

THE HOSPITALIZED CHILD OR ADOLESCENT AND THEIR PARENTS:
IMPLICATIONS FOR FAMILY LIFE EDUCATORS 309

by

CYNTHIA E. MAY

B. S., Kansas State University, 1978

-

A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Family and Child Development

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1980

Approved by:

A handwritten signature in dark ink, appearing to read "Anthony P. Smith", is written over a horizontal line.

Spec. Coll.

LD

2668

.R4

1980

M39

c.2

"Possibly the day will come when the release of a patient (a child) with a serious disability (or illness) from the hospital without the careful involvement of the family will be considered in the same light as child therapy without parental conferences." (Christopherson, 1968).

"Nurses and physicians forget that he does not have the adult's wealth of experience to draw upon. At the same time, he does not have the child's youthful ignorance and trust", (Hammar, 1968).

"Though sufficiently mature to appreciate the implications of his diagnosis and prognosis, the adolescent has not yet completed the personality integration or fully evolved the adult defense mechanisms which might enable him to adjust successfully to the knowledge of his illness." (Moore, Holton and Marten, 1969).

"People talking without speaking

People hearing without listening

People writing songs that voices never shared

No one dared disturb the sound of silence."

"Whatever in connection with my professional

Practice, or not in connection with it,

I may see or hear in the lives of men which

Ought not to be spoken abroad I will not divulge,

As reckoning that all such should be kept secret."

"Hear my words that I might teach you

Take my arms that I might reach you."

"In looking at the voice beneath the silence of adolescence and showing how medical service fits..." (Allen and Mondochain, 1976).

Table of Contents

	Page
The Hospitalization of Children	1
Separation Anxiety	2
Fantasy	3
Hospital Surroundings	4
Individual Reactions	6
Age	7
Regression	9
Aggression	9
Fear and Anxiety	10
Effects of Hospitalization	11
Intensive Care	12
Self Esteem	12
Post Hospital Stress	13
Control	14
Coping with Pain	14
Chronically Ill Children	15
Supporting Hospitalized Children	17
The Child's Cues	17
Lack of Preparation	18
Sleep-Wakefulness	18
Placement of Critically Ill on Ward	19
Behavior Modification	19
The Family and the Hospitalized Child	20
Not all Children Want to go Home	21
Supports Present in Hospitals	22
Play Therapy	22
Activity	24
Rooming In	24
Group Discussion	25
Preparation	27
Health Care Team	28
Staff/Patient Relationships	29
Changes in Ward Policy and Set-up	29
The Hospitalization of Adolescents	30
Admission	32
The Stages of Hospitalization	33
Defiance and Aggression	33
Depression	34
Death	35
The Coping Process	35
Patient Groups and Meetings	37
Disengagement	38
Adolescent Wards	38
Size	39
Age	39
Location	40

Maintenance of Peer Relationship	41
Food	41
Recreation	42
Education	43
Privacy and Modesty	44
Rules on Wards	45
Staffing the Adolescent Ward	46
Interest in Adolescent	46
Staff and Parents	47
Age of Staff	47
Trust in Staff/Adolescent Relationship	48
Honesty with Adolescent Patient	49
Staff Support	49
Staff Teamwork	50
Staff as Role Models	51
Anger at Staff	51
Tasks of the Adolescent	53
Independence	53
Establishment of New Relationship with Parents	54
Body Image	55
Self-Concept/Self-Esteem	56
Role Definition	57
Sex Role	57
Future Roles in Occupation and Family	58
Control and Self-Care	59
Hospitalization and Family Life Education	61
An Unfulfilled Need	61
Training of the Family Life Educator	62
Role as Advocate	62
Role as Educator	63
Role of Guiding to Acceptance	65
Changing Interaction Patterns	65
Parent Groups and Meetings	66
Fostering Parental Support	67
Family Problem Effects on the Hospitalized Child	67
Problems of Hospitalization Effect on Family	68
Support of Parents	69
Family Centered Care	71
Resistance to Change	72

Hospitalization is an occurrence that many people face at some point during their lifetime. It is my intention, in this report, to explore the effects, issues and concerns of children, adolescents and their parents during the hospitalization experience. From there I will draw some implications for family life educators working in the hospital situation. There has been little or no research done on family life education in the hospital context, so my implications will be drawn from the effects of hospitalization and the work that related fields have done in hospitals. Some of these fields are social work, play therapy, psychology, psychiatry and education and these have most greatly been related to the fields of pediatrics and adolescent medicine.

The first section of this report will deal with the concerns of pediatric medicine and the hospitalization of children. The second section deals with the effects of adolescent medicine and hospitalization of adolescents. The third section of this paper will draw from the first two in the effects of hospitalization on these patients, and relate this information to the field of family life education in the hospital.

Many steps have already been taken to alleviate some of the deleterious effects of hospitalization on the younger person. The development of adolescent medicine is one of these changes, as well as the institution of many new strategies in the hospital areas dealing with children and adolescents. Many of these strategies can be used effectively by family life educators and often times they are better trained to use them than those professionals who presently are. This issue will be further dealt with later, in the third section of the report.

The Hospitalization of Children

It is a recent development in the field of pediatrics to plan for other

needs that children have, as well as medical ones. With the beginning of this interest came the onset of many of the strategies mentioned above. In pediatrics the change over of teenagers to adolescents medicine and units, was a part of this as well as mothers rooming in, play therapy and talk groups to name a few. An integral part of this is the boon of research on the effects of hospitalization on children and adolescents and on the ways that the hospital situation can be improved upon.

For years there has been information on the effects and changes that hospitalization has on children and the concerns they have about being in the hospital situation. Frank (1977-1978) stated that the threat of hospitalization comes not from a single source, but rather from multiple sources. He mentions physical and emotional separation; discomforts, injury or altered body function; transfer of body management to others who are strangers; fantasies of hurt and mutilation; invasion of privacy and uncertainty about the future as a few concerns that children have during hospitalization that make it a significant event in childhood. Hospitalization has all-encompassing effects on the child, not just on the physical health, but also the emotional, psychological and social well-being.

Separation Anxiety

Of the above mentioned threats to or concerns of hospitalized children, separation anxiety received by far the most attention in the literature (Danilowicz and Gabriel, 1971; Eikeland, 1973; Neff, 1974; Cofer and Nir, 1975; Conway, 1975; Drexler, 1975 and David, 1978). It seems that separation anxiety is a major issue in the younger children who are not accustomed to being separated from their parents. The extent of anxiety varied from child to child (Danilowicz et. al., 1971). Separation was thought to be the main source of hospital anxiety (Cofer et. al., 1975). Drexler (1975) felt that anxiety in

a four-year old was lessened perhaps by the familiarity of separation due to pre-school. David (1978), in her study on types of play, noted that, when the child was feeling separation anxiety, the major type of play was regressive in approach. Neff (1974) noted that the age of one year to age three or four is the time when separation-individuation takes place and this is an especially difficult time for the child to be separated from his mother. Separation anxiety is a very pervasive response in the hospitalization of children, especially young children. The extent of this anxiety is dependant upon the individual child, his previous experiences with separation and the circumstances surrounding the child.

The anxiety of separation can, at times, lead the child to believe he has been abandoned at the hospital (Conway, 1973; Conway, 1975; Sheridan, 1975 and David, 1978). David (1978) goes so far as to say that the fear of abandonment is the greatest fear of the hospitalized child. Conway (1973) stresses that this fear of abandonment is especially evident if the child does not know why they have been put in the hospital. Abandonment is not a realistic fear in most hospital cases, but rather is a fantasy that children have about hospitalization (Conway, 1975 and Sheridan, 1975).

Fantasy

Conway (1973); Cofer and Nir (1975); Conway (1975); Sheridan (1975); Holmes (1976); and Frank (1977-78) all discussed the topic of fantasy and distortion in hospitalized children. Abandonment was included, among others such as pain, mutilation, guilt, oedipal fantasies (castration punishment, damaged genitals, etc.), surgical fantasies and fantasies about parental neglect causes of hospitalization. Sheridan (1975) notes that these fantasies involved in illness all have a common thread among hospitalized children.

Cofer and Nir (1975) felt that, if the facts are known about hospitalization causes and medical procedures, the distortions would decrease and the children would be more relaxed about them. This would also help to promote the transfer of proper information from one child to another rather than the fantasy or distortion.

A common fantasy in the younger child is that of mutilation. This goes hand-in-hand also with the concerns of genitals and the oedipal child has, even during hospitalization. When strong oedipal tendencies are apparent, the staff might be especially aware of the fear of genital mutilation (Conway, 1975). In other cases there is the belief that children, often due to a lack of knowledge, fear mutilation of their body, especially in cases where intrusive procedures such as vein punctures and surgery need to take place (Frank, 1978). At times, in dealing with children in the hospital, there is not so much fear of mutilation as there is a threat of medical procedures that need to be done and the bodily harm or injury that entails (Mason, 1965; Conway, 1973; Conway, 1975; Sheridan, 1975; Wolfer and Visentainer, 1975; Holmes, 1976 and Frank, 1977-78). Manson (1965) notes that, if an honest account of anticipated events is given, a child is helped to maintain trust in the hospital environment.

Hospital Surroundings

Sheridan (1975) states in her article that it is not just the threat of mutilation or bodily harm that exists for the hospitalized child, but, in fact, all surroundings and aspects of the hospital are threatening. Wolfer, et. al. (1975) lists five general categories of threats to hospitalized children. They are 1) physical harm or bodily injury, 2) separation anxiety, 3) strange and unknown surroundings with the possibility of surprise, 4) uncertainty about limits and expected acceptable behavior and 5) loss of control,

autonomy and competence. It is important to remember, in dealing with hospitalized children, that whether the threat is a fantasy or reality is not the issue. To the child the threat as he perceives it is very real even though we as adults realize it isn't. The issue is to deal with the child's fear and feeling of threat on his level, rather than on a level he can not as yet perceive, and, at the same time, begin to strive towards correcting his misperceptions through explanation and education. It is too much to expect the child to be able to immediately see this reality. He may never reach this during the hospitalization. Therefore, it is important to deal within his level of conceptualization.

