The model group counseling program consisted of six 1½ hour sessions. In the following narrative, each session's goals are presented.

Session One

Becoming acquainted and building group cohesiveness were the goals of this session. To help meet both these ends, an art technique called conversational drawing as well as a sentence completion form were used. During the former, children were paired and had to draw without talking on the same sheet of paper. The latter involved completing sentences about one's experience with cancer in the family and its ramifications on the family's lives. The Quieting Reflex (QR) for
Young People was introduced also. Goals, expectations, and group rules were discussed.

**Session Two**

The purpose of this session was for the children to understand their feelings and themselves in relationship to their family. The group drew with markers line drawings of such words as drink, dance, and love. Then they drew pictures depicting their fears. Death of their parent was a common fear. A discussion of feelings was held. Finally, they did a family and self collage in which they depicted the positive and negative attributes of each parent and of themselves. This was processed and followed by the QR.

**Session Three**

The goal for this session was understanding oneself. The first exercise involved talking about rating oneself between one and ten, processing that, rating a person one is angry with, describing the angry situation by using wooden blocks and processing it. Afterwards a discussion was held about safely expressing anger. The second exercise involved the children in drawing a picture of an existing or previous pain in their body, then modeling it in clay. Afterwards, they processed the pain and their feelings about it and then they smoothed out the pain image in clay to rid the molded body of the pain. They were asked to respond to having no pain in that area. The session was ended with the QR.
Session Four

The goal of this session was to build skills by teaching the children empathic assertiveness training. Two video-taped vignettes were shown on: (1) the children being excluded from packing for the parent's hospital visit, indicating parents keeping information and inclusion from the children; and (2) the mother at home suffering treatment effects and how that affects her interacting with the children. During the vignettes, a nurse was present. After each vignette, the children discussed the vignette, their experiences, and their feelings, practiced empathic assertiveness statements they could use in these situations, and talked of their mother's cancer with the nurse. The QR also was employed.

The researcher began the session with the QR and then a story and discussion of the disruptive behavior of the youngest child. The child agreed to be placed on a behavior modification program to help him become an effective listener and contributor. He earned a plus ten cents for each time he waited his turn to talk and a minus ten cents for each time he interrupted. His reward was to go shopping with the researcher and spend what was left out of $2.00 after he added and subtracted his behavior points. The group members were in full accord as to supporting his attempt for good behavior.

Session Five

Practicing empathic assertiveness training was the main goal of this session. The children viewed three vignettes: possible loss of a parent; role changes of parents; and home management. These were processed, and then the children practiced empathic assertiveness
communication. A nurse was present for the discussion. The session was ended with the QR.

Session Six

The continuation of skill building, wrapping up, and evaluating were the goals of session six. The sixth vignette on peer reaction to a child's parent having cancer was shown and processed, and empathic assertiveness communication skills practiced. Dr. Brunk visited with the children at their request. To help the children focus on their own growth, they were asked to paint a mural of what each had learned about himself/herself. Then they verbally processed what they learned. They also completed a likert scale type evaluation form. The session was ended with the QR.

Presentation of the Counseling Session Results

The six counseling sessions were evaluated individually as to their lowering of the A-State anxiety as expressed by the children. The session results are discussed in this section.

Session One

This session had the next to the highest A-State anxiety reduction ($\overline{0}_{4} - \overline{0}_{3} = 4.86$) and was significant at the .05 level ($t = 1.95$). It was the only session that had a statistically significant reduction of expressed A-State anxiety.

The students had waited from twenty-six to twenty-eight days for this first session. Possibly there was relief just in the fact it occurred. The students did express relief in knowing they were not the
only children who were in families who had cancer and were experienc-
ing the same problems. Since this was the first time the QR was intro-
duced, it is thought that the effect would not be that substantial.

Session Two

This session had a mean change between pre and post test
A-State anxiety scores of 1.00, the next to the lowest improvement in
lessening A-State anxiety. Possibly it was not an effective session
in that the group members were protecting their family situations and
not sharing enough to alleviate their anxiety.

