

THE EFFECTS OF HOSPITALISATION ON CHILDREN
AND THE IMPLICATIONS FOR THE HOSPITAL TEACHER

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DISSERTATION FOR THE DEGREE OF MASTER OF EDUCATION

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I ABSTRACT

TITLE OF DISSERTATION FOR MASTER OF EDUCATION DEGREE:

The Effects of Hospitalisation on Children:- The Implications for the Hospital School Teacher.

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The study examines the special psychological and educational problems of the hospitalised child from the hospital school teacher's viewpoint. It falls into three main sections:-

- (i) Chapter I - "A Survey of the Literature on the Effects of Hospitalisation on Children"

An historical survey of the clinical literature 1945-65 which traces the evolution of the philosophy governing current paediatric theory and practice in regard to the case of the hospitalised child, and describes the effects of hospitalisation on the child, the main factors affecting his successful adjustment, and the remedial measures proposed to modify his distress.

- (ii) Chapter II - "The Education of the Hospitalised Child"

This brief survey of available educational literature discusses the unique double role of the hospital school teacher - her therapeutic role in the amelioration of the hospitalised child's anxiety and her educational role in the prevention of retardation due to interrupted schooling. It also discussed the special learning problems of the student in a hospital special class.

(iii) Chapter III - "An Illustrative and Descriptive Study"

Comprises a discussion of the experiences in hospital of 37 patients in a paediatric ward - all pupils of a Hospital Special Class. Illustrative and supportive material for the major issues discussed in the previous two chapters is presented. The subjects' positive and negative reactions to hospital are described and their pre- and post-hospital behaviour is compared on Stotts' "Bristol Social Adjustment Guides" as assessed by their own class teacher.

I INTRODUCTION

The task of educating the hospitalised child presents the hospital school teacher with unique problems, both educational and psychological in nature.

There are special educational problems in that the students vary in age, grade, ability and level of achievement and may suffer from various physical, mental, emotional or learning disabilities. Furthermore, the composition of the class is constantly changing as students are admitted or discharged.

There are also special psychological problems arising from the hospital setting. The hospital pupil is separated from his normal home and school environment and is struggling to adjust to his illness and hospitalisation. It is therefore important that the hospital teacher understands the possible detrimental effects of hospitalisation on the individual child and the various factors modifying his successful adjustment.

This study aims to examine the special problems of the hospitalised child from the hospital teacher's point of view. It falls into three main sections:-

(1) A survey of the literature on the effects of hospitalisation on children attempting to trace the development of modern attitudes towards the care of the hospitalised child and to analyse the main factors affecting his successful adjustment.

(2) A brief survey of the literature on the education of hospitalised children attempting to examine the problems, aims and special role of the hospital teacher.

(3) A descriptive study of the experiences in hospital of 37 children from the point of view of a hospital school teacher; seeking firstly to illustrate some of the main issues discussed in Chapter I and to a lesser extent in Chapter II; secondly, to describe possible positive or negative effects of hospitalisation on those children by comparing their pre-hospital and post-hospital behaviour and thirdly to describe the various factors modifying their successful adjustment by observing their responses while in hospital.

The emphasis is on the reading survey. The descriptive study is presented as an adjunct to the survey of the literature.

CHAPTER I

A Survey of the Literature on the Effects of
Hospitalisation on Children

"Adults deceive themselves when they dismiss the facts that small children in hospital are often anxious or sad and that such anxiety often permanently lessens the child's reserves of self-confidence. They are, in fact, resorting to a functional blindness by which they spare themselves awareness of children's suffering."

(MacKeith, 1953, p845)

Maternal Deprivation

Early Studies

At the beginning of the twentieth century it was common practice to place infants in institutions and hospitals for very long periods away from their mothers (Glaser and Ersenberg, 1956).

Gradually, evidence began to accumulate that such severe deprivation could have harmful effects on the future development of the young child. The recognition of possible deleterious effects on institutionalised infants came before any recognition of possible concomitant detrimental reactions on the part of the older child to hospitalisation.

The evidence came from three main sources:-

Retrospective studies of children who had been deprived in their early years;
direct studies of the development of children in institutions, hospitals and foster homes; and
follow-up studies of adolescents or adults who had spent their early years in institutions.

Retrospective Studies

Early workers in the field of child-care began to recognise that hyperactivity, destructiveness and aggressive behaviour were especially characteristic of children whose babyhood had been spent in institutions.

Lowrey (1940) studied twenty-eight children under the age of four waiting for adoption, who had spent the first three years of life in an institution. He found that these children developed an 'isolation type of personality' characterised by an inability to give or receive affection. Certain behaviour traits appeared frequently:-

Hostile aggressiveness, temper tantrums, enuresis, speech defects, attention seeking behaviour, stubbornness, negativism, selfishness, finger sucking and excessive crying (p519). Lowrey considered that their low level of speech development was due to lack of social stimulation (p580).

Levy (1947) studied the Developmental Quotients FN (1) of 122 infants waiting for adoption, 83 of whom had been institutionalised and 59 boarded in foster homes for the first two months of life. She found the Developmental Quotients of the former below normal while that of the latter was slightly above. She concluded that institutional placement in early life not only affects the child's personality in later life but measurably slows down his development from the inception of such placement (1947, p241). She also noted that "day by day contacts between parent and child '.....' appear to play a major role in the child's ability to develop into an emotionally healthy individual. This cannot be duplicated in an institutional atmosphere" (p234).

Goldfarb (1943a, 1943b, 1945, 1946), in a series of carefully controlled investigations, contrasted the development of three year old children raised in institutions with that of children raised in foster homes. He found that institutionalised children were not only severely impoverished in personality development, but showed serious intellectual retardation. He described a restricted capacity for making

relationships, aggressive distractible uncontrolled behaviour and impoverished, undifferentiated, apathetic personality development with reactions at a primitive, infantile level (1945, p20). The children were below average intelligence, with poor concentration, poor school achievement, and deficiencies in rational control and abstract thinking. They also showed lack of drive and emotional immaturity.

Deficiencies with regard to speech development as well as to other uses of language continued up to the third year of life in institutionalised children even after a period of foster home placement (1943).

Goldfarb (1945, p19) emphasised the importance to the child of the development of a close attachment to a specific adult before the end of the first year. The contact should be warm, loving and continuous, a source of constant stimulation, and should involve a high degree of reciprocation.

"The existence of a relationship and the nature of this relationship with the mother or parent are the cornerstone of developing identifications. They colour the child's grasp of himself, his relation to people outside the primary group, his relation to the material world of things, his mode of solution of problems that may arise to meet him, his level of conceptualisation and probably even his simplest perceptions." (1945, p18).

Direct Studies

Bowlby (1951, p17) cites the early (1933) study of Durfee and Wolf. After comparing the Development Quotients ((1) FN) of 118 infants in various institutions and correlating their findings with the amount of maternal care which the infants received, they found that institutionalised children over the age of three months, almost without exception, showed

psychiatric disturbances, those institutionalised for more than eight months in the first year being so severely disturbed that they could not be tested FN (2).

Bakwin (1949) described the typical behaviour of infants under six months of age in a residential nursery of the time where only the simplest hygienic care was provided. They presented a well-defined clinical picture:-

"The outstanding features are listlessness, emaciation and pallor, relative immobility, quietness, unresponsiveness to stimuli like a smile or a coo, indifferent appetite, failure to gain weight properly frequent stools, poor sleep, an appearance of unhappiness, proneness to febrile episodes, absence of sucking habits." (Bakwin, 1949, p512).

This syndrome, termed 'hospitalism', was not observable during the first two to four weeks but at any time thereafter - sometimes within a few days of separation from the mother. Because the infants promptly recovered when returned to their homes, Bakwin concluded that the observed ill-effects were due to psychological neglect:- "An important measure for preventing hospitalism is the presence of the mother (1949, p520).

Freud and Burlingham (1944) observed the responses of evacuees separated from their mothers in wartime Hampstead nurseries. They described the deep psychological craving of the child for its mother which they found was particularly violent and despairing in infants aged between six months and three years.

Immediate after-effects noted were:-

Hostile reaction to the mother after her return;

Excessively demanding behaviour; cheerful

shallow attachments to any adult, and apathetic

withdrawal from all emotional contacts.

Broadbeck and Irwin (1946), in a comparison of the speech behaviour of orphanage infants using data based on a careful phonetic analysis of speech sounds, found evidence of retardation in the first few months of life; whereas Freud and Burlingham (1944) using observational methods found no such evidence before the age of twelve months.

Spitz with Wolf (1945, 1946a, 1946b, 1949, 1965) compared the development of infants residing in the nursery of an institution for delinquent girls where each mother cared for her baby, with that of infants in a foundling home under the care of nurses.

Both groups suffered deprivation with resulting damage to personality growth proportional to the length of deprivation. Spitz distinguished two syndromes:-

Partial effective deprivation termed 'anaclitic depression' and total effective deprivation termed 'hospitalism' (1965, p267-268).

Anaclitic Depression

Of the 123 unselected infants in the nursery, nineteen children aged between six and eight months were deprived of their mothers for a period of approximately three months.

Spitz found these infants manifested extreme depression, weepy withdrawing behaviour, loss of weight, increased susceptibility to infection, retardation and gradual decline in personality development, physical malfunctioning, extreme apathy and perseverated movements.

The condition was progressive in nature and, if unrelieved, could merge into the more serious syndrome of 'hospitalism'.

"After three months the weepiness was replaced by a frozen rigidity of expression ... "The children lie or sit with wide-open expressionless eyes, frozen immobile face and a far-away look" (Spitz, 1965, p269).

Because recovery was swift on return to the mother, Spitz attributed the cause to deep mourning over the loss of the love object.

'Hospitalism'

After deprivation of all object relations for periods of three to five months or more, symptoms of increasingly serious deterioration appeared which Spitz considered "in part at least" to be irreversible (1965, p278).

A new clinical picture appeared:-

..."motor retardation became fully evident, the children became completely passive; The face became vacuous, eye co-ordination defective, the expression often imbecile. When mobility reappeared, it took the form of 'spasmus mutans' in some of the children; others showed bizarre finger movements reminiscent of decerebrate or athetotic movements." (Spitz, 1965; p279).

Eventually, if the deprivation continued into the second year, a spectacular increase in mortality resulted (Spitz, 1965, p271).

Spitz emphasised the unique importance of adequate and satisfactory mother-child relationships in the first year in order to avoid the irreparable psychological consequences deriving from neglect during this period (1965, p282).

Although Spitz's studies have been challenged on the grounds of statistical validity (Pinneau, 1955), his conclusions are supported by the findings of Bakwin (1942, 1949), Lowrey (1940), Goldfarb (1943, 1945), and others and by later follow-up studies by Robertson (1958, 1962).

Rheingold (1943), compared the development of twenty-nine infants, aged between six months and two and a half years, waiting for adoption, fifteen of whom had been the only baby in the home - the remainder having had to share their foster mother's attention with at least three others. She found accelerated development in the former while the latter were retarded to a statistically significant degree. She advanced the following hypothesis:-

"If early in life an infant has not the opportunity and the encouragement to form a satisfying affectional attachment to an adult (the one responsible for his care), he may have difficulty in establishing satisfying relationships with other persons and with objects. It is through this affectional relationship that the baby responds to his environment. Without it, he may develop intellectually at a slower rate or display little emotional warmth" (Rheingold, 1943, p44).

A Follow-up Study

Bowlby's (1944) study of delinquents found a significantly high proportion had suffered prolonged separation from their mothers in the first years of life, as a result of which some developed 'affectionless' characters, that is, they were unable to form permanent, mutually satisfying relationships with others (Bowlby, 1951).

Summary

The early studies noted the following deficiencies which could be associated with institutional care in early childhood:-

General intellectual retardation (Goldfarb, 1945; Levy, 1947; Lowrey, 1940; Spitz 1945, 1946); retardation in language functions (Brodbeck and Irwin, 1946; Freud and Burlingham, 1944; Lowrey, 1940); including disturbances in abstract thinking and deficiencies in the level of conceptualisation (Goldfarb, 1943, 1945); and social and personality disturbances, particularly in the capacity to establish and maintain close personal relationships (Bowlby, 1944; Goldfarb, 1943, 1945; Lowrey, 1940). Other deficiencies noted were extremes of activity including hyperactivity, passivity and motor disturbances (Bakwin, 1942; Goldfarb, 1943; Spitz, 1946).

Not all children were affected and there was great individual variation in the nature and extent of the impairment. The damage to personality development was believed to be greatest in the child who was separated during the second half of the first year (Freud and Burlingham, 1944; Goldfarb, 1945; Lowrey, 1940; Spitz, 1945) (i).

(i) Case Study No. 11. App. I, pl30.

Bowlby's Theory of 'Maternal Deprivation'

The early studies had revealed that much emotional ill-health could be traced to disturbances in mother-child relationships. In particular, they postulated that a child who suffered a break in his relationship at a critical period in his development might suffer impairment of a more or less permanent nature in his ability to form continuous relationships with others (Levy 1947; Lowrey, 1940).

These findings stimulated interest in the importance of the mother-child relationship in early childhood. In 1950 Bowlby was commissioned by the World Health Organisation to advise them on the mental health of homeless children. (3) (FN)

In 1951, after a survey of the literature, he advanced the hypothesis that prolonged separation from the mother figure, 'maternal deprivation', could have very adverse effects on personality development and mental health. He reported a high level of agreement among psychologists and psychoanalysts in the field of child care on certain basic concepts which he summarised thus:-

"What is believed to be essential for mental health is that the young child should experience a warm, intimate and continuous relationship with his mother or permanent mother-substitute in which both find satisfaction and enjoyment.... It is this complex, rich and rewarding relationship with the mother in the early years, varied in countless ways by relations with the father and with siblings, that child psychiatrists and many others now believe to underlie the development of character and of mental health" (1951, p11).

Though Bowlby concentrated his attention on the mother-child relationship, he did recognise the father's importance as the provider of economic and emotional support to the mother (1951, p13).

From the evidence of the direct studies he concluded that, "when deprived of maternal care, the child's development is almost always retarded, physically, intellectually and socially; and that symptoms of physical illness may appear...."; and from retrospective and follow-up studies he deduced that such damage was not easily overcome - "Some children are gravely damaged for life. This is a sombre conclusion and must now be regarded as established." (Bowlby, 1951, p15).

The fact that not all children were so affected could, Bowlby suggested, be attributed to hereditary factors of such factors as the child's age or the length and degree of deprivation (Bowlby, 1951, p15,16).

Variations in Degree of Deprivation

There were variations in the degree of deprivation:-

A child could be deprived at home if his mother failed to provide the loving care he needed; a child could be partially deprived if removed from home in the care of a trusted adult; whereas children in residential nurseries and institutions could suffer almost complete deprivation.

The ill-effects of 'partial deprivation', Bowlby suggested, were acute anxiety, guilt, depression and the need for revenge. It could also lead to psychological disturbance or neurotic, unstable personality development (1951, p12).

Complete deprivation had even more far-reaching effects as it could disturb character development and cripple the capacity to form relationships with others. Bowlby, however, did concede that, because the evidence thus far was largely clinical in nature, there was a need for systematic follow-up studies.

Because of the evidence of Spitz and Wolf (1945, 1946) of the insidiousness of the development of the depressive state of 'anaclitic depression' into the more serious syndrome of 'hospitalism', which was much less easily reversed by restoration to the mother, Bowlby cautioned that damage could result in changes even at three months and advised that substitute cure was indispensable and should not be withheld.

Age: Infancy the Vulnerable Age

Bowlby considered that the depressive state of 'anaclitic depression' was the infant's normal response to the loss of its mother as Spitz had noted that children with unsatisfactory relationships with their mothers failed to exhibit the syndrome (Spitz, 1946, p336) - evidence in Bowlby's opinion that "their psychic development is already damaged and their later capacity for love unlikely to be impaired (1951, p23). Furthermore, he warned that the prevention of responses in the second and third year, when the emotional reaction could be just as severe, was often very difficult.

Causative Factor

As proof that the causative factor was 'maternal deprivation', Bowlby quoted studies by Durfee and Wolf (1933), Spitz and Wolf (1946) and others which showed that the longer the period of deprivation the lower the fall in the Developmental Quotient; evidence from Bakwin

(1942) that spectacular changes in the child's condition followed restoration to the mother and evidence from other studies that extra mothering from a mother substitute could diminish ill-effects (Bowlby, 1951, p21).

Follow-up Study

In 1956, Bowlby compared the development of school children who had spent long periods in a sanatorium before their fourth birthday with similar data on their classmates. He found that more sanatorium children than expected were able to make friends and fewer appeared to show the severe disturbances of object relations which underlie persistent delinquency (Bowlby, Ainsworth, Boston and Rosenbluth 1956, p240).

He was therefore forced to revise his conclusions and to admit that "statements implying that children brought up in an institution or who suffer other forms of deprivation commonly develop psychopathic or affectionless characters are seen to be mistaken. Outcome is immensely varied and of those who are damaged only a small minority develop those very serious disabilities of personality which first drew attention to the pathogenic nature of the experience." (Bowlby et al 1956, p240).

Nevertheless, although the study revealed such variations in outcome, in Bowlby's view, it did nothing to cast doubt on the many studies which showed that some children did suffer grave damage and others lesser damage; nor did it detract from the studies of Prugh and associates (1953) which confirmed that during a separation experience the majority of young children are emotionally disturbed (Bowlby, 1958, p480).

He further stated,

"There are no grounds for complacency, the disturbances are serious and affect a far from negligible proportion of children. The fact that we now know that only a small minority are left affected has not altered our estimate of it as a serious illness to be prevented at all costs.... It is my judgement that the separation of a young child from his mother is not to be undertaken without weighty reason and then only provided there is a suitable and stable substitute to care for him." (Bowlby, 1958, p480).

Importance of Accessibility of Attachment Figure

In later works Bowlby pursued the theme, studying the processes at work in the ontogeny of object relations and the responses of anxiety and depression which follow the separation of the young child from the mother figure.

He has postulated that whether an individual child or adult is in a state of security, anxiety or distress depends on his expectations concerning the accessibility and responsiveness of his principal attachment figure. Those expectations are built up through the years of immaturity and adolescence, are tolerable reflections of actual experience, and tend to persist through life. An individual's self concept, his model of the world and himself in it, is dependent, according to Bowlby, upon his notion of how acceptable or unacceptable he is in the eyes of his attachment figure (1971, p23, 97, 202, 203).

Criticisms of Bowlby's Theories

Bowlby's work aroused a storm of controversy. His findings were severely criticised by some writers who found fault with the research design of the early studies on which his conclusions were based (Casler, 1961; Yarrow, 1961).

The term 'maternal deprivation' implying a single syndrome was criticised as it was felt to be a blanket term covering a variety of conditions of infant care (Ainsworth, 1962; Yarrow, 1961). Ainsworth (1962) emphasised the need to distinguish the many variables involved, such as discontinuity, insufficiency of interaction and distorted relations with the mother. Rutter (1972) attempted to distinguish between various degrees of deprivation such as privation, separation and lack of stimulation and to define various qualities of mothering such as love, continuity, the development of enduring bonds, stability and stimulating interaction.

Another important development has been the emphasis on individual differences in the children's responses to deprivation. Not all children gave evidence of intellectual or personality damage and there was a range in the extent of injury (Ainsworth, 1962; O'Connor, 1956; Yarrow, 1961). It was suggested that the effects might vary in nature, severity and duration according to the interaction of a set of variables, such as the child's age, sex, temperament, previous separation experience, duration of separation/deprivation, nature of experience during separation/deprivation, though the precise relationship between each variable and its effects was not clear (Ainsworth, 1962; Rutter, 1972).

