THE USE OF DENIAL OF THE NEED FOR MOTHER AND FOR MOTHERING IN A TODDLER WITH BURNS

BY

CAROLYN KISLO

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CHAPTER I

INTRODUCTION

A young child's entrance to a hospital, whether planned or emergency, is a new experience for him in an unknown, often painful, and frightening world. To this strangeness is the added stress of separation from his mother, most pronounced in the child under four years.

Robertson described the young child's pattern of defensive adjustment to loss of maternal care, which he called "protest, despair, and denial."[1] The child, who has been loved during the first eighteen months of his life, passes from an active protest of his loss of maternal care to a period of mourning for his mother (despair). If hospitalization is prolonged and accompanied by maternal deprivation, the child may enter the phase of denial which, in turn, is divided into two types. The first type is denial of the need for mothering by his own mother.[2] The child, seemingly failed by his mother in this time of need, transfers his affection to a substitute mother to obtain the loving care and physical satisfactions which he cannot provide for himself. The

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[1]James Robertson, Young Children in Hospitals (New York: Basic Books, Inc., 1958), p. 20.

[2]James Robertson, "Some Responses of Young Children to Loss of Maternal Care," Nursing Times, XLIX (April 18, 1953), 382-386.

second type of response is denial of all need for mothering.[1] If he cannot find a substitute mother or has "loved and lost" repeatedly through the frequent change of favorite nurses, he will eventually act as if mothering or contact with humans has little meaning to him. The child in this stage frequently accepts any person superficially, prefers "things" (toys, candy) to loving care, and is not disturbed by the comings and goings of his mother. It is this last phase of adjustment to loss of maternal care that is difficult to recognize. Frequently it is thought to be constructive adjustment or "settling-in," but actually it may be a forerunner of future emotional problems in the child, particularly the formation of a psychopathic or affectionless personality.

When the child of one to four years learns to ambulate on his own and to explore, his curiosity may make him a victim of household accidents. Burns are common and frequently acquired when the child gains access to matches. To be burned is a painful and shock-producing occurrence, and to a young child this accident may even threaten his life. Hospital admission is sudden; the child is surrounded by strangers, and his treatments are frequently painful, prolonged, and threatening.

A child, emotionally close to his mother, traumati-

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[1] Ibid.

cally injured, subjected to many painful procedures, and away from the familiarity of home and loved ones, cannot help but suffer greatly. A hospitalization is stress in itself, add maternal deprivation, compound it with a serious and/or painful illness, and a three-fold reason arises to increase the child's negative adaptation. Thus, perhaps, could Robertson's previously described theory pertaining to young children's pattern of defensive adjustment to loss of maternal care be strengthened.

The Purpose of the Study

In this study, the writer's purpose is to demonstrate how one child gave "warning signals" of this potentially harmful phase--the phase of denial--which may help others in discerning similar behavior in hospitalized children. A second purpose is to introduce a plan of nursing intervention to help children find healthier solutions to their problems. A tentative hypothesis might then be made for testing. It is: careful nursing assessment of a child's responses to hospitalization and loss of maternal care will enable the nurse to identify his problems and strengths, and help her plan purposeful nursing intervention.

Statement of the Problem

The problem is to (1) identify and describe the behavior of a two-year-nine-month-old boy with burns,

depicting the use of the defense mechanism, denial of the need for mother and for mothering, after a three month hospitalization, (2) analyze its implications for his growth and personality formation, and (3) formulate a plan of care to help him deal with his problems in a healthier way.

Objectives

The objective of the study is to find answers to these questions.

1. What has been the life situation of this child prior to the beginning of this study, particularly the maternal-child relationship, traumatic burn and post-burn episodes, and previous hospitalization?
2. How did care by many persons in a hospital, painful procedures, absence of mother, and operative procedures provoke the use of denial of this child's need for mother and for mothering?
3. How did this child's behavior depict the use of the defense mechanism called denial of the need for mother and for mothering?
4. What purpose did the defense mechanism serve this child?
5. What conclusions can be drawn from an assessment of this child's responses to the hospital milieu?
6. What plan of nursing care could be implemented to

lessen the child's fear of his exploratory impulses, to relieve the child's guilt, to encourage overt expression of feelings, and to help him deal with his problems in a healthier way?

Assumptions

This study has been based on three assumptions.

1. All children experience a period of adjustment to the hospital milieu;[1]
2. The separation will be more stressful, the younger the child and the closer the mother-child relationship;[2]
3. "All behavior is the meaningful expression of fundamental emotional needs."[3]

Definition of Terms

For the purposes of this paper, terms have been defined as follows.

Alleviating anxiety is decreasing the feelings from

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[1]Robert Heavonrich, Florence Erickson, and Martin Saren, "Viewpoints of Children in Hospitals," Hospitals, XXXVII (May 16, 1963), 40-52.

[2]Leon J. Yarrow, "Separation From Parent During Early Childhood," Review of Child Development Research (New York: Russell Sage Foundation, 1964), 89-137.

[3]A. H. Vanderveer, "Foreword," p. xi, in Florence G. Blake's, The Child, His Parents and the Nurse (Philadelphia: J. B. Lippincott Co., 1954).

within the person that evidence in apprehension, agitation, and worry.

Defensive adjustment is the self-protective or guarded settling into a situation.

A defense mechanism is "an attempt to alleviate anxiety by using methods that deny, falsify, or distort reality, and that impede the development of the personality."[1]

Denial of the need for mother and for mothering is the rejection of close relationships, indiscriminate and superficial acceptance of care by anyone, apparent lack of disturbance by the comings and goings of his mother, and preference for "things" over loving care.

Maternal deprivation is being removed from the direct loving care of the mother for a prolonged period of time.

Muteness is the refusal or emotional inability to verbalize, with the production of sounds limited to whimpering and alarmed cries.

Negative adaptation is the adjustment to a situation in a self-defeating, non-constructive manner.

Negative pleasure is satisfaction obtained in self-defeating ways since normal desires would be anxiety producing. The child prefers toys his mother brings to

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[1]Calvin S. Hall, A Primer of Freudian Psychology (New York: The New American Library, 1956), p. 85.

the physical comfort she could give, because to openly crave his mother's love would overwhelm him with unhappiness, hostility, anxiety, and frustration of his longing for her continuous care.

Stressful hospitalization is one causing a high level of anxiety, excess fears, and unhealthy personality changes, which impede healthy physical and emotional growth and development.

A traumatic injury is a physical injury sustained in shock-producing circumstances which may have long lasting emotional effects.

Withdrawal is physical recoil from comforting touch, and emotional recoil by not seeking out others and demonstrating an indifferent and apathetic response to care and surroundings.

Review of Literature

Separation of the one to four year old child from his parents, particularly the mother (biological or permanent substitute), by hospitalization, places demands on the young child that he is ill equipped to handle. Each child comes armed with a history of unique experiences, and may respond in varying degrees of distress to hospitalization. However, the general feelings noted in the young child are a sense of being abandoned, sadness from loss of love of his parents,

and fear of mutilation and punishment for his misdeeds.[1,2,3]

In the young child, the loss of maternal care has greater or lesser impact dependent on the pre-existing relationship between the mother and the child. The child who has had a continuous pleasant relationship with his mother will experience a tremendous loss, and react with anger, fear, grief, and revenge.[4] Yarrow[5] states that the closer the parent-child relationship, the more traumatic will be the separation.

Robertson[6] made further observations of young children's responses to loss of maternal care, and noted a characteristic pattern in these responses. He coined the terms, "protest, despair, and denial", described them, and gave case histories. Longitudinal studies, up to eight years in length, showed residual behavior difficulties stemming from long stay hospitalizations. He claimed the following outcomes in varying

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[1]Ednita P. Bernabeu, "The Effects of Severe Crippling on the Development of a Group of Children," Psychiatry, XXI (1958), 169-194.

[2]Heavonrich, Hospitals.

[3]Ner Littner, Some Traumatic Effects of Separation and Placement, N. F-17 (New York: Child Welfare League of America, Inc., 1956).

[4]Florence G. Blake and F. Howell Wright, Essentials of Pediatric Nursing (Philadelphia: J. B. Lippincott Co., 1963), p. 444.

[5]Yarrow, Review of Child Development Research.

[6]Robertson, Young Children in Hospitals.

degrees and combinations: difficulty in making and sustaining relationships, shallowness of attachments, immaturity, excessive stubbornness and self-centeredness, distractibility, and inability to concentrate, resulting in inadequate use of intellectual endowment. Robertson also compiled a book of letters from parents who volunteered information about their children's responses on return home from the hospital. The general impression obtained is that separation increased disturbance in children's personalities; while in instances where mothers "lived-in" or had unlimited visiting, the children seemed little or unaffected by the hospitalization.[1]

Bowlby[2] acknowledged that ill effects of maternal deprivation may show symptoms of neurosis and instability of character. He quoted from an earlier work of his own:

> Prolonged breaks [in the mother-child relationship] during the first three years of life leave a characteristic impression on the child's personality. Clinically such children appear emotionally withdrawn and isolated. They fail to develop libidinal ties with other children or with adults and consequently have no friendships worth the name.3

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[1]James Robertson, Hospitals and Children: A Parent's Eye View (New York: International Universities Press, 1963).

[2]John Bowlby, Child Care and the Growth of Love (Baltimore: Penguin Books, 1965).

[3]John Bowlby, International Journal of Psycho-Analysis XXI (1940), 154.

In a study of one hundred children, aged two to twelve years, Prugh et al.[1] noted that all children showed at least minimal reactions to hospitalization, while up to 92 per cent in the control group showed moderate to severe reactions. Unhealthy reactions of children two to four years were the most marked, and occurred mainly at separation from the parents. Regression, excessive fears, and sleep and eating disturbances were common reactions. Changes in behavior persisted after discharge, but were less apparent in the experimental group which had received added emotional support during hospitalization.

Literature showed that children with burns are particularly susceptible to the anxieties that overwhelm children in hospitals, perhaps because of the extreme vulnerability, pain, and seriousness of their illness. Guilt feelings were common, particularly if the accident occurred while the child did a forbidden activity.[2,3,4]

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[1]Dane G. Prugh et al., "A Study of Emotional Reactions of Children and Families to Hospitalization and Illness," American Journal of Orthopsychiatry, XXIII (Jan. 1953), 70-105.

[2]Ruth Cowin, "Social Factors in Treating Burned Children," Children, XI (Nov.-Dec. 1964), 229-233.

[3]Joan Woodward and Douglas Jackson, "Emotional Reactions in Burned Children and their Mothers," British Journal of Plastic Surgery, XIII (IV) (1961), 316-324.

[4]Aldo Vigliano et al., "Psychiatric Sequelae of Old Burns in Children and Their Parents," American Journal of Orthopsychiatry, XXXIV (July 1964), 753-761.

Long and Cope,[1] in their extensive study of burned children, analyzed their marked behavior responses. They noted that in response to the stress of injury, the adrenal cortex increased its secretions causing physiological changes, among which were ulcers of the stomach and duodenum. These physiological changes along with the fever that accompanies burns, may be instrumental in causing behavior changes. Some of the children studied were more disturbed than others, and much of this psychopathology was credited to pre-existing personality disorders that were masked initially by the burn.

With such formidable odds against them, one wonders how children ever emerge undamaged from hospitalization. Winning trust and confidence,[2] liberalized visiting,[3] and concentrated programs of care by the health team,[4] have been suggested and tried in many institutions

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[1]Robert T. Long and Oliver Cope, "Emotional Problems of Burned Children," New England Journal of Medicine, CCLXIV (June 1961), 1121-1127.

[2]Katherine Jackson, "Psychologic Preparation As a Method of Reducing Emotional Trauma of Anesthesia in Children," Anesthesiology, XII (May 1951), 293-300.

[3]Edward A. Mason, "The Hospitalized Child - His Emotional Needs," New England Journal of Medicine, Feb. 25, 1965, pp. 406-414.

[4]Emma N. Plank, Patricia A. Caughey, and Martha J. Lipson, "A General Hospital's Child Care Program to Counteract Hospitalism," American Journal of Orthopsychiatry, XXIX (Jan. 1959), 94-102.

as a means of minimizing the dangers.

