PREPARATION OF CHILDREN FOR HOSPITALIZATION

by

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This project
is dedicated to
my Father

TABLE OF CONTENTS

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CHAPTER I

INTRODUCTION

There is now abundant evidence in the literature that illness has numerous implications for the individual patient. Moreover, we need only to examine our own feelings concerning such a personal experience in order to understand something of the impact of illness and how threatening it is to personal equilibrium. We know, too, that there can be a combination of circumstances or a particular period of life when the impact is more severe. If there is added to the element of illness itself the need for hospital care, the entire experience becomes a greater source of anxiety. This is so, even when we have known countless individuals who have been completely restored to health as the result of such care. Fears of the unknown play a large part in this anxiety - fears of death, of injury at the hands of another person, of loss of control over our own persons and our environment. Added to this is the adjustment to separation from the family and to a new environment that is very complex and confusing.

Dr. Carl W. Sawyer has pointed out,

> "Hospitals are unlike anything else in the world. To the patient first coming to them, they are disorderly; people are racing about with no purpose; no one seems to know anything about anything; everybody is busy, too busy in fact, to do what the patient wants done; there is no system, everybody is in everybody's way. This early impression is very greatly erroneous. ..... Nobody is working at random. They are all definitely striving for the patient's welfare."

And, further, Dr. Sawyer points out,

"Having once overcome the shock of the physical entering of the hospital and its total reversal of normal life, the sick person rapidly discovers another startling fact. The individuality and personality of the patient is rapidly done away with. With a startling swiftness the patient finds himself, as he or she feels, 'merely another patient', a 'guinea pig' and a 'field for experimentation and exploration' for quarreling doctors and inhuman nurses. Without his willingness and understanding he is thumped, punctured, punched and gone over needlessly, unmercifully, unreservedly. He is stripped of his clothing, he is examined in what he thinks is an immodest way and he is given no opportunities to present his own ideas about matters. It is not until he leaves the hospital some time later, and gets back into normal life, a well individual again, that he appreciates the thoroughness with which he was examined and studied." [1]

We know how difficult it can be for an adult to face this experience, even with the explanations he is able to obtain from his medical advisor and by drawing on his own experiences and those of acquaintances. How much more threatening and even terrifying may this experience then be to a child, particularly a small child who lacks these adult resources.

Medical procedures have become more and more complex with the increase in diagnostic and treatment devices which serve the patient well but complicate life in a modern hospital. We are beginning to recognize, also, that separation of a child from those upon whom he has depended for love and security plays a major role in his hospital experience. A study was made in 1950 by the Department of Pediatrics of Albany Medical College as to the effects of anesthesia and tonsillectomy upon the behavior and emotional reactions of children. The factor of negative reaction to separation was recognized in their preliminary study. It indicated that in those who have had a separation experience, negative reactions to it were noted in 56% of the cases, and among "only" children 75% reacted negatively compared with 45 to 52% of those in families having two or more children. [2]

It is planned herein to quote evidence from the literature, chiefly professional, to substantiate the growing recognition of the separation factor. Much is based upon the observations made by Anna Freud and Dorothy B urlingham while they were caring for child evacuees in England during World War II. These two authorities found that children were comparatively undisturbed by bombing and destruction if their parents were with them.[3] This is a newer concept than that of Drs. Leo Kanner, Douglas Thom and others who have regarded the effect of illness on children as arising primarily from the "gain" of attention, or "spoiling".[4] These men based their theory primarily on the element of adverse conditioning, whereas Freud and Burlingham relate theirs to the important relationship between parents and child.

Any new experience requires some preparation or advance knowledge of what is to happen if the individual is to participate fully and thus direct all his energies toward a successful outcome. The strength he requires for facilitating such an experience is derived from previous successes or the support of someone upon whom he can depend - someone he knows is concerned with his welfare. For an adult, the doctor is probably the source of this strength in the event of illness. The source of a child's confidence, however, is primarily his parents.

Some of the individuals who have been engaged in the care of children in hospitals have long wondered how much, if any, preparation is given young patients before admission. So far as it can be determined, little material has been published on the details of preparation given children prior to hospitalization. Edith G. Seltzer, consultant of the United Hospital Fund of New York in 1947, refers to their "review of a group of cases of children sent to (medical) institutions thousands of

miles away from their families". In this study it was found "that this (preparation for separation) was not always done".[5] There is no indication that this "review" was any more than a cursory investigation and no details were supplied.

For these reasons it was felt that an exploratory study might be undertaken of a representative group of children admitted to a hospital. Because the patients of the University of Wisconsin Hospitals come from communities throughout the state, the separation factor is almost universal. This hospital, therefore, seemed an appropriate setting for such a study. The approval of the administration and of the physicians and nurses on Pediatric Service was readily granted. Permission was obtained to interview the parents of the child patients within the hospital itself, and the day of admission was decided upon as most suitable.

The study then was designed to look into the experiences of a group of children admitted to the University of Wisconsin hospitals, to observe analytically the treatment to which each one was exposed for his particular medical problem, and to study the preparation he received for the treatment, the new environment and the separation from his family.

Details of the plan and the methods employed are outlined in Chapter III. In Chapter II which follows, we will consider in some detail the meaning of hospitalization to the child who is ill.

CHAPTER II

HOSPITALIZATION - ITS IMPLICATIONS FOR CHILDREN

The great strides in medical knowledge and improved methods of treatment have, as we know, led to more and more hospital admissions for acute illnesses. They have contributed immeasurably to the welfare of the people through lowered mortality and increased comfort of living, and we can be grateful for improved health facilities. Children have shared in the fruits of this progress and many have been enabled to live longer and more useful lives through the treatment made possible by the skilled services of a hospital.

Nevertheless, there are some negative factors to be considered. The most important one is the consequent separation of the child from the security of his home and family. Less traumatic are the fears that develop from treatments to which he must submit. Dr. Marian Putnam told a conference of pediatricians and psychiatrists in 1947,

> "It is amazing how little pediatricians hear about the aftermath of hospitalization, but we psychiatrists get it. It has just not occurred to mothers to tell pediatricians that their children began to wet and soil after they came home, although they may not have done so in the hospital; that they began talking badly or wanting to be fed or were sometimes not able to sleep for months unless the mother was right beside the bed all the time. I know these are the exceptions but, as in all medicine, we have to direct our practice toward the child who may get diphtheria and the child who may have emotional disturb ances, not toward those who do not have them. I believe that a great deal can be done that will contribute toward the mother-child relationship in general if we can help mothers to anticipate with their young children - two years old or perhaps even younger - what is going to happen in the hospital, to describe it in detail so that events don't come as overwhelming shocks to the children."

Also,

> "A young child has an extraordinary capacity for repressing his emotions. We blame mothers for children crying on visiting days and infer they are bad mothers. Actually this is the first time the child has dared to allow himself to know how bitterly disappointed he is in his mother, how angry and how terribly anxious he has been made by this experience." [6]

This, then, is our theme. We concede that there are some children for whom separation through hospitalization can be beneficial - those who are rejected or overprotected and can be helped emotionally by removal from the home and by the provision of a warm and free relationship. But for most children - particularly the younger ones - the experience can be harmful. Since the trend is now toward, rather than away from, hospitalization, despite some recent movements to set up home care programs, [7] it seems best to accept this trend because of the benefits to be derived from hospital care but to minimise its dangers through whatever means we have available. If hospital care is necessary for recovery, we should prepare the child for the experience, help the parents maintain contact with him after he is there, and allow him to express himself afterwards so as to reduce emotional disturbance.

Our basic concept is the importance of the parent-child relationship, to the study of which Margaret Ribble and Anna Freud have contributed so much. As Dr. H. S. Lippman has pointed out,

> "The young child needs to belong to someone; needs to be able to share the excessive affection he has for himself - a characteristic of all children during the very early years. This sharing is possible with one who sees that he is comfortable, well fed and happily amused; one who has affection to give him in return for that which he may be willing to give up." [8]

Freud and Burlingham point out that the emotional relations of the small child to his parents are of importance for his development in two

main respects: one, that this childish love is the pattern for all later love relationships and wherever, through the absence or interruption of personal ties, this opportunity (to learn to love) is missing in childhood, all later relationships will develop weakly, will remain shallow. The second respect is of equal importance. It is this first love of the child which contributes to his education. Education demands from the child continuous sacrifices - to become clean, to lessen his aggression, to restrict his greed, to renounce his first sexual wishes. He is ready to pay this price if he gets his parents' love in return.[9]

Hospitalization may be brief, and we may be accused of exaggerating when we compare a stay in a hospital to a more lengthy and complete separation such as in a foster home placement or the disruption of a home in wartime. However, it is important to remember that, at least to the small child, the impact of even a short separation can be severe because he has little conception of time. Separation from parents for a few days can seem like eternity to the small child. As to the effect of long-term care in hospital, there should be no doubt as to its danger unless careful steps are taken to reduce the trauma by proper handling.

When we add to this, the fact that the child's limited experience causes countless fears, we may gain some conception of what it means to him to be brought to a strange environment and left there by those upon whom he has always depended. Fear of desertion and rejection strike at the roots of his "primitive need for security" - which is the interpretation of the English school of thought referred to by H. Edelston. It is differentiated from the Freudian stress on loss of the mother as a sexual object.[10] Anna Freud concluded in her study of war evacuees that the

exposure to death and destruction on all sides (short of actual physical injury to the child or parent) had little effect on children, providing the parent - usually the mother - was nearby to supply the reassuring presence he required.[11] By the same token, the mother's own anxiety (if any) was communicated to her child and produced insecurity in him.

H. Edelston's study is probably the most significant and pertinent of those found in the published material related to separation anxieties in children due to hospitalization. He feels that separation is the essential element in disturbed behavior, as he has seen disturbance when the mother herself goes to the hospital and leaves the child in the care of relatives or a stranger. His study covered forty-two cases of children with hospitalization experience ranging in age from two through adolescence. He criticized the common recommendations of doctors that the child be sent away from home for convalescence or to correct poor behavior. Such a plan gives little consideration to what happens when the child returns to his home or even to the possibility that the separation may set up fresh emotional disturbances. Thus it may aggravate the original condition rather than cure it.[12]

Relation to Levels of Development

It is apropos here to consider briefly how the meaning of hospitalization varies with the different age and developmental levels of the child. Even though the present study does not include children under two years, we might consider the needs of infants for the purpose of understanding later age groups.

The infant under one year is completely dependent upon his mother for all his needs, and from this turning to her for satisfaction "an ade-

quate answer to this seeking force brings out in him the reaction of recognition and love".[13] During the first six months he may respond to any person who can supply his intimate needs, not necessarily his own mother. However, during the second six months, according to Anna Freud, the increasing impact of stimulation and emotional interplay in the home takes place.[14] Disruption of his early observation and imitation which begins at about the eighth months may be disturbing.

Also, of great importance in the first year, is the weaning process. Many authorities such as Drs. Benjamin Spock, Mabel Huschka, Gerald Pearson, David M. Levy and others, advocate avoidance or postponement (if possible) of hospitalization for all children who are facing anxiety-provoking situations such as weaning. Certainly the infant who is faced with relinquishment of breast or bottle will find a change in environment plus medical intervention very threatening. Toilet training, which starts between twelve and eighteen months and is usually completed by three years, is also a source of conflict for a child and unnecessary problems ought not be added at this time. The mother's ego is the source of the child's strength to accomplish bowel and bladder control successfully and, therefore, separation may well affect its progress. Also, if the specific illness is related to these organs of elimination, much anxiety may be aroused and cause a distortion of the child's attitude toward them.

Speech evolvement, too, during the second year and into the third is highly dependent upon the relationship with the parents, although it does not arouse the same pressures from the family as does failure to conform to eliminative patterns. Walking is learned somewhere near the first birthday. As it, too, is a complicated process, physically and

mentally, illness and perhaps separation through hospitalization may discourage the child and delay its accomplishment. Walking provides locomotion and, therefore, access to new objects, and it stimulates curiosity. Inhibition of these powers will delay the growth of the child's control over his environment and, therefore, his ego development.

Dr. David M. Levy made a study of one hundred twenty-four children seen in his psychiatric clinic, whose trauma were traced by the mothers to surgical procedures in early life. He concluded that the one- and two-year-olds (none under one year was recorded) are generally more sensitive to pain, more dependent upon their mothers, had a more circumscribed world and are thus less able to handle their anxiety. For these reasons the anxiety broke through into night terrors, since the small children could not yet play out their feelings with toys or verbalization as the older children can. Moreover, the forcib le separation from home results in a fear of all strangers and places and hurts.[15]

The well-known Dr. Benjamin Spock commented at the 1947 conference of podiatricians and psychiatrists about separation anxiety. He said that the child becomes peculiarly liable to alarm if the mother leaves him. He is not as susceptible at one and one-quarter years nor at two and one-half years. However, at the age of three years the child seems to show "more elaborate and morbid anxieties that seem so unrelated to the experiences that the child has had". Dr. Spock does not theorize as to why this is so.[16]

The observation about more trouble with three-year-olds seems confirmed by a study made by Mary Shirley and Lillian Poyntz of one hundred ninety-nine children from two to eight years who were brought to an all-day clinic for thorough physical examinations. These children were given

x-rays and photographs, blood tests and psychological tests. The two authors noted the highest incidence of upset among the three-and-one-half-year-olds and attributed this phenomenon to the beginning of recall of previous experiences taking place in this period.[17]

The ages of three to six, roughly, constitute the so-called "oedipal period" which is characterized by widening relationships, first in the home and then the neighborhood. There is increasing curiosity concerning many things including the child's own origin and his discovery of sex differences. He begins to identify himself with the parent of the same sex and becomes involved, according to psychoanalytic theory, in conflicts arising from his rivalry with this parent for the love of the other parent. This, together with lack of understandable explanations regarding sex relationships, complicate illness and hospitalization for him because of his feelings of guilt and fears of castration by the rival parent. He may, then, see his hospitalization as punishment for his "badness" and surgery may arouse even more terror. Other anxieties may arise from the birth of other children in the family and from early experimentation in sex play. Parents usually fail to see the basic reasons for such difficulties. They do not understand how a child's imagination conjures up fantastic ideas in these areas.

