

The Development, Implementation and Evaluation of a Group
Counseling Program and Its Influence Upon Anxiety
Levels in Newly Diagnosed Cancer Patients

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CHAPTER I

INTRODUCTION

Recently much attention has been given to the stress and anxiety which cancer patients undergo. It is now becoming apparent that we cannot treat the physical aspects of cancer and ignore the emotional and psychological repercussions.

Cancer patients must be regarded as people under a special and severe form of stress (Bard, 1972). That stress stems from drugs, the prospect of death, poor physician-patient communication, problems relating to relationships with family and friends, inability to discuss the cancer with family members, and job security. As a result of these stressful factors, anxiety is also aroused. If not dealt with, this anxiety can intermix with other negative feelings and is likely to manifest itself in such aggravated symptoms as deep depression, continual apprehensiveness, anger, or obsessive dependence upon others (Bard, et al., 1972). The devastating impact upon the person who learns that he has cancer strikes all phases of his life and the lives of his family members. Hence, helping the cancer patient cope with these stressful factors is not an easy task.

Psyche and soma are complexly intertwined in the disease of cancer. Although modern medicine has made great strides through the development of new chemotherapeutic drugs, advances in radiotherapy, and increased knowledge of the disease process, it does not resolve the human, personal problems faced by the cancer patient and his family. It may be

able to arrest or remove the tumors, but it does not deal with the anxiety that results from losing a breast, an arm, or one's voice.

Most people in the medical profession seem to agree that the chances for recovery from cancer are much better if the emotional well-being of the patient is considered (Bard, et al., 1972). Until recently, however, little emphasis has been placed upon helping cancer patients and their families cope with the anxiety and emotional stress arising from cancer. As a result, cancer patients have been forced to live as outsiders, isolated in fear, anxiety and frustration.

Various programs have been developed in the past few years to help the cancer patient cope with stress and anxiety. Some such programs are the well-known "Reach To Recovery" program or "Ostomy Clubs" sponsored by the American Cancer Society, the "Make Today Count" program, and other programs developed by former cancer patients. Some medical centers, in addition, are developing group counseling programs for cancer patients. All of these programs seem to be meeting with resounding success. Cancer patients are given the opportunity to allay their fears, to discuss their problems, and at the same time to offer one another support and hope in dealing with the emotional stresses and anxieties which they face. Little research has been done, however, to determine whether these programs do, in fact, result in less anxiety and an easier adjustment back to the home and community for the cancer patient.

Statement of Problem

A study should be conducted to determine whether participation in a group counseling program results in less anxiety for cancer patients.

Need for the Study

There is a pressing need for research in the area of the emotional repercussions of cancer on the patient. This need is so strong because of the millions of people that will be afflicted with cancer. Statistics indicate that one out of four Americans (i.e. approximately 55 million) alive today will contract some form of cancer; one out of six (approximately 37 million) will die from it (Gonzalez, 1976). Yet talking about cancer, on the personal level, has been taboo in the American culture. The often crushing fears and anxieties of the cancer patient, consequently, have not been dealt with adequately. As a former cancer patient who has lived through these fears stated: "No one should have to undergo the cancer experience alone. To be saddled with the torture of cancer is enough; to have no one there to help is beyond human endurance" (Keeling, 1976).

Recently programs have been developed which focus on the emotional state of the cancer patient, (University of Alabama, 1976, Mount Sinai Medical Center, Milwaukee, Wisconsin, 1976) but so far nothing has been done to determine which are the best methods of reducing anxiety and whether group counseling programs do, in fact, achieve that goal.

A second reason that this research is needed concerns the quality of the relationships between the patient and his family, the patient and his physician, and the family and the physician. Too often communication involving a cancer patient fails. People act and respond in ways that are hurtful or at best do not help the patient to cope with the realities of the disease.

It is hoped that as a result of this research the need for improved lines of communication among the patient, his family, and his physician will be seen and appreciated, and action taken. This would include education of the medical and lay community about the importance of cancer counseling groups, and the importance of positive outlets for the frustration and apprehension of cancer patients and their families. Another component of this is that it could lead to further research concerning the effect of such programs on the cure or remission of the disease.

The investigator does not believe that group counseling programs will cure cancer. She does believe, however, that the link between the mind and body is a strong and undeniable one, and that group counseling programs may be a means of helping the patient adapt and live with the much coveted "dignity and respect."

Purpose

It is the purpose of this study to develop a group counseling program for newly diagnosed cancer patients at the University of Wisconsin Hospitals, Madison, Wisconsin and to evaluate its effectiveness in reducing anxiety in cancer patients.

Null Hypothesis

The anxiety scale gain scores of Group I (cancer counseling program) will not be significantly greater than those of Group II (control).

Assumptions

The investigator had made the following assumptions:

1. A need exists for programs to help cancer patients cope with stress and anxiety.
2. The random sample represents the general cancer patient population.
3. There is a strong interaction between physical and mental processes in relation to certain disease processes.
4. The anxiety of the random sample is typical of most cancer patients.
5. Subjects will respond accurately to questions on the State Trait Anxiety Inventory.

Delimitations

The present study had the following types of delimitations:

1. This study utilized the cancer patient population at the University of Wisconsin Hospitals, Madison, Wisconsin, and at the Quisling Clinic, Madison, Wisconsin.
2. It included only those patients considered non-terminal and diagnosed within a previous six month period.
3. The patients were receiving chemotherapy or radiotherapy, although no one was hospitalized or anticipating surgery.
4. The study did not include patients being treated for psychological problems.

Limitations

The present study had the following types of limitations:

1. Patient characteristics, type of cancer, past medical history, age, social class, and educational background were not

considered for subject assignment to groups. For data analysis, inclusion of such variables would have complicated the study beyond reasonable limits.

2. A relatively small sample of subjects were obtained during the specified research time period.
3. Some subjects were unable to attend all three counseling sessions.
4. The coping mechanisms of the patients and families could have influenced the individuals anxiety more than the counseling program.

Definition of Terms

Cancer Counseling Program: A series of meetings with cancer patients and their families under direction of a qualified leader in order to focus on problems group members encounter as a result of their disease. The specific aim of the program is to decrease or eliminate emotional and situational crises.

Group leader: The person who guides the group discussion and assumes an active role in the group with the idea of helping patients work through their problem areas.

Anxiety: A feeling characterized by loneliness, helplessness, and fear of a potentially hostile world.

Emotional support: Encouragement, hope, and inspiration given to one person by another.

Fear: An unpleasurable feeling consisting of psycho-physiological changes in response to a realistic threat or danger to one's existence.