Reversibility

Rutter (1972), after a careful survey of the literature, concluded that complete reversal of cognitive effects was possible if there was a complete change of environment in early infancy. Growth defects showed rapid improvement but not complete recovery with improved nutrition. According to clinical accounts, only partial reversal of social defects was possible and this was achieved with great difficulty after the infancy period (Rutter, 1972, p77).

Ainsworth (1965) pointed out that the conflict of opinion on the reversibility of the effects of maternal deprivation could be explained by the various methods of personality appraisal used - "The more superficial the assessment, the more evidence of reversibility; the more intensive, clinical and descriptive the assessment, the more evidence appears of lasting damage." (Ainsworth 1965, p227).

Bowlby's emphasis on the importance of the mother's role was criticised as it was felt that father, mother, sisters, brothers, friends, school-teachers etc., all had an impact on the child's development (Rutter, 1972).

This emphasis, deliberate on Bowlby's part, was due to the corresponding emphasis and orientation of the research at that time.

Rutter (1972) also reported great individual variations in the strength and distribution of attachment. The suggested bias on the part of the child to attach himself to one principal figure was not supported by the evidence. The main bond was not always with the mother, some people having several bonds instead of one.

Schaffer and Emerson (1964, p31) suggested that the number of attachment figures could be determined by the infant's own characteristics or the social setting.

In spite of these criticisms, there was, in the literature, general acceptance of Bowlby's central conclusion that "deviating conditions of maternal care in early life tend to be associated with later disturbances in intellectual and personal-social functioning." (Yarrow, 1961, p459).

Rutter (1972) pointed to the large body of evidence from animal studies on the effects of early life experiences together with a small group of well-controlled human studies which demonstrated that "early life experiences may have serious and lasting effects on development" (1972, p121).

He further declared.

"We may now take for granted the extensive evidence that many children admitted to hospital or to a residential nursery show an immediate reaction of acute distress; that many infants show developmental retardation following admission to a poor quality institution and may exhibit intellectual impairment if they remain there for a long time; that there is an association between delinquency and broken homes; that affectionless psychopathy sometimes follows multiple separation and institutional care in early childhood, and that dwarfism is particularly seen in children from rejecting and affectionless homes"

Rutter (1972, p121)FN (4).

Hospitalisation

Separation: A Factor in the Child's Distress

Bowlby's important monograph (1951) which had demonstrated the dangers of gross 'maternal deprivation' stimulated research in many fields of child care including paediatrics where attention was focused on separation as a possible factor in the hospitalised child's distress.

Follow-up clinical observations of the young child in hospital revealed that separation from the mother, particularly in the under five group, could lead to unhappiness and fretting in hospital and behaviour disturbances such as night fears, bed wetting, aggressiveness and undue clinging after discharge. These symptoms could be overlooked by professional workers or misinterpreted as 'spoilt' behaviour by harassed mothers (Robertson, 1958). (i)

Immediate Responses

Edleston (1943) has first identified separation from the mother figure as a source of particular anxiety in the hospitalised child because his responses were complicated by illness. The sick child, craving the security and comfort of his mother's presence, could interpret her absence as rejection. Edleston described three phases characteristic of the behaviour of the hospitalised child:-

Firstly, a period of disturbed behaviour after the upheaval of the removal from the home environment, secondly, a period of 'settling in' and apparent adjustment and thirdly, on his return home, a period of 'awkwardness' characterised by enuresis, hostility, defiance and clinging behaviour.

"It would almost seem as if the child now feels the need to assure himself of his mother's love and has to try out all his hostile impulses to test her affection for him." (Edelston, 1943, p84).

Edelston interpreted these responses as "manifest or latent exhibitions of 'separation anxiety' or of reactions to overcome it." (1943, p82).

Robertson (1958), in an elaboration of Edelston's ideas, described three phases:-

'Protest, 'despair' and 'detachment'
each of which merged into the next phase.

According to his observations, the immediate reaction of the young child was one of acute distress and crying, followed by a period of apathetic misery. Finally the young child, apparently 'settled' and contented, seemed to have forgotten his parents altogether.

Robertson's film, "A Two Year Old Goes to Hospital", vividly portrayed the acute distress of the separated child in hospital (Bowlby, Robertson, Rosenbluth, 1952). Further investigations by Robertson and Robertson (1973) revealed that provision of substitute mothering could reduce the degree of distress caused by separation which in some cases could be more severe than that caused by the child's illness.

Post-Hospital Responses

Most children undergo quite lengthy periods of hospitalisation without obvious or permanent symptoms resulting (Edelston, 1943; Langford, 1948, 1961; MacKeith, 1953). Some, however, do not.

The traumatic shock of losing his mother, especially when it is intensified by pain and illness, may prove to be too much for the young child to tolerate. Consequently he may become so anxious and insecure that he may manifest feelings of distrust and hostility against the environment and those he loves; feelings which can persist for a long time and in some cases permanently (Edelston, 1943; Levy, 1945; Prugh et al, 1953; Robertson, 1958).

The following significant changes in behaviour, some of which can persist for years, have been noted in the literature:-

Regressive behaviour such as increased dependence, loss of bowel or bladder control, whimpering, baby talk, excessive clinging, demands to be kissed or cuddled; fears of the dark, of being alone, excessive fears of hospitals, fear of bodily harm, night terrors; sleep disturbances, speech disturbances such as voice changes or refusal to talk, eating disturbances; negativistic reactions such as disobedience, temper tantrums, defiance, destructive behaviour (i) (Freud, A. 1952; Levy, 1945; Gofman, 1958; Jessner and Kaplan, 1949; Prugh et al, 1953; Vaughan, 1953.) .

Children under five were considered particularly vulnerable (Prugh et al, 1953; MacKeith, 1953).

Correlation between Hospital and Post-Hospital Reactions

Reports of studies vary. Prugh et al (1953) found a relatively high correlation between the appearance of severe disturbances on the

(i) Ch III p81 and 82.

ward and their persistence after discharge. Vaughan (1957) found that some of the most disturbed children in hospital were least so at home. Jessner and Kaplan (1949) suggested that disturbed ward behaviour could be beneficial in that it enabled the child to express his anxiety.

Various Interpretations of Psychological Processes Involved in Child's Responses to Hospitalisation

Bowlby (1960) interpreted the three phases 'protest', 'despair' and 'detachment' as the child's expression of grief and mourning at the loss of his live object. The 'protest' phase was related to 'separation anxiety', 'despair' to grief and mourning and 'detachment' to defence. He warned that the repression of the responses of grief and mourning in the final phase could lead to harmful effects on later personality development and social adjustment.

Edelston (1943) saw the reactions as attempts on the part of the child to master anxiety - "the 'ego' defences of orthodox psycho-analysis" (p79).

Anna Freud (as reported in 'Lancet', 1949, p785) described the mental isolation of the very young child.

"To the distress of illness is added the distress of separation and the child is quite defenceless. He submits with his body, but retreats into his mind. If this retreat is unchecked his mental unfolding is temporarily arrested."

Woodward and Jackson (1961) suggested that such behaviour as temper tantrums, refusal to eat and talk, regression to babyish ways was the child's desperate way of coping with the feeling of frustration

due to separation anxiety and feelings of inadequacy in a situation over which he had no control.

Reversibility

According to Bowlby (1960), if the child had not progressed past the second stage, 'despair', the psychological upset was quickly reversible. However the deeper the degree of 'detachment' the more likely was the process to be irreversible. This therefore depended on the length of the separation.

Both Robertson (1958) and Edelston (1943) were in agreement that though disturbed behaviour usually disappeared with careful handling, it could persist in some children. Those Edelston considered particularly vulnerable were young children, 'anxious-prone' children, 'pre-neurotic' children and 'problem' children.

Age

Vernon et al in a review of the literature found a curvilinear relationship between the age variable and psychological upset. Children between the ages of six months and three to four years were particularly vulnerable to upset during hospitalisation; younger infants and older children less so. The relationship was less clear when reactions in the period after hospitalisation were considered (1965, p157) (i).

Separation - The Principal Variable

Separation was held to be the principal variable by many authorities (Bowlby, 1973; Robertson, 1958, 1962; Woodward and Jackson, 1961). It is generally accepted that separation can be very distressing and that its effects can be differentiated from that of illness.

(i) See above p14.

However Vernon et al (1965, p56) point out the difficulties in differentiating the overt behaviour of the superficially friendly, but emotionally 'detached' child, from that of the child who has really happily adjusted to the hospital environment.

Vernon et al (1965, pp51,52) found that separation contributed to upset during and after hospitalisation but was unlikely to have long-term consequences for emotional adjustment.

Nature of Previous Separation Experiences

Vernon et al (1965) found a consensus of opinion in the literature that if a child had had previously unhappy separation experiences he was more likely to be disturbed in hospital than a child without such experience.

Rutter (1970, p34) cites a study by Stacey and associates (1970) (FN 5) which found that children who had normal nonstressful experiences of separation with familiar adults (relations, teachers, baby-sitters or friends) were more likely to be undisturbed by the event.

However Prugh et al (1953, p84) found no general patterns of response among children with a history of previous hospitalisation.

Remedial Measures

Preventive measures known to reduce the effects of separation are:-

The provision of substitute mothering; the companionship of another sibling; the presence of a familiar object from home - a toy, blanket or a picture etc.

(Bowlby, 1971; MacKeith, 1969; Jessner et al, 1952;

Robertson, 1958).

Two important measures were considered quite revolutionary when first introduced, namely, the admission of the mother with her child and the liberalisation of visiting hours.

Visiting

Until the 1950's, parents were actively discouraged from visiting their children in hospital except for perhaps an hour once or twice a week because of fear of infection or fear that the children would be upset by their parents' visits (Illingworth, 1958; Vernon et al, 1965; Walton, 1964.)

With increasing awareness of the possible adverse effects of hospitalisation on the small child came a gradual acceptance that frequent visiting could be beneficial in reducing the degree of separation anxiety.

Powers' (1948) proposal of daily half-hour visits was an innovation. Robertson (1958) and the Ministry of Health (1959) suggested that unrestricted visits by the mother could result in a more relaxed atmosphere between staff and parents and increased comfort and security for the child.

It was soon discovered that the small child aged three years or under still showed distress when the mother left. Proponents of unrestricted visiting argued that it was better for the mother to be present than the child feel abandoned; it was also considered preferable for the child to give vent to his feelings in his mother's presence than suppress them in her absence. The quiet, submissive, unvisited child could be storing up trouble for the future while the rebellious child, busily protesting his need for his mother, was fighting clear of it (Illingworth, 1958; Lancet, 1949; Powers, 1948; Robertson, 1958).

Relationship between Visiting and Emotional Upset

Prugh et al (1953) found no correlation between frequency of visiting and severity of the child's reaction to hospitalisation in children and between two and twelve years. Schäffer and Callender (1959) found no relationship between frequency of visiting and the deviation of post-hospital symptoms in infants under one year of age. Vernon et al cite Woodward's 1959 study (6) which found a negative relationship between frequency of visiting and emotional upset in children under five years as observed two to four years after hospitalisation. He also notes Woodward's suggestion that the quality of parent/child relationships, and not frequency of visiting, could have been the decisive underlying factor (Vernon et al 1965, pp52,53).

Rooming in

A number of authors, believing that the needs of the young child were not fully met by the liberalisation of visiting hours, recommended that the mother be admitted with her child (Bakwin, 1949; Bowlby, 1952; Robertson, 1958; Ministry of Health, 1959). It was considered that the increased contact between the mother and her child would lead to more normal reactions and behaviour in both (Robertson, 1958).

Although practised in Europe considerably earlier (Bakwin, 1951), the method was pioneered with success by Spence in Newcastle on Tyne, by Powers in America and by the Pickerills in the Bassam Clinic in New Zealand, (Pickerill and Pickerill 1949; Powers, 1948; Spence, 1947).

There were two main objections raised to the practice of admitting the mother with her baby. It was argued that the presence of mothers on the ward could disrupt the ward routine and secondly would result in accommodation problems.

Meadow (1964, 1969) studied the reactions of mothers who had been invited to accompany their children to hospital. He found that many preferred to stay at home. A considerable number had felt imprisoned as a result of being unnaturally confined with their child twenty-four hours a day in one room. Others reported feelings of boredom, conflict, difficulties with the nursing staff and a tendency for normal anxieties to become magnified.

However most mothers believed the practice benefited the child. Meadow emphasised the artificial position of the 'captive mother' and stressed her need for information, special consideration and attention.

Mothers' Presence as a Factor in Reducing Distress

Rutter (1972, p35) cites several studies including those of Illingworth and Holt (1955) and Prugh et al (1953) which showed that children's distress during hospital admission is greatly reduced if admitted with the mother or if there is daily visiting. Nevertheless he points out that it is not possible to determine how much the reduction of distress is due to the mother's presence and how much to other factors designed to alleviate trauma such as the provision of play facilities, preparation for admission, reduction of traumatic procedures such as venipunctures and enemas.

Vernon et al (1965, p37) found unanimous agreement in the literature that the child should have frequent contacts with its parents, but a difference of opinion over how much contact was necessary and over the advisability of the parent being present at particular times - e.g. prior to or following surgery.

Many believed the mother should be present during admission procedures, stay with the child prior to surgery and be there to reassure him afterwards (Langford, 1948; Levy, 1945; Ministry of Health, 1959; Prugh, 1948; Robertson, 1958). Others believed that the mother's presence could make the situation more stressful for the child (Vernon et al, 1965, p37). (i) (ii).

(i) Ch. III, p86.

(ii) Case Studies 9, 10, 11, 12. App I, p127-132.

Modifying Factors

A child's response to hospitalisation may vary according to many interrelated variables which have been identified in the literature. They can be divided into entogenous factors (such as the child's age, sex, physical and personal characteristics, his illness, including its particular meaning to the child, the nature of the illness and its treatment) and exogenous factors (such as parent/child relations, parental attitudes, quantity and quality of hospital experience).

Entogenous Variables

Age

The infant and toddler aged under four years. There is general agreement in the literature that the emotional stress occasioned by hospitalisation is most pronounced in children aged between six months and four years due to the greater degree of 'separation anxiety' suffered in this age group although only some are seriously affected. Older children may be so disturbed but the disturbance is less prolonged and less severe than in the lower age group (Illingworth, 1958; Prugh et al 1953; Ministry of Health, 1959; Schaffer and Callender, 1959; Robertson, 1958; Schaffer and Callender, 1959; Robertson, 1958; Vaughan, 1957). Schaffer and Callender (1959) found no distress in the child under six months due to the fact that it had not yet learned to recognise its mother.

Other writers have suggested that the young child's immature sense of time may influence the degree of distress caused by separation in the hospital setting. They explain that the young child lives in the present, his memory is short, he has no concept of the future. He cannot therefore understand the separation as an episode as can the older child (Lancet, 1949; Robertson, 1958). His understanding of the situation is fragmentary; the image of his real mother undergoes changes and may be confused with that of the idealised mother he longs for and that of the frustrating mother who has deserted him. It is not surprising then that when his mother reappears he may fail to recognise her (Bowlby et al, 1952).

Prugh et al (1953) studied 200 children aged from two to ten years divided into a control group of 100 and an experimental group of 100 for whom a special prophylactic programme designed to modify the trauma of hospitalisation was provided.

The most common reaction in toddlers aged between two and four years in the control group was anxiety over separation from parents, which, the most intense of any age group, manifested itself in crying behaviour, widespread depression and withdrawal. Regression was the most common defense mechanism available to this age group. Other reactions noted were feeding disturbances, smearing of faeces, hostility, restlessness, hyperactivity, irritability, rocking, thumb-sucking and aggressive behaviour.

The preschool child aged between three and five years. The preschool-aged child finds the separation experience involved in hospitalisation less severe than the toddler, particularly if he has had previous happy experiences of separation from his mother in the care

of trusted adults. He no longer lives in the present and is able to conceive of a time when his mother will return. His language development also allows simple explanations to be given by way of preparation (Bowlby 1951, 1973; Marlow 1969; Robertson and Robertson, 1973).

Ideally, he should be prepared for hospitalisation by his parents. He may be less anxious if he is reassured that he will come home again, helped to pack his bag ready for homecoming and allowed to play out his anxieties. The success of preparation will depend on the level of his understanding and the degree of parental anxiety manifested (Marlow, 1969, p401).

According to Bowlby, children in this age group with normal, happy relationships with their mothers suffer more distress from separation than those who have been brought up in institutions with no permanent mother figure and who consequently show no responses of this kind at all; the result of their affective life already having been damaged (1951, p24).

The child of this age needs the comfort of his mother's presence otherwise he may respond with hostile behaviour and excessive demands for affection. Indeed he needs maximum contact with both parents and their understanding and acceptance of his illness (Marlow, 1969). According to Plank (1962) the chief fears of this age group are fear of bodily harm and fear of abandonment in strange places.

The school-age child (five to twelve years). The school-age child finds hospitalisation no great hardship. He is able to accept and adjust to his illness better as he has had some previous experience of stress. His adjustment will depend on previous personality structure and previous parental relationships. He should be prepared by telling him the truth and by reassuring him that his parents will visit (Marlow, 1969;

Robertson, 1958).

He may, however, be beset by many fears and anxieties. According to Bowlby, the child's vulnerability to separation diminishes slowly after the third birthday. Consequently, a fair proportion of children aged between five and eight years still cannot adjust to separation, especially if it is sudden and without preparation. In this age group the secure child, certain of his mother's love, is better able to tolerate separations than the insecure child who may misinterpret events and believe he has been sent away as punishment for wrong-doing. However, "Much will depend on how the child is prepared for the situation, how he is treated during it, and how his mother handles him on his return." (Bowlby, 1951, p28).

The child of this age may also be confused by the nature of his illness and its outcome. If he feels he is to blame for his injuries, he may be beset by guilt feelings. Absence from school may also be a cause for concern. He may feel rejected and deserted by his peers. If confined to bed, he may resent the enforced physical inactivity, become depressed or resigned or react with hostile aggressive behaviour. Phobic manifestations common to this age group are fear of bodily harm, fear of death, of losing control under anaesthetics, of inability to compete with ones peers, and the fear of being different (Bakwin, 1951; Marlow, 1969; Plank, 1962; Prugh et al, 1953). (i) (ii).

He needs the company of children of his own age, responsibility, reassurance, conversation, reasonable limits to his behaviour and opportunities to continue his education. Care should be taken in discussing his illness in front of him in case he misinterprets and becomes disturbed by what he overhears (Bakwin, 1951; Ministry of Health, 1959).

The adolescent. The adolescent is able to understand the nature of his illness, accept its restrictions and handle a moderate degree of stress. He is ready to relate to new adults. However, being neither child nor adult, he may alternate in his behaviour, demands and expectations between the two. Therefore his ambivalence, insecurity or immaturity may require careful handling (Marlow, 1969).

If prepared for hospitalisation, he will be able to adjust according to his level of maturity. The explanation should be truthful and as detailed as possible (Marlow, 1969).

Common reactions of this age group noted in the literature are fears:-

Of loss of status because illness may not be acceptable to his peers; of loss of independence; of mutilation; of disfigurement; permanent disability or death; and fear of losing control in front of others.

The teenager may resent the lack of privacy or show concern over interruptions to his schooling and social life. He may suffer from guilt feelings (Jenner et al, 1952; Langford, 1961; Marlow, 1969; MacKeith, 1963; Plank, 1962).

