NURSING INTERVENTION TO HELP A HOSPITALIZED MATERNALLY DEPRIVED TODDLER INCREASE HIS COPING ABILITIES

BY

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CHAPTER I

INTRODUCTION

Those concerned with the welfare of children realize that the basic needs and rights of the infant and young child include those aspects of care which only interaction with a loving mother or permanent mother substitute can provide. These aspects include protective physical care, gentle physical contact, opportunity for safe play, the pleasant and varying sounds of the human voice, visual stimulation from the environment, and interpersonal communication.

These aspects of child care are often taken for granted in our culture and society today. We now live in a civilization which is family-oriented and child-centered: a civilization which emphasizes children's rights and parental responsibility in the development of a healthy personality for the child. Because of this, it is only in the absence of adequate maternal care that we recognize its overwhelming importance. Then, the lack of it becomes apparent by the appearance of a syndrome which observers[1,2,3] have called maternal deprivation.

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[1]John Bowlby, Maternal Care and Mental Health (Geneva: WHO Monograph Series, No. 2, 1952), p. 11.

[2]Mary D. Ainsworth, "The Effects of Maternal Deprivation: A Review of Findings and Controversy in the Context of

The syndrome of maternal deprivation was first recognized in children who had been removed from, or abandoned by, their mothers and placed in institutions. Study of these children revealed that many of them failed to thrive and demonstrated retardation in social, emotional, and intellectual development even though they were provided with adequate physical care. Studies [4,5,6] have shown that optimal growth and development is dependent on more than nourishing food and good hygiene. The major factor missing from the environment of these children, as distinguished from other children, was the provision of continuity of loving and intimate care such as that provided by a mother in the normal home situation.

In the normal home situation, the mother provides the child with emotional warmth and the basis for responsiveness and attachment to other human beings. In addition, she is the source of stimulation and provides the motivation and permission for motor, intellectual, and psychosocial growth. In as much as the child is motivated by his relationship with

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Research Strategy," Deprivation of Maternal Care (Geneva: WHO Public Health Papers, No. 14, 1962), p. 98.

[3]Robert Patton and Lytt Gardner, Growth Failure in Maternal Deprivation (Springfield, Ill.: Charles C. Thomas, 1963), p. 3.

[4]Dorothy Burlingham and Anna Freud, Infants Without Families (London: Allen and Unwin, 1944).

[5]Rene Spitz and Katherine Wolf, "Anaclitic Depression," The Psychoanalytic Study of the Child, Vol. II (New York: International Universities Press, Inc., 1946), pp. 313-340.

[6]W. Goldfarb, "Psychological Privation in Infancy and Subsequent Adjustment," American Journal of Orthopsychiatry, XV (April, 1945), p. 247.

his mother, he strives at mastery of the physical and psychosocial tasks for which she bestows appreciation and affection.[7]

The child in an institution who does not have the opportunity for continuity in a relationship with one loving person lacks the basis for attachment to other human beings and the motivation to achieve the developmental tasks which are necessary to move toward maturity. Thus we see a child developing with the personality deficiencies which characterize the child who has been maternally deprived; his behavior demonstrates decreased ability to relate to adults or peers, retarded intellectual function, indifference to the environment, and poor physical stamina.[8]

The earlier researchers[9,10,11] have predominantly studied the plight of the institutionalized child thereby emphasizing the effects of separation from the mother in producing the syndrome called maternal deprivation. However more evidence and opinion is accumulating that deprivation can occur at home without the child being physically separated from the mother. Prugh and Harlow[12] provide evidence from

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[7]Kurt Glaser and Leon Eisenberg, "Maternal Deprivation," Pediatrics XVIII (July-Dec., 1956), pp. 626-627.

[8]Ibid.

[9]Burlingham and Freud, pp. 11-128.

[10]Spitz and Wolf, pp. 313-340.

[11]Goldfarb, pp. 247-255.

[12]Dane G. Prugh and Robert G. Harlow, "'Masked Deprivation' in Infants and Young Children," Deprivation of Maternal Care (Geneva: WHO Public Health Papers, No. 14, 1962), pp. 9-25.

case studies to demonstrate that emotional deprivation can produce effects in the child as pathologic as those that follow severely depriving separation experiences. They distinguish two other forms of deprivation: 1) insufficient emotional communication between mother and child; 2) distortions in the relationship which lead to abnormal patterns of interaction between mother and child. Clarke and Clarke[13] also discuss various conditions of maternal deprivation including separation, rejection, neglect, and abuse. Since about 1960 there has been increasing attention paid to the problems of child abuse and neglect. Some evidence[14,15] has also been provided to support the conclusion that the effects of maternal deprivation can be observed in children who remain in the home situation.

Although vast literature has been accumulated (Ainsworth[16] lists over 120 studies and research reports in her review of literature and bibliography) concerning the effects of maternal deprivation, relatively little of it has dealt in any depth with the contribution nursing intervention could make to alleviate this problem. However, the most significant

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[13]A.D. Clarke and A. M. Clarke, "Some recent advances in the study of early deprivation," Journal of Child Psychology and Psychiatry I, (1960-1961), pp. 26-36.

[14]C. H. Kempe and R. E. Helfer, The Battered Child (Chicago: University of Chicago Press, 1968).

[15]Leontine Young, Wednesday's Children (New York: McBraw Hill Book Co., 1964).

[16]Ainsworth, p. 159-165.

improvement in the child's motor and psychosocial development has come in response to intensive care provided by one or two members of the nursing staff within the institution or hospital to which the child has been admitted. Another form of intervention, which has apparently prevented further deterioration but has not yielded much actual improvement, has been the provision of environmental stimulation such as that provided in nursery schools.[17,18,19,20,21]

Goldfarb[22] and Williams[23] have reported the difficulties that maternally deprived children encounter when placed in foster homes without remedial help and preparation for transfer. Maternally deprived children are more prone to failure in becoming integrated into the life of the foster family and often suffer the consequences of repeated rejection as they are transferred from one home to another. This only intensifies the problems which have resulted from separation and/or maternal deprivation.

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[17]Ainsworth, p. 133.

[18]Glaser, p. 629.

[19]Goldfarb, p. 247.

[20]Patton, p. 29.

[21]Betty M. Flint, The Child and the Institution (Toronto: University of Toronto Press, 1966).

[22]W. Goldfarb, "Infant Rearing as a Factor in Foster Home Placement," American Journal of Orthopsychiatry, XIV (Jan., 1966), p. 162.

[23]J. M. Williams, "Children Who Break Down in Foster Homes: A Psychological Study of Patterns of Personality Growth in Grossly Deprived Children," Journal of Child Psychology and Psychiatry, II (1961), p. 5.

Many children who are suspected victims of child abuse and neglect and/or have failed to achieve developmental norms are admitted to hospitals for study before foster home placement. This provides nurses with opportunities to give remedial help to support and promote growth and to prepare these children for placement. There remains a need to identify the specific intervention that can be provided by nurses to promote normal growth and development in maternally deprived children and prepare them for foster home placement.

Statement of the Problem

The intent of this study is to describe and analyze the nursing intervention which was provided to assist Brice, a maternally deprived preschool child to increase his coping abilities during hospitalization prior to his foster home placement.

Objectives

The objectives which will be used to study the problem are stated in the form of questions:

1. What was Brice's level of psychosocial development at the time of admission to the hospital and what factors helped to explain this?
2. What were the stressors that were particularly threatening to Brice in the hospital?
3. What coping devices and mechanisms of defense did he use to deal with the stressors?

4. What was the nursing diagnosis based on an assessment of behaviors and knowledge of past history?
5. What goals of nursing intervention were formulated as a result of the nursing diagnosis?
6. What plan of intervention was developed in an attempt to achieve the goals?
7. How was the plan of nursing intervention implemented?
8. What were Brice's behavioral responses to the nursing intervention?
9. How effective was the intervention and what conclusions can be drawn?

Definition of Terms

Maternal deprivation--a lack or loss of "a warm, intimate, and continuous relationship with his mother (or permanant mother-substitute) in which both find satisfaction and enjoyment."[24] Maternal deprivation may also refer to the condition which results from lack of this kind of relationship. It includes such manisfestations as 1) decreased ability to relate to adults and peers, 2) retarded intellectual and psychosocial functioning, 3) indifference to the environment, and 4) poor physical development and stamina.[25]

Stress--"outer or inner conditions or both that 1) make demands on the child beyond his capacity to handle

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[24]Bowlby, p. 1.

[25]Glaser and Eisenberg, pp. 626-7.

with his usual resources and 2) arouses anxiety that he will not be able to deal with the threat."[26]

Panic--"an attack of acute, intense, and overwhelming anxiety."[27]

Anxiety--"apprehension, tension or uneasiness which stems from the anticipation of danger, the source of which is largely unknown or unrecognized."[28]

Coping abilities--"the child's capacity to make use of opportunities, challenges and resources of the environment and to manage the pain, frustrations, difficulties, and failures with which he is confronted. . . ."[29]

Defense mechanism--"an attempt to alleviate anxiety by using methods that deny, falsify, or distort reality, and that impede the development of the personality."[30] Withdrawal, immobilization, and regression are examples of defense mechanisms.

Withdrawal--"retreat from a stimulus which is perceived by the child as a threat. The retreat may be physical

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[26]Lois Murphy, "Preventive Implications of Development in the Preschool Years," in Prevention of Mental Disorders in Children, ed. by Gerald Caplan (Ner York: Basic Books, Inc, 1961), p. 219.

[27]Robert T. Morse, et. al., eds., A Psychiatric Glossary (Washington, D.C.: American Psychiatric Asso., 1964), p. 54.

[28]Morse, p. 13.

[29]Murphy, p. 222.

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

or by retirement into himself manifested as"[31] immobilization, muteness and/or deafness.

Immobilization--the inability to carry on purposeful activity for comfort or alleviation of distress.[32]

Regression--"the reactivation of behavioral patterns appropriate to an earlier stage of development after they have been given up"[33] especially when the individual is confronted with a stressful situation.

Behavioral responses--"observable actions and expressions of feeling which arise in a person as a result of internal or external stimulation."[34]

Trust--a feeling or expectation that one can rely on the sameness and continuity of persons providing care and of being able to control one's own urges.[35]

Autonomy (Sense of)--the second phase of psychosocial development as described by Erikson. It is the development of the awareness of self as separate from others with increased potential for control over self and the environment.[36]

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[31]Mary Denyes, "A Preschool Child with Hirschsprung's Disease Uses a Nurse to Gain Ego Strength" (unpublished Master's paper, School of Nursing, University of Wisconsin, 1967), p. 5.

