Therapeutic intervention in the treatment of adult patients with metastatic cancer: a comparative study of two group counseling approaches

Gilbert Garner Cumbia

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THERAPEUTIC INTERVENTION IN THE TREATMENT OF ADULT PATIENTS WITH METASTATIC CANCER: A COMPARATIVE STUDY OF TWO GROUP COUNSELING APPROACHES

A Dissertation Presented to
the Faculty of the School of Education
The College of William and Mary

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

by
Gilbert Garner Cumbla
April 1985
THERAPEUTIC INTERVENTION IN THE TREATMENT
OF ADULT PATIENTS WITH METASTATIC CANCER:
A COMPARATIVE STUDY OF TWO
GROUP COUNSELING APPROACHES

by

Gilbert Garner Cumbia

Approved April 1985 by

Fred L. Adair, Ph.D.
Kevin E. Geoffroy, Ed.D.
Jack A. Duncan, Ed.D.
Chairman of Doctoral Committee
DEDICATION

To my friend, Carlton Joseph White, whose struggle against cancer inspired me to pursue my personal development and professional goals.

"Should you shield the canyons from the windstorms you would never see the beauty of their carvings."

Elisabeth Kubler-Ross
ACKNOWLEDGMENTS

The author is indebted to many individuals who played key roles in this study. Jack A. Duncan, Ed.D., the Committee Chairperson, provided advice and encouragement and always was available when a need for consultation arose. I extend my gratitude and appreciation to him and also to the other committee members, Fred L. Adair, Ph.D., and Kevin E. Geoffroy, Ed.D. In addition, I would like to acknowledge Sanford Snider, Ed.D., who provided statistical assistance with my research design.

Debbie Hall and my sister, Darlene Browder, devoted many hours piecing together and typing the manuscript. I appreciate their patience and hard work.

Without the interest and willingness of 18 adult metastatic cancer patients to participate in the treatment and control groups, this study would not have been possible. I am very grateful to them and also to Ms. Beth Woolford and Ms. Rusty Smith, social workers at the Medical College of Virginia, who gave unselfishly of their time and expertise to facilitate the group sessions.

A special note of appreciation goes to my best friend, Perry, who became my wife during the time that this study unfolded. Her constant praise and encouragement gave me the energy to complete my work, and to feel proud of what I have accomplished.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Rationale</td>
<td>1</td>
</tr>
<tr>
<td>Sample and Data Gathering Procedures</td>
<td>5</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>5</td>
</tr>
<tr>
<td>Limitations</td>
<td>7</td>
</tr>
<tr>
<td>II. REVIEW OF RELATED RESEARCH</td>
<td>9</td>
</tr>
<tr>
<td>Theory - History - Position</td>
<td>9</td>
</tr>
<tr>
<td>Summary of Rationale and Relationship to Problem</td>
<td>12</td>
</tr>
<tr>
<td>Nondirective Therapeutic Intervention</td>
<td>12</td>
</tr>
<tr>
<td>Summary</td>
<td>19</td>
</tr>
<tr>
<td>Stress Management</td>
<td>20</td>
</tr>
<tr>
<td>Summary</td>
<td>25</td>
</tr>
<tr>
<td>Other Therapeutic Approaches</td>
<td>26</td>
</tr>
<tr>
<td>Summary</td>
<td>30</td>
</tr>
<tr>
<td>Summary of Research and Relationship to Problem</td>
<td>30</td>
</tr>
<tr>
<td>III. METHODOLOGY</td>
<td>32</td>
</tr>
<tr>
<td>Population and Selection of the Sample</td>
<td>32</td>
</tr>
<tr>
<td>Data Gathering</td>
<td>36</td>
</tr>
<tr>
<td>Treatments</td>
<td>37</td>
</tr>
<tr>
<td>Ethical Safeguards and Considerations</td>
<td>39</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>40</td>
</tr>
<tr>
<td>State-Trait Anxiety Inventory</td>
<td>40</td>
</tr>
<tr>
<td>Tennessee Self Concept Scale</td>
<td>42</td>
</tr>
<tr>
<td>Personal Orientation Inventory</td>
<td>44</td>
</tr>
<tr>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Research Design</td>
<td>.46</td>
</tr>
<tr>
<td>Statistical Analysis</td>
<td>.47</td>
</tr>
<tr>
<td>Specific Hypotheses</td>
<td>.47</td>
</tr>
<tr>
<td>Summary of Methodology</td>
<td>.48</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>.50</td>
</tr>
<tr>
<td>Hypotheses and Assessment Instruments</td>
<td>.50</td>
</tr>
<tr>
<td>Post-Group Interview Data</td>
<td>.59</td>
</tr>
<tr>
<td>V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS</td>
<td>.75</td>
</tr>
<tr>
<td>Summary</td>
<td>.75</td>
</tr>
<tr>
<td>Conclusions</td>
<td>.78</td>
</tr>
<tr>
<td>Recommendations</td>
<td>.79</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>.81</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>.87</td>
</tr>
<tr>
<td>APPENDIX A. Consent Form</td>
<td>.88</td>
</tr>
<tr>
<td>APPENDIX B. Post-Group Interview: Treatment and Control</td>
<td>.90</td>
</tr>
<tr>
<td>APPENDIX C. Letter to Medical College of Virginia Staff Personnel</td>
<td>.92</td>
</tr>
<tr>
<td>APPENDIX D. Letter to Doctors</td>
<td>.94</td>
</tr>
<tr>
<td>APPENDIX E. Letter to Mass Media</td>
<td>.105</td>
</tr>
<tr>
<td>APPENDIX F. Newspaper Ad</td>
<td>.106</td>
</tr>
<tr>
<td>APPENDIX G. Letter to Cansurmount Volunteers</td>
<td>.107</td>
</tr>
<tr>
<td>APPENDIX H. Letter to Group Participants</td>
<td>.109</td>
</tr>
<tr>
<td>APPENDIX I. Chronology of Topics Discussed in Nondirective Group Counseling Sessions</td>
<td>.110</td>
</tr>
<tr>
<td>APPENDIX J. Outline of Stress Management Group Counseling Sessions</td>
<td>.113</td>
</tr>
<tr>
<td>APPENDIX K. State-Trait Anxiety Inventory</td>
<td>.139</td>
</tr>
<tr>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td></td>
</tr>
<tr>
<td>APPENDIX L. <strong>Tennessee Self Concept Scale</strong> .................. 141</td>
<td></td>
</tr>
<tr>
<td>APPENDIX M. <strong>Personal Orientation Inventory</strong> ................. 148</td>
<td></td>
</tr>
<tr>
<td>VITA ................................................................. 156</td>
<td></td>
</tr>
<tr>
<td>ABSTRACT ............................................................. 157</td>
<td></td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>Analysis of Variance for the State and Trait Anxiety Scales of the State-Trait Anxiety Inventory, Total P Score of the Tennessee Self Concept Scale, and Inner Directed and Time Competence Scales of the Personal Orientation Inventory for the Nondirective, Stress Management, and Control Groups</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Analysis of Variance for the State and Trait Anxiety Scales of the State-Trait Anxiety Inventory, Total P Score of the Tennessee Self Concept Scale, and Inner Directed and Time Competence Scales of the Personal Orientation Inventory for the Nondirective, Stress Management, and Control Groups</td>
<td>52</td>
</tr>
<tr>
<td>2.</td>
<td>Sums, Means, Standard Deviations, and Variances for the Nondirective, Stress Management, and Control Groups on the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory</td>
<td>53</td>
</tr>
<tr>
<td>3.</td>
<td>Scores on the State Anxiety Scale of the State-Trait Anxiety Inventory for the Nondirective, Stress Management, and Control Group Subjects</td>
<td>54</td>
</tr>
<tr>
<td>4.</td>
<td>Scores on the Trait Anxiety Scale of the State-Trait Anxiety Inventory for the Nondirective, Stress Management, and Control Group Subjects</td>
<td>55</td>
</tr>
<tr>
<td>5.</td>
<td>Total P Scores of the Tennessee Self Concept Scale for the Nondirective, Stress Management, and Control Group Subjects</td>
<td>56</td>
</tr>
<tr>
<td>6.</td>
<td>Scores on the Inner Directed Scale of the Personal Orientation Inventory for the Nondirective, Stress Management, and Control Group Subjects</td>
<td>57</td>
</tr>
<tr>
<td>7.</td>
<td>Scores on the Time Competence Scale of the Personal Orientation Inventory for the Nondirective, Stress Management, and Control Group Subjects</td>
<td>58</td>
</tr>
<tr>
<td>8.</td>
<td>Summary of Post-Group Interviews: Treatment Groups</td>
<td>60</td>
</tr>
<tr>
<td>9.</td>
<td>Summary of Post-Group Interviews: Control Group</td>
<td>61</td>
</tr>
<tr>
<td>TABLE</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>10. Post-Group Interviews of Nondirective Treatment Group</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>11. Post-Group Interviews of Stress Management Treatment Group</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>12. Post-Group Interviews of Control Group</td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Statement of the Problem

The problem to be investigated by this study is the effect that two different group counseling approaches, nondirective and stress management, have upon the anxiety, self-esteem, innerdirectedness, and time competence of adult patients with metastatic cancer.

Need for the Study

While birth and the development of the individual have been studied by many professionals in various fields, the phenomenon of dying has only recently received such attention. Indeed, there has been very little research that has addressed the clinical investigation of patients dealing with life threatening illnesses and only a limited number of theoretical formulations constructed in this area. Few systematic studies have been designed to evaluate the efficacy of any type of therapeutic intervention with such a population. The purpose of this study is to examine specifically the effect that two different group counseling approaches have upon adult patients with a catastrophic illness. This study will help determine what theoretical approaches and treatment interventions are therapeutic and when they should be implemented.

Theoretical Rationale

There appear to be certain psychological stages or phases that a person goes through during the dying process. E. Kubler-Ross (1969, 1970) interviewed, observed, and counseled 400 terminally ill patients and found five distinct stages in the dying process. She noted that if there is a short time between diagnosis and death, the patient moves quickly through the stages. She acknowledged that these stages are not always in order
and that they sometimes group together, overlap, or shift positions at various times. There are also exceptions, be they rare, where a patient only goes through one or two stages. However, many patients she observed went through the following stages in the order that they are presented here. She has theorized that these stages would generally apply to anyone faced with imminent death.

The first stage is shock and denial. The patient feels a mistake had been made or minimizes the seriousness of the situation. Information given by the doctor may often be distorted or dismissed. Sometimes such information is absorbed intellectually without any emotional involvement. The fact of imminent death can not be accepted. This stage does not last very long.

The second stage is anger. The patient becomes angry about dying, and this anger is oftentimes displaced on "living, healthy" others, e.g., doctors, family members, and friends. The question "Why me?" is asked frequently. Once the anger is expressed or at least defused somewhat, the patient usually becomes less demanding and critical and is more receptive to medicinal measures taken by the doctors and nurses.

In the third stage the patient bargains with God or life's forces for an extension of time or special considerations, e.g., avoidance of pain. This is seen as a time for the patient to relax and muster strength for what is to come.

Reactive depression, which is very normal and healthy in this situation, is seen as the first phase of stage four. Many "little deaths" are experienced as the patient realizes and begins to accept the imminent loss of everyone and everything. It is a time for letting go of the important things in life. As these little deaths are experienced and/or acknowledged, the patient is very expressive in his/her grief. He/She is often loud, angry, and concerned over such problems as having to be bathed and fed by someone. It is at this time that the patient wants to talk and be heard.

Preparatory grief follows this expressive grief. During this second phase of the grief process the patient becomes quiet and wants to be left alone. It seems to be an
inward grief to separate himself/herself from others and a time to adapt to decathexis.

The fifth and final stage is acceptance. The patient is no longer afraid, but ready to die. Few needs are expressed, and usually the presence of one or two loved ones is all that is desired. This is a time for silent companionship.

Kubler-Ross felt that this stage of acceptance is very natural and attainable by many patients. It is witnessed by a progressive withdrawal from an active interest in life. Physical comfort, peace, and an end to the suffering seem more important, as does the momentary passage of time. There appears a readiness for death. While this stage is not necessarily a happy one, it brings relief to the patient since physical suffering has abated. With the surrendering of all personal attachments, emotional distress is alleviated as well.

Kubler-Ross discovered that depression and hope occur to some degree through all stages. She also reported that there is facilitation through these stages when the doctor is frank about the seriousness of the illness, but adds that he/she will stick it out with the patient and that there is always hope (To Die Today, 1970).

Imara, writing in a book edited by Kubler-Ross, endorsed Kubler-Ross's stages and stated that a patient moves through these stages better when denial is confronted and resolved. In this way there are healthier interpersonal relationships with significant others, and the patient comes to accept the positive with the negative and moves more into the here-and-now.

Gass (1979), while working as a clinical psychologist intern at a cancer clinic, confirmed the stages of dying as proposed by Kubler-Ross. He did not find them to be in any particular order, though denial usually comes first and acceptance last. The only stage that rarely occurs is the "bargaining" stage. The others are quite discernible in each patient at different points in time.

Having spent countless hours with terminally ill patients, Kubler-Ross proposed a nondirective or patient-centered approach to use when counseling with the dying. She
emphasized the qualities of empathy, honesty, and acceptance and felt that these are basic to the therapeutic process. She noted that it is okay to say, "It must be tough," or "I don't know what to say." The patient is understanding and very helpful in facilitating communication. Most times the patient really wants to talk with someone who acts natural, i.e., does not have a facade (Varney, 1975).

Kubler-Ross viewed the therapist as a support system. The patient is not reasoned with or ridiculed, but rather accepted and assisted during this crisis. Feelings such as anger and grief are openly discussed without the patient being made to feel ashamed, awkward, or guilty. As a result of this relationship, the patient gains insight into his/her emotional turmoil and begins resolving personal issues that weigh heavy on his/her mind. Silence is employed by the therapist during times of catharsis and decathexis. Thus, two-way communication is not always necessary or appropriate. It is the goal of the therapist to share and accept the feelings of the patient so as to enable that person to reach the stage of acceptance and realize that death is a part of life.

It was suggested by Kubler-Ross that the patient should decide when communication will occur. While she felt that dealing with unfinished business is "most therapeutic," she still maintained that the patient should initiate such discussions. She added that the therapist must be able to accept and express personal feelings and beliefs related to death and dying. This is done with the patient when self-disclosure seems appropriate.

Kubler-Ross has, therefore, proposed a theoretical rationale for working with the terminally ill that couples her stages of dying with therapeutic intervention. She has postulated two major tenets: (1) There seem to be certain stages or phases of dying that can cause undue emotional distress; and (2) there appears a genuine need for non-directive therapeutic intervention with patients trying to cope with such a crisis.
Sample and Data Gathering Procedures

Eighteen adult outpatients from metropolitan Richmond, Virginia area hospitals who had been diagnosed with metastatic cancer since August 1, 1980 were the focus of this study. Their cooperation was obtained through informal personal interviews. When the patient agreed to participate in the study, a consent form (Appendix A), which outlined the major focus of the group counseling experience, articulated the obvious lack of mental or physical health risks, and cited testing procedures, was signed by the patient.

Volunteers for this study were assigned, using a modified random assignment procedure, into one of three groups: nondirective, stress management, or control. The nondirective and stress management groups met for 90 minute sessions twice a week for five consecutive weeks. The control group did not meet. An eleventh session was scheduled to distribute and explain the directions for self-administering the State-Trait Anxiety Inventory, Tennessee Self-Concept Scale, and the Personal Orientation Inventory. The same instruments were hand-delivered to the homes of the control group members for self-administration. Group scores were compared by using an analysis of variance. Individual interviews (Appendix B) were conducted within two weeks of the termination of each group to help validate the results of the findings yielded by the test instruments.

Definition of Terms

**Adult patient.** An adult patient is a patient who is 18 years of age or older.

**Anxiety.** Anxiety is a psychological state marked by distress or uneasiness.

**Cancer.** Cancer is a large group of diseases distinguished by uncontrolled growth and spread of abnormal cells.

**Catastrophic illness.** A catastrophic illness is an illness which has life threatening implications.
Decathexis. Decathexis is a psychological phenomenon whereby an individual disengages emotional and psychic energy from an activity, object, person, or idea.

Group counseling. Group counseling is a type of therapeutic intervention in which a counselor assists a group of nonpsychotic (or normal) clients as they attempt to resolve conscious personal problems that are not severely debilitating.

Innerdirectedness. Innerdirectedness is the tendency of a person to respond to and be guided by his/her own internal volitions and principles rather than be controlled by extraneous variables.

Malignant tumor. A malignant tumor is an enlarged abnormal mass composed of cancer cells which grow and invade surrounding tissues.

Metastatic cancer. Metastatic cancer is a medical condition in which cancer has spread from the original site to other sites in the body.

Nondirective group counseling. Nondirective group counseling is a type of therapeutic intervention in which the counselor employs genuineness, acceptance, and empathy so as to enable individual group members to understand and resolve their own problems.

Self-esteem. Self-esteem is a psychological trait that denotes a person’s impression of himself/herself, especially regarding sense of worth.

Stress management group counseling. Stress management group counseling is a type of therapeutic intervention in which a counselor trains group members in the use of stress management techniques so that they can learn how to relieve stress and anxiety.

Therapeutic intervention. Therapeutic intervention is a strategy or strategies implemented by a counselor so as to assist clients in resolving personal problems.

Time competence. Time competence is the tendency of a person to live in the present, with minimal time spent analyzing past problems and events and futuristic concerns.
Limitations

This study analyzed only the efficacy of two group counseling approaches, nondirective and stress management, on adult patients with metastatic cancer.

This study analyzed only the efficacy of these two group counseling approaches in regards to the anxiety, self-esteem, innerdirectedness, and time competence of adult patients with metastatic cancer.

This study included 18 adult outpatients from metropolitan Richmond area hospitals who had been diagnosed with metastatic cancer since August 1, 1980 and had the physical potential to attend group sessions conducted twice a week for five weeks.

This study included only adult patients 18 years of age or older who had been informed that they had metastatic cancer.

This study was limited by the fact that prospective group participants were self-selected volunteers, who because of their interest were most likely to benefit from group counseling.

This study did not control for previous therapeutic interventions concerning the patients' metastatic disease.

This study did involve therapeutic intervention that was intensive. Each group met for 90 minute sessions twice a week for five weeks.

This study did not control for any therapeutic benefit that participants may have gleaned from meeting as a group.

This study did not control for the effect of the facilitator's personality on her group.

This study did not control for the medical conditions of group participants that necessitated their absence from one or more group sessions.

