

ANXIETY AND COPING MECHANISMS OF TERMINALLY ILL CHILDREN AND THEIR MOTHERS

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Children's and their mothers' reactions towards terminal illness was cross-sectionally investigated. Through the use of interviews, observations and psychological tests, it was found that terminally ill children underwent external anxiety observable only to themselves as opposed to their mothers who experienced external and internal anxiety observable not only to themselves but also to others. Coping mechanisms of the children were exhibited through their need to feel important, to be assured of freedom from danger and through recreation. While for the mothers, they coped through isolation, increased motor activity, and turning to religion.

Terminal illness can be a nightmare, not only for the patient suffering from it, but also for the people who see him pass away slowly. However, the presumption that the threatening loss of life can be a trauma is challenged by those who contend that traumatic experiences are just projections on the child by the people around him. This study then offers to look into the child's own point of view by studying his areas of concern and his own perception of the situation.

In our society, mothers play a significant role from the time the child is born up to the time he becomes liberated into the independent world. In an atmosphere where there is an impending death, the whole family is affected although it is the mother who carries the burden most. It is therefore important that the dynamics of what these mothers go through during the child's illness be explored. How are they able to stand the pressures of the situation and preserve the stability of their personality?

Anxiety among Children with Terminal Illness

In 1953, Richmond and his associates

noted that children rarely manifested a preoccupation with death. Natterson (1960) tried to provide basic clinical information about the impact of a fatal illness on children and he discovered that existential or death anxiety tends to be prominent among 19-year-old boys and 14-year-old girls. In addition, those from 0-4 years experienced separation fears, those from 5-10, mutilation fear, and those 10 years and older, fear of death.

Morrissey (1965) stated that while it was commonly held that younger children were not as aware of death as older children, death anxieties have been demonstrated by children as young as three-and-a-half years of age. Although they do not verbalize their feelings, they seem to vent that affect through play or through drawings. Waecuter (1971) provides affirmation that death anxiety is intense in younger children. He believed that there seems to be no valid basis for any categorical recommendation that children in any particular group should or should not be told about the fatal nature of their illness. Rather, each child should be handled as an individual with emotional conflicts since needs changed and shifted in the course of illness.

In 1977, Codden found that the child's concept and fear about death were influenced by his past experiences. This concept developed over time on a continuum from total awareness of death to the point where the concept of death could be dealt with logically in terms of cause and effect.

Anxiety among Mothers of Terminally Ill Children

Fross, Moriss, and Solnit (1964) observed a phenomenon called "vulnerable child syndrome", which represented the mother's fear of separation from the child. This anxiety felt by the mother was denied through an extreme involvement in the physical care of the child. Richmond (1955) noticed this reaction in addition to the mother's underlying motive of communicating something positive to the child.

Hamovith (1964) in his study of patterns of adaptation of parents with terminally ill children found that parents generally exhibited high initial anxiety which tapered off as the child's medical condition was established.

Bluebond-Langer (1978) talked about "mutual pretense" between parents and children so as to contain the anxiety brought about by the terminal illness. Erickson (1979) asserts the same approach in handling anxiety and termed it the "double-bond" hypothesis.

When serious long term illness afflicted the child, the initial reactions of his parents usually included acute fear and anxiety related to the possible fatal outcome of the disease (Natterson, 1972).

Coping Among Terminally Ill Children

The rare manifestation of "death pre-occupation" among children is not a reflection of unawareness, but rather, it represents a passive acceptance and resignation, and an air

of melancholia (Richmond, 1955). Morrissey (1965) believed that a child has his own inner resources to deal with a life-threatening illness. He added that together with these inner resources, the quality of his attachment to his parents, and the extent of their support determined the child's adaptation.

Bluebond-Langer (1978) noted that children are capable of choosing behaviors which affect the way others see them. Children who know that they are dying wish to conceal this knowledge from their parents by doing some things physically normal children do, and therefore momentarily change their parents' view. A form of behavior common among these children is called "exhibition of wound" which underlines how children try to affect not only the way others see them, but also how they see themselves.

Coping among Mothers of Terminally Ill Children

Although each parent reacts to the stress in a unique and individual manner, a fairly uniform natural history of the sequence of adaptational techniques employed could be observed (Chodoff, 1964). The psychic ways and means responsible for the stages of this process were conceptualized as coping strategies which were either aided by personality defenses when they were operating at the optimum range, or were interfered with when the defenses were ineffective. The various defenses observed as most important were isolation of affect, denial, and motor activity.