Aside from separation anxiety, fantasies and threats to the body, the child also has other concerns while hospitalized as noted by Frank (1977-78) above. One of these is the transfer of control and body care to others, usually total strangers to the child. Adams (1976) notes the importance of looking, not only at the fact the child is obliged to surrender his freedom, privacy and sense of control to others but also look at the fact that, at the same time, the child is separated from his familiar world of parents, siblings and peers. Sheridan (1975) also says that during hospitalization not only the child, but also the parent, is frequently denied environmental support of familiar surroundings. At the same time, the child is asked to give up control and care of himself to strangers, the parents are asked to give up a lot of their parental roles to strangers. Then the child is not only hospitalized and, therefore, turning care over to strangers, but he is also losing contact with parents, then he is deprived of the basic trust and security that he particularly needs during his illness. The younger the patient the more vital the protection of his source of nurturance and the fostering of the optimal relationships to mother, father and siblings (Mason, 1965). Mason (1965)

and Sheridan (1975) both mention that this all occurs within the context of new and strange surroundings that are often lonely, painful, threatening and frightening to many.

Individual Reactions

In addition to these concerns that seem to be common to most hospitalized children, there are also a group of reactions that are found in most hospitalized children. Children will respond in different ways and with differing degrees in each of these reactions. Leyn (1976), in his article on dealing with death by the families of terminally ill children, stated that each family will deal with the dying, death and grievance in totally individual ways. This is an important factor to keep in mind in dealing with hospitalization of children. Each will react differently with the confrontation of hospitalization as well as with death. Individuality is a key in dealing with people and it should be kept in mind, even when approaching a person in a common situation. It is also important to note that not only the child, but the parents as well, will each have an individual approach during reaction to a hospitalization. These reactions vary, due to the differences in people, in family constellations and the interaction patterns they have established, as well as the circumstances and concerns surrounding the actual hospitalization.

Sheridan (1975) states that, in general, children react more strongly to hospitalization and, therefore, they need more help in dealing with the event. She notes that this is due to the child's components of separation and loss being very strong and their need is to have these met in surroundings that are unfamiliar to him and when he is being cared for by strangers. It is based in circumstances that the child doesn't understand, such as the fact that he is expected to release most of his control of self and his closest supports, for unfamiliar ones. Quite often the child simply does not under-

stand, especially in a first hospitalization, why he has to come here to get better. The child has probably been ill before and has regained his health at home; why does he have to go to the hospital this time, he no doubt wonders.

Pill (1976) in the article on health "careers and competence" notes that previous data has to be considered concerning the child. It was noted that the child's past experience, both familial and social determines, to a great extent, how the child will react on the ward. This well-past experience affects the child's definition of the health field which, in turn, affects the reaction he will give to being surrounded by the field, rather than the usual experience of going to a clinic or doctor's office for a short time. How the child enters the social system at the hospital is frequently a function of what he has previously experienced in social contacts. If the child encounters a broad range of contacts before entry to the hospital, he may do better due to more practice at changing roles and being empathetic to different situations.

Age

Adams (1976) notes, in her article on hospital play programs, that the child's response to hospitalization depends a lot on maturational factors. It seems that the past experiences discussed above also affect these maturational factors. Maturation is not only an effect of age, but also significant of experience that one has had. Wolfer et. al. (1975) stated, in an article on pediatric surgical patients that generally the older children exhibited less upset than the younger ones. This could illustrate both of the factors above at work. The older child can not only understand the hospitalization better, due to his greater ability to communicate and conceptualize about it; but also he has had more experience with the health field in general, as well as the hospital in particular. Merely as a function of living more years, the child has a greater reserve of information on which to pull and a greater chance

of actually being in contact with a hospital. In general, the authors have noted a break down in the type of reaction most prominent by age group.

The youngest children are exceptionally concerned about separation and the anxiety it entails, Natterson and Knudson (1960) noted ages 0-5 yrs., Adams (1976) noted the "younger ones" 0-4 years, Eikeland (1973) was discussing the case of a two year old and Neff (1974) was discussing the period of separation-individuation at about one year through the third or fourth year. The next most prominent reaction was in the age group noted as four years to seven years by Adams (1976) and as five years to ten years by Natterson et. al. (1960) and the reaction noted was one of fear of mutilation and procedures. It is interesting to note that this is the general time that Conway (1973-75) has stated also is the time of great concern over genital mutilation due to oedipal concerns. Holmes (1976) also noted, in a five year old girl, that this is the time in which sexual identity is established and that the child's greatest concern is related to task of body integrity and control. There is more variance in the last two groups than there has been in others. Adams (1976) notes this as a stage from age eight through puberty and says that it is important for the child to feel competent and to expand his understanding and that he can now talk-out, as well as act out his conflicts. Natterson et. al. (1960) feels that the age range is in the over ten group and the reaction was to death. In general, it is noted that the fears are in those children who were fatally ill in Natterson's sample and that largely the fears over the age span followed the maturational consciousness level of the child. Sides (1973) notes that child's behavioral response to medical treatment is affected by the child's age, the adjustment of the child before hospitalization and the mother's anxiety level to name a few. Korsch, Negrete, Gardner, Weinstock, Mercer, Gruskin and Fine (1973) note that it is not the

severity of illness that determines adaptation but rather the period in the child's growth and development, his personality attributes and the attitudes and help of his family members.

Regression

Shade-Zeldow (1977) also notes that age helps to predict reactions to hospitalization that children have. It was stated the younger the child, the greater the degree of regression, inhibition and aggression than their older counterparts. The reaction of regression that was noted here has also been addressed by many other authors. Manson (1965) says that regression to more immature behaviors is common both as a protective maneuver and a symptom of stress in response to the situation. David (1978) noted regressive behavior also, but focused on the regressiveness of play behavior in the hospitalized child, especially when he lacks trust in the adult with whom he is dealing. Since play reveals the child's current feelings, regression noted in play is evidence of feelings of regression in the child. Sheridan (1975) and Holmes (1976) note that regression is due to the experience of hospitalization occurring at a time when child's ability to cope is already strained by physical discomfort and lowered esteem, as well as at a time when the child is feeling the loss of control discussed earlier in the paper.

Aggression

Aggression is another reaction that goes hand-in-hand quite often with regression and was mentioned not only by Shade-Zeldow (1977) but others as well. It was noted that the adjustment to hospitalization was predicted by the length of stay and the longer the stay the more aggression noticed in the child. Emergency admissions were also predictive of greater aggression and inhibitory behavior, presumably due to the lack of preparation for the hospitalization that the child received. Mason (1965) says that, under age

of five due to lack of verbal ability, sense of time and understanding of reasons for procedures the reaction is more severe and entails more aggressive reaction. In older children, he notes that there is resentment and hostility due to enforced dependency. Sheridan (1975) and Adams (1976) both note the feelings of rage that need to be ventilated by these children, both the rage of threatened mutilation and the rage at doctors and other health workers. David (1978), in her study on play, notes that aggressive play is a very good way for the child to ventilate these feelings and can afford the patient much relief. Adams (1976) reminds that limits still need to be placed on the child to prevent harm to self or others in the play situation.

Fear and Anxiety

Sheridan (1975), Conway (1973) and Adams (1976) all note the areas of fear in hospitalization. Many of these have been expressed previously in this report under the title of concerns that children have. It is an individual factor on whether these concerns develop to the degree of fear. Adams points out that this fear in cases can lead to the feelings of anger and rage that are expressed by the child in hostility and/or aggression. Danilowicz et. al. (1971) discussed reactions of children to surgery as anxiety, fear, overt anger and combative behavior along the same type of sequence that Adams (1976) has.

Anxiety was mentioned by several authors to be another reaction to hospitalization (Danilowicz et. al., 1971; Korsch et. al., 1973; Cofer et. al., 1975; Adams, 1976 and Holmes, 1976). Aside from the issues of separation anxiety, anxiety seems to be dealt with generally in the literature. Any of the concerns that were mentioned in the earlier part of this report could develop very readily into anxiety. In light of the outlook of fear or anxiety developing into hostility or aggression, these reactions might be good things to deal with in the hospitalized child, helping them to work through to

aggression in an acceptable manner. Adams (1976) noted that play is one way to do this. Cofer et. al. (1975) notes that there are many different ways that anxiety and depression are manifested. Danilowicz et. al. (1971), in their article on postoperative reactions in children, found the greatest complications in the group characterized by fear and the second greatest complications in the group characterized by anxiety. Korsch et. al. (1973) noted that high anxiety often leads to damage of the self-esteem in cases of kidney transplantation. These samples perhaps could have benefited from some usage of play to help them deal with their anxieties. More research needs to be done on what causes anxiety in hospitalized children and how it can be prevented or lessened.

Other reactions to hospitalization mentioned by authors were depression and denial. Depression was only mentioned in dealings with cases of serious, chronic or fatal illnesses (Natterson et. al., 1960; Korsch et. al., 1973 and Cofer et. al., 1975). Denial was only mentioned in one article in the case of a four year-old boy in for surgery on his penis (Drexler, 1975). The cause in this case could have been anxiety alone or in combination with some oedipal concerns the child had.

Effects of Hospitalization

So far in this report, I have discussed some of the frequent concerns and reactions of children to the issue of hospitalization. I would like now to note a few of the effects of hospitalization on children and some of the ways authors have noted how children gain control to deal with hospitalization and the procedures it entails, furthermore how they cope with pain and chronic disease. The effects I am going to briefly mention are, those brought about by contact with intensive care unit (ICU), self-esteem changes and post hospital

upset.

Intensive Care

When a child is placed in an intensive care unit there is usually little time to prepare either him or the parents. This leaves him very vulnerable to the coming events. Parents are usually unable to reach out to the child at a time when the child's need for them is acute. The first goal is to start the needed life-preserving measures and then reunite the parents and child. Often times, it is wise to prepare both the parents and child for the sight of all the elaborate machinery present, before entering the unit. The responses of the child during ICU time are usually high anxiety, tolerance of most procedures with crying or physical resistance (Jay, 1977). It is important to note, in light of the material already covered, ICU care is even more reacted to by children. There is the added protection in that most children admitted to the ICU are usually more ill and, therefore, often less alert to surroundings. With admission to the ICU there is more separation, more loss of control, more strangeness in surroundings and therefore more room for greater fantasy and distortion. The effects of hospitalization of a child who has been in the ICU is even greater than a child who has been in the hospital alone.