This study did not control for the effect that the following may have had on group participants: age, sex, race, socioeconomic class, religiosity, and the number of years diagnosed with cancer.
This study, because of the aforementioned limitations, deserves close scrutiny in regards to generalizability of results to similar populations.
CHAPTER II

REVIEW OF RELATED RESEARCH

Theory - History - Position

Historically, the nondirective or patient-centered approach to therapeutic intervention can be traced to humanistic perspectives developed by Carl Rogers in the early 1940's. Corey (1981, 1982) stated the basic assumptions postulated by Rogers: (1) People are trustworthy and responsible; (2) people have the power to understand themselves and their problems and resolve these problems without the direct assistance of a therapist, i.e., they have the inner strength to guide their own lives and make good decisions; and (3) people are capable of, and tend toward, self-direction and self-actualization when involved in a therapeutic relationship where there is respect and trust.

Meador and Rogers (1979) cited three conditions that are deemed necessary and sufficient to bring about therapeutic change in a person. The first is genuineness or realness, which is seen as most important. The therapist is authentic and integrated in that there is a congruency between his/her inner feelings and outer expressions. Positive and negative feelings and attitudes are expressed at appropriate times. In this way the therapist serves as a model for honest communication and genuineness.

The second core condition is an unconditional positive regard and acceptance of the person. There is a nonpossessive warmth and caring demonstrated by the therapist regardless of the person's feelings, thoughts, or behavior. There is no condition that the person must feel or behave a certain way before the therapist cares about and accepts the person. Thus, there is an acceptance of the person's right to any feelings, but this does not imply approval of all behavior. Behavior is not unconditionally approved of or accepted.

The last core condition is a deep empathic understanding of the person's internal
The therapist acquires an accurate, subjective understanding of the person's feelings, thoughts, and experiences and helps the person do the same. The therapist does not get lost within the person's internal world but uses a here-and-now orientation to help the person become more aware of powers within the inner self and how they may be harnessed for personal gain.

Rogers (1961) stated that:

... the relationship which I have found helpful is characterized by a sort of transparency on my part, in which my real feelings are evident; by an acceptance of this other person as a separate person with value in his own right; and by a deep empathic understanding which enables me to see his private world through his eyes. When these conditions are achieved, I become a companion to my client, accompanying him in the frightening search for himself, which he now feels free to undertake. (p. 34)

Meador et al. (1979) stressed that the genuineness, acceptance, and empathy demonstrated by the therapist may help the person become less defensive and more receptive to his/her positive qualities. They did note, however, that these three core conditions are not all or none propositions. Because the therapist is also in the process of "becoming," a continuum must be established whereby the therapist strives for higher levels of each. There will be times, however, when the therapist will not truly feel, or even want to feel, genuine, accepting, or empathic.

Corey (1981) pointed out that the determinants of the nondirective therapeutic process and personality change in the person are: (1) the quality of the relationship between the person and the therapist; and (2) the attitudes and personal characteristics of the therapist. The therapist is seen as a change agent who leads the person toward deeper self-exploration without the use of techniques or psychological diagnosis. By helping the person focus on his/her phenomenal world and personal characteristics that have stunted the process of self-actualization, the therapist assists the person in
becoming more fully functional in all aspects of living. Thus, the focus is more on personal growth than the presenting problem.

Corey noted that the therapist must let the person choose the direction that therapy will take and the pace with which it will go. The person also chooses his/her own goals and maintains the responsibility to refine and clarify them. The therapist and person both are able to grow from the therapeutic experience if the three core conditions are met.

Rogers (1981) listed four major goals of therapy. The first is the ability of the person to be more open to experiences now and in the future. There is a mitigation of defensiveness and rigid beliefs and more experimentation, integration of feelings, and awareness of the present moment. The second is a greater trust in oneself and enhanced ability to direct one's own life. The third is an internal locus of evaluation. Answers are found within oneself, and choices and decisions are made by consulting oneself. The person derives a greater sense of self-approval from the therapeutic experience. The fourth goal is a willingness to be a process, a "process of becoming." The person sees growth as a continuing process and becomes more flexible, allowing beliefs, feelings, and behavior to change over time.

While others conducted extensive research to validate Rogers's nondirective approach, he continued to conduct his own research. His reports of follow-up studies assessing the outcomes of small person-centered groups run by himself and his associates corroborate the findings of other researchers. Surveying hundreds of group participants through the use of self-report questionnaires, he discovered that most felt the experience was very positive and had made a significant impact on their lives, i.e., there had been a positive change in their behavior. He still continued to stress, however, that his theory of counseling is not to be viewed as fixed or static. It is, rather, a set of tentative principles that will change as new research reveals a better understanding of human nature and interpersonal relationships (Rogers, 1970).
Summary of Rationale and Relationship to Problem

Based on comprehensive research conducted by Rogers and others, some strong arguments can be made for adopting a nondirective therapeutic approach when working with a distressed person. Empathy, acceptance, and genuineness do seem to be core conditions for establishing a therapeutic relationship and facilitating catharsis. Many people report positive gains from this type of intervention, especially in the areas of personal growth and interpersonal relationships. Most appreciate the nondirective stance of the therapist through which they determine the course and outcome of therapy.

Such a nondirective approach, however, raises some concerns. There is the issue of whether or not the person really knows what is best for him/her. Since this is a non-confrontive, non-behavioral mode of treatment, much of the work associated with resolving the person's problem becomes the responsibility of the person. There is very little professional direction by the therapist. With many research studies utilizing a self-report questionnaire, one must also wonder how objective the respondent can be, especially when he/she has been involved in a warm, caring relationship with a therapist.

The purpose of this study, therefore, was to analyze systematically the efficacy of two therapeutic approaches with adult patients dealing with a catastrophic illness. Nondirective therapeutic intervention was compared with a more directive, didactic model involving stress management skills. This latter approach necessitated the use of gentle but direct confrontation with subjects, structured role-playing in therapy, and behavioral prescriptions given as homework assignments.

Nondirective Therapeutic Intervention

Much has been written about the use of nondirective therapeutic intervention with the terminally ill. LeShan and Glassmann (1958), spending over 1,400 hours in intensive therapy with 10 dying patients, found the presenting problems to be anxiety, obsessive fear of death, repressed guilt and hostility, psychological isolation, lack of strong
cathexes, and despair over never having been satisfied in life. They also noted that the therapist, through the extensive use of understanding, empathy, support, reassurance, and a here-and-now orientation, helps the patient gain control over his/her emotional trauma. The therapist reassures the patient that anxiety is very appropriate and that the patient has the ability to face life and fate in a positive way and live a full, emotional life in the time that remains. Together, therapist and patient look at what has blocked the patient's ability to function fully and express himself/herself. Hopefully, in therapy such blocks would be removed so that self-understanding and self-respect would be enhanced. Interpersonal relationships would be improved as well.

Thus the therapist helps the patient recognize and harness inner sources of strength, especially when death is near. Nevertheless, LeShan and Gassmann pointed out that it is important to pace the therapy so as not to tire the patient or make the patient deal with too much too soon, e.g., guilt and hostility. They said that, "our experience tends to affirm that psychologically stressful events in the patient's life or in the course of his therapy frequently appear to relate to changes in tumor growth rate" (p. 730).

It was suggested that the therapist have a professional confidant to help him/her resolve any countertransference problems, especially when death is imminent. Related emotional problems can be dealt with also. In addition, therapy is seen as continuous and not to be interrupted by being called out of town or going on vacation. When there is an interruption, the patient seems to get sicker and more depressed.

Three years later LeShan (1981) reported on some new insight he had gained. During this three year period he had spent 3,500 hours in therapy with dying patients. In addition to what was noted before, he found that there is a very positive correlation between the therapist's orientation toward the patient and life in general and the patient's orientation toward the same. He wrote, "his being is being cared for unconditionally and so he cares for it himself. The presence of the therapist affirms the
Importance of the here and now. Life no longer primarily seems to have the quality of fading away, but takes on new meaning and validity" (pp. 318-319).

Norton (1963) presented a case study of a 32 year old mother who was dying. Through the catharsis that took place as problematic issues were discussed, he noted that there was "a diminution of her depression, complete absence of any talk of suicide, impressive absence of anxiety, and an increased sense of well-being and of hope which was quite at odds with her deteriorating physical condition" (p. 548). The therapeutic relationship was enhanced by his nondirective orientation and constant availability. In particular, there was resolution of actual and anticipated object loss anxiety which led to a natural decathexis.

While Kubler-Ross (1969, 1970) urged that the therapist follow the patient through all five stages of dying, some recommendations were also made. It was suggested that, while the therapist frequently visits the patient, the patient is the one to decide when communication will occur. Dealing with unfinished business was termed "most therapeutic." The therapist was advised never to challenge defense mechanisms, but rather maintain a supportive and accepting stance. Further, the therapist must be able to express personal feelings and beliefs and not be afraid of his/her own mortality. For dealing with the exception to the five stages of dying, the therapist must be able to help the patient die at whatever stage he/she is in, e.g., a "fighter" sometimes stays angry and dies fighting. Family members must also be assisted, especially in the final stages where emotions are intense and unintentional interference a problem.

Kubler-Ross (1970) found her work with the 400 terminally ill patients to be very successful. The patients seemed to be more accepting of their plight as time went on and more at ease in general. No objective, clinical tests were used to verify these assumptions, however. She reported that there were objective, clinical observations and mini-counseling sessions on a daily basis which led to her findings.
Cramond (1970) saw the desperate need for therapeutic intervention with the terminally ill and formulated some very lucid and cogent guidelines for any professional working in this area. Communication with the patient over his/her feelings is the most important. Only in this way can true catharsis and remediation of emotional turmoil take place. This is a patient-centered approach unless time is very short, and there are business affairs that need to be settled.

The professional emphasizes with the patient what he/she has done and where he/she has met with success. In this way value is placed upon the patient's past activities and personal worth. Simple reassurances during this time are needed. It is also helpful to encourage the patient to talk about fond memories and pleasant dreams, especially those involving significant others who are deceased. To some it helps to point out that a part of them will live on in their children and in the memories of their friends.

Cramond also warned the professional to be cognizant of possible transference and countertransference. He urged him/her to work with the patient until death so that there would be a continuity in the therapeutic intervention. Because of the time element and emotional involvement, no more than two patients should be worked with at any one time. He felt weekly visits for a half to three quarters of an hour are appropriate when death is three to four months away. Five to ten minute visits three or four times a day are appropriate when death is imminent.

The professional must come to terms with his/her own mortality so as to deal with death without heightened anxiety or loss of objectivity. In this work Cramond strongly recommended a supervisor to help the professional deal with his/her emotional involvement. Weekly, open-ended support groups were suggested. He also urged the professional to assist family members as they work through loss, hurt, anxiety, depression, anger, and guilt. Cramond cited no pre-post control studies, but presented subjective case studies to verify his therapeutic approach.
Feigenberg (1975) felt that the physiological deterioration in a fatal illness calls for the patient to protect and emphasize his/her individuality, i.e., that he/she is okay and relating to the world in a positive way. The therapist, using trust, empathy, genuineness, and respect, supports and helps strengthen the patient's individuality and assists him/her with unsatisfied needs and unresolved conflicts. Through such intervention individuality is enhanced, and there is an increased ability to deal with the dying process. No supportive research was cited to verify Feigenberg's therapeutic approach.

Franzino, Geren, and Meiman (1976) worked with a small group of terminally ill cancer patients over a period of three months. Most of the weekly discussions focused upon the patients' disease, current medical treatments, and their side effects. The group facilitators adopted a nondirective stance. They were very informal and relaxed, did not confront defense mechanisms, facilitated discussion without leading it or choosing topics for group consideration, and were very supportive of all participants.

Some group sessions were quite intense as intimate personal fears and struggles were discussed. When it was announced in one session that a group member had died, the mood was very sad and tearful. While no one liked talking about that member's death, and even told the leaders so, the discussion was continued the following week under veiled terms, e.g., dead friends, plants, and pets.

The results of this study were quite encouraging. Because of the supportive, comfortable atmosphere surrounding the group, participants were assisted in coping with their terminal illness and related problems. They were able to become more open and genuine as they communicated their thoughts and feelings to each other in the group. Both the leaders and participants felt similar groups were needed for other patients faced with imminent death.

McCarthy (1976) used a nondirective therapeutic approach with a group of six terminally ill cancer patients over a period of 42 weeks. The four most frequently
discussed topics were: (1) coping with cancer; (2) the physical treatment of chemotherapy; (3) death and life expectancy; and (4) the interaction with family members. The patients, however, saw cancer as the topic of discussion and the reason why they were meeting. The main feelings expressed were fear, anger, and depression. While fear concerning their own prognosis and emotional and physical well-being was prevalent throughout the sessions, the patients over-shadowed this fear with anger and depression during the initial sessions. This was because they previously had no outlet for the expression of anger and frustration. As catharsis took place, these two emotions reduced in intensity.

The feeling of fear was rekindled during the middle sessions and remained with the group when one member died and new tumors were discovered in two other members. These events caused others to become more pensive and fearful of their own imminent demise. Discussions centered around fragility, prognosis, effectiveness of the chemotherapy, who would take care of their family members when they were gone, and whether close family members would be there when they needed them the most. There was an intensive fear of being alone or abandoned during the actual dying process.

The group goal, as designed by McCarthy, was to help the patients live their remaining time in the best possible way. He found that they were able in therapy to get new perspectives on their life situations, and some personal needs were met. Many emotions concerning cancer were expressed, and there was much group support and encouragement in regards to developing new and more adaptive ways of handling these emotions and life in general. Four months after the group sessions ended, three members were dead, but the other three seemed to be doing quite well. There were reports of supportive and peaceful family interaction, more social involvement, less stress and more adaptive behavior in regards to their illness, and a greater appreciation for life and what it has to offer.
As a result of his experience, McCarthy concluded that group therapy would probably be beneficial for many and that terminal patients could still be productive and enjoy life. To enhance problem-solving of the many conflicts during this time, he advised the therapist to be empathic and be an emotional ally. He said there needs to be psychological education for death and dying and urged psychologists to begin dealing with the crisis of health loss and illness, not only for the patient but also for family members as well. With professional consultation, relatives would be in a better position to support and assist the terminally ill.

Palchowsky (1977) reported on a catastrophic illness group established in the Las Vegas, Nevada area for terminally ill patients and their relatives. The group had a basic nondirective orientation which focused on warmth, love, and understanding. There were no formal rules or regulations, and group members were encouraged by professional facilitators to make their own decisions about what would be discussed. Two popular topics were the rights and needs of medical patients. When self-pity was apparent, it was gently confronted within the group so that, through self-expression, the related depression would be alleviated.

The main goal of the group was to help terminally ill patients and their relatives accept and live with the present state of affairs. Participants felt the group supported them and gave them some good reasons to continue fighting for a purposeful existence.

Lindenberg (1978) studied the effects of an existential-type of group psychotherapy on attitudes about death and dying, self-concept, and perception of life and existence for those who were dying. Before the onset of the group he found his seven group members to present many emotional problems, with the main ones being depression, anger, psychological isolation, frustration, fear, and unsatisfied interpersonal relationships. He felt that an eclectic humanistic approach using a patient-centered base would help these patients resolve emotional issues and place more value on themselves and life in general. They would also develop more positive attitudes toward death and dying and live more in the here-and-now.
The Time-Competence and Inner Directed Scales of the Personal Orientation Inventory were used as assessment instruments as well as the Lindenberg Death and Dying Scales, a semantic differential. No significant gains were found. When analyzing the data yielded by these two instruments, there was no occasion variance. At the end of the group much depression and loneliness was still apparent. Also, there remained a lack of emotional depth and expression, even in close, interpersonal relationships. This stoic approach to life and its problems had been openly endorsed by all group members and defended many times.

Some positive gains surfaced, however. There were reports of improved relationships with significant others. A few members began seeking some sort of temporary employment, be it volunteer or paid. One member began chemotherapy because of the group's support and feedback. She had initially refused it.

Ms. A. represented an interesting case study. Because of her experience in the group, she was able to resolve some interpersonal problems with her son. She first wrote him a letter and later met with him for what she described as a warm mother-son talk. She also said that this group was better than any other group in which she had been a participant and that she had stopped seeing her other therapist.

Summary

Concerning the efficacy of nondirective therapeutic intervention with the terminally ill, very little experimental research has been conducted. Though many case studies have been presented, they are quite subjective in nature and may represent only the more successful ones. One issue that must be addressed is how much psychic energy is necessary before the patient can benefit from this type of therapeutic intervention.

This approach leaves the responsibility with the patient for breaking down communication barriers to reach uncomfortable feelings and unresolved problems. Of course, many important issues may never be discussed and/or settled. The therapist does not challenge defense mechanisms but rather maintains a supportive, accepting stance.
Problems would arise, however, if a particular defense mechanism were truly injurious to the mental health of the patient. Oftentimes people must be confronted in a therapeutic manner if deleterious behaviors or thought processes are to be eliminated or at least ameliorated.

Another option open to the therapist would be to develop strategies that could stimulate thought and discussion into important areas not heretofore explored or only temporarily or superficially visited. Harmful defense tactics could also be handled with different therapeutic styles that would be more sensitive to the element of time and the need for immediate action to address such concerns. Thus, a more proactive approach could be designed to assist the terminally ill, but a nondirective base of empathy, unconditional positive regard, and genuineness would still need to be developed with the patient first.

**Stress Management**

In regards to therapeutic intervention with the terminally ill, several researchers have reported on the benefits of different cognitive-behavioral orientations. Shephard (1975) studied the effects of situational play therapy on a group of 11 children who had a potentially fatal disease. Through group discussion and role playing, the young participants were given the opportunity to deal directly with threatening thoughts and events in their environment. Practically all discussions and activities focused upon hospital life, medical treatment, and related feelings.

At the end of the eight week counseling period it was found that general anxiety was significantly reduced. Death and mutilation anxiety, however, were not affected. Based on test scores and subjective assessments by the therapist, some children appeared to benefit more from the counseling experience than others.

As a clinical psychologist intern at a cancer clinic, Gass (1979) developed a therapeutic intervention style in which cognitive-behavioral techniques were employed
after a nondirective base, i.e., empathy, acceptance, and genuineness, had been established with the dying patient. While there was not enough time with some patients to develop this type of intervention, others benefitted from the additional time spent in therapy. They were taught, for example, to reduce the level of pain by closing their eyes, relaxing, and directing their attention to their breathing. Pain was allowed to come without fighting it in any way. They were instructed to breathe right into the sensation of pain and relax instead of struggle with it.

Another technique involved the use of a fantasy dialogue where patients, in a Gestalt fashion, took on the role of different sides or polarities within themselves. These roles were verbally acted out so as to enhance the awareness of introjections and projections, which in turn led to significant personality integration. Even dialogues with "absent" parents and significant others seemed therapeutically beneficial.

Fantasy and role playing were also combined when patients were allowed to play out in fantasy the recurrence of their tumors and then actually role-play the tumor. Powerful thoughts and emotions were released through these combined techniques, and much emotional pressure was relieved.