Session Three

Expressed A-State anxiety had the most increase (\(\bar{O}_7 - \bar{O}_5 = 6.30\))
prior to group counseling session three. The pre counseling A-State
anxiety level fell between the \(O_1\) and \(O_2\) control levels. Predomi-
nantly one child's score raised and lowered the anxiety level.

This child processed at length his anger with his father. The
problem was looked at from both his side and his father's, and in terms
of their feelings, possible solutions, and the consequences for each.
In the second exercise, this same child told of wanting to go out for
sports and the physical price he would have to pay. He seemed to find
relief in the session and also reported back the next session that he
was working on the problem. His pre and post test scores on session
three and four reveal less A-State anxiety 58-42 and 30-27.

One can offer other guesses as to why the pre counseling ses-
sion anxiety was very high. Living with a life threatening illness is
a tension-producing situation. Counseling can temporarily relieve the
stress but the children had not had a counseling session for ten days.
It is possible there was apprehension about sharing feelings in the session.

This session had the most decrease ($\bar{O}_{8} - \bar{O}_{7} = 6.14$) in A-State anxiety, but it was not statistically significant at the .05 level ($t=1.74$). Other reasons for the decrease might be: (1) possible relief to be back to counseling after ten days absence; (2) possible relief at being back to a support group after ten days recess; (3) being able to process one's feelings and to have a better understanding of one self; and (4) being better able to employ the QR relaxation technique.

**Session Four**

Mean change in this session was third highest, 3.57. The children seemed to be relieved that an attempt was being made to tackle the one student's behavior. The QR could better relax the group at this point and was employed at the beginning of the session to get their attention as well as the end. This session was the following day of session three which appeared so relief providing. There was no art during this session.

**Session Five**

Session five's mean change of A-State anxiety had the lowest improvement of all six sessions. No counseling had occurred for twenty days and pre-test anxiety had risen ($\bar{O}_{11} - \bar{O}_{9} = 3.29$). However, not as high as before the third session ($\bar{O}_{7} - \bar{O}_{5} = 6.30$).

The youngest child on the behavior modification contract was ready to give up the contract, fearing he would fail. The situation was processed in the group, and he was encouraged to keep trying. His
A-State anxiety increased from 65 to 78 during this session. The group problem-solved with another member on her relationship with her father. Her anxiety remained the same (58-58).

The session was highly cognitive. No art was used. If there is high A-State anxiety, the children will be prone to less likely handle cognitive material. The cognitive material, the vignettes, were centered on the family about which the children might still be blocking sharing their feelings as in session two. Both of these sessions showed the least improvement in lessening A-State anxiety.

The children knew when they returned to this session it was one of the last two sessions. Maybe the children were beginning to feel abandoned, maybe lose interest, maybe felt less like sharing since the group sessions were almost over. The family situations the children lived in were high in stress, and stress is hard to totally alleviate. Four of the seven children had been on vacation during the twenty days.

Session Six

Mean change between the pre test A-State anxiety and post test was 1.85, the fourth lowest change in A-State anxiety. One child who confided a problem to the group during session five reported relief during this session. Two of the six children confided problems with peers in relation to cancer in the family.

The mural reflected happiness, a change from drawings in earlier sessions. The children expressed their positive feelings about the group, its support, making friends, lessons learned, and relaxation. There was talk about maintaining the support group during the
coming school year. Two of the boys had spent an over night with each other.

Possibly some of the reasons of the lowered anxiety-reducing effect of the session were: the children knew it was the last day; they had been to the fifth session the previous day; they may have been beginning to feel abandoned; or they may have begun to lose interest.