Even if depression and marked anxiety may accompany the initial impact of diagnosis, the period of illness preceding death could be one of integration of parental feelings and one in which mourning took place (Richmond and Waisman, 1955). The process of anticipatory mourning, which is the gradual detachment of a mother's emotional investment from her children, resulted in a muting of the grief interaction. Thus, the terminal phase and

death of the child were often received with an attitude of philosophical resignation. However, there appeared to be a reciprocal relationship between this process and unusually strong denial defenses, so that in parents with strong denial defenses, reaction to death and post mortem mourning would likely be more distressing (Linden, 1944).

Morrissey (1963) postulated that there would be different patterns of coping which would reflect the degree and quality of the parents' participation. It was conjectured that those who participated most fully would react to remission and relapses as indicators of their abandonment of their child. Consequently, there would be a display of guilt. It was anticipated that adequate but moderate participation would be accompanied by the least guilt. Findings however showed the emergence of some coping patterns though not necessarily following the model cited.

In 1960, Natterson reported the following conclusions about mothers whose children outlived the fatal prognosis for more than four months: the mother showed a triple-phased response— initial, intermediate, and terminal. In the initial phase, denial and guilt were frequent. In the intermediate phase, reality testing improved and mothers tended to direct their interest toward realistic measures that gave hope of saving their child. In the terminal phase, the mothers' energies moved away from their respective children, signifying an acceptance of the child's impending death.

Chodoff (1963) recognized that when the diagnosis was made, the parents initially blamed themselves for not having paid attention to early non-specific manifestations of the diseases. Cadden (1977) described how the feelings of competence and control became foreign to parents when their child's life was in jeopardy. As the child's body intactness became violated by the ravages of illness and the effects of therapy, and as the threat of death became imminent, he no longer seemed

the same child to his parents. They felt helpless and threatened because the role that they had known was not the same. Instead, they had to relinquish their role to others — the care-takers — with the hope that the treatment imparted would regain the child in the way they had known him before.

STATEMENT OF THE PROBLEM

This study attempts to answer the following questions:

1. Is there anxiety among children who are aware of their impending death?
2. How do terminally ill children emotionally cope with the span of life left for them to live? What coping mechanisms do they employ?
3. Is there anxiety among mothers of children who are terminally ill?
4. How do mothers of terminally ill children cope with the situation of having a terminally ill child?

HYPOTHESES

1. Terminally ill children tend to manifest more or less the same degree of external anxiety as healthy children.
2. Terminally ill children tend to have higher internal anxiety than healthy children.
3. Terminally ill children tend to manifest higher levels of external coping mechanisms than healthy children.
4. Terminally ill children tend to employ higher levels of internal coping mechanisms than healthy children.
5. Mothers of terminally ill children tend to manifest higher external anxiety than mothers of healthy children.
6. Mothers of terminally ill children tend to have higher internal anxiety than mothers of healthy children.
7. Mothers of terminally ill children tend to employ higher levels of external coping mechanisms than mothers of healthy children.

METHOD

Subjects

The sample of children totalled twenty boys aged 6-13 years. Ten experimental subjects were chosen from among children with acute lymphocytic and acute lymphoblastic leukemia from three hospitals: the Cardinal Santos Memorial Hospital, the Children's Medical Center of the Philippines, and the Philippine General Hospital. These children's average remaining life was three-and-a-half years after diagnosis and all were informed of their illness and life terms. The ten control subjects came from a similar socioeconomic background as the experimental ones. Seven of these control children were playmates of the experimental subjects.

The sample of mothers totalled twenty also, with ages ranging from 30-40. Ten mothers of the leukemic children or those who were acting such a role, were designated to the experimental group, and the ten who were the mothers of healthy children to the control group.

Major Variables and Instruments

1. Manifest Anxiety Scale for Children (MASC)— deals with self-reports of physiological states and affective states; also provides an L scale as an index of the respondent's tendency to falsify answers.
2. Manifest Anxiety Scale (MAS)— includes questions that elicit varying types of responses, i.e., physiological signs and chronic affective states.
3. Digit Span (DS)— is a timed subtest of the Wechsler Intelligence Scale tapping attention.
4. Object Assembly (OA)— is also a timed subtest of the Wechsler tapping attention as well as anxiety and coordination.
5. Philippine Children's Apperception Test (PCAT) — employs a projective method of assessing personality by studying the

dynamic meaningfulness of individual differences in the perception of a standard stimulus. It consists of a series of pictures representing various life situations in which the child is asked to tell stories.