[32]Janet Ruhde, "Nursing Care of a Toddler Hospitalized for Palatoplasty" (unpublished Master's paper, School of Nursing, University of Wisconsin, 1968), p. 7.

[33]Robert I. Watson, Psychology of the Child (New York: John Wiley & Sons, Inc., 1959), pp. 142-43.

[34]Denyes, p. 3.

[35]Erik H. Erikson, Childhood and Society (New York: W. W. Norton and Co., Inc., 1963), p. 248.

[36]Ibid., p. 85.

Methodology

The subject of this study was Brice, a two-year, eleven-month old boy, who was admitted to the children's hospital in a large midwestern university medical center for evaluation of developmental retardation and deafness. According to the county social agency files, his past history reported maternal deprivation. He had been separated from his mother on several occasions and had had inadequate maternal care.

The study of Brice began two hours after his admission, when the writer and her instructor observed him for the first time, and continued through the forty-five days of his stay in the hospital. During the period of study the writer collected data as she functioned as a nurse-participant-observer. In this role the writer was actively involved in providing Brice with physical care, relationship experiences, play opportunities, help in familiarizing himself with a strange environment, and support during frightening diagnostic and medical procedures. Daily experiences with Brice ranged from one to eight hours in length. They averaged approximately three hours in length and were arranged in accordance with his anticipated needs.

Process recordings were made of observations and interactions at intervals throughout the study. Recordings were made of changes in Brice's behavior in relation to activities of daily living, new experiences with which he was confronted, and situations which were stressful to him. Recordings were made as soon as possible after the experience.

They were based on the writer's memory of the events which had taken place. The writer's instructor, a professor of nursing, functioned both as an observer and a participant-observer on occasions and, in these instances, she provided written recordings of nurse-patient interactions. Validation of the writer's interpretations of Brice's behavior were made by this professor through written communication on the recordings and/or conferences. Additional information was obtained from conferences with the staff nurses, doctors, social workers, and other paramedical personnel involved in Brice's care.

Limitations of the Study

Limitations of the study as recognized by the writer are as follows:

1. The study was limited to the care and observation of only one subject.

2. Recordings were made from the writer's memory of the events which had taken place. The writer concentrated her efforts on recording all changes in behavior and the interactions which occurred during the experiences which were new to Brice.

3. Because the writer was directly involved in Brice's care she influenced his environment and his behavior. Her involvement with the child also influenced her observations and interpretations.

4. Brice received care from many other people during

his hospitalization. The writer has no knowledge of how this influenced his behavior.

Organization of the Paper

Chapter II presents Brice's past history with an interpretation of the life experiences which may have influenced his psychosocial development and his current problems. Chapter III describes and interprets Brice's behavior during the first three days of hospitalization. Chapter IV presents the nursing diagnosis, goals, and the plan of nursing intervention. The implementation of the plan of intervention and Brice's behavioral responses to it are also discussed. Chapter V presents the summary, conclusions, implications, and epilogue.

CHAPTER II

BRICE'S PAST HISTORY, CURRENT LEVEL OF PSYCHOSOCIAL DEVELOPMENT, AND CURRENT PROBLEM

Brice's Past History

Brice R. was born prematurely on May 15, 1965, with a birth weight of three pounds six and one-half ounces, and immediately encountered his first experience of maternal deprivation. For the first forty-five days of life, Brice remained in the hospital in an incubator. Physiological instability and confinement to an incubator usually necessitates care which provides only a minimum of physical contact. Thus physical contact for purposes of cuddling and comforting as well as the number of normal stimuli impinging on the newborn are severely decreased. Instead of being comfortably held, and hearing the soothing sounds of the human heart beat and voice while being fed, it is possible that Brice was subjected to the unpleasant stimuli of gavage feedings and diagnostic blood tests and many periods of high tension. Although the exact events of Brice's first month and a half of life are not known, it is reasonable to assume that they varied significantly from the normal ones which provide opportunity for beginning development of security and trust in the newborn infant.

Although his parents were reportedly pleased with the birth of their baby, Brice went from the sterile conditions of a premature nursery into a home which was environmentally less than adequate. The family needs had been brought to the attention of various social service agencies many times in previous years. Both Mr. and Mrs. R. were adjudged to be of below normal mentality and emotionally unstable. Their marriage had been a turbulent one. Mr. R., who had completed about eight grades of formal education, was regularly unemployed and this created severe economic problems. Two other children of Mrs. R. by previous marriages had been removed from her custody on grounds of neglect and had been placed in foster homes.

When Brice was about seven months old, his mother was admitted to a state psychiatric institution with a diagnosis of paranoid schizophrenia and the prognosis of expected progression of symptoms was given. For the next year, Mr. R. assumed the major responsibility for Brice's care and for household chores. According to a social service report, he fed, clothed, bathed, and gave Brice much personal attention. Upon her return home, Mrs. R. was usually inactive and spent much of her time sleeping or lethargically sitting in a chair listening to the radio. Mr. R. continued to care for Brice.

Before his second birthday Brice encountered another painful separation experience. His father's death in March, 1967, deprived Brice of the one person who had provided him with any consistent care.

After her husband's death, Mrs. R. seemed capable of performing more tasks than previously. However, despite the support of a social worker and homemaker services, her level of functioning was not assessed to be sufficient to provide adequately for Brice's physical and emotional needs.

Level of Development

The following section is an excerpt from a summary written by the county social worker approximately one month before Brice was admitted to the hospital. It includes: 1) a brief developmental history; 2) a description of Brice's activities and behavior; 3) an indication of how he spends his day. Altogether it was an accurate description of his level of motor and psychosocial development at the time of admission to the hospital.

> Brice is overly attached to his mother and is just now learning to overcome some of his fear of strangers and other persons. He spends much time sitting in his mother's lap and there is presently little opportunity for him to play with other children. The only other adults he is exposed to are men friends of Mrs. R.'s. . . .
>
> Until the last several months, Brice has shown little curiosity towards his surroundings and appears to have little ability to play with toys and to entertain himself. Currently, he has a limited ability to play and does display some curiosity toward other people and objects. Brice has few toys to play with and poor housekeeping standards prevent him from playing much on the floor. Before Brice began to walk at the age of two, he did not creep very much. When placed on the floor, he would usually lie there or roll around somewhat restlessly; however, he did not play with any toys at this time and received little parental encouragement to do so.
>
> . . . Brice first walked at about twenty-four months. There was a period of months between the time when

he first stood up and when he was able to walk alone. At the present time, (two years and nine months) he cannot speak any phrases and only speaks several words such as "mama" and "bye-bye".

Brice was fed baby food until he was approximately two years of age. Mrs. R. was very resistant toward placing him on solid foods and did not encourage him to drink milk from a cup until he was over two years old. He seems to have a poor appetite, but likes candy and sweets. Presently Mrs. R. has had little success in toilet training Brice and does not persist in her efforts. She states that when she tries to train him, he cries and she does not stay with it. Brice is often wet and Mrs. R. puts forth little effort to keep him dry and clean. Brice's sleeping habits are probably quite poor. Mrs. R. tries to give the impression that he goes to bed early in the evening and rises early in the morning; however, in view of her mannerisms and habits, it is more likely that he goes to bed early in the evening and sleeps until about 10:00 a.m.; thus, spending much of his time in bed.[1]

Discussion and Interpretation

The following section presents an analysis of Brice's major life experiences and the manner in which they may have influenced his motor and psychosocial development. This interpretation is based upon the theory of development set forth in Erik Erikson's Childhood and Society.[2]

According to Erikson, development is an evolutional process based upon a sequence of biological, psychological, and social events. Erikson divides the developmental process into eight critical periods or phases. In each phase the

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[1]Social worker, letter summarizing agency data concerning Brice and his mother, Feb. 6, 1968.

[2]Erik H. Erikson, Childhood and Society (New York: W. W. Norton & Co., 1963), pp. 58-85, 247-254.

individual is faced with a critical problem which he must resolve. Successful solution of the conflicts in each phase motivates upward movement toward maturity and into the next phase. Development is a continuous process with each phase closely interrelated with the others: each phase finds its antecedents in previous phases and its ultimate solution in subsequent phases. Successful solution of the critical conflicts in each phase of development is dependent to some extent on successful solutions to preceding and subsequent phases.

Erikson places the foundation for all future development in the first phase of development in which the child struggles to resolve the core conflict which he designates as "basic trust versus basic mistrust." Therefore the basis of normal psychosocial development is trust--trust in others, trust in oneself, trust in one's world. A sense of trust begins to develop in early infancy as a result of the dependable, loving care given the child by his mother. The care and atmosphere resulting from a mutually satisfying mother-child relationship provide the infant with trust and the security of knowing that others can be depended upon to meet his needs. This, in turn, assures him of a feeling of self-worth; he develops the self identity of a person who feels worthy of receiving care. If his mother is able to comfortably meet his needs as he signals them in early infancy, he also begins to realize that he is capable of exerting some control over himself and his environment.

The circumstances of Brice's first years of life were not conducive to the development of a sense of trust. The major requirement of continuity of a relationship with one dependable, loving mother was lacking. After receiving care from multiple caretakers in his first month and one-half in the hospital, he went home to a mother who was deeply enmeshed in her own problems. Brice did not have the love and the pleasure of dependency conveyed to him through his mother's embrace, her warmth, her smile, and the pleasure of her talking to him because she did not have love to give at the time. Emotional deprivation was further complicated by actual separation when his mother was admitted to a state institution.

The year during which his father assumed the major responsibility for his care may possibly have been the best period of Brice's young life. However, it was probably much less than ideal because of his father's own lack of stability and the return of his emotionally ill mother into the home. His father's death, when Brice was almost two years, produced another separation experience at a critical age which once again disrupted the continuity in relationship that is so important if the child is to develop trust in himself and the world. Again Brice had to rely upon the care of his mother who had proven herself undependable in meeting his needs in the past.