Cancer: A general term frequently used to indicate any of the various types of malignant neoplasms, most of which invade surrounding tissues and may metastasize to several sites. They are likely to recur after attempted removal and to cause death of the patient unless adequately treated.

Chemotherapy: Treatment of disease by means of chemical substances or drugs.

Radiotherapy: Relates to the use of electromagnetic or particulate radiations in the treatment of disease.

"Make Today Count" Program: A rehabilitation program for cancer patients focusing on problems resulting from the disease. Orville Kelley, a former cancer patient, started the program in 1972.

"Reach To Recovery" Program: A rehabilitation program for women who have had breast surgery, designed to help meet their psychological, physical and cosmetic needs. Since 1969 it has been sponsored by the American Cancer Society.

"Ostomy Club": A rehabilitation program sponsored by the American Cancer Society for patients who have undergone colostomies or illeostomies.

Stress: A condition of intense strain or pressure.

State Trait Anxiety Inventory: A research instrument for investigating anxiety phenomena in "normal" adults, medical and surgical patients.

State Anxiety (A-State): Is conceptualized as a transitory emotional state or condition of the human organism that is characterized by subjective consciously-perceived feelings of tension and apprehension and heightened autonomic nervous system activity. A-States may vary in intensity and fluctuate over time.

Trait Anxiety (A-Trait): Refers to individual differences in anxiety proneness, that is, to differences between people in the tendency to respond to situations perceived as threatening with elevations in A-State intensity.

CHAPTER II

RELATED LITERATURE

Historical Perspective

A review of the literature on the Psychological aspects of cancer revealed very limited exploration or research in this area. The studies found can be divided into three groups:

1. Those pointing out the impact of stress and anxiety on the remission or cure of the disease.
2. Those focusing on group discussion as a means of coping with anxiety resulting from the complexities of a cancer life crisis.
3. Those dealing with the personality characteristics of persons with cancer. No studies were found that evaluate group counseling programs or their effect on the anxiety of the cancer patient.

Plato is perhaps the first to have concerned himself with the psychological aspects of physical disease. He is quoted to have said: "The great error in the treatment of the human body is that physicians are ignorant of the whole. For the part can never be well unless the whole is well" (LeShan, 1976). It was also noted by Ewing (1940) that Galen considered that melancholy women suffered from breast cancer more often than sanguine women. And again in 1870, Sir James Piaget, was to have noted a link between cancer and mental depression.

Although several studies were conducted between 1905-1955 on the psychological aspects of cancer, it was not until the latter half of the 1950's that great interest was taken in this area. These early studies dealt primarily with similar personality characteristics noted in individuals with cancer. The new interest was sparked principally by observations made by Lawrence LeShan, (1959) who is currently known for his intensive therapy with cancer patients and research on the psychological aspects of cancer. LeShan noted similar personality characteristics among the cancer patients he was treating in psychotherapy. Some of these characteristics included a weakened ability to form emotional relationships, loneliness, hopelessness and placid, non-aggressive dispositions. In 1956, he published a critical review of the available literature in which he stated that this new field was bound to lead the way to new means of approaching the neoplastic problem.

Also in 1956, several other critical reviews of the studies done between 1905 and 1956 were published. Bartmeier, (1961) in his review of the studies stated that the emotional reactions to physical illness could be described as the silent areas in medical practice. Perrin and Pierce (1956) in their discussion of the studies conclude that they were inadequately designed and the findings raised many questions. Perrin and Pierce (1956) did, however, express the idea that improved research techniques would pave the way for more fruitful research in the area. They discuss the studies again in 1959 in another critical review and state that "despite the sparseness of literature on the relationship between cancer and the psychiatric phenomena, the few studies which have been done contain statements that, if validated,

would be of considerable importance to medicine" (Perrin and Pierce, 1959). And again they point out the need for further research in the complex field dealing with the psychological aspects of cancer.

In the 1960's there was a growing realization on the part of many researchers of the importance of the psychological, along with the physical considerations in treating the cancer patient. Almost all of the research in the first half of the 1960's, however, dealt with the psychological factors that predispose the onset of cancer, or with the pattern of personality characteristics noted in cancer patients. Because this study is concerned with anxiety that results from having cancer, and focuses on group counseling programs as a means of coping with that anxiety, the studies of the early 1960's will not receive further attention. However, it should be noted that they are relevant since they emphasize the physical and psychological aspects of cancer being complexly intertwined.

In the later 1960's a new emphasis is placed on the emotional considerations in cancer. In 1966, Fred Brown presented a paper to the New York Medical Society on the relationship between cancer and personality, and stated that "psychology and psychiatry have deepened our understanding of the sick individual and have oriented their efforts toward the alleviation of psychic distress that may otherwise hinder recover." He goes on to say that "it should be possible to devise psychotherapeutic modalities that, in conjunction with medical techniques, retard or arrest the malignant process." He then makes the point, which is particularly relevant to this study, that "man does not live by cells alone nor is personality invulnerable to the moral-

corroding impact of physical disease." The most fruitful approach to treating cancer, according to Brown, is to take into consideration both personality and physical factors. Also in 1966, LeShan strongly suggested from observations of his cancer patients in psychotherapy, that psychotherapy "considerably slowed the development of the neoplasm" (LeShan, 1966).

Present Day Considerations

In 1972, Dr. Rene Mastrovito presented a paper to the Annual Medical Society meeting in New York in which he noted some emotional considerations in cancer. He categorized human needs into three parts: 1) the need to survive, 2) the need to survive with relative freedom from physical and psychologic pain, and 3) the need to survive with some sense of accomplishment, gratification of needs, and a sense of fulfillment. He proceeds to point out that although medicine has responded competently and with increasing expertise to the first need, it seems to have responded incompletely to the second need. He goes on to say that cancer has an extreme impact on, and threatens, the three needs. He points out the importance of the physician-patient farther than ever from the physician. He indicated that because of this distant relationship, anxiety results, causing the cancer patient to be afraid of expressing his feelings and fears because he thinks it is wrong to do so. In the paper he also points out his belief that the patient's psychological responses to having cancer, and how these responses are handled can contribute to remission or cure. He implies that if the patient is allowed to express his fears

and feelings, his coping mechanisms will be strengthened, which can positively affect the outcome of the disease.

A further sign of the new awareness of the importance of emotional considerations of cancer treatment was the focus of the American Cancer Society's 1972 National Conference: Human Values and Cancer. The papers presented at the conference stressed the need to consider the emotional problems faced by the cancer patient and his family. Dr. A. Letton (1972) stated "that the problems in the care of the disease process of cancer are not nearly so insolvable as the other problems in the lives of my patients and their families. A slide presentation at the conference stressed involvement of the family in the patients situation and indicated that patients want to relate their fears, their fantasies, their hopes. In his paper, "What Cancer Meant To Me," Herbert Black (1972) states: "One thing I know now is that the patient cannot handle rehabilitation by himself, no matter how good his attitude. He needs a great deal of support."