The literature plainly shows that children are disturbed by hospitalization, however minor or major the ailments. The young child, particularly, must also cope with his separation from his mother. Leaders in child care, some more rapidly than others, are becoming increasingly aware of the dangers of hospitalization and maternal deprivation, and strides are being taken to minimize them.

Methodology

Carl, a two-year-nine-month-old boy with old burns, was selected by the writer as a good candidate for a study of the effects of prolonged and stressful hospitalization. This child, burned three months previously, was hospitalized on a burn unit of a large midwestern city hospital[1] during the acute phase of his illness. The burns, acquired when playing with matches, involved both legs, the genitals, and the perineum. The seriousness of his condition required many intrusive procedures--intravenous feeding tubes, stomach feeding tubes, urinary catheters--plus skin grafts, and many painful dressing changes. He was later transferred to a children's hospital[2]

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[1]For the remainder of the paper, this hospital will be referred to as Hospital A.

[2]For the remainder of the paper, this hospital will be referred to as Hospital B.

in a large medical center in another midwestern city for plastic surgical repair of his burn scars. A recommendation was also made to evaluate the possibility of mental retardation because of his muteness and lack of affect.

Carl was cared for by the writer (a nurse) for a period of two months, but only the observational data obtained during the first two weeks of study were used. During these two weeks, hours of care were arranged in accordance with his specific needs. These ranged from three to eight hours each day during the week, for a daily average of four hours. A visit of one to two hours was made during the weekend days. "Care" included ordered medical procedures, physical care for comfort and cleanliness, play activities, accompaniment to the operating room, and provision of emotional support as all aspects of care were given. Weekend visits were used to maintain a personal link with Carl and the writer, and to note his behavior on "quiet" weekend days.

Observation began when the writer viewed Carl initially through the window of an adjoining room, on the day of his transfer to Hospital B. The writer was unobserved by Carl during this initial study period. The next day he was observed with the writer in his room but not overtly interacting with him. Subsequently, the writer gradually began to develop a relationship with Carl, as a participant observer. His responses to the

writer, nursing staff, food, play materials, other children, and his surroundings were noted and recorded as the observations were made. On the occasions when on the spot notes were unfeasible, the writer relied on her memory and recorded immediately after her experience with him.

Carl was observed by an instructor on two occasions. In the first study period, she recorded Carl's responses to the nurses and his environment during and after a Hubbard Tank bath. In the second period of study, the instructor and the writer sat in Carl's room and made simultaneous recordings of his behavior. Then the writer began to interact with Carl while the instructor observed and recorded their transactional activity.

An instructor was available at all times to answer questions and give direction as needed. Conferences were scheduled once a week to correlate and evaluate findings, and to establish a plan of care.

Both parents were seen one day of each weekend. The writer used this time to study the parents and the parent-child interaction, to obtain information on his past experiences, to keep the parents informed on Carl's progress, and to be available to help them deal with their concerns. Telephone calls were made between their visits which provided supplementary information and opportunities to help Carl's mother. After Carl's eventual discharge

from the hospital, the writer made a home visit in order to obtain more material on his background and family relationships.

A visit was made at a later date to Hospital A, where Carl had spent the first three months for treatment of burns. The physical arrangement of the rooms and methods of care were noted. The writer also had an opportunity to interview the head nurse of the unit on which Carl was a patient, and to gain more insight into his problems.

Limitations

According to the writer, the study was subject to these limitations.

1. The study was conducted on only one child.
2. The writer conducted a personal interview with a member of the nursing staff of Hospital A, but detailed information was not obtainable.
3. The parents were able to visit only on the weekend days, so parent-child contact was limited to two days during the study period.
4. The writer was a participant observer and personal overtones may have pervaded her observations. Because the writer had to rely on memory, and an instructor was not always available to validate many of the observations, misinterpretations and/or omissions were possible.

The paper is developed in the following manner. Chapter II presents background information which includes a description of the child, his family unit, the social and developmental history, and the medical history. Chapter III is a presentation and interpretation of the observational data. Behavior which depicts Carl's use of the defense mechanism, denial of the need for mother and for mothering, is identified and described. Chapter IV identifies Carl's problems, a nursing diagnosis is made, and methods of nursing intervention are presented. Chapter V includes a summary of the study, conclusions, and implications.

CHAPTER II

PRESENTATION OF BACKGROUND INFORMATION

This chapter consists of four parts. The first part describes Carl as perceived by the writer and hospital personnel. The second part presents the family structure, physical environment, and a picture of its interpersonal relationships. The third part, social and developmental history, gives an account of Carl's growth and development from birth to the present. The fourth part, the medical history, describes the burning incident, subsequent events, the treatment regimen, the emotional climate of Hospital A, and Carl's responses to them. Lastly, the recommendations made by Hospital A upon Carl's transfer to Hospital B are reported.

A Description of the Child

The writer first observed Carl through the window of an adjoining room, and her attention was caught by a small boy about to be seen by four doctors. The bottom half of the child's torso and both legs were wrapped thickly with gauze, from which emerged a large catheter draining clear yellow urine. As the bandages were removed, Carl held his torso rigid, with occasional quivering, and clutched an arm of one of the doctors with both hands.

His face was contracted with apprehension, and he looked as if he were emitting small cries. It was striking that there was none of the usual protest which would be expected from a child of two years and nine months of age. When the dressings were removed, old burn scars were seen that completely covered the perineum. There was no scrotum evident, and only a nubbin of a penis remained, from which emerged the large catheter. Further inquiry into Carl's problem revealed that he had been burned three months previously when playing with matches.

Closer observation of Carl showed that he was a handsome boy with a thatch of dark hair in an overgrown brush cut. He had a round, pink cheeked face, which flushed easily with excitement, and an endearing smile that revealed even white teeth. His expressive brown eyes could change quickly from sparkling imps to mournful dark pools. The light and dark patterned skin on his arms and torso gave evidence of being extensive donors for skin grafts. His perineum was terribly scarred and contracted, resulting in his inability to abduct his legs more than a few inches. His penis was imbedded in scar tissue; it was small; it had an acquired hypospadius. The doctors surmised that the hypospadius was a result of being burned and having contained an indwelling catheter for three months. There was no evidence of scrotal tissue. His legs

showed scar tissue and areas of unhealed graft sites. Both popliteal areas had heavy fibrous bands that kept his legs in ninety degree flexion. His feet were relatively free from burns, except one heel, and his toenails were blackened from previous silver nitrate therapy. He was well nourished, weighed thirty-five pounds and measured thirty-eight inches, which put him in the 75th percentile on the antrhopometric chart (see Appendix, p. 89).

When in Carl's room, the writer was particularly aware of his lack of affect on the approach of other children or adults. Several nurses had noted in the chart that he "doesn't take much interest in other children." He was disinterested in his environment and only occasionally, as if with great effort, he cast a vacant look around him. Only when his burn sites were approached, did he exhibit any signs of emotion; such approach engendered apprehensive looks, dilated pupils, and plaintive low whimperings, reminiscent of a frightened, wounded animal. Carl demonstrated little interest in who cared for him; he accepted anyone, and only an occasional nurse was able to elicit a smile from him. After the first two days in Hospital B, Carl ceased to cry for his mother, and only mentioned her again after the writer had worked closely with him for two weeks.

During the first two days in Hospital B, Carl's

appetite was reported to be good. It is significant to note that his mother was present at these meals. After she left the third day to return home, Carl's appetite noticeably dwindled. He acted as if there was no longer any incentive or pleasure in eating. If an attempt was made to feed him, he refused this semblance of dependency by either taking the spoon away from the nurse, or clenching his mouth closed. When tube feedings were deemed necessary to increase his protein intake, these were accepted without protest. He never made an attempt to pull out the tube.

The Family Structure, Environment, and Interpersonal Relationships

The writer's first contact with Carl's mother (Mrs. Sanders) was by telephone. In this telephone conversation, she was guarded at first, but soon expressed her relief in knowing that her son would be cared for so closely by the writer. She also remarked that it was a comfort to know that there was someone she and her husband could talk with, whenever they felt they need to do so.

At the first visit, the writer found Mrs. Sanders to be an easily approachable and very talkative person. She was approximately five-feet-five- inches tall, thirty-five years old, and of medium build. She had a pretty but tired looking face framed by curly, medium brown hair,

and was dressed in a blouse and skirt. Mrs. Sanders talked quickly and steadily throughout the entire visit, giving little opportunity for Carl or the writer to respond. She alluded to her talkativeness by saying "The boys probably don't talk much because I do enough talking for everyone."

When questioned about Carl's accident, Mrs. Sanders spoke freely and seemed overtly unconcerned, almost as if she completely dissociated herself from it. She seemed to have her emotions well under control, a trait that was evident later in Carl. She showed distress, which she quickly hid, when Carl did not respond initially to her on the first visit. Only later, over the telephone, did she admit how frightened she was at his lack of response to her during the visit.

Carl markedly resembled his father, particularly the ruddy complexion and dark hair. Although weighing nearly two hundred pounds, Mr. Sanders carried it well over his large frame and height of six feet, and gave a comforting impression of great inner, as well as outer, strength. He spoke little, perhaps inhibited by his wife's loquaciousness, but when he did, it was brief and in a low timbered voice. He also expressed little of his feelings about Carl's accident, which may have been a part of his particular character, but may also have had overtones of guilt, as he was the only person home

at the time of the accident. Although he was always interested in Carl's medical progress, he only asked questions and showed marked interest, when reconstructive surgery on Carl's penis and scrotum was mentioned.

Carl's parents were neighbors in their youth, and lived on adjoining farms in a rural area in the middle of the state. Mr. Sanders was two years younger than his wife, and served in the Navy before returning home and marrying. They lived on property near to their parents' homes, and dairy farmed for many years until it became unprofitable. Then Mr. Sanders joined his father in a trucking business, but they retained about thirteen acres of land, the farmhouse, and the barn. The five room farmhouse was two storied, plain and surrounded by spacious lawn and trees. The inside of the house gave evidence of being occupied by a number of children--furniture lumpy from numerous bouncings, baseboards and door jambs chipped from tricycles, and floors worn down from the steady stream of active feet.

There were five boys in this family, ranging from two and a half years to thirteen years, of whom Carl was the youngest and frequently called "baby." The isolation of rural living provided few neighbor children, but the boys found each other to be good playmates. Carl was particularly fond of his brother a year older than himself. Mr. Sanders keenly enjoyed fishing, hiking, and

other outdoor activities, and liked the company of his sons during these times. The brothers were close, active, and Mrs. Sanders once remarked, "They sure like to fight a lot." Mrs. Sanders also liked outdoor activities and frequently took the boys tobagganing, ice skating, and swimming, as the seasons permitted. The boys also had the company of Flicka, the horse, and Frisky, the lively collie dog.

The writer found the parents to be simple, honest, and loving people, who dearly cared for their children and tried to provide a happy, secure homelife. Their religion was Lutheran; they attended church regularly, and the boys went to Sunday school. They were sincere and appreciative of any care and assistance given to Carl, and fiercely proud of paying off their debts, especially the terrific expense of Hospital A. Hospital personnel were given their untmost confidence and hope, and any faults were explained away in this manner: "The nurses are so busy with so many other sick children."

The Sanders were a tight-knit family, and until the accident Carl had never been separated from his mother for more than a few hours. Mrs. Sanders explained that she believed in keeping young children at home until they were old enough for kindergarten. Physical contact by holding, hugging, and kissing was practiced by both parents when the children were young. Mrs. Sanders reported that

Carl derived much comfort when he was under stress, by pressing his mother's cheek to his and encircling her neck with his arm. He also frequently patted his mother's and occasionally a brother's hair. The writer noted that Carl was frequently comforted by patting and hugging a fuzzy brown teddy bear, which was acquired when he was in Hospital A, and became his constant companion.

Social and Developmental History

"Poor Carl, he's had it rough from the very beginning," said Mrs. Sanders when she reflected on Carl's problems. Mrs. Sanders' pregnancy was uneventful, and she chose to have the fifth baby by natural childbirth methods because, "I didn't want to miss seeing it, if it was a girl!" As the baby's head was delivered, he was noted to be cyanotic and the cord was wrapped around his neck. Mrs. Sanders remembered the baby being blue, but with resuscitation he quickly recovered from anoxia. Anxiety over the child's life may have overcome her disappointment at having a fifth boy.