Ideally he should be housed in an adolescent unit. He needs contact with his peers, diversion, respect for his individuality, information, opportunities to discuss his illness, reassurance and educational facilities (Marlow, 1969; Schaffer, 1971). (i)

(i) Case Study No. 14 App I, pl36.

Resilience of all age groups. Langford, (1961, p679), emphasises that most children weather the period of hospitalisation remarkably well, are able to join in activities on the ward and enjoy interaction with other children and adults. Most are able to deal with their reactions to the illness and emerge with renewed courage and vigour provided they are not overwhelmed by the experience.

Sex Differences in Response to Hospitalisation

Both Vernon et al (1965) and Rutter (1972) note the general lack of theoretical interest in the literature in sex differences in response to hospitalisation. They consider it likely that boys and girls differ in response to stress but conclude that exactly how remains ill-understood. There is a general suggestion that boys may be more vulnerable to the emotional upset of separation and hospitalisation. Prugh et al (1953, p65) found some differences in immediate reaction to diagnostic procedures in girls and boys. Boys were more inclined to react in a defensive aggressive manner while girls were more likely to show passive, submissive or withdrawn behaviour. Jessner et al (1952) noted no differences in reactions in boys and girls after tonsillectomy. Finally, according to Vernon et al (1965), no consistent relationship between sex and reactions to hospitalisation has been revealed in the literature. They suggest, however, that sex differences in reaction could vary according to age and type of situation and stress the need for further research into this possibility (1965, p141-142).

Physical and Personal Characteristics

There is ample evidence that children differ strikingly in their behaviour and in their responsiveness to the experience of hospitalisation. Individual physical and personal characteristics can greatly

influence the feed-back a child receives. Bakwin (1949, 1951), for instance, noted that the attractive, animated child received more attention from the nursing staff than the unhappy negativistic one.

Prugh et al (1953) and Edelston (1943) found that pre-hospital disturbances tended to be intensified by hospitalisation. The 'problem' child, the 'anxiety-prone' child, the child subject to phobic fears tended to show an increase in emotional upset during and after hospitalisation.

(i) (ii).

Jessner and Kaplan (1949) found that the children who coped best with hospitalisation were confident children who were able to transfer affection from mother to nurse, who were interested in toys and games and who were allowed to express their feelings with only moderate limitation or self-control. (iii) (iv).

Illness

The meaning of the illness to the child. Clinical and psychological observations reveal that the physical illness may have its own unique meaning to the child which in itself may contribute to the degree of emotional upset experienced. Prugh et al (1953, p101) have suggested that the psychological meaning of the illness and its treatment, particularly at the oedipal stage of late childhood and early adolescence, may have greater potential traumatic effects than the actual separation in that it involves misinterpretation, fears of mutilation and death, and unconscious anxieties.

Rejection and punishment. The child may believe he has been abandoned or rejected by his parents and placed in hospital as

(i) Ch. III, p87.

(iv) Case Studies, 3, 45, 67 and 8
App. I, ppl20-127.

(ii) Case Studies 1 and 2 App. I,
p117, 118.

(iii) Ch. III, p87.

punishment for wrong doing. As a result, he may learn to mistrust his parents or blame himself for his illness. Parental threats which use visits to hospital or the doctor's surgery as punishments may be factors in this reaction (Langford, 1961; Edelston, 1943; MacKeith, 1953; Woodward and Jackson, 1951).

Marlens (1959) compared the responses of hospitalised and non-hospitalised children using three projective measuring techniques. She found that the hospitalised child manifested feelings of rejection and punishment more frequently than the non-hospitalised.

Misconception through Misunderstanding

The child may misconstrue what he hears. Many authorities warn that the discussion of a child's case in his presence is an undesirable practice because of the danger that the child may misinterpret what he hears (Bakwin, 1951; Ministry of Health, 1959; Powers, 1948; Prugh et al, 1953.) (i).

Fears and fantasies. Through lack of knowledge of their own physiology, lack of information, erroneous information, misinterpretation of overheard conversations of parents or others, or through communicated parental anxiety, children may have varied, bizarre and sometimes frightening ideas about their condition or treatment, which in themselves can contribute to their emotional upset (MacKeith, 1953; Pearson, 1941). (ii)

The experience of being nursed. According to Anna Freud (1952, p72), in adjusting to the experience of being nursed, the

(i) Case Study 5, App I, pl23 .

(ii) Case Study 6, App I, pl24.

child must renounce newly found ownership of his body and return to the dependent state of early childhood. If this happens at a critical stage of his development, newly acquired skills may be lost. The enforced regression may lead to intense frustration. For instance she observed toddlers who had just learned to walk refusing to lie down and insisting on standing up all day in their cots.

Sensori-motor restrictions. Illness usually significantly limits the child's physical activity which is one of the channels available to him to dissipate his anxiety. Thus Bakwin (1951) and Cooke (1961), among others, condemn as physiologically and psychologically unsound the practice of confining the child admitted for an elective procedure to bed.

Bakwin warned that extended periods of bed-rest could lead to metabolic deficiencies in nitrogen, calcium, phosphorus and sulphur; failure of the circulatory reflexes necessary to maintain adequate circulation in the erect position; progressive generalised weakness and easy fatiguability. He recommended that it be discontinued as soon as possible (1951, p389).

Periods of immobilisation in a plaster cast severely restrict the child's contacts, tax his adaptive capacities to the utmost and produce evidence of emotional and intellectual deprivation. Anna Freud found that the blocking of the avenues of aggressive discharge led to the emergence of stereotyped tic-like movements, increased docility, or rages and temper tantrums. She noted a heightening of aggression during and after motor restraint with an increase in restlessness, irritability and the use of bad language (1952, p.73). (i)

(i) Case Study 2, App 1, p118.

Langford (1961, p673) described the explosion of intense motor activity which can occur after the removal of an intensive plaster cast. This release of dammed up aggression can sometimes result in further injury to the child. (i)

Painful nursing and medical procedures. Because of the belief that some medical and nursing procedures - such as intravenous injections, rectal temperature taking and enemas - may be disturbing to the child, many authorities recommend that uncomfortable or painful routine procedures be kept to a minimum and, if possible, be performed under an anaesthetic (Illingworth, 1958; Ministry of Health, 1959; Powers, 1948).

The nature of the illness. Vernon et al (1965; p146) list the following illnesses as those considered most likely to be associated with emotional upset by various authorities:-

Diarrhoea, ulcerative colitis and tonsillectomies.

Edleston (1943) noted that the degree of emotional distress associated with tonsillectomies was out of all proportion to the length of stay in hospital and was probably due to the emotional impact of surgery.

The trauma of surgery. Surgery presents threats to the child not present in routine hospitalisation. Haller (1967, p19) described operative treatment as ".....a controlled injury in an unfamiliar environment", Levy (1945, p8) described it as "....an experience of pain performed by strange persons after forcible separation from the familiar home and the protecting mother the main source of security."

Haller (1967) pointed out that the period immediately following an injury was the poorest time to adjust to new emotional experiences and surroundings.

(i) Case Study 13, p134.

Levy (1945) studied 124 children who had undergone an operative treatment of some kind. Twenty-five manifested negativistic, dependent, regressive or phobic reactions, children under the age of three years being particularly vulnerable. Levy advised the postponement of all operations under the age of three or later if possible. He also recommended that the child should be spared the sight of surgical instruments and that the mother should be at his bedside to quiet him when he recovered consciousness. (i).

Jessner and Kaplan (1949), in a prospective analysis of 124 children undergoing tonsillectomy, found 25 (20%) suffered relatively severe residual emotional disturbance. Jessner et al (1952) also studied sixty tonsillectomy and adenoidectomy patients while in hospital and for several months afterwards. Nineteen were moderately poorly adjusted to hospital and developed many residual fears and phobias; while thirteen were poorly adjusted and developed major difficulties afterwards.

The high degree of emotional trauma after minor surgery may be due to factors such as lack of preparation, lack of time to adjust to the hospital and the suddenness of the attack on the body. Vernon et al (1965, p78), reports conceptions of mutilation, hostile acts of castration with respect to treatments such as anaesthesia and surgery. Pearson (1941) suggested that the child may be overwhelmed by unrealistic fears and fantasies aroused by the operation which render the experience more frightening than it need be.

He may repress the memory of the whole operative procedure in order to stop thinking about his fear-filled notions. This repression

(i) Case Study 1 and 6, App I, pp117 and 124.

will result in alterations to his behaviour, his emotional reactions, his character, and it may lead to far-reaching difficulties in his later life" (Pearson, 1941, p716).

Prugh et al (1953) and Schaffer and Callender (1959) reported little or no relationship between the severity and duration of the illness and the degree of psychological upset in children. This may be due (as Vernon et al point out) to the difficulty in "equating different illnesses for degree of inherent objective stress" (1965, p150). Or it may be possible that it is not the illness itself, nor the degree of severity, nor the length of hospitalisation that is upsetting to the child but its particular symbolic significance to him; which will depend on the intent to which it is possible to adequately prepare him; and the degree of guilt engendered in the child and his parents by the injury or illness (1).

Exogenous Factors

Parent/Child Relationships

Vernon et al (1965) found general agreement in the literature that short-term distress was less if a good relationship with the parents existed before the separation experience. Illingworth (1958) and Prugh et al (1953) suggested that the better the parent/child relationship, the more secure the child and the more likely he was to make a successful adjustment to the experience of hospitalisation (ii) (iii).

Bowlby (1960), Robertson (1958), and Spitz (1945) appear to believe

(i) Ch. III, p94.

(ii) Ch. III, p91.

(iii) Case Studies 3 to 8, App. I, ppl20 to 127.

that the very young child between the ages of six months and four years with normal, happy relationships with his parents is more likely to manifest the distress symptoms of 'protest', 'despair' and 'detachment' than the child with distorted relationships with his parents. In this regard Vernon et al (1965, p119) note the difficulty in accurately interpreting a child's overt behaviour because of a tendency among writers to interpret a child's reactions according to a particular psychological theory and because of the problem of establishing a criterion of a 'good', 'satisfactory' or 'poor' parent/child relationships.

Parental Attitudes

It is frequently suggested that the emotional responses of the parents and the degree to which they have accepted and adjusted to their child's illness and hospitalisation may affect the child's responses through a transference of anxiety from parent to child (Bakwin, 1951; Illingworth, 1958; Prugh, 1953). (i).

"....disturbances in the behaviour of the child arising from the illness and hospitalisation may reflect the attitudes and anxieties of the parents before and after the child's discharge, and may also set off reverberations in the family group to which the child returns." (Prugh et al, 1953, p72.)

Suggested causes of such anxiety are:-

Underlying feelings of guilt and hostility on the part of the mother; the fear of separation from the child; a feeling of helplessness and inadequacy because others have taken over her maternal role; fear of the strange

(i) Case Study No. 12, App I, p132.

environment; lack of information on diagnosis, treatment procedures and prognosis; fear of the future; fear that the child will suffer; fear that the illness is infectious; financial worries; conflict between her responsibilities to the sick child and other siblings; prevailing attitudes of society towards chronic illness (Bakwin, 1951; Freiberg, 1972; Langford, 1948; Marlow, 1969; Meadow, 1969; Woodward and Jackson, 1961.)

Parent/Staff Relationships

It is suggested that friendly, supportive sympathetic understanding from hospital personnel can aid in reducing maternal anxiety and thus help to prevent emotional upset in the child. In addition it is emphasised that any anger or hostility evoked in the staff by the parents or vice-versa can be transmitted to the child (Marlow, 1969; Langford, 1961).

Duration of Hospitalisation : Immediate Reactions

Schaffer and Callender (1959), in a study of infants less than twelve months old, found evidence that the degree of overt disturbance decreased according to the length of hospitalisation; whereas Prugh et al (1953) found no correlation between length of stay and adjustment on the ward in children aged from two to twelve years.

Post-Hospital Responses and Length of Stay

MacKeith (1953, p170) reasoned that if the severe deprivation involved in long periods of hospitalisation could seriously damage personality development, then it was likely that shorter periods could

lead to slight but still handicapping disorders such as diminished self-confidence.

However Schaffer and Callender (1959), Prugh et al (1953) and Woodward and Jackson (1951) found no relationship between length of stay in hospital and post-hospital disturbance.

Degree of Objective Stress

Cooke (1967) postulated that the actual degree of physical stress the child has undergone could be a factor in the development of psychological upset, but Vernon et al (1965), found no support for this theory as yet in the literature.

Quality of Hospital Experiences

The attitudes and procedure of hospital personnel, the methods which are used to minimise the harmful effects of hospitalisation and the way the hospital handles emotional problems affect the quality of the child's experience and are generally considered to have an important bearing on the degree of upset suffered by the child.

Child/Staff Relationships

Good child/staff relationships are believed to be influential in modifying emotional disturbances as warm personal contact can enable the child to express his feelings, allow explanations of procedures to be given and thus facilitate preparation (Plank, 1962).

Personal Attention

The importance of personal attention and continuity of care is stressed by those authors who advise case-assignment systems of nursing in order to limit the number of persons caring for the child (Prugh et al, 1953; Robertson, 1958). (i)

(i) Case Study 8, p126.

Strangeness of the Hospital Setting

It is frequently suggested that a major cause of anxiety in the hospitalised child may be due to the fact that he is exposed to a strange environment, strange apparatus, routines and procedures, strange food, an unfamiliar bed and strange people, including doctors and nurses in large numbers (Bakwin, 1951; Gofman, 1956; Levy, 1945; McLennon 1949; Plank, 1962; Powers, 1948).

Preparation

The importance of adequate preparation is therefore emphasised in order to minimise the trauma. It is advised that the explanation given to the child should be simple, factual and truthful and couched in terms appropriate to his understanding (Gofman, 1956; Robertson, 1958; Vernon et al, 1965).

Various arguments are advanced in favour of adequate preparation:-

Simple explanations, it is believed, can prevent the emotional upset caused by strange surroundings, procedures and people (Illingworth, 1958; Vaughan, 1957).

Painful procedures are less disturbing if explained (Gofman, 1956; Haller, 1967; Pearson, 1941; Robertson, 1958).

Sudden unexpected trauma are doubly disturbing (Haller, 1967). The potentially traumatic effects of admission

procedures, diagnostic or therapeutic procedures or surgical operations can be thus prevented or modified by preparing the child (Levy, 1945; Ministry of Health, 1959;

Powers, 1948; Prugh et al, 1953). The child, if inadequately prepared, could learn to distrust his parents and adults in general (Haller, 1967; Vernon et al, 1965). Preparation, by

substituting knowledge and comprehension for fear and misunderstanding, may correct distorted ideas and fantasies. The child may learn to control his fears if he is encouraged to express them to a trusted adult (Pearson, 1941; Plant, 1962; Vaughan, 1957; Vernon, 1965).

Strategy. Some authorities hold that preparation is more effective if performed by the child's own parents (MacKeith, 1953; Ministry of Health, 1959; Robertson, 1958). Others, like Plank (1962), favour a combined approach involving parents, nurses and medical personnel (1962). Vaughan (1957) reported success with effective preparation by one single individual psychologist.

Various factors believed to influence the effectiveness of preparation are the child's age, intelligence, type of disability, personality and previous experience (Vernon et al, 1965). Robertson (1958), points out that it is impossible to prepare the child of under two or three years so that very little can be done to make the loss of his mother tolerable in this age group by this means.

Gofman (1956), conducted a survey of 100 children aged three to fifteen years and found that 75% had not been adequately prepared for hospitalisation. They concluded that most children over the age of three or four can gain understanding of their illness and treatment if explanations are given in simpler terms if only physicians realised the need and made the effort. Vernon et al (1965, p157) report evidence from a number of studies which indicate the preparing a child for surgery or hospitalisation tends to decrease the incidence of psychological upset in the post-hospital period, but no real support for a postulated relationship between psychological preparation and responses during hospitalisation.

The beneficial effect of improved hospital conditions in reducing children's distress following admission has been demonstrated by Prugh et al (1953), Robertson (1968), Schaffer (1971).

Vernon et al (1965) reports a greater awareness on the part of hospital authorities to the possibility of emotional upset in children and many positive changes in terms of visiting policies, preparation programmes, provision of play and educational facilities etc. which have developed in recent years in an effort to reduce the degree of emotional trauma involved in hospitalisation. (7) FN

Conclusion

Clinical writers have successfully distinguished the many inter-related factors which may cause emotional upset in young children and ways in which this disturbance may be modified. As yet there is little evidence from the experimental studies in regard to the relative importance of these factors or the manner in which they are related.

Vernon et al (1965, p157), consider that four factors have been sufficiently investigated to evaluate their relative importance. They find the evidence conclusive that unfamiliarity of environment is an important source of emotional disturbance as results of various studies have indicated that preparing the child for hospitalisation tended to decrease the incidence of post-hospital upset.

Separation, they found, contributed to upset both during and immediately following hospitalisation but was unlikely to have long term effects on the child's development. The degree of parent/child contacts helped in mitigating upset but the importance of visiting was still open to question.

Age is undoubtedly important. Children between six months and four years are particularly vulnerable to upset, infants and older children less so. It is also evident that the focus of anxiety varies according to age, with separation a major source of upset in the younger group and various phobic fears and fantasies being more prevalent with the older group. Evidence in regard to children's reactions following discharge is inconclusive.

It is clear from the evidence from the theoretical observations and experimental studies that hospitalisation can be an upsetting experience for many children. It is also possible that the many improvements in conditions in a growing number of hospitals due to these theories and studies may have so modified the trauma that the experience is not now as upsetting as formerly.

Nevertheless, there is as yet no reason for complacency. As Robertson (1973) points out, one can still find, even in the most progressive paediatric ward, an unaccompanied child in distress whose vital emotional needs are not being met in spite of the good intentions of the staff. The battle for the provision of suitable ward foster-mothers and of systems of care which put first the needs of young patients for stable, meaningful relationships is by no means complete.

This survey has focussed chiefly on the two decades between 1945 and 1965 as this would seem to be the crucial period in the evolution of current theories concerning the care of the hospitalised child, in the analysis of the effects of hospitalisation, and in the development of remedial measures to modify those effects. The emphasis in recent years has been on encouraging the implementation of practices arising from policies based on those theories, and on the continuing assessment of the relative importance of the major variables involved in the hospitalised child's distress.

CHAPTER IFOOTNOTES

(1) According to Bowlby (1951,p17), "The Developmental Quotient, although calculated in a way similar to the Intelligence Quotient (I.Q.), is concerned with general physical and mental development of which intelligence is only a part."

(2) Durfee H. and Wolf, K.

"Institutional Care during the First Year of Life."

Zillschift der Kindesforch Vol. 42, pp273-283 (as quoted by Bowlby, (1951, p17)).

(3) Dr. J. Bowlby was a psychiatrist attached to the Tavistock Institute of Human Relations which from 1948 had been engaged in research into the effects of loss of maternal care in early years upon the total personality development of the child (Robertson, 1968, p ix Preface to 1st Edition).

(4) Quoted by Rutter from -

Rutter "Maternal Deprivation Reconsidered" Journal of Psychosomatic Research, Vol. 16, pp241-50, 1972.

(5) Stacey, M.; Deardin, R.; Prel, R.; and Robinson, D.

"Hospitals, Children and Their Families", The Report of a Pilot Study: Routledge and Kegan Paul, 1970.