Also at the Conference Dr. Morton Bard (1972) stated: "There is no specific psychology of cancer patients; there is only the psychology of individuals caught in a special and severe stress situation." Dr. Sol Baker expressed his feeling that "more than any other disease that affects man, cancer has tremendous impact upon human behavior. In part because certain cancers can cause pain and suffering; in part because cancer can be fatal; in part because cancer evokes the entire gamut of emotions." He then relayed the results of a survey that had been conducted in California in which an effort was made to learn as much as possible about the fears and needs of the cancer patient. The survey revealed that the

most common complaint was "related to the poor rapport between the patient and physician, between the family and the patient and between the doctor and the family." He felt that this was due "to the resistance of the family to become involved, to the inability of the patient to verbalize his fears and apprehensions and to the physician's inability or failure to talk with and to the patient and family."

Offering a possible solution, he cites the attempt--one of the first of its kind--made at one of the medical centers in Los Angeles, to organize post-mastectomy patients in a group session. It was observed that the women soon lost their inhibitions and began to verbalize their fears. The main implication was that the patient, doctor, and family must all be involved in the patient's return to society and that a cooperative approach needs to be taken. After this first attempt, several other programs have been developed at various medical centers, although no formal assessment or evaluation procedures have been developed to determine the actual effects of the programs.

In July, 1976, the University of Alabama Medical Center established one such program involving six cancer patients and their family members. A structured group with specific goals and objectives is used. A similar program is in existence at the Mount Sinai Medical Center in Milwaukee, Wisconsin. This program began in 1974 and although it does not focus specifically on cancer patients it is very similar to group counseling programs. Several changes have occurred in this program since it began, such as moving to more structured group meetings rather than open-ended which apparently only met immediate needs causing members to drop out of the group. There has also been no formal evaluation of this program.

Only in the last two decades, then, has there been a serious concerted effort to examine the psychological repercussions of the cancer patient. A major assumption--implicit or explicit--of these studies is that the cancer patient's psychological state greatly influences the outcome of this disease. The emphasis has been placed on involvement of the patient's family, improved patient-physician relationships, the needs and fears of the cancer patient, and the introduction of group counseling programs for cancer patients. It appears that no evaluations of these programs have been made. A contribution of the present study is to form such a program at the University of Wisconsin Hospitals, Madison, Wisconsin, and to systematically assess and evaluate its effectiveness in reducing anxiety in the cancer patient.

CHAPTER III

METHODS

Introduction

This study was designed to determine anxiety levels of two groups of twelve cancer patients. Baseline data was established through administration of the State Trait Anxiety Inventory. One group was exposed to a group counseling program, while another was not, and thus served as a control. To check for differences within the two groups, a post-test was administered utilizing the State Trait Anxiety Inventory again.

Instrument

The State Trait Anxiety Inventory (STAI) developed by Spielb^erger (1970) was the instrument chosen to be used in this study and it is presented in Appendix B. The inventory was chosen for the following reasons:

1. It measures two distinct anxiety concepts: state anxiety (currently experienced anxiety) and trait anxiety (general anxiety).
2. It was developed to measure anxiety in "normal" (non-psychiatrically disturbed) adults.
3. It has been found most useful in the measurement of anxiety in medical patients.
4. It has been demonstrated that scores on the A-State scale

increase in response to various kinds of stress and decrease as a result of relaxation training.

5. This inventory was designed to be self administered and may be given either individually or to groups.
6. The inventory has no time limits, and less educated or emotionally disturbed persons may take longer but can complete both scales.
7. Most persons with fifth or sixth grade reading ability spontaneously respond to all of the STAI items without special instructions or prompting.
8. Test - retest reliability of the STAI A-Trait Scale is relatively high, but stability coefficients for the STAI A-State scale tend to be low, as would be expected for a measure designed to be influenced by situational factors.
9. Both the A-Trait and A-State scales have a high degree of internal consistency.

Subjects

The cancer patient populations at the University of Wisconsin Hospitals, Madison, Wisconsin and the Quisling Clinic, Madison, Wisconsin were the sources of the twenty-four cancer patient subjects. Patients were referred by physicians working in Oncology and Radiotherapy. The twenty-four subjects were divided into two groups of twelve patients.

To be selected as a subject for this study a patient:

1. Must have had cancer diagnosed within a period of six months prior to the scheduled beginning of the group counseling program.

2. Was receiving either chemotherapy or radiotherapy, but was not considered terminal.
3. Could not have been hospitalized or anticipating surgery during the time of the study.
4. Could not have been treated for serious psychological problems or receiving psychotherapy during the time of the study.

The Group Counseling Program

I. Objectives. The objectives of the program were three-fold. First, to offer the twelve cancer patients in the experimental group and their families an opportunity to share common concerns; to receive support from one another; and, to effectively employ their strengths in coping with the disease. Second, to provide a means of discovering and dealing with any emotional, financial or legal problems confronting the patient. Thirdly, to help the cancer patients and their families face the reality of their disease and help them live with dignity and respect.

II. Group Leaders. The investigator and Suzi Sylvester, a registered nurse working on the Minimal Care Oncology Unit at the University of Wisconsin Hospitals co-led the groups. Special resource persons were used in discussing specific issues.

The Nutrition issue was discussed by Donna Becker, a dietician at the University of Wisconsin Hospitals.

The Assertiveness session was led by Dr. Barbara Brockway, a professor in the Family Practice and Medicine Department at the University of Wisconsin, Madison.

Kathryn Kainz, a counselor at the Moon Tree, a women's counseling center in Madison, led the session on Relaxation.

III. Group Sessions.

A. Physical Setting

The group sessions were held at the University of Wisconsin Student Union, in a room that afforded privacy and freedom from distraction.

B. Type of Group

A closed group format was used. Once it began no new members were accepted, since it was meeting for a pre-determined number of sessions.

C. Duration and Frequency of Meetings

The length of the sessions was set at sixty minutes; although, in certain instances, additional time was required to work through patient problems and major themes of the sessions. This was particularly true during the sessions dealing with nutrition and assertiveness training. Both sessions lasted approximately two hours. Two meetings were held during week I, and the third meeting was held the following week.

IV. Size of the Group. The group consisted of 12 patients although approximately five additional family members also attended. The investigator noted that this size group offered the opportunity for total group participation.