Normally, as the infant grows physically and matures psychologically, he begins to discover that his behavior is his own. This initiates the onset of Erikson's second

developmental phase in which the child struggles to attain a sense of autonomy rather than a sense of doubt and shame. The young child begins to assert his autonomy and his ability to control his own behavior. At the same time he experiences a sense of doubt about his ability and his freedom to assert his autonomy and thereby exist as a person in his own right. This doubt is compounded by shame of his instinctive revolt against previous dependency and by fear lest he exceed his own or his environmental limits.

A child, such as Brice, who has had inadequate care and unfortunate experiences during the time when trust is normally developing probably reaches the second phase of psychosocial development at a later age than usual. Besides having missed the optimal time, physiologically and psychologically, for onset of autonomy, Brice came to this stage with overwhelming odds predisposing him to feelings of doubt and shame. His previously unmet needs for dependency impelled him to continue to seek desperately for their fulfillment and to anxiously avoid any behavior which would jeopardize the little security he had attained. A basic feeling of mistrust in himself and his environment must have evoked an excessive amount of doubt in his ability and freedom to assert his autonomy.

The child who has been able to develop a psychosocial balance in favor of trust through satisfactory experiences in infancy, requires "sympathetic guidance and graduated support [for emergence into autonomy] lest he find himself at a loss

and forced to turn against himself with shame and doubt in his existence."[3] Brice's environment and relationship with his mother could not supply "sympathetic guidance and graduated support." The housekeeping conditions and the lack of toys were not conducive to the exploratory activity which is so much needed to develop autonomy. His mother could not bring herself to introduce regular foods, institute toilet-training, or encourage play, motor activity, or the acquisition of self-help skills. This must have conveyed to Brice that his mother lacked trust in his abilities or did not want him to grow up. Consequently, instead of using his recently acquired motor ability in exploratory activities and play, Brice spent much of his time passively sitting on his mother's lap.

Current Problem

Because the County Social Worker was becoming increasingly concerned about his welfare and developmental retardation, Brice was admitted twice to a community hospital for evaluation, once in September, 1967, and again in February, 1968.

X-rays taken for bone age during the second hospitalization revealed that skeletal maturation had reached only sixteen and one-half months. Excretory urograms revealed left pyelectasis. The results of other laboratory tests were within normal limits. There is no report that specific tests

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[3]Henry Maier, Three Theories of Child Development (New York: Harper & Row, Publishers, 1965), p. 37.

for developmental evaluation were done during these hospitalizations.

During the second admission, a question of Brice's hearing ability arose. During this seven day hospitalization, Brice had not been noticed to be using any speech frequently or consistently although he made understandable gestures and some vowel sounds.

When seen by the hospital audiologist, Brice demonstrated essentially no functional speech, gave no evidence of understanding when given short simple commands, and did not even consistently make noises to make his needs known. Gross evaluation procedures based on auditory stimulation provided by environmental noises and toy noisemakers led the examiner to conclude that Brice probably had a severe bilateral hearing loss. This finding was significant for future speech and language development.

On the recommendation of the local physician and personnel at the community hospital, Brice was referred to the large university medical center, where this study took place. He was admitted for complete diagnosis of hearing loss, mental retardation, and abnormal kidney function.

At this same time the county social service agency was also contemplating court proceedings to remove Brice from his mother's custody and place him in a foster home. For this purpose the agency was seeking information which would indicate the basis of Brice's retardation and his potentiality for future development.

CHAPTER III

INITIAL OBSERVATIONAL DATA WITH INTERPRETATION

This chapter presents data which were collected by the writer and her instructor during the first three days of Brice's hospitalization. The data were categorized and interpreted to depict Brice's initial reactions to 1) separation from mother, 2) hearing and communication, 3) toys and play experiences, and 4) the hospital environment. Interpretation of this data provided the basis for formulation of a nursing diagnosis, planning nursing intervention, and evaluating its effectiveness as described in the next chapter.

Reactions to Separation from Mother

Observational Data

The following description, as recorded by Miss Blake, the instructor, after the initial period of observation, portrays vividly Brice's reaction to separation from his mother.

> When 2 year, 11 month old Brice R. was first observed, his behavior manifested a high level of anxiety. He was crying piteously; his face was streaked with tears; his eyes were swollen and his lids drooped; and he was bent over and dejected. His hair was shaggy and rumpled; his face showed remnants of his lolly pop; and his nails were dirty. He was dressed in hospital clothing and his own wearing apparel was on the bedside table which validated the assumption that he had just been admitted. He was alone and his mother

was nowhere in sight. After scanning the room, a tray of uneaten food was spotted. Before approaching Brice with the goal of reducing his anxiety, the instructor left for a carton of chocolate milk.

Brice stopped crying when the instructor re-appeared but protested again when she walked around his bed, put the crib side down and caught him as he thrust himself into her arms. He clung like a leech, clutched at the instructor's clothing and sobbed. He made grunting sounds but spoke no words. He drank when seated on the instructor's lap. A cup of chocolate milk was placed at his lips but he made no gesture to communicate readiness to participate in self-feeding. After a swallow of milk, he pushed the cup away angrily. Then he leaned toward it to communicate his need for another sip or two. His behavior betokened conflict about food; he wanted to drink but simultaneously was unable to control his impulse to strike out against the food which was being offered. His protests continued. When the word "ma ma" was used, he hit out at the cup with such vigor that it would have gone flying through the air if it had not been held tightly. The word "ma ma" was used four or five times to validate the assumption that Brice was not as deaf as he was alledged to be and that aggressive impulses were being stimulated by the use of this specific word. Soon he began to peer over the instructor's shoulder at the door of the unit. He was acutely aware of his loss, wanted to find his mother and acted as if he expected her to re-appear in the doorway through which she had vanished from sight.

To give Brice an opportunity to search for his mother and to prove to him that his need for her was observed, he was carried into the hallway. His mother and the social worker were standing and facing his room when he was carried into the hallway. He lunged toward his mother with outstretched arms and was quickly taken into the arms of his mother. He clutched her and protested loudly.

Upon re-entry into Brice's room, his mother held him on her lap with his back to her. Her arms encircled his trunk as she sat looking helpless in the company of the social worker and two nurses [instructor and writer]. Brice's crying ceased but his facial expression was sad and showed tension, fatigue, and uncertainty. At this point he did not make eye contact with either nurse.

Throughout the next half hour, Brice continued to sit erect on his mother's lap with his back toward her. It was noted that, during this time, Brice and his mother had almost no interaction. They did not exchange glances and Mrs. R. made no attempt to talk to him. Brice sat almost immobile and his facial expression remained tense and unhappy. Mrs. R. appeared sad and lost in thought responding only in short, terse sentences to direct questions from the instructor.

When, a little later, the doctor asked Mrs. R. and the social worker to step out of the room to answer a few questions, they took their coats as if planning not to return. At the instructor's suggestion, his mother said goodbye to Brice, kissed him on the cheek, and told him not to cry. Then, she ran from the room and down the hall.

> His mother's departure overwhelmed Brice with strong feelings. He shrieked, clutched, and indicated his wish to go into the hall by looking through the doorway and moving his body in the writer's arms. He clung desperately to the writer but avoided looking into her face. He was almost totally unresponsive when she talked to him, seeming not to hear or comprehend. When his crying subsided, he put his thumb in his mouth, smeared the area around it, and appeared desolate.

For the next three days when the writer entered his room, Brice began crying, "I wan, I wan, I wan.. . . ." As the bedside rail was lowered, he lunged into the writer's arms and clutched her clothing tightly. If placed in a chair or on a blanket on the floor, he sat immobile and did not move unless given verbal permission. He made little attempt to play, feed himself, or assist with getting himself dressed. He ate and slept poorly.

Interpretation

Separation from mother and the care she provides is the most stressful problem confronting hospitalized children in the toddler age group. Bowlby[1], Robertson[2], and Blake[3], have described and discussed in great detail the observable behavior and need for intervention to support the child in coping with the feelings aroused by separation.

Brice's behavior, as initially observed and recorded, indicated that he was suffering intensely from separation from his mother and also from fear of the hospital milieu. His reaction was one of utter panic. Past experiences in hospitals and with emotional deprivation and separation had left him with even less trust that his mother would return than most children his age possess.

Brice acted as if he were well aware of his state of extreme dependency on others for having his needs met. He was probably also able to sustain little hope that others in this strange environment would meet them. Although dismayed and distressed by separation from mother and fear of the

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[1]John Bowlby, Child Care and the Growth of Love (Baltimore: Penguin Books, 1955), pp. 11-182.

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

[3]Florence Blake, "Nursing Intervention to Reduce Suffering from Separation Anxiety," Current Concepts in Nursing Care, Report from Conference on Maternal and Child Nursing held under the auspices of the Graduate Faculty in Obstetrics and Pediatrics of the School of Nursing, University of Pittsburgh, June, 1962 (Columbus, Ohio: Ross Laboratories, 1965), pp. 1-17.

hospital milieu, beloved, trusting three-year-olds retain a basic expectation that help is forthcoming from others. With few resources of his own for coping with separation, Brice clung desperately to the nurse who made herself available to him. His aroused feelings of grief, anger, fear, and anxiety overwhelmed him. The writer could not help but surmise that Brice felt doomed without physical contact with another person.

Although Brice's tenacious clinging demonstrated his intense need for physical contact with the nurse, being held did not significantly decrease his anxiety. His behavior betokened much conflict. He cried piteously and then struck out angrily; his behavior demonstrated thirst but he refused to drink; he reached out to be held but could not cuddle. Even when being held, Brice could not relax and get the comfort he so frantically sought and needed.

Reunion with his mother brought Brice temporarily out of his state of panic but still left him tense and fearful. He was unable to seek close physical contact with his mother although he sat on her lap. Brice and his mother were unable to communicate with each other through either verbal or nonverbal means. Although he seemed partially reassured by his mother's physical presence, Brice became more immobilized and withdrawn.

Brice's relationship with his mother in the past had been interrupted and unstable. Although his mother was his only known safe world, it is probable that their relationship was not such that he could actively seek help

from her and trust that he would receive it. Mrs. R. looked as if her energy was so tied up with her own problems that she could neither perceive nor meet Brice's needs. For these reasons Brice was able to obtain enough support from contact with her to gain control over expression of his feelings but not enough to allay his anxiety.

Mrs. R.'s reaction to stress, in the presence of the social worker and nurses, provided some additional insight into Brice's manner of dealing with threatening situations. Her response to anxiety was withdrawal and immobilization. Her rapid, distressed departure was reminiscent of the panic Brice had displayed earlier. Her behavior looked as if she too suffered from unmastered separation anxiety. Brice had probably seen his mother use few positive coping devices with which he could identify and from which he could learn.