6. Philippine Thematic Apperception Test (PTAT) — is intended to draw out the underlying dynamics in the adult's personality.
7. Children's External Coping Mechanism Checklist — is a checklist wherein the observer rates the child's concern for bodily needs, safety needs, self-esteem and play activities.
8. PCAT Internal Coping Mechanism Checklist — measures the different adaptive mechanisms as the following: reaction formation, undoing and ambivalence, isolation, repression and denial, regression, weak control.
9. External Coping Mechanism of Mothers — consists of five categories related to behaviorally observable coping mechanisms: isolation, denial, increased motor activity, turning to religion and altruistic beliefs.
10. PTAT Internal Coping Mechanism Checklist — taps the following mechanisms: reaction formation, undoing and ambivalence, isolation, repression and denial, deception, regression and weak control.

Procedure

Experimental and control children were matched on the following criteria: age, sex, intelligence and socioeconomic status; while mothers were matched on their socioeconomic status, intelligence and level of education.

A pretesting was done from which standardized tests were modified.

For the actual testing, instructions differed according to the test given. For the Object Assembly, children and mothers were instructed:

"If these pieces are put together correctly, they will make something. Go ahead and put them together as quickly as you can".

All subjects were asked to repeat the set of digits presented consecutively to them for the Digit Span. Afterwards, they were presented another set of digits in a backward fashion and told to repeat them also.

The MASC and MAS were administered twice to the children and their mothers, first as the S rates himself, and second, as an observer rates S.

For the PTAT and PCAT Internal Anxiety Checklist, the Ss were given the following instructions:

"Narito ang ilang larawan. Magkuwento ka tungkol sa mga nakikita mo. Puwede mong bigyan ng pamagat ang kuwento. Sabihin mo kung ano ang iniisip at nararamda-

man ng tao, ano ang nangyayari, at mangyayari".

A behavioral checklist was used to note down the non-verbal behavior of the respondents.

As to the clinical rating of internal anxiety, raters made use of their clinical insight to rate the PTAT and PCAT. Rating was done by placing a check mark on any story which seemed to evince anxiety. Interrater reliability using the G-index was 0.97.

For the external coping mechanism checklist, items were read to the children and mothers with the instruction to say "yes" or "no" to each. Additional comments were noted.

With the internal coping mechanism checklist, the PTAT and PCAT stories were rated by the judges using the guidelines of the internal coping mechanism checklist. A check mark was placed whenever a mechanism was present.

RESULTS

External Anxiety

Table 1. Means and Corresponding t and Binomial Probability Values for External Anxiety of Children Using Three Measures

	Object Assembly		Digit Span		MASC	
	E Grp.	C Grp.	E Grp.	C Grp.	E Grp.	C Grp.
Mean	18.9	18.8	8.1	9.2	18.5	11.1
Parametric Test	$t = .04$		$t = 3.77^*$		$t = 2.29^*$	
Non-Parametric Test	$p < .06^*$		$p < .001^*$		$p < .02^*$	

$p < .05$

Table 1 shows the three measures of external anxiety. Two of the measures, Digit Span and MASC, showed significant differences

between groups. With regard to the OA, the binomial probability value showed that the control group tended to score higher than the experimental group.

Table 2. Means and Corresponding t and p Values of MASC Ratings of Children and Their Mothers

Manifest Anxiety Scale for Children (MASC)		
	Self-Rating	Mother's Rating
Mean	18.5	14.8
Parametric Test	t = 2.26*	
Non-parametric Test	p<.98	

Table 2 shows the children's rating of themselves using MASC as compared with their mothers' rating. Although a significant t value was found, the prediction that the

mothers' rating would be higher than their children's self-rating by using the binomial test was not proven.

Table 3. Means and Corresponding t and p Values of Mothers' Measure of External Anxiety

	Object Assembly		Digit Span		MAS	
	E Grp.	C. Grp.	E Grp.	C Grp.	E. Grp.	C Grp.
	Mean	2.5	2.85	9.6	19.9	13.7
Parametric Test	t = 1.36		t = .38		t = 5.76*	
Non-Parametric Test	p<.09		p<.04		p< 0*	

p<.05

In the MAS self-rating measure, the t value (t = 5.76) showed a significant difference between groups. The binomial test further strengthened the assumption that experimental mothers tend to get higher MASC self-rating scores than control mothers.

The other external anxiety measures showed no significant difference between groups but were all in the direction of the prediction using the binomial test that more mothers in the control group would get higher OA and DS scores than those in the experimental group.