Self-Esteem

The effects of disease on self-esteem were mentioned on two occasions in my research and both times the issue arose it was in conjunction with a sample of chronically ill children. There was never any mention of a deleterious effect on the self-esteem of a child with an acute (short-term) illness thus leading me to believe there is rarely any long-term effect on the self-esteem of a child who is only sick temporarily. In both cases the authors reported that the chronically ill children had low or damaged self-esteem and

that the illness will have an effect on the child's self-image (Korsch et. al., 1973 and Sheridan, 1975).

Post-Hospital Stress

Three of the authors I read mentioned post hospital upset in their patients. Sides (1977) noted the variables contributing significantly to prediction of post hospital behavior two weeks after discharge were child's behavioral response to medical treatment during hospitalization, the adequacy of child's adjustment prior to hospitalization, as well as the child's age and mother's anxiety level during hospitalization of child. There were a substantial number of children in this sample who were found to be emotionally upset after a hospitalization experience. Jay (1977) notes behavioral response after hospitalization in ICU to be social age scores drop in surgical conditions, forms of sleep disturbance and a decrease in anxiety level. Eikeland (1973), in the study of a two year old tonsillectomy, noted the onset of conditioned fear in him. The fears were of anything being put in mouth and of entering strange or relatively strange buildings (Significant of the hospital). The child had started putting hand to mouth as a result of any unpleasant experience. "Systematic desensitization" was used in both instances with much success. The author felt that every parent should be told to observe their child upon return home, not only physically, but for conditioned forms of behavior which might lend itself to treatment before secondary or tertiary complications occur. Danilowicz et. al. (1971) noted, in one case, the girl coming in for cardiac surgery had been told she was going for a clinic visit, not surgery and she was an extremely uncooperative case in hospital and continued to act out for months after her return home. This illustrates the importance of the need to be honest in explanations to the child about hospitalization.

Control

Several authors noted various ways patients gained control over the environment or gained attention on the ward. Holmes (1976) noted in a study on a five year-old girl that she was controlling by nature and would control hospital staff by commanding them to do things. These commands were especially frequent when she had a sense of helplessness over her condition. She also exercised control by demanding order in her environment and requesting staff to place things in orderly fashion, where they belonged. Pill (1976) stated many tactics she observed to gain some control over staff and some attention. It was noticed that, in cases where a child couldn't control their body or condition, there was a desire to control nurses and other staff members. Some of these tactics were to cry or call out. These were especially effective when one knows the nurses name and status. Bedpan call was a particularly good way to control staff. Impaired children usually had more trouble gaining control due to their lessened ability to be manipulative and communicative about situations. "Normal" children at times played a "good" patient role to gain control and attention of ward and staff. This is a very good method on some wards but Danilowicz, et. al. (1971) warns that compliance and good behavior can be indicative of fear and subsequent withdrawal. It is very important to look for and catch these cases, as they can result in a much greater degree of maladjustment if they are left alone.

Coping with Pain

Savedra (1976) noticed, in dealing with burned children, that even though pain is a constant feeling for weeks and the child exists in a state of confusion, panic and hurt, they can develop strategies to help them cope with pain. The burned child is in a situation where pain is constant and procedures that need to be done all add additional pain to what already exists.

It is weeks before helping a burned child is no longer hurting him. The author stated that the most intense pain is involved in direct care of the wound and, as time went on, the children grew less tolerant of the pain. The strategies the author recorded that the children used to cope with pain were: reduction of threat, postponement, bypassing pain, creating distance between self and threat, dividing attention, sleep and responses to crying of others. Savedra (1976) noted that different children used different strategies and they would change their strategies at times. These strategies could be used by other children to deal with different types of pain and can be recognized by staff members and parents for what they are, so that they will be more patient with the child's behavior.

Chronically Ill Children

It was noted earlier in the report, when dealing with some of the effects of hospitalization, that a decrease in self-image was a factor in cases where children have chronic illness. Within the hospital context and involved in group meetings, it became apparent to Frank (1977-1978) that chronically ill children are especially subject to feelings of loss of control over bodies, shame, weakness and vulnerability. Christodoulou, Gargoulas, Papaloukas, Marinopoulou and Sideris (1977) note that the personalities of children with primary peptic ulcer are shy, lonesome, submissive and with limited social interaction. Mason (1965) noted that hospitalization of chronically ill children "complicate the child's emotional response: the child's focus is on lengthy treatment procedures rather than the normal developmental challenge and families are strained to maintain positive and healthy relations with a child away from home frequently." These qualities make the chronically ill child even harder to deal with when in the hospital context, but in greater need of extra concern and support than others.

Pless and Roghamann (1971) state that the chronically ill fare significantly less well in: education, achievement behavior and psychological maladjustment. They also note that a large proportion of chronically ill children have serious psychological or social problems and need to reappraise the present pattern for care to these children to see if any secondary handicaps can be reduced. In the chronically ill child the risk of behavior pathology is roughly proportionate to the duration of the disorder and to a less degree it's severity. The authors propose comprehensive care in these cases so as to prevent as many of these problems as possible.

One such type of care is described in an article by Matus (1978) on growth perspective in care of the chronically ill children with asthma. She states that there are two imperatives in rehabilitation of chronically ill child the first, being acceptance of self as asthmatic and the second, developing competency in areas of knowledge and self care of the illness. It is presumed that every child expresses growth-resistant and growth-striving tendencies but the chronically ill child has an imbalance toward the growth-resistant side. The program centered on changing this to more of a balance. Staff affirmative attitude helps give child respect and confidence in self to try to meet this change. A comprehensive team assesses, creates plan of steps toward goal and reviews child each week, then also has a meeting with the child each week, as well as giving continually adult support to help child attain the goal. It takes a lot of support from many different fields to meet the needs of these children and help them start to obtain their goals. Pless, Satterwhite and Van Vechter (1976) note that medical education, at all levels, has failed to prepare doctors for the provision of anything much greater than sympathetic treatment of these chronically ill children and also at the same time state that, for a significant proportion of these children, there is an inadequate

use of supportive services at the primary care level. It is, therefore, correct to assume that, in many cases, the needs of the child are just not being met either by the doctor or other supportive services. This is even more the case in the family's needs.

Supporting Hospitalized Children

Support services leads to the next issue, in this report, being supportive of children during their hospital experience. In dealing with this issue, the format will be to divide it into two sections. The first section focuses upon things that should be watched for in dealing with hospitalized children, in order to get an idea of some of the needs a child might have. The second section centers on actions that were reported in the research as having already been successfully implemented in at least one hospital. Many of them have already been added to and are being used on a fairly common basis in hospitals to support children in the hospital situation.

Mason (1965) expressed, in his study on the emotional needs of hospitalized children, that he saw a common process that children go through when they are hospitalized. He showed this process through Robertson's three stages of the child's settling into the hospital. The three stages are: 1) protest period of crying, confusion, fright and searching for mother; 2) despair period of apathy, withdrawal and monotonous wailing and, if separation lasts long enough, 3) detachment occurs, the child turns away from his disturbing feelings toward the mother and recovers an interest in his environment.

The Child's Cues

In dealing with a hospitalized child, one can look for cues as to when the child has had all he can handle of the information he needs. The child can manifest this appeal both verbally and non-verbally through denial, avoid-

ance, direct confrontation or starting to deal with other unrelated issues. At times, these cues may be extremely subtle. One must be really "listening" for them in order to pick them up. Drexler (1975) points to the cues the child can give out, in his article on a four year old boy hospitalized for surgery. Other good points the author brings out are that, all the preparation for surgery need not be done at once, but can be broken down into more readily comprehensible segments. The child, quite often, wants to learn and cooperate with procedures but just needs some extra time to prepare himself to do this and hopes to get this time by giving 'cues' or signals for it.

Lack of Preparation

By the same token, if preparation has not taken place at all before a child enters the hospital, staff need to be aware of this and to help the child deal with their own lack of knowledge. The most common issue here is the event of an emergency admission to the hospital when there is little time to prepare the child for the possibility of admission. Danilowicz, et. al. (1971), in their article on cardiac surgery, speak to the issue of a child coming to the hospital on a planned visit without proper preparation. The particular case that the authors discuss is a five year old girl who was told she was coming in for a routine clinic visit instead of surgery. After surgery, she withdrew from contact, refused feedings and would not cooperate, often screaming and thrashing after direct contact. She improved drastically, once her release date was set, but continued to act out for months after she returned home. It is obvious that this type of case needs to be handled by very concerned people who can help the child work through his problems, which are more than most hospitalized children have.

Sleep-Wakefulness

Three articles in the review looked at the nature of the hospital and

its staff to find concerns that effect children who are hospitalized. The first of these concerns deals with the sleep-wakefulness patterns of young hospitalized children during naptime. Beardslee (1976) suggests that there be an avoidance of hospital housekeeping and routine checks on patients during the hours that young children are napping. It was also noted that it is possible that the child has a better ability to fall asleep when an adult, whom the child knows and from whom can gain some security, is present. It was felt also that the child, if a room change was planned, was frequently moved after lunch because of the convenience of changing room assignment in dietary department. This, it was pointed out, is a bad time, in that the child is disoriented just prior to naptime and is, therefore, more likely to remain wakeful.

Placement of the Critically Ill Child on the Ward

The second article dealt with the tendency of the staff to put critically ill children or dying children in a room, away from playroom and nurses station, because the child "needs their rest" and will less likely be disturbed there (Northrup, 1974). The staff felt that they "don't want to interfere" but, at the same time, they failed to begin to realize, much less meet, the needs of these children and their parents. Staff need to look at their actions to be sure they aren't pushing people and their needs away, merely to supply themselves comfort, rather than comfort the child and their family.