**Evaluation by the Children**

At the end of the sixth counseling session, each child was asked to evaluate the model group counseling program. (See Tables 5 and 6.) Questions 3, 5, 7, and 9 were reversed, necessitating the subject to read all questions. For purposes of arriving at the mean, these questions are reversed below. One subject's evaluation was eliminated because he marked very satisfied or strongly agree for each question. Below is the Likert Scale for the evaluation, each question and its mean.

<table>
<thead>
<tr>
<th>Weight</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not satisfied at all or strongly disagree</td>
</tr>
<tr>
<td>2</td>
<td>Could do better or mildly disagree</td>
</tr>
<tr>
<td>3</td>
<td>So-so or neither agree nor disagree</td>
</tr>
<tr>
<td>4</td>
<td>Moderately satisfied or mildly agree</td>
</tr>
<tr>
<td>5</td>
<td>Very satisfied or strongly agree</td>
</tr>
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</table>
Table 5
A-State Anxiety Reduction for Each Counseling Session

<table>
<thead>
<tr>
<th>Session</th>
<th>Pre Test</th>
<th>Post Test</th>
<th>Difference</th>
<th>D^2</th>
<th>Mean</th>
<th>t Test</th>
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<tr>
<td>1</td>
<td>343</td>
<td>309</td>
<td>34</td>
<td>260</td>
<td>4.86</td>
<td>1.95*</td>
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<tr>
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<td>320</td>
<td>313</td>
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<td>.33</td>
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<td>3</td>
<td>364</td>
<td>321</td>
<td>43</td>
<td>521</td>
<td>6.14</td>
<td>1.74</td>
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<td>330</td>
<td>305</td>
<td>25</td>
<td>481</td>
<td>3.57</td>
<td>1.06</td>
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<tr>
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<td>335</td>
<td>13</td>
<td>205</td>
<td>1.85</td>
<td>.84</td>
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</tbody>
</table>

df = 6

* alpha < .05

The highest mean on the following table (Table 6) is for question 10. The participants seemed to feel relief and a sense of comraderie with others in their same situation. Questions 9, using art, and 1, level of satisfaction, had the next highest means. The third highest, 7, was using the QR to calm themselves.

Helping to understand oneself and one's emotion, question 2, ranked fourth. Using empathic assertiveness training, 3, was ranked fifth out of eight by the participants. Question 5, enough time for individual participation, and 8, video tape vignettes, both were seventh as ranked by the subjects. Understanding my parents' feelings, 4, ranked lowest, mean 3.67, in the minds of the children.
Table 6

Children's Evaluation of the Model
Group Counseling Program

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Mean</th>
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<tbody>
<tr>
<td>1</td>
<td>What was your overall level of satisfaction with the group?</td>
<td>4.5</td>
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<tr>
<td>2</td>
<td>The group helped me understand myself and my emotions better.</td>
<td>4.17</td>
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<tr>
<td>3</td>
<td>The group helped me understand my values about life-threatening illness.</td>
<td>4.0</td>
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<tr>
<td>4</td>
<td>The group helped me understand my parents' feelings a little better.</td>
<td>3.67</td>
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<tr>
<td>5</td>
<td>I felt there was enough time for individual participation.</td>
<td>3.83</td>
</tr>
<tr>
<td>6</td>
<td>Using empathic assertiveness training helps me to relate to my family.</td>
<td>4.0</td>
</tr>
<tr>
<td>7</td>
<td>Using the QR helps me to calm myself.</td>
<td>3.3</td>
</tr>
<tr>
<td>8</td>
<td>Using the video tape vignettes helped me to evaluate how I felt having a parent with cancer.</td>
<td>3.83</td>
</tr>
<tr>
<td>9</td>
<td>Using art helped me to express and evaluate my feelings.</td>
<td>4.5</td>
</tr>
<tr>
<td>10</td>
<td>I learned that others shared similar problems because of their parent having cancer.</td>
<td>4.83</td>
</tr>
</tbody>
</table>

Summary

Because there are so many variables involved in the counseling content, in the counselors themselves, in the children, and in their feelings, it is difficult to isolate why the A-State anxiety was not reduced significantly over time by counseling. However, there was reduction at the .10 level.
A small sample can cause problems when children do not cooperate. It appears that two of the seven children on eleven out of the twelve intervention pre and post test scores individually answered the same questions. Because of their not participating honestly, the significance of the measurements likely dropped.