V. The First Meeting. At this meeting patients and family

members were given a review of the purposes of the program and were encouraged to be open and share feelings and experiences. Topics to be covered at each of the sessions were reviewed and group members were then asked to briefly introduce themselves. It was noted that all the patient group members shared with the group the type of cancer they had and also the type of therapy they were receiving. Several members expressed pleasure at having an opportunity to participate in the program.

The specific issue discussed was Relaxation Techniques. This particular issue was introduced and led by Kathryn Kainz, a counselor at the Moon Tree, a women's counseling center in Madison, Wisconsin. The topic was chosen because it has been shown to be of value in breaking the "pain - anxiety - depression - more pain cycle" experienced by persons with chronic diseases (Mount Sinai Medical Center, 1976).

The group was led through a series of various relaxation exercises (See Appendix D) and concluded with a discussion of participants reactions and feelings. It was pointed out that nurses at the University of Wisconsin Hospitals have observed that those patients who appear more relaxed seem to tolerate chemotherapy and radiotherapy treatments better than patients appearing tense or anxious.

VI. The Second Meeting. Group members were given an opportunity to present and discuss any immediate concerns or needs. The group expressed a desire to immediately move on to the specific topic for the session which was Nutrition (See Appendix D).

Donna Becker, a dietician at the University of Wisconsin Hospitals

gave an overview of the relationship between cancer and diet. She stated that it has been shown that if a good nutritional balance can be maintained, a patient is better able to tolerate therapy, has a better chance of successful therapy and a greater feeling of well being throughout the course of illness.

The group members had many questions regarding diet and most expressed concern that while hospitalized they did not receive more adequate information regarding nutrition. Some of the questions which arose concerned marijuana and its affect on nausea, laetril, vitamin supplements and dieting.

This group lasted two hours and it was noted that all members of the group interacted and shared experiences.

VII. The Third Meeting. As with the previous two meetings this session began with a discussion of any immediate concerns or questions of the group members. Several persons expressed concern that this was to be the last meeting. The group discussed continuation of the program on a monthly basis and the leaders assured the group that they would consider this possibility or alternatives.

Assertiveness Training (See Appendix D) was the specific topic discussed. It was led by Dr. Barbara Brockway, a professor in the Family Practice and Medicine Department at the University of Wisconsin-Madison. This particular topic was chosen because many patients feel they are at the total mercy of the doctor and that the doctor many times is seen as an unreachable god-like figure (Barksdale, 1976). Also many patients feel

they are thrown into a passive role with little control over their own lives. Assertiveness Training was seen as a possibility for changing that position as well as reducing anxiety.

The goal of this meeting was to give the group an overview of Assertiveness Training and information as to how it might be useful in their patient-physician or patient-family communication difficulties.

It was noted that several group members expressed difficulty and frustration in communicating with physicians. Dr. Brockway discussed this problem and stated that a common concern among many of her residents is how to tell a patient that he has cancer or communicating with him about the illness or death.

Group members were given various hypothetical situations and were asked to respond in several ways (see Appendix D). It was noted that the group initially exhibited some uneasiness, although at the end of the meeting many expressed the feeling that they found the activity most worthwhile. Several members shared with the group situations in which they felt they had lacked assertiveness in communicating with others.

This meeting lasted approximately two hours. The group was given information as to where they could pursue Assertiveness Training.

NOTE: As a result of this meeting Dr. Brockway will lead a six-week Assertiveness Training session which will include six of this group's members.

Procedure

The investigator personally contacted each of the twenty-four cancer patients selected as subjects for this study. She introduced herself as a graduate student in community health education at the University of Wisconsin-La Crosse, and explained that she was interested in developing and evaluating a group counseling program for cancer patients and their family members. The subjects were asked to participate in the study along with other cancer patients and were informed that it would entail completion of two self evaluation questionnaires. Subjects were given an example of the type of questions to be asked; but, were not told it was a measure of anxiety.

The subjects were divided into two groups. Those designated for Group I (group counseling program) were given a brief description of the program and were asked to read and sign a consent form (See Appendix A). The subjects were given an explicit statement of the program purposes. Length and duration of the sessions, number of participants, and possible benefits through participation were discussed. It was made clear that participation was voluntary, possible risks were spelled out and subjects were informed about the techniques and issues to be discussed at the sessions. The subjects were told that family members were invited and encouraged to attend the sessions. Participants were also informed that information gathered at the sessions might be used in establishing further programs or carrying out research.

Subjects for Group II (control group) were asked to complete the two self-evaluation questionnaires and were told it would help evaluate a group counseling program for cancer patients.

The pre-tests were administered one week before the group counseling program was scheduled to begin. The counseling program ran for two weeks, and after the last session the group completed the post-test and a program evaluation questionnaire.

The control group completed the post-test during the week of the final session and mailed them to the investigator.

Statistical Treatment of the Data

State and Trait anxiety level differences between Group I (group counseling program) and Group II (control) were compared using the Mann Whitney U-test. This non-parametric statistic was employed to determine whether change scores between the groups were statistically significant; $p \leq .05$ level of significance was used.

The groups were compared on the pre-treatment measures to determine equivalency between the groups on both state and trait anxiety. The Mann Whitney U-test was also used for this comparison.

CHAPTER IV
RESULTS AND DISCUSSION

Table I shows State and Trait anxiety levels for Group I and Group II, pre and post tests. It also shows the change scores for both Group I (experimental) and Group II (control).

Table 1

Group I

	PRE-TEST		POST-TEST		CHANGE SCORES	
	STATE	TRAIT	STATE	TRAIT	STATE	TRAIT
A	23	24	20	20	-3	-4
B	48	35	26	25	-22	-10
C	69	66	67	57	-2	-9
D	58	50	57	50	-1	0
E	48	46	33	48	-15	+2
F	44	22	24	23	-20	+1
G	57	46	44	44	-13	-2
H	20	24	21	22	+1	-2
I	26	24	26	28	0	+4
J	34	41	27	30	-7	-11
K	31	30	31	28	0	-2

Group II

	PRE-TEST		POST-TEST		CHANGE SCORES	
	STATE	TRAIT	STATE	TRAIT	STATE	TRAIT
A	29	52	24	57	-5	+5
B	38	21	51	35	+13	+14
C	50	51	41	41	-9	-10
D	33	36	34	41	+1	+5
E	63	39	39	33	-24	-6
F	35	30	33	38	-2	+8
G	45	41	46	46	+1	+5
H	50	38	44	39	-6	+1
I	35	37	33	29	-2	-8
J	41	43	43	39	+2	-4
K	36	48	33	48	-3	0

The Mann Whitney U-test was used to test for a difference in change scores between Group I and Group II. It was anticipated that the state scores for Group I would show a difference reflecting a decrease in state anxiety after the counseling program. Trait scores were expected to show no difference as the program was not expected to change the subjects basic character.