Carl was breast fed for over a year, as were all his brothers. Mrs. Sanders jokingly referred to this by saying, "I produced more milk than our cows". Carl fed well during this time; he was weaned directly and uneventfully to the cup, and continued to be a good eater until his hospitalization. He usually arose in the morning to have breakfast with his father, then went back

to sleep for four hours, and upon awakening would eat another breakfast.

Carl's growth proceeded along normal patterns and he attempted to walk early. He was placed in a walker at about four months of age, and was walking with support by eight months of age. By two and a half years, he was active, climbing cabinets, inquisitive, and given full opportunity to explore his environment. His toilet training was well underway, with mother's efforts and his brothers' examples, when he was burned. He lost the capacity to control bowel and bladder sphincters at the time of the accident, and did not attempt to regain control until nearly five months later.

Speech developed slowly in Carl, as it did in all his other brothers. Mrs. Sanders attributed this to her constant talking and her habit of anticipating her children's needs. She said that all Carl frequently needed to do was to nod or shake his head to answer "yes" or "no." Mr. Sanders, however, was a quiet man who spoke infrequently, and may have been imitated by his children. At the time of the accident, Carl spoke a few words and short phrases, to express himself and make his wants known. His non-verbal communication was extremely well developed, and he had little hesitation, or difficulty, in being understood.

Medical History

The sequence of events that led up to Carl's being burned was hidden away in the mind of this little boy, but much evidence of the catastrophe remained. Carl was taking a nap, and since he usually slept a long time, Mrs. Sanders went to town and Mr. Sanders went outside to work around the yard. The following account is speculation on the sequence of events. Carl apparently awoke, and true to the inquisitiveness of the two year old, he prowled around the house. No one knows what he was seeking, but he climbed up to the kitchen cabinets, and found matches that were kept on a shelf. The living room couch was found charred, so it is assumed that he took his find there, and while investigating the matches, he set his pajamas on fire. A bathroom towel was probably used to extinguish the flames; the burned towel was later found. At this point Mr. Sanders was alerted to the situation by Carl's cries. Mrs. Sanders had taken the family car, but a relative was found who drove Carl and Mr. Sanders to obtain medical attention.

Emergency treatment for shock was done in the local hospital; the child was sedated, and the burns were wrapped in sterile gauze. The distraught mother arrived at the hospital in time to accompany him to a burn center in a large city about 150 miles away. Mrs. Sanders recalled the ambulance as containing no

oxygen, and that she was alone in back with Carl, while both ambulance attendants sat in front. About halfway on the trip, she noted that Carl had turned blue and cold, and she cried out to the attendants, "My baby is dead, my baby is dead!" They turned into the nearest hospital they could find, and emergency treatment by the doctor revived Carl, who was apparently deep in shock.

When Carl was able to travel again, the ambulance set off at a rapid pace. Mrs. Sanders remembered the next incident clearly, and recalled that the ambulance, going over ninety miles an hour on the Interstate highway, overtook and collided with a passenger car ahead. Mrs. Sanders anticipated the collision and threw herself over Carl to protect him. She suffered numerous cuts and bruises; the ambulance was wrecked, but Carl was apparently unharmed. A call to the nearest hospital produced another ambulance. It was equipped with oxygen and other emergency equipment, and an attendant who stayed with Carl and Mrs. Sanders for the rest of the trip.

At their destination (Hospital A), treatment was started initially to combat shock. Using the "rule of nines" (see Appendix, p. 90), the doctors ascertained Carl's burned areas to be about 30 percent of his body, comprised of second and third degree burns. He was put

in a room specifically equipped to use open air treatment of burns, and weeks later was started on silver nitrate therapy. An indwelling urinary catheter was in place during his entire stay, frequent debridements and skin grafts were done as he recovered, and stomach and intravenous feeding tubes were inserted as needed. His scrotum was intact on his arrival to Hospital A, but during his hospitalization it became edematous, burst, and scarred over. No attempts at splinting his legs or other contracture prevention was done, but Mrs. Sanders stated that he was encouraged to walk with support.

Mrs. Sanders was allowed to "live in" with Carl during the first week. When the immediate crisis was over, she continued to have unlimited visiting privileges but slept at the home of relatives. These first few weeks found Carl nearly unresponsive, suffering from severe shock from burns, the harrowing ambulance ride, and the painful treatment regimen. He did not respond to anyone, not even to his mother, and maintained an affectless countenance except for occasional whimperings.

After Carl's first month in Hospital A, Mrs. Sanders returned home. The whole family visited every weekend, including the brothers, who were occasionally allowed in to see Carl. The antics of his four year old brother sparked the first response from Carl since the

accident--a laugh. From then on, he seemed to recognize and acknowledge his mother, but did not speak a word or show any signs of wishing to verbally communicate with anyone. The hospital staff were concerned about his behavior. Frequently they questioned Mrs. Sanders about his development, and eventually mental retardation was suspected. Mrs. Sanders strongly denied this, but Carl gave little evidence to disprove the staff's hypothesis.

During the last month in Hospital A, one or two nurses were able to elicit some signs of emotion from Carl--an occasional smile or hug. One nurse was able to get him to brush his teeth and comb his hair, activities he used to enjoy at home. Other than these few incidents, Carl was reported to do little to seek care for himself or express his wants. He continued to be unable to, or not want to talk.

When the burn treatment in Hospital A was nearly finished, the doctors found that Carl's genitals would need extensive reconstructive work, and the severe leg contractures would require physical therapy. A children's hospital in another city with a plastic surgical service, was recommended for further treatment, and transfer arrangements were made. A recommendation was also made for neurological examination to evaluate Carl's intellectual

ability, because of his lack of affect and inability to talk.

CHAPTER III

PRESENTATION AND INTERPRETATION OF OBSERVATIONAL DATA

This chapter will portray the behavior which demonstrated Carl's use of the defense mechanism called denial of the need for mother and for mothering during his initial period of adjustment to Hospital B. Interpretation of the behavior, was perceived by the writer, will be presented, as well. In analyzing the observational data, four distinct patterns of behavior were identified. They were: (1) muteness; (2) apathy and lack of response to his environment; (3) inability to seek care and use mothering; and (4) inhibition in the expression of feelings.

Carl's Muteness

Communication by speech is one of the first steps in socialization of the child. He learns that the sounds he makes are pleasurable, not only to him but to his caretakers, namely his mother and father. He learns that if he says certain sounds to a certain person, he is rewarded by joyful exclamations. Mamamamamama becomes "mama" as mother approaches and reacts. Gradually his vocabulary increases, its speed dependent upon satisfactions

obtained and the child's incentive for growth. He can communicate his needs, wants to communicate them, and is understood.

Observational Data

Carl's muteness was disturbing to all members of the health teams in both hospitals. In Hospital A, muteness had been the decisive factor in suspecting mental retardation. Again, in Hospital B, Mrs. Sanders was questioned about his development, as concern by the staff mounted. It was understandable that the staff would be concerned, since normally a child of two-years-nine-months would be at the three word sentence stage of speech development.

It was frustrating to care for and attempt to establish a relationship with Carl, and obtain no feedback. To some nurses[1] this presented a challenge, and eventually when Carl began to speak, each word that he used was received with pleasure and announced in the nurse's station. To other nurses, Carl's muteness was frustrating and discouraging, and Carl was frequently forgotten and ignored. To compound this, patients were

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[1]The term "nurse" is used to designate a registered nurse, student nurse, practical nurse, or nurse-aide unless specifically differentiated.

frequently admitted to Carl's room who were younger and spoke little or not at all. The only excursions out of his room were to the Hubbard Tank room twice daily, and an occasional trip to the playroom. A silent and unassuming child is often forgotten by other children and hospital personnel, and thereby deprived of challenging relationship experiences which are required for growth.

One sided conversations were common when caring for Carl. The following incident was typical of his response to questions. Carl was sitting in an armchair when an aide entered the room to serve nourishments. The interchange which took place serves to illustrate the behavior under discussion.

Aide: "Hello, Carl. What do you want to drink?"

Carl: (He sat silently but glanced at the aide.)

Aide: "I have milk, juice, and Kool-ade. Which do you want?"

Carl: (He was still silent, but he looked over at the cart.)

Aide: "How about some milk. Would you like that?"

Carl: (He made no response.)

Aide: "How about some chocolate milk? Here it is." (She handed the milk carton to Carl.)

Carl: (He took the milk carton silently.)

Aide: "Would you like a straw?" (She handed him a straw with the cover partly off.) "Can you blow the cover off?"

Carl: (Feebly he blew the cover off the straw and listlessly watched as it fell to the floor.)

Aide: "That's good, Carl, now drink up all the milk." (She left the room.)

The sounds that Carl made were limited to crying and whimpering of varying intensity. He frequently cried when dressing changes were attempted by the nurses, and when a procedure was particularly painful, he cried or whimpered louder. All his behavior was reminiscent of an infant who is able to communicate only with cries and vague sounds.

Even though Carl did not use words, he was well able to listen and to understand instruction. The third day in Hospital B, a play teacher arrived to spend some time with Carl. She stood by the bedside, handed him toys and talked about them. He did not reply verbally to her questions but took the toys from her. When she took a toy duck, petted it and said caressingly, "Ooh, soft," Carl eagerly imitated her non-verbal behavior.

Activities with the writer prompted similar behavior from Carl until the eighth day of the study. The writer talked and manipulated toys while Carl listened and occasionally participated. If the writer stayed with Carl, he eventually played but in a half-hearted fashion. A few days later, when he began to form words with his mouth, he glanced surrepticiously at the writer. Then came the day when he wanted something so badly, he asked for it. He had been given some soda crackers, of which he was fond, and the remainder were

put on the bedside stand. Carl eyed them for a long time and periodically glanced at the writer, but the writer purposely ignored his non-verbal behavior. Then he denied his wish for them and turned away. After a few more minutes, he turned back again and looked longingly at the crackers and then up at the writer. Finally he reached out an arm, pointed to the crackers, and said explosively, "Dos!" (those) and then, "Cracker." The pleasure expressed by the writer resulted in an expression of pleasure on Carl's face which increased when he obtained the crackers.

Interpretation

What did this muteness mean? Why did not Carl use speech which is normally such a pleasurable activity for a child? In studying the data, the writer formed some impressions to answer these questions.

Carl's mother was separated from him throughout much of his hospitalization, and in his two and a half year old eyes, he must have thought that she deserted him. Left with strangers, his trust in the loving kindness of adults was shattered as his world grew more painful. He was wary about forming relationships and put a wall of silence between himself and human contact. To talk was to reach out and communicate with people, which he did not feel secure enough to do since all the

people he had known in the past few months contributed to his pain and loneliness. His body integrity was violated by numerous intrusive and painful procedures; he lost control of many of his bodily functions; and the pleasurable activities he had been accustomed to at home were gone. His voice became the only part of his body over which he had any control, and control it he did. He had little or no control of his outer environment either, which must have increased his feelings of helplessness to an unbearable level. To withhold what others demanded or wanted must have provided an outlet for revenge and made him feel more powerful.

Before the accident, talking was a pleasurable experience that Carl shared with his mother. Perhaps talking resurrected feelings of longing for his mother that he was unable to face. Therefore, he may well have denied his longing for her by refusing to talk. By witnessing the frustration, and sometimes sadness, in the faces of those who attempted to talk to him, he further derived a sense of satisfaction (negative pleasure) from controlling his speech and witholding from others what they were demanding of him. Perhaps regression was also a means of conserving energy and an attempt to regain trust and get care similar to that which gave him pleasure when he was a baby.

Carl's Apathy and Lack of Response to his Environment

Behavior Relating to Surroundings, Food, and Play

Observational Data

Carl was not only a silent child but also an apathetic one. He showed little interest in his surroundings, adults, children, food, or play. He initiated no activity spontaneously; he sought nothing. Instead, he laid in bed gazing with unseeing eyes at the wall ahead of him or occasionally at the television set. Data collected on the eighth day of the study demonstrates his withdrawal and/or apathetic behavior.