Gass also guided patients in the use of visualization. They were asked to visualize a warm ball of light centered in the heart. It was seen as shining brightly and growing in size and strength with each breath. This light was allowed to grow until the tumor was touched and healed. This technique was used as well for the amelioration of pain. Thus, the tumor would be replaced with localized pain. Gass found that visualization could likewise be used to picture the chemotherapy and radiation attacking and destroying cancer cells. Most of these visual techniques were well-received by patients and practiced religiously outside of therapy.

Body therapy was also employed where patients pounded on pillows or kicked something soft. In addition, they were allowed to push against Gass's hands and think and yell whatever they wanted. He was often replaced, through fantasy, with a boss or
relative. Afterwards, each patient reported a more free-flowing energy level and sensed less tension, stress, and anxiety within his/her body.

Gass also used homework assignments to get patients to: (1) observe how and when they back down from situations; (2) assess the feasibility and success of defense mechanisms discussed during therapy; and (3) apply the techniques and problem-solving strategies discussed and/or utilized in therapy. Role playing was used when patients needed to get a better perspective of another's point of view. They often played the role of a parent or spouse, and gained much from the experience of being in someone else's position. Some family dilemmas were resolved, or at least modified, by the use of this technique.

Jampolsky, a psychiatrist, consultant, and founder of The Center for Attitudinal Healing, presented a philosophy in which attitude is the key in combating medical crises and living life to the fullest (Jampolsky, 1979). While fear, anger, depression, and loneliness are normal responses, the patient learns, with support from others, that he/she can obtain inner peace by letting go of fear. It is possible to choose peace rather than conflict and love rather than fear. Jampolsky later defined health as inner peace and healing as the process of letting go of fear. Honest communication with oneself and others is very important through all of this (Donahue and Kids, 1981).

His theory included the notion that the patient helps himself/herself when extending help and love to others:

For a child or an adult experiencing a catastrophic illness, there is a temptation to feel anger towards the world, alone, different, and isolated; to feel that the universe is unloving and attacking. Healing begins where there is a shift in perception about illness and its related problems. This shift in perception can occur as a child or an adult learns how to focus on helping others by extending only love, learns that each instant is the only time there is, and discovers that within that instant they do not perceive

-22-
themselves as ill or in pain. One such instant can become two and three
and many. (The Center for Attitudinal Healing, 1979, p. 1)

At the Center there are weekly support groups for children and adults with
cancer, and similar groups for the parents and siblings. A non-judgmental, loving
atmosphere prevails as people share common concerns and problems. Case studies show
that these groups have been helpful to many:

When I first came to the Center I was 7. I had leukemia. I blamed my
doctor for everything. He was supposed to make me feel better but all the
medicines did was make me sick. I was really scared of the needles, so I
was really mad at my doctor. By talking to the other kids in the group I
figured out that the leukemia wasn't his fault. I didn't have to be angry or
blame someone. When I stopped being angry, I felt much better. (The
Center for Attitudinal Healing, 1979, p. 5)

Greg Harrison, an 11 year old, drew pictures of good cells and bad cells as
soldiers. The good cells were winning the battle. A year and one-half after
he drew these pictures, Greg died of leukemia, but he lived longer than the
doctors expected. Long after he should have been able, Greg continued
with school and participated in activities others with the same limitations
were not capable of performing .... ("Replacing Fear With Love Brings
Inner Peace," 1979)

The second case study involves group support and interaction as well as art
therapy. Some of this artwork created as part of the art therapy at the Center was
actually published (The Children, 1979). Other techniques besides artwork to focus upon
the positive include relaxation exercises, guided imagery, visualization, meditation, and
expanded breathing (The Center for Attitudinal Healing, 1979).
There are also Phone Pal and Pen Pal Programs for those who can only communicate by phone or in writing. One person noted that "our relationship has made all the difference for both of us. I am very glad we were put in touch through the Center" (The Center for Attitudinal Healing, 1979, p. 7). The mother of a leukemic child said, "Letters are exchanged often, along with small gifts, photographs and secrets. It is a very special contact and they hope to meet each other one day" (The Center for Attitudinal Healing, 1979, p. 7). Many others wrote or called to say that, through sharing, many things had been clarified in their own minds.

Simonton, Simonton, & Creighton (1973) surveyed the literature concerning the psychodynamics of cancer patients and found that frequently patients respond with hopelessness to a major frustration in life or loss of a loved one. This is believed to lead to a breakdown in normal cell growth, which precipitates neoplastic growth. Their theory base became one that acknowledges psychological factors influencing not only who gets cancer, but also who recovers from it. Stress is seen as the main precipitating factor and its relief the goal of therapy. Their approach seems quite appropriate since they discovered that those who quickly succumb to cancer remain in states of denial and depression. Those who live much longer are emotionally resilient, physically active, flexible in their beliefs, socially autonomous, and have a strong, healthy self-concept.

The Simontons, therefore, developed a program whereby the patient gains a better understanding of his/her role in the development and course of the disease. New ways of coping with stress are learned, e.g., assertiveness training, goal setting, physical exercise, mental imagery, guided fantasy, relaxation techniques, transactional analysis, play therapy, and good nutrition. The patient also begins in therapy to incorporate more positive attitudes and beliefs about everything, including cancer. In addition, cassette recordings are used three times a day to relax, followed by visualization of cancer cells being attacked by conventional treatment and the body's immune system. Reports from the patient on his/her imagery, which sometimes include imagery drawing, help the
therapist ascertain whether positive attitudes and beliefs are being utilized (Kolata, 1980).

A research study was conducted with 225 patients with advanced malignancies, who participated in the Simonton program. It was found that they lived twice as long as the national average (Simonton, Simonton, & Sparks, 1980). Critics pointed out, however, that these patients were strong enough to make the trip to Texas, yet they were compared with many bedridden patients (Kolata, 1980).

The Simontons (in Kolata, 1980) presented a case study of Bob, who had less than 1% chance of cure. He had been through chemotherapy and surgery before visiting the Simontons. Two months after his visit there was no sign of cancer. He wrote, "I've learned a lot about my responsibility for my disease, my responsibility for healing, and about the techniques for unlocking the powers that can be found in all of us" (p. 53).

Summary

The studies presented give therapists some direction in using cognitive-behavioral therapeutic techniques when working with the terminally ill. There seem to be some concerns, however, that still need to be addressed. At the present time, there are few structured research studies analyzing the efficacy of these techniques with the dying. It is uncertain how therapeutic they are and whether they should be administered individually or in groups. Much will be learned when more rigorous research results become available. This will lead to modifications in the techniques so that patients will receive the optimal benefit from therapeutic intervention.

One concern with the Simonton's theory and its application is that it causes many people to feel guilty for causing their cancer. Most medical experts contend that there is no scientific evidence that people create cancer by their behavior and personality nor cause the cancer to disappear when these variables are changed (Kolata, 1980). Be that as it may, many people find comfort and support in the Simonton approach, and peace of mind during such a crisis is therapeutic. Some get physically better, but more research
must be undertaken before the Simontons can accept this as an outcome of their intervention.

These different therapeutic techniques cited above seem to be well received by the patients, especially when they have enough physical and/or psychic energy to become involved. Also, such an orientation seems appropriate when dealing with the major problems that confront patients during this time, e.g., relaxing, communicating, being assertive, and handling stress.

**Other Therapeutic Approaches**

While many studies cite the benefits of either a nondirective or stress management style of therapeutic intervention with the terminally ill, there are several that report positive results when other treatment modalities are employed. An early approach to working with dying patients was psychoanalytical. Eissler (1955) viewed the dying process as one where the libido is fighting the death instinct and its release of self-destructive energies. Thus, there is no libidinal energy for normal libidinal functioning, much less coping with dying. He said the role of the therapist, if the patient does not acknowledge the imminence of death, is to enhance his/her libidinal energy by showing concern such as sorrow or pity. The therapist also shows a conviction in the patient's immortality. Eissler said that this is conflicting, but the patient still gains in trust, courage, and consolation.

If the patient acknowledges that he/she is dying, the therapist, through countertransference, bonds with him/her to the bitter end. This helps the patient with object loss anxiety since the therapist is always available to provide comfort, emotional support, and meet other needs. Eissler, however, provided no research or case studies to validate his theory.

Rosenthal (1957) felt the main problem for the dying patient is the fear of death. Often this fear is repressed, and negative feelings, e.g., anxiety, rejection, and
abandonment, surface. If there are strong negative feelings toward himself/herself and/or the past, guilt will also be a problem.

While acknowledging this fear of death and the need to address it, Rosenthal felt the primary concern of the therapist is to help the patient resolve any guilt issues. By the use of insight techniques such as clarification and interpretation, good rapport, and emotional support, the therapist helps the patient gain insight into his/her past so as to rid the ego of any remaining guilt. In this way the fear of death abates, and the patient, having gained self-acceptance, is more prepared and ready to die. The idea is that a strong ego does not take dying as hard as a weak one; a strong ego feels that it has lived a good life so it views dying with much less anxiety. Rosenthal stated that emergence into creative endeavors enhances the ego during this time and should be encouraged by the therapist. No supportive research was provided to verify these views.

Wylie, Lazaroff, and Lowy (1964) found that group psychotherapy based on a psychoanalytical approach proved beneficial for one participant who was dying. Because of her group experience, she was able to confront the idea of impending death. This helped her maintain a stable ego and resolve some major life problems. Her self-esteem was stimulated with the discontinuance of debilitating defense mechanisms. She returned to work temporarily, obtained new personal gratifications, and strengthened family ties. In this way she did not feel the need to isolate herself, and significant others did not want to withdraw their support from her.

Bowers, Jackson, Knight, and LeShan (1964) saw the dying as very fearful of death because of the feeling that they have "never lived." The therapist helps these patients develop a greater sense of self-awareness and individuality so as to lead to personal growth and self-actualization. In this way they come to understand themselves better and how they fit into the life process, which ultimately helps them view the dying process in a more positive light.

The main emphasis is on living fully for whatever time is left. It was suggested
that the "will to live" is stimulated through self-actualization and creative endeavors, and consequently the patient lives a longer, happier life. No research was presented to support these contentions.

Pattison (1967) presented a counterattack proposal as the patient deals with the dying process. He cited the many problems that must be resolved: rational and irrational fears; the loss issue, e.g., family, friends, self, and body; death as insoluble; the threat to life's goals; heightened anxiety; and unresolved conflicts from the past. The therapist helps the patient deal with such a dilemma by helping him/her break up the problems and approach one at a time. In this way the patient, as each problem is resolved, gains in dignity and self-respect. Acceptance of death is enhanced as the patient demonstrates more and more ability in mastering various dying crises.

Pattison stressed the need for the patient to retain all possible decisions and authority during the dying process so as not to be reduced to the status of a child. Even minor daily decisions and tasks are important to keep the self-esteem and self-control components intact. The therapist retains a watch-dog role in this regard. He/She is also a motivating agent when necessary. Case studies were presented to validate this approach.

Fisher (1970) believed that dying patients experience an identity crisis because of the deterioration of the physical body. He also noted that they are plagued with emotional lability as well as intense anger, fear, and pain. Other emotions that emerge to some degree include psychological isolation, panic, anxiety, dependency, despondency, and apathy. The therapist, through the use of lysergic acid diethylamide (LSD) in an intensive marathon counseling session, helps him/her adopt a new view of life whereby an appropriate, healthy identity is formed. The focus is outside of himself/herself and toward an identification with the "life process." In this way fear of extinction or annihilation of the body and ego abates as a new equilibrium and consciousness emerge.

Fisher cited many other studies that provided results similar to his. The most
significant patient reactions were: (1) reduction in pain; (2) heightened disregard for the gravity of the situation; (3) open attitude about death; (4) acceptance and surrender to the loss of control; (5) will to live strengthened; (6) new zest for experiencing life; (7) new insights into oneself, life, and relationships; and (8) desire to share these insights with others (ff. 3-8). He presented a case study of a 65 year old, married female with radical mastectomies for breast cancer who later developed terminal lung cancer and underwent the "guided" LSD experience. She was able to work through pain, fear of death, conflict resolution with a dead sister, and dependency needs. She also became more at peace with herself and others.

Hineman (1971) met individually with terminally ill patients and explored their ability to live creatively knowing that death was imminent. He also investigated their self-concept and acceptance of self and others. The patients were eager to talk about their innermost feelings concerning death and dying. The Semantic Differential, a method for measuring attitudes, was administered to 10 patients before and after the eight week counseling period. Four patients made definite gains in the areas of self-concept, self-acceptance, and acceptance of others. All 10 patients, however, demonstrated that they were trying to live meaningful lives. Those most positive and creative were very mobile, participated in hobbies, cared for a spouse and/or family, and continued working on the job. Those more negative and less accepting were fearful and hesitant about getting involved in any type of activity. None of the 10, however, felt suicide was justifiable in this situation. The appropriate action was to try to live fully and completely until death.

Zuehlke (1976) studied the effectiveness of logotherapy, an existential psychotherapeutic technique, with terminally ill patients who volunteered for individual psychotherapy sessions. There were eight, 45 minute sessions over a two week period. The results were quite impressive. There was an overall significant difference between the treatment group and the control group. For those involved in therapy, there was
more self-exploration and communication with others as well as an activated interest in
seeking out a meaningful purpose in life. In addition, denial, repression, and
defensiveness decreased in intensity.

Schoenberg (in McKinick, 1981-82) felt the pressing need for the dying patient is
to reduce feelings of isolation and loneliness, especially during a time when significant
others are starting to withdraw. The therapist helps by offering support and comfort and
assists the patient in getting back into life emotionally. Other feelings such as fear,
guilt, and depression are addressed as well. Negative images and fantasies about death
are confronted and resolved.

Schoenberg stated that the therapist should always be available to support and
assist the patient, especially when loneliness and isolation strike. He also noted that
such a regressive relationship where the therapist is seen as an omnipotent figure can
actually enhance the counseling relationship. No research or case studies were provided.

Summary

A number of studies cited different types of therapeutic intervention that are
helping patients cope with catastrophic illnesses. There remains, however, a paucity of
research methodology employed by the investigators. Case studies are presented, but
they are quite subjective and biased in nature. Even when treatment effects were
analyzed critically, there were few subjects and usually no control group.

Summary of Research and Relationship to Problem

In reviewing the literature, it is apparent that many of the same characteristics of
the terminally ill are reported; i.e., fear of dying, depression, anxiety, and anger. Not all
researchers comment on the need for therapeutic intervention, although for those who
do, therapeutic intervention seems to be appropriate and helpful to the patients. There
are reports of an increased sense of well-being and hope and a diminution of depression
and anxiety. The use of coping skills is facilitated, which seems to result in
psychological homeostasis for a person faced with imminent death. Most investigators analyze the effects of therapy on a small treatment group and do not provide for a control group. Nevertheless, many case studies are presented, but they seem subjective and biased in nature. Few comparisons are made among different therapeutic styles.

With the present state of the art, more research is needed to ascertain what psychological characteristics truly describe the terminally ill and what defense mechanisms are employed. States of dying must also be studied to determine whether they do, indeed, exist and if so, how they work, e.g., nature of occurrence and interaction and degree of power. With such information, therapists would be able to give special consideration to any emotional or situational dilemma that might arise. As a result, the personal-social adjustment and self-esteem of the dying would be enhanced.

The purpose of this study was to analyze the efficacy of two group counseling approaches, nondirective and stress management, on adult patients who had been diagnosed with metastatic cancer since August 1, 1980. Groups were compared with each other and a control group. The personality characteristics that were examined were anxiety, self-esteem, innerdirectedness, and time competence. In this way more will be learned about the effectiveness of therapeutic intervention with adult patients suffering from a catastrophic illness.
CHAPTER III

METHODOLOGY

Population and Selection of the Sample

The population of this study consisted of adult outpatients from metropolitan Richmond, Virginia area hospitals who had been diagnosed with metastatic cancer since August 1, 1980. In order to obtain a sample of such a select population, referrals were solicited from many sources. Staff personnel at the Medical College of Virginia (MCV), Richmond, Virginia in the Cancer Rehabilitation and Continuing Care Program, Joint Cancer Clinic, Radiation Therapy Department, and Social Work Department met informally with the investigator so that he could explain his study. Shortly thereafter, each received a letter (Appendix C) which reiterated the nature of this study and requested referrals that met certain criteria. A similar letter (Appendix D) that included with it the "Proposal for Research with Human Subjects" was sent to 24 doctors from MCV and eight from other metropolitan Richmond area hospitals. This proposal was submitted to and approved by both the School of Education and College of William and Mary Human Subjects Research Committees.

The mass media was utilized in an attempt to inform potential group participants of this study. A letter (Appendix E) was hand-delivered to Ms. Lauren Haney and Ms. Norma Blalock from WTVR-TV Channel 6 and WWBT-TV Channel 12, respectively. These public service announcees presented this information several times a week on the Community Calendar, which aired at 6:30 a.m. daily. In addition, Ms. Blalock conducted a two-part television interview with the investigator concerning his own cancer experience and his interest in helping others cope with this life-threatening disease. For newspaper coverage, an ad (Appendix F) was run in the retail advertising section of the Richmond News Leader stating the pertinent information and soliciting volunteers for this study.
CanSurmount volunteers who work in a supportive role with cancer patients and their families received a letter (Appendix G) informing them of this study and requesting appropriate referrals. Additional medical personnel, e.g., clinical nurse specialists, registered nurses assisting with radiation therapy and chemotherapy, hospice coordinators and nurses, and chaplains and social workers, from metropolitan Richmond area hospitals and staff members at the American Cancer Society received the same information (Appendix D) that was sent to the physicians. Excluding the mass media contacts, 103 people were provided information concerning the solicitation of subjects for this study.

As the investigator began implementing the recruitment design, staff personnel from the Cancer Rehabilitation and Continuing Care Program and the Joint Cancer Clinic at MCV became encouraging in their comments and enthusiasm. They felt that there would be no problem recruiting 18 to 24 participants for this study. They stated that the investigator should be able to recruit this number from MCV alone. This did not prove to be the case.

By the middle of August, 44 patients from MCV had been referred. Eleven of these patients did not fit the criteria for the study because there was no medical diagnosis of metastasis in their charts. One patient had metastasis which had occurred five years ago. In addition, two patients had actually expired before the time of the referral.

It is worth noting that, while 24 doctors from MCV had been contacted by letter (Appendix D), not one provided a referral during this time. Of the eight from other metropolitan Richmond area hospitals, only one proved to be supportive and helpful.

Thus, 30 patients from MCV qualified for an interview. Only 25, however, were contacted because four were too ill and one could not be located. Nineteen agreed to participate in the study, but only six actually became group participants. Of the 13 that did not attend, six became too ill to join a group, four expired before the study
commenced, one changed her mind about becoming involved, one became too busy, and one moved out of town.