(6) Woodward, J. "Emotional Disturbances of Burned Children". British Medical Journal, No. 5128, pp1009-1013, 1959.

(7) However, in spite of this trend, there is evidence from surveys conducted in England and the U.S.A. that, as yet, no uniform approach to the emotional problems of the hospitalised child has developed in either country. Many hospitals have not yet relaxed visiting restrictions,

provided live-in accommodation for mothers, organised play programmes nor provided educational facilities for the children (Dimkro, 1957, pp89-116; Robertson, 1958; Postscript to 1970 edition).

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CHAPTER II

The Education of the Hospitalised Child

The Special Role of the Hospital School Teacher in the Modification of the Distress of the Hospitalised Child

Among remedial measures recommended by the Ministry of Health in the Platt Report (1959), was the provision of schooling for the child over the age of three years. Although the child of this age does not suffer the same degree of distress in hospital through separation as the younger child, he can still find the period of hospitalisation a stressful experience, particularly if it involves pain, surgery or a long period of immobility. (i) One of his greatest problems can be boredom. It has recently become the practice to provide educational facilities to the child in hospital as a means of modifying his distress, of providing a link with his normal work and of ensuring continuity of his educational progress.

The term 'hospital school' originally referred to schools attached to hospitals or institutions where children attended for the whole or a greater part of their school lives. These still exist. However, more recently the meaning of the term has widened to include those schools attached to hospitals or convalescent homes where the main concern is to tide the child over the days, weeks or months he is away from his normal school.

(i) Ch. I., p32.

This chapter will attempt to explore the unique role of the hospital teacher in this second situation and the special problems with which she and her pupils are confronted.

That schools of this nature have sprung into being over the last few decades is evidence of changing attitudes towards the hospital care of children and the growing realisation on the part of the medical profession of the positive role that education can play in the recovery of the child patient.

At the beginning of the century, children were hospitalised for long periods because of infections or crippling diseases such as rheumatic fever or tuberculosis. Later, poliomyelitis epidemics took their toll and resulted in an increase in the services offered. Improvements in medical techniques and knowledge have resulted in a decrease in the number of children hospitalised through infectious diseases and an increase in the number of patients surviving with congenital defects and conditions such as leukaemia, and chronic illnesses such as asthma or diabetes. The stresses and strains of our modern way of life have resulted in an increase in orthopaedic patients and in patients with behavioural disorders.

The present trend appears to be that a child's stay in hospital can be reckoned in days rather than months; - that is, an increasing number of children are hospitalised for shorter periods of time.

It has become the practice to provide educational facilities for these children as a way of ensuring education for all children.

Main Advantages of Hospital Schools

There would appear to be two main advantages to the child in continuing his education while in hospital.

Firstly, from a medical point of view, it is believed to have therapeutic benefits. The child in a strange, frightening environment can, it is suggested, gain security from the contact with a familiar adult and the continuing use of his own school books and usual assignments. The link thus forged with his own school provides a bridge between his past and his future thereby reassuring him of his eventual recovery and return to a normal life with his peers. Again the school is seen as part of the child's normal life. It is therefore argued that to introduce schooling in hospital can be one way of modifying the possible traumatic effects of hospitalisation (Hammon et al, 1967, p459) (Marlow, 1969, p53) (McDonald, 1963, p227).

"No matter how handicapped the child, his world always includes the school, therefore provision for instruction is usually found in any hospital or nursing centre serving children." (Wolinsky and Baker, 1968, p62).

"For the School-aged child, the most important missing activity beyond his home and his family is the educational experience." (Hammon, 1967, p459).

Patricia Burke (1966, p559) lists certain special needs of the hospitalised child which she considers the educational programme can fulfil:-

The need to release anxieties and hostility; the need to adapt to the hospital environment and his special disability and the need for security and

social growth.

Secondly, from an academic point of view, schooling is regarded as necessary to prevent educational retardation. As Hammon (1967, p459) points out:-

"....for students precariously balanced academically and for those deprived of significant periods of schooling this lack could be disastrous."

The Platt Report (Ministry of Health, 1959, p23) cites two main reasons for educating children in hospital:-

"Firstly, an endeavour is made to ensure that they do not fall behind in their schoolwork and that they will be able to return to their normal place in an ordinary school. Secondly, and this particularly for the under-fives, they are assisted to develop in an orderly and harmonious manner."

A Report of the Office of Education, Washington, U.S.A., December 1st, 1948, states:-

"The very conditions which necessitate a long stay in hospital make also desirable an educational, diversional and mental health program such as a modern school should provide. Many physicians prescribe schooling as part of the total program of care." (1) FN.

Miss H. M. McDonald (1969, p33), teacher at the Royal Children's Hospital, Brisbane, writes of the very definite psycho-therapeutic boosting power for the child who may otherwise become severely retarded in his scholastic progress because of hospitalisation and mentions a secondary aim:-

"....to encourage the young patient to adjust to his surroundings, to accept his present circumstances and to endeavour to cope with his disability. A child who

early in life learns to adjust to his circumstances and take difficulties in his stride despite physical handicaps and inconvenience will be better equipped to meet the problems and demands of life and will not weaken so easily under future hardships and set-backs."

In her view the hospital teacher has the task of "...providing education in the fullest sense to promote the well-being and recovery of the child." (McDonald, 1969, p32).

Difference in Emphasis

Although the aims of education for hospitalised pupils are the same as those for normal children, there is an important difference in the extent of the emphasis on education which the hospital teacher must bear in mind.

M. Leigh Rooke (1962, p261) points out:-

"The major concern is the correction or alteration of the disability and the restoration of health. Every other aspect of his care and welfare, of his growth and development, must, to a certain degree, be subservient to his medical treatment and physical health. The circumstance limits his activities, restricts his freedom and conditions the implementation of his educational programme. The acceptance of this constitutes the frame of reference within which every educational, recreational and social decision is made and every plan is developed."

Special Problems of the Hospital School Teacher

The Isolation of the Teacher

In many instances, the Hospital School is a recognised Education Department instrumentality functioning in another separate Government Department. The teacher is thus in the contradictory situation in that she is essentially alone, isolated from her fellow professionals, but at the same time working as a member of a complex interdisciplinary team. Wolinsky (1968, p62), emphasises the initial inconsistency of her position in a facility which is primarily medically oriented:-

"She is a representative of a normative aspect of life of all children, that of the school - but, at the same time she is attempting to follow normative patterns in a secluding environment. The seclusion results from a medically defined need for a specified period of time in a sheltered setting. Yet the hospital provides a permissive environment, it permits non-performance of physical activities, self-care and other tasks that are ordinarily expected of children. The teacher in this situation is therefore concerned not only with the curriculum, but also with the special problems of the youngsters and the particular demands of the hospital situation."

Special Problems of the Hospital Situation

The teacher is indeed faced with a multitude of problems. The range in age and ability of the pupils is greater than in the normal school. Because of necessary medical, nursing and therapeutic procedures their daily contact with the teacher is brief. There is a multiplicity of levels and subject areas to be covered as well as an unselected assignment of pupils in regard to ability and type of ailment. Because some pupils are confined to bed and cannot be moved to a central class-room if one exists,

there is the additional problem of transporting aids and facilities normally freely available in the average class-room.

If there is no class-room, the class may be scattered over a wide area. The teacher has therefore to divide her time carefully and judiciously between her pupils according to need and visit each one often during the teaching period to maintain interest.

Because children are in hospital now, on average, for shorter periods of time the length of enrolment in the hospital class can vary from a few days to a matter of months. The teacher is therefore faced with a diversification of pupil programmes and teaching activities and a constantly changing group of children of all ages and stages of education.

There may be several long-term patients dependent on her for their regular education and some children wishing to participate for a few days only. The eager short-term child may take up an undue amount of time and prevent the long-term patient receiving the attention he desperately needs (McDonald, 1963).

In addition to these stresses, the teacher must also be prepared to tolerate frequent interruptions to the programme from doctors, physiotherapists and nursing personnel wishing to carry out necessary treatments, examinations or medication or from visitors who may call in at any time to see the child (Connor, 1964, p4; Rooke, 1962, p261) (McDonald, 1963).

The frequent interruptions, the limitation of experiences and the lack of class stimulation renders the task of developing favourable attitudes towards schoolwork in each child difficult (McDonald, 1963). This is particularly so in the case of long-term patients and those children taught in an open-ward situation.

Special Problems of the Hospitalised Pupil

It requires great self-disciplinary powers for a young child to concentrate on a school assignment in the midst of a busy children's ward, with the coming and going of medical and nursing personnel, the noise of T.V. sets, transistor radios and the chatter of other children engaged in recreational activities. Moreover he may have to tolerate interruptions from younger patients, or from disturbed maladjusted children expressing their anxieties and fears.

The child who is secure and happy at school may gain great support from daily contact with the hospital teacher whom he regards as a trusted adult, whereas the child who is unhappy at school may resent the unwanted intrusion of the teacher and react with antagonistic hostile behaviour. These children require special help and informal recreational activities until they are ready to join in the regular class programme.

The Long-Term Patient

Teaching the long-term patient requires special qualities of observation and understanding. The teacher must be aware of the known negative aspects of long-term institutionalisation such as the development of dependency and the restricted range of experience. It is easy for a child in such a situation to lose his sense of self-reliance and initiative and the desire to relate to and serve others. (i).

There is also a danger that the long term patient may develop an increased preference for the hospital situation so that he becomes too comfortable and less able to cope with future realities. The teacher must therefore seek to foster in each of her pupils a spirit of self-reliance and independence (Kaplan, 1967, p44).

(i) Ch. I., p38.

The Dying Child

The child with a progressive disability or terminal illness needs the benefits of a constructive, mentally healthy environment. The stimulation and interest derived from simple educational activities can help to avert the child's understandable apathy, withdrawal and depression. The teacher's role in this situation vacillates according to the fluctuations in the child's physical condition. Moreover, the personal impact of working with a dying child may require a personal adjustment, a development of a partial detachment from the situation which could be beyond the ability of the most experienced teacher of exceptional children. Connor (1964, p10) emphasises the need for "....a momentary blurring or loss of clear self-image" and refers to Schafer's term "regression in the service of ego", (FN 2) which she defines as "....a partial, temporary and controlled lowering of the psychic functioning to promote adaptation.... by maintaining, restoring or improving inner balance and organisation."

Criteria for a Hospital Teacher

The teacher who can cope with these problems and function happily in this unique situation must possess special qualities.

Lee (1960, p39) Inspector of Schools, N.S.W. cites the following:-

"Teaching ability above average....special qualities of controlled sympathy, a keen understanding of the needs and development of normal children as well as the special problems of hospitalised ones, patience, initiative and the ability to get on well with other adults."

Other writers including Bourke (1966), Connor (1964), Lee (1975(b)), McDonald (1969) and Sellars (1975) stress the importance of flexibility. Connor (1961, p9) emphasises "....the ability to 'shift gears', to adjust to unexpected change of pace due to the child's altered physical

status of the effects of the therapeutic regimen." McDonald (1969, p36) warns that the teacher must bear in mind that the child is sick and temper her expectations accordingly. Bourke (1966, p560) cautions that the child "....should not be expected to perform as he did before entering hospital or as he will when he return to his own school."

Successful Programming

Successful functioning depends on careful planning and meticulous preparation. Records should be kept on each student's progress so that his teacher may be informed and continuity of instruction guaranteed (Wyatt, 1975). It is important that contact with the student's normal school is maintained on admission during and after hospitalisation and a happy liaison with other teaching staff and paramedical and medical personnel established to ensure acceptance and understanding of the teacher's role in the successful rehabilitation of the child (Connor, 1964, p36; Department of Education and Science, 1974; Lee, 1975; McDonald, 1963; Sellars, 1974; Wyatt, 1975).

Several authorities emphasise the importance of the teacher maintaining close contact with the parents, encouraging their visits and involving them and the siblings in the child's educational and recreational activities in order to help preserve the family as a unit (Lee, 1975; Noble, 1976; Sellars, 1974.)

In planning the programme, Connor (1964) advises the teacher to regard the concept of readiness as a continuous process. She should therefore start with what the child already knows. Any developmental discontinuity or breaks in context can be noted and attempts made to restore the balance. Skill is therefore needed "....in determining the

child's speed of learning, in recognising learning problems and identifying unevenness of learning." She should also "...search continually for evidence of inadequate sensory function, unusual emotional development and behavioural disturbances, perceptual imperfection, motor defect, lowered vitality and limited stamina or undue distractibility." (Connor 1964, p17). In short, she must look at her pupil ".....in depth rather than as a crippled child or one with an isolated psychiatric condition. Seldom does a handicap appear simply or singly." (Connor, 1964, p19).

Due to the individuality of approach, the difference in emphasis, the limited time available and the heterogeneity of abilities and levels of the pupils, the programme must be flexible and the pupil to staff ratio low, Lee (1960, p39) recommends not more than twelve to a teacher. The child should be allowed to work at his own level and at present speed. Acquired skills can be reinforced, problems remedied and new skills taught when he is ready. Basic subjects necessarily have priority because gaps here are harder to make up but there is scope for remedial help where necessary and for recreational and cultural activities.

The Teacher's Role

The teacher is denied the normal satisfactions of the classroom teacher in seeing her pupils progress from grade to grade. She has, however the satisfaction of helping a child in need through a difficult and trying experience. Moreover, she has the assurance that it is her sympathetic understanding and awareness of the many problems, both emotional and educational of the hospitalised pupil, her willingness to meet them in an individual way and the flexibility with which she is able to adjust to changing circumstances in the ward, frequent interruptions and fluctuations in mood and physical condition of her charges, that ultimately determine the educational worth of that experience.

FOOTNOTES CHAPTER II

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CHAPTER III

An Illustrative and Descriptive Study

Discussion of the Experiences of 37 Children
in a Paediatric Ward from the point of view
of a Hospital School Teacher : An Attempt to
Illustrate major issues arising in Chapters
I and II

This chapter comprises a discussion of the responses of a random selection of 37 subjects mainly long-term or chronically ill 'regular' patients who were referred by the Sister-in-Charge to the Hospital School Teacher for schooling.

It is an attempt to find supportive or illustrative material for theories and issues discussed in Chapter I and to a lesser extent in Chapter II. Indications of any positive or negative effects of hospitalisation on the school-age child were sought by a comparison of pre-hospital and post-hospital behaviour as assessed by school teacher on D.H. Stotts' Bristol Social Adjustment Guides⁽¹⁾ Illustrations of various factors involved in the child's adjustment or distress were sought by recording his responses in the form of case study and observational notes.

Procedure

The first task was to obtain the consent of each class teacher and parent. Next, in order to compare pre- and post-hospital behaviour B.S.A.G. forms were sent to the class teacher of each subject within a few days of his admission for completion in respect of the child's

pre-admission behaviour and again within a week of his discharge for completion after observation of his behaviour on return to school.

During the period of hospitalisation, observational notes were kept on each subject with special regard to his behaviour at lessons and at play, his relationships with his parents and his peers and his reactions to his illness, medical treatment and hospitalisation.

Information was also obtained from follow-up questionnaires to parents, hospital and school records, children's sentence completion forms and from informal interviews with parents, teachers and nursing staff (i). After discharge an effort was made to maintain continuing contact with parents and teachers.

Problems

The usual problems in regard to the return of forms were encountered. Of forty-seven case studies initiated, thirty-seven were completed. In the case of a change or transfer of teachers, sometimes two teachers co-operated in the assessment. The number of teachers involved in the education of the High School student resulted in considerable communication problems. The extended period of convalescence which some children experienced made it difficult to ascertain when they would return to school.

Lastly, the follow-up questionnaire to parents was not sufficiently precise to elicit the detailed information required. It was simply framed in order to avoid confusing or disturbing parents. However, while some gave detailed descriptions of their child's behaviour, others responded with brief comments such as "no change". A different format consisting perhaps

(i) See Appendix III.

of a check list of possible reactions such as sleeplessness, nightmares, clinging behaviour, defiant behaviour, aggressiveness....., may perhaps have been more effective.

Discussion of the Main Issues

Maternal Deprivation

"Severe deprivation in the early years can have harmful effects on a child's future development." (i)

As the children were of school-age and were hospitalised in a progressive paediatric ward with open visiting, it was not expected that many would exhibit symptoms of extreme deprivation. However, one subject had been parted from his mother figure for an extended period in early childhood. Subject B8 (ii), who had been separated from his mother in the second half of his first year and who had spent the remainder of his life in a variety of institutions and foster home placements, exhibited many of the deficiencies believed to be associated with maternal deprivation in early childhood although there were other factors involved.

Variations in the Degree of Deprivation

Partial deprivation. Failure to provide the quality of care which the child needs can result in feelings of acute anxiety, guilt and depression (iii).

There were ten children who had apparently suffered partial deprivation prior to hospitalisation through:-

- (i) Ch. I pl1.
- (ii) Case Study ii, App. I pl30.
- (iii) Ch. I, pl3.

- (i) Long periods of hospitalisation with infrequent visiting due to distance FN (1) (B17).
 - (ii) Distorted relationships with mother (6) which could be attributed to -
 - (a) mother's inability to accept the child's disability and limitations (i) (B7).
 - (b) mother's tendency to overcompensate for child's disability (B21).
 - (c) over-protectiveness on the part of the mother (B24) (R14) (ii).
 - (d) an over-critical mother, making unrealistic demands on the child (B12) (iii).
 - (iii) Disruptive, chaotic home circumstances [3] (G7, B22, B13)
- With the exception of B14 (iv), these subjects had great difficulty in adjusting to hospitalisation showing anxiety, depression, restlessness and an inability to tolerate frustration.

Importance of the accessibility of the Principal

Attachment Figure. Whether a child or adult is in a state of security, anxiety or distress depends on the availability and responsiveness of his principal attachment figure (v).

Most of those children who had apparently enjoyed warm, stable relationships with their mothers were able to control their anxieties secure in the continuing support of their parents. The exceptions were G4 (vi) and B23 (vii), whose inability to settle could be attributed to

- (i) Case Study 12 p132
- (ii) Case Studies 4 & 13, App I, p121 and 134
- (iii) Case Study 2 App I p118
- (iv) Case Study 4, App I p121
- (v) Ch. I, p16.
- (vi) Case Study I, App I, p117
- (viii) Case Study 7 App I, p125.

acute illness and intense pain over a considerable period and B16 (i) whose distress may have been related to the strange, noisy hospital environment or anxiety over his disability.

Reversibility. The damage is not universal and can be modified to some degree in some cases but only with great difficulty (ii).

With a complete change of environment the behaviour of B8 (iii) became more settled.

Separation : Infancy, the Critical Age

Separation from the mother, particularly in the under-five group can lead to unhappiness and fretting in hospital and behaviour disturbances such as night fears, bed-wetting, aggressiveness and undue clinging after discharge. (iv)

Most children of school age can endure quite lengthy periods of hospitalisation without obvious or permanent symptoms resulting (v), but they can be beset by fears and anxieties (vi). A fair proportion of children between 5 and 8 years cannot adjust to separation particularly if it is sudden and without preparation (vii).

Common reactions of subjects during hospitalisation. All subjects showed some signs of initial distress but most (22) settled later and were able to adjust. The child was considered unable to adjust if he continued to exhibit signs of severe distress or emotional disturbance, or behaviour typical of maladjustment such as severe hostility, timidity, withdrawal, aggressiveness, inconsequentiality, distractibility or attention seeking behaviour over an extended period [15] (2).^{FN} He was x

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| (i) Case Study 8, App I, p126 | (ii) Ch I, p18 | (iii) Case Study 11, App I, p130. |
| (iv) Ch I, p20 | (v) Ch I, p24 | (vi) Ch I, p37 |
| | (vii) Ch I, p33 | |

Considered to be well adjusted if, apart from some initial distress, he failed to exhibit such behaviour to any great degree, was able to relate to the nursing staff and his peers, join in ward activities and eventually appeared relatively cheerful and contented for the greater part of his stay (3). FN.