> Carl looked at the writer when she came in to join another observer. He was lying on his back with his head turned to the left. A television set was near the foot of the bed which he looked at with no expression on his face. For ten minutes he did not move except to blink his eyes; his respirations were deep and regular. He raised his hands as if to scratch his ears. Then he lowered them to finger a small metal car, and moved his legs slowly and cautiously. These movements were meager and done lethargically. Later he picked up two plastic toys, one in each hand, and immediately put them down again. With the right hand he moved the toys about a few inches, stopped, and clasped his hands together. He sighed deeply, loosened his hands, his eyes fluttered closed, then opened and he gazed at the observers. His gaze showed little interest and he made no attempt to verbally communicate with them.

Other children aroused little interest in Carl. He looked at them when they entered his room but made no attempt to gain their attention.

> When two children entered the room, Carl looked quickly at them, then lifted himself up to see them better as they left the room. He went back to looking at television. The two children came back in but he did not look at them until one spoke. Then Carl glanced apathetically at them for only an instant. Until the children left the room, he kept his eyes on the television set.

Although the two children ran in and out of the room repeatedly, neither of them talked to Carl. At one point a child ran into the room, and without a glance at Carl, he switched the television set to another station. Carl made no move or protest, not even a change of expression.

Food had no appeal for Carl except when he was intensely hungry. At these times he attempted to pull himself up into a sitting position in anticipation of his food. He refused help from the nurse and took the fork himself, but the attempts at eating were feeble and selective. He frequently ignored the meat and vegetables and settled for slices of bread and a sip or two of milk. The bread was chewed slowly for long periods of time before being swallowed. Throughout his entire meal he showed little expression of pleasure or interest in his food. When the writer perceived Carl's need for old pleasures and met it, his response was encouraging.

> Carl's eyes focused on the crackers, juice, and peanut butter which the writer carried into his room. He watched carefully as she elaborately spread peanut butter over a cracker and talked about it as she spread it. Then with a smile Carl eagerly took

> the cracker and ate it. The writer figured the cracker would make him thirsty and sure enough, he drank down a glass full of juice. When another cracker was offered, he pushed it away. Still wanting to increase his protein intake, the writer placed a glob of peanut butter on her finger and licked it off with much enjoyment. Carl's interest was captured. Then he stuck out his finger which the writer smeared with peanut butter. First he contemplated it and squeezed it. Then he licked it off and smiled. The writer repeated this process until the peanut butter was all gone. Before he was finished he had peanut butter on all his fingers, which he licked carefully and with obvious pleasure.

Carl had an ability to "blot out" unpleasant procedures as if he were mentally willing himself away from them. At these times he seemed "far away" and only with great effort could he be brought back to reality. In the Hubbard Tank, where he went to have his dressings soaked off twice a day, he lapsed into a drowsing state. At times he listlessly manipulated a few toys, but then closed his eyes in feigned sleep. The warmth of the water may have been instrumental in relaxing him, but this is difficult to believe in view of the fact that nurses were standing beside him removing dressings from his legs. An occasional dressing stuck and caused discomfort which aroused Carl from his world of fantasy and elicited a cry. At these obviously painful times, he made little or no attempt to protest or inhibit the nurses in any way. This level of resignation was ominous. Past experience must have aroused anxiety relating to his aggression and fear of retaliation. With an ego as

immature as Carl's, his only recourse was to withdraw into himself.

Play was virtually impossible for Carl; he could use few of his resources and he had little surplus energy with which to play. His physical condition and maladaptive mechanism of defense sapped his energy and what surplus supply he had, was used for healing purposes. Toys were offered to Carl but he could not use them. The writer wondered if he were not afraid of the aggression that would be aroused if he played with them. He manipulated cars and plastic clowns with little enthusiasm. Frequently, he let them drop out of his hands to the floor without his notice. Did he not have energy to hold them or was he attempting to communicate his problem about separation from his mother? If a person stayed with Carl and kept the play moving, he listened and watched, and occasionally reached out to take a toy. He was only able to imitate others, and this he could do well. Apparently imitating the adult was perceived by Carl as a safe course of action. Passively he listened to stories, and looked at pictures when they were pointed out to him, but never did he attempt to identify items which were familiar to him. Television provided passive entertainment and he gazed at the set for endless periods of time, without overtly becoming involved in the picture or in the person standing near him.

Interpretation

Passive resignation was Carl's mode of adjusting to his painful environment. As long as he was quiet, he did not attract any attention to himself. He did not want to call attention to himself, since attention usually meant a painful disturbance of his body. He denied himself interest and activity because to do so meant resurrection of feelings he feared--he might need someone--he might need his mother; he might become overwhelmed with aggressive feelings he could not control. Slowly he built a cocoon of silence around him; there in the world of his own making he would be safe; the real world was too unpleasant. He could escape from the torments submerged from consciousness and those he perceived in the world beyond himself.

Behavior Relating to Noxious Treatments

Observational Data

Carl accepted noxious treatment with little semblance of concern. A feeding tube insertion was done with hardly more than a murmur from Carl. Once it was in, restraints were superfluous because he never attempted to remove the tube. High protein, high caloric tube feedings were done every two hours, and later every hour, without much change of expression in his face. He looked at the nurse when she poured in the feeding but

soon lost all interest and even lapsed into sleep on occasion. Intravenous tubes were dealt with similarly by Carl. He was aware of the tubing and the armboard, but never attempted to remove it or even to touch it.

Interpretation

The above type of behavior was applauded by the doctors and many of the nurses. They perceived his behavior as that of being a "good cooperative boy." This type of behavior in so young a child is not usual and it is unfortunate to consider it "good." Admittedly it facilitates medical care but does little to help a child learn to accept a natural part of himself and to deal with his feelings. The writer speculated that expression of feelings must have been inhibited either by reprimands or by fear of punishment, and also by approval which reinforced what was perceived as "goodness." Experiences such as this must have been deeply etched on his mind to provoke such lack of normal response.

Behavior Relating to Persons Caring About Carl

Observational Data

The persons who cared about Carl were particularly victim to his indifference toward them. When Carl's parents made their first visit during the study period,

they were greeted by an impassive gaze that showed no recognition of them. It was a matter of many minutes before a smile finally flickered across Carl's face and he attempted to touch his mother. After the visit, Mrs. Sanders expressed her opinion about Carl's behavior. She said, "He seemed so far away." When the writer became more familiar to Carl, she had many experiences such as his parents had and there were rebuffs as well.

Interpretation

The above behavior disclosed Carl's method of denying the importance of people to him. He acted as if he had crushed out the image of his mother and felt revengeful toward her. A period of time elapsed before he could involve himself with her, and then his involvement was meager and without demonstration of warm feelings. The closer persons were to Carl, the more rejecting he was of them. He could not bear to face the feelings he had, since they aroused more anxiety than he could endure. Therefore, he tried to push his feelings from awareness, cover them with a mask of indifference, and in this way make himself safe from emotional harm. Love and need for his mother were emotions he could not endure in the vulnerable, immobile state in which he found himself.

Carl's Inability to Seek Care and Use Mothering

To the world that viewed him (the hospital), Carl gave the impression that he wanted nothing, sought nothing, needed nothing, and expected nothing. Life in the past few months had proved unfriendly, painful, lonely, and offered little pleasure. No wonder he did not want, or feel he needed, any part of it. People were a part of this unfriendly world; therefore he did not seek them. Even his mother, who had always been at his side and a source of pleasure, had deserted him and left him in the care of strangers. A mind not even three years old finds this separation and discomfort incomprehensible and, through a veil of pain, views the world as hostile.

Behavior Relating to Carl's Inability to Seek Care

Observational Data

Carl's apathy, muteness, and inactivity were methods he used to protect himself from fear, lest he become involved with people and lose them as he had in the past. He never called out for anything and, even if there were persons in the room, he did not attempt to attract their attention. He laid in bed quietly with an inscrutable look on his face as he infrequently gazed at the writer or other observers in the room. He

made no attempt to obtain their attention, but followed them with his eyes as they moved around the room. Although he frequently slipped into a world of his own making, he had protective awareness of activity around him and occasionally turned his head to watch the source.

Although he did not seek, Carl accepted attention and care submissively. Volunteers, play teachers, nurses, or whoever had time to spend with him, were accepted in a similar manner, and he looked at whatever they had to offer. Stories were a favorite stimulus which he demonstrated by turning on his side and listening intently. Carl demonstrated his recognition of familiar objects, but only with persistent encouragement by the person reading the story.

Writer: "What a nice story, Carl. It's about a dog."

Carl: (He was silent, but looked at the book.)

Writer: "Look at the doggie, Carl. Isn't he pretty?"

Carl: (He looked at the book with bright eyes.)

Writer: "Ooh, where's the doggie on this page?"

Carl: (He remained silent, but looked.)

Writer: "Do you see the doggie, Carl?"

Carl: (He made no response but continued to look at the page.)

Writer: "Oh, you can see the doggie, can't you?"

Carl: (He looked up at the writer and nodded his head.)

Writer: "Show me where he is. I bet you know."

Carl: (With a smile, he pointed to the dog in the picture.)

Gradually it became apparent that Carl was unable to give of himself until he was given to first. He needed to draw strength from others and take what they offered, before he could give anything in return.

Even discomfort did not prompt Carl to seek help. During one period of observation, he spent the time apathetically looking at television, with occasional squirmings and picking motions of his hands under the sheet. His supper came, and he ate sparingly while he looked at television; he occasionally glanced at the observers. After dinner, the writer encouraged Carl to involve himself in play activity.

Two hours later, when the writer turned Carl over to do his dressing soaks, she noticed a large amount of dried stool on his buttocks. Apparently, he had had a bowel movement during the experience reported above, but never once did he signal his wish to be taken care of.

Interpretation

In retrospect, the writer accounted for the squirmings and picking motions reported above to have been Carl's attempts to make himself more comfortable. This behavior was repeated frequently in the following days while the writer or another nurse was in Carl's room. Even an infant can voice his displeasure in being soiled and try to attract attention to his plight

with cries. Carl demonstrated by this behavior that he could not seek the care that he needed, because denial of his need for his mother and for mothering was necessary to keep his overwhelming feelings under control.

Behavior Relating to Carl's Inability to Use Mothering

Observational Data

Operations were faced alone, also. Carl could not reach for, or use help when it was offered, even in this anxiety producing period. His first surgical procedure, on his ninth day in Hospital B, was for the application of postage stamp skin grafts. The writer planned to stay with Carl before, during and after the operation. When she arrived in his room, he looked through her rather than at her, then eagerly showed her a plastic syringe he was clutching. When preparation for his operation was given, Carl assumed a still and remote expression on his face and would not listen. He turned from the writer, looked at television, and could only be interested in play with some adhesive tape.

When Carl was taken to the operating room by the orderly, and accompanied by the writer, he whimpered a little but refused all overtures of comfort. The writer

offered her hand hoping to give some comfort, but this was shrugged off by Carl, as he desperately clutched the adhesive tape and syringe.

Upon awakening from anesthesia, Carl turned his face away from the writer. Only when the syringe was offered to him, did he seize it eagerly and looked as if he derived comfort from it. This exemplified Carl's behavior when he interacted with persons--he preferred the toys and activities they provided to the person who brought them.

Carl could not seek out or use comfort from those who had been most dear to him in the past. On the occasion of their first visit during the study period, Carl's parents and his brothers were victims of his revengeful attitude toward people. When the parents and two of his brothers entered the room, Mrs. Sanders rushed up eagerly to Carl's bed. Carl did not move nor let a flicker of expression pass over his face; he gazed at her as if she were someone he had never seen before. Mrs. Sanders was obviously painfully stricken by this reception, but covered over her initially crestfallen face with a pseudo-happy voice. Then she gave Carl a kiss, and called attention to his two brothers. By this time, Carl must have banished from consciousness the flood of feelings that overcame him, and he became able to smile. Quickly, he turned his head to look at

his brothers, but made no other move toward them. Each parent and both brothers went over to hug him, but he made little movement to hug them back. Only after ten minutes of studying his brothers and watching them play with his toys, did he reach out and pat one of them on the head. His mother was the last one he turned to. Then he reached out to pull her head down to make her cheek touch his. At no time during the visit, did he utter a word or make any other overtures. The family's departure caused no overt expression of grief in Carl. However, the nurse's notes stated that he was particularly irritable after his family left.