Table 4. Means and Corresponding t and p Values of MAS Ratings of Mothers and Their Children

M A S		
	Self-Rating	Children's Rating
Mean	12.3	13.7
Parametric Test	t = 1.16	
Non-Parametric Test	p<..36	

No significant t was found between mothers' self-rating and that of their children's. The prediction was nevertheless proven using the

binomial test that mothers' MAS self-rating scores tend to be higher than their children's rating.

Internal Anxiety

Table 5. Means Corresponding t and p Values for the Measure of Internal Anxiety Among Children

	Checklist		Clinical Rating	
	E Grp.	C Grp.	E Grp.	C Grp.
Mean	16.5	21.2	4.6	2.2
Parametric Test	t = 1.42		t = 1.67	
Non-Parametric Test	p < .83		p < .02	

* p < .05

No significant t difference was found for the Internal Anxiety Checklist and the Clinical Rating. The binomial test, however, showed that in the Internal Anxiety Checklist, the control

group pairs had higher internal anxiety scores, though in the Clinical Rating, experimental group pairs had higher internal anxiety scores.

Table 6. Means and Corresponding t and p Values for the Measure of Internal Anxiety Among Mothers

	Checklist		Clinical Rating	
	E Grp.	C. Grp.	E Grp.	C Grp.
Mean	2.8	2.42	4.6	2.2
Parametric Test	t = 1.095		t = 3.87*	
Non-Parametric Test	p < .053*		p < .053*	

* p < .05

Using the Internal Anxiety Checklist, no significant difference was found between experimental and control mothers. However, the binomial coefficients showed that more pairs of experimental mothers tend to have higher scores in the Internal Anxiety Checklist

than the control mothers.

On the other hand, a significant t resulted using the clinical rating with the experimental mothers having a higher internal anxiety than the control mothers (p = .947*).

External Coping Mechanism

Table 7. Means and Corresponding t and p Values of External Coping Mechanisms of Children

	Experimental	Control
Mean	7.336	6.185
Parametric Test	t = 1.81	
Non-Parametric Test	p < 6.83	

* p < .05

No significant t difference was found between the experimental and control groups. Nevertheless, the binomial test showed that

more experimental children had higher scores than those in the control group.

Table 8. Means and Ranking of External Coping Mechanism Categories of Children

	Experimental								Control							
	A	B	C	D	E	F	G	H	A	B	C	D	E	F	G	H
Mean	.94	12.24	13.12	12.20	7.44	9.16	6	6.26	4.62	10.61	10.45	11.70	4.10	8.12	5.5	6.6
Rank	6	2	1	3	5	4	8	7	7	2	3	1	8	4	6	5

Table 8 presents the ranking of external coping mechanisms of the experimental and control groups. The letters correspond to the

categories of the mechanism. Ranking them side by side, they appear as:

Experimental	Control	Experimental	Control
Showing a need to feel important (C)	Recreation (D)	Showing need for physical needs (A)	Preoccupation with fantasy (G)
Showing need that he is free from danger (B)	Showing need that he is free from danger (B)	Avoidance of interaction with other people (H)	Showing need for physical needs (A)
Recreation (D)	Showing a need to feel important (C)	Preoccupation with fantasy (G)	Showing aggressive behavior (E)
Getting attention (F)	Getting attention (F)		
Showing aggressive behavior (E)	Avoidance of interaction with other people (H)		

The Spearman Rank Correlation of the two groups obtained a significant r_s of .69 (p < .05).

Table 9. Means and Corresponding t and Binomial Probability Values of Measures on External Coping Mechanism of Mothers

	Experimental	Control
Mean	4.473	2.428
Parametric Test	$t = 2.40^*$	
Non-Parametric Test	$p < .01^*$	

* $p < .05$

Table 10. Means and Ranking of External Coping Mechanisms Categories of Mothers

	Experimental					Control				
	A	B	C	D	E	A	B	C	D	E
Means	12.2	7.4	8.5	8.1	8	5.75	3.7	5.91	6.15	3
Rank	1	5	2	3	4	3	4	2	1	5

A significant difference was found between the experimental and control mothers, with more experimental mothers scoring higher in external anxiety than control mothers. The mean of the control group was 2.428 with an SD of 1.74.