With only six participants, the investigator rigorously pursued referrals from other sources. A letter (Appendix E) was hand-delivered to public service announcers from WTVR-TV Channel 6 and WWBT-TV Channel 12. Information concerning the support groups was aired several times a week during the month of August. During the middle of August Channel 6 aired a two-part interview conducted with the Investigator in hopes of recruiting even more participants. No referrals were obtained from these sources. A newspaper ad (Appendix F) was run in the Richmond papers the third weekend in August. This led to two calls from concerned relatives of cancer patients. One of these patients did not have the opportunity to become involved because she was never told about the support groups. It was felt by the relative that these groups might depress her too much. The group format and intent was explained in detail, but to no avail. The other patient became too ill to consider participating in a group.

Having had no success with the mass media, the investigator then mailed a letter (Appendix G) to approximately 25 CanSurmount volunteers. Only one responded, but she gave the investigator eight referrals. Three actually became involved in a group; two were interested but became too ill before the groups began; one was too busy to participate; one did not have a medical diagnosis of metastasis; and one was interested but expired before her group was to meet.

The Investigator then contacted a clinical oncological nurse specialist from St. Luke's Hospital who provided four referrals. Three joined a group. The fourth, while initially quite interested, was too busy when her group began meeting. A registered nurse working directly with an oncologist in his office provided five referrals. Four said that they would be interested. Only two became involved in a group. One became too ill; another expired before her group began meeting. The fifth person said she was too busy at this time to participate.

-34-
A registered nurse working on an oncology unit at Richmond Memorial Hospital (RMH) provided four referrals. Two became group participants; one wanted to be a participant and was able physically but never attended a group session; and one said she was not ready at that time to talk about cancer in a group. Another registered nurse at RMH provided one referral who did join a group.

The investigator contacted the hospice coordinator from the Instructive Visiting Nurse Association. She only provided one referral, but he became involved in a group. The American Cancer Society was able to provide one referral, and she was very interested in being a participant. She was too ill when the groups began meeting and, therefore, did not participate.

Medical personnel, e.g., clinical nurse specialists, registered nurses, and social workers, from Henrico Doctors' Hospital, St. Mary's Hospital, Johnston-Willis Hospital, McGuire Veterans Medical Center, and Retreat Hospital were contacted for referrals. None were gathered from these sources. One hospital administrator would not allow his patients to be referred to a group that would be held in another hospital for fear that they might change hospitals. He did, however, welcome the investigator to conduct the study at his hospital and use his patients. Another administrator stated that such a study would have to be approved first by an administrative review board before any of his patients could be referred. This board would not meet until the middle of September, which would have been after the groups had begun.

By the time the support groups began meeting, i.e., September 10 and 11, 1984, the investigator had received a total of 70 referrals. All were reviewed and processed with the following results: 39 volunteers qualified for participation in the study and were interviewed by the researcher. After the interview was completed and all questions answered, a consent form was signed by each person. Of this number 19 people chose to participate in the study. Each received a confirmation letter (Appendix H) from the investigator and became actively involved in the groups.
The remaining 52 people were unable to or chose not to participate for the following reasons: (1) 14 were too ill to consider being a group participant; (2) eight expired before the groups began meeting; (3) 12 had no medical diagnosis of metastatic cancer; (4) seven were too busy; (5) four were simply not interested because of personal reasons, e.g., not quite ready to discuss cancer in a group setting, not interested in talking about cancer to anyone at anytime, and physical concerns more pressing at the time; (6) one said he would attend but never showed up; (7) one was interested but moved out of town; (8) one was interested but changed her mind about becoming involved; (9) one could not be located; (10) one was never told of the group by her relative; (11) one lived too far away, i.e., South Boston; and (12) one had metastasis which had occurred five years ago.

The sample of 18 volunteers were listed alphabetically and assigned randomly to the nondirective, stress management, or control group. Logistics and patients' schedules, including medical treatment regimens, quickly proved the use of this procedure to be ineffective. Using a modified random assignment procedure, 10 of the patients were reassigned to a group other than their originally assigned group. Even though this modified random assignment procedure was used to place these 10 patients into these groups, a review of the demographics of each group tends to support the truly randomness of the assignments. There was no control for age, sex, race, socioeconomic class, religiosity, or the number of years diagnosed with cancer.

**Data Gathering**

Each group facilitator distributed the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory to her group participants at an eleventh session and explained the directions. These assessment instruments were self-administered at home. Proper test-taking procedures were stressed by the facilitator. These included reading the test instructions first, making an honest attempt
to answer all test items without conferring with anyone else, and assuring that there are no disruptions during the testing period. The same instruments were hand-delivered to the homes of the control group members for self-administration.

All test data were considered confidential. Statistical comparisons were made among and within groups, but the identity of participants was not disclosed. After the test data were gathered and grouped, all answer sheets were destroyed.

As a validity check of the instrumentation results, an interview with each group participant was held within two weeks of the termination of each group. Open-ended statements which relate directly to major test constructs were utilized. A content analysis was conducted with the interview data.

Treatments

The design of this study necessitated the use of two treatment groups and one control group. The two treatment groups met for 90 minute sessions twice a week for five weeks. The first group received nondirective therapeutic intervention. Participants were involved in discussions about cancer, medical treatments and their side effects, and personal-social issues as they relate to the cancer experience (Appendix I). The group facilitator, through the appropriate use of empathy, acceptance, and genuineness, facilitated discussion rather than guided or directed it. An eleventh and final session was designed to process the termination of the group experience and explain test materials that were self-administered at home.

The second group was trained in the art of stress management. Each of the 10 sessions had a specific focus (Appendix J). In the first session the concept of stress management was introduced to group members. In addition, a handout (Appendix J, pp. xxix-xxx) which pertained to existential choices which confront cancer patients was discussed.
A videotape entitled "Living with Stress" was viewed and discussed at the second session. To complement this presentation, a handout (Appendix J, p. xxxi) outlining ways to become less vulnerable to stress was discussed.

The third and fourth sessions focused on topics of assertiveness as related to daily living and functioning as a cancer patient in society. Role playing situations were designed to stimulate discussions and enhance the problem-solving skills of group participants. There were numerous handouts (Appendix J, pp. xxxii-xli) to help facilitate the group process.

The fifth and sixth sessions involved instruction in proper breathing, relaxation exercises, and massage. A certified myotherapist was the group facilitator for these sessions and presented the art and science of therapeutic massage, i.e., myotherapy, and its preventative and remedial qualities. The facilitator emphasized the contention that myotherapy stimulates and relaxes different body parts so as to foster relaxation, relieve stress, tension, and fatigue, and assist in the recovery from specific maladies (Potomac Myotherapy Institute, 1984). A handout (Appendix J, pp. xlii-xlili) was presented for group discussion and edification.

A videotape entitled "Donahue and Kids" was viewed and discussed at the seventh session (Donahue and Kids, 1981). This presentation centered around children with cancer and coping skills they had developed and mastered. All were actively involved at The Center for Attitudinal Healing in Tiburon, California. The eighth session entailed a more in-depth discussion of issues raised in the videotape (Appendix J, p. xliii).

A hypnotherapist was the group facilitator at the ninth session. He explained the steps related to hypnosis and self-hypnosis, i.e., autorelaxation, autosuggestion, autoanalysis, and autotherapy, and guided the group members through a hypnotic experience. The value of self-hypnosis, thought control, and guided imagery were emphasized at this session. A handout (Appendix J, pp. xlv-xlvi) reinforced points presented for consideration.
A videotape entitled "Humor" was viewed and discussed at the tenth session. This session focused on the use of humor and other strategies to cope with the pressures of daily living.

An eleventh and final session was designed to process the termination of the group experience and explain test materials which were self-administered at home. An additional handout on stress management (Appendix J, pp xlvii-li) summarized many points emphasized during the group sessions.

The control group did not meet.

Each group was facilitated by a social worker from MCV who holds a Masters of Social Work (MSW) degree and has had a minimum of three years successful clinical oncological experience immediately preceding this study.

**Ethical Safeguards and Considerations**

Because of the nature of this study, established procedures for protecting the rights of human subjects were followed. A "Proposal for Research with Human Subjects" was submitted to the following committees for approval: (1) The College of William and Mary Human Subjects Research Committee; and (2) The College of William and Mary, School of Education Human Subjects Research Committee.

In addition, the investigator's three member doctoral committee, the coordinators for the MCV Cancer Rehabilitation and Continuing Care Program, and the physicians of the participating cancer patients approved this study before it was conducted. The close scrutiny that the aforementioned groups provided in regards to potential risks to subjects and safeguards established to counter these risks helped assure that the rights of these patients were not infringed upon.

All discussions, interviews, and written results of this study were treated in a confidential manner so as to protect the patients' anonymity. Patients were advised that they could terminate their participation in the group at any time and could opt not to
respond to particular questions or participate in certain activities.

Patients were encouraged to maintain a high degree of confidentiality within the group, and confidential comments remained within the context of the group. Facilitators constantly monitored this process and reminded patients when appropriate of its importance.

Two social workers (MSW), each with a minimum of three years successful clinical oncological experience immediately preceding this study, facilitated the treatment groups. This assured that a trained professional was always present to conduct the group and assist any patient suffering from severe psychological trauma. While the group experience was not expected to lead to undue psychological stress, plans were made to ameliorate debilitating problems for any patient. The patient would be removed from the study and referred to a Licensed Professional Counselor in the Cancer Rehabilitation and Continuing Care Program at MCV.

**Instrumentation**

**State-Trait Anxiety Inventory**

The State-Trait Anxiety Inventory (STAI) is a self-report instrument consisting of 40 descriptive statements designed to assess the degree of anxiety in a testee. There are two forms: (1) State-Anxiety (A-State); and (2) Trait-Anxiety (A-Trait). A-State is defined as a "transitory emotional experience characterized by subjective feelings of tension and apprehension" (Anastasi, 1982, p. 530). The testee responds to 20 statements in regards to how he/she feels at the moment. A-Trait refers to a "relatively stable anxiety-proneness" (Anastasi, 1982, p. 530). The testee responds to 20 statements in regards to how he/she generally feels. There are only three identical items on both forms. This test is appropriate for grades 9 to 18 and adults and can be completed in 15 to 20 minutes.
The norms for the STAI are based on 377 high school juniors, 982 college freshmen, 484 college students in introductory psychology classes, 461 male neuropsychiatric patients, 161 general medical and surgical patients, and 212 prisoners. Thus, reported test scores can be compared with the normalized and percentile ranked scores for the related norm group.

The internal consistency reliability as measured by the Kuder-Richardson reliability formula (K-R 20) is .80 to .90 for both forms. The retest reliability for A-Trait is in the .70s but much lower, i.e., .27 to .54 for the A-State. This is to be expected since this form does not measure persistent characteristics of the testee (Spielberger, Gorsuch, and Lushene, 1970). Dreger (in Buros, 1979) noted that these reliabilities, especially for A-Trait, are as high as those of intelligence tests.

Katkin (in Buros, 1978) found the A-Trait scores of the STAI to be positively correlated with the IPAT Anxiety Scale, Taylor Manifest Anxiety Scale, and the Affect Adjective Check List. He concluded that the STAI basically measures the same general anxiety construct and may be interpreted in the same manner. The validity of A-State scores is demonstrated by many experimental studies that manipulate the anxiety level of a given situation. The mean scores change in the appropriate direction.

Katkin felt that there is a valid difference between A-State and A-Trait based on extensive research conducted with the STAI. He stated that this test appears to be a reliable and valid measure for assessing the anxiety-proneness and transitory anxiety of normal and patient populations.

Dreger (in Buros, 1978) found the A-Trait scores to be related to real life criteria. A-State scores are questioned in this regard. While faking is a problem with this test, expected differences among selected groups still emerge. The state-trait dimension appears to be valid, even though A-State appears to be multidimensional.

Anastasi (1982) found the construct validity of the STAI to be soundly established. In revisions, test items have been selected based on the strength of their
correlations to retests and external criteria. There are high correlations of A-Trait scores with other anxiety inventories and significant correlations with personality inventories measuring the same construct. The validity of both forms is substantiated by studies using contrasted groups. This study used both forms of the STAI. In this way the investigator assessed two types of anxiety and how each responded to therapeutic intervention.

**Tennessee Self Concept Scale**

The **Tennessee Self Concept Scale (TSCS-Form C)** consists of 100 self-descriptive statements designed to assess self-esteem. Test measures include response defensiveness, total self-esteem score (Total P Score), and eight self-perception subscores. This test is appropriate for individuals 12 years and older with at least a sixth grade reading level. It is self-administered and can be completed in 10 to 20 minutes.

Normative data are based on 626 people from various parts of the United States. The age range is 12 to 68 years old (Pitts, 1965). However, Suinn (in Buros, 1972) reported that there are no descriptive statistics on the normative sample nor methods presented for the selection of this sample. He was very critical of the overrepresentation of college students, white subjects, and people ranging in age from 12 to 30 years old. He found that TSCS scores for southern Black students are different from Caucasians. While this enhances construct validity, it generates concern about the representativeness of the normative sample. In addition, there is no presentation of research studies that confirm the author's contention that there are no significant relationships between demographic variables and TSCS scores.

Crites (1985) noted that the test-retest reliability of total scores and subscores is high, i.e., .70 to .90. The TSCS correlates well with other personality inventories, e.g., Minnesota Multiphasic Personality Inventory (MMPI) and Edwards Personal Preference Schedule (EPPS). It also discriminates between normal and psychiatric groups and
records significant differences among psychiatric groups. There is evidence supporting
the positive effect that psychotherapy and related experiences have on certain TSCS
scores. However, Crites questioned if the TSCS is a true measure of self-concept since
the testee is not allowed to use his/her own words to describe himself/herself. Because
of this, he felt that the construct validity needs more verification.

Stuinn (in Buros, 1972) stated that the construct validity is sound. Literature
surveys on self-concept, patient self-reports, and analyses by seven clinical psychologists
were considered during the construction of this test. He added that the TSCS seems to
have content validity but will need to be validated empirically over time. In regards to
criterion related validity, hospitalization and psychotherapy seem to affect scores in the
expected direction. Sensitivity training, however, has no effect.

Benter (in Buros, 1972) stated that there is discriminant validation of the TSCS
(Total P Score) with a negative correlation, i.e., .70, with the Taylor Manifest Anxiety
Scale. Convergent validation is established with correlations from .50 to .70 with the
Cornell Medical Index and an unpublished Inventory of Feelings. Correlations with
related MMPI scales range from .50 to .60. He believed that there is enough overlap with
other sound testing instruments to allow the TSCS to be substituted in their place when it
is appropriate.

Benter believed that the content areas investigated by the TSCS are well
conceived and provide pertinent information about the self-esteem of the testee. While
the normative population is not representative of the total population, he contended that
it seems appropriate for most practical purposes. Concerning psychometric qualities, the
TSCS appears to meet test construction standards. However, there is no analysis in
regards to the internal consistency of the overall scale or subscores.

Investigating the high intercorrelations, i.e. .60 to .90, of the subscores, Renta and
White (1967) conducted a factor analysis and found only three factors, with the main one
being self-acceptance. Vacchiano and Strauss (1968) found 20 factors but no support for the Identify, Self-Satisfaction, and Behavior subscores.

Because of the nature of this study, the investigator utilized the TSCS Counseling Form (Form C) and its Total P Score. This score reflects the overall level of self-esteem and is supported by research studies as a reliable and valid measure of self-esteem.

**Personal Orientation Inventory**

The **Personal Orientation Inventory (POI)** is a 150 item forced choice test consisting of paired value judgments designed to assess values, attitudes, and behavior relevant to Maslow's (1962) concept of self-actualization. There are two major scales: (1) Time Competence (Tc); and (2) Inner Directed (I). The Tc Scale (23 items) assesses the tendency of the testee to live in the present, with little time spent analyzing past problems or future concerns. The I Scale (127 items) assesses the tendency to be controlled by internal volitions and principles, not extraneous factors. There are 10 subscales. This test is appropriate for grades 9 to 16 and adults. It is a self-report instrument and can be completed in 30 to 40 minutes.

Normative data are based on selected occupational and clinical groups and 2,607 entering college freshmen at western and midwestern liberal arts colleges (Shostrom, 1974). Bloxom (in Buros, 1972) noted that the normative data are biased toward the college student population and do not include norms for psychiatric outpatients even though the manual suggests that the POI would be useful with such a population.

The test-retest reliability of the POI ranges from .55 to .85. Shostrom (1974) reported studies supporting concurrent validity and noted that construct and predictive validity are supported by the use of the POI with special interest groups. It is used as an assessment tool to analyze the efficacy of human relations training, growth groups, T-groups, and sensitivity training groups.
Coan (in Buros, 1972) was concerned that no construct validity is cited for individual scales. He noted that the nature of this test, i.e., forced choice, causes some testees to select statements that are not appropriate descriptors of their personality. Test defensiveness is not accounted for in the scoring of the POL, and variables designated as valid components of self-actualization seem to be arbitrary and not based on sound construct validity. However, supportive validity data are available. Scores are higher for those seen as self-actualized by clinical psychologists. Scores also increase as a result of psychotherapy.

Bloxom (in Buros, 1972) found that the content validity of the major scales is good, item content in each scale is varied, and the variables to be assessed are broadly defined. However, internal consistency is not reported in the manual and subscale intercorrelations are too high. He discovered so much item overlap in the subscales that their statistical independence and content validity can not be supported. The conceptual schema is loosely designed, which causes such item overlap. The I Scale shows promise as a measure of self-actualization, and there are studies that support its convergent and discriminant validation. There is a positive correlation with this scale and extroversion, college grades, and creativity measures. There is a negative correlation with neuroticism, dogmatism, and the Depression, Psychasthenia, and Social Introversion Scales of the MMPI.

Bloxom reported that there are contrasting studies that question the I Scale as a measure of complete self-actualization. From these studies it appears that a person may score high on this scale but still not be utilizing all personal resources in a self-actualized manner.

This study used the To Scale and the I Scale of the POL. There were several reasons for this decision. The first was that the investigator, having studied the constructs of this test, was only interested in assessing the time competence and innerdirectedness of his subjects. The second was that these two scales do not have item
overlap and their reliability and validity are supported by the research. The third was that the 10 subscales of the POI are not significant for this study and not sufficiently supported by the research.

**Research Design**

The research design used in this study was Campbell and Stanley's (1963) Posttest-Only Control Group Design. The design was as follows:

<table>
<thead>
<tr>
<th>Experimental Group 1:</th>
<th>( R \rightarrow X_1 \rightarrow O_1 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group 2:</td>
<td>( R \rightarrow X_2 \rightarrow O_2 )</td>
</tr>
<tr>
<td>Control Group:</td>
<td>( R \rightarrow O_3 )</td>
</tr>
</tbody>
</table>

**Key:** An "R" indicates that subjects were randomly assigned to treatments; "X" represents exposure to an independent variable manipulated by the researcher; "-" refers to isolation from the experimental factors; "O" refers to the posttests which measured the effects of the independent variable; and all symbols in a given row apply to the same specific group.