Jean Piaget points out the evolution of a child's conception of causality, especially the common phenomenon of juxtaposition. Up to two or three years, the child has no clear consciousness of self; then "why's" appear and he becomes aware of the "resistance in the external world" and can observe objectively. At four or five, he sees no intermediates — relations are immediate or direct, i. e. if two things

exist at the same time they must be related. At seven and eight, understanding of true causality begins to appear, and then physical laws are recognised by the child. At eleven or twelve years, generality of law takes deeper root and he can make deductions.[16] From this brief exploration into the child's ideas it can be seen that the smaller children may be fully convinced of their naughtiness and that they have been sent to the hospital for this reason. Since most children feel guilty over some act or thoughts of hatred, this reaction is quite common.

H. Elelston, in his study, comments about the younger children (and even up to eight years), in this regard,

> "Coming at a time when the young child is more helpless than ever owing to his illness and feels the need for his mother's care and affection most, removal from home must be a most distressing experience and will undermine his trust and confidence in his parents..... A true understanding of the position is quite beyond the child's egocentric outlook and he consequently feels (or even actively misinterprets) the situation as a 'rejection' or a punishment. The inevitable emotional insecurity which is aroused I consider to be identical with the anxiety arising from 'fear of the loss of the mother' (in the psychological sense) which lies at the root of so many neurotic disorders. The further reactions and many of the 'symptoms' of the hospitalized child are now seen to be the familiar 'attempts to master anxiety' or 'ego-defenses' of the orthodox psychoanalysis." [17]

During the so-called "latency" period, from about six to twelve years, a child becomes engrossed in his social world at school and among friends of his own age. He works out his own adjustment and his ego becomes strengthened along the way so that the dangers of the previous period become less threatening if patient handling has been supplied. He is much less dependent upon his parents, but may still misconstrue what he hears due to inadequate information. He may also be carrying along hidden anxieties which can be reactivated. Then too,

as Frances Upham points out, in the oedipal and latency periods a boy "may develop a severe conflict between his passive and masculine tendencies if he is subjected by a powerful mother person to a series of hospitalisations, operations, braces and restrictive home routines". Also, if "the father alone takes responsibility for the girl's surgery or medical care, she may associate treatment with fantasies of sexual injury at the hands of the male".[20] It is recommended, therefore, that both parents in each case strengthen the masculinity or femininity of the child so that there is no feeling of attack by the parent of the opposite sex.

Although this study is not directly concerned with adolescent patients, we might mention that they too have problems insofar as they are beset with a flow of sexual impulses and an "exaggerated fear of helplessness and dependency".[21] Illnesses and hospitalization associated with sexual organs or those which threaten status in their own groups are sources of greatest anxiety to them. They should be drawn into planning for their own care even more actively than should the younger children.

Corollary of Placement and Related Dynamics

It should be pointed out here that the damage to the child's personality can be immeasurably diminished if he is assisted in accepting hospitalization by those whom he feels he can trust. The greatest trauma results if the impact is sudden, or very severe, or if the underlying personality structure is poor. It is felt that almost any experience can be converted into positive value for the individual if the necessary support is given, either beforehand in preparation or, th ough less satisfactorily, later.

Participation is the essence of preparation. It must be geared to

the capacity of the individual facing the new experience. Lacking it, he tends to resent everything and everyone associated with the plan, and poor behavior results. Our concern for the individual requires that we contribute toward his understanding of the situation and the required change. It is best that this be given by the most trusted person and in the familiar surroundings which are the source of security from which he must move. If he learns there some of the aspects to be anticipated in the new situation, facing them later will result in less shock. He must, if at all possible, have some choices so as to insure a feeling of some control over what is happening to him. If there are deep conflicts about the change, he needs assistance in bringing them out at the earliest possible moment. The persons in the new environment, too, should be prepared to ease the transition for the individual child as much as possible, accepting subsequent disturbed reactions as quite normal when the causes are understood.[22]

These principles are basic in social casework and are applied carefully to the placement process in the child welfare field. It might be well to borrow from the placement experience and enlarge on our parallel situation somewhat further, with emphasis on separation as a psychological process.

The Rankian school of thought and the Pennsylvania School of Social Work contend that "growth implies spearation", as Dr. Frederick H. Allen expresses it. He points out that separation begins with the very earliest stages of cell division in the development of a human life - a giving up in order to go on growing - and the birth process is also a separation as well as a beginning. Further, "the infant must have a sense of oneness with another in order to grow".[23] Because he "feels his strength

in relation to another person usually stronger and always different from him"[24] he needs identification with such a person to provide the bridge to new achievement. He must, however, experience something himself in order to change. This recognizes, then, the acceptance of separation as a process of growth but points up the importance of method. It concedes that protection from difficult life experiences is not the solution, but that human beings "find fulfillment in experiences that are hard to leave" and "they can overcome the traumatic aspects of a painful parting by the discovery of unused strengths for living in the self". Jessie Taft says further,

> "What man resists, above all, is external interference with any phase of his living before he himself is ready to abandon it. It is not the leaving, but the lack of control over leaving, that he fears. If he can possess to some degree the ending phase of even the deepest relationship, so that he feels as part of himself the movement toward the new, then he can not only bear the growth process, however painful, but can accept it with positive affirmation."[25]

More specifically, those most concerned with child placement refer to

> "The child changing from one living experience to another, perhaps more complicated, and certainly carrying the fear of the unknown and the loss of accustomed landmarks and supports which ..... may so easily mean a threat of loss of self",

and, further,

> "A child can be stopped in his whole process of growth, temporarily — and sometimes fundamentally — by a placement experience for which he is not prepared. Somehow he must be helped to find a possible way of bringing himself into the new situation, through struggle and denial, through a differentiation of his own responsibility from that of the other person, be it parent or caseworker, eventually finding his own place in the whole configuration of circumstances which necessitate and constitute placement."[26]

Ethel Verry, Executive Secretary of the Chicago Child Care Society, described preparation of a child for foster home placement before a sectional meeting of the Wisconsin State Welfare Conference on November 27, 1951. She, too, stressed the idea of "helping the child to move" and encouraged focus on what he is doing rather than on what someone else is doing for him. She pointed out that for any of us to make a move brings a number of feelings: anxiety because of fear of what we are going to, even though the decision is ours, and we are concerned as to what to take along; grief at leaving things behind us, which we have a right to feel and might well express while being helped to see the strength to go on to the new; excitement, and recognition of the good aspects of the change; and confusion, with the resulting fatigue.

Miss Verry points out too the guilty feelings of the parents who are relinquishing their control over the child. She pleads for honesty and kindness toward him, no matter how much easier it would be to minimize the truth. Both parents and child need to have clear views as to why the change is made, and all must participate. Parents need to be helped to regard the child and his feelings objectively, and this may touch off the beginning of a realization that the child is a separate person - as he surely is.

Miss Verry further recommends that when the child arrives at the new place, it be arranged for a time when there is a minimum of confusion, so that he can get his bearings. He needs, also, a feeling of moving to things that are reserved for him in particular. She warns not to undress him at once because it strips him of his own things, but to allow this to be done somewhat at his own volition so as to enlist

his participation. Thus, it is his experience and his gain will be tremendously greater.

Another unconscious plea of the child is to "let me keep some of my own things" to help the transition. For a small baby it would mean milk that suits him, his old bottle, the smell of a familiar blanket, perhaps simple word patterns to which he is accustomed (even if he cannot understand their meaning). For those beyond the infant stage, other familiar possessions such as a doll, a toy, a book or two, favorite articles of clothing — all these are a source of security in the transition.

Miss Verry adds that in being honest one need not tell all the disturbing facts but just those elements that satisfy the child at his particular stage of development - much as in the matter of sex instruction - what he can use in adjusting to the move ahead. The pre-placement visits to the new home are fine, but in the cases of small children they should not be made too far ahead of the actual transfer because of the inability of small children to tolerate a long delay.[27]

Application to Hospital Admission

The foregoing recommendations seem to represent the most recent thinking and practice in placements, and the principles have been adopted by a number of authorities in the medical field, particularly in pediatrics. Helen McDonel, R.N., pointed out in an article in the American Journal of Nursing of March 1938, the importance of lessening the intensity of the emotional problems involved in a child's admission to the hospital. It would "decrease markedly the whining, screaming and shouting which, in turn, would promote a smoother organization of service". She also referred to the need of discussing with the nursing

staff "whether preparation of the child for hospitalization (currently being given) by the parents, nurses and doctors was helpful or truthful", and wonders if he is "told the names of the different pieces of hospital equipment which were never seen at home". She also asks, "Did anyone help him through the first night?"[28]

Drs. Mabel Huschka and Owen S. Ogden in 1938 decided that a children's clinic was a good place to apply the new thinking in medicine which was placing greater emphasis on the needs of the patient as a whole. They chose this type of clinic because of so many emotionally painful experiences there which might well need attention. "Needles" were recognized as especially frightening and probably precipitated or aggravated latent anxiety in a child. Because neuroses begin in childhood, it was felt imperative that efforts be made to reduce childhood anxieties wherever possible. Drs. Huschka and Ogden altered the clinic procedures in the following ways. They minimized the use of restraints in handling a child in order to foster more cooperation and to reduce the feeling of helplessness, particularly in relation to the first doctor who examined the child. They decreased waiting time. They provided toys and a playroom for pleasant associations. They arranged to have a psychiatrist handle a very anxious child. They had less apparatus exhibited, including needles and syringes, and avoided having one child witness another receiving an innoculation. They also encouraged the parent's presence unless he was too anxious himself. Parents were given an explanation, and so were the children who were over four years of age. The doctors told the child the truth about the probability of hurting him, but modified this by adding that it would be "not for long".

They reduced physical restraints to babies and avoided the use of them by parents so as to protect the parent-child relationship. They administered less treatment in the area of the body with which punishment is associated. As many injections as possible were given at once to avoid prolonging the process by many visits. The child was freed at once to end his helplessness quickly and to minimize the anxiety of danger at the hands of a human foe. The doctors spent a little time reassuring the child, and then sent him at once to the playroom. This also reduced the amount of crying. These physicians concluded that the little added time which had been required for these modifications of procedures was well worth it in terms of reducing anxieties and producing more favorable conditioning to medical treatment.[29]

Elizabeth Lee Vincent, Ph. D., had advocated a year earlier in the periodical "Hospitals" the idea of enlisting the child's cooperation rather than holding him supine by force and meeting with resistance. She felt he should be permitted to follow and cooperate as well as possible. She also stressed honesty with children as the first requisite.