Subjects considered unable to adjust were:-

G4, G7, G8, B7, B8, B12, B13, B16, B17, B20, B21,
B22, B23, B24, B26

A common tendency was for the child to become quieter than usual at first as if gathering his defences against the assault on his body [28]. Most children were amazingly patient and able to tolerate a high degree of discomfort. Other common reactions were:-

Withdrawal [18], boredom [15], restlessness [20],
general misery and emotional distress [13].

Fears. The most commonly expressed fear was that of 'needles' or intravenous injections [37]; others were:-

Fear of surgery [9], bodily harm [6], plaster casts [2],
strange surroundings [4], noise [4].

Apprehensions and anxieties. Some showed anxieties concerning return to school [1], acceptance by their peers [2], results of medical tests [4], loss of hair [2], separation from family and home [1].

Sleep disturbances. Five subjects reported sleep disturbances, two had nightmares.

Regressive reactions. Many subjects regressed and showed behaviour typical of much younger children such as dependent [17], demanding [7], clinging [7], weepy [12] behaviour. Some actively sought

adult attention (13).

Negativistic reactions. The following negativistic reactions were noted:-

Hostility [6], destructive behaviour [1], aggressiveness [6].

Separation anxiety. Twenty children openly showed distress or fretted in the absence of the mother figure especially when under stress or in pain or acutely ill. Of these, twelve were between the ages of five and eight years.

Post Hospital Responses

After a period of separation, the young child may manifest feelings of distrust and hostility against the environment. However, this disturbed behaviour usually disappears with careful handling. It can persist. Those considered vulnerable are young children 'anxious-prone' children, 'pre-neurotic' children and 'problem' children (i).

Eleven mothers reported the following improvements in their child's behaviour:-

more mature, more self-reliant, more confident [9] (ii) more loving and affectionate [2] (iii). Of these, nine had shown stable behaviour prior to hospitalisation according to B.S.A.G.I. (ii) and only two had shown negative reactions to hospitalisation (v).

Six mothers reported no change in the child's behaviour (vi). Two had previously shown low scores on B.S.A.G. I (vii), four had high Unract or Ovract Scores.

Twenty mothers reported a deterioration in behaviour during the first few weeks at home (ix) although nine emphasised that this was only temporary (x). Of those subjects exhibiting a severe reaction (xi),

seven had shown high Ovract or Unract scores on B.S.A.G. I. (xii). Age may have been a factor in the distress of subjects G1 (five years), G2 (seven years), B3 (six years), B4 (six years) and B5 (6 years).

The following negative reactions were noted by the mothers:-

Regression to more dependent behaviour with the child becoming more demanding; clinging, weepy or attention seeking behaviour [9] (xiii), more aggressive behaviour [3] (xiv); more withdrawn behaviour [4] (xv); restlessness or hyperactivity [4] (xvi).

Two of the above subjects also suffered sleep disturbances.

The mothers interpreted this behaviour in two ways. Some considered it was due to the child being 'spoilt' in hospital. Others attributed it to the child's frustration because of enforced immobility in hospital or inhibited mobility during convalescence.

Though the mothers were forced to bear the full brunt of the child's reaction, most children settled quickly at home or on return to school. None of the twenty subjects exhibited a corresponding deterioration in behaviour on return to school.

FOOTNOTES

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| (i) Ch I, p24 | (vii) B15, B27 |
| (ii) Subjects G3, G5, G6, G9, B2, B6, B7, B10, B25, B28. | (viii) B1, B14, B17, B26. |
| (iii) G3, B24. | (ix) G1, G2, G4, G7, G8, B3, B4, B5, B8, B9, B11, B12, B13, B16, B18, B19, B20, B21, B22, B23. |
| (iv) G3, G5, G6, G9, B2, B6, B10, B25, B28. | (x) G1, G2, G8, B11, B12, B18, B19, B20, B23. |
| (v) B7, B24. | |
| (vi) B1, B14, B15, B17, B26, B27 | |

FOOTNOTES (Continued)

(xi) G4, G7, B3, B4, B5, B8, B9,
B13, B16, B21, B22.

(xii) G4, G7, B8, B13, B16, B21,
B22.

(xiii) G1, G4, B3, B4, B5, B8, B11,
B16, B20

(xiv) B9, B16, B13.

(xv) G2, G8, B18, B22

(xvi) G7, B4, B8, B12

Correlation between Hospital and Post-Hospital Reactions

Research reports varied concerning possible correlation between hospital and post-hospital reactions⁽ⁱ⁾. Of twenty children showing negative reactions at home, fourteen had shown negative reactions in hospital. This would seem to support Prugh's (1953) findings but any conclusion is difficult because of the many factors involved.

Age and Ability to Adjust

Vernon et al (1965) found a curvilinear relationship between the age variable and psychological upset⁽ⁱⁱ⁾. Subjects ages ranged between five and fifteen years (5 to 7 years [8]; 8 to 11 years [23]; 12 to 15 years [6]). Average age was nine years three months.

Negative reactions occurred over the whole age range but certain responses seemed to occur more frequently in particular age groups. Younger children (5 to 7 years) showed a slightly greater tendency to withdrawal, passivity and dependent regressive behaviour. Aggressive/hostile behaviour was more prevalent in the older group (12 years and over), particularly the boys. This group also tended to be over-critical or over-familiar with staff and evasive and argumentative with the teacher. There was less fretting between parents' visits in children over eight years as these children did not need the constant presence of parents after the first few days.

FOOTNOTES

(i) Ch. I, P.22

(ii) Ch. I, P.24

Nature of Previous Separation Experience

If a child has had previously unhappy separation experiences, he is more likely to be disturbed in hospital (Vernon et al, 1965).

Prugh et al (1953 p84) found no general patterns of response among children with a previous history of hospitalisation⁽ⁱ⁾.

Previous hospitalisation and ability to adjust. Only seven of the thirty-seven subjects were in hospital for the first time.

TABLE 1

Summary of Subjects' Previous Hospital Admissions

No. of Previous Admissions	Total Subjects	Able to Adjust	Unable to Adjust
0	7	4	3
1	9	6	3
2	3	2	1
3	2	2	0
4	2	1	1
5	3	1	2
> 5	11	6	5
	37	22	15

From the above table, there is no apparent relationship between ability to adapt to hospitalisation and number of previous admissions as negative reactions were evenly distributed over the whole range. However the responses of the thirty subjects with prior experience of hospital may have varied according to whether or not they retained happy memories of their previous visits.

(i) Ch. I P25

Frequency of Visiting and Emotional Upset

Studies by Prugh et al (1953), Schaffer and Callender (1959), Vernon et al (1965) found no relationship between frequency of visiting and severity of the child's reaction to hospitalisation (i)

Of the fifteen children who experienced difficulty in adjusting to hospitalisation, eleven were visited frequently by their mothers, one regularly (B16), one infrequently (B13) and two not at all (B3, B17). This would seem to illustrate the conclusion of Vernon et al (1965) that the quality of previous relationship and not frequency of visiting was the decisive factor in the age group 2 to 12 years.

Mother's Presence as a Factor in Reducing Distress

Children's distress in hospital is reduced if they are admitted with their mothers or if there is daily visiting (ii).

In all cases the mother was present during the child's admission and was free to visit as often as she wished at any time but, although facilities exist for 'rooming-in', none of the 37 subjects was so acutely ill that this was deemed necessary. However it was not just the mother's presence which seemed to ensure the child's stability, but the presence of a calm, supportive mother, able to control her anxieties, which seemed to be the crucial factor (iii).

(i) Ch. I, p27.

(ii) Ch. I, p28.

(iii) See below Ch. III, p91.

Modifying Factors : Entogenous Variables

Age: The School-Age Child

The adjustment of the school-age child will depend on previous personality structure and previous parent-child relationships. In this age group the secure child is better able to tolerate separations than the insecure child (i).

Stable pre-hospital behaviour and ability to adjust. According to B.S.A.G. I., twenty-two subjects were well adjusted, emotionally stable and secure in a classroom situation. They were on the whole friendly, confident children, able to relate with their peers, with positive attitudes to learning. Most settled easily in hospital, adjusted well to their surroundings and tolerated discomfort and pain with patience and fortitude. Four subjects (B15, B16, B19, B23) showed signs of acute distress and experienced great difficulties in adjusting because of severe pain, communication problems, difficulties in preparation due to subject's low intelligence, fear of operations, severe homesickness, the stress of immobility, noise or strange surroundings. Two (B15, B19) adjusted later, two (B26, B23) did not (ii).

Unstable pre-hospital behaviour and ability to adjust. With two exceptions (Subjects B1, B14), those subjects showing signs of instability or maladjustment according to B.S.A.G. I., exhibited signs of such severe distress and emotional disturbance while in hospital that they were unable to adjust. In all, fifteen subjects showed signs of behaviour disturbance in varying degrees prior to admission (iii).

(i) Ch. I, pp32, 33

(ii) Case Studies 3, 4, 5, 6, 7, 8. App I, ppl20 to 127.

(iii) Ch. I, p36. (Jessor and Caplan (1949)).

TABLE IISUMMARY OF B.S.A.G. I

	No.	Subjects
Appreciable under-reaction	1	G8
Maladjusted Under-reaction	2	B7, B14
Appreciable Over-reaction	2	G7, B13
Maladjusted Over-reaction	5	B1, B8, B21, B24, B26
Appreciable Under-reaction and Over-reaction	3	G4, B12, B8
Maladjusted Over-reaction	1	B22
Maladjusted Under-reaction and Appreciable Over-reaction	1	B17

These subjects showed the following negative reactions to hospitalisation:-

Detachment [6], withdrawal [10], quietness [1], depression [4], passivity [1], timidity or shyness [3], nervousness [2], extreme tension or anxiety [6], restlessness [11], hyperactivity [9], attention-seeking behaviour [7], moodiness [7], fretting for parents [7], impulsive, unrestrained behaviour [9], regressive behaviour such as dependent [11], weepy [7], or clinging behaviour⁽ⁱ⁾

FOOTNOTES

(i) Case Studies 1 and 2, App. I. pp117,118.

Post-hospital behaviour according to B.S.A.G. II. Nine

subjects showed signs of emotional instability on return to school according to B.S.A.G. II

TABLE IIISUMMARY OF B.S.A.G. II

	No.	Subjects
Appreciable Under-reaction	3	G1, G8, B14.
Appreciable Over-reaction	2	B8, B26.
Maladjusted Over-reaction	2	B1, B22.
Appreciable Under-reaction, mild Over-reaction	1	B20
Appreciable Under-reaction, appreciable Over-reaction	1	B17

All nine had shown correspondingly high Ovract or Unract scores in B.S.A.G. I. Therefore six subjects exhibiting signs of instability prior to admission were rated stable on B.S.A.G. II (G4, B7, B12, B13, B21, B24).

Of thirty-seven subjects, fourteen showed a variation in scores in B.S.A.G. I and II of more than two points. Five showed lower Unract scores (G4, B6, B12, B17, B22). Of these, two (B12, B6), were assessed by a different teacher and one (G4) had been in poor health prior to hospitalisation. Consequently the improved Unract score could be attributed to regained health.

Twelve subjects showed improved Ovract scores (G2, G4, G7, B4, B8, B12, B17, B21, B22, B24, B26, B28). Four (G2, G7, B12, B17) were scored by a different teacher. One had transferred to a different school (B21).

Two subjects showed deterioration in behaviour with higher Unract scores (G6, G7). One (G7), was assessed by a different teacher.

Of the fourteen subjects showing variation in behaviour, ten had shown signs of previous maladjustment with high Unract or Ovract scores in B.S.A.G. I. The behaviour of these children would tend to vary in any case.

Any definite conclusion from a comparison of B.S.A.G. I and B.S.A.G. II is difficult owing to the impossibility of controlling variables such as transfer of pupils and teachers to other schools. There was however, no discernible deterioration in behaviour in the hospitalised children on return to school after discharge but rather some tendency towards improved behaviour (i).

There are several possible explanations of the tendency towards lower scores on B.S.A.G. II. The subject may have been able to express his fears and frustrations in hospital or at home. There may have been a tendency to inhibit this expression on return to school because of problems of readjustment. An increase in attention and sympathy from his teacher and classmates may have led to improved behaviour. Some schools made positive efforts to assist the rehabilitation of disabled students. The lower B.S.A.G. II score may reflect a changed attitude on the part of the teacher towards the subject as a result of the child's illness or because the teacher had now recognised as maladjusted, behaviour previously regarded

as directed against himself. There is a known tendency towards lower scores on retest (Stott 1974, pl8). Finally, the improved behaviour of some unstable subjects could be attributed to reactions to a different teacher or school environment.

Previous Parent-Child Relations

Ability to adjust and quality of parental support. The quality of previous parental relationships was demonstrated by the quality of parental support the child enjoyed while in hospital which was an important factor in his successful adjustment. Reassured by the regular presence of supportive loving parents, (or, in the case of G2, grand parents) the small child showed amazing qualities of resilience and endurance. Of the twenty-two children able to adjust, twenty enjoyed this support. The exceptions were B2, who found suitable parental substitutes among the ward staff and B14, whose mother was rather overanxious and overprotective, and who seemed to benefit from the freedom of the ward (i).

Inability to adjust and inadequate parental support. Thirteen of the fifteen subjects who were unable to adapt to hospitalisation did not receive adequate parental support because of:-

Disturbed or distorted parental relationships [3],
 (G4, B12, B21), disruptive home circumstances [3]
 (G7, B13, B22), lack of permanent mother-figure
 [1] (B8), inability of mother to visit because of
 responsibilities to other siblings [2] (B17, B26),

FOOTNOTE:

(i) Case Studies 9, 10 App I, pp127 to 130.

or over-anxiety, over-protectiveness or over-permissiveness of the part of the mother [9] (G8, B7, B20, B24). The remaining two were subjects B16 and B23, previously discussed, who though receiving adequate calm, loving support were unable to adapt because of other factors (ii), (iii), (iv).

The adolescent. The adolescent is able to adjust according to his level of maturity as he is better able to understand the nature of his illness but he may show ambivalence, insecurity and immaturity. He may suffer fears, anxiety, resentment or feelings of guilt. He needs careful preparation and contact with his peers (v).

There were great individual differences in the reactions of the adolescents (G7, G8, G9, B25, B26, B27, B28) (vi). Reactions ranged from quiet, placid acceptance (G9); alternating periods of acceptance and depression (B25); passivity, misery and detachment (G8); angry hostility and resentment (G7); and restless, inconsequential, impulsive behaviour (B26). Those able to adjust were G9, B25, B27, B28. Possible factors in their adjustment were:-

Ability to understand and discuss their illness with parents, doctors and nurses (G9, B25, B27): operation initiated by subject's own request (G9): careful preparation by parents and doctor (B25, B27, B28); previous successful adjustment to hospitalisation (G9); reliance on visits and understanding support of parents (G9, B25, B28).

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| (ii) Case Studies 11, 12 App. 1, pp130,133 | (v) Ch. 1, pp34. |
| (iii) Ch. I, p28. | (vi) Case Study 14, App. I, p136. |
| (iv) See above Ch. III, p87. | |

Those unable to adjust were G7, G8, B26. Possible factors influencing their negative reactions to hospitalisation were:-

Painful illness or treatment (G7, G8, B26); unstable previous personality structure (G7, G8, B26); immobilisation (G7, G8, B26); lengthy hospitalisation (G7); over-anxious parent (G8); disruptive home circumstances (G7); sudden unprepared discharge (G8); history of previous painful admissions (B26); guilt and anger because the subject felt responsible for her own injury (G8).

Physical and Personal Characteristics

Physical and personal characteristics can modify the child's hospital experience by their influence on the feed-back he receives from the hospital staff (i).

Those children who were generally friendly, co-operative and cheerful engendered a corresponding positive response in the nursing staff (28). There were a few 'problem' children who were not as easy to manage, whose personalities were not as attractive, who succeeded in alienating staff attitudes with the following negativistic behaviour:-

Restlessness or hyperactivity (B8, B13, B17, B20, B21, B22), provocative behaviour (G7, B20, B21, B24, B26), incessant, demanding, attention-seeking behaviour (B8, B12, B20, B21, B22), clinging behaviour (B8), a disdainful, superior attitude (B21, B24), sulky or sullen reactions (G7, B8, B12, B24), unresponsiveness or withdrawal (B8, B17, B24), aggressiveness (B13, B17, B22, B26.)

The unfortunate effect of these subjects' behaviour upon their environment was sometimes compounded by unattractive physical characteristics such as:-

A wan, sullen, unhappy, facial expression (G7, B8, B12, B24), a waxen, pallid complexion (B8, B26), a dull vacant expression (B8, B17), a gaping, open mouth (B8, B17), incessant drooling (B17), an unsteady, shifting gaze (B8, B12, B13, B17, B24, B26), or an unsteady, limping gait (B8, B17).

As a result of an inability to stimulate consistently positive responses in the staff, the quality of the hospital experience of these nine subjects would almost certainly differ considerably from that of the attractive, secure children.

The Illness : The Meaning of the Illness to the Child

The physical illness may have its own unique meaning to the child which in itself may contribute to the degree of emotional upset (i)

Rejection and Punishment. Subjects (G7) and (B7) (ii) suffered increased anxiety because they felt to blame for their injuries. Guilt feelings in (G7) were so intense they expressed themselves in feelings of hostility, anger and resentment towards the environment. To (G7) and (B7), the period of hospitalisation may have been conceived as a form of punishment for wrong-doing. Other subjects suffered feelings of rejection by their peers because of particular physical differences, either congenital abnormalities such as deformed hand and ribs (B21), cleft palate (B11); or disfigurement through injury in infancy such as a scarred face and neck through burns (B26), a mangled, crippled hand (B16) (iii) or an ileal conduit operation (B13). Subjects B13, B24, B25, B26 particularly resented their inability to participate in sport.

(i) Ch. I, p36

(ii) Case Study 12, App I, P132

(iii) Case Study 8, App I, P126.

Fantasies and fears. A heightened state of anxiety after an accident or surgery; or lack of understanding of the circumstances of the illness led others to suffer imaginary fears and anxieties. Subject B12 (i) for instance, imagined that the boys, who had by chasing him caused him to fall and break his leg, had caused his injury by attacking him with the axe they had brandished. Subject B19, in pain after the surgery, feared the ward would be flooded when rain seeped in during a rain storm (ii). Subject B28 suffered grave apprehension through his inability to understand the implications of a spinal operation and the use of a spinal bed (iii).

Misconception through misunderstanding. Subject B15's anxiety was increased when he misunderstood what he overheard his doctors discussing. Subjects G4 and G8 suffered anxiety through lack of information on their treatment or discharge and B19 because he misunderstood explanations given to him.

The Nature of the Illness and its Treatment

The effects of various medical and nursing procedures. In adjusting to the experience of being nursed the patient may regress to a state of dependency. This enforced regression may lead to intense frustration (iv).