An initial period of protest and panic after his mother's final departure was followed more rapidly this time with an increasing demonstration of despair. Periodic outbursts of anger and cries, especially when "ma-ma" was mentioned, were intermingled with longer periods of immobilization and withdrawal. Although he continued to cling tightly to the writer, he was predominantly unresponsive to her voice and seldom looked into her face or met her eyes.

Separation from the writer's body was difficult for Brice when he had to be placed on the bed for physical examinations or sleep. He demonstrated this difficulty by his struggles to get back into her arms and his reiteration of

"Iwan, Iwan, Iwan. . . ." This behavior led credance to the belief that Brice feared complete abandonment and the hazards of a world which he anticipated as a consequence of his earlier experiences in a hospital.

Although Brice's response to separation from his mother was similar to that of the beloved, secure toddlers studied in hospitals by Robertson[4], his history made it difficult to believe that he was a secure, loved child. Fear of the hospital environment may have been a greater influence in producing the behavior described than was loss of his mother as a person. Separation from his mother in this situation probably also aroused memories and feelings connected with previous separation experiences such as loss of his father.

In summary, Brice's initial responses to separation from his mother provided evidence to support the hypothesis that previous life experiences with the resulting impaired development of trust and autonomy had left him inadequately prepared to deal with the feelings aroused by this separation and what he imagined might happen in the hospital world. His primary mechanisms of defanse were withdrawal, immobilization, and regression.

Brice's main strengths lay in the fact that he could protest separation from the person he was grossly dependent on; he could overtly express his fear of the hospital environment; and he could use the writer to lessen his anxiety when

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[4]Robertson, pp. 382-386.

she made herself available to him. These strengths led the writer to hypothesize that Brice could use her to gain more positive ways of dealing with his problems.

Behavior Related to Hearing and Communication

Observational Data

One of the primary factors arousing concern about Brice's developmental retardation was his lack of speech. At an age when he should have been using three word sentences to communicate with others, Brice was using only two single words ("mama" and "byebye") consistently at home. The results of observations and tests at the community hospital, where he had been hospitalized earlier, indicated that he had a severe bilateral hearing loss. Thus, an important goal of hospitalization at the University Medical Center was to provide a complete evaluation of Brice's hearing ability and potential for speech development.

Within the first few minutes of observation, it became apparent to the writer and her instructor that Brice was not deaf. His initial agitated behavior in response to use of the word "mama" by the instructor prompted further testing of his hearing ability. The word "mama" was repeated several times at various intensities from both behind and in front of Brice. Each time, he responded with increased crying and agitated movement, striking out vigorously at a nearby cup of milk. He also began peering at the door to his room and indicating with movement of his body that he

wished to go out the door through which his mother had disappeared.

There were many other indications during this initial period of observation to confirm the conclusion that Brice was indeed able to hear. They were such things as: 1) his quick, frightened compliance to the doctor's stern, "Be still," during the physical examination; and, 2) his quick turning in the direction of noises in the hall.

The next day during the second period of observation Brice went to the ENT clinic and audiometry department for specific testing. The instructor recorded as she observed Brice's responses to this situation:

> In the audiometry room to test hearing, Brice sat on the writer's lap as the technicians worked with him. A toy was shaken in front of him to divert him while bells were rung behind and then near his ears. He showed no signs that he heard these loud sounds. However, once or twice, he looked around as if he wanted to see the bell. He reached for it and the doll when it was offered. "What is it?" "Is it a baby?" brought no response. He peered at the floor when he dropped the tongue blades. When the male technician said, "Is it a baby? Give it to me," he did. Then a pig and bird were held before him. "That's a piggy. Give the pig to me." He did but it could have been happenstance that he selected out the pig from the other two objects.

In order to have a more accurate indication of the range of Brice's hearing ability, another test using the principles of conditioned learning was employed. An empty cylindrical box and a box of large wooden beads were brought into the room. With Brice continuing to sit on the writer's lap, a technician who was observing from another room, began to give instructions through a speaker system. For the first

few minutes another technician assisted Brice in dropping a bead into the empty container each time the instruction to "put it in" was given. She gently restrained his hand if he attempted to drop the bead before the instruction was given. After just a few trials Brice demonstrated his ability to hear even a very low-pitched whisper by consistently dropping the bead in response to "put it in"; he also demonstrated his ability to wait until the instruction was given. Brice responded with giggles and smiles each time his ability to perform the desired behavior was praised with applause and the comment, "That's good, Brice!"

On the third day of the study Brice was taken to the x-ray department for an intravenous pyelogram. Because the writer had not known he was going, she arrived shortly after he did in the x-ray department and observed an episode relating to Brice's deafness.

> When I got to the room, Brice was frantically clutching the technician as she tried to put him on the table for another x-ray. By the time I got the apron shield on and got to the other side of the table, Brice was lying there on his back crying pitifully. His eyes were closed and he rolled his head back and forth. I began to talk to him but he made no response as if he were totally deaf. As soon as the x-ray was over Brice made a flying leap into my arms and clutched tightly. (I was the closest person and his response seemed more like a frantic reflex response than an awareness of me.) I continued to hold him and talk to him. He began to settle down and relax somewhat. I felt at this point that he recognized me.

During the first three days of the study, there were only two types of situations seen to which Brice responded with purposeful speech to communicate his needs. The first

occurred when Brice was separated from the writer's arms and placed on the bed for a physical examination. Throughout the examination Brice repeatedly cried "all done" and reached in the direction of the writer; he obviously meant and was communicating effectively that he had had enough and wanted the procedure over with immediately. The second type of situation in which Brice used recognizable speech occurred whenever the writer entered the room and Brice was in bed awake. On these occasions he immediately began crying and calling "Iwan, Iwan, Iwan. . . ." as he lifted his arms to indicate that he wanted to be taken out of bed and held. Although "Iwan" probably signified a much greater basic need than just being held by the writer, it at least served to have this most apparent need met immediately.

The only other verbalizations heard from Brice were the monosyllabic sounds he used as he tried to prevent giving in to his need for rest. These sounds ("oh", "sit", "ooh") were used as a means of self-comfort and distraction rather than purposeful attempts to communicate with another person.

Even with lack of verbal speech, Brice was often able to effectively communicate his most important needs. With the body language of movement, gestures, and expressions, Brice indicated his wish to go out into the hall. By leaning forward he communicated his craving for a drink of milk. His frantic clinging to the writer told, far better than words, his fear of separation and the terror he felt when left alone. Such nonverbal behavior provided the writer with many of the

cues necessary for giving the care Brice needed and sought and, of course, became easier to interpret the longer she worked with him.

Interpretation

Observation and diagnostic testing provided proof that Brice's retardation in speech development was not due to an organic hearing deficit. There was also evidence to suggest that, at least on some occasions, Brice's "deafness" was a result of overwhelming fear and anxiety which caused him to withdraw into himself.

The development of communication by speech in a child is usually an outgrowth of the relationship he has with the mother who supplies his care. He finds that, not only are his sounds pleasurable to himself, but they bring positive responses from others. The utterance of sounds and, eventually, words brings the attention of his obviously delighted mother. Speech is enhanced by the relationship between mother and child and the relationship is deepened by communication with speech. Brice's history of lack of continuity of relationship with one adequate mother may account to some extent for his retarded speech development.

The mechanism of identification is also a very important factor in language development. The child tends to repeat the words which are said to him or those words which he hears most frequently. Brice's mother was noted to be quiet and withdrawn. During the time when they were observed together after his admission to the hospital, she spoke short

sentences to him only twice and he made no attempt to communicate verbally with her. This led the writer to hypothesize that very little verbal interaction occurred between mother and child in the home situation. Therefore speech was not learned by identification; nor was it encouraged or rewarded.

Brice was adept at making his wants known by nonverbal communication. This, too, would provide some explanation for his slow speech development. Perhaps he learned at an early age that he could make his needs known and have them met sooner by use of gestures and movement than by verbally asking for help.

Although there are many possible explanations for Brice's failure to develop speech, the aforementioned ones are consistent with his past history and the behaviors observed in the hospital. They also provided a basis for planned intervention to encourage developing speech.

Reactions to Toys and Play Experiences

Observational Data

During the first period of observation, an opportunity was taken to evaluate Brice's ability to separate from his mother and explore the environment through the use of play. After he had been reunited with his mother and seated on her lap for about an half hour, a number of toys were brought into the room and placed on the floor a few feet from her chair. The following results were recorded by the instructor.

> Brice eyed the toys which were brought in and placed on the floor beside Mrs. R.'s chair and then made movements which led the instructor to think that he

> wanted to get to them. Because the instructor had learned from his mother that he liked cars, several were placed with the other toys beside him. When Mrs. R. failed to respond to Brice's efforts to move from her lap the instructor intervened, "I think Brice wants to get down from your lap." Mrs. R. moved her arms and helped Brice to the floor. He got a dumptruck and then went to stand in front of his mother as if he wanted to get back onto her lap. Again his mother held Brice tightly on her lap as he moved the wheels of the truck and raised the moveable compartment of the dumptruck. Each time he raised the compartment, Mrs. R. replaced it in its original position and said, "You'll break it that way."

Soon Brice tried again to get down from his mother's lap. The instructor intervened in the same manner as before. When down, Brice sat at his mother's feet, eyed the toys two feet from him but made no move to get them. The writer made the following observation:

> Although Brice occasionally eyed the group of toy trucks, cars, and tractors, he made no move in their direction. Miss B. encouraged him to get them and gave him permission to play with them. Finally Miss B. rolled one in his direction. Brice smiled and reached out for it. He still made no move for the others. One by one, Miss B. rolled them to him. As each one came within easy reach, he picked it up and clutched it to him. When one tractor came toward him but just slightly out of reach, he looked longingly but did not attempt to retrieve it. Brice made no attempt to roll the toys or play with them in any other way. He seemed to try to hoard them and clutched as many to him as he could handle. He had still not made eye contact with Miss B. or myself.

A few minutes later another attempt was made to involve Brice in play and interaction with the nurses.