Table 10 shows the order of the external coping mechanism of mothers according to their rank. The letters A to E correspond to the categories of the mechanism. Experimental and control rankings appear as:

<u>Experimental</u>	<u>Control</u>
Isolation (A)	Turning to religion (D)
Increased motor activity (C)	Increased motor activity (C)
Turning to religion (E)	Isolation (A)
Altruistic behavior (E)	Denial (B)
Denial (B)	Altruistic behavior (E)

The Spearman Rank Correlation showed no significant relationship.

Internal Coping Mechanism

Table 11. Means and Corresponding t and p Values of Children's Measures of Internal Coping Mechanisms

	Experimental	Control
Mean	2.676	3.47
Parametric Test	$t = 1.82$	
Non-Parametric Test	$p < .06$	

* $p < .05$

The mean of the experimental group ($\bar{X} = 2.67$) was apparently lower than the control group mean ($\bar{X} = 3.47$). No significant t difference was obtained but a significant binomial probability value showed that more

control children had higher scores than experimental children.

The individual internal coping mechanism, as ranked, is shown in Table 12.

Table 12. Means and Ranks of Internal Coping Mechanism Scores of Children

	Experimental							Control						
	A	B	C	D	E	F	G	A	B	C	D	E	F	G
Mean	8.99	5.25	2.41	3.82	1.16	8.49	.067	9.98	3.55	2.3	2.82	0	14.86	.5
Rank	1	3	5	4	6	2	7	2	3	4	5	7	1	6

<u>Experimental</u>	<u>Control</u>
Reaction formation (A)	Regression (F)
Regression (F)	Reaction formation (A)
Undoing and ambivalence (B)	Undoing and ambivalence (B)
Repression and denial (D)	Repression and denial (D)
Isolation (C)	Isolation (C)
Deception (E)	Weak control (G)
Weak control (G)	Deception (E)

Using the Internal Anxiety Checklist, no significant difference was found between the experimental and control mothers. However, the binomial coefficients showed that more pairs of experimental mothers had higher scores in the internal anxiety checklist than control mothers.

On the other hand, a significant t resulted using the clinical rating. The experimental mean was apparently higher than the control mean. As predicted, the experimental mothers had higher anxiety than the control mothers.

The Spearman Rank Correlation of the two groups obtained a significant r_s of .93.

Table 13. Means and Corresponding t Value and Binomial Probability Value of Mother's Measure of Internal Coping Mechanism

	Experimental	Control
Mean	4.35	3.31
Parametric Test	$t = 1.05$	
Non-Parametric Test	$p < .055$	

No significant difference was obtained between the experimental and control mothers but a significant binomial value showed that

more experimental mothers tended to have higher internal coping mechanism scores than the control mothers.

Table 14. Means and Ranks of Internal Coping Mechanism Scores of Mothers

Experimental						Control						
A	B	C	D	E	F	A	B	C	D	E	F	
Means	2.29	7.05	8.64	3.75	7.68	2.49	6	9.5	5	1.99	9.29	0
Rank	5	1	2	4	3	6	3	1	4	5	2	6

Based on Table 14, the ranking of the specific internal coping mechanisms are as follows:

<u>Experimental</u>	<u>Control</u>
Undoing and ambivalence (B)	Undoing and ambivalence (B)
Isolation (C)	Regression (E)
Regression (E)	Reaction formation (A)
Repression and denial (D)	Isolation (C)
Reaction formation (A)	Repression and denial (D)
Weak control (F)	Weak control (F)

The Spearman Rank correlation showed an insignificant relationship ($r_s = .72$).

DISCUSSION

External Anxiety of Terminally Ill Children

Absence of external anxiety among terminally ill children was not confirmed. However, indications of external anxiety are present as seen in their lower Digit Span, lower Object Assembly scores, and higher MASC self-ratings.

As speculated in the preliminary study, children had general anxiety attendant to being ill and the prospect of dying.

Internal Anxiety of Terminally Ill Children

The significant *t* differences which showed healthy children as having higher internal

anxiety was unexpected. This may be because the checklist was not a good or encompassing measure of internal anxiety. As shown in the results, surprisingly, healthy children had higher internal anxiety than terminally ill children as far as the checklist was concerned. This may be due to the structure of the checklist which was not valid enough to measure internal anxiety for this particular group of children. The original checklist from which this checklist was based was tested among normal students (Lindzey, 1953). It may also be that there was only a small sample to extrapolate differences in the presence of anxiety using a structured analysis for the projective protocols.

The presence of internal anxiety among terminally ill children just strengthens the earlier findings that children tended to deny their anxiety. If they were directly asked, they did not accept that they were anxious though unconsciously they were.