Some patients confined to bed for considerable periods grew accustomed to having someone else attend to their bodily needs. Some showed an increasing unwillingness to do things for themselves (G7, B4, B7, B12, B22, B24, B25) and one a gradual regression to a state of dependency (B12). Many like B1, G9, G3, G5, B25, developed some initiative when allowed to plan their own education activities and

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| (i) Case Study 2, App. I p119 | (11) Case Study 6, App. I, p124 |
| (iii) Case Study 10, App. I, p128 | (iv) Ch. I, p37-38 |
| (v) Case Studies 2, 12, 13, 14, App. I, pp118, 132, 134, 136. | |

found solace in recreational activities (i).

Sensori-motor restrictions. Periods of immobilisation in a plaster cast can produce evidence of emotional and intellectual deprivation (ii)

Twelve subjects showed such reactions as:-

Increased docility (G9, B1, B4, B18, B23, B25, B28); rages and temper tantrums (G7, B22, B24); aggression (G7, B22, B24); increasing restlessness (G7, B11, B19, B22, B25); irritability (G7, B11, B22, B24, B25) and bad language (G7, B22, B24). The explosion of intense motor activity described by Langford (iii) was exhibited by B24, B25, B26 after the removal of the plaster cast (iv).

Painful nursing procedures. Painful nursing procedures may be distressing to the child (v). Subjects G2, B6 and G3 showed distress during intravenous injections or enemas but recovered quickly with the support of parents and nurses.

The nature of the illness. Some illnesses such as diarrhoea, ulcerative colitis and tonsillectomies are likely to be associated with emotional upset. Consequently the extreme distress exhibited by G4 (vi) may have been associated with the nature of her illness - ulcerative colitis.

(i) Case Studies 2, 12, 13, 14, App. I, pp118, 132, 134, 136.

(ii) Ch. I, p38

(iii) Ch. I, p39

(iv) Case Studies 2 & 13. App. I, pp118,134.

(v) Ch. I, p39

(vi) Case Study I, App. I, p117.

The trauma of surgery. Surgery presents threats to the child not present in routine hospitalisation (ii). Twenty-three subjects underwent surgical operations. The following reactions as noted in the literature were observed immediately after surgery:-

Negativistic reactions (G7, B3, B12, B16, B22, B26);
 dependent reactions (G1, G2, B11, B12, B14, B23);
 regressive reactions (G2, G4, B1, B2, B3, B9, B10, B12, B25); phobic reactions (G4, B10, B12, B19). Four of these showed residual distress on return home (G4, G7, B3, B9).

Exogenous FactorsParental Attitudes

The child's distress may be increased by a transference of anxiety from parent to child (i)

All parents showed signs of anxiety and tension to a greater or lesser degree, particularly if the child was in pain; prior to, or following the child's operation; or while waiting for test results. This was often communicated to the child (G5, B10, B12, B13, B19, B25). Most parents were able to control their anxiety in order to comfort their children.

Duration of Hospitalisation

Very little correlation was found by researchers between length of stay and ability to adjust on the ward (ii)

Of those unable to adjust, four spent two weeks in hospital (B13, B20, B21, B26), six from between two and five weeks (G7, G8, B8, B6, B17, B23) and five were hospitalised for periods of six weeks or more (G4, B7, B12, B22, B24).

The average length of hospitalisation was five and a half weeks. Long term patients (iii) seemed to go through a sequence of periods of distress, adjustment, further distress and re-adjustment. After an initial period of distress the subject generally settled down to a state of resignation and acceptance interspersed with occasional outbursts of restlessness, impatience, frustration or periods of boredom, gloom or depression. Girls tended to withdraw; boys were more likely to relieve tension in outbursts of horse-play. Tension and frustration commonly increased just prior to mobilisation. Once on his feet the

(i) Ch. I, p42 (ii) Ch. I, p43 (iii) 4 weeks or more.

child often released all his pent-up energy in intense activity (i).

Length of stay and Post-Hospital Responses

Researchers found no relationship between length of stay in hospital and degree of post-hospital disturbance (ii)

Of the eleven children who, according to their parents, showed severe reactions immediately after discharge, six (B5, B8, B9, B13, B16, B21) were in hospital less than four weeks and five (G4, G7, B3, B4, B22) were in hospital for a period of four weeks or more.

Degree of Objective Stress

Opinions of researchers varied on the relationship between the degree of objective stress and the development of psychological upset (iii).

Thirty-one subjects suffered severe physical stress through the nature of their illness or treatment. Whether they were able to cope seemed to depend on such factors as previous personality development and the degree of support they received from parents and the environment.

Quality of Hospital Experience

The quality of the child's hospital experience can affect the degree of upset suffered. (iv)

As the study was set in a progressive paediatric ward with team assignment nursing, emphasis on communication between staff and parents, provision for occupational therapy and play and educational facilities, it is likely that this policy may have been a factor in

(i) Case Studies 2, 10, 12, 13, 14 (ii) Ch. I, p43.

App. I, pp118, 128, 132, 134, 136.

(iii) Ch. I, p44.

(iv) Ch. I, p44.

reducing the degree of the individual child's distress.

Problems in the implementation of the policy would appear to be the low ratio of staff to patients so that children hospitalised for behavioural disorders cannot receive the individual care and supervision they require; constant rotation of nursing staff; difficulties in supervision due to the unsuitability of the architectural design of the ward for its purpose; and occasional communication problems between the various personnel involved in the overall care of the hospitalised child.

Strangeness of the Hospital Setting

The strange environment may be a major cause of anxiety in the hospitalised child. Adequate preparation can minimise the trauma (i).

Sixteen subjects, through accident or sudden illness, were completely unprepared prior to admission. This unpreparedness was undoubtedly a factor in their initial distress as they struggled to adjust to illness and a strange environment.

Twenty-one subjects were prepared prior to hospitalisation by mother or principal attachment figure (10); by the mother and doctor (8); by the father and doctor (1); and by the mother, father and doctor (2).

B28, who is mentally retarded, was very carefully prepared for his spinal operation by his parents and his doctor who even arranged for him to visit the ward prior to his admission so that he would become accustomed to a spinal bed.

(i) Ch. I, p45.

However, despite this care, during the month prior to his admission, he exhibited, according to his teacher, signs of apprehension and fear, due perhaps to the prematurity of his preparation or to his inability to fully comprehend his doctor's explanation. (i).

Although the staff endeavoured to explain strange or painful procedures to the children during hospitalisation in an effort to ease the trauma, some mothers still complained of inconsistent or inadequate information on the part of the medical staff:-

Regarding the consequences of the illness (G5);
prior to an operation (B15, B9); or prior to
discharge (G8, B10, B16) (ii).

- (i) Case Study 10, App. I, pl28.
- (ii) Case Study 6, App. I, pl24.

Education of the Hospitalised Child

Therapeutic Benefits

Education in hospital can have therapeutic benefits for the sick child (i). Most subjects (26) with previous positive attitudes to schooling accepted lessons in hospital willingly, enjoyed being occupied, worked happily and busily and found satisfaction in success and achievement (ii). Some gained a measure of independence when allowed to plan each morning's programme (G3, G9, B11, B23, B28). Those in distress appreciated the opportunity to express their fears and anxieties to the teacher (G1, G3, G4, B22, B23, B25, B27, B28). Even those who rejected schooling were encouraged to express their anxieties and fears during the teacher's daily visits (G7, B21). Those patients who were rarely visited found solace in the daily company of a trusted adult (G2, B1, B2, B4, B8, B13, B17, B22). Others too ill for regular lessons benefited from recreational activities offered (G4, G9, B27). Immature children and emotionally deprived children enjoyed the individual attention (G1, G2, B1, B2, B3, B13, B17, B22).

Some over-anxious, over-protective mothers gained comfort, reassurance and relief when they were able to confide their anxieties to a sympathetic listener. They became co-operative and trusting. This attitude was often transferred to their children (B7, B10, B12, B13, B16, B19, B25).

(i) Ch. II, p62.

(ii) (G1, G2, G3, G4, G5, G6, G8, G9,

B1, B2, B3, B4, B5, B6, B10, B11, B14, B15, B16, B18, B19

B22, B23, B26, B27, B28).

Close liaison between the hospital school teacher and the child's own class teacher resulted in a deeper understanding of the problems experienced by the hospitalised child during convalescence and when struggling to readjust to school. Many schools made special arrangements to accommodate and support those subjects returning to school in plaster or on crutches (G3, G6, G7, G9, B1, B4, B5, B10, B12, B14, B15, B18, B19, B22, B24, B25, B28).

Academic Benefits

Education in hospital can help to prevent educational retardation by providing continuity of schooling (i)

In order to ensure continuity of education, schools were contacted on admission, during hospitalisation and on discharge. The subject used his own books and followed a familiar programme set by his own teacher. Thus the link with that important part of his normal world was maintained. Parental involvement in daily lessons was encouraged to ensure continuity of education after discharge as many parents had to supervise their child's lessons during convalescence.

Those subjects gaining special benefits from the hospital school programme were long term patients (B7, B24, B25, B28), children from Special Schools (G1, B2, B8, B9, B15, B19, B24) and children on remedial programmes (G7, B1, B3, B10, B22).

Though information was not available on the educational progress of all subjects on their return to school, twenty-one were reported to be progressing satisfactorily. Subjects experiencing learning difficulties were B1, B3, B7, B12, B15, B22 and B27. Subjects B1, B12 and B27

(i) Ch. II, p63.

had to repeat a year's schooling. In the case of B1 and B12, this decision had been taken prior to hospitalisation due to their immaturity. B27 had been absent most of the school year due to chronic illness. Subject G7 left school. Subjects B3 and B15, although regressed, were progressing and gradually making up lost ground.

Possible factors in the lack of progress of above subjects were:-

A previous history of learning difficulties (B1, B7, B12, B15, B22); inability to concentrate on lessons in hospital due to illness (B15, B27); or to emotional upset and inability to adjust (G7, B7, B12); inability to continue lessons in convalescence due to illness (B15, B27); or inability or unwillingness of parent to supervise (B3, B7, B22); lengthy period of convalescence (B27 - 14 weeks, B3 - 8 weeks, B7 - 8 weeks, B15 - 8 weeks, B22 - 12 weeks) FN (4); disruptive home environment (G7, B22), as well as a long period of hospitalisation (B7 - 6 months, B22 - 8 weeks, B12 - 10 weeks).

Problems of the Hospital School Teacher

Teaching in hospital presents the teacher with a multitude of problems (i)

The subjects varied in age, grade, intelligence and degree of handicap. They were taught in open ward conditions with parents free to visit at any time and with constant interruptions from nursing or medical personnel.

(i) Ch. II, p65.

Consequently, owing to the shortage of time available for lessons because of the necessity to give precedence to the child's medical care and the need to fit in with hospital routine, it was necessary to plan lessons carefully so that each pupil should receive optimum benefit therefrom.

The teacher encountered problems in avoiding tiring the child suffering from a debilitating illness (B7, B12), in varying her approach to the child's fluctuating condition, mood, behaviour or attitude (G5, G7, B17, B21, B24, B25); in encouraging independence and initiative in the dependent hospitalised child (G4, G7, B7, B12, B22, B24, B28); in sustaining interest in the long-term patient (B7, B12, B22, B24, B25, B28) and in devising methods of teaching the child in an uncomfortable position or with a short attention span (B17, B8, B9, B13).

The emotionally deprived children presented special problems because of their incessant attention-seeking behaviour; their unwillingness to share the teacher's attention with others; their inability to relate with other children and their increased distractibility and restlessness in the hospital environment (B7, B8, B12, B13, B17, B20, B21, B22, B24, B26).

The over-anxious, excitable, highly emotional or over-protective parent required careful diplomatic handling. Some set unrealistically high scholastic standards for their children (B7, B12). Paradoxically others at first suspiciously rejected offers of schooling in case undue stress was placed on their children but later appreciated the progress made (B10, B18).

Both the hospitalised child and his parents have a very special need for the teacher's support, understanding, encouragement and attention because of the special stress, anxieties, fears and fantasies involved in the hospital experience.

The Problems of the Hospitalised Student

The child in hospital may experience problems concentrating on his lessons (i). In attempting lessons, the subjects had to tolerate not only the constant interruptions of nursing staff, but also the fluctuations in their own physical, mental and emotional state due to illness, enforced immobility, length of hospitalisation or methods of treatment.

Some children had difficulty in concentrating because of anxieties and fears (G4, G7, G8, B12, B15, B19, B23). Others were distracted by the noise of other children (B4, B16, B18). Many (28) in uncomfortable positions in traction, plaster casts or spinal beds found it difficult to write. Another was upset by the sight or sound of other children in distress or pain (B4).

Hyperactive children found the noise, bustle, movement, crowds and bright lights of the hospital environment highly stimulating (B8, B13, B17, B20, B21, B22, B26). Their disruptive, aggressive behaviour often annoyed and frightened other patients attempting to concentrate (B7, B10, B25).

Various factors as difficulty in concentrating, strangeness of the hospital setting, noise, frequent interruptions, stress of illness,

(i) Ch. II, p67.

various anxieties and fears led to a tendency in the hospitalised pupil to require a greater degree of personal supervision and attention than the pupil in the normal classroom. Only twelve of the thirty-seven subjects were capable of working independently (i). The remainder required individual guidance to a greater or lesser degree, five requiring the exclusive one to one relationship in order to concentrate (ii).

Implications for the Hospital School Teacher

It is important for the teacher to adopt a realistic, objective attitude to her demanding work. She alone cannot supply all the love and attention needed by her students, particularly those emotionally deprived, insecure or maladjusted. For no matter how strong the bond which develops between teacher and pupil, it is at best a temporary bond which will be broken on discharge. She can best support the child emotionally by adopting the role of a friendly, sympathetic, reassuring adult, by shedding all appearance of business and efficiency, by giving the impression of calm leisureliness and by spending time to listen - even if only for a few minutes.

Similarly, in regard to her educational role, she may not always be able to bridge the gap in her pupil's schooling where there is acute illness or emotional distress. The educational programme must be flexible, tempered to the circumstances of the child's illness and the daily fluctuations in ward atmosphere in order to make the best use of time and energy available; and directed towards the development of basic skills or the remediation of weaknesses under the guidance of the child's own class teacher who knows him best.

(i) G3, G5, G6, G9, B5, B6, B11, B15, B16, B18, B23, B27,

(ii) B7, B8, B12, B13, B17.

Lastly, it is clear that her responsibilities do not cease on discharge. There is a need for continuing liaison with the schools in order that the teachers are fully informed of any emotional or educational problems observed in hospital and to ensure that the long period of convalescence experienced by some patients does not result in further educational retardation.

Conclusion

There was no indication available from the observational studies of grave impairment in the children due to hospitalisation. Indeed, some evidently found it a rewarding experience. Nevertheless, most still suffered considerable emotional distress in their struggle to adjust. That so many were able to adjust was possibly due to the following factors:-

The friendly, relaxed hospital atmosphere; the provision of recreational and educational facilities; the availability of parental support; various inherent constitutional personality factors in the individual child; and the natural resilience of childhood.

Those children best able to adjust appeared to be stable children with secure parental relationships and adequate parental support. The children showing severe reactions in hospital tended to be those with a history of emotional insecurity or maladjusted behaviour and those not receiving adequate parental support. Other factors modifying the child's distress were age, length of hospitalisation, severity of illness, communication problems, difficulties in preparation due to subject's limited intelligence, various fantasies and fears due to the subjects' own conception of his illness, the high noise level in the ward and the disruptive behaviour of other children.

The emotionally deprived child is 'at risk' in a hospital ward. At present total nursing care is given unquestioningly to the extremely physically ill child. Yet the desperate need of the deprived child for a 'psychological parent' - for someone to fulfil his absent or non-existent parent's role - is not recognised. Instead he is subjected to the fragmented care of a constantly changing nursing staff. There is a great need for substitute parents to care for children at present alone in hospital wards and reacting to the lack of attention with aggressive, disruptive behaviour.

FOOTNOTES CHAPTER III

(1) The Bristol Social Adjustment Guide (B.S.A.G.) by a process of observation, description and classification, provides a means of assessing behaviour disturbances in children aged 5 - 16 years in a classroom setting. It consists of a series of paragraphs containing descriptive phrases which give variants of responses to defined situations and are carefully worded to arrive at the least ambiguous means of reporting mal-adjusted behaviour. The teacher, who it is assumed has had the opportunity to observe the child for a period of a month or more, is required to underline one or more phrases in each paragraph which best apply to the child or may leave the whole paragraph blank if none applies. There is no overall score. Instead, there are two main scales representing under- and over-reacting modes of behaviour, named for short "Unract" and Ovract. The core syndromes within these scales are also scored separately to indicate that one is not dealing with homogenous dimensions. The B.S.A.G. does not claim to be a measure of the child's 'personality' but merely purports "to record the child's responses to a particularly human and physical situation notably to a single teacher" (Stott, 1974, p8).

(2) It was difficult to retain objectivity and avoid 'observer bias' when assessing whether or not subjects had adjusted to hospitalisation. For example, Subjects B15, and B19 who showed initial distress but successfully settled later were rated 'adjusted' whereas B26, apparently settled at first but later reacted with aggressive, disruptive behaviour and was rated 'not adjusted'.

(3) Observations on subjects' reactions were charted on a simple tick graph to obtain quantitative data.

(4) The average length of convalescence was 10 days. Seven subjects (G9, B3, B7, B12, B15, B22, B27) experienced a convalescence of more than five weeks. Subject G9 (3 weeks hospitalisation plus 13 weeks convalescence) continued her lessons at home and needed no remedial help on return to school. Subject B22's mother had refused to allow him to return to school in plaster for fear of further injury.

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CONCLUSION

Early studies of institutionalised infants revealed the detrimental effects of severe deprivation on the future development of young children. Bowlby's subsequent research emphasised the importance of the mother-child relationship in early childhood and demonstrated the dangers of gross maternal deprivation. The controversy aroused by Bowlby's theories stimulated further research in the whole field of child care and focussed the attention of paediatricians and others on 'separation anxiety' as a possible factor in the distress of the hospitalised child.

Consequently, follow-up studies revealed many other possible modifying factors involved such as age, sex, deviation of deprivation, degree of preparation and parental attitudes. Moreover they emphasised the great individual variation in children's responses to deprivation and recognised the need to distinguish various degrees of deprivation and qualities of mothering.

In the paediatric field, research findings led to energetic attempts to alleviate possible damage to the individual child due to hospitalisation. Various measures, aimed at reducing the degree of 'separation-anxiety' were introduced including the admission of the mother with her child and the liberalisation of visiting hours. Other innovators sought to improve the quality of the hospital experience by the provision of recreational and educational facilities.

Gradually it has become the practice to introduce schooling in hospital as one way of modifying the trauma of hospitalisation. The principal aims are to assist the child to adjust to his illness and

his surroundings and to prevent possible educational retardation. There is an important difference in approach in hospital teaching in that medical treatment and the child's physical health must take priority over the educational programme.

The special problems of the hospital teacher include isolation from her fellow professionals, the diversification of pupil programmes and teaching activities, the heterogeneity of abilities and levels of the pupils and the ever-changing composition of the class. The special problems of the hospital student include limitation of experiences, lack of stimulation and difficulties in concentration due to illness, fatigue, lassitude, emotional distress or frequent interruptions.

Consequently there is a need for individuality of approach and the development in the teacher of special qualities of perception, sympathy, understanding, patience, flexibility and of the ability to relate to others. In order to be effective hospital teaching must be not only academically strong, but creative, versatile, ingenious and adaptive to changing circumstances. Above all, the hospital teacher must be aware of the possible adverse effects of hospitalisation on the child and the various factors modifying his emotional distress.