A-State anxiety is transient anxiety and depends upon how the child interprets the stimuli that is impinging upon him/her at that moment whereas A-Trait anxiety is relatively stable over time and indicates the child's predilection for anxiety. A-Trait anxiety, both during the control and intervention period, remained relatively consistent over time which was as expected.

The children lived in crises situations in that the mothers were being treated for cancer. The unknowns were recovery, recurrence, and death. Each counseling session was an intervention into that crisis. Because the crises never really ended, it would be hard to totally alleviate the stress.

It appears as if the most successful counseling session in reducing A-State anxiety had to do with expressing personal feelings. A-State anxiety in session one was reduced significantly at the .05 level. The other five sessions did not significantly reduce A-State anxiety as measured by the STAIC and STAI.

As far as the children's evaluation was concerned, they indicated very strongly that they learned others in the group shared similar problems because of their parent having cancer. The children were satisfied with the group. They also seemed to think using art to arrive at feelings and learning the QR and affective assertiveness communication training were helpful. They indicated counseling helped
them become more in touch with their feelings, more so than with their parents' feelings.

The children also said they would have liked more time to express themselves. The six vignettes occupied a third of the counseling time. The same material could have been presented differently to allow the children more time. Possibly, this could be done by having the children themselves role play the vignettes.
Chapter 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The research summary, conclusions, and recommendations will be included in this chapter.

Summary

Children suffer situational stress when their family experiences one of the parents having a life-threatening disease such as cancer. The stress never seems to totally dissipate as the family lives through the initial shock, hospitalization, chemo-therapy, remission, and possible reoccurrence. The children's lives are affected as they experience their parent weak and unable to parent. The situation causes a role change in the family, in decision-making, and in communication within the family and with the outside world.

Just as children have an external and internal homeostasis so does the family. Changes in one part of the family system will bring about changes in the other parts. The family system will arrive at homeostasis with the advent of changes. However, the way it reasserts itself may be dysfunctional rather than functional. A dysfunctional family can negatively affect the children. Helping it to remain functional will depend on the coping skills of the parents, whether they keep their children informed, whether they allow their children to be involved with the ill parents at the same time able to lead their own lives, and whether the parenting and home are managed effectively.
Children identify with their parents and need the boundaries they set. To be fully functioning, they need to be loved and cared for.

If parents have trouble coping, turning to others for help can be very helpful. Counseling is one source to which they may turn. Crisis counseling can help the families gain new coping skills and support systems to withstand the stress. One part of the system that could be counseled is the children which is what this research focused on.

Patients of S. Fred Brunk, M.D., and Thomas R. Buroker, D.O., oncologists in private practice in Des Moines, Iowa, volunteered selected children to form a group of seven for counseling. (See Appendix A.) This researcher wrote a model group counseling program which included such components as learning about oneself and one's significant others through art, understanding and expressing feelings, skills in relating to others including their parents, empathic assertiveness communication training, video-taped vignettes of family's coping skills, medical information on cancer, and a relaxation technique entitled the Quieting Reflex for Young People.

This researcher interviewed the parents and their children to gather information about the presenting problems, coping skills and family system. (See Appendix D.) The interview was also helpful in establishing a rapport with the family, in motivating them to come to the counseling sessions by explaining the content and how the counseling would support their family through the children's learning of new skills, and setting up the dates and times of the sessions.

The purpose of this study was to ascertain if the children's
situational stress herein described as A-State anxiety could be reduced over time through attending a model group counseling program.