**Experimental Group 1:** This group received nondirective therapeutic intervention.

**Experimental Group 2:** This group was trained in the art of stress management.

**Control Group:** This group did not meet.

There were two reasons for selecting the Posttest-Only Control Group Design. The first concerned the educative nature of the instruments which could contaminate the effects of treatment. Test items could stimulate in the participants a particular psychological orientation toward the treatment. The second concerned the psychodynamics of patients with metastatic cancer. The interaction of emotional
factors, especially stress and anxiety, with the pretest could cause group participants to be more sensitive or responsive to the treatment.

**Statistical Analysis**

The statistical procedure that was used to determine the efficacy of two different group counseling approaches with adult patients suffering from metastatic cancer was the analysis of variance (Li, 1964). All statistical treatments were based on a five percent level of significance. The analysis of variance was selected for two reasons: (1) its sensitivity to within-group and among-group variance; and (2) the decision that this study would employ the Posttest-Only Control Group Design.

**Specific Hypotheses**

The following null hypotheses provided the basis for testing whether or not there was a significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on posttest anxiety, self-esteem, innerdirectedness, and time competence measures:

$H_{01}$: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the State Anxiety Scale of the State-Trait Anxiety Inventory.

$H_{02}$: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Trait Anxiety Scale of the State-Trait Anxiety Inventory.

$H_{03}$: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Total P Score (Self-esteem) of the Tennessee Self Concept Scale.
There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Inner Directed Scale of the Personal Orientation Inventory.

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Time Competence Scale of the Personal Orientation Inventory.

Summary of Methodology

Eighteen adult outpatients from metropolitan Richmond, Virginia area hospitals who had been diagnosed with metastatic cancer since August 1, 1980 were the subjects of this study. All were volunteers and were assigned, using a modified random assignment procedure, into one of three groups: nondirective, stress management, or control.

The nondirective and stress management groups met for 90 minute sessions twice a week for five consecutive weeks. The control group did not meet. Each group facilitator distributed the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory to the participants at an eleventh session and explained the directions. These assessment instruments were self-administered at home and proper test-taking procedures were stressed by the facilitator. The same instruments were hand-delivered to the homes of the control group members for self-administration.

Individual interviews were conducted within two weeks of the termination of each group. They served as a validity check of the instrumentation results.

The research design used in this study was the Posttest-Only Control Group Design. The statistical procedure that was used to determine the efficacy of the two different group counseling approaches was the analysis of variance. Five null hypotheses provided the basis for testing whether or not there was a significant difference ($\alpha = .05$)
among the nondirective, stress management, and control groups on posttest anxiety, self-esteem, innerdirectedness, and time competence measures.
CHAPTER IV
RESULTS

Hypotheses and Assessment Instruments

Because of the nature of this study, a Posttest-Only Control Group Design utilizing an analysis of variance was selected by the investigator. In question was the efficacy of two different group counseling approaches with adult patients suffering from metastatic cancer. To test whether or not there was a significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on posttest anxiety, self-esteem, inner-directedness, and time competence measures, five null hypotheses were constructed.

The first null hypothesis was:

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the State Anxiety Scale of the State-Trait Anxiety Inventory.

An analysis of the data, summarized in Table 1, revealed that there was no significant difference among groups at the .05 level of significance. The significance of $F$ was .69. The investigator failed to reject this hypothesis.

The second null hypothesis was:

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Trait Anxiety Scale of the State-Trait Anxiety Inventory.

An analysis of the data, summarized in Table 1, revealed that there was no significant difference among groups at the .05 level of significance. The significance of $F$ was .51. The investigator failed to reject this hypothesis.
The third null hypothesis was:

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Total P Score (Self-esteem) of the Tennessee Self Concept Scale.

An analysis of the data summarized in Table 1, revealed that there was no significant difference among groups at the .05 level of significance. The significance of F was .87. The investigator failed to reject this hypothesis.

The fourth null hypothesis was:

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Inner Directed Scale of the Personal Orientation Inventory.

An analysis of the data, summarized in Table 1, revealed that there was no significant difference among groups at the .05 level of significance. The significance of F was .64. The investigator failed to reject this hypothesis.

The fifth null hypothesis was:

There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Time Competence Scale of the Personal Orientation Inventory.

An analysis of the data, summarized in Table 1, revealed that there was no significant difference among groups at the .05 level of significance. The significance of F was .81. The investigator failed to reject this hypothesis.

A description of the summative data for the nondirective, stress management, and control groups on the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory is presented in Table 2. Individual subjects' results on these instruments are presented in Tables 3 through 7.
### Table 1

**Analysis of Variance for the State and Trait Anxiety Scales of the State-Trait Anxiety Inventory, Total P Score of the Tennessee Self Concept Scale, and Inner Directed and Time Competence Scales of the Personal Orientation Inventory for the Nondirective, Stress Management, and Control Groups**

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Source of Variation (Main Effects)</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>Sig of F</th>
</tr>
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<tr>
<td><strong>State-Trait Anxiety Inventory</strong></td>
<td></td>
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<tr>
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### TABLE 3

**Scores on the State Anxiety Scale of the State-Trait Anxiety Inventory for the Nondirective, Stress Management, and Control Group Subjects**

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| 2. STRESS MANAGEMENT  | 7       | 28    |
|                       | 8       | 55    |
|                       | 9       | 38    |
|                       | 10      | 65    |
|                       | 11      | 34    |
|                       | 12      | 49    |
| RANGE                 | 28-65   |       |
| \( \bar{X} \)        | 44.83   |       |

| 3. CONTROL            | 13      | 32    |
|                       | 14      | 42    |
|                       | 15      | 34    |
|                       | 16      | 34    |
|                       | 17      | 53    |
|                       | 18      | 31    |
| RANGE                 | 31-53   |       |
| \( \bar{X} \)        | 37.67   |       |
TABLE 5

TOTAL P SCORES OF THE TENNESSEE SELF CONCEPT SCALE FOR THE 
NONDIRECTIVE, STRESS MANAGEMENT, AND CONTROL GROUP SUBJECTS

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### TABLE 7

**SCORES ON THE TIME COMPETENCE SCALE OF THE PERSONAL ORIENTATION INVENTORY FOR THE NONDIRECTIVE, STRESS MANAGEMENT, AND CONTROL GROUP SUBJECTS**

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Post-Group Interview Data

Individual post-group interviews were conducted within two weeks of the termination of each group. They served as a validity check of the Instrumentation results. A content analysis of the interview data was also conducted.

Each group participant was asked to respond with a "YES" or "NO" to four statements which relate directly to the major test constructs, i.e., anxiety, self-esteem, innerdirectedness, and time competence. If a "YES" was recorded for any statement, the investigator asked for clarification with an open-ended statement.

Table 8 shows a composite of the nondirective and stress management subjects' responses to the interview statements, while Table 9 shows the responses by the subjects in the control group. Tables 10 through 12 provide individual subjects' responses to these same statements.

The first interview statement for the nondirective and stress management group participants was:

"The group experience has had an effect on my feelings of stress and anxiety."

In each group five people responded "YES" and one responded "NO." The open-ended statement to clarify the "YES" responses was:

"My feelings of stress and anxiety have changed in the following ways:"

All 10 people who responded "YES" to the initial statement commented that the group experience helped relieve their level of stress and anxiety. Talking about cancer with other cancer patients and learning about their problems, feelings, and coping strategies appeared most therapeutic.

The first interview statement for the control group participants was:

"Since the first week of September, my feelings of stress and anxiety have changed."
### Table 8
SUMMARY OF POST-GROUP INTERVIEWS
TREATMENT GROUPS

<table>
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<th>STATEMENTS</th>
<th>NONDIRECTIVE</th>
<th>STRESS MANAGEMENT</th>
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<tr>
<td>If your answer to a is YES, please respond to b.</td>
<td>N=6</td>
<td>N=6</td>
</tr>
</tbody>
</table>

1.a. The group experience has had an effect on my feelings of stress and anxiety.  
   - YES: 5  
   - NO: 1

b. My feelings of stress and anxiety have changed in the following ways:
   - *  

2.a. The group experience has had an effect on my feeling about myself.  
   - YES: 4  
   - NO: 2

b. My feeling about myself have changed in the following ways:
   - *  

3.a. Because of the group experience, a different person(s) and/or thing(s) is/are now in control of my life.  
   - YES: 2  
   - NO: 4

b. The following person(s) and/or thing(s) is/are in control of my life:
   - *  

4.a. The group experience has had an effect on the way I spend my time thinking about the past, present, and future.  
   - YES: 5  
   - NO: 1

b. Now I spend most of my time thinking about the ___________.  
   (Past, present, or future)
   - *  

* Refer to Table 10  
** Refer to Table 11
| STATEMENTS |
|-----------------|-----------------|
| If your answer to a is YES, please respond to b. |

1.a. Since the first week of September, my feelings of stress and anxiety have changed.  
   b. My feelings of stress and anxiety have changed in the following ways:  
      YES 5  NO 0

2.a. Since the first week of September, my feelings about myself have changed.  
   b. My feelings about myself have changed in the following ways:  
      YES 3  NO 3

3.a. Since the first week of September, a different person(s) and/or thing(s) has/have been in control of my life.  
   b. The following person(s) and/or thing(s) has/have been in control of my life:  
      YES 2  NO 4

4.a. Since the first week of September, I have changed the amount of time I spend thinking about the past, present and future.  
   b. Now I spend most of my time thinking about the _________. (Past, present, or future)  
      YES 2  NO 3  UNDECIDED 1

*Refer to Table 12
<table>
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<tr>
<th>Subject</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
</table>
| 1.      | YES|"Stress and anxiety are relieved by talking about cancer...getting it out in the open. Talking with other cancer patients helps also."
| 2.      | YES|"Others' situations have given me encouragement, thus reducing my level of stress and anxiety."
| 3.      | YES|"Talking with other cancer patients helped relieve the level of stress and anxiety."
| 4.      | NO |"I don't feel I really have much stress and anxiety."
| 5.      | YES|"I'm comforted by the fact that my feelings of stress and anxiety are similar to those shared by others."
| 6.      | YES|"Relating with other cancer patients and hearing their ideas and thoughts helped relieve some stress and anxiety. Now I'm able to deal better with cancer issues. There was a positive effect of how others are coping ... if they can do it, so can I."
2. a. The group experience has had an effect on my feelings about myself.
   b. My feelings about myself have changed in the following ways:

   Subject 1
   a. YES
   b. "I have stronger feelings about a positive self. Makes me feel better just to be in a congenial group."

   Subject 2
   a. YES
   b. "If others can do more, I can, too."

   Subject 3
   a. YES
   b. "I'm more relaxed now in dealing with cancer and talking about it."

   Subject 4
   a. NO

   Subject 5
   a. YES
   b. "I feel better knowing that my feelings are similar to those shared by others."

   Subject 6
   a. NO

3. a. Because of the group experience, a different person(s) and/or thing(s) is/are now in control of my life.
   b. The following person(s) and/or thing(s) is/are in control of my life:

   Subject 1
   a. NO "I'm still in control."

   Subject 2
   a. NO "I'm still in control."

   Subject 3
   a. YES
   b. "Cancer is less in control. I'm learning to relax and be with my family and do more of my own stuff."

   Subject 4
   a. NO "God and I are still in control."

   Subject 5
   a. NO "I'm still in control."

   Subject 6
   a. YES
   b. "God and faith are in control."
4. a. The group experience has had an effect on the way I spend my time thinking about the past, present, and future.

b. Now I spend most of my time thinking about the _________________.
(Past, present, or future)

Subject 1  
a. YES

b. "present."

Subject 2  
a. YES

b. "present."

Subject 3  
a. YES

b. "present and near future."

Subject 4  
a. NO

Subject 5  
a. YES

b. "present and near future."

Subject 6  
a. YES

b. "future."
If your answer to a is YES, please respond to b.

1. a. The group experience has had an effect on my feelings of stress and anxiety.
   b. My feelings of stress and anxiety have changed in the following ways:

   Subject 7
   a. YES
   b. "Stress and anxiety were greatly relieved after talking with other cancer patients and hearing about their more serious problems."

   Subject 8
   a. YES
   b. "There was a reduction in stress and anxiety due to having more confidence in myself and expressing myself. Also, others' problems made me feel better about my own problems."

   Subject 9
   a. YES
   b. "Techniques of handling stress helped reduce my stress and anxiety."

   Subject 10
   a. YES
   b. "I can talk with others about cancer now and even say, 'You know, I am a cancer patient.' My stress has subsided and there is less fear of death and dying. I'm not taking valium now."

   Subject 11
   a. NO
   b. "But it helped me be more aggressive and do things for me."

   Subject 12
   a. YES
   b. "The positive attitude of group members helped reduce my level of stress and anxiety."
2. a. The group has had an effect on my feelings about myself.
   b. My feelings about myself have changed in the following ways:
      Subject 7
      a. YES
      b. "I just feel better about myself."
      Subject 8
      a. YES
      b. "My depression has abated. I have more positive feelings about myself and life in general. I'm going out more, especially to church."
      Subject 9
      a. YES
      b. "I'm more in control of myself. I feel better about myself and my coping skills."
      Subject 10
      a. YES
      b. "I don't feel as defeated. I'm more accepting of life, cancer, and mortality."
      Subject 11
      a. NO
      Subject 12
      a. NO "But it reinforced my present thoughts and feelings about myself."

3. a. Because of the group experience, a different person(s) and/or thing(s) is/are now in control of my life.
   b. The following person(s) and/or thing(s) is/are in control of my life:
      Subject 7
      a. YES
      b. "I'm in control. Before, the devil was in control."
      Subject 8
      a. YES
      b. "I'm in control, not depression and pessimism like before."
      Subject 9
      a. YES
      b. "I'm more in control now. A friend, my mother, and daughter are less in control."
      Subject 10
      a. NO "But I'm in greater control of myself and personal powers."
      Subject 11
      a. NO "God is still in control."
      Subject 12
      a. NO "Sam and I are still in control of my life."
4. a. The group experience has had an effect on the way I spend my time thinking about the past, present, and future.

b. Now I spend most of my time thinking about the ________________.
   (Past, present, or future)

   Subject 7
   a. YES
   b. "present."

   Subject 8
   a. YES
   b. "present and near future."

   Subject 9
   a. YES
   b. "present and near future."

   Subject 10
   a. YES
   b. "present."

   Subject 11
   a. NO

   Subject 12
   a. NO
# TABLE 12

## POST-GROUP INTERVIEWS OF CONTROL GROUP

If your answer to a is YES, please respond to b.

1. a. Since the first week of September, my feelings of stress and anxiety have changed.

   b. My feelings of stress and anxiety have changed in the following ways:

   **Subject 13**
   
   a. YES
   
   b. "There was an increase due to my loss of strength and stamina. I felt better after talking to my doctor."

   **Subject 14**
   
   a. YES
   
   b. "Due to my new therapy, my stress and anxiety fluctuate...go up and down like a roller coaster."

   **Subject 15**
   
   a. YES
   
   b. "There has been an increase in stress and anxiety due to family problems, a neighbor's problem, and the trauma related to trying to get a son into medical school."

   **Subject 16**
   
   a. YES
   
   b. "There was an initial increase in stress and anxiety due to arm surgery, loss of a dog, and gynecology tests which came back negative. Now everything is okay and I have less stress and anxiety."

   **Subject 17**
   
   a. YES
   
   b. "There has been a reduction in stress and anxiety because my physical and mental health have improved. I'm getting away from negative thinking and negative energy and more into positive decision making."

   **Subject 18**
   
   a. YES
   
   b. "My level of stress and anxiety has declined because of physically feeling better, especially during the last six months. Also, it's a positive thought that it's been a year since chemotherapy was completed."
2. a. Since the first week of September, my feelings about myself have changed.
   b. My feelings about myself have changed in the following ways:

   Subject 13  
   a. NO

   Subject 14  
   a. NO

   Subject 15  
   a. YES
   b. "I'm feeling better about myself because of working again and doing positive, constructive things."

   Subject 16  
   a. NO

   Subject 17  
   a. YES
   b. "I'm feeling better about myself because my disposition has changed for the better. I'm nicer and more pleasant to be around. Also, I'm not as upset when others aren't solicitous and sympathetic."

   Subject 18  
   a. YES
   b. "I have a better self-image because my physical health has improved."

3. a. Since the first week of September, a different person(s) and/or thing(s) has/have been in control of my life.
   b. The following person(s) and/or thing(s) has/have been in control of my life:

   Subject 13  
   a. NO

   Subject 14  
   a. YES
   b. "The new drug treatment, interferon, is in control of my life for the most part."

   Subject 15  
   a. NO "Chemotherapist and I are still in control."

   Subject 16  
   a. NO "God and I control me."

   Subject 17  
   a. YES
   b. "I'm more in control now, not cancer, doctors, doctor appointments, or treatment appointments."

   Subject 18  
   a. NO "But I'm in more control now."
4.  

   a. Since the first week of September, I have changed the amount of time I spend thinking about the past, present, and future.

   b. Now I spend most of my time thinking about the ________________.
      (Past, present, or future)

   Subject 13  
   a. NO

   Subject 14  
   a. UNDECIDED "There has been a change, but I'm not sure whether it began before the second week of September or not."

   b. "present and near future."

   Subject 15  
   a. NO

   Subject 16  
   a. NO

   Subject 17  
   a. YES

   b. "present and near future."

   Subject 18  
   a. YES

   b. "present."
All six participants responded "YES." The open-ended statement to clarify the "YES" responses was:

"My feelings of stress and anxiety have changed in the following ways:"

Two participants reported that their level of stress and anxiety had declined over the control period, while three participants reported an increase in both areas. The sixth participant stated that his level of stress and anxiety fluctuated throughout the control period. Participants appeared to be very sensitive to their physical and mental health and any unresolved personal problems.

It appears from analyzing the interview data related to the anxiety construct that there was no significant difference among the nondirective, stress management, and control groups. The level of stress and anxiety was relieved for most participants in the nondirective and stress management groups while only two participants in the control group noted a diminution of stress and anxiety. The interview data, therefore, support the results of the State-Trait Anxiety Inventory.

The second interview statement for the nondirective and stress management group participants was:

"The group experience has had an effect on my feelings about myself."

In each group four people responded "YES" and two people responded "NO." The open-ended statement to clarify the "YES" responses was:

"My feelings about myself have changed in the following ways:"

All eight people who responded "YES" stated that they were feeling better about themselves and life in general. They said they were focusing more on the positive aspects of life and becoming more involved in physical activities.
The second interview statement for the control group participants was:

"Since the first week of September, my feelings about myself have changed."