The results were as follows:

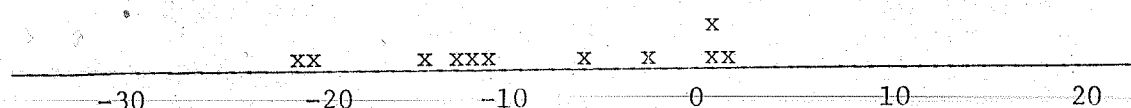
Median change scores for state anxiety were -11 points for Group I and -2 points for Group II. In the Mann Whitney one-tail test at the .05 level of significance the difference for state anxiety was just short

of significance. The Mann Whitney statistic = 34.5; the critical value = 34. A 5% confidence limit for the median difference is 0 (one-sided). Therefore, there is not enough evidence to indicate that the group counseling program causes any reduction in state anxiety. There is, however, a suggestion that the program might have some effect and could possibly be detected if a larger sample were available.

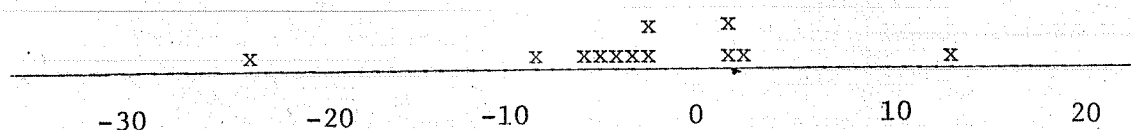
Median change scores for Trait anxiety were -2 for Group I and +1 for Group II. The Mann Whitney statistic = 44 which was not significant. The results for state anxiety and trait anxiety are illustrated graphically in Figures 1 and 2.

Figure 1
State Anxiety

Group I (Experimental)



Group II (Controls)

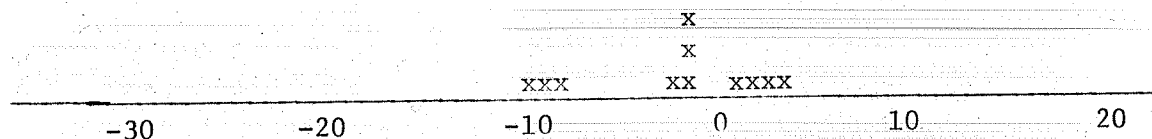


Mann Whitney counts = 34.5 and 75.5

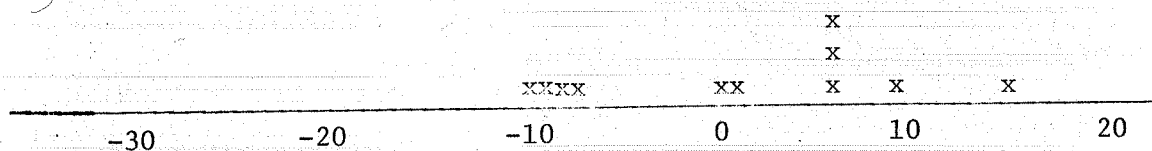
Figure 2

Trait Anxiety

Group I (Experimental)



Group II (Controls)



Mann Whitney counts = 44 and 77

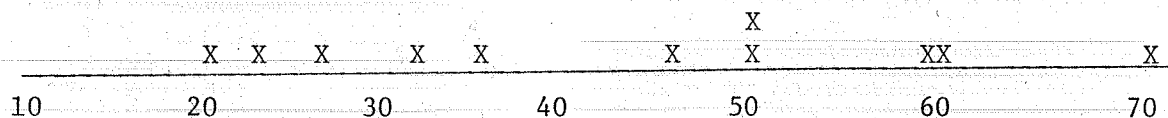
In order to investigate a possible difference in the initial composition of the two groups, the initial state scores were compared. State medians were: 44 points for Group I and 38 points for Group II with a Mann Whitney count of 57 which is very close to the expected value of 60.5. The difference was not significant.

Initial trait scores had medians of 35 points (Group I) and 39 points (Group II) with a Mann Whitney count of 50. There was clearly no significant difference between the initial scores of Group I and Group II. This is illustrated in Figures 3 and 4.

Figure 3

Initial Scores, State Anxiety

Group I (Experimental)



Group II (Controls)

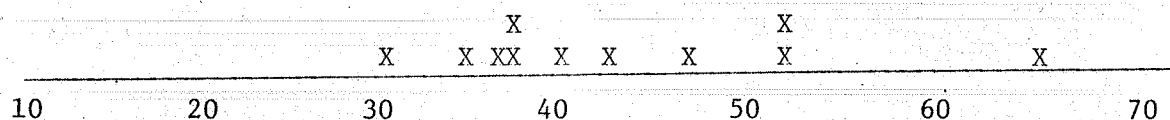
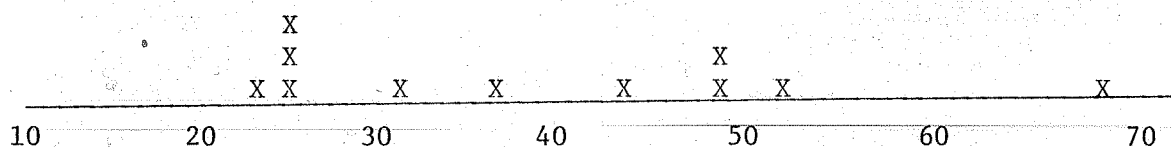


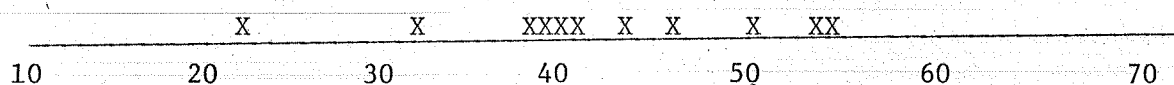
Figure 4

Initial Scores, Trait Anxiety

Group I (Experimental)