> Miss B. next tried rolling a ball toward him. He laughed as it reached him. Brice purposefully rolled the ball away from himself (not in the manner of a child engaged in a <u>game</u> of ball-rolling, but in a pushing away, rejecting manner). The ball came toward me. Since his initial response had been to laugh, I

rolled the ball back to him. Again Brice laughed and pushed the ball away. This same pattern was repeated several times although the ball did not always come directly to me. Finally Brice looked up, made eye contact with me, and laughed as he pushed the ball in my direction. This activity now seemed to become a game involving real interaction between the two of us. Each time he rolled the ball, he laughed and seemed to have a "proud" expression on his face. I commented to him several times, "You're a pretty smart boy, Brice." Eye contact became more frequent as he looked up to gage my reaction each time he rolled the ball. He frequently laughed as the ball bumped his leg when I returned it to him.

After we had continued to play for a short time, Brice began to roll the ball in a direction away from me. However, he continued to respond positively when I retrieved the ball and rolled it back to him. On several occasions, I tried to encourage him to retrieve the ball himself. Once he made a slight move in its direction but did not go further. He continued to sit at his mother's feet. During this time period, he made no attempt to interact with her; nor did she make any overtures toward him. She seemed hardly to notice our activity at all, but rather seemed isolated in her own thoughts.

As the ball-rolling game continued, I began to roll the ball a little more gently each time so that it stopped just short of Brice. The first time, he did not have to move to get it but had to shift his position somewhat. He did not hesitate to retrieve the ball. The next time he had to move a few inches to reach the ball. He hesitated briefly, looked at the ball and looked at me. I smiled and encouraged him verbally to "get the ball." Finally he moved enough to get it by stretching. For the next few successive times, I rolled the ball so that Brice had to move a little farther. Finally he had to crawl about three feet in order to retrieve it. He reached the ball, rolled it toward me, and quickly returned to his position at his mother's feet. At this time the doctor arrived to take a history and play ceased.

Recordings of observations during the next two days indicated that Brice had very limited ability and energy for play. When toys were presented, Brice would finger them

briefly but showed little interest or understanding of what to do with them. If placed on a blanket on the floor with toys around him, he sat immobilized and apathetic.

On one occasion Brice was taken to an office playroom[5] to provide an opportunity for play and exploration. When we reached the office, the writer took her hand away and sat on a chair a few feet away. Brice immediately came and held up his arms to be picked up. When he was not picked up immediately, he did not seek further but stood leaning against the writer's legs. He surveyed the room with a solemn expression. During the thirty minutes in the office, Brice maintained some form of physical contact with the writer at all times. He would not venture even a foot or two away for a toy which was offered; although he smiled when he saw it.

On another occasion, Brice was left in the ward playroom with other children and a nursery school teacher when the writer had to leave for a short period. When the writer returned, an hour later, Brice was still seated in the same position and place as when she had left him; and, the toys with which he had been provided had not been disturbed. He had apparently remained immobile the entire period.

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[5]The office playroom is an instructor's office which frequently serves as a small private playroom where a child may be taken for uninterrupted, individual observation or play. It is equipped with toys for all age groups including such things as paints, cards, puzzles, blocks, hospital equipment, and dolls for dramatic play.

Interpretation

Brice's reactions to toys and the opportunity for play during the first three days of hospitalization raised many questions in the writer's mind and led her to make some hypotheses to explain his behavior.

The first incident in which Brice was presented with toys in his mother's presence led the writer to hypothesize that he had had little opportunity or encouragement to engage in play or exploratory activity. His mother used words to verbally restrain him from manipulating the dumptruck; her physical restraint prevented him from reaching the toys on the floor. She gave no indication of understanding a small child's urge to investigate new objects or situations. Brice was not able to communicate his need beyond a brief squirming and longing looks. Most children his age would have been autonomous enough to let mother know in no uncertain terms that they wanted to get down or wanted a particular toy. The mere presence of mother in the room gives most children the courage they need to explore in great detail and manipulate all moveable objects in a new situation. Brice obviously did not get the reassurance that he needed from his mother or receive any encouragement to play.

Initially Brice did not seem to realize that the toy cars or the ball could be rolled back and forth in a game. The writer wondered if Brice had never had the opportunity to play "with" someone. Had Brice's play activities always been solitary experiences? Although all children need some periods

of solitary play, often much of the pleasure of play is derived from the interaction and sharing of an experience as well as from the praise and feeling of accomplishment that mastery evokes. The supposition that Brice had had few opportunities to share the pleasures of play was reinforced when he began to react with greater enjoyment, seemed "proud", and increased his eye contact with the writer as the ball-rolling game progressed.

Fear of the hospital environment and fear of separation from mother also influenced Brice's ability to play. He could keep his anxiety under control only by maintaining some form of physical contact with another person. In many situations this kept him from engaging in play. This was vividly portrayed in his behavior when left alone in the ward playroom; his energy was bound up in keeping a watchful vigilance against anticipated dnagers and keeping his feelings under control.

Even though Brice was unable to initiate or maintain play activity by himself, he demonstrated in the ball-rolling episode, that he could participate with enjoyment when he was given the opportunity, encouragement, and permission to do so. In this episode, and also during the hearing test [6] which he may well have interpreted as a game, Brice smiled more frequently and made more eye contact with adults as he became engrossed in the play. This behavior and "proud" expressions

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[6]Described on pp. 30-1.

indicated an increase in self-esteem during these play experiences.

Reactions to the Hospital Environment

Observational Data

Much of Brice's behavior during the first three days of hospitalization betokened fear of the strange, threatening environment. These reactions have been described and discussed to some extent in the preceding sections: 1) his inability to separate from mother; 2) his inability to play and explore; and, 3) his apparent inability to hear when confronted with a threatening diagnostic test.

Other behaviors also indicated his deep-seated fear and his need to learn about and master this new situation. During the evening of his first day in the hospital, Brice clung to the writer and repeatedly strained against her to indicate his desire to go out into the corridor. Once out in the corridor he strained to go further. As this need was met and he was carried about the unit while the writer described and talked about his surroundings, Brice became more quiet and displayed less searching activity. However, Brice was only able to engage in this exploratory activity when held tightly in the arms of the writer. During the next two days, Brice continued to need physical contact with the writer in order to engage in exploratory activity. If left alone in his room or separated by a short distance from the writer he remained rooted in one place.

Constant vigilance was another characteristic which indicated his fear of this strange, new environment. Brice turned quickly and anxiously in the direction of any new sound, movement or light emanating from the corridor. His fear and need for protective vigilance also prevented him from yielding to his need for sleep. The following data depicts his behavior on the evening of admission.

> Brice was then carried back to his room, held for a few minutes, and prepared for sleep. Brice made one or two vigorous efforts to leap back into the writer's arms when he was placed on the bed but then settled down. For the next thirty minutes Brice lay relatively quiet. Although he lay quietly [immobilized] he continued to actively fight sleep. Occasionally he pulled at his lips with his left hand or sucked a finger for a brief instant. His respirations were irregular with periodic big sighs. When he seemed just about to drop off to sleep, he began to blink his eyes forcefully and vocalize. His sounds were monosyllabic such as "oh" and "sit". They did not seem distressful but rather were used as a form of distraction. Although the curtains were pulled as much as possible, Brice was aware of the lights and activities in the next room [fear] and seemed to use these to help him stay awake. As his forehead and face were stroked, he began to decrease the blinking and vocalization. When the lights in the next room went out, Brice finally dropped off to sleep. He had struggled valiantly for an hour and one half before giving in to his exhaustion.

Interpretation

Fear of separation from mother and fear of a strange environment are closely related in the young child. The presence of his mother provides reassurance that strange places are safe. The child can usually return to the safety of mother's arms if a situation becomes too threatening or he feels he has exceeded his own limits. Curiosity and a deep-seated need to master a new situation compel the basically

secure child to move further and further in exploration of new territory. Initially the child may need to return briefly to mother or at least look in her direction for reassurance. However, even this need decreases as the child explores and becomes more sure of himself and the strange environment. Brice was unable to move away from either mother or the writer to make beginning explorations. His feelings of fear and anxiety were so great in the hospital environment that he required the reassurance of constant physical contact.

In his past life experiences Brice had had little opportunity to explore and become acquainted with areas or people outside of his own home. His mother and their home were the only safe world he knew. Because of his experiences of deprivation and separations, both in his home and as a consequence of hospitalizations, he had not gained enough trust in himself, others, or the world in general to transfer the little security he had to new situations.

There was also evidence from past history and observations to indicate that Brice's innate tendency for exploration was often unheeded and thus stifled. Until the instructor intervened, Brice was unsuccessful in his brief attempt to leave his mother's lap and explore the toys. This led the writer to hypothesize that perhaps Mrs. R. held Brice to meet her own needs as much as to meet his. If mother held him on her lap at home as she did in the hospital, his desire for exploration and play would have been greatly discouraged. Because of his mother's own needs, their relationship might

have been threatened if he had tried to separate and develop the autonomy he needed to meet new situations with some feelings of security.

CHAPTER IV

DEVELOPMENT OF A NURSING DIAGNOSIS, GOALS OF NURSING INTERVENTION, DESCRIPTION OF NURSING INTERVENTION AND BRICE'S BEHAVIORAL RESPONSES

This chapter presents the conclusions, the nursing diagnosis, and goals of nursing intervention which the writer formulated after her initial period of study. The remainder of the chapter describes elements of nursing intervention and Brice's behavioral responses to them. Elements of nursing intervention were placed into four categories: 1) promotion of trust; 2) development of autonomy; 3) encouragement in developing speech; and, 4) support for coping with the strange, threatening environment.

Development of a Nursing Diagnosis

Conclusions Leading to a Nursing Diagnosis

Based on the information available about Brice's past history (Chapter II) and the evidence obtained from observation of his behavior during the first three days of hospitalization (Chapter III) the writer reached the following conclusions:

1. Because of previous maternally depriving life experiences, Brice had had little opportunity to develop the

trust and autonomy which would provide the basis for coping in stressful situations.

2. A hospitalization experience with its inherent potential for stress (separation, procedures, strange environment, etc.) superimposed on the previously inadequate life experiences would probably decrease even further Brice's ability to cope with future experiences unless he received supportive intervention during hospitalization.

3. A foster home placement following hospitalization without supportive intervention would impose another environmental crisis which, based on failure to cope successfully in the preceding situations, could very possibly lead to failure to adapt and be integrated into the new home.

4. This pattern of failure to develop adequate coping abilities (or the basis for them) could well perpetuate itself in multiple sequential foster home placements.