> "If we are going to hurt them, we must tell them and not walk in the night before and say we are going to stick him with a needle the next day. He should know what the hospital staff is doing to him."[30]

Dr. Edith B. Jackson of Yale University, in discussing the treatment of the young child in the hospital, advocated these same techniques and condemned threats and trickery which make hospitalization a punishment to the child. She also discouraged careless remarks in his presence about his illness and the use of reassurances based on false promises. More than one child has later accused a doctor or parent of trickery be-

cause they had assured him the operation or other treatment would not hurt. Dr. Jackson indicates, as others have done, the mistaken idea many hospitals' staffs have held that a child has become adjusted when, after a few days in the hospital, there is less crying and then only in the presence of the parents. She suggests that staff personnel do not realize "the power of a child's reserve about his innermost concerns", and that he uses silence to cover his anxiety. She warns that good behavior is not always evidence of good emotional adjustment.[31] Beata Rank recommends, following this article of Dr. Jackson, that it is good to let the child play out before and after an operation his feelings about it, in accordance with Freud's theory. Freud said that "affect can be greatly alleviated, if not completely mastered, through repetition and transformation from passivity to activity".[32] This process of "playing out" has gained wide acceptance through the encouragement of child psychiatrists, and the idea has found expression in a fairly recent issue of one popular magazine. McCalls of February 1952 described in pictures how "Smitty has his tonsils out" and his parents acted out the operation with him. In the final picture, the little boy prepares his toy rabbit for a similar experience and the author comments below, "Children often dramatize experiences that are difficult or exciting. It's wise to let them. This kind of play helps them understand what's happened to them."[33]

Dr. David M. Levy states, further, in his article,

> "The children who had remained free of emotional difficulties after their operation h ad been told the reason for the operation and how it would be performed. They were taken to the hospital by the mother or father and anesthetized or given sedatives in the bedroom. A fter the operation the mother or father or a governess was there to greet them, usually with a present. Under the conditions described, the children were

spared the following experiences recorded in the text and in the appended records: being tricked into the hospital; being wheeled down a corridor; struggling against the anesthetic; suddenly seeing weird instruments; seeing the white surgical room; seeing many people in white, some in the distance and some hovering over him, and returning to a new bedroom with a strange nurse, another person in white." 34

A s a solution, Dr. Levy further recommends the following: the patient should be told it is necessary to do the operation and it should be explained, even though inaccurately, as it relieves tension. This may be done simply and briefly and repeated as often as necessary. The child experiences less fear if he goes to a hospital with a familiar person, preferably the one to whom he is closest. If it is a young child, the mother should help him to bed. A sedative should be administered before the general anesthetic. He should be spared seeing the instruments and the operating room and the elevator ride up and down. It is best he awaken in the same room from which he has come. His mother should be there to greet him when he awakens, which is the important time since he is in a strange place - perhaps for the first time in his life - and in acute distress and he needs his mother for protection. Dr. Levy elaborates on the subsequent use of play to which we have referred above. The child may

"generalise the experience, deal with specific aspects of it, play off in repetitive form the anxiety elements, reversing the roles of patients and physician, or distort and manipulate the experience in the same manner as is done in dream formations and with the same goal - the solution of a difficulty." 35

Paul Bergman, in The Nervous Child issue of January 1946, states

"It is not imperative that the anatomical and technical details of an impending operation be previously explained to the child, but a description of the aspects which he will experience - anesthetic and its effect, the pain after awakening, the scar and the reason for the scar - is also essential, and no effort should

> be spared to give him truthful, reassuring information. If the parent cannot do this because of his own emotional involvement in the sick child's anxieties, a trusted teacher, physician, social worker or a specialist in child psychology should be called in to perform this vital service." [36]

He further warns never to ridicule a child's anxiety as it may drive it underground but will not alleviate it, and it will make the anxious child feel more alone and helpless about his anxiety. [37]

Pediatric textbooks have been giving recognition to the implications of preparing a child for his hospital experience and his right to share in the activity. They also see the value of maintaining the vital parent-child relationship and of minimizing the separation through frequent visiting. [38,39,40] Formerly, all institutions have required almost a complete surrender of the child to the staff, which is an autocratic practice and at variance with our current philosophy. Instead of shutting out the parents, there is a trend toward utilizing more frequent visits for the mutual education of parents and staff. It is felt, in some hospitals, that the presence of the parents can provide an extension of the limited nursing personnel, inasmuch as mothers can do all but handle technical nursing procedures and they frequently help neighboring patients on the ward.

Dr. James Spence of the University of Durham, England, has been an outstanding proponent of this thinking. His recommendation of admitting mothers to the hospital along with their small children (particularly those under three years) has been carried out for some time in several hospitals in his own country, in New Zealand and on the European Continent. [41] For some years the medical men in Middlesex county in England have even advocated treating young tuberculous patients in their own homes, with

what they feel are better results.[42] In our country, a Cincinnatti hospital has instituted the practice of admitting mothers along with their children, and they consider it an advantageous arrangement for parents and staff members alike.[43]

The protest that cross-infections develop when visiting regulations are relaxed has been answered by some who conclude that experience shows little of this actually occurs. They add that the positive results of greater emotional security for the child patients far outweigh the threat of infections. Objections of staff to the loud wailing which occurs after parents depart have been met by many of the nurses themselves, who concede the real value of frequent and necessary visits for reassuring small patients.

Dr. Spence deplores the wasted energy of a mother as she sits at home fretting about her child - energy which she might better be using in his care at the hospital. He also considered separation unfair to the mother because it robs her of her right to care for her own child. The idea of permitting a mother to live in the hospital with the child has probably developed from recognition of Anna Freud's experiences in her wartime nurseries, to which reference has been made previously.

There are a number of other medical men who have advocated better understanding of a child's emotional reaction to his hospital experience and some measures to alleviate it. Some of them are Drs. Milton Senn of Cornell University; Dr. Reynold A. Jensen, University of Minnesota Medical School; Dr. Ruth M. Pillsbury of the University of California Department of Pediatrics; Dr. John Bowlby, Director of the Child Guidance Department, Tavistock Clinic, London; Dr. Marian Putnam of Roxbury Massachusetts Children's Center; and Dr. Grete L. Bibring of Cambridge, Massachusetts.

The Bi-Regional Conference Report on Long Term Care of Ill Children, given at Phoenix, Arizona in March 1949, referred to some excellent material contributed by Dr. Bibring. Dr. Keith Perkins, who also participated, suggested the value of preparing the family first, because the way they feel has much to do with how the child feels, and both need reassurance so that they are convinced the proposed hospitalization is the best thing. He said the doctor should know if the child has been separated before, so that he has some precedent to build upon, and judge how traumatic this present experience may be.[44] Dr. Bibring stated that an interruption of the relationship of a child under five to his own mother may lead to a great deal of distress and eating problems. She said it helps if a new attachment to a mother-substitute can be established by the child, but loyalty conflicts result and his own mother may become jealous. Just as in frequent replacements in foster homes, so also do frequent moves between homes and hospitals induce shallow relationships, so that the child will find it hard to form strong and lasting identification with a grownup environment so necessary for his development. Such frequent changes can also lead to confusion as to what is expected of him. If he must go to an institution, small groups with the same mother-person caring for all his needs is the best approximation of home life. For those over six years, separation is less harmful and threatening, because non-family groups have become more important to him. He still, however, needs frequent contact with his own family.[45]

Dr. Bibring also contributed these specific recommendations:
1st, the one who will be around the child for the first period of his hospitalization should be a person the child knows well before he enters

the hospital and he should not be left alone before he has related to his new environment; 2nd, as to the time for preparation, the child should know what he must face and go through some of his feeling about it beforehand; 3rd, the mother should be permitted to remain awhile on the ward after admission; 4th, there is a need to be honest toward the child, even though the effect is unpleasant at first; 5th, one should not forget "the protective pet or pillow or toy" to give him real security against the dark or separation or loneliness; 6th, we should remember we cannot expect to really smooth out everything./ As to surgery and fear of mutilation, Dr. Bibring expressed what previously quoted authorities have indicated - this need for a child to know exactly what will happen in order to avoid, out of his limited experience, the anxiety arising from his active imagination.[46]

As to who should prepare the child, few writers have been very specific about it, though they imply that the parents should assume this responsibility. Dr. Reynold A. Jensen does state, in connection with surgery, that immediate preparation is the doctor's responsibility and he adds that "it is our obligation to inform him (the child)" if something is to be done. Also, he feels the child should be encouraged to share his feelings with the doctor so that his questions can be answered honestly and simply, without elaborate discussion.[47] Dr. Ruth M. Pillsbury also assumes this and believes the preparation actually begins with the first contact with parent and child when the doctor undertakes guidance of the mother-child relationship.[48] Ruth Frank, nurse of the Orthogenic School at the University of Chicago, feels the nurse should explain procedures to a child before they take place - as to what is to

be done and why, preferably on the way to the clinic for an examination or a procedure.[49] It would surely seem logical that the referring physician is the best qualified person to take the initiative. Dr. Pillsbury feels that a week in advance is sufficient because "too long a period of preparation gives the child time to build up anxiety". She recommends a preview of coming events including, if possible, a trip to the hospital for sightseeing, perhaps a ride in the elevator, or an inspection or ride in a wheelchair. She goes on to say, concerning a child facing a tonsillectomy,

> "The procedure can be explained to him, little details in terms he knows; getting up in the morning; riding to the hospital without breakfast; being undressed and having his temperature taken; the shot (yes, the shot!) to make him more comfortable afterwards; talking to the nurse or doctor who will give him something funny to smell; going to sleep and waking up later with his throat feeling queer and sore; feeling very sleepy all day and all that night and having mother come for him in the morning. These are things he can understand and anticipate without too much anxiety. The knowledge of what to anticipate will make the situation easier for him to face."[50]

The same idea has been translated into an article which appeared in another popular magazine, Woman's Day, in April 1952. It was written under the supervision of an unidentified department of Columbia University, and was meant to be read to the child who was preparing for hospital admission. It provides "a glimpse of what brother, cousin or friend may have experienced in the hospital", narrating with accompanying illustrations what a little boy did when he had his tonsils removed in a hospital.[51]

Other similar articles have been noted more recently in newspapers and periodicals bearing the same message, with varying details but a noticeable trend toward greater consideration of the child's needs as

he prepares for hospital care.

* * *

The foregoing material demonstrates, then, how important many authorities feel that it is to prepare a child for his hospital experience, particularly if it is his first. It would appear that it may be a flexible procedure but should deal with the essential elements in terms the child can understand. It may be done by any of several persons, but the parents and physician carry the major responsibility.

We will now proceed to describe in more detail the methods used in the study of twenty-one cases of children admitted to the University of Wisconsin Hospitals during February and March of 1952. We may then determine whether the principles advocated by leading pediatricians and psychiatrists were being applied in the admission of these child patients.

CHAPTER III

METHODOLOGY

The case study method was felt to be best suited to this project, and the guided type of interview selected as most useful because it can provide statistical comparison of factors in the samples studied. The interview with the parent who accompanied the child at admission seemed the best source of information from the standpoint of being both direct and fairly intimate. A secondary value lay in the possibility of offering an educational experience to the parents. If the interview were handled carefully so as not to arouse further anxieties, it could point out the meaning to the child of entering the hospital for the first time.

It might have been helpful to supplement these parent interviews with material obtained from the local physicians who had referred the patients to the hospital, since it would seem that the responsibility for interpretation of hospital care is a part of their service to the family. This, however, would have involved the use of questionnaires, a type of report which often receives a poor response from busy people such as medical practitioners. It appeared most feasible to inquire only of the parents and to rely on their recall of what the child was told and whatever reactions they observed about his awareness of the plans being made for him.

A study such as this might ideally have included, besides the content of the preparation given the child, an evaluation as to its effect

upon his adjustment to the hospital. This would, however, have involved the establishment of criteria for judging the child's adjustment and their application by those persons (probably ward nurses) who could be considered best able to observe the patient's behavior. Evaluation of post-hospital adjustment would have required securing information from the parents after a period of time had elapsed following discharge to the home. Such reports might be very interesting but the process would involve difficulties in obtaining such information by mail from points throughout the state, with inevitable delay in completing the study. Therefore, the present plan confined the investigation to material regarding the nature of the preparation for hospitalization as it was secured directly from the parent or parent-substitute who accompanied the child for admission. This was supplemented by factual data concerning the medical experiences of the child while in the hospital to clarify further the adjustments which the child subsequently faced.

The parents of each child studied were then approached on the day of admission and asked whether they would be willing to contribute to our study. The purpose was explained as an effort to learn how children feel about coming to the University Hospitals for the first time. No refusals were encountered. It might be well to mention that four of the twenty-one interviews took place on a day subsequent to that of admission: one on the day following admission, another three or four days later when the mother came to visit, and another sixteen days after admission. Still another was nearly two months after admission, on the day of discharge. These deviations from the original plan were made during the latter part of the study in order to supply data on children

of certain ages which had been unavailable up to that point, so as to secure wider age representation. As far as can be determined, this deviation did not affect the desired results. The parents' recollection of what was said to the child or conveyed by other means seemed as complete two months later as it was under the usual apprehension surrounding the day of admission.

Only child patients admitted to the Pediatrics Ward were included in the study, in order to simplify the planning with medical and nursing personnel and also because this provided sufficient sampling of children in terms of their varying medical and surgical experiences (with the exception of tonsillectomies). This automatically set the upper age limit at twelve years, since none above that age is admitted to the Pediatrics Ward. The lower age limit of two years was established - not because it was felt that children below that age cannot be prepared for such an experience, but because until a child reaches two he is generally unable to express his feelings verbally, even in the form of simple sentences. Also, there was interest in learning what questions each child might ask when the idea of hospitalisation was made known to him. This age limit was arbitrary, despite the realisation that children vary considerably from the so-called "normal" in speech development. The fact that three of the four two-year-olds studied were finally diagnosed as mentally retarded is not considered as invalidating the conclusions about that age group. Those with mental age below two might still benefit from preparation, although it would be more limited.

The reliability of information secured during the tension and confusion of admission may be justifiably questioned. It is subject also

to the selectivity of the parents' memory of details regarding what the child was told about coming to the hospital. Moreover the parents may not have realised that the child may gain impressions from chance remarks of those in his surroundings as well as from direct statements to him. The interviews might also be affected by the parents' possible guilt over failure to protect the child from illness, and by other factors such as hesitancy over relinquishing control of the child, possibly their own fears projected onto the small patient, or their concern as to what the separation will mean to the child and to them. Added to these is the uncertainty of the outcome of the illness and, perhaps, of the future life of the child.

A schedule was designed to meet what were felt to be the requirements of the study. A sample is shown in the Appendix. The rationale for the plan was as follows:

The item indicating the relationship of the informant to the patient is fairly obvious, as is the name of the child, his age and sex - all under the first section devoted to social data. The names were, of course, disguised to protect the identities of the patients. The name of the home community was obtained in order to consider the distance between the hospital and the home in terms of separation by mileage and travel time. Greater distance also reduced the frequency of visits to less than the two a week permitted by the hospital.