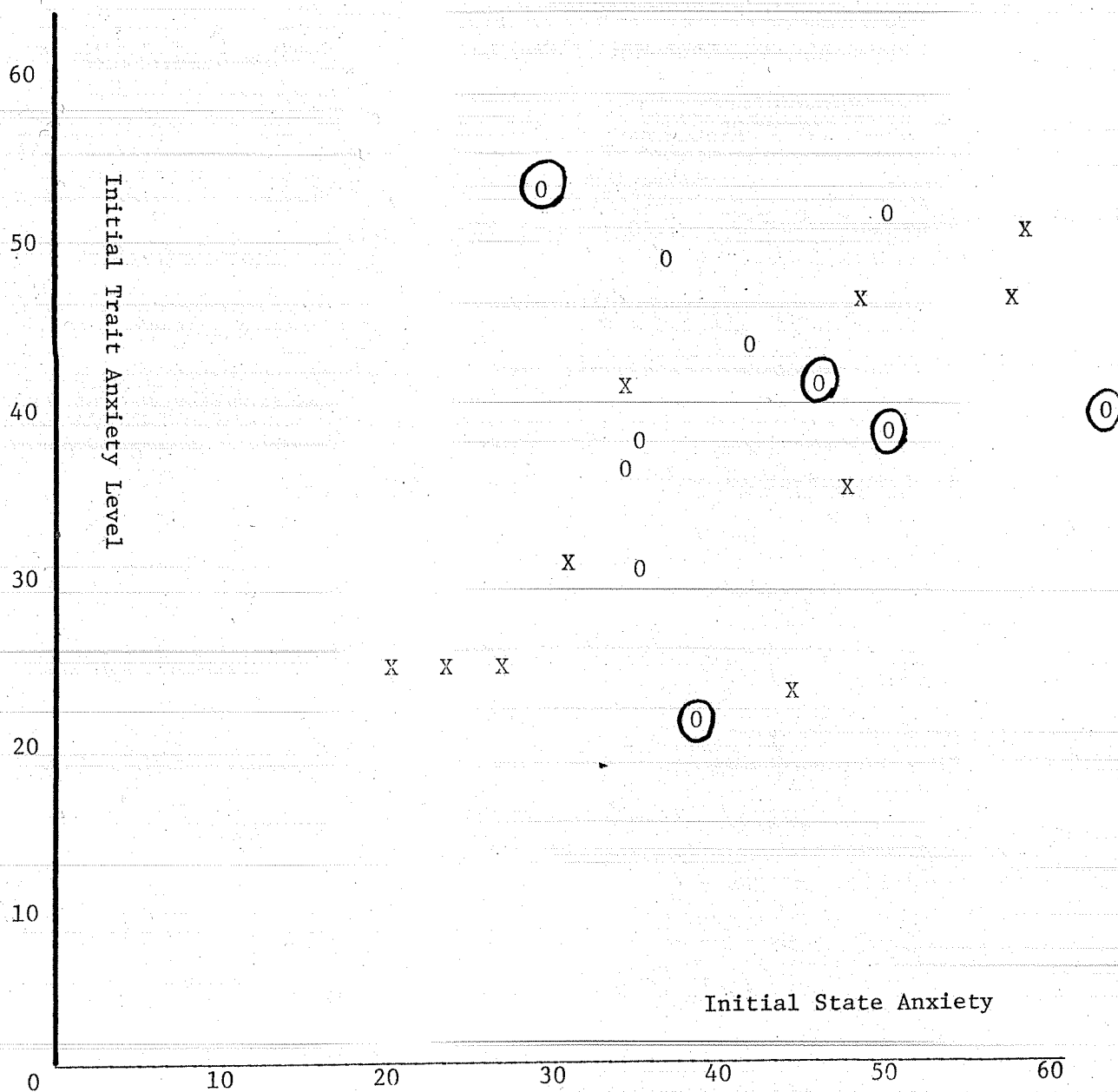
Group II (Controls)



The scatterplot in Figure 5 shows the relationship between initial state and trait anxiety levels between Group I (experimental) and Group II (Controls). Group I is shown by crosses and Group II is shown by circles.

Figure 5

Scatter diagram for initial state - trait anxiety.



Group I is shown by crosses.

Group II is shown by circles.

Encircled circles show those subjects in group II who completed pre and post tests by mail.

The scatterplot suggests a high correlation between the initial state and trait anxiety levels in Group I but no correlation between state and trait anxiety levels in Group II. The correlation coefficients were .85 and 0 respectively. The difference between these is significant at the .05 level and almost at the .01 level (two-tail) by Fishers Z test.

It is difficult to think of an explanation for this phenomenon. However, five of the subjects in Group II (control) completed both pre and post tests by mail. These are shown by the double circles. It was noted that when they are eliminated the sample looks more correlated.

Results of this study have not produced evidence to establish that the group counseling program was effective in reducing anxiety, therefore the null hypothesis cannot be rejected. There is, however, a suggestion that (borderline significance) it may have some effect which could possibly be detected if a larger sample were available.

Program evaluations were completed by Group I (group counseling program) and revealed that participants felt the program had been valuable. The program evaluations appear to support the statement that "counseling reiterates and strengthens, and sometimes enables the patient to get a perspective on his problems by not standing too close-- he finds that he can back away and ruminate because he is not alone" (Barckley, 1973). In evaluating what participants liked most about the program it was noted that nine of the group members indicated "the opportunity to interact and share common concerns with other cancer patients" was most valuable. It was further noted that participants felt the meetings provided much useful information.

A full report of the participants comments are reproduced in
appendix E.

CHAPTER V

CONCLUSIONSSummary

Much has been written about the stress and anxiety which cancer patients undergo. Group counseling programs have been seen as a means of helping the cancer patient cope with this stress and anxiety. However, until now there has been no formal evaluation of these programs or of their effect upon anxiety in cancer patients.

It was the purpose of this study to develop a group counseling program and to evaluate its effectiveness in reducing anxiety. To do this the State Trait Anxiety Inventory (STAI) was administered to two groups of twenty-four newly diagnosed cancer patients. Group I participated in a group counseling program; Group II was the control. Both groups were retested with the STAI at the close of the program. Group I also completed a program evaluation questionnaire.

Conclusions

The hypothesis that cancer patients will feel less anxious as a result of attending a group counseling program was not supported in this study; however, the data did suggest that a counseling program may have some positive effect on anxiety reduction (Statistical significance may not be practical significance).

A willingness of group members to share experiences was impressive, as was the fact that they all kept returning to the meetings, some with family members. Judging from the comments that group members made in

their program evaluations, the group found the program worthwhile. The highly structured meetings with clearly identified agenda and the useful knowledge gained were what most people liked best about the program. Increased number and length of sessions with additional topics were what most people suggested to make the program more effective.

Recommendations

More research on group counseling programs for cancer patients is indicated. It is possible that the State Trait Anxiety Inventory is not a sensitive enough instrument for testing anxiety levels of cancer patients and that other systems such as physiologic measures or parametric statistics could be used. It may also be useful to control more variables such as age, educational background and social level. Research on the effects of group counseling on a group of cancer patients who all have high anxiety and/or were all diagnosed as terminal might be highly beneficial.