Behavior Modification

Magrab and Papadopolou (1977), in the third of these articles, make a very important point about behavior modification programs used with child patients. In this case, the program was used to promote dietary compliance for children on hemodialysis. The issue they raised was that any behavioral

program should be based on enhancing the quality of life for the child, rather than making contingent the few special pleasures and privileges he or she may already have. This is a very important issue for the staff to keep in mind.

The Family and the Hospitalized Child

In addition to being aware of their own actions, the staff can also be supportive of child by being alert to the child's family and some of the effects they might have on the child's hospitalization and illness. Magrab, et. al. (1977) notes that, if there are family problems, there is often a lack of family support to the child, due to their attention on the problems. Korsch, et. al. (1973) noted that some of the problems families have, especially in relation to long hospitalization, are financial strain, restrictions in social life, problems with siblings and the need for intensive medical contact. These are just a few of the problems families, dealing with hospitalization, have in addition to others they might have had anyway. It might be advantageous to note that the normal problems could very easily be blown out of proportion, due to the added strain of the hospitalization. Korsch, et. al. (1973) also notes that a good interpersonal relationship in the family and the attitudes of family members toward the child and his illness have a lot to do with a child's overall adaptation in a kidney transplantation sample. A staff, who is able to pick up on these issues from a patient, can help him to deal with these problems and give him the added assistance and the family the added help they might need to support the patient.

Two other articles dealt with family issues that are important enough to be mentioned here. The first is Christodoulou, et. al. (1977) and their idea that of the children in a peptic ulcer sample, it is possible that a considerable number of them had limited opportunities for identification with a healthy adult. They drew this conclusion from the fact that 60% of the

sample had close relatives with ulcers (15) and twelve of these had more than one relative with ulcers. The second article, Hall's (1977) article on innovation in a hospital setting, noted that the nursing staff often felt that the reason for the child's poor behavior was that he was spoiled and that this is fixed in the child's background and upbringing, rather than caused by the conditions following hospital admission. It is very easy for staff members to gain or create negative attitudes about families in this way and prematurely close the doors to fostering the family's help in dealing with a young patient. The staff needs to keep an open mind, and an attitude that will help them to solicit the help of even these families, rather than closing the door

Not All Children Want to Go Home

Another issue to address, in dealing with things which staff members need to look for or be aware of, is that not all patients want to go home. Some would rather stay in the hospital. Sheridan (1975) notes that this occurs frequently when there are serious problems at home and/or the benefits of the hospital are too great. If a child stays in the hospital, not only does he escape a possibly bad home life, but he can also continue to receive the attention he has gotten previously for being ill, by both family and medical staff. The author noted that this can be dealt with, to some extent in a talk group, but that staff might also need to make a referral to someone able to deal with serious family problems, that are causing the poor home life or to at least explore it. Frank (1977) noted, in the group meetings that they had held, those children who were wards of the city and lived in temporary placement centers often don't want to go home. The center was often more threatening to the child than the hospital. These issues can be dealt with, if a staff member becomes aware of them through "watching and listening." Aside from the issues mentioned in this section for the staff to be on alert

for in dealing with hospitalized children, all of the reaction and concerns of the children, which were discussed above, also need to be attended to by open and caring staff members, so they can begin to be dealt with on a more overt basis for the child's and his family's benefit.

Supports Present in Hospitals

The second section on supports given to hospitalized children begins here, by addressing the methods that authors cited as having already been used with some degree of success. These supports can be broken down into three categories: programs offered for the added support of patient, efforts of staff and staffing practices to be supportive of patients, and the physical additions that are supportive of patients. Under the first category of programs were play therapy and importance of activity, rooming in of mothers, group discussions and preparation of children for hospital and its procedures. The second category entailed the use of a health care team, enhancement of the doctor/patient relationship and prediction of possible high risk patients. The final category mentioned physical changes of objects the ward uses at various times to help support the children in their hospital experience.

Play Therapy

Play therapy is a relatively recent development in the pediatric ward. It offers an outlet for the hospitalized child. There are instances where the medical profession is dealing with more than just the physical needs of a hospital-bound child. Play therapy was, by far, the most frequently mentioned program, to help reduce a child's feelings about hospitalization, by offering them a release. Brain and MacLay (1968) noted, in their article on mothers and children in hospital, that, when an older child was hospitalized without mother, at times their anxiety could be controlled through play

education. Frank (1977-78) notes that, in his hospital's approach to patient care, there is a play therapist who works as a part of that team. Drexler (1975) noted, in the case of surgery in a four year old boy, the fear he had of needles was worked out through play with syringes. Cofer, et. al. (1975) noted also the benefit of play therapy as a supportive method in helping a child work through anxiety and depression about hospitalization. Jolly, Finnie, Hall, Newton, and Roussounis (1977), in an article about Charing Cross Hospital Child Development Center, stated that play therapists ran the groups of four children, each with not more than one handicapped child, and it was the play therapist who dealt with them. Each of these is an example of the different programs of play therapy employed in dealing with children's needs.

David (1978), in an article on play as a diagnostic tool, noted that play is an important behavior in that it reveals the child's cognitive level, as well as his current feelings. She also defined seven types of play: passive, inhibited, manipulative, aggressive, symbolic, creative and social. She hypothesized that it is aggressive play that offers the child patient much relief. Adams (1976) agreed with this, in her article on hospital play program, by saying that anxiety is common and therapeutic play is a sound means of expressing this in three of the four ways: verbally, behaviorally, symbolically and psychologically. She stated three purposes of the play program as: preventing social isolation of the child, providing an educational experience that will facilitate his ability to cope, and obtaining a better understanding of the child. An added benefit is derived from helping the older children to deal with death. Given all this information, Hall (1977) wrote an article on the problems of innovation in to a hospital setting, focusing primarily on introducing a play therapist into wards of children.

He noted that hospitals are especially resistant to change, even if well backed up by previous experiences.

Activity

A topic that goes hand-in-hand with play is that of activity, mobility and ambulation, especially in the support of a child who is hospitalized. Mason (1965) noted the benefits of activity in a hospitalized child as being the opportunity to be more active psychologically, as well as physically. Children can help one another through activity. Lastly, passivity to activity allows healthier coping and activity discourages repression and dependency. Pill (1976), Holmes (1976) and Williams (1975) all state that mobility, ambulation and gross muscle activity are ways of dealing with hospitalization and the stress that goes with it. Allowing the child, especially the younger one, the freedom to express himself through his activity, is a method that is not only supportive of the child physically, but also emotionally and psychologically.

Rooming In

The second, as frequently mentioned supportive program, is that of the mother or father "rooming in" with the child. This program is much more widespread than play therapy and has adapted itself well to many hospitals. Mason (1965); Natterson, et. al. (1960); Brain, et. al. (1968); Eikeland (1973); Cofer, et. al. (1975) and Frank (1977-78) all mention rooming in of the mother, with the child, around the clock as being a supportive means to help them deal with anxiety, both separation and generalized. Mason (1965) went on to note that, in the past, it was the danger of infection and cross-infection that kept mothers off the ward and that this concern is no longer justified. The use of rooming in was still discouraged in some hospitals, as it was not primary to the medical care of the child. Now the emotional

well being of the child is increasingly taken into account and the child is no longer deprived of the basic trust and security that he particularly needs during his illness. The author also stated that the stay of the child is usually shorter when the mother roomed in.

The attitudes of staff members are great in determining the success of such a program. Natterson (1960) stated that the most commonly noted distress of the child was the absence of the mother. While the mother's presence during hospitalization did not reduce the stress of threat in procedures, the mothers were of help to the nursing staff in the simple caretaking of the child. Brain, et. al. (1968), in a study of mothers and children in hospitals, noted those, who have published reports on mother-child units, have been impressed with beneficial effects. The group with mothers present showed less emotional upset and, when the upset was present, it lasted for shorter periods of time, as well as fewer complications after surgery. Nurses, it was written, preferred the child to come alone for three reasons, even though they admitted it was a great comfort to the child to have the mother present. The reasons were that it was easier to carry out nursing procedures, they could make more personal contact with the child, and a few of the mothers were "difficult" and upset children and other parents on the ward. The author felt the key to this problem was in staff selection.

Group Discussions

Another program, that hospitals have sponsored in order to support patients who are children, was group discussions by the children on the wards. These groups were the major focus of several articles (Mason, 1965; Cofer, 1975; Sheridan, 1975 and Frank, 1977-78). The frequency of the meetings varied from daily to weekly and attendance was voluntary. Issues that were discussed in the group were all of those discussed in this report - threats,

concerns, reactions and need of support. The groups were run by play therapists, child psychiatrists, social workers and regular staff members. These sessions were times when, as a group, the children could become more supportive of one another and encourage one another to cope. It was noted that, only through the respect and acceptance of the children, would they begin to express their hostile feelings. They often started by poking fun or expressing hostility at safe things such as, dietitians, the rooms, the food, etc. and then became more secure in expression of their negative emotions on important issues. It was very helpful to the group, if they knew that they were free to "take flight", if the discussion gets to be more than they can deal with. The issues of discussion were repetitive, due to the fast changeover in group membership. The leaders promoted closure at the end of meeting so that those who were dismissed would not be left hanging.

Cofer et. al. (1975), noted that the group they wrote about had characteristics of both counseling and guidance groups. The role of the therapist was to keep the theme hospital-oriented, encourage interaction, being supportive, giving a model and being an informative resource for the children. The advantages, these authors noted, were the use of the group as a diagnostic tool, raising consciousness of mental health problems to other staff, improving daily functioning of ward by reducing child anxiety and offering a place for cathartic expression by the children. Frank (1965) discussed the purposes of the group that was observed. They were listed as a time when the child could speak openly what's on his mind, encouragement of the child to bring out his partial and fragmentary understanding of the hospital experience accompanied by fantasies and distortions, the allowance of the child psychiatrist to meet face-to-face with a large number of children he might not otherwise see and, lastly, a training ground for medical students

on aspects of normal and pathological child development. It is easy to see that these groups provide a lot of different supports to the children who attend them.