With the preceding conclusions in mind, the writer decided that her nursing intervention during this hospitalization would be based upon two primary objectives: 1) to provide the active support and assistance Brice needed to cope with the stress caused by hospitalization; and 2) to prepare him and his future foster mother specifically for placement when the situation and opportunity arose. This paper is concerned with the first objective; that is, how Brice was helped to cope with the stress caused by hospitalization. The writer believed that successful fulfillment of the first objective would not only prevent the development of

a cycle of failure but also would have positive, growth-producing outcomes as well. If Brice could cope more successfully with the stresses confronting him during hospitalization, he would have more trust and autonomy which would increase his coping capacity when he encountered the newness of a foster home and family.

Nursing Diagnosis

In order to plan the effective support and assistance which Brice needed during hospitalization, it was necessary that the writer formulate a nursing diagnosis. A nursing diagnosis is "an assessment of the patient's and/or the family's unmet needs, the stressors causing them and their strengths and limitations in coping with them."[1]

On the basis of information concerning his past history and the observations and interpretations presented in the previous chapter the following nursing diagnosis was made: Because of previous life experiences of maternal deprivation, Brice is physically, intellectually, and emotionally retarded. He has not developed the resources based on trust and autonomy which are necessary for coping with stressful experiences. Among the stressors he encountered during hospitalization, the major ones were separation from mother and fear of the strange, threatening environment. His primary means of dealing with these stressors were essentially

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[1]Florence Blake, "Support of the Person in 'Accidental' Crisis," University of Wisconsin, 1969, p. 3. (Mimeographed).

self-defeating, unsatisfying defense mechanisms: 1) withdrawal, 2) immobilization, 3) regression. Brice was further handicapped by his inadequate speech development. Brice also had some major strengths which could be utilized and fostered. He had maintained his need for mothering and was able to communicate this need. This left him accessible to the assistance of the writer and others who became interested in him. Brice also demonstrated a latent ability to play and learn through playing when assistance, encouragement and the opportunity were provided.

Goals of Nursing Intervention

As a result of the nursing diagnosis the following goals were formulated to guide the writer in the provision of nursing intervention: 1) to help Brice gain trust in himself and others; 2) to encourage Brice's search for autonomy through play and learning experiences; 3) to encourage speech development; and, 4) to help him develop more healthy means of coping with stressful experiences so that his energy could be conserved for physical and psychosocial growth.

Elements of Nursing Intervention and Brice's Behavioral Responses

Brice is Helped to Gain Trust

The underlying basis and essential ingredient for effective nursing intervention for Brice was the establishment of a trusting relationship between him and the writer. The

factors which were most conducive to the establishment of this kind of relationship were 1) Brice's initial need for dependency and mothering, and 2) the writer's availability to provide continuity of care in the form of daily periods of interaction.

Brice's state of panic and disorganization which was observed soon after admission demonstrated his virtual inability to maintain even a minimal level of trust when confronted with the stresses of separation from mother and a strange hospital environment. It was the writer's task to initiate the care which would provide Brice with some basis for trust in this overwhelming experience. As will be discussed again and again in later sections of this paper, the primary objectives at this time were: 1) to provide the contact comfort which Brice demanded and 2) to meet his most immediate needs as much as possible. In this way the writer would demonstrate that she would provide as much comfort and support as he could use.

Through the provision of daily physical care the writer would convey to Brice that he was an important person worthy of care. It would also help Brice to realize that, even if separated from mother, his most basic needs would be met.

Daily periods of care from one person would provide Brice with a more secure routine. Both Brice and the writer would become aware of each other's behavioral characteristics. As the writer worked with Brice she would become increasingly

able to interpret his form of communication and would be more able to adequately meet his needs. Brice would be more at ease as he interacted with the writer and discovered her expectations and his ability to meet them.

By the fifth day of hospitalization, Brice was showing indications that he had become more comfortable with the writer and was discriminating between her and other caretakers. The writer's instructor recorded the following data as she functioned as an observer:

> Enroute out of the Unit to get the toy case, Brice skipped gaily and often without holding the nurse's hand.
>
> D.P.: "Show me where we're going."
>
> Brice: (He went ahead of the nurse and worked to open and close doors. He acted as if he felt better about himself than when previously observed. He looked as if he felt safer, more in control of himself and the hospital environment and pleased with his accomplishments. After opening the door to the room where the toy cases are kept he peered at the observer then past her. Then he drew the door toward him and closed himself and his nurse in the room together.)
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> . . . . . .
>
> Back in his room, Brice and his nurse sat together on the floor and then Brice tried to open the toy case. He turned and looked when the observer closed the door to his room but did not focus on her.

Throughout hospitalization Brice's behavior indicated inconsistency in his degree of relatedness to the writer. However, in all instances after he had been with the writer for a short period of time, he refused to go with another person.

> When we reached the neuropsychology department, the test administrator tried to take his hand.

> Brice immediately batted her hand away and clung more tightly to mine. Although I tried to convey she was a friend and it was okay to take her hand, he continued to bat it away. Finally, she said for me to come in with him.

However, on many occasions Brice would react shyly or "ignore" the writer when she arrived for the day.

> When I spoke to him, he smiled shyly and then looked down at the floor. As I continued to talk to him, he snuck glances at me but quickly looked at the floor again if he made eye contact.

On several occasions when the writer first entered the playroom, Brice ignored her except for occasional furtive glances. Then he systematically made rounds of all the other adults in the room seeking their attention. A possible explanation for this type of reaction could be that this was his way of retaliating for having been left the preceding day. If the writer sat quietly observing his activities and smiling in response to his furtive glances, Brice eventually came to seek her attention. By accepting his need to reject but remaining receptive and interested in his activities, the writer supported Brice's expression of feelings, gave permission for separation and independence, and helped to preserve their relationship.

Although acceptance of Brice's dependency needs was necessary in the beginning of the study to establish a basis for developing a trusting relationship, the focus of intervention for promoting trust was altered as the study progressed. When Brice began to be more confortable with the writer and the hospital environment, he started to develop some autonomy in self-help skills and play experiences. (This

aspect of care is discussed in greater detail in a later section.) It was extremely important that this behavior be promoted and integrated into the relationship. Brice's relationship with his mother had apparently been based on his need to receive care and her need to keep him close and dependent. In order to sustain and increase his ability to trust, Brice needed to be shown that a trusting relationship could be maintained as he grew to be a more autonomous individual.

Brice is Helped to Develop Autonomy

During the first three days of hospitalization Brice demonstrated virtually no indications of developing autonomy. In almost all situations his behavior reflected the developmental level of infancy and, even more significantly, a non-trusting infancy. Brice seemed to communicate that he needed to be allowed complete dependency if he was to survive in this new environment. Brice clung desperately to the writer when she was near him; but when he was put down, Brice either cried frantically or became immobilized. He displayed no inclination or ability to participate in self-help skills. He lay back passively waiting to be fed, bathed, and dressed. When encouraged to help himself, he was sometimes able to perform the task but obviously derived no pleasure from his accomplishment and indicated no wish to continue. Brice initiated no activity on his own and rarely indicated his own preferences except by withdrawing or immobilizing during stressful experiences.

> Brice sat apathetically beside the bath basin of water. When the nurse handed him the soap dish and said, "You could put it in the water," he did so. Yet he never put his hands in until they were guided into it. His affect never changed. There were no signs of enjoyment or distaste for his bath.

Initially the writer focused on meeting Brice's dependency needs. She held, sympathized, and attempted to comfort him when he clung so desperately. When Brice had to be placed on the bed for examinations, the writer maintained some form of comforting physical contact such as stroking or patting as she talked to him. Brice was not urged to help himself although the opportunity was offered periodically. This period of dependency was imperative for Brice if he were to regain some level of equilibrium under the stresses of separation from mother and entrance into a strange, threatening environment. Satisfaction of Brice's dependency needs was also the vehicle through which a beginning, trusting relationship based on trust could be established between Brice and the writer. It was essential that a relationship be established and that Brice regain some measure of trust before he could begin to move in the direction of autonomy.

While trying to meet Brice's dependency needs, the writer also watched his behavior for indications that he was ready to move on to taking a more active part in his own care and explore his environment. On the fifth day of hospitalization Brice showed more interest in feeding himself. The instructor recorded the following description.

> At lunch Brice acted starved and he gorged himself with food, alternated between feeding himself and

> waiting to be fed and communicated his wish for seconds. He especially enjoyed bread and potatoes. He took huge bites, pushed food into his mouth with his hands, chewed minimally and ingested the largest amount of food since admission.

The writer sat by praising his efforts and ready to assist when he handed her the spoon to indicate that he wanted help. Praise for his efforts and assistance when he needed it would provide the graded independence which was important to Brice in developing autonomy. Through such actions in daily activities, the caretaker demonstrates that: 1) she gives permission for the child to strike out on his own; 2) strivings for independence are rewarded with as much love as strivings for dependency; and, 3) he will be protected from exceeding his own limits and may return for security if he feels a need for it.

On the fourth day of hospitalization, Brice was able to make beginning attempts to help dress himself. When his shirt was placed on his head, Brice reached up to pull it down. He tried to put his arms through the sleeves but needed some assistance. Because of these cues from Brice, the writer began providing more time and opportunity for him to help himself with dressing. During the next week Brice increased his skills in dressing himself. Eventually he was able to pull his shirt, trousers, and socks on with minimal guidance from the writer. He struggled intently for as long as an half hour to get his shoes on by himself. Brice indicated his pleasure and pride in these new accomplishments by laughing and prancing when told to get his pants and when he had finished the task of getting dressed.

Play is another medium through which the young child develops autonomy. Play provides the opportunity to learn about his world and his place in it. Through play the child tests and improves his abilities to deal with the environment around him. Evidence was provided earlier in this paper to support the hypothesis that Brice had had little opportunity to learn about his environment through play. Instead, he had probably had little opportunity to develop his motor skills through exploration and play. Brice's passivity and lack of interest as he apathetically fingered toys placed before him indicated to the writer that different kinds of play opportunities were necessary to meet his needs. His responsive giggle and prance when a walk was suggested supported the writer's interpretation of his behavior.