Three people responded "YES" and three responded "NO." The open-ended statement to clarify the "YES" responses was:

"My feelings about myself have changed in the following ways:"

All three people who responded "YES" said they were feeling better about themselves. They commented that their feelings were influenced greatly by a recent improvement in their physical and mental health.

It appears from analyzing the interview data related to the self-esteem construct that there was no significant difference among the nondirective, stress management, and control groups. All three groups had a substantial number of participants whose feelings about themselves had improved by the end of the group experience. The interview data, therefore, support the results of the Tennessee Self Concept Scale.

The third interview statement for the nondirective and stress management group participants was:

"Because of the group experience, a different person(s) and/or thing(s) is/are now in control of my life."

In the nondirective group two people responded "YES" and four responded "NO." In the stress management group three people responded "YES" and three responded "NO." The open-ended statement to clarify the "YES" responses was:

"The following person(s) and/or thing(s) is/are in control of my life:"

Of the two people in the nondirective group who responded "YES," one said that God and faith were now in control, while the other stated that she had regained control. All three people in the stress management group who responded "YES" stated that they were now in control and not other people and/or things.
The third interview statement for the control group participants was:

"Since the first week of September, a different person(s) and/or thing(s) has/have been in control of my life."

Two people responded "YES" and four responded "NO." The open-ended statement to clarify the "YES" responses was:

"The following person(s) and/or thing(s) has/have been in control of my life:"

Of the two people who responded "YES," one stated that an experimental drug was in control of his life. The other asserted that she was more in control now.

It appears from analyzing the interview data related to the innerdirectedness construct that there was no significant difference among the nondirective, stress management, and control groups. All three groups had a substantial number of participants who felt that they were in control of their lives. The interview data, therefore, support the results of the Personal Orientation Inventory.

The fourth interview statement for the nondirective and stress management group participants was:

"The group experience has had an effect on the way I spend my time thinking about the past, present, and future."

In the nondirective group five people responded "YES" and one responded "NO." In the stress management group four people responded "YES" and two responded "NO." The open-ended statement to clarify the "YES" responses was:

"Now I spend most of my time thinking about the _____________." (Past, present, or future)

In each group two people stated that their focus was mainly on the present, while another two said their focus was on the present and near future. One person in the nondirective group felt his thoughts were now on the future.
The fourth interview statement for the control group participants was:

"Since the first week of September, I have changed the amount of time I spend thinking about the past, present, and future."

Two people responded "YES," three responded "NO," and one was "UNDECIDED."

The open-ended statement to clarify the "YES" responses was:

"Now I spend most of my time thinking about the ________." (Past, present, or future)

Of the two people who responded "YES," one's focus was now on the present and near future, while the other's was now on the present. The person who was "UNDECIDED" had begun focusing more on the present and near future, but he was not sure when this change occurred.

It appears from analyzing the interview data related to the time competence construct that there was no significant difference among the nondirective, stress management, and control groups. All three groups had a substantial number of participants whose focus was on the present or the present and near future. The interview data, therefore, support the results of the Personal Orientation Inventory.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to analyze the efficacy of two group counseling approaches upon adult patients who had been diagnosed with metastatic cancer since August 1, 1980. Eighteen adult out-patients from metropolitan Richmond, Virginia area hospitals were the subjects of this study. All were volunteers and were randomly assigned, using a modified random sampling procedure, to a nondirective, stress management, or control group. Five personality characteristics were examined: state anxiety, trait anxiety, self-esteem, innerdirectedness, and time competence.

The nondirective and stress management groups met for 90 minute sessions twice a week for five consecutive weeks. The control group did not meet. Each group facilitator distributed the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and the Personal Orientation Inventory to the participants at an eleventh session and explained the directions. These assessment instruments were self-administered at home and proper test-taking procedures were stressed by the facilitator. The same instruments were hand-delivered to the homes of the control group members for self-administration.

The research design used in this study was the Posttest-Only Control Group Design. The statistical procedure employed was the analysis of variance. Five null hypotheses provided the basis for testing whether or not there was a significant difference (α=.05) among the nondirective, stress management, and control groups on posttest anxiety, self-esteem, innerdirectedness, and time competence measures.
Ho₁: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the State Anxiety Scale of the State-Trait Anxiety Inventory.

Ho₂: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Trait Anxiety Scale of the State-Trait Anxiety Inventory.

Ho₃: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Total P Score (Self-esteem) of the Tennessee Self Concept Scale.

Ho₄: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Inner Directed Scale of the Personal Orientation Inventory.

Ho₅: There will be no significant difference ($\alpha = .05$) among the nondirective, stress management, and control groups on the Time Competence Scale of the Personal Orientation Inventory.

An analysis of the test data revealed that there was no significant difference among the nondirective, stress management, and control groups on any of the posttest measures. The investigator failed to reject all five null hypotheses.

Individual post-group interviews were conducted within two weeks of the termination of each group. They served as a validity check of the instrumentation results, and a content analysis was conducted with the interview data.
The dynamics of this study necessitated the implementation of a few modifications to the original design. The investigator planned to use 24 subjects who would be randomly selected and assigned to the nondirective, stress management, or control group. Because of the difficulty experienced during the recruitment of appropriate subjects, only 18 patients were able and willing to participate in this study. This circumstance eliminated the random selection procedure. Furthermore, the random assignment procedure had to be modified for 10 subjects because of logistics and their personal schedules.

The control group was to meet a week after the termination of the nondirective and stress management groups for delayed treatment. Because of a change in the personal schedules of three of the six group participants, this group was not able to meet.

The State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory were to be administered to the participants at an eleventh and final session. The investigator decided to allow these tests to be self-administered at home for the following reasons: (1) the administration of these tests would take approximately one and one-half hours and consequently the termination of the experience could not be properly processed during an eleventh group session; (2) group participants would probably feel more relaxed taking these personal assessment inventories in the comfort and privacy of their own homes; (3) four participants had commented to the investigator on several occasions their apprehension about taking the tests while in the company of others; and (4) since proper test-taking procedures were stressed during the eleventh session, the investigator felt that the reliability and validity of each test would not be adversely affected.

As noted previously, an analysis of the interview data revealed that there was no appreciable difference among the nondirective, stress management, and control groups. There was, however, a qualitative difference when comparing the nondirective and stress management groups with the control group. In each treatment group, the group
experience was credited for a diminution of stress and anxiety and an enhancement of self-esteem, innerdirectedness, and time competence. Ten of twelve participants in the treatment groups stated that they were more at ease; eight of twelve felt better about themselves; four of twelve had regained a sense of self-reliance and self-direction; and eight of the twelve were beginning to focus more on the present. The control group period did not appear to be as meaningful or beneficial.

Conclusions

The following conclusions were drawn from this study:

1. Based on interview data only, intensive group counseling that utilizes a nondirective or stress management orientation appears to be a viable therapeutic approach for helping cancer patients cope with the psychodynamics of metastatic cancer.

2. The State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory may need further refinement to detect more subtle changes in the state and trait anxiety, self-esteem, innerdirectedness, and time competence of patients with metastatic cancer.

3. Researchers wishing to conduct groups with similarly diagnosed participants should be cognizant of the special constraints confronting this select population and the rigorous recruitment procedures and logistical strategies which must be implemented before a group can meet.

4. Counseling groups designed for metastatic cancer patients should be conducted by licensed professionals who have expertise in group facilitation and successful clinical oncological experience.
While this study deserves close scrutiny in regards to generalizability of results to similar populations, a replication of this study using logical situational relationships existing in the lives of metastatic cancer patients could produce similar results.

**Recommendations**

The following recommendations are made based on the findings of this research:

1. It is recommended that this study be replicated with similar groups of metastatic cancer patients so that the efficacy of nondirective and stress management group counseling can be explored further.

2. It is recommended that research be developed to examine other theoretical approaches and treatment interventions that may have psychotherapeutic value for the metastatic cancer patient.

3. It is recommended that research be developed which uses other assessment instruments which may be more sophisticated in assessment of the psychodynamics which confront metastatic cancer patients.

4. It is recommended that the mass media and the American Cancer Society develop programs informing the public and medical personnel of the benefits of group counseling and group psychotherapy for cancer patients.

5. It is recommended that medical institutions employ full-time professional counselors to work directly with cancer patients and oncological staff personnel.
6. It is recommended that doctors who are caring for metastatic cancer patients consider group counseling as a viable addition to the overall program of treatment for these patients and refer them whenever possible.

7. It is recommended that all medical staff personnel in cancer rehabilitation and continuing care programs be cognizant of the medical definition of metastasis to avoid referring inappropriate patients to counseling groups designed especially for metastatic cancer patients.

8. It is recommended that research be developed to ascertain efficacious strategies and techniques for the recruitment of cancer patients for group counseling and group psychotherapy.
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REFERENCES


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APPENDICES
APPENDIX A

THERAPEUTIC INTERVENTION IN THE TREATMENT
OF ADULT PATIENTS WITH METASTATIC CANCER:
A COMPARATIVE STUDY OF TWO
GROUP COUNSELING APPROACHES

Consent Form

I, ____________________________, am willing to participate in a study of
patients who have been diagnosed with metastatic cancer since August 1, 1980. I
understand that this study is being conducted by Mr. Gilbert G. Cumbia, a doctoral
student in the counseling program at the College of William and Mary.

I am aware that I will be involved in the following procedures:

A. Participation in group counseling sessions which will last for 90 minutes
twice a week for five consecutive weeks.

B. Administration by the group facilitator of the State-Trait Anxiety
Inventory, Tennessee Self Concept Scale, and Personal Orientation
Inventory at the eleventh session.

C. Participation in a post-group interview conducted by Mr. Cumbia within
two weeks of the termination of the group.

I understand that there are no obvious or imminent risks to my mental or physical
health as a result of this experience. I realize that there are alternatives to these
procedures, including referral to a Licensed Professional Counselor in the Cancer
Rehabilitation and Continuing Care Program at the Medical College of Virginia. I
understand that all discussions, interviews, and written results of this study will be
created in a confidential manner so as to protect my anonymity. I am aware that I may
terminate my participation in the group at any time and may opt not to respond to
particular questions or participate in certain activities. I also understand that a written
summary of the results of this study will be mailed to me upon request.
I hereby consent to participate in this study.

______________________________
Patient's Signature

______________________________
Investigator's Signature

______________________________
Date
APPENDIX B
POST-GROUP INTERVIEW
(Treatment Groups)

If your answer to a is YES, please respond to b.

1. a. The group experience has had an effect on my feelings of stress and anxiety.
   YES ____
   NO ____

b. My feelings of stress and anxiety have changed in the following ways:

2. a. The group experience has had an effect on my feelings about myself.
   YES ____
   NO ____

b. My feelings about myself have changed in the following ways:

3. a. Because of the group experience, a different person(s) and/or thing(s) is/are now
   in control of my life.
   YES ____
   NO ____

b. The following person(s) and/or thing(s) is/are in control of my life:

4. a. The group experience has had an effect on the way I spend my time thinking
   about the past, present, and future.
   YES ____
   NO ____

b. Now I spend most of my time thinking about the _________________.
   (Past, present, or future)
POST-GROUP INTERVIEW
(Control Group)

If your answer to a is YES, please respond to b.

1. a. Since ________________ (date) my feelings of stress and anxiety have changed.
   YES ____
   NO ____
   b. My feelings of stress and anxiety have changed in the following ways:

2. a. Since ________________ (date) my feelings about myself have changed.
   YES ____
   NO ____
   b. My feelings about myself have changed in the following ways:

3. a. Since ________________ (date) a different person(s) and/or thing(s) has/have been in control of my life.
   YES ____
   NO ____
   b. The following person(s) and/or thing(s) has/have been in control of my life:

4. a. Since ________________ (date) I have changed the amount of time I spend thinking about the past, present, and future.
   YES ____
   NO ____
   b. Now I spend most of my time thinking about the _____________ (Past, present, or future)
Dear Staff:

I am ready to begin recruiting cancer patients for my doctoral study that will commence this September. I will need referrals for outpatients that fit all of the following criteria:

1. 18 years of age or older.

2. Have been informed within the past four years that they have metastatic cancer. (Patients were informed either at the time of original diagnosis or when there was metastasis.)

3. Have physical potential to attend group counseling sessions that will begin in September and meet two nights a week for five and one-half weeks.

I will provide transportation when it is needed by outpatients who live within a 20 mile radius of the Medical College of Virginia. If you have patients who meet the above criteria, I would appreciate a referral ASAP with the following information:

Name ________________________________

Address ________________________________

Home Phone Number ________________________________

Work Phone Number ________________________________

Other Phone Numbers ________________________________
Diagnosis

Comments

Referred by

Thanx,

Gil Cumbia
Dear __________________:

I am a doctoral student in the counseling program at the College of William and Mary. I am presently working as a counseling intern in the Cancer Rehabilitation and Continuing Care Program and am actively recruiting cancer patients for group counseling sessions that will commence this September. I am interested in outpatients who meet the following criteria:

1. 18 years of age or older.

2. Have been informed within the past four years that they have metastatic cancer. (Patients were informed either at the time of original diagnosis or when there was metastasis.)

3. Have physical potential to attend group counseling sessions that will begin in September and meet two nights a week for five and one-half weeks.

I will provide transportation when it is needed by outpatients who live within a 20 mile radius of the Medical College of Virginia. If you have patients who meet the above criteria, I would appreciate a referral. You may call me at 786-9901.

Many Thanks,

Gil Cumbia
APPENDIX D (continued)

Proposal for Research with Human Subjects

Name: Gilbert G. Cumbia

Department: School of Education

Status: Doctoral Candidate

If student, faculty advisor: Dr. Jack A. Duncan

1. In a 2 to 3 page precis, provide a general description of the research project, noting (a) the research question, (b) the scientific or educational benefits of the work, (c) the potential risks to the participants, (d) the investigator responsible (must be a faculty member), and (e) a clear statement of the research methodology.

2. Provide copies of (a) all standardized tests to be used, (b) any questionnaires to be administered, (c) any interview questions to be asked.

3. Provide copies of consent forms (one form for each different class of subjects). If the subject is a minor (under 18), parental permission must be obtained in writing. The consent form should contain (a) the researcher's name, (b) the title of the project, (c) a statement about whether or not the results will be anonymous (and if not, what will be done to protect the subject's confidentiality), (d) a brief description of what the subject will be asked to do, with this statement indicating in a general fashion what risks are involved, and what procedures either will be employed or have been employed. If the consent is obtained after the data have been collected, it must include a release for the researcher to include the data in any subsequent analysis. If no consent form is possible, the general description above (1) must include a justification for that procedure.

4. Describe the intended participants, the procedures that will be used to recruit those subjects, any payments for participation that will be provided, and an indication of
whether the results will be made available to interested subjects (and a description of how that will be accomplished).

5. Will the subjects be: (check one)
   - X yes ___ no (a) fully informed
   - ___ yes ___ no (b) partially informed
   - ___ yes ___ no (c) deceived

6. Will subjects be told that they may terminate participation at any time?
   - X yes ___ no

   Will subjects be informed that they may refuse to respond to particular questions or refuse to participate in particular aspects of the research?
   - X yes ___ no

7. Does the research involve any physically intrusive procedures or pose a threat to the subjects' physical health in any way? If so, please explain.
   - No.

8. Will the research involve:
   - ___ yes X no (a) physical stress or tissue damage?
   - X yes ___ no (b) likelihood of psychological stress (anxiety, electric shock, failure, etc.)?
   - ___ yes X no (c) deception about purposes of research (but not about risks involved)?
   - ___ yes X no (d) invasion of privacy from potentially sensitive or personal questions?
If any of the above is involved, explain the precaution to be taken. Also, if any of the above is involved and the research is conducted by a student, explain how the faculty advisor will supervise the project.

9. If any deception is involved, explain the debriefing procedure to be followed.
APPENDIX D (continued)

1. (a)

**Statement of the Problem**

The problem to be investigated by this study is the effect that two different group counseling approaches, nondirective and stress management, have upon the anxiety, self-esteem, innerdirectedness, and time competence of adult patients with metastasized cancer.

1. (b)

**Scientific or Educational Benefits of the Work**

Possible psychological benefits for group participants will include an enhancement of self-esteem, time competence, and innerdirectedness and a diminution of depression and anxiety. In addition, an increased sense of well-being and hope and a facilitation of coping skills will be expected as a result of the group experience.

1. (c)

**Potential Risks to the Participants**

There are no obvious or imminent risks to participants. While stressful topics and issues will be discussed in the group, the therapy is designed to reduce ultimately the level of stress and anxiety experienced within and outside of the group. Through the gentle confrontation of painful circumstances, personal growth will be enhanced. Thus, the potential risks to the participants appear negligible.

1. (d)

**Investigator Responsible**

The investigator responsible for this study will be Dr. Jack A. Duncan, Professor of Education, Virginia Commonwealth University.
Summary of Research Methodology

Twenty-four adult outpatients from metropolitan Richmond area hospitals who have been diagnosed with metastasized cancer since August 1, 1980 will be the subjects of this study. All will be volunteers and will be randomly selected and assigned to one of three groups: nondirective, stress management, or control with delayed treatment.

Each group will meet for 90 minute sessions twice a week for five weeks. Each group facilitator will administer the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory to the participants at the eleventh session. Proper testing procedures will be followed, and the assessment instruments will be administered separately.

Individual interviews will be conducted within two weeks of the termination of each group. They will serve as a validity check of the instrumentation results.

The research design used in this study will be the Posttest-Only Control Group Design. The statistical procedure that will be used to determine the efficacy of the two different group counseling approaches will be the analysis of variance. The null hypotheses will be rejected at the five per cent level of significance.

2.(c)

POST-GROUP INTERVIEW

(Treatment Groups)

If your answer to a is YES, please respond to b.

1. a. The group experience has had an effect on my feelings of stress and anxiety.
   
   YES ___
   
   NO ___

   b. My feelings of stress and anxiety have changed in the following ways:
2. a. The group experience has had an effect on my feelings about myself.
   YES ______
   NO ______

   b. My feelings about myself have changed in the following ways:

3. a. Because of the group experience, a different person(s) and/or thing(s) is/are now in control of my life.
   YES ______
   NO ______

   b. The following person(s) and/or thing(s) is/are in control of my life:

4. a. The group experience has had an effect on the way I spend my time thinking about the past, present, and future.
   YES ______
   NO ______

   b. Now I spend most of my time thinking about the ______________________. (Past, present, or future)

---

POST-GROUP INTERVIEW

(Control Group)

If your answer to a is YES, please respond to b.