It was considered desirable to learn the family constellation and the patient's place within it, hence the item of "siblings - age and sex" and whether "in the home" or not. From this and the specification as to whether the parents were living in the home or elsewhere, we could

understand something of the effect of separation upon the relationships within the home. Whether the child was brought directly from home or from another hospital or elsewhere informs us further about the meaning of this impending separation. If someone else in the home - either sibling or parent or other lodger - has been hospitalized, the child could well have gained an impression of hospitalization from him, directly or through hearing discussions about it. The interviewer tended to record chiefly the hospital experiences of others in the home and family when they occurred during the child's lifetime.

The section referred to as "Medical" provided originally for listing the admitting diagnosis and the chief complaint, but it was soon found sufficient to obtain only the latter which was, after all, the problem as the family saw it, and has more meaning than the pre-hospital medical diagnosis. Later, after the interviews were completed, the final diagnoses were added, as well as the date of discharge for computing the length of stay. Further, the hospital procedures which the patient had undergone were noted for each child. To this was added whatever comments were noted in the medical charts as to the child's behavior as it related to separation. Comments about his general adjustment to the hospital were also noted but later discarded because this had not been part of the purpose of the study.

The item of previous hospitalization with details as to duration, recency and locality were of great importance in considering the background for the meaning of the present experience. Whatever happened previously would certainly affect his present expectations. It might also represent a deep disappointment and the child might feel rejected

if transferred directly from another hospital. Such transfer robs him of an opportunity to satisfy his natural longing for a sight of home and to reassure him that it still exists and that it holds a place for him.

The third, and largest, section was devoted to the nature of the preparation given the child for this particular hospital experience. It was considered important to know who gave it - parent, physician, nurse, social worker or anyone else - and when and where it was given. The manner or form seemed interesting to investigate - whether by verbal means, drawings, photographs of the hospital or patients, play-acting or dramatization, a personal visit to the hospital, or in any other way. The patient's own questions, if he had any or felt able to express them, were requested of the informant. These could furnish significant clues to the child's greatest concerns and help determine the degree to which he received satisfactory answers. Whether he expressed his concerns reveals too how satisfactory his relationship to the parents might be, and whether they provided an atmosphere that encouraged free expression of anxiety. Such questions also indicate the child's level of development as a determining factor in the kind of explanations he might understand and accept. If possible, it was hoped to secure a quotation in the child's own words.

The matter of plans for maintaining contact between the family and the patient so as to modify the degree of separation were suggested by the items of personal visits (which, in this hospital, except in critical illness were restricted to only the parents and to two a week), correspondence, telephone calls, gifts, or any other method permitted by the hospital.

The actual content of the experience within the hospital, and preparation for it, was outlined in some detail so as to cover nearly all possible activities and aspects of a child's stay at the hospital: the daily routine as it differed from his previous experience (not necessarily just those at home but as compared to his previous living experiences anywhere); the people who would be in this new environment and caring for him; and the things they would do to him at admission which he may or may not have experienced previously in his life. The daily routines were broken down into the items which would mean most to a child: sleeping in a high bed (especially if he had progressed from a crib to a low bed at home); the early awakening and retiring hours; not eating at a table, perhaps having no free choices of foods as at home; having his own familiar clothing removed and being given strange garments; being restricted in activity, if not to bed to playing inside and in smaller space. He might well be prepared for the presence of other child patients and this might be pleasant news or, on the other hand, constitute the threat of rivals for the attention of the parent-persons in the hospital. He may find the numerous strangers in the hospital, all uniformed and lacking in individuality of appearance, difficult to accept, as might also be their impersonal treatment of him.

Although it was suspected that the admission procedures might be largely unknown to a good number of parents in spite of their own possible hospital experiences, it was felt that they should be able to interpret to the child at least some of the commonest aspects of admission. He would tend to feel more secure and his faith in his parents would be strengthened if they could tell him such things as: how he

would be weighed, measured and his temperature taken ; how his nose and throat would be inspected, and the good reason for this; that the nurses would help him take off his clothing a number of times for examinations (he may have been accustomed to a good deal of modesty); that the doctors would take a little blood with a large needle and this would feel like a mosquito bite; that a picture would be taken of his chest using a very large machine, but it would not hurt him at all; and the doctors might take a picture of how his heart pumped, by having him lie still while they put little bands on his wrists, none of which would hurt.

Perhaps other more complicated procedures need not be described, but they were included in the event that parents had dealt with them in their preparation. Intravenous feedings and blood transfusions involve needles too, but as the puncture by a needle is the most threatening aspect of these procedures, the acceptance of any needle prick might suffice. The matter of surgery, if planned, should certainly be introduced in a way the child can understand - much as Dr. Pillsbury had suggested - because, as we have pointed out before, surgery has the more serious implications of injury and loss of consciousness.

The section of the schedule concerned with the child's own participation in plans, in terms of the choices permitted him, represents the emphasis on bringing the patient - immature as he may be - into sharing to the greatest extent possible. In this way it could contribute to his growth instead of thrusting an experience upon him and arousing resistance and resentment. Some of the choices indicated might be impossible - such as which person should accompany him, or the means of transportation to be used - because there might be no alternative.

However, he could be expected to be given the choice at least of one favorite article of clothing, an article which he may or may not be permitted to keep at the hospital but wear on the trip. He might also have choices as to what toys he might take, facing the risk of losing them on the ward; a book or two, a game, pictures of his family, possibly a radio, a religious article of special significance. In the case of a small child a favorite blanket can give comfort. Any piece or symbol of home and family might be considered helpful.

Lastly, a space was provided for comments and was used to note any special impressions or descriptions of the situation as seen by the family or the interviewer.

All interviews were conducted by the same person. The items were not always dealt with in the order appearing on the schedule and therefore the interview was fairly flexible although directed. When the interviewer felt the need of referring to the schedule for guidance, no adverse reaction was observed on the part of the informant. It had been suggested that calling attention to the many aspects of hospitalization for which his child was unprepared might arouse apprehension in a parent. The interviewer met little of this, and when a trace of it appeared the parent was reassured that we were merely studying the whole process and were uncertain as to how advisable it is to mention all these things to a child.

Most of the interviews took place at one of the several desks on the Pediatric Ward, amid the usual activities of the nurses, attendants and physicians. This arrangement was necessary because of lack of private rooms for interviewing purposes and also served to keep the parents avail-

able for occasional questions from the medical personnel. If the child were apprehensive, the parents were then near to reassure him. Usually the interview took place after the parents had furnished medical history to the doctors, but if a long delay were anticipated before the physician could arrive, our interview preceded the medical history-taking. In some instances, the small patient was present during all or part of our interview. Because this had not been considered particularly significant, the child's presence or absence was not included on the original schedules but later noted.

In conclusion, we might comment that the data on these schedules was meant to be largely objective and factual but was obviously limited by the awareness of the problem on the part of the informant and the selectivity of his memory.

A total of twenty-one cases were studied from February 5th to March 25th, 1952. Sampling was based primarily on the availability of children within specific age limits admitted to the hospital at times when the writer was free to interview parents. There was some attempt to include at least one child at each age level. The frequency of the ages of children studied coincided closely with that of the total of those admitted to the hospital during the period of the study. The table shown on the following page shows the ages and sex of the children studied. The nearly equal representation of both sexes was coincidental but desirable.

The information secured in the interview for each child is presented in the chapter which follows.

TABLE I

Ages of Children at Last Birthday*

	Boys	Girls
2 years	4	0
3 years	0	1
4 years	2	0
5 years	0	1
6 years	1	1
7 years	0	1
8 years	1	1
9 years	0	3
10 years	1	2
11 years	2	0
Totals	11	10

* one girl was considered 7 and one boy 4 years because their birthdays would occur within two months

CHAPTER IV

PRESENTATION OF CASES

1. DANIEL, 2 years — Diagnosis: cerebral atrophy and mild hydrocephalus

Hospital stay: 2 days

Family: parents and patient

Distance from home: 45 miles

Accompanied by his parents who were interviewed together.

Medical Data: The parents were chiefly concerned that Daniel did not walk. Diagnostic procedures included an electroencephalogram, a pneumoencephalogram, an eye examination (which was difficult because the child cried a good deal), a skull x-ray, and intravenous feedings.

Previous Hospital Experiences: Daniel had been hospitalized in a local hospital for two or three days, six months previously. The mother had been hospitalized shortly after the child's birth for a short period.

Preparation: The mother felt Daniel indicated no reaction whatsoever when they had spoken freely in his presence about taking him to the hospital. She did not feel he would have reacted differently if they had spoken to him directly about the plan. When they started the trip to the hospital that morning, they merely told Daniel he was "going byebye". They felt he could ask no questions as his speech consists of only single syllable words. There was no mention of how long he would be at the hospital or what would be done to him there, nor did he have any choice of a toy or other object to take with him. There was no reference to visiting.

Separation: When the interview was completed, the parents slipped out of the ward without a word to the child as he sat quietly in the Taylor-Tot near the interviewer. Later, when placed in his bed by the nurse, he cried bitterly and loudly for some time, calling for "Mommy". He begged to be picked up and held by the interviewer when she went into the room to observe him. It is possible that the interviewer represented the last association with the mother.

2. FREDDIE, 2 years Diagnosis: cerebral atrophy, cause undetermined

Hospital stay: 12 days

Family: parents, patient, a brother of 5 years

Distance from home: 70 miles

Accompanied by both parents, interviewed together.

Medical Data: The parents were concerned about convulsions. Procedures other than routine hospital admission procedures included pneumoencephalogram, skull x-ray, eye examination, intravenous feeding and oxygen by nasal catheter.

Previous Hospital Experiences: Freddie had spent a month and a half in a local hospital six months previously. The parents stated no one else in the home had been hospitalised, at least during the lifetime of the child.

Preparation: Nothing was said in advance to the child, according to the parents. They felt he did not comprehend much of what was said. They reported that formerly he had talked a little, but no longer did so. They believed he might recall a little of his former stay in a hospital. Although it was not Freddie's idea, he brought along the cowboy boots of which he was very fond. His parents made this effort to provide a familiar object which would offer security. When asked if they had plans for

maintaining contact between the child and his family, the mother said she would come during the week to visit him. The boy, however, had not been informed of this.

Separation: As the little boy was asleep in his mother's arms when they were ready to leave, they did not awaken him and merely slipped out. Freddie used none of his limited vocabulary to express himself and only cried when he awakened later.

3. HAROLD, 2 years Diagnosis: cerebral atrophy and epilepsy

Hospital stay: 17 days

Family: parents and patient

Distance from home: 85 miles

Accompanied by both parents, interviewed together.

Medical Data: The problem presented by the parents was that of convulsions. Special procedures administered were electroencephalogram, pneumoencephalogram, spinal puncture, x-ray of the skull, examination of the eyes, ears, nose and throat, a neurologic examination, and later an enema and subcutaneous glucose feeding.

Previous Hospital Experiences: Harold was hospitalized twice before for a week each time, once a year previous and then six months prior to the present period. B oth took place in the local community. The father stated that he himself had been hospitalized twice. The second time was the only one within the child's lifetime. Harold was then eleven months old and was taken to visit his father in the hospital.

Preparation: The parents merely told Harold before they left home that morning that they were "going bye bye" with him. They said he speaks

only a few words. No other explanation was given him. They had not thought of bringing his teddy bear which he likes very much. They believed he might have wanted to take it along, but he was excited as he is when they are about to drive anywhere. Visiting plans were not discussed with the child. Because he adjusts easily to new "baby sitters", they felt he would react similarly to the new people in the hospital setting.

Separation: This was not observed. However, Harold cried the first night and the nurse attributed this to his being "lonesome".

4. RONALD, 2½ years Diagnosis: pectus excavatum and adenoid hypertrophy

Hospital stay: 6 days

Family: parents, patient, three brothers 17, 9 and 5 years; also a foster brother 16 years who has been living in the home for the past two years.

Distance from home: 45 miles

Accompanied by the mother who was the informant.

Medical Data: The problem was a deep indentation in the child's chest. The planned surgery was postponed and a tonsillectomy and adenoidectomy performed at once under general anesthetic. The chest condition was to be followed in the outpatient clinic two weeks following discharge. Ronald was given oxygen by nasal catheter and injections of duracillin.

Previous Hospital Experiences: This boy had never before been hospitalized, although he had been seen in the outpatient clinic of this hospital shortly before admission. The mother said that two of the older boys had tonsillectomies in a hospital, but she believed these events had occurred before the patient's existence. She recalled no others in the

family.

Preparation: The mother appeared to be a very intelligent, well-poised woman. She referred to activity in parent-teacher associations and seemed to have much understanding of and interest in her children. She had read a recommendation in the Childcraft series of books about preparing a child for the hospitalization experience and had done this to some extent with her older children when they were about to enter a hospital. She felt they had little difficulty in adjusting. Since the previous Fall when Ronald was examined in the outpatient clinic by the surgeon, he had been told by his mother at home that the doctor would "fix the hole" in his chest. It had been planned for an earlier date but deferred because of a skin condition. The mother gave no further details of what would be done to him. She said he spoke so little he would not be expected to ask any questions about it, adding that he is a little "slower" than the other boys. She did tell him he would be at the hospital a "couple of days". She felt he had an introduction to the size of the hospital when he was examined in the outpatient clinic on two occasions. She told the boy he would sleep in a different kind of bed and would not have his own clothing - just his own slippers. She played out the way the nurse would feed him so that he could learn that such a person would care for him. He knew the surgeon who would operate on him. None of the admission procedures were dealt with, but in our review of each item the mother pointed out that the boy had often been weighed and that he is accustomed to un - dressing before strangers. She felt that it would be too frightening to him to be told of needle punctures and surgery, and that it was sufficient if he knew the doctor would "fix the hole". The child had a choice as to

the clothing he wore enroute to the hospital that day; and he brought a doll, some books and a slate - presumably his own selection. There was no discussion of visiting.