Interpretation

The family's visit and leavetaking must have disturbed Carl's emotional equilibrium or he would not have responded with such unusual behavior as irritability. Overt expression of grief or rage did not appear, because he had no other devices but denial to cope with these threatening feelings.

Carl did not have the resources that he needed to face the longing or need for his mother's loving care. He was forced to crush out the image of his mother to deal with grief and rage aroused by loss of her and her care. He also had feelings of revenge which required discharge. Carl's rejecting behavior punished the persons

who had been most dear to him. He punished his mother for deserting him and leaving him in the care of strangers. Revengefulness was a negative pleasure; it provided momentary relief from tension but carried with it the danger of further distortion of the image he had of himself.

Frequently, a young child seeks out a person for maternal care when he believes that his mother has failed him. Carl may have attempted to do this with nurses in Hospital A, but made no attempt to do so during the study period in Hospital B. Most likely Carl had "loved and lost" repeatedly in Hospital A, because nurses change shifts and leave the unit for other arrangements. Under these circumstances, a child discovers that he has no one to rely upon. Such a discovery overwhelms the child with feelings of helplessness and fury. Each time he loses a person in whom he has invested his trust, he is confronted with feelings evoked by loss of his own mother's care. To protect himself from such painful feelings, the young child has no other recourse but to deny his need for his own mother and for mothering by others, as well.

Carl's Inhibition in the Expression of Feelings

Carl's marked over-control and his efforts to

deny and suppress feelings were other facets of Carl's behavior which concerned the writer. Other than infantile cries, he could not express overtly the myriad of feelings he must have had. Emotions of joy, anger, fear, or sorrow were minimally expressed or not seen at all. Only daily care and close observation of Carl disclosed the minute changes of emotion in him; these changes were missed by most nurses as they scurried about the ward caring for a large group of children.

Behavior Relating to Carl's Feelings About Doctors

Observational Data

The doctors frightened Carl; this was grossly evident whenever they entered the room and came to him. His body stiffened, his face paled then flushed, and his eyes became dark and fearful. He hardly moved a muscle. Only his eyes moved as he watched the doctors warily when they crossed the room. If the doctors passed him by, his body relaxed like air coming out of a balloon. During an examination, he maintained a stiffened position, but never uttered a sound unless the area examined was particularly painful. His eyes were kept fastened on the doctor's face but he did nothing to help or impede his examination. He was "paralyzed with fear."

The insertion of a feeding tube was particularly illustrative of Carl's immobility in the presence of

doctors. The writer was caring for Carl when a doctor came in and announced that he wished to insert a feeding tube. When the writer returned to the room with the needed equipment, she found Carl in the exact position as when she left. Elbow restraints[1] were placed on Carl's arms because the writer had not learned how he reacted to inserted tubes. The writer's past experience with children of this age showed that they usually kicked, choked, screamed, and tried to pull out the tube. Carl allowed his arms to be encased in the elbow restraints. He even lifted his arms to facilitate application. When the restraints were applied, the doctor inserted the feeding tube with no resistance from Carl, who laid passively with his arms held loosely by his side. A drink of water was offered to Carl by the writer, to facilitate the passage of the tube, but he refused to suck through the straw. Then the doctor took the glass and, in a no-nonsense voice, said, "Swallow it," which Carl hurridly did. This token bit of resistance was the only protest Carl made to the entire procedure. After the tube was inserted, the doctor complimented Carl for cooperating with him, but Carl sat with downcast eyes and refused to look at the doctor.

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[1]Elbow restraints consisted of a rectangular piece of material with pockets in which to insert tongue depressors. Ties of cotton twill secured the cloth once it was wrapped around the arm. This enabled the patient to have full movement of the arm but prevented bending of the elbow.

Interpretation

Two interpretations could be made of Carl's compliancy during the application of elbow restraints. First, he was well acquainted with them from the previous hospital and secondly, he was fearful of the doctor and fell back into his non-protesting state. Past experiences had probably proved to Carl that little could be gained by resisting; he may well have felt that he would always be overcome.

Doctors, no matter how kindly they are, rarely have the time to form close relationships with hospitalized children. Frequently, most of their contact with children entails examinations of afflicted areas, which usually is uncomfortable for patients. Added to this is the number of doctors that make patient rounds together. The young child has difficulty enough forming a one to one relationship with a stranger, but being confronted with three or four is too much for him to handle. A child who is subjected repeatedly to this type of attack may well become immobilized because he soon learns that he is outranked by numbers and size!

Behavior Relating to Carl's Feelings About Nurses, Tank Baths, and Operations

Observational Data

Nurses did not trigger the same paralytic fear

reactions in Carl. Apprehension was the predominate emotion, particularly when the burned areas of his body were approached for soaking or dressing change. However, he displayed little physical resistance; usually his only response to fearful situations was a whimpery-cry. Occasionally, he reached out a trembling hand and tried to push away the nurse's arm, but this he attempted only with those nurses with whom he was beginning to feel safe.

Trips to the Hubbard Tank room were accompanied by whimpery-cries that ceased once Carl was wheeled through the halls. He enjoyed the distraction of seeing other surroundings and usually gazed right and left. Hails by other patients and nurses engendered no change in expression.

When wheeled into the Hubbard Tank room, he apprehensively eyed the equipment and whimpered softly when moved from the cart. Once in the tank, his tension lessened as the warm water covered him, but he never was totally relaxed because he frequently slipped down in the water and needed to be raised up. He protested little when the dressings were removed except when a particularly painful one was found. Initially, his glances at his burned legs prompted nurses to say, "Don't look, don't look, it doesn't hurt as much that way." What falacy this was! One of Carl's strengths

at this point was his ability to look. Generally, however, he laid passively on the canvas and allowed the nurses to continue uninterrupted. On occasion he even appeared to be sleeping.

When dressings were reapplied to Carl's legs, he usually whimpered louder, and distraction was provided with his toys or an extra pair of rubber gloves. Distraction was a method Mrs. Sanders used when Carl cried at home, and this unfortunately was used extensively during the study period. Distraction tended to suppress rather than encourage expression of feelings. It certainly communicated the distress the nurses felt from his crying.

The two days during the study period when Carl went to the operating room were also marked by his inability to express how he felt. Only a rigid body and watchful, wary eyes gave evidence to his fears and knowledge of what was coming. He surveyed the writer's scrub gown and mask carefully each time, and other than the aforementioned look in his eyes, he made no response or murmur. He turned away when explanation was given, as if he could not, or would not face what it meant. Sanction was given to let him express fear by crying, but he could not. Even though he was on the verge of tears and acted as if he could not be brave another minute, he was not able to use encouragement to cry to relieve his tension.

Carl's awakening from surgical anesthesia was

stormy. For the first half hour in the recovery room, he thrashed about, and angrily cried as hard as his little body would allow. As he regained consciousness and recognized persons by his bed, he became markedly still and silent.

Interpretation

What purpose did the suppression of feelings serve for Carl? Had frowns and scoldings for loss of control inhibited expression of feelings, and thereby caused him to feel that he was deserving of punishment? Or was he afraid lest giving way to his feelings would force him to face his need for his mother, and the mothering he was trying to deny? Or was he trying to make himself believe that he was self sufficient--that he needed no one? Or had the accident itself been perceived as punishment for doing forbidden things or for being carried away by his own curiosity and impulsiveness? If so, had the accident made him anticipate that all subsequent painful procedures were meant to punish him?

Carl's behavior when coming out of anesthesia led the writer to hypothesize that all of the above factors might well have played a part in producing the behavior already described. When anesthesia weakened Carl's controls, all his pent up rage from frustration and fear was released. In this twilight zone beyond

his conscious will, he cried loudly and so angrily that his whole body shook with muscular contractions. Once he became conscious of his surroundings, the rage was quickly submerged, and the placid, deceptively self-contained Carl reigned dominant again.

A Concluding Statement

To grow emotionally, the young child needs trust in and love for his parents, the capacity to identify with their expectations and values, physical and psychological readiness to adapt to new learning experiences, and parental support to succeed in coping with the core problems confronting him as physical growth and development take place. Motivation to grow and dependence upon his parents for guidance is essential. When care during early childhood fulfills the child's requirements, motivation to grow is sustained. He wants to please his parents, give in return for what he has received, and to acquire the knowledge and skills which will make him a person in his own right, more self-directing and competent in solving his problems.

Each of the behavior patterns observed in Carl is atypical for a two-year-nine-month-old child; when seen together in one child, they form a syndrome which manifests gross psychopathology, rather than constructive adjustment to illness, treatment, and the hospital milieu.

This behavior should alert health workers to the child's need for help. It should stimulate action to plan nursing intervention to conserve his energy for physical recovery and to help him make optimum use of his body, emotions, and mind for psychosocial development.

CHAPTER IV

PROBLEMS, NURSING DIAGNOSIS, AND INTERVENTION

Carl had many problems which were frustrating his basic human needs for physical recovery and growth toward maturity. He also had latent resources which could be mobilized with purposefully planned nursing intervention. This chapter identifies Carl's problems, presents a nursing diagnosis of his mode of adapting to them, cites goals of nursing care, and describes the nursing intervention which was needed by Carl to make progress physically and to deal more constructively with his problems.

Problems

Study of the data demonstrated the problems that were thwarting Carl in obtaining satisfaction of his common human needs for physical progress and development of a healthy character structure. They appear below.

1. He had lost trust and was unable to relate himself to his mother or to nurses in a meaningful way, or to face his need for maternal care and to seek it.
2. He had lost his ability to verbally communicate with others.

3. He had lost the autonomy he had acquired before the accident. He was unable to manipulate the environment to attain satisfaction of his needs, and had little control over or understanding of it, which generated feelings of helplessness and anxiety.
4. He was not secure enough to express his feelings of anger, fear, anxiety, grief, revenge, and helplessness which had been aroused by his injury, treatment, separation from his mother and loss of her care.
5. He had little self-esteem, which fostered self-punishment.
6. His appetite was poor and protein intake limited, which resulted in insufficient energy for tissue building and activity.
7. He had little interest in his environment and initiated no spontaneous play, because of depleted energy stores from nutritional deficit, the use of maladaptive defenses to protect himself from his aggressive and exploratory impulses, and fear of the external world.

Nursing Diagnosis

Before a nursing diagnosis was made, identification of Carl's personality strengths and limitations was necessary.

The writer identified these personality limitations from study of the data.

1. He had regressed, lost trust and self-esteem, and become passively resigned to his fate.
2. He did not reach out to people to obtain satisfaction of his need for maternal care.
3. He had inhibition of feelings and drive to obtain the satisfactions and guidance he needed to resolve his problems.
4. He was unable to face his grief, rage, fears, need for dependence, and longing for his mother, or let himself become attached to another person.
5. The defenses he had assumed were using energy which he needed for relationships, active coping with his problems, and self-therapeutic play.

The writer observed personality strengths in Carl, as well.

1. He wanted to be in tune with people (he followed them with his eyes and watched what they offered).
2. He struggled to solve his problems when help was provided (he attempted to play with nurse's support).
3. He showed concern about his physical appearance (he was able to look at his damaged body).

4. He evoked feelings of empathy in persons who understood his behavior.
5. His ability to control himself, even when his body was grossly threatened, demonstrated unusual physical strength. If the energy bound in controlling his feelings could be released, he would have a large store of it to be used for relationships and problem solving.

After studying the data, isolating Carl's problems, and identifying his strengths and limitations, the writer formulated her nursing diagnosis. It was: due to separation from a mother that he had learned to love and depend upon, severe burns, care by many strangers, and painful treatments, Carl had developed unhealthy personality defenses to deal with his feelings of anxiety, anger, fear, revenge, helplessness, grief, and loss of independence and mobility. Maladaptive defenses prevented the relationship experiences and the reception of care which was needed for recovery, physical and psychological growth and development.