Preparation

The final supportive program type, that was mentioned in the literature, was that of preparation of children for the hospital experience and procedures that take place with certain specific conditions that the children have. The effect of a lack of preparation was mentioned earlier in the section on what staff members need to be aware of. At times, the preparation simply can't take place because the admission to the hospital or change to ICU are not planned and they take place on an emergency basis (Danilowicz et. al., 1971 and Jay, 1977). With a planned admission, there should be an effort to prepare the child through explanation by medical staff and parents and possibly a tour of the pediatric unit. Mason (1965) stated that, depending on the age of the child, an honest account of the anticipated events can help the child maintain trust in parents and remove some of the strangeness and, therefore, fear from the events. Drexler (1975) and Matus (1977) both show, in their articles, ways that staff members can gain the help of their patients in cooperating with their routines, by preparing them for what will happen to them. This preparation gives the child a chance to bypass some of the anxiety and fear, by giving some control over their hospital environment, even if it is just the knowledge of what is going to happen next.

The major programs used by hospitals that were mentioned in the literature were play therapy, rooming in of the mother, group discussions and preparation for hospital events and procedures. From this point, the focus will be shifted to three other supports offered to hospitalized children. These are the uses of a health care team, enhancing the doctor/patient relationship and the possible prediction of high risk patients.

Health Care Team

Frank (1977-78) discussed, in an article on group discussions, that there was a team effort from medical doctors, pediatric nurses, social workers, teachers, play therapists, psychiatry and psychology in being supportive to the children in the hospital situation. The author showed that these staff members were involved on the ward at all times, not just during group meetings. The presence of nearly all of these professions during the group meetings enforced the support of the children, in that any issue that came up could be dealt with from several directions, and this gave the assurance that the children's needs were met. Matus (1978) elaborated the effort to meet all of the needs in the chronically ill child with asthma by looking at the condition from physiological, pharmacological and psychological points of view. This hospital held weekly meetings with the child care staff and other personnel dealing with the child to collaborate on the case, breaking professional barriers and enhancing learning. They also held meetings once a week with the child and all of the staff who served him to discuss his progress. Jolly, et. al. (1977) noted that their assessment center used a broad team approach, combining many programs and the community, as well as center medical staff. They have been criticized for this, due to the added expense, but have noted that it saves money in cutting down the "shopping around" for answers that parents frequently engage in.

Korsch, et. al. (1973) showed there was not a greater number of children in the kidney transplant sample with clear-cut personality disturbances than was found in the control. They gave, as one explanation of this, the continued support and attention provided for the patients, by the comprehensive health care team. It was in this article also, that the authors mentioned that personality testing might be one adjunct in predicting high risk patients.

They noted that, in the sample, those with high anxiety and damaged self-esteem were the ones who had personality disturbances. The key phrase in their discussion of their results was that they were not clear cut and that the reader needs to keep in mind that there may be a lot of maladjustment problems, dealt with by this team which were not related to personality.

Staff/Patient Relationships

Magrab, et. al. (1977) felt that patient compliance is recognized as a major problem in clinical medicine and few useful techniques, beyond enhancing the quality of the doctor/patient relationship, have been developed to alleviate this problem. This problem becomes evident in pediatrics, only as the child is old enough to refuse to comply with the treatment methods. The concern is very real none-the-less, and many of the supportive measures, mentioned thus far, can help the child come to grips with his feelings and deal with the need for the treatment. Then, perhaps, there will be more compliance on a willing basis, due to deeper understanding, rather than haltingly going along with it for no reason other than the fact that it has to be done. The staff needs to make an additional effort for compliance in those cases where family support is weak or lacking. This will help to enhance the relationship between the patient and staff in general, including the doctor.

Changes in Ward Polices and Set-up

This last section on supportive measures, that have been established in some hospitals, will be a list of some of the physical changes in ward set-up. These have been noted by the authors to have been important supports in at least one case. Frank (1977-78) noted some things to be supportive of children in the hospital, as expressed in group meetings. There were: liberal visiting hours for all family members, communal eating, foster grandmothers for infants and toddlers whose mothers can't be present and

living areas of the child separated from surgical and treatment areas. Hennessey (1976), in an article on toddler's response to tape recordings of stories read by their mother during brief separations, showed that this event was pleasurable twice as many times for the child than unpleasurable, and that this technique was readily usable in the hospital. Neff (1974) noted that, in children under two, touch was a great source of comfort in the absence of their mother. Fleming (1974) found that acutely ill, chronically ill and physically disabled children focused more on objects than control groups did, especially if they were in the hospital for at least ten days. Those working in the hospital, when they leave, need to look more closely at "things" as measures of comfort to young children being left without close interpersonal relationships for a while.

These are all means of supporting children during a hospital experience and are the beginning of a sincere effort to make a hospitalization more productive emotionally and psychologically, as well as physically, for the children and their families. There is still much more that can be done to further this effort. One of the ways is through the efforts of family life education. This issue will be dealt with later in the third section of this report, dealing with support to parents and patients through the efforts of family life educators.

The Hospitalization of Adolescents

Until the recent innovation of adolescent medicine, the developmental tasks and psychological needs of hospitalized adolescents were even less well known than those of the child. Once again, the family life educator can help to fill the role of defining these to the professionals in medicine who are treating adolescents. Unlike pediatrics, the history of adolescent

medicine is short and is mainly attributable to Dr. J. Roswell Gallagher.

In 1934, he became full time physician at Phillips Academy, Andover where he served for 19 years. It was here that he created a model medical program for adolescent boys and learned first hand of all their clinical problems, physical and emotional. He and colleagues spent time on many studies of adolescent medicine these years.

In the late 40's, Children's Hospital, Boston was planning a new hospital and medical center for children and spurred on by orthopedists who needed to plan throughout the growth period, decided to break away from the traditional age 12 break off and give care to adolescents. Ros Gallagher served as consultant to this program from the start and, in 1951, he joined the full time staff as Senior Physician and Chief of the Adolescent's Unit. This was the first general clinic for adolescents in the country (Janeway, 1973).

Gallagher was insisting that the primary job was to provide service of a high order, and that, when this was achieved, training of other specialists and research should become important functions. He felt that the "two fundamental purposes of a general medical program for adolescents are to provide a setting where this age period will be some one group's concern -- everybody's business ends up being nobody's responsibility; and to permit a group constantly to strive to improve the quality of these young people's health and care" (Gallagher, 1973, p. 459).

Although this has been only the beginning of adolescent medicine, there have been a lot of significant insights gained into the field and into the people it serves.

Adolescents deal differently with hospitalization than either a child or an adult and, because of this, they need the special attention of their own breed of medicine that will deal with their marginal existence. When

approaching the hospital situation, the adolescent is quite often like the child, poorly prepared. They have thousands of questions, not only on what their condition is but also concerning hospital routines and what is going to happen to them there. The young child does not have as great a knowledge and tends not to fear the condition or the procedures but, rather, suffers more from separation anxiety (Hammar, 1968 and Little, 1960). The adolescent also can suffer from this anxiety (Blafman, Becker, and Gabriel, 1976), but usually the questioning takes precedence over this anxiety and creates fear in the new environment. Too often the staff and parents forget that the adolescent does not have former experience to draw on for support and security. Schwartz has found (1972) that, up until age 11, the child does not understand the meaning of research hospitalization; but past this age, if the adolescent is aware that the hospitalization is for research, there is a tremendous increase in anxiety, even if they have had preparation.

Admission

Cholcher and Burtis (1964), as well as Duran (1972), show, in a survey, that admission is a time when support of the staff persons can help to relieve this anxiety. Admission has been recorded to be the teenager's most anxious moment and, with the acquaintance of a friendly, cooperative staff person in moving in and meeting roommates, these feelings fade. These things reach even greater proportions in the case of an emergency admission and the staff has to work especially hard to stop the anxiety in these cases, through friendly attitudes and explanations of what is being done to the adolescent and why.

It is also at this time that the adolescent can be informed of the routine and rules of the ward. Hammar (1968) states that the adolescent needs the security of an established routine and solid structure to prevent or lessen anxiety. She also believes that an adolescent is less likely to test known

limits when the consequences of this testing are known. There will be less testing by these patients if they are told the rules, and the results of breaking them, such as, "if you smoke you will be moved to the adult ward." There is more freedom to move about and interact without fear if there is knowledge of what is right and wrong.

The Stages of Hospitalization

In helping an adolescent adjust to hospitalization and to understand their needs better, it is helpful to look at three stages of hospitalization namely, pre-engagement, engagement and disengagement. Abend, Kachalsky, and Greenberg (1968) cited these stages as reflecting the degree of emotional involvement the patient has with other patients and the staff. The authors state that pre-engagement is a time of denial of illness, and of reacting as isolates, fearful and helpless. Engagement, on the other hand, is when, after testing, the patient permits themselves to become involved and attached in the hospital situation and admits their need for medical help. Disengagement is a time when approaching discharge threatens these relationships and the patients become angry, hurt or disappointed. This third and final stage is reacted to in one of two ways - aggression or depression. Usually the males held the former and females the latter reaction, due to their sex role conditioning. Although this model was used in this article to primarily deal with psychiatric hospitalization, it is felt that it is readily adaptable to evaluate the process of medical hospitalization as well. There are strong similarities between these experiences.

Defiance and Aggression

Sometimes, with the hospitalization of adolescents, there is aggression and defiance during the first or second stage. Wesseling (1965) stated that adolescent amputees often become hostile towards themselves or the staff and

ward. Patridge, Garner, Thompson, and Cherry (1972) also mentioned some defiance in adolescent patients with diabetes who were pressured into assuming responsibility for care before they felt ready. Meanwhile, Showalter and Anyan (1973) mentioned that some emotional patients will at times strike out -- usually at objects not persons. They also noted that at least half and probably more of the physical damage was done by visitors to the ward, citing that this was due to the uneasiness of being in strange surroundings and seeing friends who are sick. Hammar (1968) stated, in her book, that often teenage patients are seen as "difficult" because their response to illness is unpredictable. Little (1960) stated that adolescents in the hospital also become fussy and demanding, which can lead to more serious reactions. It was assumed that this was also a reaction in the direction of aggression and defiance and Little later stated this was an expression of hostility.

Most of these aggressive, defiant and difficult reactions found in hospitalized youth stem from the insecurity that this situation impresses upon them. They often feel that they have no control over what is happening to them and they have the same lack of control over their environment. As will be noted later, several authors have stated the need to give the adolescent some control in these situations.