Separation: Although the mother knew it was not the precise plan, when she left Ronald to return home, she told him the parents would come the following day to take him home.

5. ANITA, 3 years Diagnosis: congenital heart disease

Hospital stay: 23 days

Family: parents, patient, a sister 4 years old

Distance from home: 160 miles

Accompanied by both parents who were seen together. They had all stopped off at the home of relative the night before, enroute to the hospital, and left the older child there.

Medical Data: The parents were concerned because Anita had been listless and short of breath. She underwent special laboratory tests, an electroencephalogram, and then surgery for ligation of the patent ductus. This required special procedures such as chest suction, oxygen by nasal catheter and intravenous feedings.

Previous Hospital Experiences: The child had never before been hospitalised, but her sister had spent a few hours in a local hospital as an outpatient a year previously for lancing of her ear. No one else in the home was said to have been hospitalized within the lifetime of the patient.

Preparation: Anita's mother had spoken to their local physician by telephone the week before admission, but she said the child had been napping at the time and heard nothing. A t breakfast next day, or thereabouts, the

mother told Anita she would be coming to see the doctor in Madison. The only question Anita asked was whether her sister would go along too. She was pleased at being the one chosen to go on the trip with her parents. The parents said they themselves hadn't known how long the girl would be in the hospital so they did not refer to it except to vaguely state they would "see her later". No mention was made of what Anita would do in the hospital. The parents felt she had not overheard anything nor did they believe the sister knew more than that Anita was going to Madison. The patient was able to choose her new red overalls to wear to the hospital, but was not given a toy or other object. She had wanted to bring along an old history textbook of which she had been fond, but the parents did not allow this as they felt it would not be permitted by the hospital. There was no discussion of visiting.

Separation: The parents planned to, and did, leave while Anita was still napping in her hospital bed. They realized she would wonder about their disappearance. The mother's anxiety was rather outstanding, and when the interviewer recognized this verbally the mother remarked stoically that she did not want to let herself think about it. It was felt she had referred to the outcome of the treatment.

6. KENNETH, nearly 4 years Diagnosis: cortical and cerebellar atrophy

Hospital stay: 19 days

Family: parents, patient, sister 11 months old

Distance from home: 25 miles

Accompanied by both parents, interviewed together.

Medical Data: The presenting problem was the boy's retardation and his

tendency to lean to one side. He was given an electroencephalogram and a pneumoencephalogram and, after examination by the psychologist, it was recommended that he be placed in an institution.

Previous Hospital Experiences: This boy had never before been hospitalized although he had been seen in the outpatient department of this hospital. His small sister had been brought to the hospital shortly after birth, and remained for two and one-half weeks. His mother had been absent from home for delivery of the sister in a hospital.

Preparation: Kenneth was told nothing, according to his parents. He was reported to speak only a few words like "mama", "hot". They felt he would not have comprehended any explanation or conversations he might have overheard. They said he adjusted well to anyone who cared for him. The mother brought along a favorite stuffed doll for the boy to keep with him in the hospital. No plans for visiting were discussed with him.

Separation: This was not observed.

7. FRANCIS, 4 years Diagnosis: aplastic anemia

Hospital stay: over 16 days

Family: parents, patient, brother 9 years, sister 6 years

Distance from home: 40 miles

Accompanied by mother and uncle. The mother was interviewed alone on the 16th day after admission of the child. Kenneth was then in critical condition and his mother exhausted from watching him constantly for the previous several days.

Medical Data: Francis was brought to the hospital because of frequent and excessive bleeding from the nose. Up to this point in his hospital-

ization, the child had received 13 blood transfusions, a bone marrow biopsy (by needle puncture), injections of cortisone, several blood samples taken by needle, and had undergone several episodes of severe bleeding through the nose, followed by packing and transfusion.

Previous Hospital Experiences: This boy had been brought to the hospital directly from one in the home community where he had been cared for for two weeks. A year previously he had been in a local hospital for four days due to a strangulated hernia. His 6-year-old sister had been hospitalised frequently for asthmatic attacks.

Preparation: The mother said she had felt unable to tell Francis anything about the transfer to this hospital before it took place. She knew he would cry but felt he would get over it. He had not been prepared for the admission to their local hospital either - because, she explained, it had been an emergency. However she had remained very close to the child there, too. No toys which might have been brought from home were noted.

Separation: This was the only instance where the mother of a patient included in this study ignored hospital rules and remained nearby. She slept on a sofa in the corridor outside the boy's room for several days, without even going out for meals. She told the interviewer that Francis is different from her other children in that he is particularly reluctant to stay with anyone - even his grandmother - unless she or the sister or brother is present also.

6. DIANE, 5 years Diagnosis: collapse of one lung, left hemiplegia

Hospital stay: 11 days

Family: parents, patient, sister 8, brother 7, sister 3, brother 1-1/2

Distance from home: 90 miles

Accompanied by mother and maternal grandmother from the home of the latter where they had stayed for three days before admission; both mother and grandmother were present at the interview.

Medical Data: The presenting problem was the collapsed lung, the cause of which was not determined during this hospitalization. However, the hemiplegia was felt to be due possibly to birth trauma. Procedures included vital capacity test, bronchoscopy (under general anesthetic), fluoroscopy, left bronchogram with barium swallow (also under anesthetic). A pneumonectomy was being considered when the child was removed by the father, against medical advice. He did so because he felt "the child was not happy" according to the medical chart.

Previous Hospital Experiences: Diane had been in a private, local hospital for ten days until three days before this admission. None of the other children was said to have been hospitalized. The mother had had Cesarean deliveries of the two younger children within the lifetime of the patient.

Preparation: During the three days Diane had been at the home of her grandparents before this admission, the grandparents discussed rather openly the plan to bring her to this hospital. The parents had said nothing previously. Diane had been told there would be other children in this hospital, but no familiar objects were brought along nor was any

mention made of contact with her family while she remained. The mother told the interviewer, however, that she planned to inquire about visiting rules before leaving that day. Diane asked no questions and her mother and grandmother described her as usually being very quiet and shy. The mother taught school daily so that she was absent from home most of the day, but the person who supervised the children during that time was not identified.

Separation: Not observed.

9. FAY, 6 years — Diagnosis: acute glomerulonephritis with cardiac failure

Hospital stay: 3 days (then expired)

Family: parents, patient; brothers 16, 14, 12, 10, 8 years; sister 4

Distance from home: 100 miles

Accompanied by county nurse in ambulance; nurse was informant.

Medical Data: The presenting problems were shortness of breath and pain in the abdomen attributed to rheumatic fever. Procedures other than routine admission were two extra chest x-rays, intravenous feeding, oxygen and special injections.

Previous Hospital Experiences: Fay had come directly from a five-day stay in a hospital in the home community. Her mother had undergone surgery in a hospital three years previously, and one brother had an eye removed when he was ten and the patient was two years of age.

Preparation: The county nurse felt sure that Fay had been told nothing about the plan to move her to this hospital. The local physician had recommended the plan to the father as they stood outside the door of the child's room at the local hospital. The physician had not wished the

mother to accompany the child here, according to the nurse, because he felt her anxiety would aggravate the child's already critical condition. While enroute to Madison in the ambulance, the nurse kept reassuring Fay and told her where they were going, but because the girl was heavily sedated she felt there was little comprehension of what was said. While Fay had been a patient in the local hospital, she had been visited almost constantly by some member of the family. Nothing which was familiar to her was brought along for this admission - no toy or article of clothing - only the nurse whom she knew fairly well.

Separation: This was not observed. The nurse expressed the hope that the medical resident of this hospital would allow the parents to visit that same evening due to the child's poor condition. This was arranged subsequently.

10. BERNARD, 6 years Diagnosis: congenital nystagmus

Hospital stay: 3 days

Family: parents, patient; half-sisters 20 years (living away from home) and 16 years; brothers 13, 12, 11, 10, 8 years, 7 months.

Distance from home: 180 miles

Accompanied by mother who was the informant.

Medical Data: The presenting problem was the child's frequent twitching of the eyes. He was given a skull x-ray and examined by the oculist, but a refraction had to be deferred for two and one-half weeks because of Bernard's fear of examinations.

Previous Hospital Experiences: Bernard had never before been a patient in a hospital. Three of the older boys had undergone tonsillectomies but

these had taken place prior to the existence of the patient.

Preparation: The mother had told Bernard about coming to the hospital six weeks previously while they were at home. Also, their physician had mentioned it to the child in the office. When the school nurse learned of the plan, she was said to have discussed hospitalization in the classroom. The mother had told Bernard she would remain in Madison for the estimated two to four days he would be there, and said she would visit him whenever permitted. She also told him she would bring him some toys. He had not cared to bring anything from home because he felt he would not stay very long. His only questions were about how long he would remain and whether his mother would stay too.

Separation: This was not observed. The mother of this child was somewhat uneducated and she was protective of the boy who, she said, was more shy than the other children - probably because he was the baby for so long. She felt the father favored him a good deal and was especially concerned about the effect of separation on the child. The father had, moreover, insisted that she remain near Bernard and be sure that surgery was not performed without their specific consent. The mother and child had stopped overnight to visit the father in the town where he had been working the past month or more and staying with the grandmother.

11. MARIE, 7 years Diagnosis: diabetes mellitus

Hospital stay: 53 days

Family: parents, patient, brother 3 years

Distance from home: 74 miles

Accompanied by mother on admission; mother interviewed on day of discharge.

Medical Data: Diabetes mellitus was suspected before admission, was confirmed in this hospital and then a regimen established. In addition to the routine procedures at admission, there were urine tests twice daily, insulin injections, blood sugar tests, dental x-rays and injections of penicillin.

Previous Hospital Experiences: Marie had spent a month in a local hospital three years previously when she was ill with intestinal flu and a kidney infection. Her small brother had never been hospitalized, but her mother had been a patient in this hospital's neuropsychiatric unit when Marie was one year old. The mother had been given shock therapy.

Preparation: The local physician had told the parents that Marie would need to remain only four to ten days, and this was what the child was told five days prior to admission by this same physician in his office. The mother planned with the girl for frequent visits and for correspondence and gifts. No details of hospital care were mentioned to her before admission, and the doctor telephoned the mother advising against discussing details of probable treatment. Marie was permitted to choose her red dress to wear on the day of admission, and also the slippers she would take. She selected a doll, some cut-out books, a writing tablet, her housecoat and a religious medal. She asked many times about getting "shots" and was told she would not receive any because she was going only for a checkup. She wondered, too, how long she would stay and was told that it would be only a few days. She wished her mother to remain in Madison.

Separation: The mother did remain in Madison for five days. Details of her leave-taking were not obtained. Marie confessed she cried the first night in the hospital.

12. LINDA, 8 years Diagnosis: cortical atrophy

Hospital stay: 7 days

Family: maternal grandparents and patient; both mother and father had been separated and remarried for some time; no known siblings.

Distance from home: over 200 miles

Accompanied by grandmother who was the informant.

Medical Data: The grandmother had previously been told the child was rather hopelessly retarded but she wished further diagnosis. Special procedures included an ear, nose and throat examination, a pneumoencephalogram, an electroencephalogram, skull and wrist x-rays, and a psychological examination.

Previous Hospital Experiences: Linda had been hospitalized for a couple of days four years previously. The experience of the family members was not disclosed. The child had been placed in an institution for retarded children a year prior to this, at the recommendation of a physician, but she was removed by the grandmother when Linda showed great unhappiness there.

Preparation: A week before this admission, the local physician had told the grandparents in the presence of the child at home that they might bring her here. The grandparents then spoke of it to her directly. They furnished no details except to speak of other children being in the hospital. The girl was allowed to choose the dress she wore on the trip and some books and a radio. As to plans for maintaining contact with the family, the grandmother told Linda she would come to get her when she would be ready to leave. The duration was not mentioned. Linda did not

speak at all, so she asked no questions. She cried as they climbed the stairs up to the hospital. The grandmother believed the girl associated it with the institution which she had disliked.

Separation: Not observed.

13. LARRY, 8 years Diagnosis: head injury and convulsions

Hospital stay: 13 days

Family: mother, stepfather, patient, sisters 23 and 22 away from home; sisters 17 and 14, twin brothers 11 years, half-brother 4 months old. Real father is deceased.

Distance from home: 30 miles

Accompanied by mother who was the informant.

Medical Data: The problem was the patient's "fits", presumab ly due to an accident. Larry underwent special neurologic and eye examinations, he had an electroencephalogram and a pneumoencephalogram, a skull x-ray, he was given injections of penicillin and duracillin, and then it was recommended that a tonsillectomy be performed because of acute infection.

Previous Hospital Experiences: This boy had never before been hospitalized. All his siblings except the oldest girl and the small baby were said to have had tonsillectomies in hospitals, and some of these were probably known to the child. The mother's recent delivery took place in a hospital. It was not learned whether the child's own father had been hospitalized at the time of his death.