Goals of Nursing Intervention

These goals of nursing intervention were constructed by the writer:

1. To help him to re-establish trusting relationships with himself and others;
2. To help him to communicate his needs more

easily and effectively;

3. To help him in accepting his need to seek and/or use help from others;
4. To help him to regain autonomy;
5. To help him to acquire more security to facilitate expression of his feelings of anger, fear, anxiety, revenge, grief, and helplessness;
6. To help him to regain self-esteem;
7. To stimulate interest in his meals and to increase protein intake;
8. To promote closer contact between Carl and his mother and a re-establishment of pre-hospitalization rapport;
9. To conserve energy and diminish fear of the results of his curiosity in order to stimulate interest in his environment and release energy for play.

Nursing Intervention

Nursing intervention is presented under these headings: (1) helping Carl re-establish trusting relationships; (2) helping Carl to communicate his needs more easily and effectively; (3) helping Carl to accept his need to seek and use help from others; (4) helping Carl regain autonomy; (5) helping Carl acquire more security;

(6) helping Carl regain self-esteem; (7) stimulating Carl's interest in his meals and increasing his protein intake; and (8) conserving Carl's energy and diminishing his fear of the results of his curiosity.

Helping Carl Re-establish Trusting Relationships

Hospitalization had caused Carl to lose the trust his mother had so carefully nurtured in him for two and a half years. The suddenness of his hospitalization, the wrenching away from all that was near and dear to him, and the pain and helplessness with which he was confronted, were experiences he was ill equipped to handle. Carl was too young to understand that these strange and painful procedures were an attempt to save his life and to help him. He acted as if he could only visualize them as an attack on his helpless body. Even his mother, who until this time had always provided a safe haven of refuge when in pain, was unable to protect him. No wonder he lost all trust in people.

Because Carl was mistrustful, he could not cope with the multitude of health workers with whom he was confronted in Hospital B. If he could no longer trust his mother, how could he possibly trust unknown persons in a new and unfamiliar hospital? First Carl needed one person he could trust, dare to become attached to, and with whom he could feel safe enough to express his

his feelings, and then learn to channel them into constructive learning activities. She would be responsible for giving his care, medications, treatments, and emotional support. Because he needed consistency and continuity of care, it was necessary that this primary nurse share her plans with other nurses so Carl did not have to adapt to many ways of doing things for him.

Carl needed advance preparation for all changes in his nursing care, and simple but careful explanation of forthcoming procedures. He needed to know what he could expect in these situations, and knowledge that he would not be left alone, but have help to participate. He needed preparation for care by other nurses when "his" nurse expected to be off the ward. Statements something like this were needed by Carl: "This is Miss Smith, Carl. She is going to take care of you while I'm away for a day. Let's show her how you like things done. Then you can help her if she does not do it exactly like I do."

When Carl begins to trust his nurse and dares to attach himself to her, he will need strong support when he exhibits signs of possessiveness and increasing courage to express his negative feelings. This behavior is healthy; it means that he is beginning to feel safe in the nurse's presence. He may turn away from her, or resist treatments that he always had submitted to

before. It is important not to take such behavior as a personal affront, to desert, or to show disapproval in any way. Young children's thinking is primitive. If they are angry at their nurse, they will think that she, in turn, must be angry at them as well. Young children cannot understand that adults do not feel and think as they do. When Carl dares to exhibit these displays of emotion, he will need his nurse close by to protect him from fear of his wishes, feelings, and aggressive impulses. Sitting down with him and expressing approval something like this will be helpful: "I know you don't want your dressing done. It must make you cross with me, but I'm not angry at you. I'm going to stay with you. When you are ready for me to help you, you tell me."

When Carl regains more security in his relationships, he will need protection from fear of his impulses provided in other ways, as well. Reasonably imposed limits are protective devices. They help children get controls within themselves. When Carl begins to protest, resist, and explore, and shows fearfulness of his impulses, he will need limits to know that he will be protected from hurting himself, destroying property, or from disrupting relationships which he wants to preserve. Acceptance of his feelings and guiding overt expression of them through such activity as pounding, ball throwing, or water splashing, for instance, will help him become

increasingly less fearful of his emotions.

Carl needed his mother close by so he could have opportunities to re-establish his relationship with her. "Living-in" or unlimited visiting hours would provide Carl's mother an opportunity to care for her child again, an activity which had been pre-empted by nurses during the preceding three months. Knowing her own child, how much better equipped she was to identify his needs and know his methods of communication. So much trial and error by the nurses would be eliminated, because his mother would know his habits, pleasures, and annoyances. Moreover, his incentive to live and learn would be increased, since this was the person whom he had been motivated to please for two and a half years.

Three months of alienation can change children, so Carl's mother would need a tremendous amount of support from the nurse. She would need help during the time she was with Carl particularly in understanding his behavior. She would need to be prepared for rejection and other punishing techniques which Carl might employ as a revenge for being left with strangers. She would need to know that the nurses did not expect super-human efforts from her, or perceive her as a bad mother because Carl rejected her and punished her by asking for nurses to care for him at times. When she became discouraged, she would need support and opportunities to

get satisfaction for herself. She and the nurses would have to plan time for relieving each other, and time for Carl to be alone to nap or rest. Carl would need to know that his mother needed relief and that when she was gone, she entrusted his care to the nurse.

Carl's mother could also participate in his treatments. How much more comfort he could receive from his mother that he ever could from his nurse. If the mother was willing and able to, she could support Carl during blood taking, dressing soaks, and baths. The mother should never be made to feel that she was expected to take full charge of her son's care, but only do as much as she wished. Participation in Carl's treatments and care would also prepare her for possible home treatments upon his discharge from the hospital.

If the mother could not stay with Carl in the hospital, the nurse needed to learn as much as possible about Carl and his habits. The nurse needed to learn the mother's methods of handling Carl's eating, sleeping, and toileting, which would bridge the gap between the hospital and home.

Carl needed to have the image of his mother re-inforced. The nurse needed to talk to Carl about his mother, show photographs of her, the father, and the brothers. Stories about mothers could lead into talks

about Carl's mother. Telephone calls could also be made frequently so he could have the satisfaction of hearing his mother's voice. Telephone conversations can be poignant, however, and the nurse should be ready to handle the feelings they resurrect in children. The sound of a beloved mother's voice can arouse feelings of profound grief and loneliness in children. The nurse needs to be available to provide comfort and strength to grieve when feelings of loss are reactivated during telephone calls, visits, and talk about mother and family members.

Helping Carl to Communicate His Needs More Easily and Effectively

Carl's muteness hampered his communication with others, and made it necessary for nurses to become more sensitive to his non-verbal communications. Until Carl felt safe enough to talk, he needed nurses who were astutely observant of his needs and of the meager direct signals that he gave. Licking of his lips and the nurse's knowledge that he had not had fluids for a long time usually indicated thirst. Squirming around in bed, slight shifts in position, and a miserable look on his face usually indicated that Carl was uncomfortable and needed a position change or a bedpan. Eye movements or a beseeching look betokened his desire for a cracker or a particular plaything that was in his line of vision. Carl gave other signals of need which could be picked up

easily by interested perceptive nurses.

Carl needed encouragement to re-establish former patterns of verbal communication by such means as this: "I can help you more when you get ready to tell me what you want. Someday you will. I know you will." Carl required this kind of help to learn the nurse's expectations and the faith that they had in him. As Carl became more trusting and able to seek what he wanted, he needed nurses who saw what he had his eyes on and had the patience to wait until he asked for it. When Carl wanted food or a toy badly enough, he asked for it. Then the nurse was able to reinforce his seeking behavior with praise which not only heightened his self-esteem but also motivated him to use speech more often.

Above all, Carl needed nurses with patience to help him to communicate verbally. It is necessary to stop, look, and bear silences until children become ready to talk. Sitting down beside them, instead of perching at the foot of their beds as if posed for immediate flight, tells children a great deal. It tells them that nurses want to communicate with them, are able to bear their silences, and are not concerned because they have little to give at the time.

Willingness to talk with nurses and other adults will not come quickly; it may take a number of weeks before children with problems such as Carl's become

motivated to give what adults want to receive, and/or relinquish a means of control from which they derive pleasure. When children have not talked for three months, it will take a while for them to regain what they have lost.

Helping Carl to Accept His Need to Seek and Use Help From Others

Carl was not able to face his need to seek and use others, because he had denied his need for mothering, and had become conditioned to expect pain and discomfort when approached by members of the health team. It was necessary then to short circuit this stimulus-response mechanism he had acquired.

Because uncomfortable and painful treatments were frequently necessary, Carl was in special need of having pleasurable activity with nurses, as well. Association with "his" nurse for play opened a way to reach him. Just as he loved his mother (and unconsciously still needed her greatly) despite some uncomfortable conflictful experiences with her, he will become able to attach and relate himself to "his" nurse if he sees her at regular intervals and enjoys his experiences with her. Play time, stories, and pleasant surprises prepared and executed by the nurse will soon become associated with her in Carl's mind. Then he will become more able to tolerate uncomfortable procedures because

he has learned that the nurse would not do painful things unless they were necessary for his recovery.

Carl needed help when he became threatened by new experiences, medical examinations, and laboratory tests. When help is provided during stress, children soon perceive the nurse as helpful and a source of comfort. Then they become more able to use her or ask for her when they are threatened at another time. They draw strength from the nurse; her presence tells them that she cares and will do all in her power to help them.

Helping Carl Regain Autonomy

The sudden and severe nature of his illness, and the subsequent painful and intricate treatment did much to rob Carl of his autonomy. Seldom was he consulted as to when, how, and why treatments had to be done, which was probably due initially to his critical state and later to his block in verbal communication.

Carl needed help to regain his autonomy during all interactions with nurses. During his morning and evening care, he needed opportunities to control the amount of care he wanted to do by himself, and the parts he wanted done by "his" nurse. Small decisions, so slight to the nurse yet so meaningful to young children, can be played to advantage--whether or not to wear the blue shirt or the striped one, whether they would rather

wash or dry themselves or both, and whether they want to squeeze their own toothpaste on their brushes or leave it for the nurse to do.

Mealtime also needed to be a time of decision making for Carl. He required encouragement to select which foods he wanted to eat and how much. He needed opportunities to serve himself, and to choose whether or not he wanted to put chocolate in his milk. Even if the choice was an odd combination, it was his choice and he needed the privilege of making it!

Carl needed opportunities to choose whether he would rather stay in bed, sit in a chair, or go to the playroom. He required protection from fatigue, and study to determine whether or not repeated preferences for the bed was used to withdraw from reality. If so, it seemed wisest to firmly encourage him to get up, and then provide companionship to help him learn that being up was more pleasant than staying in bed.

Even dressing changes and Hubbard Tank baths offered opportunities for Carl to regain autonomy. He needed encouragement to help take off dressings, assist in opening packages, and directing the manner in which his dressings were applied. He was given a syringe to help the nurse during dressing soaks; he took off and/or applied adhesive tape when the opportunity arose.

Helping Carl Acquire More Security

When feelings are bottled up within children because they are afraid to release them directly, and/or because they have not had the help they needed to channel them into constructive activity, they are turned back against the self, partially expressed in subtle devious ways, and cause distress. They can suffer physically; they can lose weight, protein, and vitamin stores, look wan and listless, heal slowly, or develop psychosomatic disease such as stress ulcers, for instance. They also suffer emotionally. Without help they build up tension, lose self-esteem, and dissipate energy in the maintenance of unhealthy defense mechanisms.

Carl needed unconditional acceptance from a trusted person to mobilize his latent resources. This element of support was especially needed when he was most tempestuous and fearful of losing control of himself. It was also required when he let himself wince or cry during a procedure. Words such as these, expressed with sincerity were needed by Carl: "I'm glad you can tell me when it hurts." When he refrained from expressing pain, and it was obvious that he was uncomfortable, permission to express himself could be given this way: "Someday you'll be able to tell me when you hurt. I can see you're uncomfortable. Oh, I'd be so happy if

you could tell me when you are."

With the support of unconditional acceptance, children become increasingly more courageous about the expression of their feelings. Then the energy released can be used for healing and strengthening their ego to cope with the treatment regimen which faces them.

Carl needed to learn about his environment, to explore it, and to study its influence on him. He needed to examine new treatment materials or areas of the hospital where he would be examined or treated but had never seen, before he was actually involved in them.