The data collected were from the administration of the State-Trait Anxiety Inventory for Children (STAIC) and the State-Trait Anxiety Inventory (STAI) for older children and adults. The anxiety measures make a distinction between A-State and A-Trait anxiety as described by test-maker C. D. Spielberger. State anxiety is transitory and depends on how the environment is perceived. Trait anxiety is relatively stable over time and pertains to children's innate tendency toward anxiety. It was hoped in this study that the children's trait anxiety would be stable over time while their state anxiety would decrease because of their help through counseling. Information from interviewing the parents, children, and doctors as to the parents' health status were also used to explain any unusual stress. An evaluation of the group counseling by the children was another source of information collected. (See Appendix G.)

Assumptions underlying the study were that a volunteer group of children could be found whose parents' lives were such that the children were in situational stress, that the children were in a state of anxiety, and that a model group counseling program would be helpful to them in reducing their anxiety.

The subjects counseled were children of patients of S. Fred Brunk, M.D., and Thomas R. Buroker, D.O., oncologists in private practice in Des Moines, Iowa. Their parents needed to be diagnosed as having cancer at least two weeks and be still living. The children also needed to be of middle and late latency and not be mentally retarded.

There were several limitations of the study: no control group;
the small sample size; two families had five of the children in the sample; and lack of control for sex and intelligence of the group members.

Conclusions

The two null hypotheses tested were:

1. There will be no statistical difference among the repeated measures of A-State anxiety; and

2. There will be no statistical difference among the repeated measures of A-Trait anxiety.

Findings were that the F-test for the repeated measures of A-State anxiety was not statistically significant at the .05 level. The F-test on the repeated measures of A-Trait anxiety also was not significant at the .05 level. Both null hypotheses were accepted.

Information from the interviewing was not needed to explain the children's scores. However, it appeared as if two of the seven children on eleven out of the twelve intervention pre and post test scores individually answered the same questions. This could have affected the significance of the measurements. These subjects were two of the three youngest. Even though precautions were taken with administering the self-report measures, maybe they were not as serious as the other subjects.

The treatment was a model group counseling program of six one and one-half hour sessions over a five-week period. The six counseling sessions were ranked as to their lowering of the A-State anxiety scores. The counseling sessions having to do with expressing personal feeling seemed to be the most successful in reducing A-State anxiety. Those
dealing with the children in relation to their parents seemed to be the least successful in reducing expressed anxiety.

The children also evaluated the counseling sessions. One child's form was discarded because he answered very satisfied or strongly agree for each question. The highest ranked was that they learned others in the group shared similar problems because of their parent having cancer. The children were satisfied with the group. Using art to facilitate expression of feelings and learning the QR and empathic assertiveness communication training were all helpful indicated the children. They also felt that counseling helped them become more in touch with their feelings more so than with their parents' feelings.

About two-thirds of the children expressed in the evaluation that they would have liked more time to express themselves. Likewise the same amount said the vignettes helped them.

**Recommendations**

The following recommendations are based upon the findings in this study:

While no significant reduction in A-State anxiety was found over time, there is evidence from the children's ratings of the counseling sessions that they were helpful, and possibly further examination is still in order.

A better measurement of the treatment might be made by a self-concept scale such as the Piers-Harris Children's Self-Concept Scale. It is designed for grades three through twelve and has a total positive self-concept score and six subscores in the areas of behavior,
happiness-satisfaction, intellectual and school status, physical appearance, anxiety, and popularity.

To reproduce the study, the sample size should be increased. A small sample can reduce the significance and when, as in this case, two children did not cooperate, the outcome can be affected. A control group could be studied, or multiple groups in which the data is pooled. In the latter, a series of researchers could be commonly trained to administer the same treatment. Also, variables such as religion, intelligence, sex, family stability, and previous experience with stress might be controlled in a future study.

The counseling sessions' content could be changed in a repetition of the study. Possible the vignettes but not the themes could be eliminated. Their content could be arrived at in a different manner such as the children role-playing the themes. The children said they would have liked more time to express themselves and since the vignettes occupied a third of the counseling time, both of these ends might be met.