Preparation: About two months prior to this admission, the mother and local physician had told Larry at the clinic of a nearby town that he would need to enter the hospital. He was prepared for a stay of two or

three days, he was told there would be other child patients and nurses there, but given no other details. Nothing was said in advance about keeping in touch with him except that his mother said she would come to get him in a few days. She also told him "not to be afraid". His school friends planned to write to him. Larry was permitted to choose the clothing he wore for the trip, but brought along no other article except a dime which he wanted to keep. He was said to have asked no questions.

Separation: Not observed.

14. ANN, 9 years Diagnosis: atopic eczema and allergic rhinitis

Hospital stay: over 29 days

Family: parents, patient, sisters 13 and 4 years, brother 1-1/2 years

Distance from home: 200 miles

Accompanied by father who was interviewed on the 29th day of hospitalization while he was visiting and conferring about discharge.

Medical Data: Ann was brought to the hospital for relief from eczema. Her discomfort from this difficulty seemed a source of much anxiety to the father. She was given special scratch tests for allergies, special baths and oil rubs, applications of coal tar, a sinus x-ray and trial periods on various diets.

Previous Hospital Experiences: The girl had never before been hospitalized, nor had any of the other children in the family. The mother had spent some time in a hospital for two deliveries and for a gall stone operation. The father had been hospitalized for regulation of diabetes.

Preparation: Ann had been treated by numerous physicians, particularly in the preceding four months, for relief from her skin condition. A few weeks prior to admission, a physician and one of the parents informed her at home of the plan for admission to this hospital. She told the doctor she would go if it would make her better. The plan was discussed several times in the period before admission. Ann was told she would remain for a couple of weeks, that there would be other children there, and she was given some description of the size of the hospital. No preparation was given as to procedures she could expect. She was able to choose the clothing she wore on the long trip down to Madison, and also the slippers she brought along. Her questions were as to whether she "would be lonesome", if she would need to stay inside, and if she would receive anything to eat. Frequency of visits was discussed and plans for correspondence were made when her grandmother gave her some stationery and her father presented her with postcards.

Separation: There was no information about the actual separation on admission day.

15. JANE (twin), 9 years Diagnosis: no disease found, except pinworms
Hospital stay: 9 days

Family: parents, patient and her twin (identical); sisters 21 and 17 years live away from home, also brother 20; at home were brothers 15, 14, 6 years, and sisters 12 and 8 years.

Distance from home: 90 miles

Accompanied by mother and paternal aunt and twin; mother was interviewed alone.

Medical Data: Diane and her twin had similar complaints of headaches, nausea and gastric pain, and were suspected of having rheumatic fever. Special procedures included several blood and stool samples, and psychological examination for both girls.

Previous Hospital Experiences: Both girls had spent 18 days in a hospital in the nearest town about four months previously. The mother spoke of only one other child being hospitalized.

Preparation: Two weeks prior to admission, the twins learned from their doctor and the mother that they would be coming to the hospital. It was discussed at home later. They were prepared for a week or two, perhaps longer. The mother felt their previous hospitalisation had served as a basis for this experience and she had not included any discussion of various routines, personnel or treatment. The girls were given no choice of articles to bring along, except three books and their bedroom slippers. The latter had to be sent back home. Probable visits of relatives were mentioned and the mother said she would come in a couple of weeks if the girls remained that long. No specific questions were recalled. However, Jane told her mother that her twin confessed she was fearful. The mother stated that the twin had been more ill and is more "nervous" generally.

Separation: This process was not observed. The nurses commented that the other twin was "content when in the room with Jane", implying she was fearful when separated from her. The psychologist later remarked that "the initial fearful reaction to the hospital situation" had subsided.

16. SHARON, 8 years Diagnosis: minor motor cortical scar due to trauma

Hospital stay: 16 days

Family: parents, patient, sisters 17, 15, 14, 7 and 5 years; brother 8 years

Distance from home: 135 miles

Accompanied by father who was interviewed, with Sharon present part of the time.

Medical Data: The problem as stated by the father was the "spells" experienced by the child. He spoke of a blow on the head from a rock a few months previously. Special procedures were an electroencephalogram, pneumoencephalogram, eye examination, formal testing by the psychologist and medications for seizure control.

Previous Hospital Experiences: Sharon had not previously been hospitalized. The father believed that the only other person in the home to have had such an experience was the 15-year-old sister who spent six months in a tuberculosis sanatorium for observation.

Preparation: This girl was informed by her mother the previous Fall and frequently since then in the home about this plan for hospitalization. The parents explained it would "help her out so she wouldn't get sick any more". Sharon asked no questions. She was told it would last for "a few days" and the father added that he would not be able to visit her for "two Sundays". He had brought the girl down to the hospital two weeks previously, ready for admission, but she was not accepted because of a cold so they returned home at once. At that time Sharon was able to observe the size of the hospital but inspected only the lobby of the interior. The parents felt they had little information about care and treat-

ment planned and were therefore unable to explain this to Sharon. No reference was made to other child patients. The father apparently had little formal education and felt unable to write to the girl, but Sharon had asked an aunt and a friend to write to her while in the hospital. She had chosen some of the clothing she were to the hospital, and her slippers. She had wanted to bring a doll but this was not allowed by the parents. The father confessed to the interviewer that he was somewhat "afraid" to tell Sharon about details of hospital care, at least those he recalled from his own stay in a Chicago hospital years ago.

Separation: Not observed.

17. WALTER, 10 years Diagnosis: epilepsy and retardation due to cerebral palsy

Hospital stay: 8 days

Family: parents, patient, brothers 6 years and 3 months

Distance from home: 100 miles

Accompanied by parents who were interviewed together.

Medical Data: Walter had been having convulsions and falling down. Besides routine admission procedures he was given neurologic and psychologic examinations, was seen by the dermatologist and the oculist, given special x-rays of wrists and skull, an electroencephalogram, some special laboratory tests and photographs.

Previous Hospital Experiences: This boy was said to have had no previous hospitalisation except for treatment of a minor injury as an outpatient three years before. The mother was delivered of both younger siblings in a hospital, and the father had been hospitalised while in the Armed Services.

Preparation: Five months previously, while at the doctor's office, the plan was proposed by the mother, and later at home. She felt Walter knew what a hospital would be like because of examinations in outpatient clinics at hospitals. The boy was told he would stay five or six days. The mother mentioned the different kind of bed he would sleep in, the possibility of not wearing his own clothing, that he would probably be restricted in activity. She also told him of other child patients and of the doctors and nurses. She referred only to needle punctures as methods of treatment, and felt he was acquainted with x-rays and enemas though they were not mentioned specifically. Walter was promised cards and toys and the parents said they would visit when able. The boy was able to choose the green plaid shirt he wore on the trip, he brought a toy airplane, and he asked for some new comic books. He asked questions about other children, toys, nurses "to talk to", and whether "they will give me some pills and make me sleepy until they put my head under that thing" (anesthesia mask used in tonsillectomy).

Separation: Not observed.

18. DORIS, 10 years Diagnosis: congenital heart disease
Hospital stay: 24 days

Family: parents, patient, brothers 21 and 18 years away from home, brother 11 years at home.

Distance from home: 170 miles

Accompanied by mother who was interviewed a few days after admission day.

Medical Data: Doris had been known to have a congenital heart condition. She was given an angiocardiogram, several bedside chest x-rays, several blood tests, an electroencephalogram, then a Blalock operation followed by intravenous feedings and injections of penicillin.

Previous Hospital Experiences: Doris had been a patient in a local hospital five years previously for a tonsillectomy. The brother who is 21 had undergone an appendectomy at about the same time, and the father had recently spent a couple of days in a hospital for a diabetic checkup.

Preparation: When examined in the outpatient clinic nearly a year prior to admission, the possibility of hospitalization was discussed, evidently with Doris present. Two days before admission the mother received telephone confirmation of an appointment for this admission from their doctor, and she informed the child at that time. The plan was for a stay of a week or ten days. The mother said she told the girl about the hospital itself, about the nurses and doctors, about awakening and retiring hours, medical examinations. She felt the girl knew from experience about needle punctures and that having an electrocardiogram would closely resemble an orthodiagram. She assured the child that it was all done to make her better. Apparently no mention was made of planned surgery. Doris was permitted to choose the dress she wore on the trip, the slippers she brought, and the school books which would help her keep up with her class. The family planned visits and correspondence. The only specific question of the child which the mother recalled was about "what they do at the hospital".

Separation: No details obtained. The mother was seen on several occasions sitting with Doris on the sunporch among the other children.

19. EILEEN, 10 years Diagnosis: cardiospasm

Hospital stay: 18 days

Family: parents, patient, brother 12 years, sisters 6 and 4 years

Distance from home: 210 miles

Accompanied by both parents who were admitted to different wards on the same day and with similar symptoms. The mother was interviewed on her ward the following day.

Medical Data: The complaint was of a lump in the child's throat, with some loss of weight from poor appetite. Besides routine admission procedures, there were the following: barium swallow for gastrointestinal examination, x-ray, an Ewald tube was inserted, a Maloney test given, a bronchogram, injections of duracillin and chloramycin, an eye examination and the resulting prescription for glasses, sputum and stool samples for culture, special x-ray of the sinus, and a psychiatric interview.

Previous Hospital Experiences: Eileen had been in the hospital at a nearby town for three days a year previously, and had a tonsillectomy. The mother had been delivered of the two younger children in a hospital, and the father had spent a week in a hospital the previous winter because of measles sequelae.

Preparation: About a month before admission, the parents told Eileen while they were at home that they would all go to the hospital. The girl was said to have been pleased. They told her they would visit her, but not how often. She expected to remain three or four days. The mother described the size of the hospital as compared to the small one in the neighboring community. She spoke of sleeping in a different kind of bed and of wearing different clothing and of being with other children. No

reference was made to eating differently nor of toilet facilities because the mother felt Eileen knew this. No other details were given, except that the child would be examined. As to the possibility of surgery, the mother felt that her statement that "they might do something" for her would cover this kind of treatment. Eileen selected the dress and underclothing she wore on the trip down, and also her slippers and her embroidery project. Her only question quoted was about whether she would be given "shots".

Separation: The process was not observed. However, Eileen was visited by her parents almost daily during their hospitalization.

20. ROGER, 11 years Diagnosis: rheumatic fever, inactive

Hospital stay: 8 days

Family: parents, patient, brother 24 and sister 23 years lived away from home; brothers 20, 18, 14, 8, 3 years, and sisters 14, 12.

Distance from home: 290 miles

Accompanied by the father and the married sister (age 23) who lives across the street from the boy and was interviewed for this study.

Medical Data: The complaints were of rheumatic fever and "nervousness". Other than routine admission procedures, the boy had a chest x-ray following a barium swallow, and some dental extractions.

Previous Hospital Experiences: Roger had stayed overnight for a tonsillectomy about three years previously in a local hospital. None of the other children in the family had been hospitalized during the boy's lifetime. The father had been injured in an accident ten years before, and remained in a hospital overnight. The mother was delivered of the two youngest children in a hospital, and she was planning on entering their

local hospital the next day for diabetic treatment after postponing it to see Roger's departure. The boy was said to know about this.

Preparation: A week previously the physician at home told the mother, with Roger present in his office, that he would need to enter this hospital. They spoke of visits on weekends and of correspondence with the family. Duration was estimated to be thirty days. The father and sister drove the boy around the hospital grounds on the day of admission so that he might see the building. No details of daily routine seemed to have been discussed except that Roger would not wear his own clothing and that there would be other children there. As they walked through the corridors, according to the sister, they pointed out the internes and orderlies. She felt the medical examinations had been mentioned to Roger and also the matter of needle punctures, but no other procedures were described. He was able to wear a special belt he liked and to bring a radio, his B ible, some books and a "magic slate". The boy's questions were about whether he could walk around in the hospital and visit other children. The sister felt he might have asked other questions of their mother but she was not aware of them. The mother was said to have obtained some of the information about this hospital from another mother in the same town and also from the grandmother who had once been a patient here. The mother was reported to be quite sensitive to the meaning of hospitalization to Roger, and to be anxious to get her diabetes under control so that she might come and visit her son.

Separation: Not observed.

21. DAVID, 11 years Diagnosis: pleural effusion and post viral pneumonitis

Hospital stay: 2 days

Family: parents, patient, brothers 15, 13 and 3 years

Distance from home: 60 miles

Accompanied by parents, interviewed together on day of admission.

Medical Data: The chief complaint was of fluid in the chest following pneumonia. David was given only an extra chest x-ray and a blood test besides the routine admission procedures.

Previous Hospital Experiences: This boy had stayed two weeks at a local hospital, leaving it a week prior to admission to this hospital. Two brothers had been hospitalized in the past, one for a tonsillectomy and the other for surgery on his hand. The mother was delivered of one child in a hospital.

Preparation: A week before this admission, the doctor at home telephoned the mother to recommend that David come to this hospital. The father was present, too, and they both informed the child. His only question was as to how long he would stay. There was no reference to visiting him, although duration was estimated at a couple of days by their physician. When David entered the local hospital a month before, the parents said they told him a little about what it would be like, but for this admission they made no reference to details of hospital routine. He chose the sweater and sox he wore on the trip, some comic books, his toothbrush, comb, candy and gum.

Separation: Not observed.