Depression

It was noted by several authors that, during hospitalization engagement, there are some feelings of depression. It was noticed in the articles that mentioned depression, that there was a thread of sameness in that they all dealt, as in the pediatric cases, with chronic conditions. Some of these were: a follow-up study on kidney transplant patients (Korsch, Negrete, Gardner, Weinstock, Mercer, Grushkin, and Find, 1973), a study on adolescents and young adults with cystic fibrosis (Boyle, diSant'Agnese, Sack, Millican and

Kulczycki, 1976) and a study on role modifications in the disabled male (Christopherson, 1968). Depression was not mentioned in the hospitalization of the adolescent without the chronic cause, leading to the conclusion that these cases were ones in which there was a lot of hope in the realities of getting better, but, when this hope was not present, depression more easily set in. Along this same thought is Kohlberg and Rothenberg's (1970) FAGS syndrome (fear, anger, guilt and sadness), which they noted in cases of severe illness or injury with hospitalization, in patients and their families. In this study, they noted the same syndrome in an adolescent male leading to feelings of hostility and agitation.

Death

Death is a very frequently mentioned subject among engaged hospitalized adolescents. Throughout the review of literature the authors stated repeatedly the notion of death on adolescent wards. Little (1960) suggested that this may be because adolescents are so very alive and have come to realize the totality of death and its significance. Kohlberg, et. al. (1970) mentioned the fear in his subject's reaction to possible death. Hammer (1968) illustrate the need to be honest and precise in dealing with the adolescent's questions on death in other patient's or himself, thus helping to reduce fear. This subject is brought up during this stage because there is an attachment and trust with the staff and concerns for other patients on the ward at this time.

The Coping Process

A major part of the engagement stage is the coping process mentioned by Meyers, Friedman, and Weiner (1970) in relation to girls with scoliosis treated with a Milwaukee Brace. The authors described the process as a "means by which anticipated threat or harm is reduced or eliminated."

This was done through intra-psychic defense mechanisms and motor-behavioral reactions, not involving a third category of reactions of disturbed affect. The process was considered effective by the degree to which it protected the patient from overwhelming psychological stress, whether or not the behaviors used were considered socially or medically desirable. The authors gave a suggested definition for optimal coping as "protecting the individual from being psychologically overwhelmed, yet allows for sufficient recognition of the illness to seek medical help."

Freeman (1970, p. 68) in his article of psychological problems in adolescents with cerebral palsy, has also dealt briefly with coping and has quoted Eisenberg to say (1968) "...but whether attained by drugs or by psychological means, symptom control is not an end in itself; it provides a climate in which the patient can learn more effective coping patterns." This is a vital factor to remember in dealing with a severe case of coping inadequacy leading to a disturbance. More realistically, all health care workers should be fully aware of the fact that some degree of coping mechanism use is normal and vital to the adjustment process and that, only in extreme cases, is there reason to raise concern. The mechanisms give the adolescent time to adjust to their new illness or renewed illness.

Some of the mechanisms used for coping, as written in depth by Moore, et. al. (1969) and only listed here are: denial, overcompensation, intellectualization, and anger. Moore and his colleagues also stress the problems that can arise when the coping mechanisms prove inadequate or the process is not complete. Hofman (1975) also has an in-depth discussion of mechanisms, which will be listed: denial, intellectualization, regression, compensation, projection, displacement, acting out, panic, rationalization, depression, withdrawal and isolation. She also stated that, although the ideal response

is one of "insightful acceptance whereby the patient accepts the reality of his situation without any sense of personal devaluation", this is hardly to be expected from an adolescent, or an adult.

Several other authors have also found and briefly mentioned coping mechanisms within their sample population. Kaufman (1972) and Alexander (1975) both noticed and mentioned repression in their samples facing physical illness that is life threatening. Kaufman's sample involved body image drawings and he felt the drawings show varying degrees of awareness and repression. Schowalter, et. al. (1973) and Schowalter and Lord (1971) stated in both articles, the observation of regression to a previous state in hospitalized adolescents. Schowalter, in both articles, attributed this to the adolescent's dependency, confusion and depersonalization in the hospital environment.

Patient Groups and Meetings

While involved in the hospital settings, there are many ways that the adolescent's feelings and concerns have been drawn out -- from stage 1 through stage 3, although, most of this process is carried out during the stages of engagement and disengagement. The range of programs provided are patient meetings, both voluntary (Scholwalter et. al., 1971) and mandatory (Abend et. al., 1968), as well as informal discussion groups, both lead by nurses (Cholcher et. al., 1964) and those spontaneous among the patients (Hammer, 1968). Formal psychiatric services were also mentioned by several authors as vital when dealing with some patients. Kohlberg, et. al., (1970) also mentioned the use of a pediatrician taking a child mental health fellowship, in informal talks with a severely injured adolescent. In the discussions, both groups and staff to patient, all possible topics were discussed--from routines, the reason for rules, what certain illnesses entail, parent and sibling

relationships, to roles for adolescents or the death of a fellow patient. These groups have been shown to be quite effective, as might be expected, in helping the patient to understand their illnesses, one another, death, the hospital and its routines, as well as more general information about the world and offering feedback to the hospital.

Disengagement

In relating the medical hospitalization of the adolescent to Abend, et. al. (1968) stages of hospitalization the final stage of disengagement is present but differs somewhat. The adolescent will have some mixed feelings about leaving, if the staff and ward design have truly supported them throughout the hospitalization treatment. Bach (1970) says that they want to go home, but they do secretly enjoy the care and attention they have received and they don't like to leave new friends. Some adolescents, he feels, will need to resolve these feelings by return visits. Hofmann, et. al. (1976) also expresses the strong need to make sure that a schedule of return visits for both medical and supportive care can be established. This issue takes on special significance in dealing with a new handicap or disability. Wesseling (1965) states that, often, negative feelings arise because the amputee must leave an atmosphere where he is secure in his acceptance. In dealing with adolescents, whether it is this latter case or a routine type of hospital admission, the transition needs to be well planned and, ideally, should entail emotional support, both outside of the hospital and within at the beginning if the patient needs it.

Adolescent Wards

In almost all of the articles reviewed during research, when the authors discussed the actual hospital facilities, they discussed a ward set aside

for use by adolescents only. This ward was almost always in close proximity to the pediatric section, frequently sharing a nursing station. It is felt that, with a separate facility, the staff could concentrate on the particular issues that the adolescent has to deal with and can also reduce the deleterious aspects of hospitalization. Hammar (1968) states that the anger and boredom an adolescent might have in response to being placed on a unit with infant and child noise and activities and that such surroundings would also encourage dependency and regression in some cases. The major danger in placing an adolescent on an adult ward is that adults may take advantage of the youth's ignorance and immaturity by unleashing their feelings and ideas about illness, causing considerable anguish in an adolescent.

Size

The facilities ranged in size from 15-25 beds, depending on geographic location and determined by hospital records showing how many adolescents were within the hospital each day for the last several years. One committee offered the suggestion of a flexible zone at one end of the unit where beds could also be used in conjunction with a neighboring adult or pediatric ward, using their nursing station. The authors emphasized the importance of these beds on the periphery being the only ones that are shared with other wards. To have a patient that is not within the age span, housed in the center of the unit, could disrupt the morale of the entire unit (Piel, Ewell, Rauh, Biehuse, Sparks, Hammar, Dougela, Anyan, Benjamin, Cohen and Cooper, 1973). This committee on inpatient care for adolescents also suggested a flexible age limitation as another solution to the possible patient overload.

Age

The age limits on adolescent wards in one study were found to be age 12 or 13 for the lower limits, with the upper limits varying from 17 to 21

(Rigg and Fisher, 1970). Of the articles reviewed, one mentioned 12 to 18 (Abend, et. al., 1968) and one mentioned 13 to 20 (Cholcher, et. al., 1964) as the age span accepted on the unit. The committee members from the patient care for adolescents, suggested "a mature 12 to an immature 20 with flexibility for size control of the wards (Piel, et. al., 1973).

Location

Although several hospitals isolated their adolescent area from the rest of the hospital by placing on a different floor or wing (Rigg, et. al., 1970), others only partially separate it. It must be kept in mind that the need of the adolescent to get around, to the gift shops, lounge etc., and the increased amount of noise contraindicated it from being placed next to ICU or heart patients (Piel, et. al., 1973). Most hospitals sent all of their adolescent patients to the wing, unless it was full, or the patient required intensive care, special medical services (maternity or cardiac) (Rigg, et. al., 1970) or smoking was not permitted and they wished to smoke (Cholcher, et. al., 1964). In these particular cases, their medical needs could be better met elsewhere in the hospital.

All of the hospitals separated the males from the females by area of the wing or by room assignment (Cholcher, et. al., 1964, Rigg, et. al., 1970 and Scholwalter, et. al., 1971). All of the facilities had male and female patients sharing the recreational and social areas available to the ward. The rooms varied in size with one bed facilities for the acutely ill who needs quiet, the infectious needing isolation, or the dying patient to be placed in. The committee recommended that 1 or 2 single rooms be available while the rest have 2 or 4 beds remembering 3 bed rooms can invite tension, if 2 patients continually exclude the third and that 4 bed rooms can prove chaotic during visitation (Piel, et. al., 1973).

Maintenance of Peer Relationships

The ideal result of this set up, as viewed by almost all of the authors, was an establishment and maintenance of a peer group relationship during hospitalization. This is a time in life that is focused around peers and the building of these relationships. Therefore, it is important, even in illness, to maintain this group. Piel, et. al., (1973) noted this, and the ways that the hospital peers bolster one another's morale by support and helpfulness, as well as the need for unlimited numbers of visitors. Schowalter, et. al., (1973) noted that the hospital can take advantage of this support system by communal meals, group activities and meetings. Wesseling (1965) noted the need for group belonging, especially among handicapped and disabled patients. Hammar (1968), noting the peer group support and rehabilitative effects, stated that an additional effect is that peers rapidly tire of the self-pity and the attention-seeking in fellow patients, consequently decreasing these tendencies among themselves. Certainly, this peer relationship effect is so great outside of the hospital that extended or unrestricted visiting by peers from outside, with respect to age, number and amount of time spent, is desirable (Bach 1970, Cholcher, et. al., 1964 and Hammar, 1968).