Carl needed play through which he could overtly express his concerns and frightening impulses and feelings. Young children cannot use words to tell nurses what they are concerned about, but with toys and raw materials, they can get their message across to knowledgeable people, express their feelings, obtain more understanding of them and gain self-therapy from play. The toys children select repetitively and the patterns of behavior they repeat again and again in play provide clues to their wishes, concerns, and needs. Hammers, guns, clay, family dolls, paints, and scissors are media that are used by children to express their feelings of anger, grief, fear, anxiety, and helplessness. Separation

anxiety may be expressed and relieved in throwing and retreiving games. Anger can be let out by shooting a gun or hitting a punching bag. Many feelings can be released in doll play--figures representing mother, father, brothers, doctor, and nurse. Sensual pleasures of finger painting and manipulating clay may relieve tensions associated with toilet training. Cutting paper with scissors may help them to master their fear of castration (of their feelings about) removal of dressings. As children's needs change, appropriate toys and play materials can be introduced that will satisfy these needs.

When children are as deeply troubled as Carl was, and the source of their fears and worries cannot be found, the consultation services of a psychiatrist will be invaluable. Careful description of their patterns of behavior with adults, and during play, can be interpreted by him. He can also provide guidance which will be helpful to nurses who care for them.

Helping Carl Regain Self-esteem

Carl acted as if he thought he had little of which to be proud, and called as little attention to himself as possible. His legs were scarred and disfigured with open lesions and areas in many stages of healing. His genitals were virtually non-existant and he had lost his ability to control his elimination.

He could not lie straight, sit up without support, or stand straight. It was painful to envision that he was once a straightlimbed, happy, and active youngster.

Carl needed to be kept clean, comfortable, and dressed as well as his burned areas would allow. This was necessary to give him pride in his appearance. If he saw that his nurse cared enough to carefully attempt to spruce him up, her pride could not help but be communicated to Carl.

Carl needed help to regain the pride he once had in himself. Even his terribly disfigured legs could become a source of pride to him. The nurse needed to point out unceasingly the areas that were healing, and to reinforce how well the healed areas looked and that the rest would soon follow. Carl needed to be handled tenderly and respectfully, so he would learn to view himself with tenderness and respect.

Carl needed faith in his ability to re-establish bowel and bladder control. He never was totally trained before his accident so did not know the pride of accomplishment of this function. Also the incentive of his mother's pleasure on his accomplishment was gone. On occasions when Carl successfully achieved continence, he needed to be praised and told that the nurse knew he could do it.

Carl needed praise for his accomplishments. Drawings and other art work could be hung on the wall

as proof to others that Carl was capable of doing good things. He needed constant reinforcement of his capabilities--they had been squelched so long.

Opportunity for play experience with other children was also needed to rehabilitate Carl. As Carl saw himself accepted by other children, he would be encouraged to accept himself. Questions by other children needed to be answered truthfully and briefly. Avoidance of answering questions would only instill in Carl a feeling that something was shameful and had to be hidden. The more open and direct the approach, the better it would be for Carl.

Most important was the necessity to involve Carl's family. The nurse could say: "Your mommy and daddy will be so proud of you when they see this, Carl." However repressed Carl's longings were for his mother and family, his self-esteem would most suredly be elevated when he learned that he was still a source of pride to them. The parents themselves needed to become actively involved in praise of his progress. Carl will scrutinize their faces for any trace of shame or dismay, and they must be helped to become aware of this. How good he will feel when his mother or father can say with sincerity: "We're so proud of you, Carl; you are doing so well."

Stimulating Carl's Interest in His Meals and Increasing His Protein Intake

At home Carl was reported to have been a good eater, but his appetite dropped markedly in both hospitals. It seemed evident that he missed his home environment, his family, and old routines. Therefore, with this in mind, how can the nurse simulate as close as possible the pleasurable surroundings he once enjoyed at home?

If they cannot be at home, the next best thing for young children is to have their mothers with them. An effort needed to be made to have Carl's mother stay with him as much as possible during his meals. Pleasure and pride exhibited by his mother would stimulate him to do even better. In circumstances when Carl's mother could not remain in the hospital with him, having "his" nurse with him at mealtime would certainly make them more enjoyable.

Carl needed to have his meals served attractively with portions small enough for him to feel a sense of accomplishment from finishing. Even better would be to let him serve himself, thus enabling him choice in what and how much food he wished. Information derived from Carl's mother about his favorite foods and manner of serving would help the nurse more closely simulate the environment and habits of home.

It was important not to overplay or make an issue

over Carl's eating. If the reason for his lack of eating was revenge, and his caretakers were obviously distressed, then it would only serve to provide him with the satisfaction that his act of revengefulness was successful.

It was necessary that techniques be employed to increase the protein intake Carl needed for tissue building. Snacks needed to be provided that were high in protein but also fun to eat, like peanut butter. Carl, like other children, loved dramatic displays and if the peanut butter was promoted in an interesting way, he would be motivated to participate. Ice cream could be added to his milk, and if the process was done in front of him or with his help, the very novelty of this procedure might incite him to drink the concoction. Ice cream also could be presented on the lid of the dixie cup, in a cone, or in many other intriguing ways.

Carl needed to eat in the same room or even at the table with other children. Along with being similar to meals at home, the sight of other children enjoying their meals might prompt Carl to imitate them. Carl needed protection from disturbing elements in the other children, such as illness at the table, or derogatory remarks about the food, that would influence him negatively.

A talk with the hospital nutritionist could prove helpful in planning Carl's meals, particularly concerning

his protein intake. She might have a number of techniques or could offer various types of food to be tried. The nurse's interest might also prompt the nutritionist to explore other avenues of approach in food preparation, all of which would benefit Carl.

Carl needed peace before and after meals so that his intake and digestion could be improved. If treatments and procedures were scheduled too closely before meals, he would be too agitated to eat. If they were scheduled too closely after meals, he would associate mealtime as a prelude to treatment, or during the treatment might be subject to nausea and/or vomiting. The time before the meal needed to be a pleasurable and restful time, and used for quiet play activities. The time afterward needed also to be restful, or set aside as naptime.

Conserving Carl's Energy and Diminishing His Fear of the Results of His Curiosity

Physical illness and adapting to a high level of anxiety sapped Carl's energy stores. In intervention cited previously, care was directed at relieving the anxiety and so preventing the endless drain of energy. Continued emotional support throughout all phases of his care was needed by Carl to relieve his anxiety and release energy for healing purposes. As healing took place, and he became physically stronger, he would have energy to

look around himself and to play.

Carl required concrete help to lessen his fear of his curiosity. If his curiosity caused him to find matches, be burned, and result in hospitalization, he might well be fearful of exploring. Support by the nurse (or mother if she was there) was needed to help him feel safe and free to explore. He needed to be encouraged to look around the playroom, look into boxes, and seek out play materials. In these situations he needed his nurse from whom to draw the strength that would encourage him to continue. But freedom to explore would not come in a day or even a week. He needed time, patience from the nurse, and continual encouragement.

Carl needed a protected play area where he could feel safe during his initial ventures in exploration. A familiar play area, which is safe from intrusion of threatening persons or painful memories, is ideal. Security is found in the familiar, so new and strange play materials and persons should be introduced slowly.

Carl also needed exposure to the play and curiosity of other children. If he saw that they were safe and not punished for their curiosity, perhaps he might be willing to do likewise. Patience again would be important, and many weeks of exposure to other children might be necessary before he took the momentous step required to use the impulses which had become such an overpowering threat to him.

CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary

The purpose of this paper was to demonstrate how one child gave "warning signals" of the potentially harmful phase of defensive adjustment to loss of maternal care called denial of the need for mother and for mothering, which may help others in discerning similar behavior in hospitalized children. A second purpose was to introduce a plan of nursing intervention to help young children find healthier solutions to their problems associated with separation and loss of their mother's care.

This paper described how a two-year-nine-month-old boy with old burns used the defense mechanism denial of the need for mother and for mothering after a three month hospitalization, how the data was analyzed, and the nursing intervention he needed to make progress physically and to deal more constructively with his problems. The study began the day after Carl's transfer to a children's hospital in a university medical center from another hospital where he had been treated during the acute phase of his illness. Data was collected with the use of written observations of his behavior. The writer functioned as a participant observer while

she provided intensive nursing care for two weeks, for a daily average of four hours.

When data collected during the two week period of study was analyzed, four distinct patterns of behavior were noted. They were: (1) muteness; (2) apathy and lack of response to his environment; (3) inability to seek care and use mothering; and (4) inhibition in the expression of feelings. These behavior patterns were analyzed and interpretations based on Carl's past and current experiences were made.

Study of the data demonstrated problems that were thwarting Carl in obtaining satisfaction of his common human needs for physical progress and development of a healthy character structure. They were: (1) loss of trust and the ability to relate to his mother or to nurses in a meaningful way, or to face his need for maternal care and to seek it; (2) loss of his ability to verbally communicate with others; (3) loss of the autonomy he had acquired before the accident so that he was unable to manipulate the environment to attain satisfaction of his needs and had little control over or understanding of it; (4) lack of security to express his feelings of anger, fear, anxiety, grief, revenge, and helplessness which had been aroused by his injury, treatment, separation from his mother, and loss of her

care; (5) little self-esteem which fostered self-punishment; (6) poor appetite and limited protein intake which resulted in insufficient energy for tissue building and activity; and (7) little interest in his environment and lack of spontaneous play, because of depleted energy stores from nutritional deficit, the use of maladaptive defenses to protect himself from his aggressive and exploratory impulses, and fear of the external world.

The nursing intervention which was needed by Carl was described. It included: (1) helping Carl re-establish trusting relationships; (2) helping Carl to communicate his needs more easily and effectively; (3) helping Carl to accept his need to seek and use help from others; (4) helping Carl regain autonomy; (5) helping Carl acquire more security; (6) helping Carl regain self-esteem; (7) stimulating Carl's interest in his meals and increasing his protein intake; and (8) conserving Carl's energy and diminishing his fear of the results of his curiosity.

Conclusions

This study served to test the writer's hypothesis which was postulated before the data was analyzed. It was: careful nursing assessment of a child's responses to hospitalization and loss of maternal care will enable

the nurse to identify his problems and strengths, and help her plan purposeful nursing intervention.

Analysis of the data supports this hypothesis and demonstrates the hospitalized child's urgent need for careful study in the immediate period after admission or transfer from another hospital.