CHAPTER V

ANALYSIS OF FINDINGS

The results of this study have been compiled statistically in the form of tables shown in the Appendix. The tables are organised to follow as closely as possible both the headings of the Schedule, a sample of which is also included in the Appendix, and those of the case presentations of Chapter IV - i.e. Medical Aspects, Previous Hospital Experience, Preparation for Hospital Experience, and data around Separation from the Family. Comments of staff and interviewer have been included when they seem related to the study areas specified above.

If we examine Table II on Medical Aspects we might consider the meaning of their respective illnesses to the children studied, and also relate these to the child's age and to the length of hospitalisation. In the cases of the six children (four of whom were of preschool level) whose mental development lagged behind the chronological age, we should make suitable allowances and expect a somewhat lower level than average. For these four preschool children, symptoms were of more concern to the parents than to the patients themselves. Most of the medical problems were fairly serious, as they tend to be at this hospital, and had important implications for each child and his parents.

We find that the average length of hospitalisation was 13.5 days, with a range of from two days for each of the oldest and youngest children, to as much as 53 days for the regulation of diabetes of 7 year old Marie. Francis, who had already been in the hospital for 16 days and for whom no discharge was immediately foreseen, probably equaled or ex-

ceeded the next longest periods of 29 days for 9 year old Ann, 24 days for Doris who was 10 years, and 23 days for Anita who was only 3 years old. We would assume that Freddie and Harold who were two years chronologically but retarded in development would react to separation from their familiar surroundings in a way expected of smaller children.

Table II also indicates some of the more threatening procedures to which these children were subjected, in addition to those of hospital admission routine. Ten received injections or some type of examination or treatment requiring the use of a needle which so many children and adults dread. Similar to this, but of longer duration and more dramatic, was the subcutaneous administration of fluids to 6 of the children. Six of them underwent surgery which is even more threatening. The three youngest were given pneumoencephalograms and electroencephalograms, and no preparation whatever was given by their parents.

Table III sets forth the previous experiences of each child in relation to hospitalization - his own and that of the individuals in his environment. Eight children had never before stayed in a hospital, but three of these had been examined in an outpatient clinic so that they might have become aware of hospital atmosphere in a limited way. They would not, however, have experienced the living-in aspects of hospital care and the separation from home involved in in-patient care. Francis, age 4 years, came directly from a hospital in his community, and so did Fay, 6 years. Diane, also 6 years, spent an interval of three days in the home of her grandparents between previous hospitalization near home and the period at this hospital. Seven of the patients did not learn about hospitalization through the experience of parents during the child's

lifetime. None of the siblings of thirteen patients was cared for in a hospital during their lifetime; therefore only eight of the twenty-one (and they were all 4 years and over) could have learned about hospitalization through the experience of brothers and sisters in the home. Anita, age 3, who underwent cardiac surgery in this, her first hospital experience, learned nothing in advance through experiences within her family during her lifetime, nor did Bernard age 6. The other nineteen could have learned about hospitalization either through their own previous experience or indirectly through that of other members of the family.

The nature of preparation given the child patients in our study is set forth in Table IV, with an indication of whether it was done directly or indirectly. So far as could be determined from the informants, only eight children learned of the approaching experience indirectly, i.e. from overhearing parents or physician or others discussing plans for their admission. These same eight were also given some direct preparation by one or both parents and some in conjunction with the physician, as were another eight children. Of these, the critically ill Fay was prepared in a limited way enroute to Madison. This means that sixteen of the twenty-one children were told in some way that they were about to enter the hospital, while in the other five cases (all preschool children who most needed it) there seems to have been no discussion whatsoever.

Table IV shows, too, the areas covered in preparation and the amount of participation of each child in the plans for his hospitalization. Eleven of the patients were given some estimate of the duration of their stay (some deceptively), while the other ten of the twenty-one studied seemed to have been told nothing. To only fourteen of the children was

time of the study and were retarded would be unable to recall much about other personnel attending them in a hospital six months previously. This leaves Kenneth age 4 and Sharon 9 as the two who were totally unprepared in this respect.

Eleven of the twenty-one were fortified with some familiar object to keep with them in the hospital. Some of the other parents and children considered bringing something of this nature but were uncertain as to hospital rules and left the article at home. A greater number of children were given choices of clothing to be worn on the trip to the hospital. Twelve children were allowed to do this, whereas only eight of the eleven who brought along a familiar object were permitted to choose it. Bernard rejected the offer of choice because he believed he would not be away from home long. The three who did not choose what they brought were the preschool children, Freddie 2, Anita 3 and Kenneth 4 years. It is probable that the parents selected the objects they felt the children would most enjoy; thus there was an indirect choice. Other choices concerning the trip to the hospital, as recorded on the schedules, have not been tabulated because the means of transportation and the person to accompany the child were not often open to choice and therefore lack significance.

Nine of the twenty-one children were quoted on the questions they asked before coming to the hospital. The 3 year old Anita wondered if her sister were going too. The other smaller children were considered unable to verbalize and, of course, some were entirely unaware of the plan. A frequent question asked concerned "how long" the child would stay in the hospital, with three such inquiries. Three asked about

other patients or getting lonesome, and one wanted to know if his mother would stay too. Two were quoted as asking about "shots" (and one of these was unrealistically assured she would receive none). A thoroughly accurate and reliable record of all questions asked by each child would provide an interesting study, but such data would be difficult to obtain. Those indicated here are only suggestive of the types a child would ask. We believe that many of them were not recalled by the informants at the time of the interviews.

In Table V have been tabulated data to demonstrate the aspect of separation for each child from his home and family. His place in the family suggests something of the meaning of his separation. To an only child it has a special meaning, to the youngest of several it will have another significance, to a child who demands much attention from his parents and to those with strong feelings of rivalry it will have other meanings. One can speculate in regard to each child listed. Some of these meanings were brought out in the interviews with the informants.

The distance from home to hospital is an important factor insofar as it limits visiting even if the hospital permitted this more often than twice a week, since parents who are busy with their daily duties and care of other children find it difficult to travel an average of 114 miles and back in a day. The shortest distance was 25 miles for the family of Kenneth, while Larry's home was only 30 miles distant. Four children came a distance of 200 miles or more which, by auto or inadequate train service, makes separation more complete.

It was gratifying to note that most of the children were brought to

the hospital b y one or both parents on the day of admission. It is regrettable, however, that the parents of three of them failed to tell the child anything as they departed from the hospital. It might be assumed that they feared to created a disturbance. Two other children were not separated like the majority. As mentioned previously, Francis' mother remained near him and the parents of Eileen were in-patients. The other separations on the ward were not observed by the interviewer. Fay was practically comatose. From the preparation given in other respects it would seem rather safe to assume that in eleven cases the separation was handled openly with the child. In the cases of Harold, Kenneth, Diane and Linda, the interviewer cannot be as certain that the child was aware of the parents' departure, so it was safer to indicate statistically that the manner was unknown. One might assume that the parents of older children tend to be less secretive, and this may be due to the ability of the more mature child to observe and to obtain answers to his questions.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Despite the acknowledged limitations of what might be termed a pilot study and one which included as few as twenty-one cases, it seems valid to conclude that far too few children were being prepared for their admission to the Pediatric Service of the University of Wisconsin Hospitals.

Previous hospitalization of thirteen among twenty-one children is not a sufficiently large proportion on which we could assume that children are informed about the nature of hospital care. Nor does the fact that others in the home have undergone such an experience and thus may have furnished a basis of reference for the child, mean that he has received satisfactory preparation for his own prospective admission. Such may have actually increased his apprehension because of translating misinformation and half-truths into his own approaching hospitalization. One common example mentioned earlier is the child's expectation of bringing home a new baby because his mother had done this following her stay in a hospital. He may well have learned of additional and more fearful consequences of hospitalization.

It would appear that too few children were encouraged to talk and ask questions or to "play out" their feelings concerning the plans for hospitalization of which they were aware. Some were not aware that such plan had been made. Although nearly all the children in the survey were accompanied by one or both parents on the day of admission, at least three awakened later in this unusual place amid strange uniformed people,

and, we might assume, experienced complete bewilderment and a feeling of being rejected by those they most trusted. Only one-half of the children were able to derive some comfort from the nearness of an object which represented home.

The need for sufficient preparation would seem to have been well demonstrated in Chapter II. There will remain skeptical individuals who feel the problem is exaggerated, that children adjust somehow, become submissive and show no adverse results. Probably many children do adjust somehow, but it seems as justifiable to protect the more sensitive and immature child from personality damage as it is to immunize him from communicable diseases - a process which is carried on widely and is generally accepted.

The solution to this problem of inadequate preparation for hospitalization seems relatively simple in theory: to encourage the physicians to take the initiative in the education of parents and hospital personnel concerning this problem; to help the parents with their share of the preparation and to provide material to guide them; to help parents with their own special problems and thus reach the children indirectly; to prepare nurses to be vigilant and to supplement the preparation of the child when necessary; and to suggest consultation with medical social service if the problem seems severe or complicated.

The doctor, who represents the medical authority in each situation, remains best fitted for the responsibility of preparing his child patient to enter a hospital. He is best informed as to content and meaning, and his relationship is usually close enough to provide the bridge needed from home to hospital. If his relationship to the child is not very

close, he may fortify the parents sufficiently so that the child's trust in parent persons may extend to doctors and to hospital personnel. It is a more simple and direct process when the family physician is the one who treats the child within the hospital to which he is admitted, but at the University of Wisconsin Hospitals and at many others this is rarely possible.

It is proposed that the medical schools and pediatric journals offer doctors more encouragement in this respect and give them specific ideas as to how to prepare their young patients for hospital admission. Some of the material in Chapter II might be useful. A booklet which has been recently published for the Children's Medical Center in Boston, entitled "Johnnie goes to the Hospital", is a significant contribution to the needed literature on this subject. Its purpose is to "acquaint children and their parents with hospital environment and procedures in the hope of allaying the anxiety of children faced with hospitalization".[52] It is an attractively illustrated story written by a psychologist in consultation with the hospital staff and under the editorial direction of a pediatrician. It relates the experiences of a child who is hospitalised and it is meant to be read to a child before he goes to the hospital. It also offers suggestions to the parents directly, including the recommendation that they tell the child the truth in a simple, non-frightening manner.

More of this type of literature is needed as hospitals become increasingly cognizant of their responsibility in this area. Since our study was begun, the University of Wisconsin Hospitals, through its Pediatrics Department, has composed a small pamphlet which is mailed to the parents of each child prior to his admission. It provides a guide

to the various buildings and to the activities of admission day. It encourages the parents to tell the child in advance about where he is going and what he will be doing, because "this preparation will make it easier for him to adjust to the hospital".[53] The pamphlet includes rules about visiting and about the articles the child may bring with him to the hospital.

Popular magazines and the newspapers can contribute greatly through their wider circulation than the professional publications. A number of such articles have appeared within the past two years. They often consist of pictorial material which is more appealing and understandable to the general public. More thought and attention might be given to such material and to other methods of assisting parents in this responsibility. The public health nurse is another source of help through her contacts with the family. She can see them in the interval between the time the doctor makes his recommendation and that of actual admission after she learns of the plan during the child's visit to a Well Baby Clinic.

We would suggest, in general, that the elements of hospitalization which mean most to a child be presented to him in terms of his stage of development and past experience, and at the pace suited to him. In the case of an emergency admission the pace would need to be accelerated. The elements would cover such areas as how one eats and sleeps in the hospital, the people most likely to be helping him in place of the members of his family, what "they do in a hospital" (as one child framed her question) with more emphasis on activities in which he may engage and the details of less anxiety-provoking aspects; also, if and when his family hopes to visit him, or what method they will use to keep in touch

with him. If he wishes to talk about his worries and ask questions he should be enabled and even encouraged to do so. He should be given as many choices as possible in regard to the clothing and familiar objects (even though limited in quantity and type) which he may bring along.

Honesty should be stressed, so that he may not lose his trust in those upon whom he must depend. A child should learn to accept doctors and hospitals as sources of help to make him well and happy, and under no circumstances should he learn to regard them as threats. Such negative attitudes as the latter, once they are established, require much time and effort to eradicate. Parents should have information regarding visiting rules, and hopefully these will become more flexible and generous. Rules should be clarified also about clothing and toys permitted in the hospital, and encouragement be given to bring those selected by the child. It would be desirable, moreover, to impress him with the helpful interest of the nurses, and to inform the parents of the services of the medical social service department.

Among the parents interviewed for this study were found several who seemed in need of help for themselves. Because the child's welfare is so closely bound up with the parents' attitudes toward him and to one another, it is highly important that their anxieties - whether obvious or more subtly revealed through their defense mechanisms - be relieved as early as possible. A certain amount of anxiety is appropriate, especially if the medical situation is quite serious and the life of the child is threatened. So also is some reluctance on the part of the parents to leave their child with strangers and to have him submit to mysterious and fear-producing procedures. If a certain amount of clarification and real-

istic reassurance does not allay these anxieties, the problem might be presumed to lie too deeply for an immediate solution, and consultation with or referral to medical social service might be considered. The application of the special understanding and skills possessed by social workers may not wholly solve the problem, but may sufficiently free the parents so that the child will gain more security indirectly and recover more rapidly and completely. Extension of this service to the parents in their own community may then be arranged, if desirable.