There was a lack of appreciation, it seemed, on the part of the children, for their parents' feelings and problems. It seemed that in each of the families, the communication was affected. Children sometimes were afraid and angry and worried but just contained the feelings. Possibly another counselor could work with a group of their parents while another counselor worked with them. Then, at some point or points during the sessions, both groups would come together to dialog.

As the study evolved, the extensive interviewing was not needed. However, rapport and motivation were established and information
provided through this form. The initial interviewing could be shortened by a group orientation session.

Other middle and late latency-aged children, in stressful situations such as divorce, death, parental illness or disability could utilize this group counseling approach. The setting would not have to be in a medical clinic but could be in a school, hospital, or mental health agency.
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ERIC Document


Unpublished Sources


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Wright, Jeanette. "Collection of Techniques Used in Art Therapy." Des Moines, Iowa: Iowa Methodist Medical Center, 1979. (Mimeographed.)
APPENDIXES
APPENDIX A

Oncology P.C.'s Letter to Their Patients
and Return Postcard
Dear:

During the past year, as we have been offering counseling services for our patients and families, we have become aware that there are some children whose parents have cancer who need some special support. When a child finds out that one of his parents has a life threatening disease this often gives rise to many questions as well as a need to share feelings with others. Because we have children with these needs, and because there seem to be few other services provided for these children, we are beginning an experimental support group for children of our patients.

We have structured these groups to meet six (6) times over a period of four (4) weeks, beginning the week of April 14th. They will be conducted by the counselors on our staff, and will be designed to satisfy three (3) objectives:

1. Answer questions your child may have regarding the nature of the disease and treatments.
2. Help relieve stress and anxiety resulting from having to deal with this problem.
3. Help your child deal more effectively with feelings he/she has about having a parent with cancer.

This experimental program is designed for children ages 10 through 14, and we would like to have your child take part, if you feel this would be helpful. Would you please fill in the enclosed card and return it to us as soon as possible. If you indicate your child would like to participate, we will call you to set up the specific time.

We thank you for your cooperation in this endeavor.

Sincerely,
I do have children this age and am interested.

I do have children this age but am not interested at this time.

I do not have children this age.

Children's ages are____________________
APPENDIX B

Consent Form
DRAKE UNIVERSITY
COLLEGE OF EDUCATION
CONSENT FORM FOR THE STUDY ENTITLED:
COUNSELING CHILDREN WHO ARE IN A STATE OF STRESS
RESEARCHER: MOLLY MCCARTHY

I, __________________________, have read the description of the counseling study and have discussed it with the researcher. I agree to have my children participate in this study being conducted under the supervision of George Lair, Ph.D., a faculty member of the College of Education, Drake University.

I hereby attest that I have had adequate opportunity to discuss the purpose, details and hazards with the researcher and am satisfied with these discussions. The researcher has offered to answer further questions that I may have regarding this study. I have been made aware that my children's rights as subjects include the voluntary participation in this research project, the right to withdraw at any time and the right of confidentiality as to personal identity and personal data. I am aware that further information about the conduct and review of human research at Drake University can be obtained by calling 515-271-2856, the Office of the Chairperson of the Human Subjects Protection Committee. I acknowledge receipt of a signed copy of this form.

Researcher _______________________________________________________

Parent ___________________________________________________________

Witness __________________________________________________________

Date _____________________________________________________________
APPENDIX C

Project Information
ONCOLOGY P.C. COUNSELING ASSOCIATION
EXPERIMENTAL SUPPORT GROUP FOR CHILDREN
1603 22ND STREET, SUITE 207
WEST DES MOINES, IA 50265
TELEPHONE 225-9872

GOALS OF PROJECT
1. To develop a group counseling model for children who are in families that have a parent who has cancer; and
2. To ascertain if counseling, including a relaxation technique, can help those children relax in order to cope more effectively.