Various components of the group counseling program could also be researched: it is possible that measures other than Assertiveness Training, Nutrition and Relaxation Techniques may be more effective in reducing anxiety. Suggestions:

Anxiety is an important, but not the only feeling that cancer patients experienced. Research on other mental states, such as depression, which are also common to cancer patients, may be worthwhile. Additional questions for further investigation: Does group size have an effect on the success of cancer counseling programs? Does type of cancer? Do life styles? Do sex differences? Do situational factors--weather, time of day, etc.--influence the success of the program? What is the effect of a highly structured vs. a non-structured format? How do the length and frequency of sessions

make a difference? Do former cancer patients have more success as leaders than people who have never experienced cancer?

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A P P E N D I C E S

APPENDIX A

CONSENT FORM

A STUDY OF A CANCER COUNSELING PROGRAM

Date _____

I, _____, willingly agree to participate in a study evaluating the effects of a cancer counseling program, explained to me by Connie Smoczyk, a graduate student at the University of Wisconsin-LaCrosse and investigator in the study, and approved by the University of Wisconsin Hospitals, Madison, Wisconsin.

It has been explained to me that I will be asked to complete a self-evaluation questionnaire one week before the cancer counseling program is scheduled to begin and, again, one week after the completion of the program. I understand the questions will be related to feelings I am experiencing in my life at that time; and, that there are no right or wrong answers to the questions. I have been given an example of the type of questions to which I will be asked to respond. The answers to choose from will be 1. Almost Always; 2. Often; 3. Sometimes; 4. Almost Never. I will choose the answer that best describes how I generally feel at that time.

Within one week of completion of the questionnaire I might be asked to participate in a two week cancer counseling program. The three meetings will be held at 7:00 p.m. on Tuesday, March 29 --session I; Thursday, March 31--session II and Tuesday, April 5--session III, at the University of Wisconsin Hospitals. I understand that there will be eleven other cancer patients at these meetings and that our family members are also invited to attend and participate in the sessions. The objectives of the meetings have been explained as: 1. an opportunity to give cancer patients and their families a chance to share common concerns; to receive support from each other and to employ strength in coping with cancer; 2. to provide an opportunity for members of the group to discuss and deal with any financial, emotional, or legal problems, and 3. to help all the group members face the reality of cancer and to live with dignity and respect. The length of the sessions will be at least sixty minutes, but if more time is required to work through group members problems or concerns the sessions could last longer.

I agree to try to attend all three cancer counseling sessions and to stay through the complete session; although, I understand that I am free to withdraw my consent to participate in the program without prejudice at any time. It was explained that the group meetings will be led by the investigator, who also has previous counseling experience in this area, and Suzi Sylvester, who is a registered nurse working on the Oncology Unit at the University of Wisconsin Hospitals. Each of the three sessions will begin with an informal discussion focusing on immediate concerns of group members. At each session a specific topic will also be dealt with-- 1. Nutrition, 2. Relaxation, and 3. Assertiveness. These topics will be introduced by qualified resource persons.

Consent Form--page 2

It is not possible to predict whether any personal benefit will result from these meetings, but I understand that if I feel no benefit is occurring, I am free to withdraw from the program. I also understand that all group members will be encouraged to be open and share feelings and experiences, but the extent to which I share or participate is completely controlled by me.

I understand all the sessions will be tape recorded and the information could possibly be used in establishing further programs or carrying out research. I understand, further, that this information will be published as the investigator's Master's thesis; but, that NO information by which I can be identified will be released or published.

If I am not selected to participate in the cancer counseling program I do agree to complete the self evaluation questionnaire again after completion of the cancer counseling program.

I have read all of the above, asked questions, received answers concerning areas I did not understand, and willingly give my consent to participate in this study.

Patient Signature

Date

Investigator's Signature

Date

Witness Signature

Date

APPENDIX B

Appendix B

STATE ANXIETY INVENTORY

DIRECTIONS: A NUMBER OF STATEMENTS WHICH PEOPLE HAVE USED TO DESCRIBE THEMSELVES ARE GIVEN BELOW. READ EACH STATEMENT AND THEN CIRCLE THE APPROPRIATE NUMBER TO THE RIGHT OF THE STATEMENT TO INDICATE 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.

ANSWER ALL QUESTIONS		NOT AT ALL	SOME	MODERATELY SO	VERY MUCH SO
1.	I FEEL CALM	1	2	3	4
2.	I FEEL SECURE	1	2	3	4
3.	I AM TENSE	1	2	3	4
4.	I AM REGRETFUL	1	2	3	4
5.	I FEEL AT EASE	1	2	3	4
6.	I AM PRESENTLY WORRYING OVER POSSIBLE MISFORTUNES	1	2	3	4
7.	I FEEL UPSET	1	2	3	4
8.	I FEEL RESTED	1	2	3	4
9.	I FEEL ANXIOUS	1	2	3	4

ANSWER ALL QUESTIONS		NOT AT ALL	SOME	MODERATELY SO	VERY MUCH SO
10.	I FEEL COMFORTABLE	1	2	3	4
11.	I FEEL SELF CONFIDENT	1	2	3	4
12.	I FEEL NERVOUS	1	2	3	4
13.	I AM JITTERY	1	2	3	4
14.	I FEEL "HIGH STRUNG"	1	2	3	4
15.	I AM RELAXED	1	2	3	4
16.	I AM CONTENT	1	2	3	4
17.	I AM WORRIED	1	2	3	4
18.	I FEEL OVER-EXCITED AND "RATTLED"	1	2	3	4
19.	I FEEL JOYFUL	1	2	3	4
20.	I FEEL PLEASANT	1	2	3	4

Appendix B

TRAIT ANXIETY SCALE

DIRECTIONS: A NUMBER OF STATEMENTS WHICH PEOPLE HAVE USED TO DESCRIBE THEMSELVES ARE GIVEN BELOW. READ EACH STATEMENT AND THEN CIRCLE THE APPROPRIATE NUMBER 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.

ANSWER ALL QUESTIONS		ALMOST NEVER	SOME- TIMES	OFTEN	ALMOST ALWAYS
1.	I FEEL PLEASANT	1	2	3	4
2.	I TIRE QUICKLY	1	2	3	4
3.	I FEEL LIKE CRYING	1	2	3	4
4.	I WISH I COULD BE AS HAPPY AS OTHER SEEM TO BE	1	2	3	4
5.	I FEEL RESTED	1	2	3	4
6.	I AM "CALM, COOL, AND COLLECTED"	1	2	3	4
7.	I FEEL THAT DIFFICULTIES ARE PILING UP SO THAT I CANNOT OVERCOME THEM	1	2	3	4
8.	I AM LOSING OUT ON THINGS BECAUSE I CAN'T MAKE UP MY MIND SOON ENOUGH				