During the forty-five days of hospitalization, endless hours of exploratory play ensued. Brice was entranced with opportunities to engage in manipulative play which included various motor activities such as 1) opening and closing doors; 2) climbing up and down stairs; 3) raising and lowering windows; and 4) turning water faucets on and off. Through these and similar activities Brice was: 1) learning new skills; 2) learning more about his environment; 3) gaining mastery of his own body; 4) getting control over aspects of his environment; and, 5) increasing his self-esteem.

Initially Brice was unable to engage in any activity unless he maintained physical contact with the writer. He would start to charge out of his room but come to an abrupt

halt until he could grab the writer's hand. It was usually necessary that the writer initiate or suggest a new activity or learning opportunity although Brice would perpetuate it once started. Eventually as Brice became more sure of himself, the writer, and his environment, he could proceed short distances on his own. He still needed frequent reassurance that "It's okay, Brice, you can let go of my hand if you want too. I'll stay with you." This statement almost invariably resulted in Brice's giggling, dropping the writer's hand, and prancing ahead a short distance. Although Brice was thrilled by opportunities to be autonomous, his behavior often suggested that he feared that such behavior might threaten his relationship with the caretaker. He needed permission to proceed on his own and frequent reassurance that love would still be forthcoming even though he met his own needs to become more independent.

The following excerpt from a process recording is included to demonstrate the support and graded independence the writer attempted to provide in play and learning experiences for Brice. This incident occurred on the eleventh day of the study when the weather was nice enough to permit outside play.

> As we walked toward the building, Brice's attention seemed to be caught by a young boy playing on a slide nearby. The slide has steps like a staircase going up one side and then a broad sliding area down the other side. My impression from Brice's expression was that he would like to climb the stairs. When I said, "Would you like to climb the stairs, Brice?", he laughed out loud, pranced, and headed toward the stairs. I walked up the stairs with him

> the first time. I was amazed that he alternated feet while climbing. He was awkward and stumbled once or twice. When we reached the top, we turned around and walked back down. Then I moved Brice toward the side of the stairs so he could climb and hold my hand without me going up the stairs. When he got to the top, I helped him sit down and slide down the other side. He laughed gleefully, scrambled to his feet and headed back to the stairs with a prancing gait. We repeated this several times. Then I let him sit down by himself which he did without difficulty. The next progression was to get him to hold the rail while climbing up without holding my hand. Pretty soon Brice was climbing, sitting, sliding, and walking back without my intervention. Brice was obviously entranced and thrilled with this new activity and skill. He laughed each time as he reached the head of the stairs and as he slid down to the bottom. This activity continued for a long period of time. I encouraged and praised him with frequent phrases like, "Good, Brice!"

During the forty-five days of the study, Brice became increasingly autonomous in various activities. From the child who sat immobilized when left in his room alone, he became a child who could engage in solitary or parallel play in the ward playroom. He increased his self-help skills in dressing and progressed in motor skills from an awkward walk to beginning running and climbing. Brice's progress was interspersed with periods when he needed to return to more dependent behavior. He continued to need frequent permission, encouragement, and praise for his activities. However, when given this encouragement and praise, Brice's face lit up and he eagerly began to learn.

Brice is Encouraged to Develop Speech

After Brice had had a thorough evaluation by personnel in the hearing and speech departments, his basic problem in speech development was diagnosed as not being organic in

nature. The speech therapist felt that his comprehension was much greater than his speaking vocabulary. It was also believed that lack of a warm relationship and stimulation were the primary factors causing his speech retardation.

Therefore the writer's primary means of helping Brice with speech was through developing a meaningful relationship with him. A relationship with the concurrent sharing of experiences would enhance the opportunity and desire to communicate with another person. In addition to providing relationship experiences, the writer instituted specific elements of intervention to encourage speech and communication.

Initially it was important that the writer encourage any form of communication from Brice. His communication during the first three days of hospitalization was almost entirely nonverbal. During this time the writer sought to immediately meet whatever needs she interpreted his behavior to signal. Brice was carried out into the corridor when he leaned toward the door; he was picked up when he held up his arms; he was handed all objects in which he showed interest. In this way the writer hoped to communicate to Brice that: 1) he and his needs were important; 2) she wanted to provide care for him; and, 3) he could trust her to understand his attempts to communicate. By encouraging his nonverbal communication, the writer hoped that she could eventually increase his desire for verbal communication as well.

In addition to encouraging Brice's nonverbal communication by providing for the needs it signaled, the

writer attempted to put into words what his behavior communicated to her. In response to his movement toward the door, he was carried into the corridor as the writer said something like this: "You want to go out into the hall and look around, Brice." An effort was made to describe and talk about the things which they were observing and the activities in which they were engaged. Interpreting Brice's gestures verbally and discussing current activities with him were done to increase his comprehensive vocabulary and establish the expectation that he would eventually talk.

As Brice became more comfortable in the hospital environment and developed a relationship with the writer, additional methods for encouraging speech were incorporated into the daily activities. Any sounds which Brice made were repeated back to him. Although these were rarely recognizable words, they were a form of vocalization. Repetition of these sounds provided reinforcement and encouragement for any attempts at speech. Occasionally the writer's repetition of a sound resulted in imitative behavior or the production of other sounds by Brice. In these instances the exchange of sounds took on a quality of communication.

While Brice was engaged in pleasurable activities with the writer offered a prime opportunity for encouragement of speech. Brice found great enjoyment in such simple activities as opening and closing doors, turning lights switches on and off, and pushing windows up and down. During these times the writer used one or two words, such as "open" and "close", which

characterized the activity, and punctuated Brice's activity with them. The purpose of this intervention was to encourage comprehension of the connections between words and activity. The writer also felt it would be beneficial to link speech with pleasurable activities.

The following excerpt from a process recording illustrates how encouragement of speech and communication was encorporated into most interactions between Brice and the writer. Elements of intervention specifically related to speech and communication have been underlined.

> Soon Brice indicated, by leaning and pushing on me that he wanted to look out the window. I carried him over and stood him on the sill saying, "You want to look out the window, don't you?" Brice gazed out the window while I talked about the things outside (like buses, cars, people, trees, etc.). Sometimes he looked at the things I mentioned but many times I was unable to determine what he was watching. In a few minutes Brice accidentally discovered that the window was open a little bit and then he closed it with downward pressure. This quickly developed into a new game called "opening and closing the window" which continued for about fifteen minutes. Still attempting to work on speech, I repeated "up" and "down" each time he raised and lowered the window. He was unable to raise it without some assistance from me. Occasionally he punctuated our activity with "Oh", "Uhh", "Dere", and "Okay" which I repeated after him each time. However, I was not to be rewarded with a single "up" or "down". Seeming to finally tire of this new game, Brice suddenly closed the window, said "all done" and turned around to be lifted down to the floor. However, as soon as his feet hit the ground, he indicated that he wanted back up again. Then he opened and closed the window again, said, "Dere" and indicated that he wanted to go back down. Now we were playing a modification of the old game.

Changes in behavior related to speech were slow for Brice. During the first ten days of hospitalization he displayed little verbal ability and the words he did say were

usually in response to stress. However, his nonverbal communications increased in purposefulness. Instead of simply crying or becoming immobilized, Brice began to push the writer in the direction he wanted to go or to point to the object which he desired. There was almost no vocalization in the form of sounds or babbling.

The first breakthrough occurred on the occasion of an opportunity to play outside in the playground on the eleventh day of hospitalization. While swinging, Brice suddenly began humming and singing, "ah-ah, ah-ah" in time to the movement of the swing.

After this particular incident, the amount of vocalization Brice displayed during play activities began to increase. For the most part, these vocalizations were in the form of monosyllabic sounds ("oh", "sit", "aah") which could not be construed as speech.

Eventually Brice began to use single words appropriately: 1) "Dere" when he had finished a task; 2) "Okay" when things were going well; 3) "All-done" when he wanted to move on to a new activity. Finally there was one momentous occasion when Brice watched the traffic outside and said, "Bus all gone, bye-bye."

Brice's speech development was not consistent or extensive during his hospitalization. However, he demonstrated increased propensity for communication and speech. He had increased his speaking vocabulary from the two or three words he was using prior to admission to about eight

or nine words which he used consistently. The most significant change was his use of these new words to communicate his wishes to another person as when he politely said, "Bye-bye" and closed the door to shut the social worker out of our private playroom.

Brice is Helped to Cope with a Strange Threatening Environmnet

The hospital is an overwhelming environment for any child. When he first enters the door, he is deluged with new sights, sounds, and smells. If he has not been in such a place before, the size of it alone is frightening. Within the first two hours the child is confronted with the task of coping with a myriad of strange people including receptionist, doctors, nurses, attendants, and laboratory technicians. He must endure in quick succession a variety of strange, threatening procedures some of which are painful. Finger sticks for admission blood work hurt. For some children rectal temperatures, ear examinations, the use of blood pressure apparatus, and the pushing and prodding of medical examinations arouse anger, are interpreted as painful and, at the very least, are frightening and humiliating. If the child has endured these procedures and hospitalization before, unmastered feelings may overwhelm him and make it impossible for him to cooperate when they are repeated. Even the child with a strong foundation of trust and autonomy is threatened with loss of equilibrium. The child may regress to less effective coping mechanisms

to defend himself from anxiety. However, the child with a high reserve of trust and autonomy is better prepared to cope with new situations. He has an essential trust in other people, the expectation that his needs will be met, and some belief in his own ability to influence his environment.

Brice did not have a good foundation of trust and autonomy which he could use in coping with the hospital environment. When confronted with this situation he was overwhelmed with anxiety. His behavior betokened panic. Although he was extremely dependent, he acted as if he did not trust that his needs would be met. He clung desperately to the writer or her instructor but derived less comfort than he needed. His mother's return helped him to bring his panic under control but did not relieve his fear and anxiety. This was evident from the degree of immobilization which his behavior disclosed.

Support to encounter a strange hospital environment and to cope with stressful procedures can best be given if a relationship with the child has been developed. However, the child can derive some support from a sympathetic, understanding nurse even if they have not met before. The nurse who is available to provide support in stressful situations is also assured of a vehicle in beginning to develop a relationship with the child.

The most important, and indeed the only possible way of supporting Brice immediately after his admission was to provide the contact comfort he so desperately sought. Although

holding him tightly did not significantly alter his fear of the hospital environment, it demonstrated that the writer was concerned about and wanted to protect him. Holding and verbally empathizing with Brice provided him with permission and the opportunity to express his feelings and prevented him from withdrawing and immobilizing himself further.