GOALS OF COUNSELING:
1. To recognize, express and deal with emotions constructively;
2. To develop communication skills for handling difficult situations;
3. To explore their own and others' values; and
4. To learn a relaxation technique they can incorporate into their daily life.

STAFF INVOLVED:
George Lair, Ph.D., Director
Mary Brunk, R.N., Counselor
Margaret Hoffmann, Art Therapist
Molly McCarthy, Counselor

EXPECTATIONS OF CHILD:
1. Attendance;
2. Commit themselves to be a part of the group; and
3. Maintain a QR Log.

EXPECTATIONS OF PARENT:
1. Be supportive of the Project; and
2. Encourage your child or children to participate.
APPENDIX D

Interview Forms
1. PARENT'S INTERVIEW

Names of both parents

Ages

Address

Telephone Numbers

Work

Home

Employment of each

Name of ill parent

Diagnosis

Diagnosis Date

Marital history

What are your plans and goals for this child?

Daily routine

Physical health of family members

Child's performance in school

Developmental crises of parents (pregnancy, child leaving home, marriage, etc.)

What do you do as a family?

Financial status

Why did you refer your child for counseling?

How did the problem start?

How did the problem develop?

How did you try to resolve it?

What are your expectations for this child?

What happens if he/she does not fulfill your expectations?

What are your child's strengths and assets?

Institutions family interacts with (problems)

Does your child have physical or mental handicaps? If so, please describe.

Is your child under medication?

Child's peers

Religious affiliation

Does your child go to a counselor now or has he/she? Explain
Status of family friends
What have you told the child about the ill parent and his/her future?

How is your child coping with his/her parent's illness?

How are you coping with it?

How is the ill parent coping with it?

Are there any relatives involved with your family?

Counselor's perceptions:
1. Impression of parent

2. Impression of family dynamics

3. Perception and analysis of problem based on parent's statement
CHILD'S INTERVIEW

| Name         | Age | Grade | I.Q. | Parent's Names | Birth Date | Address
|--------------|-----|-------|-----|----------------|------------|---------
|              |     |       |     |                |            |         
|              |     |       |     |                |            |         

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<table>
<thead>
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</table>

How much do you know about your parent's illness and his/her future?

How are you coping with your parent's illness?
With whom do you live?
What do you do as a family?

Why did you come for counseling?
  How did the problem start?
  How did it develop?
  How did you try to resolve it?
What is expected of you in the family?

If you do not fulfill your family's expectations, how does your family deal with it?

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</tr>
</tbody>
</table>
Daily routine

How do you do in school?
Your present and future goals?

Hobbies, recreation, interests

Peer relationships

Church membership, feelings about God

Do you work, where, hours?
Are you taking any medication?
Do you have anything wrong with your health?

Do you use drugs, smoke, drink?

Suicide
What are your strengths and assets?

Have you had a counselor before or do you now? Explain

Counselor's perceptions:

1. Attitude, nonverbal language, actions, physical appearance

2. Perception and analysis of problem based on child's statement

3. Impressions of family relationships

4. Resolutions of problems as I see them
02 INTERVIEW

Name
Is there anything happening in your life that is really different—
either really good or really bad?

School--report card, fights, expulsion, boyfriend, girlfriend, homework, teachers

Friends--death, illness, fights, new friend, lost friend, accidents, getting along

Family--death, illness, fights, divorce, accidents, getting along

Pets--illness, accidents, lost, found
Other institutions--

Relatives--death, illness, fights, divorce, accidents
Work--other employees, boss, quit, fired, new job, argument, raise in pay

Yourself--taking medicine or drugs, ill, accident, run away, suicide thoughts, received a gift

How is your parent who has cancer getting along--same, change
House--chores
Feelings you have right now (why)--
    acceptance, fear, surprise, sadness, disgust, anger, anticipation, joy, other
Are you having counseling from any other person at the present time?