The descriptive study, which attempted to illustrate the reactions of individual children to hospitalisation, the various factors involved in their adjustment and any consequent positive or negative effects, was set in a ward where every effort was made to alleviate the child's anxiety by attempting to cater for his individual emotional needs.

Most children were able to adjust happily to hospitalisation. Those unable to adjust were mainly children with a previous history of emotional disturbance, those with distorted parental relationships or those whose parents were unable, for various reasons, to provide them with adequate emotional support while in hospital.

The students' reactions varied according to age, sex and length of stay. Hospitalisation also affected subjects' responses to schooling in that they manifested a greater need for individual attention than normal and experienced greater difficulties in concentrating.

While many subjects showed an improvement in post-hospital behaviour, over half showed a deterioration in behaviour at home immediately after discharge though this was usually temporary in nature. There was no discernible deterioration in behaviour due to hospitalisation after the subject's return to school. However, eight had regressed educationally due to lengthy convalescence. The study therefore demonstrated the responsibility of the hospital teacher to continue to liaise with the school and the home after discharge in order to facilitate continuity of schooling for each student. It also revealed the special educational problems of the convalescent child whose parents either neglected to, or had difficulties in, organising or supervising their child's schooling. Finally, it is clear that, in spite of remedial measures taken in the modern paediatric ward, many children still suffer considerable emotional distress during hospitalisation and may have difficulties adjusting later either at home or at school.

Consequently, the hospital teacher has a double role to play in the rehabilitation of the hospitalised child. Besides her obvious academic function of continuing the students' schooling in order

to prevent possible educational retardation, she has an equally important therapeutic role to fulfil.

The provision of stimulating, enjoyable learning activities can help distract the child's mind from his anxiety and keep him happily and busily engaged while he recuperates. The realisation that he is important to the teacher as an individual in his own right rather than as a 'condition' can help to restore his sense of perspective and balance. The teacher helps even further by providing the element of the familiar in ordinary tasks and books. More especially, she provides him with the opportunity to express his anxieties and fears in play, drawing, writing or conversation. Lastly, she can help him establish a bridge between the detached, unfamiliar world of the hospital and the familiar world outside. The provision of schooling, by reassuring the child of his eventual recovery and return to normal life, provides a link between past, present and future, and encourages a sense of continuity, optimism and reality.

APPENDIX I

Case Study Summaries

1. Unstable Pre-Hospital Behaviour. Inability to Adjust due to severe, painful illness but positive reaction after discharge.

Subject (G4) (9, 10) (4, 0) a 9 year old girl admitted for 6 weeks with acute gastritis involving three operations for abscesses in stomach and pelvis and a period in Intensive Care. FN (1)

Pre-Hospital Behaviour

G4 had shown withdrawal, timidity and depression as well as distractibility, hyperactivity and hostility due probably to the fact that she had been ill and in pain prior to hospitalisation.

Hospital Behaviour

G4 appeared to be in a state of nervous shock throughout her stay in 1A. Very thin and pale, with tight little face and frightened bulging eyes, she appeared weak, listless and fragile. Miserable and tense, she became particularly nervous before daily dressings or injections which she dreaded. She retained vivid memories of the painful probing she had endured when admitted semi-conscious. Too depressed and unhappy to participate in ward activities, she usually withdrew under the bed-clothes, communicating in a whisper only with her mother for whom she waited anxiously each day. Too ill to concentrate on lessons, she was given activities aimed at distracting her mind from her illness and at encouraging her to respond to others.

Post-Hospital Behaviour

After discharge she returned quite soon to school, made an excellent recovery and settled back very well, both at home and at school. She suffered no negative reactions although her mother reported that she was "more possessive than usual" at first.

Clearly her disturbed pre-hospital behaviour was due to her illness and lower B.S.A.G. II scores were due to the improvement in her health.

2. Unstable Pre-Hospital Behaviour. Inability to Adjust

Subject B12, an eight year old boy hospitalised for 10 weeks with a fractured femur. (7, 9) (3, 4).

Pre-Hospital Behaviour

B12 had shown disruptive, hyperactive, aggressive, hostile behaviour in school.

Home Circumstances - Background Information

His mother, who found him difficult to manage, admitted there was considerable tension between them. In an effort to foster independence and toughness in him, she had encouraged him to play on his own in the district. B12 may have interpreted this as rejection as he was evidently afraid of the youth of the district whom he regarded as his "enemies" FN (2).

Bad feeling had developed between B12's family and the neighbourhood youth because his father had denied them right-of-way through his property to the beach. These boys, busy building a tree house, had caught B12 spying on them. Thereupon they chased him, one

of them brandishing an axe. B12, terrified, fell down a bank, fracturing his leg.

Hospital Behaviour

B12 appeared to be in a state of nervous shock - dazed, apathetic and unresponsive. Gradually, it became apparent that he was (wrongly) convinced that his injury was due to his "enemies" attacking him with an axe. Even after the truth was explained, he was unable to settle but continued to show extreme variations in mood such as moody depression, grumpy hostility and noisy exhibitionism. At times he appeared delirious and irrational. He actively sought adult attention by continuously calling out in a loud voice.

He responded to his mother's visits by either adopting babyish ways (sucking his thumb, whining and grunting in a babyish voice, clinging to her; begging her not to go) or by openly misbehaving (becoming petulant, defiant or demanding); so that she became extremely worried and disturbed. She was openly critical of the standard of care he received and the lack of supervision on the wards.

Response to Hospital School

Immobilised in traction or in plaster, B12 gradually lost all interest and incentive, becoming so passive and detached that it was almost impossible to stimulate any interest in his lessons in him. He had difficulty concentrating but did his best to co-operate in accordance with his mother's wishes. School constituted his sole activity. After lessons, he withdrew under the bedclothes showing little inclination to play or communicate with other children except in occasional exhibitionistic displays. He was very fearful of one disturbed child who attacked him, and extremely jealous of any attention shown to others by the teacher. Because of his exhibitionistic and hostile behaviour he was extremely

disliked by other patients who teased him unmercifully. He remained in hospital several weeks longer than necessary as his mother was unwilling to nurse him at home in plaster.

Post-Hospital Behaviour

His mother reported unsettled, frustrated behaviour at first but said that he was "trying very hard to behave". On his return to school after a long absence, his teacher reported an improvement in his behaviour and general attitude.

Possible factors in B12's inability to adjust were his pre-hospital behaviour with a history of hyperactive disruptive behaviour, general emotional insecurity due to the strained ambivalent relationship with his mother, the emotional trauma of the accident, his fantasies and fears due to his misconception of the events contributing to his injury, his restricted mobility, the length of his hospitalisation and his general inability to relate with his peers.

(3) Unstable Pre-Hospital Behaviour - Well-Adjusted in Hospital

Subject B1 (3, 13), (5, 14) a six year old boy hospitalised for four weeks with a dislocated hip from a fall from an apple truck.

Pre-Hospital Behaviour

B1 had been unable to settle down at school where he had shown disruptive, distractible, hyperactive, attention-seeking behaviour. In Prep he had cried three mornings out of five. This weepy behaviour had persisted in Grade 1 to such an extent that his teacher intended to recommend that he repeat Grade 1.

Hospital Behaviour

Though distressed at first, B1 soon settled down to his period in traction supported by his mother's visits and those of his many relatives and friends. His mother, though involved in packing apples at the height of the apple season, managed to visit daily. There was a very close bond between her and B1, the youngest of her three children.

Hospital School

B1, who related well with the nurses and other patients, joining happily in games in the ward or playroom, also enjoyed his lessons though he needed individual help and attention. With the use of structural aids, he was able to understand the process of subtraction and complete simple sums without confusing addition and subtraction signs as formerly. The use of a Language Master extended his short concentration span and reinforced weak phonic blending skills. As word recognition of sight words and word attack skills were weak, taped reading lessons aided concentration and gave him more confidence in reading.

After his return home, he settled very happily but continued to display unsettled behaviour at school. This behaviour was possibly due to his immaturity, lack of readiness for learning, the close tie with his mother or his reactions to the school environment. His ability to settle in hospital may have been due to the relaxed, friendly environment.

(4) Inability to Adjust at School, Well-adjusted in Hospital

Subject B14 10 year old boy hospitalised for 6 weeks with fractured femur (10, 0) (8, 0).

Pre-Hospital Behaviour

B14 had shown timid, dependent, withdrawn behaviour due, according to his teacher, to the fact that his over-protective mother would not allow him to join in normal boyhood activities.

Hospital Experience

Though in distress at first, B14 quickly settled and enjoyed the company of his peers. His mother was unable to visit daily because of distance but visited regularly. B14, relishing the friendly relaxed atmosphere, gradually became more outgoing, noisy and boisterous. He appreciated help with school lessons, worked quietly, conscientiously and diligently, sought assistance only where necessary and gradually developed more self-confidence.

Discharge

Though his Doctor advised an immediate return to school on crutches, his mother, fearful that he would injure himself, resisted, inventing all sorts of excuses to prevent it.

When he eventually returned after a fortnight, B14 coped very well because the headmaster, his teacher and his fellow pupils actively aided his rehabilitation. Great care was taken not to jostle him. His friends met him at the school gate and helped him walk from the car to his classroom on his crutches.

B14, I believe, had found hospitalisation to be a rewarding experience.

5. Stable Personality and Ability to Adjust

Subject B15 (0, 0) (0, 0), a 10 year old boy hospitalised for two weeks for tests and neurosurgery. He was partially sighted and partially paralysed as a result of a tumour operation five years previously.

Pre-Hospital Behaviour

His teacher described him as a socially and emotionally mature lad, who always gave of his best in class, and whose selfless attitude was an inspiration to staff and pupils. He helped his teacher sort out other children's problems. He was very conscious of his disability but striving very hard to adjust.

"I wish people wouldn't poke fun at people who are cross-eyed like me" FN (3).

Parental Support

B15 was sustained by the quiet, loving presence of his grandmother who had brought him up. She was his constant companion. His mother, step-father and other relatives visited regularly.

Hospital Behaviour

B15, already nervous and anxious awaiting his test results, became even more disturbed when he accidentally overheard his doctors' bedside conference and concluded that he must undergo further neurosurgery. He confided in the Hospital Teacher exclaiming that he ought to be told the truth. Consequently, when his doctors had explained the forthcoming procedures fully to him, B15 was able to accept, adjust and face the operation and the long convalescence with equanimity. He was distressed after brain surgery to find that his head had been shaved but cheered up when he was given a woollen cap to wear.

He consequently made an excellent recovery, settled back extremely well both at home and at school though he had regressed academically through his long convalescence.

6. Subject B19 a 10 year old boy with cerebral palsy was hospitalised for four weeks for corrective surgery on left and right achilles tendons.

Pre-Hospital Personality

A friendly, cheerful, affectionate, stable boy whose loving, supportive parents had carefully explained that the process would involve one operation and a fortnight in hospital.

Hospital Experience

Unfortunately, the surgeon changed his mind while operating so that B19 recovering in considerable pain, found it very difficult to accept that he must undergo a second unexpected operation and a longer period in hospital. He showed considerable distress, suffered night-mares, fantasies and fears:-

For example, one night during a rain storm, he was convinced the ward would be flooded when rain seeped down the corner of the window.

His mother was also distressed as she felt she had betrayed her son's trust in her by inadvertantly giving him incorrect information.

Hospital School

B19 was mentally and physically handicapped, visually impaired with slowed, blurred speech and unco-ordinated movements. Nevertheless he was extremely well-motivated; setting himself high standards which he strove to achieve. Blessed with a retentive memory, by listening

intently he was able to retain auditorally what he was taught. Daily lessons, which he enjoyed, distracted his thoughts from pain and helped relieve some of the stress and tension. After his second operation he settled happily with the daily support of both his parents.

Post-Hospital Behaviour

After discharge he showed some frustration and restlessness, even asking to return to hospital as he had not expected to be still in pain. At school, though in difficulties at first, because his movements were restricted by plaster casts and crutches, he gamely persevered and soon settled.

Discussion

An important factor in B19's distress was his low intellectual capacity which made it difficult for him to fully comprehend the processes involved in his operation and particularly difficult for him to adapt to a sudden change of plans. However, thanks to his happy, secure family relationships, he was unaffected in the long term by his experience.

7. Stable Personality - Inability to Adjust

Subject B23 an eleven year old boy hospitalised for four weeks with internal injuries and a fractured femur due to a car accident. (0, 0) (2, 0).

Pre-Hospital Personality

A stable, courteous, sociable, cheerful lad with a positive attitude towards his studies. B23 was a member of a large close-knit family who visited regularly during his stay.

Hospital Experience

B23 had two operations for the removal of his appendix and the

insertion of a pin in his leg. Immobilised in traction, then in plaster, he suffered considerable pain and discomfort which he endured patiently. When retained longer than he expected, he became depressed and withdrawn. Though visited regularly, he was often in tears as he grieved for his home. He also missed his sport and deeply regretted the postponement of his confirmation.

Hospital School

He sought lessons, finding comfort in familiar tasks. Though in considerable pain and discomfort, he worked with great persistence and determination, revealing himself to be an interested, well-motivated, independent student.

Post-Hospital Behaviour

At home, B23 was frustrated and impatient at first through the restrictions imposed on his mobility by his crutches. On his return to school, still on crutches, he suffered another fall. Though withdrawn and quiet at first, he recovered quickly, caught up with work he had missed and performed well in his final examinations.

8. Stable Personality and Inability to Adjust

Subject B16 a 10 year old boy hospitalised for three weeks for plastic surgery on a crippled hand which he had injured two years previously in a bread-making machine.

Pre-Hospital Personality

Though a stable, co-operative, cheerful boy (2, 0) (1, 1) B16 was very conscious of his disability which prevented his acceptance by his peers.

Hospital Behaviour

Though confined to bed at first, B16 was later allowed up with his arm in a sling. A quiet, shy, sensitive lad, he was very protective and loving towards his little brother during family visits. Though visited daily by his family, he appeared drowsy, sleepy and lethargic, apparently disturbed by the noisy disruptive behaviour in his ward. Though keen on his lessons, he was unable to concentrate for long because of fatigue, restlessness and emotional tension.

Post-Hospital Behaviour

On his return home, he manifested most uncharacteristic moody, restless, unsettled behaviour. Seeking to postpone his return to school through anxiety over his acceptance by his peers, his lack of educational progress, and fear of injury to his hand, he became irritable and argumentative with his father. He was unco-operative and defiant towards his mother - often flying into tantrums - and aggressive towards his siblings. On his return to school, he appeared to be his usual quiet self, though somewhat on the fringe of things in the playground.

Parental Attitudes

Though B16's family had been very supportive and loving, his mother had been very critical of the standard of care, lack of supervision and lack of discipline in the ward. Her attitude may have contributed to his distress. Other possible factors were the strange environment, noise, fear of bodily harm and future acceptance by his peers and fear of being 'different'.

9. Adequate Parental Support and Ability to Adjust

Subject G3 (0, 0) (0, 0) a nine year old girl hospitalised for ten days

for removal of pin from previously fractured femur.

Pre-Hospital Behaviour

G3 was considered to be a stable, cheerful girl.

Hospital Behaviour

In hospital, G3 enjoyed the support of her father and mother who visited daily for long periods. She was also visited by her grandmother, relatives, friends, her school teacher and classmates. When her leg became very swollen due to an allergy after surgery, G3 suffered much pain and distress which she endured very patiently. Indeed she was even able to comfort her mother who became acutely distressed by her daughter's sufferings.

Post-Hospital Behaviour

G3 settled back very happily at home and at school. Her mother reported that, since her discharge, she had become more outgoing, loving and affectionate.

10. Subject B28, (0, 4) (0, 1) a fifteen year old, physically handicapped, mentally retarded boy hospitalised for spinal fusion and insertion of Herrington Rods.

Pre-Hospital Behaviour

B28 was stable, quiet, friendly and well-mannered.

Preparation

B28 visited the hospital some time before his operation in order to be accustomed to the spinal bed. Though very carefully prepared, he had shown considerable apprehension for months prior to the operation according to his teacher so may have been prepared too early.

Hospital Experience

After the operation, B28 was immobilised for four months in a spinal bed which was turned every three hours. After his operation, he became so quiet and withdrawn that the nurses found it difficult to ascertain whether or not he was comfortable. He was afraid to move for fear of hurting his back. Consequently, in a bid to overcome his fear, the Hospital Teacher was asked to devise activities which would encourage him to use his hands and to communicate with others.

Hospital School

B28 enjoyed his daily lessons which followed a special programme planned by his own class teacher using his own familiar books and materials. He gained comfort from the knowledge that he was keeping up with his class and satisfaction with each completed unit. He soon grew confident enough to discuss his frustrations and worries with the teacher.

"How many more days before I get up?"

"I'm half a nut."

"I haven't got too many brains." FN (4)

Together they made a calendar on which he gleefully crossed off each day and counted off those still remaining. He enjoyed tactile activities, watching television or completing jigsaws. He settled down well and endured his long immobilisation with forbearance and patience. He finally returned home, exhibiting no change in behaviour and settled happily back at school.

Parental Support

An important factor in B28's successful adjustment was the continuing presence of cheerful, loving parents, relatives and friends. His mother visited daily, his father ate his lunch in B28's room;

various relatives came throughout the day so that although B28 was isolated in a single room, he was not alone. His teacher and classmates also visited several times. His parents were cheerful and comforting. They teased him in a good humoured fashion, and enjoyed jokes together so that his spirit was cheered by their presence.

II. Lack of Permanent Mother Figure

Subject B8 (0 19) (0 10), an eight year old boy and Ward of the State, hospitalised for observation and stabilisation of disturbed, disruptive behaviour at home and at school following the transfer of his house-mother.

Health and Social History

B8 had become a spastic haemiplegic following an operation for a subdural haematoma (possibly of traumatic origin) at six months. After discharge at 2½ he was adopted but was made a Ward of the State at five when his adoptive parents found him too difficult to manage. During this period, he was frequently hospitalised for severe bruising, pneumonia, respiratory infections, burns and major epileptic fits. By the age of 8 he had been in three foster homes and several institutions with so many changes in mother figure that he had never been able to form a permanent attachment to any one. A brain-damaged child, he was mentally retarded, physically unco-ordinated, emotionally unstable with retarded language development and a clumsy gait.

Pre-Hospital Personality

A very restless, hyperactive child, with a deep craving for adult attention and affection, he needed constant assurance that he was loved. At school, he continuously disrupted the class by incessantly

calling out for attention. Totally unable to relate to his peers, he became aggressive if crossed in play. Similarly, though usually polite and courteous to adults, he reacted strongly if frustrated. He was making very slow progress in learning because of his many disabilities, his short attention span, distractibility, lack of concentration and difficulties in writing.

Hospital Behaviour

B8 incessantly sought adult attention and approval. He wandered restlessly round the ward attaching himself to any available adult. Desperate for love, he demanded one's exclusive continuous attention. Though he begged for lessons each morning, he was unable to concentrate for very long, it was the personal attention and presence of the teacher he really craved. Unable to occupy himself, too egocentric to play successfully with others, his behaviour in a play situation frequently became so aggressive and disruptive that he required constant supervision. His impetuosity, egocentricity, stubbornness, possessiveness and aggressiveness alienated him from other patients who either avoided him or abused him. He found solace in food, eating and drinking voraciously.

Post-Hospital Behaviour

After discharge, he was transferred to yet another children's home and another special School. The new placement was apparently successful as he made a happy adjustment and his behaviour at school was much improved.