External anxiety of Mothers with Terminally Ill Children

The insignificant differences on the OA and DS did not support the hypothesis. However, the binomial test tended to support the same hypothesis that control mothers would have lower OA and DS scores. This may be explained similarly to that of the children's in that cognitive functions usually are lower when the individuals are beset with anxiety. Studies on the effect of the amount of anxiety revealed an inverted "U" or curvilinear relationship between the amount of anxiety and the task performance (Doob, 1947). That is, when

anxiety is just enough, task performance is high, but as time passes, and as anxiety increases further, task performance decreases.

Internal anxiety of Mothers with Terminally Ill Children

The internal anxiety of mothers was better reflected in the clinical rating. This reaffirms the contention that internal anxiety is something unconscious and can be seen only through intuitive rating of projective tests.

In the TAT stories, anxiety was indicated by predominant themes on sick children, on their mothers, and on dead people. Themes also centered on loss of hope, on the hospital setting, on being left alone, on prayers to God, and on feelings of confusion.

External Coping Mechanism of Mothers with Terminally Ill Children

Studies on mothers and families of terminally ill children found denial as one of the initial coping mechanisms used (Friedman, 1963; Chodoff, 1963; Futterman, 1973). A possible reconciliation for this inconsistency is the fact that these studies used the longitudinal approach. However, using the cross sectional approach (from the moment diagnosis was given until the death of the child) coping was observed to begin from isolation of the affect. This was followed by intellectualization, then denial. Increased motor activity further followed. Anticipatory mourning (which includes acknowledgement, grief, reconciliation, detachment, and demoralization) ended the coping situation (Futterman, 1973). The approach of this study is to focus on a particular cross section of the child's stage of physical deterioration, particularly the stage where the children are given a one-and-a-half year life span, and denial is no longer a strong mechanism.

One paradoxical observation about the mothers was that although they had accepted

that their children would soon die, they still hoped their children would get well. This adaptive coping mechanism prevented them from being depressed. Furthermore, it aided them to continue being enthusiastic about their children until their death. A similar observation was seen by the Hamovith researchers on the patterns of adaptation of parents with dying children.

Internal Coping Mechanism of Mothers with Terminally Ill Children.

The order of internal coping mechanism used by mothers showed that there was ambivalence regarding the possible death of their children. They knew every relevant detail about their child's illness and tried to accept that sooner or later their children would die but still, they hoped for complete remission.

Undoing, as an internal coping mechanism, was seen by the predominant themes of the PTAT of over-solicitous parents. Regression was observed through the presence of much affect on the stories made, and the giving of personal references to ambiguous figures. Weak control, the last of the mechanisms used, indicated that these mothers were able to adapt to their situation.

External Coping Mechanism of Terminally Ill Children

Although no significant difference was found between the means of the terminally ill children and the means of their healthy peers, the results showed that more terminally ill children, who tended to be more anxious than their healthy peers, displayed observable mechanisms.

The similarities in the mechanisms used indicate, that in the presence or absence of illness, children possess the basic need to explore and experience their environment through play.

Internal Coping Mechanism of Terminally Ill Children

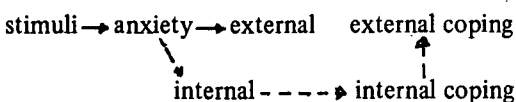
No significant difference was found between the coping mechanism of the terminally ill children and their healthy peers. The direction of the scores contradicted the prediction since healthy children scored higher in the Internal Coping Mechanism Checklist than the terminally ill.

A possible explanation for the similarities is that children, in the absence or presence of illness, have a common need to conform with adults. In the PCAT, both of the groups showed exaggerated conformity. This may be due to the fact that conformity is reinforced in our culture. Children became less sure of themselves when adults withdrew their final say on their decision.

Anxiety and Coping Mechanism of Terminally Ill Children

It is speculated that the high internal and external anxiety of these mothers were internally coped with by undoing and guilt of having been responsible for the illness of their children. Externally, however, they coped by being extra special to their children, and by isolating the unacceptable impulses that were inconspicuous. They became preoccupied with the medical proceedings for the child, and increased their motor activity by engaging in extra jobs for the child's sake. They, therefore, transferred their anxiety to these activities.

If a model on anxiety and coping of mothers with terminally ill children were to be posed, it would appear as:



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Due to a backlog in unpublished manuscripts, the editorial board has included articles written in the years 1980-1981. This accounts for citations in some of them which may not coincide with the date of this issue.



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