Doctor's analysis of patient's state
Parent's report of anything significant happening in child's life
APPENDIX E

Letter from Lynne G. Westberry
Regarding Anxiety Scores
February 25, 1981

Ms. Molly McCarthy
3171 Oahu Avenue
Honolulu, Hi. 96822

Dear Ms. McCarthy:

Thank you for your letter of February 7. Dr. Spielberger is currently out of the state and will be traveling a great deal the latter part of February and periodically throughout March. As a result, he requested that I respond to your question.

In the State-Trait Anxiety Inventory (STA) and the State-Trait Anxiety Inventory for Children (STAIC) Test Manuals, standard T-scores are reported (mean = 50, standard deviation = 10). I would suggest converting the STAI and STAIC raw scores to standard scores, thus allowing for more meaningful comparisons.

Good luck with your data analyses.

Sincerely,

Lynne G. Westberry, M.A.
Graduate Assistant to
Dr. Charles D. Spielberger
Professor of Psychology
Director, Center for Research
in Community Psychology

LGW: cw
APPENDIX F.

Letter from John A. Connolly
Regarding Children's Anxiety
Ms. Molly Claire McCarthy,
4005 Lexington Plaza Apt. 7,
West Des Moines,
Iowa 50265
U.S.A.

31 October, 1979.

Dear Ms. McCarthy,

Are you Irish, with a name like this?

Dr. Cullen has asked me to reply to yours of October, 8th, 1979, received today. Please note our new name and address.

I am not quite sure what specific information you may want. We concentrate on the area of stress-related disorders, primarily with an adult/adolescent population. We utilize a variety of approaches - meditation, biofeedback, relaxation techniques.

At present, we are also researching the neonatal responses to stress, how they develop an appropriate coping behaviour. This implies the accurate recording of cardiovascular and other response modes - heart rate, systolic and diastolic blood pressures, excretion of catecholamines. Other areas are the electro-myographic responses, respiration, motility patterns.

Both infants and adults respond to stress in the same way, and these responses can be measured objectively. Under stress, we all show changes in cardiovascular or psycho-biological patterns, and it is now increasingly possible to assess biochemical changes taking place.

The real questions appear to lie in the reasons that we become different types of responders - e.g. blood pressure or heart rate; correlation of response patterns and personality types; early influences on establishing patterns of coping. I would think that meditation is more appropriate for adults, as it demands a higher level of intellectual understanding and objectivity than may be available for most young children.

Perhaps, the input for children should be through the parents.

Please reply and specify any particular problems on areas you would like us to help you with.

Yours sincerely,

John A. Connolly, B.A., Dip.Psych., M.Psych.,
Sc., A.Ps.S.I. SENIOR CLINICAL PSYCHOLOGIST

The Irish Foundation for Human Development
Gardner Hill
E H B Box 414
J. James St
Dublin 8
Telephone 758281

Psychosomatic Unit
Director: Dr. J.H. Cullen
APPENDIX G

Children's Evaluation Form of Counseling Sessions
EVALUATION

1. What was your overall level of satisfaction with the group?

<table>
<thead>
<tr>
<th>Not satisfied at all</th>
<th>Could be better</th>
<th>So-so</th>
<th>Moderately satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
</table>

2. The group helped me understand myself and my emotions better

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>

3. The group did not help me understand my values about life-threatening illness.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>

4. The group helped me understand my parents' feelings a little better.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>

5. I felt there was not enough time for individual participation.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>

6. Using empathic assertiveness training helps me to relate to my family.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>

7. Using the QR does not help me to calm myself.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neither agree nor disagree</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
</table>
8. Using the video tape vignettes helped me to evaluate how I felt having a parent with cancer.

| Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

9. Using art did not help me express and evaluate my feelings.

| Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |

10. I learned that others shared similar problems because of their parent having cancer.

| Strongly disagree | Mildly disagree | Neither agree nor disagree | Mildly agree | Strongly agree |