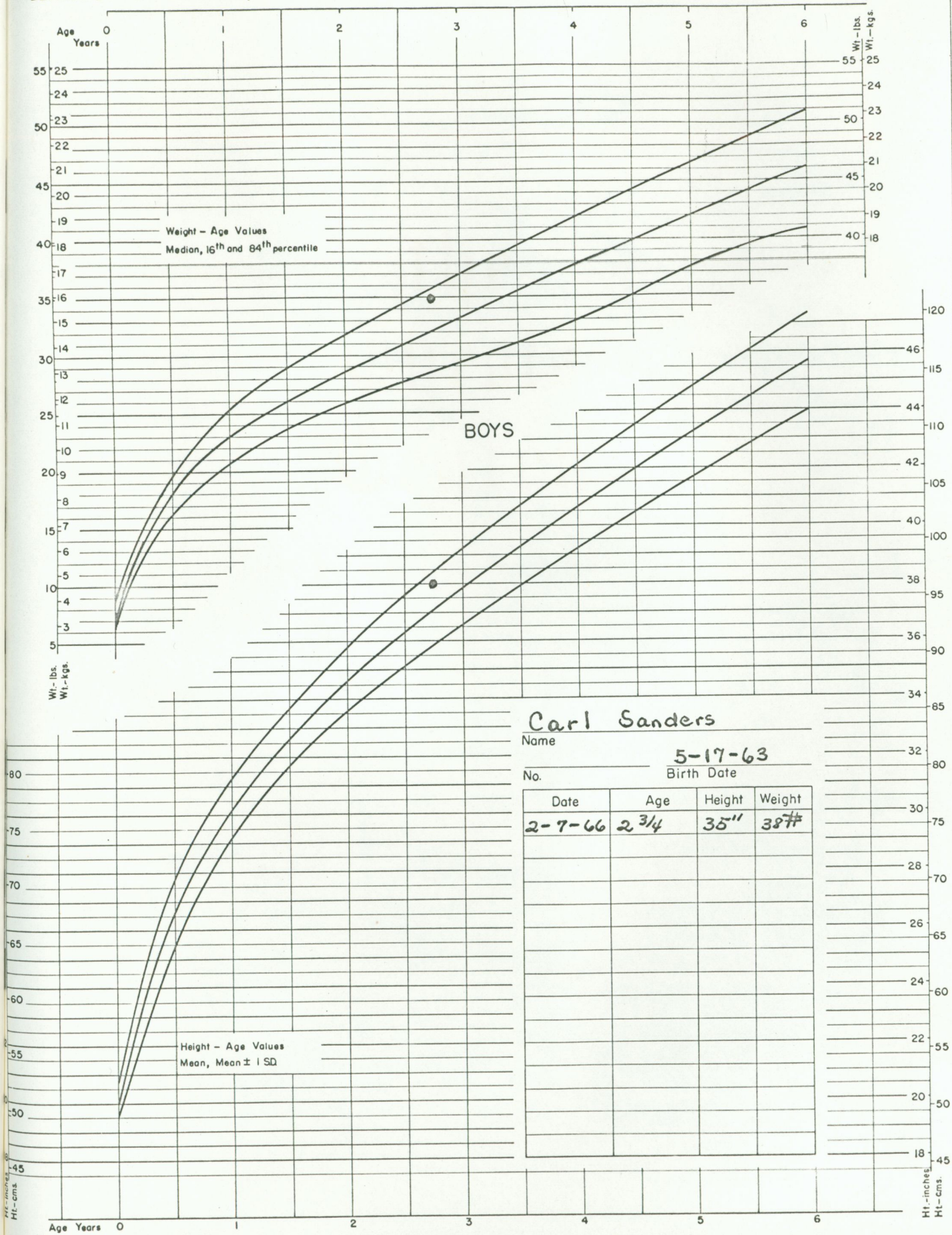
Implications

It is of great importance to prevent the necessity for children to adapt to hospitalization with such self-defeating mechanisms of defense as denial of the need for mother and for mothering. What can health workers do to prevent this needless misery that is suffered by the child and his family? The writer suggests that: (1) "living-in" arrangements be made available to all mothers of children under four years of age and encouragement given to use them; (2) unlimited visiting privileges be the rule in hospitals and the parents be welcomed at any time; (3) members of the health team be sensitized to the importance of the child's emotional tie to his mother and to the urgent necessity of helping him to sustain it during hospitalization; (4) members of the health team have help to understand and to learn to help children deal as constructively as possible with their feelings during hospitalization; (5) vigilance by nurses be sustained to lend consistant and continuous

care to young children; (6) health workers be taught to identify problems that arise in child-parent-nurse relationships in the health agencies in which they work; and (7) parents be provided with help to further their understanding of their children's behavior toward them while they are with them in the hospital.

APPENDIX

DEPARTMENT OF PEDIATRICS, STATE UNIVERSITY OF IOWA



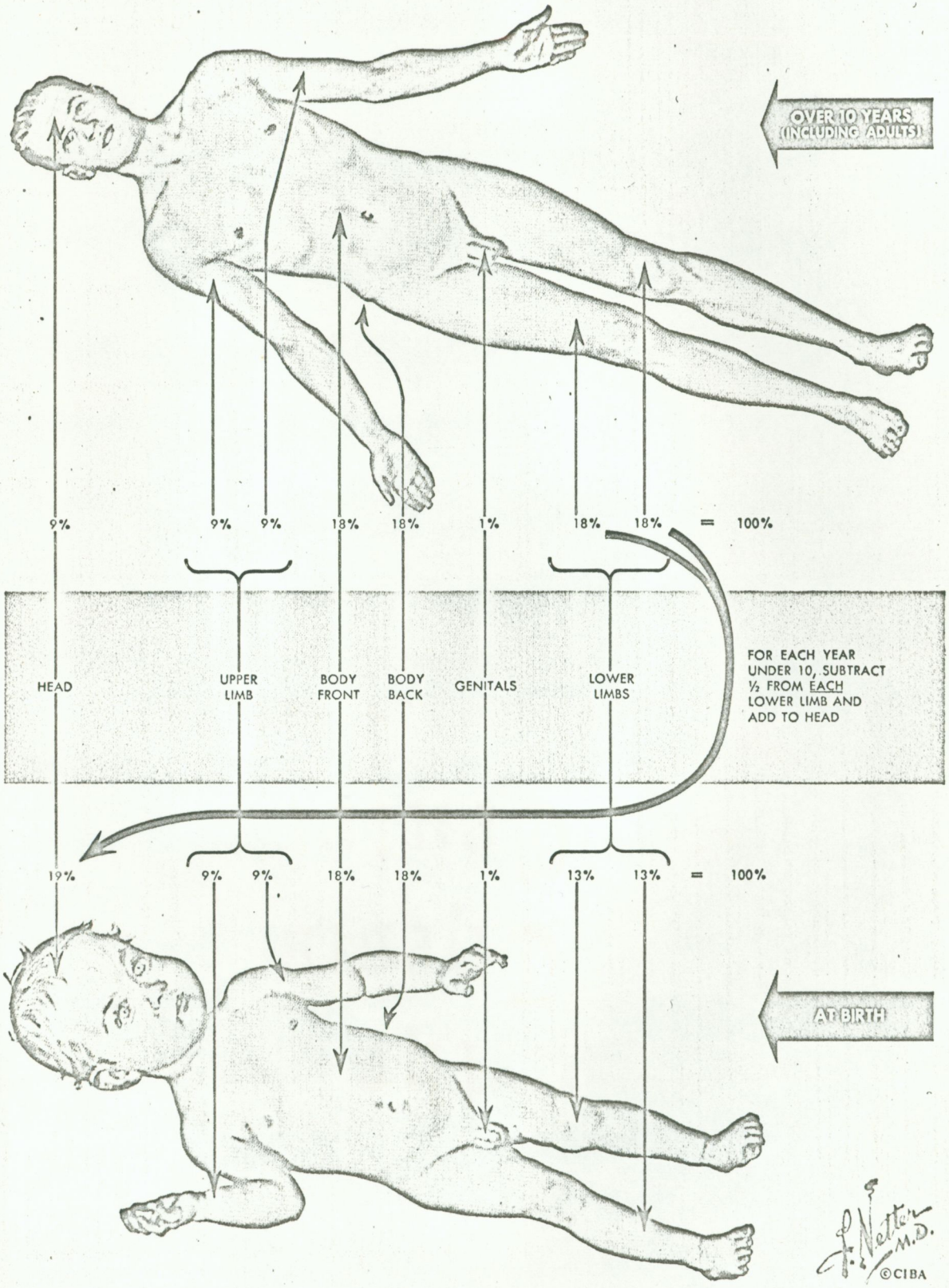
Carl Sanders
Name

No. 5-17-63
Birth Date

Date	Age	Height	Weight
2-7-66	2 3/4	35"	38#

PREPARED FROM DATA COMPILED BY IOWA CHILD WELFARE RESEARCH STATION

NO. 251-B


OVER 10 YEARS (INCLUDING ADULTS)
9% 9% 9% 18% 18% 1% 18% 18% = 100%
HEAD
UPPER LIMB
BODY FRONT
BODY BACK
GENITALS
LOWER LIMBS
FOR EACH YEAR UNDER 10, SUBTRACT ½ FROM EACH LOWER LIMB AND ADD TO HEAD
19% 9% 9% 18% 18% 1% 13% 13% = 100%
AT BIRTH
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BIBLIOGRAPHY

Books

Blake, Florence G. The Child, His Parents, and the Nurse. Philadelphia: J.B. Lippincott Co., 1954.

Blake Florence G., and Wright F. Howell. Essentials of Pediatric Nursing. Philadelphia: J. B. Lippincott Co., 1963.

Bowlby, John. Child Care and the Growth of Love. Baltimore: Penguin Books, 1965.

Erikson, Erik. Childhood and Society. New York: W. W. Norton and Co., 1963.

Freud, A., and Burlingham, D. Infants Without Families. New York: International Universities Press, 1944.

Hall, Calvin S. A Primer of Freudian Psychology. New York: The New American Library, 1956.

Heinecke, Christophe M., and Westheimer, Ilse J. Brief Separations. New York: International Universities Press, 1966.

Moustakas, Clark E. Loneliness. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1961.

Robertson, James. Hospitals and Children: A Parent's Eye View. New York: International Universities Press, 1963.

_____. Young Children in Hospitals. New York: Basic Books, Inc., 1958.

Vernon, David, et al. Psychological Responses of Children to Hospitalization and Illness. Springfield, Illinois: Charles C. Thomas Publications, 1965.

Yarrow, Leon J. "Separation from Parent During Early Childhood," Review of Child Development Research. New York: Russell Sage Foundation, 1964, 89-136.

Articles

Bernabeu, Ednita P. "The Effects of Severe Crippling on the Development of a Group of Children," Psychiatry, XXI, 1958, 169-194.

Cowin, Ruth. "Social Factors in Treating Burned Children," Children, Nov.-Dec. 1964, 229-233.

Gofman, Helen, Buckmen, Wilma, and Schade, George H. "The Child's Emotional Response to Hospitalization," American Journal of Diseases in Children, XCIII, 1957, 157-164.

Heavonrich, Robert, Erickson, Florence, and Saren, Martin. "Viewpoints of Children in Hospitals," Hospitals, XXXVII, May 16, 1963, 40-52.

Jackson, Katherine. "Psychologic Preparation as a Method of Reducing the Emotional Trauma of Anesthesia in Children," Anesthesiology, XII, 1961, 293-300.

Langford, William. "The Child in the Pediatric Hospital-Adaptation to Illness and Hospitalization," American Journal of Orthopsychiatry, XXXI, 1961, 667-682.

Long, Robert T., and Cope, Oliver. "Emotional Problems of Burned Children," New England Journal of Medicine, CCLXIV, June 1961, 1121-1127.

Mason, Edward A. "The Hospitalized Child - His Emotional Needs," New England Journal of Medicine, CCLXXII, Feb. 25, 1965, 406-414.

Pearson, G. "Effect of Operative Procedure on the Emotional Life of Children," American Journal of Diseases of Children, LXII, 1941, 716-729.

Plank, Emma N. et al. "A General Hospital's Child Care Program to Counteract Hospitalism," American Journal of Orthopsychiatry, XXIX, Jan. 1959, 94-102.

Prugh, Dane G. et al. "A Study of Emotional Reactions of Children and Families to Hospitalization and Illness," American Journal of Orthopsychiatry, XXIII, Jan. 1953, p. 70-105.

Robertson, James, "Some Responses of Young Children to Loss of Maternal Care," Nursing Times, XLIX, April 18, 1953, 382-386.

Shore, Milton F., Geiser, R. L., and Wolman, Harold M. "Constructive Uses of a Hospital Experience," Children, XII, Jan.-Feb. 1965, 3-9.

Vigliano, Aldo, et al. "Psychiatric Sequelae of Old Burns in Children and Their Parents," American Journal of Orthopsyciatry, XXXIV, July 1964, 753-761.

Woodward, Joan, and Jackson, Douglas, "Emotional Reactions in Burned Children and Their Mothers," British Journal of Plastic Surgery, XIII(IV), 1961, 316-324.

Pamphlets and Papers

Blake, Florence. Nursing Intervention to Reduce Suffering from Separation Anxiety. Columbus, Ohio: Ross Laboratories, 1965.

Deprivation of Maternal Care; A Reassessment of its Effects. (Public Health Papers No. 14) Geneva: World Health Organization, 1952.

Johnson, Dorothy E. Sensory Deprivation - One Aspect of Maternal Deprivation. Columbus, Ohio: Ross Laboratories, 1964.

Littner, Ner. Some Traumatic Effects of Separation and Placement. New York: Child Welfare League of America, Inc., F-17, October, 1956.

Films

Robertson, James. "A Two Year Old Goes to the Hospital." London: Tavistock Child Development Research Unit, 1953.