Children, Hospitals and Parents

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The brief contact of the anesthesiologist with a child undergoing operation allows little time to evaluate the patient as a human being, or to observe some of the deeper responses that are evoked by sickness or hospitalization. There is even less opportunity to learn what delayed responses might appear after discharge from the hospital.

As a pediatric surgeon, Dr. Willis Potts has been keenly aware of the need of children for sympathy and affection during hospitalization. Pediatricians and child psychologists have been chiefly concerned by the anguish caused by separating the child from his parents. Robertson of London has devoted years to studying the psychological insult inflicted upon young children by periods of hospitalization. In addition to the problem of separation from parents, there are many others that might have considerable significance. How does a child tolerate pain? How does he bear the loss of an arm or a leg? What is his reaction when a roommate dies? Finally, how does a child face the realization that it is he who is dying?

There are no specific answers that can be given to these questions, for children vary as greatly as do adults, and often are less communicative. Yet these and many other situations must be reckoned with if pediatric patients are to be cared for properly.

Problems involving the hospitalized child and his environment may consist of his reaction to his own illness or to the hospital, reactions caused by parental relationships, or responses involving other children.

Although the general behavior patterns of children differ greatly, Gesell was able to show that for each developmental phase there were several characteristic traits that the average child would show—then abandon as he passed into another stage.

Age obviously is a major factor in determining the pattern of a child's behavior in the hospital. The small infant shows only generalized reactions to hunger and discomfort during the first weeks of life, then exhibits alarm, pleasure and displeasure as weeks become months. Remembered pain and apprehension follow, and during the period between 1 and 3 years of age children reach the peak of excitability and emotional instability.

Other influences that must be considered are the behavior patterns of each individual child: some children being remarkably more stable than others throughout all age levels. Parental influence has much to do with such individual traits.

Naturally previous illnesses and hospital experience may alter a child's responses. A badly burned patient or one with severe cardiac disease or leukemia might be expected to react differently than a normal healthy child.

The child and the hospital: Most children entering a hospital face nothing more serious than tonsillectomy or a relatively short illness. Consequently the impact of new surroundings and the separation from their parents represent the major hurdles. To an unsophisticated observer not trained in child psychology this does not appear to be a harmful experience. Many even feel that an average child gains something in the way of character by overcoming such an obstacle successfully. It is commonly felt that small children will cry for a short time after their parents leave them, then appear to recover as they interest themselves in their new surroundings. Although good parents hate to see their children unhappy they expect such an outburst when visiting hours are over. In fact it even appears
that a parent may be a bit crestfallen if his child is not a little concerned at the time of parting.

Sometimes we see small infants who will not stop crying, and finally work themselves into sobbing hysteria, and require intravenous feedings and sedation, but we console ourselves with the thought that these are truly exceptional cases.

It is quite possible that such an attitude is based on shallow thinking and that it gravely underestimates the seriousness of the problem. By amassing hundreds of letters from parents and by careful long-range scrutiny of numerous children Robertson has produced convincing evidence that the child who is obviously frightened by hospital experiences may suffer years of subsequent personality derangement, and that contrary to appearances, the child who submits quietly to hospital routines may actually be doing so only at the cost of extremely painful self control. Evidence of personality change after return to the parents has been documented widely, and reversion to infantile traits, night terrors, or repulsion of parents is well known.

In order to prevent such unhappy experiences in the hospital, and their consequences, more liberal concepts of child care are slowly developing. The strict traditional rules limiting visiting hours are being relaxed. Parents are being encouraged to come frequently, and stay as long as possible. The policy of allowing a parent to sleep in the room with the child, also introduced by the British, is gaining acceptance. Although such a practice requires greater space, and certainly would interfere with the care of a seriously sick child, under most circumstances it entails little difficulty and affords very appreciable gain for the child, the parent, and frequently, by reduced nursing care, for the hospital.

Although the distress of separation from parents is limited chiefly to children of preschool age, the fear of needles is common to children of all ages, and often is carried on into later years, not without some justification. Most children are conditioned to needles by immunizing “shots” administered by pediatricians before the time of hospitalization. Such immunizations often involve injection of irritant material that causes far more discomfort than the needle point, but this is seldom appreciated. All of the pain is ascribed to the needle, and adds to the child’s general horror of all needles. The large emotional factor associated with needles is clearly evident in the child receiving an intravenous infusion. He will whimper at the initial skin prick and recover promptly. When he looks down and sees the needle being strapped in place he is horrified and screams “Take it out, take it out.” There is no pain, but he believes he is being impaled upon a spear, and reacts accordingly.

Realizing the extent of this horror of needles, we undoubtedly could do much to ease the problem simply by employing the smallest gauge needle that would be practical for each purpose, and instead of using alcohol, use Zephiran or a similar nonirritating solution before piercing the skin.