If nurses would inquire at each admission to ascertain whether or not a child is prepared for this experience, they might provide a final bulwark against neglect in this regard. A simple, direct question, however, as to whether the child is prepared might not reveal the true situation as effectively as an inquiry of the parents as to just what Johnny or Mary knows about what will happen to him (or her) in the hospital. Such a question would serve to draw out not only what the child has been told, if anything, but also whatever uncertainty or resistance there may be on the part of the parents about the child's admission. The nurse could then proceed to help the parents give the basic facts to the child before they leave him, and also a realistic promise as to when they expect to come again. If encouraging parents to remain on the ward, even until the child falls asleep that night, should seem beneficial, this might be arranged. Many parents, too, would welcome suggestions as to how to handle this unusual experience, even if they are beset with only normal anxiety. In relation to this the objectivity of the nurse would be helpful. The verbalization of the parents' fears should not take place in the child's presence, but would better be expressed while he is away being undressed, weighed and examined. To

the child, a parental conference with the nurses constitutes a transfer of interest and affection and offers him security when he is left alone with them. An indication of real interest on the part of the nurses improves relationships, but to overplay the role can bring about a replacement of the parents in the child's affections and thus constitute a threat. To win a child away from his parents to whom he must eventually return, even though the parents may be highly inadequate, can cause great conflict and pain and should be avoided. The nurses might talk to the children, when time permits, about their homes and families and in this way strengthen the ties that exist and prevent as little loss as possible through the temporary separation. The occupational therapists who provide play activities for the children on the ward could assist in this regard by helping the young patients correspond with their families. If the letters expressed fears and unhappiness about their experiences there, they would furnish the outlet to which we have referred previously and should not be discouraged. Special articles in nursing and occupational therapy journals might stimulate interest in this subject.

Methods such as those proposed above would implement some of the principles set forth in Chapter II. Undoubtedly other methods can be devised. A great contribution is possible through wider distribution of material concerning the importance of and suggestions about preparing for hospital care to reduce ignorance on the subject. Even emergency admissions would then fail to shock a child who has some awareness of what a hospital is like and the comforts it can provide. The schools might include some of such material in their curricula, particularly at the lowest levels. It is there that more positive attitudes toward hospitaliza-

ion are needed. It might be possible to demonstrate and even dramatize some common procedures - such as the study of a blood sample - so as to enlist the child's interest and foster cooperation.

By adopting some of these methods, we feel that many of the emotional difficulties encountered by children in the hospitalization experience could be prevented. It is not proposed that hospital admission be avoided if the life of the child depends upon his receiving such care, but it is felt that his emotional health is of vital importance and cannot be entirely divorced from the physical. We do, therefore, earnestly recommend that he be saved from all unnecessary trauma through the most adequate preparation for the hospital experience which it is possible to give him, and that all the individuals concerned with his welfare be sensitive to these needs and equipped to meet them.

* * *

APPENDIX

THE STUDY OF PREPARATION OF CHILDREN FOR HOSPITALIZATION

Informant_____,relationship to pt._____

SOCIAL: DATE _____

	In of residence	Age	Sex
Name of pt._____	_____	_____	

Siblings - ages and sex _____
- in the home? _____

Are parents living in the home?_____ Reason if absent _____
_____

Pt. brought from home? _____ or _____
If from other source, length of time absent from home _____

Previous hospitalization of another child in home?_____
_____; or anyone else in household?_____

MEDICAL:

Admitting diagnosis_____ Chief complaint _____

If previously hospitalized, duration and how recently?_____
_____; where?_____

Final diagnosis_____ Date of discharge_____

Medical procedures administered: _____
_____
_____

PREPARATION FOR THIS HOSPITAL EXPERIENCE:

WHO: by parent_____, local physician_____, nurse_____,
social worker_____, other_____

WHEN:_____
WHERE:_____

HOW: verbal description_____, drawings_____, photos_____,
play acting _____, personal visit_____, other_____
_____

PATIENT'S QUESTIONS (IF ANY):

PLANS with child to maintain contact with family:
personal visits, frequency _____
correspondence_____, phone calls_____, gifts_____

CONTENT OF PREPARATION:
Estimated duration of stay:_____. Physical structure of hospital, size, etc. _____

Daily routine (differing from previous experience):
sleeping in a high bed_____
early awakening and retiring _____
eating - trays, less choice of foods, plain dishes _____
toilet - perhaps not in bathroom, different equipment _____
clothing worn - not his own, plain _____
activity probably restricted, perhaps bed only _____

People - many, strange, in uniform:
other patients (children)_____; professional and attendants _____

Procedures at admission:
weigh, measure, temperature _____
inspect nose and throat (with instruments)_____
disrob ing before strangers, and frequently _____
examinations (4 or more) by doctors _____
rectal smears_____ and vaginal smears for girls_____
needle punctures for tuberculosis, blood samples, diphtheria_____
x-ray of chest (large equipment)_____
electrocardiogram (no pain, bands on wrists)_____

Others commonly done:
enemas_____; transfusions and intravenous feedings_____;
surgery, with anesthesia_____; electroencephalograms, pneumoencephalograms_____

CHILD'S OWN PARTICIPATION, CHOICES IF ANY AS TO:

who accompanied him here_____, clothing he wore_____, means of transportation used _____;

objects brought along: slippers_____, blanket_____;
photos_____, radio_____, religious articles_____;
toys _____, books_____, games_____
_____, others_____

COMMENTS: (from medical chart)

TABLE II

MEDICAL ASPECTS

No.	Name of Child	Age (yrs)	Discharge Diagnosis	Length of Stay (days)	Special Medical Procedures: Eye Exam	Pneumo-encerph.	EEG *	Nasal Cath.	Sub-cut.	Sur-gery	Ndls
1.	Daniel	2	cerebral atrophy	2	X	X	X		X		
2.	Freddie	2	cerebral atrophy	12	X	X	X	X	X		
3.	Harold	2	cerebral atrophy & epilepsy	17	X	X	X		X	X	X
4.	Ronald	2	pectus excavatum & aden. hypertrophy	6				X		X	X
5.	Anita	3	congenital heart disease	23				X	X	X	X
6.	Kenneth	4	cortical & cerebellar atrophy	19		X	X				
7.	Francis	4	aplastic anemia	16/						X	X
8.	Diane	5	atelectasis & left hemiplegia	11						X	
9.	Fay	6	acute glomerulo-nephritis	3				X	X		X
10.	Bernard	6	congenital nystagmus	3	X						
11.	Marie	7	diabetes mellitus	53							X
12.	Linda	8	cortical atrophy	7	X	X	X				
13.	Larry	8	Head injury and convulsions	13	X	X	X				X
14.	Ann	9	atopic eczema & rhinitis	29/							
15.	Jane	9	pinworms	9							X
16.	Sharon	9	cortical scar	16	X	X	X				
17.	Walter	10	epilepsy & retardation	8	X		X				

TABLE II (continued)

MEDICAL ASPECTS

No.	Name of Child	Age (yrs)	Discharge Diagnosis	Length of stay (days)	Special Medical Procedures: Eye Exam	Pneumo-enceph.	EEG *	Nasal Cath.	Sub-cut.	Sur-gery	Ndls
18.	Doris	10	congenital heart disease	24					X	X	X
19.	Eileen	10	cardiospasm	16	X						X
20.	Roger	11	rheumatic fever, inactive	6							
21.	David	11	pleural effusion	2							
	TOTALS				9	7	8	4	6	6	10
	AVERAGE			13.5							

* electroencephalogram

TABLE III

PREVIOUS HOSPITAL EXPERIENCE

Name of Child	Child's Experience	Hospitalization of Parents	Hospitalization of Siblings
1. Daniel	3 days, 6 months previously	Mother's readmission after pt's birth	None
2. Freddie	1½ months, 6 months previously	None	None
3. Harold	1 week, 1 year previously and 1 week, 6 months previously	Father twice, last when pt 11 months old	None reported
4. Ronald	None (except outpatient clinic)	None reported for child's lifetime	Two tonsillectomies prior to pt's birth
5. Anita	None	None	Sister as outpatient; minor surgery
6. Kenneth	None (except outpatient exam)	Mother at birth of sister 11 months previously	Sister in first month for 2½ weeks
7. Francis	2 wks immediately previously and 4 days 1 yr. previously	None in child's lifetime	Sister frequently
8. Diane	10 days until 3 days previously	Mother, 2 births	None
9. Fay	5 days just previously	Mother 3 years previously	Brother 4 years previously
10. Bernard	None	None reported	3 brothers, prior to pt's birth
11. Marie	1 month 3 years previously	Mother as neuropsychiatric pt, child 1 yr old	None
12. Linda	2 days, 4 years previously	None known	None
13. Larry	None	Mother for brother's birth	Tonsillectomies of older children

TABLE III (continued)

PREVIOUS HOSPITAL EXPERIENCE

Name of Child	Child's Experience	Hospitalization of Parents	Hospitalization of Siblings
14. Ann	None	Father, diabetic regulation; mother 2 births & gall bladder surgery	None
15. Jane	18 days (with twin) 4 months previously	None reported	Twin had tonsillectomy 2 years before; another sister for unexplained reason
16. Sharon	None	Father, years ago	Sister at tuberculosis sanatorium 6 months
17. Walter	None (except outpatient care)	Mother, 2 births; father, Army hospital	None
18. Doris	1 day 5 years previously	Father for diabetic checkup	Brother, surgery 5 years previously
19. Eileen	3 days 1 year previously	Mother for 2 births; father 1 week, a year previously	None reported
20. Roger	1 day, 3 years previously	Father when pt was 1 yr. old; mother for 2 births	None
21. David	2 weeks 1 week previously	Mother, 1 birth	2 brothers

Familiar Object Brot	Child's Participation in Plans: His Questions	Choices of Cloth'g	Toys
	None (retarded)		
X	None (retarded)		
	None (retarded)		
X	None (retarded)	X	X
X	Sister going too?	X	
X	None (retarded)		
	None quoted		
	None		
	(Too ill)		
	How long stay? Will mother stay?		(child rejected)
X	Get "shots"? How long stay?	X	X
X	None (retarded)	X	X
	None	X	
	Get lonesome? Stay inside? Get food?	X	
X	None quoted		X
	None quoted	X	
X	Other ch'n? Nurses to talk to? Pills?	X	X
	"What do you do in a hospital?"	X	
X	Get "shots"?	X	X
X	Walk around and visit other children?	X	X
X	How long?	X	X
11	9	12	8

TABLE IV

PREPARATION FOR HOSPITAL EXPERIENCE

No.	Name of Child	Indirectly - by whom and where	Directly - by	Areas Covered: Duration	Family Contact	Other Ch'n	Treatmt. & Care	Personnel
1.	Daniel	No one	No one					
2.	Freddie	No one	No one					
3.	Harold	No one	No one					
4.	Ronald	Dr. & mother in office	Mother	X	For disch.		X	X
5.	Anita	No one	Parents	Vague				Doctor
6.	Kenneth	No one	No one					
7.	Francis	Not known	No one		Mother stayed		*	
8.	Diane	Grandparents, their home	Grandparents			X		
9.	Fay	No	County nurse				*	*
10.	Bernard	School nurse in class	Mother & dr.		X	X		X
11.	Marie	No	Mother & dr.	X	X			
12.	Linda	Doctor, in office	Grandparents		For disch.	X		
13.	Larry	No	Mother & dr.	X	" "	X		X
14.	Ann	No	Parents & dr.	X	X	X		X
15.	Jane	Family, at home	Dr. & mother	X	X	(Sister)	*	
16.	Sharon	No	Mother	X	X			
17.	Walter	No	Dr. & mother	X	X	X	X	X
18.	Doris	Doctor in outpatient exam.	Mother	X	X		X	X
19.	Eileen	No	Parents	X	Parents adm.	X	X	
20.	Roger	Doctor in office	Mother	X	X	X	X	X
21.	David	Doctor phoned home	Parents	X	X	—	*	—
TOTALS		8	16	11	14	9	5	8

* Parents assumed child was aware through previous experience

TABLE V

SEPARATION FROM FAMILY

Name of Child	Age (yrs.)	Place in Family	Distance from Home	Accompanied by	Manner of Separation
1. Daniel	2	only	45 miles	parents	secretly
2. Freddie	2	2nd of 2	70	parents	secretly
3. Harold	2	only	85	parents	not known
4. Ronald	2	4th of 4	45	mother	openly
5. Anita	3	2nd of 2	160	parents	secretly
6. Kenneth	4	1st of 2	25	parents	not known
7. Francis	4	3rd of 3	40	mother & uncle	mother stayed
8. Diane	5	3rd of 5	90	mother & grandmother	not known
9. Fay	6	6th of 7	100	county nurse	(comatose)
10. Bernard	6	7th of 9	180	mother	apparently open
11. Marie	7	1st of 2	75	mother	openly
12. Linda	8	only	200/	grandmother	not known
13. Larry	8	7th of 8	30	mother	apparently open
14. Ann	9	2nd of 4	200	father	apparently open
15. Jane	9	7th of 10	90	mother	apparently open
16. Sharon	9	4th of 7	135	father	apparently open
17. Walter	10	1st of 3	100	parents	apparently open
18. Doris	10	4th of 4	170	mother	apparently open
19. Eileen	10	2nd of 4	210	parents	parents patients
20. Roger	11	8th of 10	290	father & sister	apparently open
21. David	11	3rd of 4	60	parents	apparently open

114 average

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