Contact comfort in the form of stroking and patting was provided during the initial physical examinations. This too, was for the purpose of reassuring Brice of the writer's continuing interest and support. During the second ear examination Brice was held in the writer's arms with his head pressed against her chest. This prevented him from moving his head which would increase his discomfort, and protected him from the displeasure and rebukes of a doctor who might be frustrated by difficulty in the examination. In this and similar situations the writer intervened to influence Brice's behavior, provided him support, and exerted some control over the stimuli which impinged on him and thus minimized the threat.

Exploration, with its potential for increasing the child's information about his surroundings and providing opportunities for mastery, is an important component of coping with new, threatening situations. Since, initially, Brice was unable to engage in exploratory activities without help from another person, it was imperative that the writer be present to lend her support and encouragement. On the afternoon and evening of admission, Brice was carried about the unit so he could visually explore his new surroundings. Explanations of

sounds and activities were important to increase his feelings of security. Such comments as "You hear the doctors walking by in the hall, Brice," and "That little boy is crying because he misses his mother, too" were made by the writer and her instructor to provide information and to alleviate undue anxiety.

Physical exploration of Brice's room was encouraged by the writer in the ball-rolling episode.[2] Rolling the ball so it stopped increasingly greater distances from Brice, was an attempt to decrease his immobility and help him move more freely about the room.

On succeeding days Brice was given the opportunity and support to physically explore his new surroundings. He was taken on many walks around the ward and the hospital. He accompanied the writer to get clean clothes, run the water for his bath, get the toy suitcase from the play office and to do many other activities. Brice opened and closed doors, climbed stairs, rode the elevator, and manipulated the water fountain. All of these activities increased his sense of security and promoted development of autonomy. Each trip out of his room provided Brice with more information and security to face his ever enlarging world.

Preparation for and support during diagnostic procedures was another means of helping Brice cope with new, threatening experiences. Preparation for Brice was usually

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[2]Described on pp. 35-6.

in the form of verbal descriptions and explanations of what the writer anticipated might occur during the test. Occasionally he was given the opportunity to handle some of the equipment which was to be used. Although Brice seldom gave any indication of understanding the preparation, the writer believed that the procedure would be less threatening if he had been forewarned about it. The following episode recounts the preparation provided by the writer's instructor when Brice was restrained for a 24-hour urine collection.

> When the urine collector was placed before Brice, he took it immediately and tried to get it from its plastic bag. When he could not get it open, he used his teeth. He handled the tongue depressors, opened the plastic container and let the cover drop to the floor several times. He looked for the lost cover and with encouragement even got down to find it. When asked to hand the label to the instructor, he refused to comply but looked for it when she took it and hid it in her hand. His interest was focused on things not on either of the nurses sitting beside him.
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> When preparation for the procedure began, the writer left, and the instructor began the procedure which she thought might prove comforting to Brice even though it entailed restraint. She had told Brice that he would have the plastic apparatus put onto his penis to collect his urine and that she would fasten him down so his "pee pee" could be collected. "Steve is having his urine collected, too. I'm going to fix you up just like Steve is placed." There was no sign that Brice attended to the preparation that was being given.

As in the other areas of behavior, Brice's progress in coping with the hospital environment and threatening procedures was not consistent or extensive. He never reached the stage where he could leave his hospital room unattended. However he became more able to proceed further distances

ahead of the writer if he was assured that she would follow. During the second week of hospitalization, Brice was able to remain in the hospital playroom and engage in solitary play activities such as rocking in a "rocking boat" and manipulating small blocks.

Entering into new territories continued to be fear-provoking for Brice. In these situations his expression became anxious; he dawdled; his verbalization decreased; and he sought the writer's hand for support. However, with the support of physical contact and explanations from the writer, Brice was able to venture into the situation, perform more effectively, and leave the situation with an expression and attitude of increased self-esteem.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND EPILOGUE

Summary

Brice, a two-year, eleven-month old boy, was admitted to the children's hospital of a large midwestern university medical center for evaluation of developmental retardation and a possible hearing deficit. At this time the county social service agency was planning court proceedings to remove Brice from his mother's custody and place him in a foster home.

From information about Brice's previous life experiences and the behavior observed during the first three days of hospitalization, the writer reached the following conclusions:

1. Because of previous maternally depriving life experiences, Brice had had little opportunity to develop the trust and autonomy which would provide the basis for coping in stressful situations.

2. A hospitalization experience with its inherent potential for stress (separation, procedures, strange environment, etc.) superimposed on the previously inadequate life experiences would probably decrease even further Brice's ability to cope with future experiences unless he received

supportive intervention during hospitalization.

3. A foster home placement following hospitalization without supportive intervention would impose another environmental crisis which, based on failure to cope successfully in the preceding situations, could very possibly lead to failure to adapt and be integrated into the new home.

4. This pattern of failure to develop adequate coping abilities (or the basis for them) could well perpetuate itself in multiple sequential foster home placements.

With the preceding conclusions in mind, the writer decided that nursing intervention was needed and should be based upon two primary objectives: 1) to provide the active support and assistance Brice needed to cope with the stress of hospitalization; and, 2) to prepare Brice and his foster mother specifically for his foster home placement when the opportunity arose. The writer undertook to identify elements of nursing intervention which were provided to assist a maternally deprived child to increase his coping abilities prior to his foster home placement.

Functioning as a nurse-participant-observer, the writer gathered data and provided nursing intervention during the forty-five days of Brice's hospitalization. Elements of nursing intervention were placed into four catagories: 1) promotion of trust; 2) development of autonomy; 3) encouragement in developing speech; and, 4) support for coping with the strange, threatening environment. Descriptions of the elements of nursing intervention and Brice's behavioral

responses to them were presented.

Conclusions

The writer found that nursing intervention was effective in helping one maternally deprived child cope with the stresses of hospitalization and gain increased trust and autonomy through the experience.

Implications for Further Study

The findings of this study suggest that research should be done to:

1. further document the elements of nursing intervention which are needed to help maternally deprived children cope with the stress of hospitalization.
2. identify other elements of nursing intervention which prove successful in promoting a trusting relationship with a maternally deprived child.
3. determine those elements of nursing intervention which are successful in helping young children develop autonomy in the hospital milieu.
4. identify elements of preparation which are effective in preparing children and foster families for foster home placement.

Epilogue

Three days before Brice was discharged from the hospital, he was taken by the writer and a social worker on a preplacement visit to his foster home. During this visit Brice had the

opportunity to explore his new home and neighborhood as well as to become acquainted with most of the members of the family. After sitting quietly on the writer's lap for about thirty minutes, Brice was able to get down and play with the toys which were invitingly placed on the living room floor. A short time later he disappeared into the kitchen to watch his new foster mother preparing lunch. His ability to leave the writer and seek the attention of his foster mother in this strange new situation demonstrated that Brice had indeed developed more trust and autonomy.

In addition to talking with the foster mother on two occasions prior to final placement, the writer provided her with written summaries describing Brice's behavior, progress, and routines in the hospital. The writer felt that this information would help the foster mother in understanding Brice and, thus, in developing their relationship.

On his third birthday, and after forty-five days in the hospital, Brice was discharged and taken to his new home by his foster mother. A telephone conversation with the foster mother a week after his placement and a letter from her two months later indicated that Brice was making a satisfactory adjustment to his new home.

After Brice had been in the foster home for four months, he returned to the pediatric clinic for evaluation. This was the first time the writer had seen Brice since he left the hospital. The following observation recorded by the writer describes Brice's reactions to seeing her again

and gives an indication of his relationship with Mrs. B., his foster mother.

> When I looked into the waiting room, I could see Mrs. B. and the social worker talking and Mary Ellen (foster sister) playing near them. I could not see Brice at that point. As I entered, Mrs. B. and the social worker seemed glad to see me. I sat down and began talking with them. Now I could see Brice playing nearby. He seemed to be enjoying putting blocks into a wagon and was engrossed in getting them in just so. He had not yet noticed me. As he finished with the blocks, he started to turn with a smile as if seeking approval from his mother. At that point he spotted me sitting next to her. His recognition seemed instantaneous and he froze. His face became solemn with his lips slightly puckered and protruded--almost tearful. This was a well-remembered expression of tension and unhappiness. He did not move further; he just stood with this expression of tension and unhappiness on his face. I smiled and spoke softly to him. Mrs. B. also spoke reassuringly to him. On hearing his mother's voice, Brice went straight to her and leaned against her legs as if for protection and reassurance. Both Mrs. B. and I thought that I reminded him of the hospital and he feared that she would go off and leave him.
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> When Mrs. B. reassured him that he, Mary Ellen, and Mama would be going home together as soon as they saw the doctor, Brice brightened noticeably, nodded his head, and said "Uh huh" vigorously. . . . In order to further increase his security, Mrs. B. made a point of placing his jacket with hers saying, "See, Brice, here's Mama's sweater, Brice's sweater, and Mary Ellen's sweater. I'll keep them here all together until we're ready to go home.

After receiving a little more attention and reassurance from his mother, Brice was able to return to play. Brice's reactions to seeing the writer again indicated that 1) he did remember her, 2) she had been important to him in the hospital, and also that her presence aroused feelings associated with hospitalization and separation. Most

important was his ability to seek comfort from his foster mother and be reassured by her care.

Later during the clinic visit Brice was able to remain with the writer and engage in play and exploratory activity while his mother took Mary Ellen into the doctor's examining room.

Conversation with Mrs. B. and observation of Brice's behavior during this clinic visit indicated that he had continued to make progress in his foster home. He had apparently grown some physically; his cheeks were chubbier and he could now reach the light switches by himself. He seemed a little less clumsy although his motor activity was still far from smooth. The writer was impressed with his attachment to Mrs. B. and her interactions with him. He apparently got along well with Mary Ellen and seemed interested in other children although his play remained parallel. Brice seemed to have gained a better self concept ego strength to enable him to cope with stressful situations more effectively. According to Mrs. B. his vocabulary had increased from the nine words he was using consistently on discharge from the hospital to about twenty five words. Moreover, he was chattering almost continuously when involved in play. His eating and sleeping patterns were also reported to be normal. Brice both laughed and cried during this one clinic visit; the writer had almost never before seen real tears from Brice. He also sought and received comfort from his mother. From the observations made during this visit, the writer felt Brice's potentialities for development still remained promising.

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