In defense of needles, it should be noted that when they are used with care, they may be more welcome for inducing anesthesia than an anesthesia mask. It is quite a commonplace incident to have a child of 6 or 7 come to the operating room the first time and shun needles at all cost, then at a subsequent operation ask for an induction “by needle.” This is usually the result of remembering several moments of unpleasantness during inhalation induction plus indoctrination by ward mates who have gone through similar experiences.

Strangely enough, the memory of postoperative pain does not appear to bother children as much as would be expected. When returning for repeated operations, they seldom complain about the prospect of more pain; on the other hand they do appear to remember any nausea they may have experienced, and express themselves feelingly.

The child’s concept of his own illness is an interesting thing. Certainly a child feels pain, and although some are extremely brave and tough, others may scream at the slightest discomfort. Nonetheless, these are signs of outward reactions. Most children have not learned to be sorry for themselves, and few seem to be truly hypochondriacal in spite of strong parental influence. The “luxury of self-pity” appears to be an acquired taste, and
one that is rarely seen before adolescence. Whether this has anything to do with drug addiction is hard to say, but addiction is very unusual in the pediatric age group, even under conditions when it could most reasonably be expected.

Morale-builders: What is it that maintains the child's courage? Visiting parents certainly rank first in the lives of younger children. Other children and hospital personnel help considerably throughout the day and night. Television undoubtedly has taken over a position of major importance for children over 3 or 4 years of age. Before the advent of television comic books played a large part in the entertainment of older children. It was customary for each child to have a stack of a hundred or more comic books of various lurid types by his bed, to pore over and trade among his neighbors.

Toys and games and "play ladies" do much to help occupy a child's attention when he is feeling well enough to fix his attention on anything. A little child, or one who is sick, gets considerable solace from a favorite doll or toy animal that can be held close. A surprisingly large number of children have an old blanket, or perhaps a special strip of rag or old cloth that they cling to, holding it near their faces while they sleep. This is seen so commonly in otherwise normal children that it appears to have no unnatural significance.

However, many of the objects of this special attachment are so shredded and dishevelled that one hesitates to allow them in a hospital.

Mealtime for smaller children often is a pathetic period. When a sick child sits alone with a cold platter of unappetizing material in front of him, he has little inclination to eat. When morale is low, appetite disappears. It often seems that more attractive dishes, and the encouragement of a sympathetic person, could accomplish great things.

The nurses and physicians working in a pediatric hospital bring something to the children, but it is undoubtedly the children who set the standards and establish the general tone of the institution. In spite of the fact that children are easily upset, cry frequently, and may be difficult to control, and in spite of the fact that a sick or dying child is far more pitiable than a sick adult, the general tone of cheerfulness is striking as soon as one enters any children's hospital. This perhaps more than anything else gives the clue to the child's outlook on life and on sickness. If he feels sick, he lets you know, but he doesn't ask why it had to be him, why he has all the bad luck. When he stops hurting he is ready to play again—like any young animal.

In a children's hospital it appears that traditional concepts become established—some obviously untrue, such as the belief that babies with tracheo-esophageal fistula are admitted in groups of three, or that only the most beautiful children have brain tumors. Many doctors and nurses admit that they prefer to have a child kick and fuss occasionally and give vent to their feelings. Although frenzied terror is certainly not desirable, I am sure it is better for the child to let out a yelp when he is hurt rather than staring at you with wide, forgiving eyes.

Why not cry? Our whole attitude about crying might be re-evaluated. We have learned that a small infant exercises his lungs by crying, and we usually condone it for reasonable periods. Under most circumstances, however, children are cajoled and entreated not to cry at any cost. On second thought it often seems as if crying were a natural release in many states of loneliness or frustration, and that it served a natural purpose.

Jersild \textsuperscript{12} emphatically condemns the immediate "Don't cry" pressure that is forced upon children. He believes that this "asks the child to bury something of himself and encourages him to go astray in his development."

We all are familiar with the tradition that distressed young ladies are thought to benefit from having a "good cry." Perhaps this might be prescribed on a wider scale, even to children who are scared or in pain.

Emotional children will occasionally cry out wildly under relatively slight provocation and insist that they are being killed or about to die. This might occur when a poorly prepared child is undergoing an intravenous pyelogram. However, among the many children we see who know that death is near, I have yet to see one panic or complain excessively.

The true story of an 8 year old girl has
recently been published, telling in detail how this child accepted knowingly the gradual painful death of leukemia and, in addition, insisted that after her death, her eyes should be donated to help the blind.