1. a. Since ________________ (date) my feelings of stress and anxiety have changed.
   YES ______
   NO ______

   b. My feelings of stress and anxiety have changed in the following ways:
2. a. Since ________________ (date) my feelings about myself have changed.
   YES ___
   NO ___
   b. My feelings about myself have changed in the following ways:

3. a. Since ________________ (date) a different person(s) and/or thing(s) has/have been in control of my life.
   YES ___
   NO ___
   b. The following person(s) and/or thing(s) has/have been in control of my life:

4. a. Since ________________ (date) I have changed the amount of time I spend thinking about the past, present, and future.
   YES ___
   NO ___
   b. Now I spend most of my time thinking about the ____________. (Past, present, or future)
3.

THERAPEUTIC INTERVENTION IN THE TREATMENT OF ADULT PATIENTS WITH METASTATIC CANCER: A COMPARATIVE STUDY OF TWO GROUP COUNSELING APPROACHES

Consent Form

I, ______________________, am willing to participate in a study of patients who have been diagnosed with metastatic cancer since August 1, 1980. I understand that this study is being conducted by Mr. Gilbert G. Cumbia, a doctoral student in the counseling program at the College of William and Mary.

I am aware that I will be involved in the following procedures:

1. Participation in group counseling sessions which will last for 90 minutes twice a week for five consecutive weeks.

2. Administration by the group facilitator of the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and Personal Orientation Inventory at the eleventh session.

3. Participation in a post-group interview conducted by Mr. Cumbia within two weeks of the termination of the group.

I understand that there are no obvious or imminent risks to my mental or physical health as a result of this experience. I realize that there are alternatives to these procedures, including referral to a Licensed Professional Counselor in the Cancer Rehabilitation and Continuing Care Program at the Medical College of Virginia. I understand that all discussions, interviews, and written results of this study will be created in a confidential manner so as to protect my anonymity. I am aware that I may terminate my participation in the group at any time and may opt not to respond to particular questions or participate in certain activities. I also understand that a written summary of the results of this study will be mailed to me upon request.
I hereby consent to participate in this study.

[Patient's Signature]

[Investigator's Signature]

[Date]

4. Population and Selection of Sample

The population will consist of adult outpatients from metropolitan Richmond area hospitals who have been diagnosed with metastasized cancer since August 1, 1980. The sample will consist of 24 adult outpatients who will be randomly selected and assigned to one of three groups: nondirective, stress management, or control. An alphabetized list of potential group participants and a table of random numbers will be utilized to assure randomization. The outpatients selected will be volunteers whose cooperation will be obtained through informal personal interviews. After the interview has been completed and all questions answered, a consent form will be signed by each patient. There will be no control for age, sex, race, socioeconomic class, religiosity, or the number of years diagnosed with cancer. A written summary of the results of the study will be mailed to interested participants.
Precautions to be Taken for the Likelihood of Psychological Stress

While the group experience is not expected to lead to undue psychological stress, action will be taken should this become a debilitating problem for any group participant. The participant will be removed from the study and referred to a Licensed Professional Counselor in the Cancer Rehabilitation and Continuing Care Program at the Medical College of Virginia.

Faculty Advisor Supervision

Dr. Jack A Duncan, doctoral advisor, will meet weekly with the investigator to discuss the study and how it is proceeding. Any problems will be analyzed and hopefully resolved during these meetings.
Dear ____________:

I am a doctoral student in the counseling program at the College of William and Mary. I am presently working as a counseling intern in the Cancer Rehabilitation and Continuing Care Program and am actively recruiting cancer patients for group counseling sessions that will commence this September. I am interested in outpatients who meet the following criteria:

1. 18 years of age or older.

2. Have been informed within the past four years that they have metastatic cancer. (Patients were informed either at the time of original diagnosis or when there was metastasis).

3. Have physical potential to attend group counseling sessions that will begin in September and meet two nights a week for five and one-half weeks.

Sessions will be conducted at the Massey Cancer Center at MCV. Group leaders will be MSWs who are currently working with cancer patients. There will be available parking adjacent to the Center and transportation will be provided when needed. Interested individuals may call 282-3765.

Many thanks,

Gil Cumbla
APPENDIX F

AD RUN IN NEWSPAPER

THE RICHMOND NEWS LEADER, Saturday, August 18, 1984

Richmond Times-Dispatch, Sat., Aug. 19, 1984

CANCER PATIENTS

Adult outpatients diagnosed with metastasized cancer since August 1980 needed for support groups. Leaders will be MSW's currently working with cancer patients. No fee.

Call 262-3765
Dear ________________:

As you may already know from our conversations at CanSurmount meetings, I am a doctoral student in the counseling program at the College of William and Mary. I am currently working as a counseling intern in the Cancer Rehabilitation and Continuing Care Program at the Medical College of Virginia (MCV) and am actively recruiting cancer patients for support groups that will commence this September and October. I am interested in outpatients who meet the following criteria:

1. 18 years of age or older.
2. Have been informed within the past four years that they have metastatic cancer. (Patients were informed either at the time of original diagnosis or when there was metastasis).
3. Have physical potential to attend support groups that will begin in September and October and meet for 90 minutes two nights a week for five and one-half weeks.

Sessions will be conducted at the Massey Cancer Center at MCV. Group leaders will be MSWs who are currently working with cancer patients. There will be available parking adjacent to the Center and transportation will be provided when needed.
Please call me at home if you know of any patients who meet the above criteria and might be interested in a support group.

Many thanks!

Gil Cumbia
262-3765
APPENDIX H

August 24, 1984

Dear __________________:

Just a short note to let you know that we at MCV are excited about the three support groups that will begin September 10, September 11, and October 22. As you may recall, we will meet for 90 minutes two nights a week for 5 1/2 weeks. I will call you over the Labor Day weekend to give you specific dates.

Please call me at the numbers listed below if you have any questions. Thank you again for agreeing to participate!

Sincerely,

Gil Cumbia
737-6081 (Work)
262-3765 (Home)
APPENDIX I

CHRONOLOGICAL LISTING OF TOPICS DISCUSSED IN THE NONDIRECTIVE GROUP COUNSELING SESSIONS

SESSION #1: Tuesday, September 11, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topic: "Most and Least Important Thing In the World"
Number Present: Five

SESSION #2: Thursday, September 13, 1984 (8:30 p.m. - 9:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Dealing with Reactions of Family and Friends"
"Physicians"
"Changing Roles"
Number Present: Six

SESSION #3: Tuesday, September 18, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Psychosomatic Symptoms"
"Placing Illness In Perspective"
"Side Effects of Therapy"
"Financial Hardship Created by illness"
Number Present: Four

SESSION #4: Thursday, September 20, 1984 (8:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topic: "Member with Newly Diagnosed Lesion"
Number Present: Five
APPENDIX I (continued)

SESSION #5: Tuesday, September 25, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Jobs and Discrimination"
        "Fear of Dying"
        "Parents"
        "Decisions Regarding Treatment, i.e., Continuing, Stopping, 
          Undergoing Experimental Procedures, or Pursuing Other 
          Alternatives"
        "Social Security Disability"
        "Changes in Sex Drive"
Number Present: Five

SESSION #6: Thursday, September 27, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Med-a-port Catheter Insertion"
        "Bone Marrow Transplant"
Number Present: Six

SESSION #7: Tuesday, October 2, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topic: "Feelings Elicited from the Support Group"
Number Present: Four
APPENDIX I (continued)

SESSION #8: Thursday, October 4, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Shifting Out of the Negative Into the Positive"
"Physical and Mental Limitations"
"Disclosing and Withholding Information from Physicians, Family, and Friends Regarding Diagnosis, Prognosis, and Current Ailments"
Number Present: Five

SESSION #9: Tuesday, October 9, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topic: "Funerals and Living Wills"
Number Present: Four

SESSION #10: Thursday, October 11, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W.
Topics: "Contradictions in Prognosis by Medical Personnel"
"Insurance Coverage, e.g., Blue Cross and Blue Shield"
"Organ Donation"
Number Present: Six

SESSION #11: Tuesday, October 16, 1984 (6:30 p.m. - 8:00 p.m.)
Presenter: Beth Woolford, M.S.W. and Gil Cumbia, M.Ed.
Topic: "Explanation of Test Materials and Termination of the Group Experience"
Number Present: Six

* Primary focus(es) of each session. Such topic(s) was/were not limited solely to one individual session.
APPENDIX J

OUTLINE OF THE STRESS MANAGEMENT GROUP COUNSELING SESSIONS

SESSION #1:  Monday, September 10, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W.
Topic: "Welcome and Orientation"
Materials: A Choice and Talking About Cancer (Handout #1)
Number Present: Six

SESSION #2:  Wednesday, September 12, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W.
Topic: "Living with Stress"
Materials: "Living with Stress" (Videotape)
Ways to Become Less Vulnerable to Stress (Handout #2)
Number Present: Six

SESSION #3:  Monday, September 17, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W.
Topic: "Assertiveness"
Materials: Basic Human Rights (Handout #3)
The "I" Message (Handout #4)
Assertiveness (Handout #5)
Comparison of Nonassertive, Assertive, and Aggressive Behavior (Handout #6)
Number Present: Five
## APPENDIX J (continued)

### SESSION #4:
- **Wednesday, September 19, 1984 (7:00 p.m. - 8:30 p.m.)**
- **Presenter:** Rusty Smith, M.S.W.
- **Topic:** "Assertiveness Role Playing"
- **Materials:** What Would the "Assertive" You Do? (Handout #7)
- **Number Present:** Six

### SESSION #5:
- **Monday, September 24, 1984 (7:00 p.m. - 8:30 p.m.)**
- **Presenter:** Barb Adams, Certified Myotherapist
- **Topic:** "Myotherapy, Breathing, and Relaxation Exercises"
- **Materials:** None
- **Number Present:** Six

### SESSION #6:
- **Wednesday, September 28, 1984 (7:00 p.m. - 8:30 p.m.)**
- **Presenter:** Barb Adams, Certified Myotherapist
- **Topic:** "Myotherapy and Massage"
- **Materials:** Beneficial Effects of Massage (Handout #8)
- **Number Present:** Four

### SESSION #7:
- **Monday, October 1, 1984 (7:00 p.m. - 8:30 p.m.)**
- **Presenter:** Rusty Smith, M.S.W.
- **Topic:** "Kids and Cancer"
- **Materials:** "Donahue and Kids" (Videotape)
- **Number Present:** Four
APPENDIX J (continued)

SESSION #8: Wednesday, October 3, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W.
Topic: "Coping with Cancer"
Materials: Donahue and Kids (Handout #9)
Number Present: Five

SESSION #9: Monday, October 8, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Fred Ward, M.D.
Topic: "Hypnosis and Cancer"
Materials: Value of Self-Hypnosis (Handout #10)
Number Present: Six

SESSION #10: Wednesday, October 10, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W.
Topic: "Humor and Coping with the Pressures of Daily Living"
Materials: "Humor" (Videotape)
Number Present: Five

SESSION #11: Monday, October 15, 1984 (7:00 p.m. - 8:30 p.m.)
Presenter: Rusty Smith, M.S.W. and Gil Cumbia, M.Ed.
Topic: "Explanation of Test Materials and Termination of the Group Experience"
Materials: Stress and Your Health (Handout #11)
Number Present: Five
A CHOICE

HOPELESSNESS is the withering of the soul, the subtraction of all sustaining emotions. It is an acceptance of negative forces invading the body, cancelling out all reasons for living and being.

HOPE is receiving miracles! It is a gift from God, a reality that transcends human language. Hope is inner excitement that energizes the body to carry on its battles. It is the inspiration for effort, the determination for progress. Hope is a positive approach to one's destiny. ("A Choice," 1984, p.2)

TALKING ABOUT CANCER

The following is an excerpt from a recent newspaper column. It is the response of advice columnist Elizabeth Winship to a letter from a young cancer patient who described herself as "lonely and hurting." The response should prove helpful to us not only as we face our own cancer experiences, but also as we assist others in coping with the disease.

"...On top of the natural fear and despair that everyone feels in your position, separation from friends makes it almost unbearably lonely for you. The problem is, most people don't know how to help. They pity you, but that's not what you want—you want understanding.

You can help yourself if you realize that even your good friends just don't know how to talk to you. They are afraid of hurting you, so they avoid talking about your illness, and even avoid you. Unfair as it may seem, YOU have to be the one to reach out. Help them to help you by showing them it's OK to mention your illness, and that you still need their closeness, love and companionship. Your close friends will most likely be able to handle this,
once you broach the topic. Then they will be able to show you how much you
still matter to them...” ("Talking About Cancer," 1984, p.3)
WAYS TO BECOME LESS VULNERABLE TO STRESS

1. Eat at least one balanced meal each day.
   (The body needs proper nutrients to function effectively.)

2. Drink less than three cups of coffee per day. For soda drinkers, drink less than three soft drinks containing caffeine per day.
   (Caffeine is a stimulant.)

3. Sleep seven-eight hours at least four nights per week.
   (Sleep replenishes energy.)

4. Give and receive affection and be able to express emotions openly each day.
   (Positive "stroking" enhances self-esteem/Expressing feelings keeps them from getting tied up in the body.)

5. Exercise twice a week hard enough to break a sweat.
   (Exercise relaxes the body and gets out pent-up energy.)

6. Smoke less than one pack per day.
   (Nicotine is a stimulant.)

7. Do not abuse alcohol.
   (Alcohol is a depressant.)

8. Do something for fun at least once a week.
   (Fun redirects energy and relaxes the body.)

NOTE: A certain amount of stress motivates. It is a stimulant encouraging a person to do something positive!

1. We all have the right to respect from other people.

2. We all have the right to have needs, and to have these needs be as important as other peoples' needs. Moreover, we have the right to ask (not demand) that other people respond to our needs and to decide whether we will take care of other peoples' needs.

3. We all have the right to have feelings -- and to express these feelings in ways which do not violate the dignity of other people (e.g., the right to feel tired, happy, depressed, sexy, angry, lonesome, silly).

4. We all have the right to decide whether we will meet other peoples' expectations or whether we will act in ways which fit us, as long as we act in ways which do not violate other people's rights.

5. We all have the right to form our own opinions and to express these opinions, as long as we do so in a way that is respectful of the opinions of others.

(Source Unknown)
THE "I" MESSAGE

Most of the messages we send to people about their behavior are "you" messages - messages that are directed at the other person and have a high probability of putting them down, making them feel guilty, making them feel their needs are not important, and generally making them resist change. Examples of "you" messages are usually orders or commands, ("Stop doing that!" "Get into the car!"), or blaming or name-calling statements, ("You are acting like a baby!" "You are driving me crazy!"), or statements that give solutions, ("You should forget that idea." "You'd better reconsider that plan."), thereby removing the responsibility for behavior change from the other person. Perhaps the worst of all "you" messages is the if... then threat, ("If you don't... then I will.")

An "I" message, on the other hand, allows a person who is affected by the behavior of another to express the impact it has on him and, at the same time, leave the responsibility for modifying the behavior with the person who demonstrated that particular behavior. An "I" message consists of three parts: (1) The specific behavior; (2) The resulting feeling you experienced because of the behavior, and (3) The tangible effect on you (either physical or psychological). Thus a teacher might say to a student:

(1) BEHAVIOR

When you tap on your desk with your pencil, I feel upset,

(2) FEELING

(3) EFFECT

because I get distracted and have difficulty teaching.
A wife might say to her husband:

(1) BEHAVIOR

When I try to help you and you don't say anything,

(2) FEELING (3) EFFECT

I feel confused because I don't know how you feel about my help.

In effect, the "I" message allows the sender to implicitly say, "I trust you to decide what change in behavior is necessary." In this manner "I" messages build relationships and, equally important, they do not place the sender in the position of enforcing a new behavior, as is frequently the case with the "you" messages discussed above.

Social Seminar Training Center
Bethesda, Maryland
(n.d.)
ASSERTIVENESS

ASSERTIVE BEHAVIOR

IS: Behavior which enables you to act in your best interest, to stand up for yourself without undue anxiety, to exercise your rights without denying the rights of others. (We're not talking about stepping on other people.)

IS: Direct, honest, appropriate expression of one's feelings, opinions, or beliefs. It shows consideration for other people. Communicates respect for the other person, but not necessarily the other person's behavior.

IS NOT: Aggressive behavior; i.e., it does not violate the rights of others. The purpose of aggressive behavior is to dominate, humiliate, or put down the other person, rather than simply to express one's honest emotions or thoughts. Example: letting someone know you are angry at the time the feeling occurs is assertive. Making the other person responsible for your feelings of anger or degrading the other person because you feel angry is aggressive.

IS NOT: Behavior which allows your rights to be violated in either of two ways:

1) Situations where you are taken advantage of by not saying "no" and
2) situations where you don't assert your needs. Honest reactions are thus inhibited, and persons typically feel hurt, anxious, and sometimes angry—frequently sending double messages.

This type of non-assertive behavior can be a subtle form of manipulation—i.e., person gives up right to make personal decisions; expects these decisions to be made by others ("Unspoken Bargain"). These kinds of bargains are seldom explicitly stated and the other person usually fails to fill the unspoken bargain and generally takes self-sacrifice for granted. The payoff for the
non-asserter is that it enables her or him to avoid potentially unpleasant conflicts; however, unpleasant internal consequences such as hurt feelings and lowered self-esteem are likely.

SIGNS OF NON-ASSERTIVE PERSONS
1. Pleases others at all costs: fears offending others, or feels moral obligation to place interests of others before own.
2. Allows others to maneuver her or him into situations she or he doesn't wish.
3. Unable to express legitimate wishes.

GOALS OF ASSERTIVENESS
1. Belief in and exercise of individual rights.
2. Development of skill through practice—skill which makes it possible to act on one's needs and feelings in such a way that other people know what you want, think or feel. The skill is learnable, but judgment must be used in deciding when to apply it.

INTERPERSONAL RIGHTS
1. Assertive behavior is based on the idea that each person has basic human rights—like the right to refuse a request without feeling guilty and the right to tell someone else what your needs are. Non-assertive people often do not believe that they have a right to their feelings and opinions. Other people may not like your feelings, but that does not deny your right to those feelings.
2. You will be happier if you appropriately exercise your rights. Feelings of personal worth are lower if you continually give in to the wishes of others. Non-assertion is hurtful in the long run—not sharing feelings limits closeness. Being passive is not being a nice guy—you're probably holding in anger or resentment. Early training of children teaches them that it is bad to be forceful and that self-denial is good. You don't have to lose gentleness through assertiveness.
COMPONENTS OF ASSERTIVE BEHAVIOR

1. CONTENT
   a. In any assertive behavior, some specific objective is involved:
      1. to establish a relationship with someone you want to know, or to change or end a relationship.
      2. to express your feelings, beliefs, or opinions.
      3. to state an objection or point of view in opposition to another.
      4. to set limits for another person in regard to what can be expected or demanded of you.
      5. to obtain something you want.
   b. Usually there are three basic components in the content of assertive behavior:
      1. recognition of the other person's feelings and rights (implicit or explicit) — "I realize you like such and such..."
      2. expression of own feelings or rights — "however, I like so and so..."
      3. description of desired action — "therefore, let's..."