ANSWER ALL QUESTIONS

	ALMOST NEVER	SOME- TIMES	OFTEN	ALMOST ALWAYS
9. I WORRY TOO MUCH OVER SOMETHING THAT REALLY DOESN'T MATTER	1	2	3	4
10. I AM HAPPY	1	2	3	4
11. I AM INCLINED TO TAKE THINGS HARD	1	2	3	4
12. I LACK SELF CONFIDENCE	1	2	3	4
13. I FEEL SECURE	1	2	3	4
14. I TRY TO AVOID FACING A CRISIS OR DIFFICULTY	1	2	3	4
15. I FEEL BLUE	1	2	3	4
16. I AM CONTENT	1	2	3	4
17. SOME UNIMPORTANT THOUGHT RUNS THROUGH MY MIND AND BOTHERS ME	1	2	3	4
18. I TAKE DISAPPOINTMENTS SO KEENLY THAT I CAN'T PUT THEM OUT OF MY MIND	1	2	3	4
19. I AM A STEADY PERSON	1	2	3	4
20. I BECOME TENSE AND UPSET WHEN I THINK ABOUT MY PRESENT CONCERNS	1	2	3	4

APPENDIX C

Appendix C

EVALUATION OF GROUP COUNSELING PROGRAM

Specific Comments

1. Was this program a value to you?
Very Much Somewhat Not At All
2. Did program facilities (location, materials, etc.) positively contribute to the proceedings?
Very Much Somewhat Not AT All
3. Did the time schedule positively contribute to the program?
Very Much Somewhat Not At All
4. Did the leaders positively contribute to the sessions?
Very Much Somewhat Not At All
5. Which of the specific issues discussed did you like the most? (Rank them 1, 2 or 3)
Relaxation Nutrition Assertiveness
6. What did you like least about the program?
7. What did you like most about the program?
8. What could be done to make the program better or more effective?

APPENDIX D

RELAXATION TECHNIQUES

A. Background of Relaxation Techniques

B. Purpose of Relaxation Techniques

1. Who can benefit most

C. Relaxation Exercises

1. Tense and relax various muscle groups in the body

2. Hands and Arms

- a. making a tight fist
- b. pushing elbow down against a chair

3. Face and Neck

- a. Forehead (lifting eyebrows, etc.)
- b. Central Section (wrinkling nose)
- c. Lower face and jaw (biting hand and pulling back)
- d. Neck (pull chin toward chest and keep it from touching chest)

4. Legs and Feet

- a. Upper leg (counterpose top; bottom muscles)
- b. Dominant calf (pull toes toward head)
- c. Dominant foot (pointing toes)
- d. Repeat for non-dominant leg, calf, foot

5. Concentrating and focusing on relaxation

- a. Focus complete attention on feelings associated with relaxation
- b. Focus on enjoying the feelings as more muscles relax
- c. Locate a place in your mind where you can escape to for total relaxation...complete concentration on "your place" while totally relaxed.

6. Questions - Comments

7. Discussion - conclusion

NUTRITION

Discussion Outline
March 31, 1977

Group Cancer Counseling Program

By: Donna Becker, R.D., M.S.

- I. INTRODUCTION - Explain what a dietitian is and the general importance of nutrition in the care plan of cancer patients.
- II. GENERAL DISCUSSION - Ask for questions from the group. The following areas will be discussed:
 1. Ideas on how to increase your appetite. Pass out copies of the American Cancer Society's, Inc. Booklet entitled, "Nutrition for Patients Receiving Chemotherapy and Radiation Therapy", 1974.
 - a. Eat with others that have a good appetite
 - b. Serve meals as attractive as possible
 - c. Pleasant meal time surroundings
 - d. Eat several meals with snacks
 - e. Try the recipes in the American Cancer Society's Booklet - especially the double strength milk
 - f. Discuss taste bud changes (based upon article by Carson and Gormican April 1977, JADA).
 2. Discuss protein, calorie, vitamin needs of individuals receiving chemo or radio therapy.
 - a. Discuss the Basic Four Food groups --give each participant a copy of the pamphlet, "Food for Health" published by the Wisconsin Department of Health and Social Services.
 - b. Explain specific requirements for protein as outlined in the Recommended Dietary Allowances, National Academy of Sciences, 1974.
 - c. Discuss how a vegetarian can get adequate nutrition
 3. Discuss the food tolerance problems of colostomy patients.
 4. Answer specific questions of the participants throughout the session.

ASSERTIVENESS TRAINING

A. Overview of Assertiveness Training

1. Background Information

2. Purpose

- a. Help patients replace passive and aggressive behaviors with assertive behaviors--ones which show respect for the patient and the person with whom he is interacting.
- b. To help the patient be freer in expressing their feelings, beliefs, desires, and thus make interactions with others more satisfying.

3. Definition of Terms

- a. Assertive Behavior--honest expression of feelings exercising rights without undue anxiety.
- b. Non-assertive Behavior--the individual is inhibited from expressing his real feelings because he fears offending others. As a result of his inadequate behavior he often feels hurt and anxious.
- c. Situational Non-assertiveness--certain situations produce a great deal of anxiety for some individuals. At these times they are prevented from responding adequately to the particular situation.
- d. Aggressive Behavior--behavior that expresses one's feelings in a situation but usually hurts others and minimizes their worth as people. This type of behavior denies the rights of others and leaves the recipient humiliated and hurt.

B. Role Playing

1. Purpose

Research has shown that a person can learn to become more assertive. This is done by learning effective responses and practicing them under non-threatening circumstances.

2. Hypothetical situations

The participants will be given a hypothetical situation and be asked to:

- a. imagine what their response would be (covert responding)
- b. the leader will then respond with what he feels is an appropriate response (modeling)
- c. participants will then be asked to give a response to a given situation (overt responding)
- d. the leader and group members will give assistance in making an assertive response (coaching)

C. Questions - Discussion

APPENDIX E

GROUP COUNSELING PROGRAM EVALUATION

Specific comments by participants on program evaluations:

What participants liked most:

1. structure of meeting
2. effectiveness of leader
3. opportunity to share common concerns and interaction with other cancer patients
4. information and knowledge gained
5. opportunity to discuss and get answers to problems

What participants liked least:

1. not enough sessions
2. not enough topics discussed

Suggestions for improvement of the program:

1. more sessions
2. longer sessions

How participants ranked topics:

Six participants ranked Assertiveness Training #1.
 Five participants ranked Relaxation #1.
 Four participants ranked Nutrition #2.
 Four participants ranked Relaxation #2.
 Three participants ranked Assertiveness Training #2.

1. Was the program a value to you?
 9-very much 2-somewhat
2. Did program facilities positively contribute to proceedings?
 8-very much 3-somewhat
3. Did time schedule positively contribute?
 7-very much 3-somewhat 1-not at all
4. Did the leaders positively contribute?
 11-very much