Food

Taking advantage of the peer relationships and helping to create environments in which they can be established, are very important in hospitals. This can be facilitated in several ways, one being the patient meetings and discussion mentioned earlier, and others being through food and recreation. Food is a central thought in adolescence. The staff can take advantage of this by group meals, as mentioned above, and through the use of vending machines (Bach, 1970) or snack kitchens in the social areas (Piel, et. al., 1983). Food and socialization tend to just go together in adolescence due to the greater

caloric needs, especially when ill (Bach, 1970 and Piel, 1973), and the equating of nutrition with nurturance that takes place in uncontrolled situations (Schowalter, et. al., 1971). Snacks provide ample opportunities for such interaction in both the afternoon and evening hours. Cholcher, et. al., (1964) and Hammar (1968), among many others, noted the need for second and third helpings but also discussed need for familiar foods such as hamburgers, hot dogs and milkshakes. A time of illness is not time to push foods not normally eaten, nor to correct food habits or whims, although this might be a good time to offer some nutritional education. The important thing is that the adolescent receives proper food and fluid intake in an atmosphere of friendliness and acceptance.

Recreation

Recreation is another time when peer group bonds can be established and fostered. The central area for this activity would be a lounge with a television and radio or stereo, as well as many games, hobbies and room for personal recreation, such as guitars and sewing (Bach, 1970 and Duran, 1972). The recreational room should be large enough to accomodate a pool or ping pong table and crowds that will gather for activities, such as song fests or puppet shows (Piel, et. al., 1973). An adolescent often responds to illness much as a young child does, in that there is a lot of activity only a short time after severe illness or surgery (Hammar, 1968). Girls will more often better tolerate reduced activity than boys and they will be satisfied with more sedentary activities. The boys however will want to have some activity, such as pool or ping pong (Bach, 1970). It is important to remember that adolescents have different interests than younger children, so their games can not be leftovers from pediatrics. Bingo and Old Maid are about equal in interest to the adolescent but it is a lack of interest, rather than an interest, in each case.

Schowalter, et. al., (1971), in their hospitalization of adolescents article at Yale-New Haven hospital, noted that there was a ward newspaper created to help patients ventilate their feelings and create group bonding through a common effort of the patients. The effort was successful not only in these areas, but also in creating a recreational and educational experience, as well as increased self-esteem, in those patients who have had their creation printed. It should be a small enough group that everyone who wanted to try could have something published and reap the benefits of increased sense of worth. Not only the dimension of recreational but also time-consuming educational efforts need also to be noted in helping the adolescent patient.

Education

In dealing with the education of hospitalized adolescents many things have been noted. Cholcher, et. al., (1964) addressed this need by noticing that, during the school year, the most used volume in the teen's library was the World Book and that the patients, hospitalized for long periods, needed to continue their efforts through the public school systems' tutors. Other authors have noted the need for the adolescent to not let his studies slide, due to the pressure of so much school work at this time and the need for completion to graduate and admittance to college (Bach, 1970, Hoffman, et. al., 1976 and Piel, et. al., 1973).

All of the authors, discussing the education of hospitalized adolescents, stated that the local school boards supplied the teachers and that the students earned full credit for work at the hospital. Some of the teachers worked with the regular teacher's topics and schedules, so that the students would be at the same point in studies as the rest of his class when they returned to school (Bach, 1970, Cholcher, et. al., 1964, Hoffman, et. al., 1976, Piel, et. al., 1973 and Wesseling, 1965). The great importance of this effort in education

may seem insignificant in short-term care but with long term hospitalization or in repeated hospitalization, the effects of no program can not be over-emphasized. Whitehouse (1964) noted the effects of such situations in his study of cardiac adolescent patients. He found that these patients had a greater academic deficiency than others and that they had a higher drop-out rate. Whitehouse attributes this to more misses of school, overprotection, and the patient's own attitudes.

Privacy and Modesty

Another issue, that needs to be dealt with in hospitalized adolescents, is the great need that adolescents have for privacy and modesty. This need must be respected and protected by the staff members. Adolescents have a true fear of the lack of privacy and it is important that there is reassurance by the staff, even if the question has not arisen. Hofmann (1976) and Piel, et. al. (1973) have stated, several times throughout their writings, that the need for privacy is strong and full-length curtains completely around the bed area and on windows are essential. There is a more intense reaction of having to disrobe in front of others, including medical staff, in adolescence than at any other time (Hammar, 1968, Hofmann, 1976, and Little, 1960). Because of this, Schowalter, et. al. (1973) has suggested that there be individual visits by the physicians, rather than group physician visits. Bach (1970) has also mentioned the need for modesty and privacy, especially in dealing with bedpans, urinals and bathing and toilet facilities. He stressed that all dealings with bedpans and urinals be explained clearly, without embarrassment, and, once the patient has gained mastery of it and no longer needs assistance, they should be left alone. All bathing and toilet facilities should be in individual stalls and clearly marked, on the outside door, "male" or "female",

in addition to "bathroom".

Related to the area of modesty and privacy is the issue of the type of clothing that should be worn. All authors on this issue stress that there is no desire or need for most patients to wear hospital gowns. Bach (1970) stressed that regular pajamas only, should be worn by both sexes and they should be of the appropriate styles for both age and sex, if given by the ward. In other words, it is better to give a smaller male solid pajamas too large for him, than the proper size with juvenile prints on them. Duran (1972), Hammar (1968) and Piel, et. al. (1973) all stressed the use of home day and night clothes by adolescents for comfort, security and body image increases.

There was brief mention of chaplain's presence and religious programs available on the wards (Cholcher, et. al., 1964 and Wesseling, 1965). The major function of these programs were to establish meaningful relationships with the youth and to give them emotional support when needed. There was caution against the attempts to force any youth to become involved in religious programs but the need for them was also expressed.

Rules on the Ward

Another very important design function of the ward is to establish and maintain rules. As was stated earlier, Hammar (1968) believes that the rules are less likely to be tested by the adolescent, if they are clearly laid out and the consequences known for violations. Duran (1972) proposed that this is one of the roles of the staff during orientation to the ward upon admittance. Cholcher, et. al. (1964) stated that, in their hospital ward the rules are spread, largely by word of mouth, among the patients. The rules they listed were "no smoking" and "isolation for upper respiratory infections". Piel, et. al. (1973) suggested, that the committee agreed rules were necessary to

regulate activity and behavior on the unit but, at the same time, the fewer the rules the better, and those established should be reasonable and enforced. These should include rules about common issues, as smoking, clothing, lights as well as visiting hours and ages. It is vital to remember that these boundaries will give the adolescent security in their new surroundings-- but only if they are informed of them.

Staffing the Adolescent Ward

The staff is also an integral part of the ward and, therefore, needs to be chosen within the light of the functions and goals of the adolescent ward. It is very clear, but still necessary, to state that not all people are created to work with adolescents. Schowalter, et. al. (1973) stated that some staff members identified too closely with the adolescents, becoming too emotionally involved, and others had difficulty in dealing with the boisteriousness of the adolescent ward. Cholcher, et. al. (1964) also realized the difficulty some staff have with this issue, in their requests to work elsewhere in the hospital.

Interest in Adolescents

Hofmann, et. al. (1976) also approached the need of looking at more than mere educational background in staff selection. "Optimally, staff should have a liking of, interest in and sensitivity to the adolescent--coupled with maturity, flexibility, and a willingness to 'tune-in' to the patient and his anxieties." They also reminded that, although experience with this age group is helpful, it is not mandatory. Bodhinayzke (1975) suggested that the personality of the physicians working with adolescents is of prime importance. He said they should be "genuinely interested in teenagers as persons and mature and open-minded in his approaches to them." This is typically not the case with most doctors who see adolescents. Janeway (1973) wrote that Dr. Gallagher's

emphasis in staff selection is on listening ability and interest in these patients.

Staff and Parents

Another important factor in selection of staff is the ability, not only to relate well to the youth but also to be able to relate to and support the parents as well. Janeway (1973) stated that Gallagher stressed the importance of not neglecting parents but hearing both sides of the story, so that a "complex story of misunderstanding and rebellion which either might be the direct cause or the reason for exacerbation of the patient's symptoms" can be heard. Bodhinayake (1975) and Duran (1972) also stated the importance of being able to communicate with the parents in order to get histories or more facts and to help illicit a group effort in the process to return health.

Hofmann (1976) clearly stated the potential of the staff's disregarding the parents' interests or always standing on the patient's side. "If a staff unilaterally ally themselves with the patient, either as a better parent substitute or as an overidentifying youth advocate, there will be inevitable competition with the true parents and a resultant struggle for control over who is really in charge and who cares most." Too often, parents are not viewed in the proper perspective of collaborators in care but are seen instead as a bother to be dealt with.

Age of Staff

A major issue in the selection of staff, is the use of young staff and medical students to work with adolescents. It seems that these younger persons can generally relate to and be more empathetic towards a hospitalized adolescent. This empathy is found to very useful but the proximity can also cause problems (Schowalter, et. al., 1971 and Schowalter, et. al., 1973). Schowalter, et. al., (1973) showed that younger staff sometimes have more trouble coping with obscene

gestures or profane remarks, both of which are common on the adolescent ward. They have noted, in both of his articles, that this empathy leads to over-identification sometimes and that this may cause the staff to find it difficult to administer (Cholcher, et. al., 1964) medical procedures. They also cautioned very strongly against romantic feelings between staff and patients and the flirtations or crushes that can arise, leading to hurt feelings. They found no evidence that any member of the staff has responded in a sexual way. It was also recommended that flirtations between staff members be curtailed completely in the adolescent ward, once again to prevent hurt feelings or jealousy. These possible problems, in dealing with the adolescents so close in age to the staff, are a small risk in comparison with the benefits of the added empathy and closeness in such a relationship.