2. EYE CONTACT AND FACIAL EXPRESSION
   a. the other person is more likely to respond if you look her or him in the eye (may take practice).
   b. appropriate expression lends credibility to assertion.

3. BODY POSTURE AND MOVEMENT
   a. the more relaxed you are, the more comfortable you'll feel asserting and the more successful you'll be.
   b. turning away from the other person conveys a mixed message.
   c. lowering head conveys a mixed message.
   d. appropriate hand gestures lend credibility.
4. **VOCAL TONE AND QUALITY**
   
a. gentle but firm.

(Source Unknown)
## COMPARISON OF NONASSERTIVE, ASSERTIVE, AND AGGRESSIVE BEHAVIOR

<table>
<thead>
<tr>
<th>Characteristics of the behavior:</th>
<th>NONASSERTIVE</th>
<th>ASSERTIVE</th>
<th>AGGRESSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotionally dishonest, indirect, self-denying, inhibited</td>
<td>( Appropriately) emotionally honest, direct, self-enhancing, expressive</td>
<td>(Inappropriately) emotionally honest, direct, self-enhancing at expense of another, expressive</td>
</tr>
<tr>
<td>Your feelings when you engage in this behavior:</td>
<td>Hurt, anxious at the time and possibly angry later</td>
<td>Confident, self-respecting at the time and later</td>
<td>Righteous, superior at the time and possibly guilty later</td>
</tr>
<tr>
<td>The other person's feelings about him/herself when you engage in this behavior:</td>
<td>Guilty or superior</td>
<td>Valued, respected</td>
<td>Hurt, humiliated</td>
</tr>
<tr>
<td>The other person's feelings about you when you engage in this behavior:</td>
<td>Pity, irritation, disgust</td>
<td>Generally respect</td>
<td>Angry, vengeful</td>
</tr>
</tbody>
</table>

(Source Unknown)
WHAT WOULD THE "ASSERTIVE" YOU DO?

1. You have been standing in a long line in Morrison's Cafeteria for 30 minutes and a party of five cuts in front of you because they know someone at the front of the line. What would you do?

2. Your physician tells you that you should be discharged in the morning. The next day he comes in and says that he's decided to keep you two more days because of a "forgotten order" (a bone scan that should have been done yesterday). What is your response?

3. This past January your boss promised you a 10% raise. It is now June and nothing has happened. You are beginning to fall behind with some of your bills. You approach your boss and say...

4. Your physician has a daily habit of breezing in and out of your room, seemingly in a hurry. He never directly answers your questions but rather side-steps them as he walks toward the door. You have some questions to ask that are very important to you. How would you handle this?

5. You told the mechanic when he took your car for a tune-up that you didn't want the oil changed because you would do it yourself. As you look at your bill, you notice you've been charged for an oil change. What would you do?

6. You have been scheduled for a 10 a.m. appointment and arrive at the office on time. At 12 noon you have yet to be seen by your physician. At 12:30 you are called back to the examination room. The physician enters and states, "Hello, how are you?" How do you respond?
7. As you leave work on Friday, a friend inquires about what you are going to do tomorrow. You respond with, "Tim, Ralph and I are going to play golf. We plan to tee off at ten." Your friend says, "Great! Since you only have a threesome, how about if I join you?" How do you respond?

Gil Cumba
Richmond, Virginia
September 1984
BENEFICIAL EFFECTS OF MASSAGE

1. Massage brings to the muscles the same benefits as a hike of several miles without causing fatigue.

2. Massage restores impaired energy flow and stimulates blood and lymph flow by bringing fresh nutrition to the cells of the body.

3. Massage brings renewed strength and vigor to muscles, nerves and organs which are suffering from the stress of today's living.

4. Massage helps to keep the internal organs vigorous.

5. It is a useful aid in hastening and improving convalescence after illness or surgery.

6. Massage aids the nervous system by improving circulation and nutrition to the peripheral nerves and the CNS.

7. Massage exercises the muscles and moves body fluids. It helps to relieve muscle soreness and stiffness, thereby alleviating pain.

8. Massage increases the number of red blood cells in the bloodstream thereby increasing the amount of oxygen carried to the cells and the amount of carbon dioxide carried away from the cells. This results in better body use of its sugar.

9. Energy is more quickly restored by massage than by a rest of the same amount of time.

10. Massage increases urine output because it moves fluids through the kidneys at a faster rate.

11. Massage improves texture, color and elasticity of the tissues.

12. Transverse massage will aid in breaking down adhesions, will break up congestion and lessen swelling in joints.
13. Massage relieves edema, and aids the body in ridding itself of toxic debris and lactic acids.

14. Massage aids in digestion and absorption and relieves constipation by increased blood circulation.

15. Massage improves muscle power after muscles are overworked or exercised.

16. Massage directly influences every function and organ of the body.

**CONTRAINDICATIONS FOR MASSAGE**

1. Injury or abrasion of the skin, burns, rashes, open wounds, infections.

2. Inflamed blood vessels; inflamed or greatly swollen joints.

3. Contagious fevers, skin diseases, tuberculosis.

4. Neoplasms or tumors. (Mainly when doing a circulatory-type massage, but there are other massages that would be safe and beneficial).

5. The abdomen and legs of women who are pregnant (because of clotting factor).

6. Hiatal hernia in upper stomach area.

Barb Adams
Richmond, Virginia
September 1984
DONAHUE AND KIDS

1. How can the cancer patient answer the question, "Why me?"

2. Should the cancer patient "protect" those around him/her? Why or why not?

3. Can anything "good" come out of the cancer experience? Explain.

4. Is crying OK? Why or why not?

5. What are positive things that a person can do to help himself/herself deal with the cancer experience?

Gil Cumbia
Richmond, Virginia
September 1994
VALUE OF SELF-HYPNOSIS

Consultant:

Mohe S. Torem, M.D., Associate Professor of Psychiatry and Medicine, Director of Consultation Liaison Psychiatry, Wright State University, School of Medicine

Many myths have existed around the subject of hypnosis. One of these is that hypnosis is projected onto the patient. In fact, all hypnosis is really self-hypnosis. The physician merely provides an opportunity for the patient to become familiar with his own capacity for hypnotic trance and to learn how to use it.

Self-hypnosis is a state of mind characterized by intense focal concentration, with suspension of peripheral awareness and critical judgment. In this state, the individual is receptive to new ideas and suggestions. In fact, a person who has the capacity for hypnotic trance will experience this state of mind spontaneously and not need a hypnotist to induce the hypnosis.

Examples from daily life include daydreaming in which individuals indulge in vivid imagery and fantasy to such a degree that usual awareness of surrounding environment is suspended, or watching an absorbing play or movie, or listening to an important talk or music, so that when it is over the person needs a moment or two to get reoriented to the surrounding environment. Natural childbirth is experienced as a trance state by many women who have the capacity for self-hypnosis.

The hypnotic experience is also associated with changes in perception, sense of time, memory, motor control and an increase in receptiveness to ideas and suggestions. These can all be used constructively to facilitate and overcome bad habits, to potentiate
learning and overcome symptoms. Self-hypnosis can be successfully used as an aid in the following:

1. Coping with stress by inducing relaxation.

2. Overcoming unwanted habits, such as smoking, drinking, overeating, nailbiting, procrastination and others.

3. Mastering certain emotional problems such as fear and phobias, undesirable hostility and irritability, shyness, anxiety, and tension.

4. Controlling certain physical symptoms such as pain, insomnia, hiccups, itching, hyperventilation, impotence, and premature ejaculation.

5. Improving skills such as in athletics, organizational ability, work performance and mechanical skills. (Torem, 1983, p. 64)
STRESS AND YOUR HEALTH

What is Stress?

Stress is defined as intense exertion -- strain and effort, the wear and tear of life. All emotions, love as well as hate, for example, involve stress. And so does physical exertion -- swimming, golfing or just a brisk walk. This type of stress is good for us. What is important is not the stress itself but its source and effects.

Types of Stress

There are varying degrees and different types of stress--mental, emotional, physical—all having some impact, sometimes good, sometimes harmful, upon health. Stress can often be the spice of life or, depending upon circumstances and a person's capacities and reactions, it may have damaging side effects that can lead to disease, cause us to age prematurely, or sometimes even shorten life.

Pleasurable emotions involving stress and tension can be exhilarating. You may get excited and tense while watching a tennis match or a football game. This type of tension can pep you up and then produce healthy relaxation.

In contrast to healthy—or positive—stress, however, intense and persistent anger, fear, frustration or worry can threaten health. It is this buildup of unrelieved stress without release of tension that leads to trouble. As a result of steady strain people may experience a variety of symptoms such as irritability, frequent headaches or digestive distress. These are warning signals indicating a need for relief.

Strong emotions cause bodily changes because emotions, in general, are meant to make us act. Fear, for example, makes us tense. This tension, in turn, causes nerve impulses and hormones to speed through the system making the heart beat rapidly. Blood vessels of the stomach and intestines contract, shunting the blood to muscles for quick action.
Breathing speeds up and other changes occur that help to fortify us to meet an emergency or cope with a difficult situation.

All of us, at one time or another, have experienced some of the effects of emotions on bodily functions. We can recall blushing when embarrassed or having the heart pound and hands perspire when excited or afraid. These are normal reactions of the body to specific situations. Once the cause is removed, these reactions generally disappear quickly. When we know how emotions influence bodily functions, we are better able to understand how, over a period of time, strong and persistent mental and emotional stress may disturb the working of body organs such as the heart or stomach. It is believed that, in some instances, continual emotional stress—that becomes distress—can eventually result in an actual change in the organ itself. Prolonged emotional tensions are thought to play a prominent role in certain kinds of heart and circulatory disorders—especially high blood pressure; in digestive ailments, such as peptic ulcer; and also headache and joint and muscular pains.

What’s to be Done?

Discovering the causes of illnesses involving emotional stress takes time and skill. A complete physical checkup is important. But other kinds of information are equally important. The physician needs to know about the life style of the patient, and that person’s responses to certain situations.

With this knowledge, a doctor may be able to help the person become aware of how fears and worries cause or contribute to illness—and how to cope more constructively with these stressful emotions. If brought to the early attention of the family physician or a specialist, many ailments of a psychosomatic nature can now be treated with greater hope of success than ever before. Aware of the connection between certain physical ailments and the emotions, doctors are better able to discover and treat these
problems. They can help to do so by encouraging the patient to understand the condition, to change it, or to learn to live with it.

Try not to bottle up feelings. That's one way to prevent stress-related ailments. Instead of keeping all worries and tensions to ourselves, we should look for the most reasonable ways to work them out. For some of us, just talking over our problems with a friend or adviser often helps to clear the air. This type of frank discussion can help us discover that others experience similar feelings.

It is important to learn how to handle our emotional tensions—to try to know and accept our physical and emotional limitations. Of course, this is easier said than done. But understanding is the first step. Everyone has strengths and weaknesses. Everyone functions better in some situations than in others. When possible, we should direct our activities to those areas of life where we function effectively and comfortably. We may then reduce the possibility of developing ailments that arise from inner conflicts.

Listen to Your Body...Listen to Your Feelings

To deal with stress a person must first be able to recognize and admit its presence. So, listen to your body. It will often give you signals indicating stress. Listen to your feelings, too. They will often tell you when you need some relief.

Are you taking on too much? A common cause of a stress reaction is attempting to do too much with the resources and time at your disposal. If you seem to be making commitments beyond your capacity, better scheduling plus the ability to say "No", when appropriate, can help.

Check it out with your doctor. Persistent signals that might mean psychological stress are sometimes due to physical problems. Better check them out with your doctor. Sometimes the physician will refer patients to specialized help, such as a
psychiatrist, psychologist, religious, marital, child guidance or family service counselor.

Balance work with play. If you feel that you are on a treadmill of work, try to schedule time for recreation. An interesting hobby or activity can be both relaxing and enjoyable.

Loaf a little. Take a breather. A leisurely walk, for example, can bring inner peace and help put things in perspective. Find the time to "make friends" with yourself.

Get enough sleep and rest. Nobody can be in the best of health for long without enough sleep and rest. Probably the best test of whether you are getting enough sleep is how you feel. Frequent inability to sleep should be discussed with a physician.

Work off tensions. When upset or angry, try to blow off steam, or work off disturbing feelings with physical exercise. Enjoying some activity such as tennis, biking, swimming or other exercise helps to relieve tension and makes it easier to face and handle problems.

Get away from it all. When you feel that you are going around in circles with a problem, try to divert yourself. When possible, a change of scene can give you a new perspective. There are times when we need a brief letup from the usual routine.

Avoid self-medication. If you should need medication, your physician may prescribe one which temporarily helps you to relax without affecting your mental agility. But, avoid self-medication. There are different types of tranquilizers or sedatives available for various purposes. A doctor can prescribe the amount and type that's safe for you.
Other Sources of Information

The following agencies offer educational materials and guidance in the area of mental health. You may wish to write to one or all of them for additional information.

**Family Service Association of America**
44 East 23rd Street
New York, N.Y. 10010

**Mental Health Materials Center, Inc.**
30 East 29th Street
New York, N.Y. 10016

**National Association for Mental Health**
1800 North Kent Street
Arlington, Va. 22209

**National Clearinghouse for Mental Health Information**
Public Inquiry Section
National Institute of Mental Health
5600 Fishers Lane
Rockville, Md. 20857

(Metropolitan Life Insurance Company, 1980, pp. 1-4)
APPENDIX K

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name ____________________________________________ Date ____________ S __
Age _______ Sex: M _____ F _____

DIRECTIONS: A number of statements which people have used to
describe themselves are given below. Read each statement and then
blacken in the appropriate circle to the right of the statement to indi-
cate how you feel right now, that is, at this moment. There are no right
or wrong answers. Do not spend too much time on any one statement
but give the answer which seems to describe your present feelings best.

1. I feel calm ........................................ i 1 2 3 4
2. I feel secure ........................................ i 1 2 3 4
3. I am tense .......................................... i 1 2 3 4
4. I feel strained ..................................... i 1 2 3 4
5. I feel at ease ....................................... i 1 2 3 4
6. I feel upset ........................................ i 1 2 3 4
7. I am presently worrying over possible misfortunes ........ i 1 2 3 4
8. I feel satisfied ..................................... i 1 2 3 4
9. I feel frightened ................................. i 1 2 3 4
10. I feel comfortable .............................. 1 2 3 4
11. I feel self-confident ............................. i 1 2 3 4
12. I feel nervous ................................... i 1 2 3 4
13. I am pious ......................................... i 1 2 3 4
14. I feel indecisive .................................. i 1 2 3 4
15. I am relaxed ..................................... i 1 2 3 4
16. I feel content .................................... i 1 2 3 4
17. I am worried .................................... 1 1 2 3
18. I feel confused ................................... 1 1 2 3
19. I feel steady ..................................... i 1 2 3 4
20. I feel pleasant ................................... i 1 2 3 4

Consulting Psychologists Press
577 College Avenue, Palo Alto, California 94306-139-
**SELF-EVALUATION QUESTIONNAIRE**

**STAI Form Y-2**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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</table>

**DIRECTIONS:** A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you **generally** feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>T</th>
<th>F</th>
<th>M</th>
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<tbody>
<tr>
<td>21. I feel pleasant</td>
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<td>22. I feel nervous and restless</td>
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<td>23. I feel satisfied with myself</td>
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<td>24. I wish I could be as happy as others seem to be</td>
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<td>25. I feel like a failure</td>
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<td>26. I feel rested</td>
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<td>27. I am &quot;calm, cool, and collected&quot;</td>
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<td>28. I feel that difficulties are piling up so that I cannot overcome them</td>
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<td>29. I worry too much over something that really doesn't matter</td>
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<td>30. I am happy</td>
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<td>31. I have disturbing thoughts</td>
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<td>32. I lack self-confidence</td>
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<td>33. I feel secure</td>
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<td>34. I make decisions easily</td>
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<td>35. I feel inadequate</td>
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<td>36. I am content</td>
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<td>37. Some unimportant thought runs through my mind and bothers me</td>
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<td>38. I take disappointments so keenly that I can't put them out of my mind</td>
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<tr>
<td>39. I am a steady person</td>
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<tr>
<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests</td>
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</tbody>
</table>

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-140-
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These consist of pages:

APPENDICES L & M; 141-155

__________________________________________________________________

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__________________________________________________________________
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ABSTRACT

THERAPEUTIC INTERVENTION IN THE TREATMENT OF ADULT PATIENTS WITH METASTATIC CANCER: A COMPARATIVE STUDY OF TWO GROUP COUNSELING APPROACHES

Gilbert Garner Cumbia

The College of William and Mary in Virginia, April 1985

Chairman: Professor Jack A. Duncan

The purpose of this study was to analyze the efficacy of two group counseling approaches upon adult patients diagnosed with metastatic cancer since August 1, 1980. Eighteen adult outpatients from metropolitan Richmond, Virginia area hospitals were the subjects. All were volunteers and were randomly assigned, using a modified random sampling procedure, to a nondirective, stress management, or control group. Five personality characteristics were examined: state anxiety, trait anxiety, self-esteem, innerdirectedness, and time competence.

The nondirective and stress management groups met for 90 minute sessions twice a week for five consecutive weeks. The control group did not meet. Each group facilitator distributed the State-Trait Anxiety Inventory, Tennessee Self Concept Scale, and the Personal Orientation Inventory to the participants at an eleventh session and explained the directions. These assessment instruments were selfadministered at home. Proper test-taking procedures were stressed by the facilitator. The same instruments were taken to the homes of the control group members for self-administration.

The research design used in this study was the Posttest-Only Control Group Design. The statistical procedure employed was the analysis of variance. Five null hypotheses provided the basis for testing for significant difference (α = .05) among the nondirective, stress management, and control groups on posttest anxiety, self-esteem, innerdirectedness, and time competence measures.

Analyses of the test data revealed that there was no significant difference among the nondirective, stress management, and control groups on any of the posttest measures. The investigator failed to reject all five null hypotheses.

Individual post-group interviews were conducted within two weeks of the termination of each group. They served as a validity check of the instrumentation results, and a content analysis was conducted with the interview data. The interview data analyses revealed that there was no appreciable difference among the nondirective, stress management, and control groups. There was, however, a qualitative difference when comparing the nondirective and stress management groups with the control group. In each treatment group, the group experience was credited for a diminution of stress and anxiety and an enhancement of self-esteem, innerdirectedness, and time competence. The control group period did not appear to be as meaningful or beneficial.