Other children: In the hospital, the interrelationship between children is most interesting, and in many ways quite ideal. At a very early age, infants appear aware of one another’s presence. Thereafter children benefit tremendously from companionship. Recently, an expensive hospital was constructed with private rooms for each child. The children were all miserable until the head of each bed was pulled out into the hall far enough for the children to see one another.

The fortunate part of the relationship between children is that they enjoy playing together, watching television, pushing others around in carts, and enjoy looking at small babies, yet the distress and misfortunes of their playmates do not appear to bother them in the least. Games go on in spite of the heartrending screams of the friend in the next bed. Although this makes children appear somewhat cold-blooded, the total effect is better for all concerned than as if each child suffered with all his neighbors.

Sometimes, of course, this lack of compassion cools the blood too much. One small boy screamed frantically during the simple application of a body cast. Finally it was learned that his “friends” on the ward had convinced him that the surgeons were going to take plaster knives and slice him in half from his head to his toes. At another time a conversation was overheard between two children in the waiting room before operation. The boy commented “I’m just going to have my toes operated on, if something goes wrong it’s only my foot. If they make a mistake on your heart, you’ll die.”

Having no ready argument, the little girl in the next bed simply replied “I know.”

The lack of pity sometimes seems cruel, but perhaps is merely a realistic point of view, for it may even be turned inward at the patient himself, as when a 3 year old boy, paralyzed from the waist down by a spreading brain tumor, was being teased by his 5 year old brother, and the father trying on the spur of the moment to help the smaller boy said “Why don’t you kick him, Jimmy?” Looking down at his useless legs Jimmy aply replied: “With what?”

What goes on inside? It is often extremely difficult to know the thoughts of a child under any circumstances. How can we possibly guess what occurs in the mind of a child who must undergo a shoulder or hindquarter amputation. Some will show little or no outward sign of emotion at operation, and later tolerate the teasing of schoolmates who laugh at them because they are funny-looking. It is barely possible that some of these children do not suffer inwardly, but it seems probable that those who conceal their feelings most deeply sometimes hurt more and take longer to recover.

A child who reacts with alarm, tears and a moderate degree of emotion may adapt to such a situation more quickly and easily than the more courageous stoic.

It is remarkable that children who are hopelessly crippled or burned and who come to operation again and again rarely blame the doctors for the pain they must inflict, or the fates that seem to be gathered against them. Those with solid family support and real affection show appreciably better morale, but it is evident that there is tremendous need for a concentrated study of the psychological problems involved.

Parental Influences: The relationship between child and parent is full of contrasts. Some childless couples will gladly spend their life earnings on an adopted mongolian idiot, while the father of a fine little 2 year old girl will beat her in the face with the buckle end of a belt. The hospitalized child will usually reflect the parents’ attitude of confidence, apprehension, or abject fear. It appears to be the child’s subconscious goal to live up to the parents’ expectation of him. If the parents pat the little boy on the head and say, “Our Johnnie is the bravest boy in the hospital,” Johnnie will usually deliver the goods, or if a sour-faced mother points at her sour-faced daughter and says, “Doctor, my Jocelyn has a very sensitive stomach. She vomits everything. If you were to give her a dish of ice cream right now, she would vomit it right up in your face,” the chances are that she would do just that.
Different parents and children seem to face minor challenges with markedly contrasting reactions. However, when faced by the actuality of death, these differences appear to fall away. It is awe-inspiring to see how parents and children can appear to accept the knowledge of coming death, and meet it without flinching. After days or weeks of waiting, it is not surprising that occasionally a mother will become hysterical when it is all over. However, to watch a procession of these family groups year after year inspires considerable respect for fellow members of the human race, and makes you ask yourself the embarrassing question if you could do as well.

Summary

Sometimes children tell us exactly what they think, sometimes their actions leave no doubt. More often, however, we are in complete ignorance of their inner reactions, and may commit serious errors either by assuming we know the answers or more often by neglecting the problem completely.

Observations of the reaction of hospitalized children leaves one with the feeling that children's reactions vary with age, individual characteristics, parental training and hospital experience. Outwardly they often appear to have an animal-like bravery and disregard for the plight of others. Occasional glimpses of the inner working of a child's mind suggests the extent of our ignorance.

References


ANESTHESIA LEVEL To determine the level of anesthesia, a strip of adhesive tape which had previously been applied longitudinally to the trunk of the patient is peeled off. This method was found to be especially helpful in nervous patients and infants. A statistical comparison of this tape method with the pin-prick and ether methods revealed it to be the most reliable. The tape method shows the level of anesthesia of pressure and tactile sensations; the pin-prick method shows that of pain sensation; and the ether method shows that of temperature sensation. (Muteki, G., and others: New Method of Determining the Level of Spinal Anaesthesia (Japanese), Jap. J. Anaesth. 12: 105, 1963.)