B8's mental retardation originally due to brain damage was compounded by disruptive, unstable home environment and considerable periods spent in institutions. His emotional instability was probably due to these factors and the fact that he had known no single mother figure but a series of foster mothers and house mothers.

12. Lack of Stable Parental Support through Over-anxiety on the part of the Parents.

Subject B7 (10, 5) (0, 4) a seven year old boy, a spina bifida, hydrocephalic, epileptic, with a Holter shunt, was hospitalised for six months with extensive burns over the lower half of his body sustained when he had scalded himself when left unattended for a few minutes in his bath.

Pre-Hospital Behaviour

Though well-mannered, polite, friendly and extremely talkative, B7 was also timid, nervous and insecure being extremely over-protected by over-anxious, excitable, highly emotional parents.

School Achievement

B7 was severely retarded intellectually due to difficulties in concentration, short attention span, distractibility, impaired visual motor control, an ocular defect, problems in direction and spatial relationships, lack of fine or gross motor control, impoverished pre-school play experiences and frequent absences from school through illness or hospitalisation. His hands were so weak and lifeless that he was unable to hold a pencil firmly enough to write.

Hospital Experience

Seriously ill, B7 had spent a considerable period in Intensive Care before admission to 1A where he endured daily saline baths, dressings and several skin-graft operations. He also suffered recurring kidney and bladder infections. Although his mother was allowed to participate in his care she was very critical of the standard of care he received.

Parental Attitudes

His mother was an over-anxious, over-protective, dominating woman who waited on B7 hand and foot to such an extent that he had become so completely dependent on her that he scarcely used his hands at all. Desperately clinging to her very unrealistic view of his intellectual capabilities, she was so impatient with his apparent lack of progress at school that she was teaching him herself. Furthermore, she criticised his school and discussed his disabilities in front of him.

Though she showered him with expensive toys, B7 played with a small collection of objects he kept in his lap:-

Keys, a syringe, a car, a pencil and a whistle.

These he simply grasped and ungrasped, and, apart from imaginative play (acting out injections with a doll) he demanded adult participation and direction before he would attempt to play with anything else.

Hospital Behaviour

B7 gradually retreated into a state of passivity, dependence and withdrawal, becoming so tense and nervous before pending operations or medical procedures that he was unable to eat or to think of anything else. He was also very fearful of a disturbed patient who regularly terrorised him.

Hospital School

Though co-operative, friendly and obedient, B7 was passive, detached, difficult to stimulate and a completely dependent learner who required a highly organised structural approach with each task organised into finely graded steps. His responses were vague, immature and often inconsequential. Because of extreme distractibility and his many learning disabilities, his retention was minimal; therefore constant revision and repetition was necessary.

Although he had made only limited scholastic progress at the end of six months, he had developed some degree of independence through encouragement to pick up and put away his own equipment. His hand grip had definitely strengthened through simple tactile activities (screwing and unscrewing, building towers with blocks) geared to his level of manipulative development.

In spite of the fact that B7's mother accompanied by a toddler she minded, continually interrupted, interfered and prompted, she was encouraged to observe his daily lessons in the hope that she might learn to recognise and accept his limitations and realise the need to foster independence.

Post-Hospital Behaviour

B7's mother reported that he had become more mature and independent. His teacher reported that though he had settled back happily, because of a long period of convalescence, he was making only very slow progress.

13. Long Period of Hospitalisation - Unsettled Behaviour in Hospital

Subject B24 (3,17) (2, 0) an 11 year old boy hospitalised for three months with a fractured femur.

Pre-Hospital Behaviour

Had shown disturbed behaviour such as distractibility, hostility, moodiness, aggressiveness, restlessness and sullenness. Though his scholastic achievement was poor, particularly in reading, he excelled in sport, having been chosen as a member of the State football team.

Family History

The youngest of three children, B24 was still babied and over-protected by his mother. In 1974 when his teacher had suggested his repeating Grade V, his mother had removed him to another school. Her critical opinion of the teaching profession was reflected in her son's attitude and behaviour.

Hospital Behaviour

B24, a handsome child, amply endowed with charm, was friendly, sociable and popular with his peers, over-familiar and flirtatious with the nurses, aggressive and impatient with younger patients and rather disdainful and superior towards the cleaners and kitchen staff. Craving the plaudits of his peers, he boasted of his sporting prowess or indulged in exhibitionistic displays. His moods varied from withdrawal, depression, sullenness to boisterous, noisy, aggressiveness. He often chafed against his immobility and length of stay. He frequently reacted to his mother's visits with weepy, whining, clinging behaviour. His tension and restlessness increased prior to his traction being removed due to his anxiety that he be left with a limp which would prevent his playing football.

Responses to Hospital School

B24 displayed a most ambivalent attitude to learning. Conscious of failure, he longed to succeed but lacked the confidence to tackle anything new or the willingness to exert himself. When faced with a task demanding concentration or effort, he often withdrew under the bedclothes, feigning sleep or threatened he would complain to his mother. His attitude towards the teacher was hostile, resentful, evasive, argumentative and tinged with malice and mistrust. Dreading the jeers of his mates, he refused to raise his voice above a whisper when reading. A dependent learner, he appreciated and demanded individual assistance, reaching jealously with attention-seeking tactics such as pencil-tapping or dis-

ruptive behaviour if the teacher's attention was engaged elsewhere. With tactful patient firm handling and a great deal of persuasion and praise, he eventually accepted the teacher as his friend and began to apply himself to his work. Gaining in confidence, he began to develop some initiative, independence and pride in his work and a sense of achievement, particularly when he began to show improvement in mathematics and reading. He was particularly proud of two projects on "A Hospital Ward" and "Football" which he had carefully completed.

Post-Hospital Reactions

Although his mother reported grumpy, moody, unco-operative 'difficult' behaviour at first, he found great physical and emotional release in weekly hydrotherapy sessions. On his return to school, his teacher reported much quieter behaviour and an improved attitude to learning.

Possible factors in B24's unsettled response to hospitalisation were his mother's over-protectiveness, a previous history of inability to adjust in a school situation, fear of bodily harm and of inability to participate in sport.

14. Long Period of Hospitalisation - Successful Adjustment

Subject B25 12 year old boy.

Complaint - Slipped epiphysis of femur - period 5 months.

B.S.A.G. Scores - (1, 1) (0 2).

Pre-Hospital Behaviour

Both parents were concerned, interested, loving and supportive. B25's father and his doctor had explained forthcoming procedures to him. His mother, who visited daily, encouraged him to talk about his problems

and frustrations. Both parents visited prior to operations.

Hospital Experience

B25 endured a period in traction, a series of operations when pins were inserted in both hip joints, followed each time by a period in a spitier cast, when, encased in plaster up to his armpits, he lay supine on his back or his stomach.

Hospital Behaviour

Blessed with a sense of humour and a great fighting spirit, B25 successfully made a series of adjustments interspersed with periods of despondency. When the removal of his plaster was delayed after the first operation due to an infection, though very anxious and worried, he finally accepted as inevitable the longer period of hospitalisation. A fluent conversationalist, he was able to express and reveal his anxieties about his health and his future ability to participate in sport, his frustration over his enforced immobility and length of stay, his fear of surgery, his impatience with noisy children who disturbed his rest and his wariness of a disturbed child who regularly attacked him and against whom he had craftily developed a defence system. On his approach, he put his school books away, hid his treasures, retracted his TV aerial and grasped his crutch as a defence.

He found solace in building complicated structures in 'Leggo' and in assuming the role of hospital jester. He successfully had his bed placed where he could superintend ward activities. He delighted in firing witty salvos at all and sundry, in playing practical jokes on the staff, in displaying elaborate "keep off" warning signs on his bed and in wearing nurses' caps or bizarre spectacles. His mother became alarmed lest this uncharacteristic exhibitionistic behaviour might offend

but B25 was popular with the staff who took all his cheeky banter in good part, there being no underlying malice or hostility.

Reactions to Hospital School

B25 was not over-industrious or keen to work in hospital. In his own cheerful, inimitable fashion, he sought to limit the time spent on lessons by engaging in long arguments, discussions or conversations with the teacher, feigning sleep, illness or other manipulative ploys. He finally admitted defeat, settled cheerfully to work and managed to keep up in basic subjects.

Pre-Discharge Behaviour

Towards the end of his stay, B25 began to show signs that he had adapted too well to his environment by exhibiting self-centred dependent, demanding behaviour and by beginning to concentrate his thoughts on his own body and its needs. This tendency was countered by sending him home for week-end visits and by allowing him to spend part of his convalescence after his second operation at home. Impatient to return on his final visit, he burst into the ward and flew around in his wheelchair renewing old acquaintances. Successfully re-established in his former strategic position, he proceeded to re-organise ward activities.

Post-Hospital Behaviour

His parents reported that B25 was struggling to adjust to his disability and to the fact that his future participation in sport would be restricted. They noted that he appeared more mature in his outlook and more sensitive and sympathetic to the sufferings of others.

On his return to school, still in pain, forced to use a stick to negotiate the stairs, very conscious of the stares and remarks of his peers, he bitterly resented being different. He set about gaining their sympathy and tolerance by limping a little more than necessary

and by carefully and openly explaining to the class why he was forced to use a stick so that he was soon accepted on his old footing. When his friend (Subject B27) returning after a year's absence through a chronic kidney complaint, was forced to repeat a year, it was B25 who befriended him and successfully eased his rehabilitation.

APPENDIX I

FOOTNOTES

- (1) Figures in brackets represent B.S.A.G. I and B.S.A.G. II scores in that order with the unract score preceding the ovract score in each bracket.
- (2) Subject B12's Sentence Completion Form.
- (3) Subject B15's Sentence Completion Form.
- (4) Quoted from:
Observation notes of B28's actual conversation.

APPENDIX II

TABLE IV

SUMMARY OF BASIC INFORMATION AND B.S.A.G. RESULTS

Subject	Age	Complaint	P.H.	P.H.	P.C.	IU	IO	IIV	IIO	DU	DO	Teacher	School
G1	5	Revision of Holter Shunt	M	2W	0	1	2	0	1	-1	-1	S	S
G2	7	Corrective Surgery	M	3W	8W	1	6	2	1	0	-5	D	S
G3	9	Removal of Pin	1	3W	2½W	0	0	0	0	0	0	S	S
G4	9	Ulcerative Colitis	0	6W	5D	9	10	4	0	-5	-10	S	S*
G5	9	Diabetes	2	3W	10D	0	0	1	0	+1	0	S	S
G6	12	Slipped Epiphesis of Femur	1	2W	4W	1	0	5	0	+4	0	S	S
G7	13	Fractured Femur	2	4W	1W	0	10	7	4	+7	-6	D	S*
G8	14	Fractured Pelvis	1	4W	4W	6	0	8	0	+2	0	S	S*
G9	15	Corrective Surgery	1	3W	13W	3	0	1	0	-2	0	S	S
B1	6	Dislocated Hip	0	4W	4W	3	13	5	14	+2	+1	S	S
B2	6	Malabsorption	M	5W	3D	0	0	0	1	0	+1	S	S
B3	6	Fractured Femur	0	4W	8W	3	2	4	1	+1	-1	S	S
B4	6	Fractured Femur	3	4W	2W	0	3	0	0	0	-3	S	S
B5	6	Irritation of Hip Joint	2	2W	0	0	0	0	0	0	0	S	S
B6	7	Rheumatoid Arthritis	M	3W	4W	3	0	5	0	+2	0	S	S
B7	7	Burns	M	6M	8W	10	5	0	4	-10	-1	S	S*
B8	8	Observation of Behaviour	M	3W	0	0	19	0	10	0	-9	S	S*
B9	8	Osteomyelitis	0	2W	10D	2	1	3	3	+1	+2	S	S

CONTINUED

Subject	Age	Complaint	P.H.	P.H.	P.C.	IU	IO	IIV	IIO	DU	DO	Teacher	School
B10	8	Slipped Epiphesis of Femur	0	3W	0	3	3	3	5	0	+2	S	S
B11	8	Cleft Palate, Plastic Surgery	M	2W	0	0	0	0	0	0	0	S	S
B12	10	Fractured Femur	0	10W	4W	7	9	3	4	-4	-5	D	S*
B13	10	Ulcerated Stoma	M	2W	0	1	8	1	6	0	-2	S	S*
B14	10	Fractured Femur	1	6W	3W	10	0	8	0	-2	0	S	S
B15	10	Neurosurgery	4	3W	8W	0	0	0	0	0	0	S	S
B16	10	Plastic Surgery Injured Hand	M	2½W	1W	0	0	1	1	-1	-1	S	S*
B17	10	Epilepsy	M	3W	0	10	11	6	8	-4	-3	D	S*
B18	10	Fractured Femur	1	3W	4W	0	1	1	0	+1	-1	S	S
B19	10	Corrective Surgery	M	8W	8W	0	1	0	1	0	0	S	S
B20	11	Irritation of Hip Joint	1	2W	0	7	8	7	7	0	-1	S	S*
B21	11	Plastic Surgery	5	2W	2W	2	16	2	2	0	-14	D	D*
B22	11	Dislocated hip	5	8W	12W	6	17	3	12	-3	-5	D	S*
B23	11	Fractured Femur	0	4W	4W	0	0	2	0	+2	0	S	S*
B24	11	Fractured Femur	1	12W	4W	3	17	2	0	-1	-17	S	S*
B25	13	Slipped Epiphesis of Femur	1	5M	0	1	1	0	2	-1	+1	S	S
B26	13	Burns - Plastic Surgery	4	2W	3W	1	12	3	8	+2	-4	S	S*
B27	13	Kidney Disease	5	4W	14W	2	0	2	0	0	0	S	S
B28	15	Spinal Operation	3	4M	5W	0	4	0	-1	0	-3	S	S

* Indicates child unable to adjust to hospitalisation in the opinion of the observer.

KEY TO TABLE IV

Age is given to nearest year.

- P.H. - Period of Hospitalisation) W = Weeks; M = Months
- P.C. - Period of Convalescence) D = Days
- I.U. - BSAG I Unract Score
- I.O. - BSAG I Ovract score
- II U. - BSAG II Unract score
- II O. - BSAG II Ovract score
- D.U. - Difference in BSAG I and BSAG II Unract scores
- D.O. - Difference in BSAG I and BSAG II Ovract scores.
- S.D. - Refers to whether Form II was scored by the same teacher
as form I. (In Teacher column).
- S.D. - Refers to whether BSAG II form was scored in a different
school.

APPENDIX III - LETTER TO ADMINISTRATOR

86 Doyle Avenue,
LENAH VALLEY 7008

The Administrator,
Royal Hobart Hospital,
Liverpool Street,
HOBART. 7000

Dear Sir,

I am about to commence the fourth year of a part-time post-graduate course at the Tasmanian College of Advanced Education leading to a Master of Education degree. To complete the degree a dissertation on some subject related to my particular professional field is required. The College has accepted my proposal to prepare a dissertation on "The Effects of Hospitalisation on Children's Social Adjustment and School Performance".

I therefore wish to apply for permission to conduct the necessary research for this study in Ward 1A during the forthcoming school year.

Yours faithfully,

(Mrs) CYNTHIA McDOUGALL

Teacher-in-Charge,
Royal Hobart Hospital
Special School.

86 Doyle Avenue,
LENAH VALLEY 7008

Dear

I am at present engaged in preparing a dissertation on "The Effects of Hospitalisation on Children's Social Adjustment and School Performance" to complete a Master of Education Degree at the Tasmanian College of Advanced Education. The subjects are long term patients in Ward 1A of the Royal Hobart Hospital who are also pupils of the Royal Hobart Hospital Special School of which I am Teacher-in-Charge. who I understand attends..... and is in your class is at present in Hospital.

I would be grateful if you would fill in the enclosed form (Stott's Social Adjustment Scale), and return in the stamped addressed envelope also enclosed. Another form will be sent to you to be completed about a week after returns to school to enable a comparative analysis of any possible effects to be made.parents have agreed to allowto participate in this study.

Yours sincerely,

(Mrs) Cynthia McDougall

Teacher-in-Charge,
Royal Hobart Hospital
Special School.

86 Doyle Avenue
LENAH VALLEY 7008

Dear

I am at present engaged in preparing a dissertation on "The Effects of Hospitalisation on children's Social Adjustment and School Performance to complete a Master of Education degree, at the Tasmanian College of Advanced Education.

I would be most grateful if you would allow your child to participate in my study. It will involve my asking the teacher at his/her normal school to supply me with some general information at the time of his/her admission and soon after his/her return to school. It is possible, that I might need to have a talk with you at a suitable time if you would be agreeable.

Would you please fill in the attached consent form and return it to me in the enclosed stamped addressed envelope as soon as possible.

Yours sincerely,

(Mrs) Cynthia McDougall

Teacher-in-Charge,
 Royal Hobart Hospital
 Special School.

Iconsent/do not consent to my child's participation in Mrs. McDougall's study towards her Master of Education degree.

Signature

Date

SENTENCE COMPLETION EXERCISE

1. Today I feel.....
2. When I have to move I
3. I get angry when
4. My idea of happiness is
5. I wish my parents knew
6. Hospital is
7. I can't understand why.....
8. Sometimes I feel bad when
9. I wish doctors would
10. Everyone thinks I
11. It's fun to think about
12. I wish my mother
13. When I go home I
14. I hope I'll never
15. I wish nurses
16. I don't know how
17. I hope I'll
18. I feel happy when
19. I wish people wouldn't
20. When I get up I'll
21. School is
22. I wish someone would help me
23. I don't like
24. Most brothers and sisters
25. I feel unhappy when
26. I feel best when
27. I'm afraid
28. In the morning

A. IDENTIFICATION DATA

1. Name
2. Date of Birth
3. Date of Admission
4. Date of Discharge
5. School and Grade
- 6.

B. HEALTH DATA

1. Reason for Hospitalisation

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____

2. Health History

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____

3. Previous Hospitalisation

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____

C. HOME BACKGROUND

1. No. in Family and Child's Position

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____

2. Social Economic Status
- (a) Father's Occupation
- (b) Mother's Occupation

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

3. Physical Care

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

4. Intellectual Stimulation in Home

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

D. CHILD'S PERSONALITY

1. Relationship with Parents

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

2. Relationship with brothers and sisters

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

3. Relationship with friends

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

4. Emotional Adjustment

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

5. Attitude to Self

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

6. Outstanding Personality Traits

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

7. Interests

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

E. SCHOOL HISTORY

1. Educational Progress etc.

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2. Attendance Record

1 _____
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3. Conduct General Behaviour

1 _____
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4. Attitude to Teacher

1 _____
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5. Attitude to School

1 _____
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F. HOSPITALISATION DATA

1. Attitude to Hospitalisation

1 _____
2 _____
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4 _____
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8 _____
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2. Degree of Preparation

1 _____
2 _____
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4 _____
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8 _____
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3. Parental Support

1 _____
2 _____
3 _____
4 _____
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4. Degree of Communication between Hospital
personnel and patient

1 _____
2 _____
3 _____
4 _____
5 _____
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5. Attitude to Doctors

1 _____
2 _____
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6. Attitude to Nurses

1 _____
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7. Attitude to Paramedical Staff

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8. Attitude to Parents

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9. Attitude to Visitors

1 _____
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10. Outstanding Behaviour Traits while in Hospital

1 _____
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11. Play Behaviour Characteristics

1 _____
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12. Attitude to Hospital School

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13. Relationships with other Patients

1 _____
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