Trust in Staff/Adolescent Relationship

Trust is an essential part of the staff-adolescent relationship (Duran, 1972). It is in these feelings of honesty and trust that the adolescent can let go his fears and continue to strive for independence, even though hospitalized. Janeway (1973), in speaking about Dr. Gallagher, told of his great faith in the patient's capacity for change, once the problems and anxieties were dealt with honestly by someone they could trust. Wesseling (1965) noted the important role that this trust plays in a surgical amputation patient. Wesseling felt that, if a relationship of mutual trust and acceptance was established, the adolescent would feel free to ask questions about his case. Hammar (1968) went further to say that the adolescent seems to appreciate knowing that he has a link with some one person in the hospital who will be responsible for their care. If there is contact with one person in general, most likely a nurse, then the establishment of trust occurs more quickly and is stronger.

Honesty with the Adolescent Patient

Hand-in-hand with this feeling of trust, and indeed necessary to establish this trust, is honesty with the patient. This theme has already been presented by Duran and Janeway, in the above discussion on trust building a relationship. This trust is also vitally needed in dealing with the numerous questions that an adolescent will ask about themselves, their conditions and fellow patients. Now that the adolescent has reached a stage where they know enough about the body and how it works, they will question procedures and why they are needed for conditions they have. Cholcher, et. al. (1964) noted that teenagers are plagued with the same disorders as adults and that they ask about specific ailments and expect answers from the staff. Not only do they expect answers, they expect honest answers. Moore, et. al. (1969), in the discussion on coping mechanisms, suggested that, when intellectualization is used, both the overt and hidden meaning of their questions should be explored. They emphasized the adolescents' lack of tolerance of dishonesty and discussed it. Moore and his colleagues stressed that the staff-patient relationship will be undermined or destroyed, if the doctor does not answer questions seriously by giving adolescents the facts, but instead emphasizes the favorable aspects of their condition. Hammar (1968) also noted that it is best to be honest with teenagers, while incorporating supportive remarks into the discussion.

Staff Support

Integral in the relationship of trust and honesty, is the fact that one of the roles of staff members is support. Mason (1965) noted that, with showing respect for the child as an individual, the staff supports the child so that he can cope with his conditions and uncertainties. Duran's (1972) article entailed trust in a relationship under the sub-title of support for the adolescent. Other ways of giving support were through honesty, limit-

setting, understanding, discussions of his expectations in hospitalization and, of course, the establishment of a relationship. Myers, et. al. (1970) also stressed the support of the staff in the continued wearing of a brace by girls with scoliosis, especially the physical therapist. It seems also that in cases where improvement has been made, it would be supportive to remind the patient of how far they have come and the positive aspects of the remaining care. This, very often, is an encouragement for the adolescent to continue in their rehabilitation.

Staff Teamwork

In addition to support, another very vital function of the staff is teamwork. If there is not working together, the end result at the very least will be a patient whose adjustments and case has some loopholes in it. Christopherson (1968) notes this in the case of helping disabled males adjust their social life to fit their new circumstances. "It is very easy to assume that someone else on the team will attend to the matter." Sometimes the teamwork is needed in the comprehensive health care unit, those concerned with the health of a patient. At other times, the teamwork is needed in the case of all or most of the people working with the patient, from the health care unit to teachers, school administrators or those involved in their recreational activities. The former could be as in Myer, et. al.'s (1970) discussion of staff support. They could include: orthopedic surgeon, physical therapist, brace-maker, secretaries and school nurses. Such a comprehensive health care team can stand ready to consult, give anticipatory guidance, and offer their services to patient and family, individually and in groups (Korsch, et. al., 1973). The latter cases are used to educate staff outside of the health team and to gain feedback on concerns and needs. Continued interpretation of the patients'

prognosis and treatment are given by the doctor to parents, teachers, school workers, camp workers and counselors (Moore, et. al., 1969 and Whitehouse, 1964). Whitehouse stressed that this is due to the fact he has found some cardiac patients, who were perfectly fit to be involved in some activities but were not allowed to participate, because these people remembered the past restrictions and haven't been updated.

It is vital also that staff for the medical care meet and discuss the patients and their progress, so that future actions can be decided and present concerns aired. This will help the adolescent in that there is a consistency in the way he is dealt with and the staff is kept up to date on recent additions to his conditions. Kohlberg, et. al. (1970) and Wesseling (1965) both stressed this in dealing with amputee patients, due to it's effect on the entire patient outlook, not just the limb. Hofmann, et. al. (1976), Piel, et. al. (1973) and Schowalter, et. al. (1971) among others, suggested that this is accomplished through routine weekly staff meetings.

Staff as Role Models

Adolescents were in a very deep stage of identity seeking and staff can often serve as role models. There are two ways the staff can provide this function. The first is merely as an adult giving support, in that they have reached adolescence and stretched beyond it, into maturity (Duran, 1972). There is an extreme amount of relief in knowing that others have made it through the difficult times you are going through now, and have gone on. Allen, et. al. (1976) also feel that physicians and medical students serve as stable role models for the adolescents involved in medical services at a crises intervention center, through emotional support as well as modeling.

Anger at Staff

The staff has an additional concern in dealing with adolescents who have

chronic illnesses. These adolescents can be expected to be angry at the staff because they are not getting well, as this is very difficult in a health-oriented society. These patients assign the task of restoring the health of their bodies to the doctors and nurses and they often express anger with them for not supplying results (Little, 1960). In looking through the articles on adolescents with chronic illness, the authors frequently brought up this anger. Armstrong (1975) found it in dialysis patients and Kohlberg, et. al. (1970) and Wesseling (1965) both mentioned it in treatment of amputees. Hofmann, et. al. (1976) stated that anger, directed at staff members, usually occurred when the patient's condition is "unresponsive to even the most vigorous application of medical skills, when the very best of diagnostic efforts fails to reveal the cause of serious symptomatology, or in other such cases when the staff must deal directly with their own inability to help."

Hammar (1968) brought up two more points about which the staff members dealing with adolescents should be informed. There is the issue of how much to tell the adolescent about his condition and the medical procedures to be used. Hammar says that the two best determinents of this are maturity and curiosity. What you would tell a 12 year old would be much too simple of an explanation for an 18 year old. The second concern of Hammar is that an adolescent needs to find more discomfort than pleasure in his illness. "His character and outlook on life are in formative period, and if he derives satisfaction from the attention he gets because he 'is sick' his immediate recovery will be delayed," p. 27. An additional concern is that, in difficult situations, he may revert to illness in order to obtain attention or avoid the realities of life. Hammar also adds that this type of behavior is unconscious, not deliberate. This last statement should be kept in the front of the mind of any staff member dealing with this situation. They should

constantly be on guard against reinforcing these behaviors, as well as informing the parents of their teenager's real needs, so that they won't reinforce either.

Tasks of the Adolescent

There are several "realities" or issues that adolescents have to deal with in their lives. Hospitalization can sometimes complicate these concerns, especially if staff members don't realize they are quite normal and very real to the adolescent. Among these concerns that hospitalization can have an effect on are: independence, body image, new relationships with parents, sex roles and role development. Next, these issues will be discussed in light of how hospitalization can affect them.

Independence

First and foremost in the adolescent lifestyle is a striving for independence. This independence is most observably manifested in defining a new relationship with one's parents who, up until this point in the child's life, have had control. This new increased focus on, and demand for, independence has been referred to by several authors, as needing to be noticed by staff members working with adolescents (Bach, 1970, Boyle, et. al., 1976, Duran, 1972 and Fuszard, 1969). Duran (1972) stated that this drive for independence leads to a unique and separate identity for the person. Fuszard (1969) stressed that independence is as much a part of adolescence as motor skills and walking are to toddler development.

As a result of the enforced dependancy and, therefore, the lack of independence in hospitalization, there are many different reactions given by adolescents. Hofmann (1973) and Little (1960) both mentioned that this is a threat to newly found independence, in that they have lost control over

their actions and body. Mason (1965) noted that these feelings can result in resentment towards staff and the hospital situation. Schowalter, et. al. (1971) described the reaction may be more function of the inability to display either independence or dependence. Hospitalization prevents the display of true independence and the adolescent's self concept prevents the display of dependency. The adolescent is stuck in the middle. Freeman (1970) noted that this independence is often delayed, in the handicapped or chronically ill child, due to their lack of experience and opportunity. Partridge, et. al. (1972) showed the effect of the diabetic patient's striving to gain independence by taking total responsibility of care too soon. He noted that this often caused or intensified later defiance. In the diabetic patient, this rebellion against the regimen can be fatal or have serious consequences.

Establishment of New Relationship with Parents

Inherent in this search for independence is the pulling away from parents and establishing a new relationship with them. Armstrong (1975) and Bach (1970) both stated that this is a time of establishment of new relationships with parents, with difficulty in denouncing dependency strivings and emerging as independent from one's family. Hammar (1975) stated that, in early adolescence, only the beginning of this emerges and the true separation from parents to establish oneself occurs in mid-adolescence. It is in late adolescence that, after finding his independence, the person realigns his relationship with parents on more adult-to-adult terms. The staff, in developing a relationship with the parents of a hospitalized adolescent, can support the adolescent's striving for independence by explaining his needs to them and helping the parents to meet those needs. Illness, whether acute or chronic, does not stifle the adolescent's need for independence. Hammar pointed out also that the adolescent has increased strength in dealing with his illness if parents

don't expect him to regress. Often times, the parents take an illness as one more opportunity to baby their adolescent and keep him close to them.

Body Image

Another concern of the adolescent is his body and the rapid changes that occur as he matures (Hammar, 1968 and Moore, et. al., 1969). This concern for and awareness of his body is centered around the adolescent's body image. Freeman (1970, pg. 65) said that "the child's concept of himself and his body image are related to the ways in which he experiences success or failure in using his body, and the meaning he attaches to the attitudes of others towards him." The adolescents' body awareness is increased during illness because of their desire to maintain the rapidly changing body image (Hammar, 1968 and Schowalter, et. al., 1971). Koegler (1957) said that the anxiety an adolescent feels about his own body, as compared to others, is a normal phenomenon that also brings into view any physical defects. Moore, et. al. (1969) also brought up the point that any physical changes due to therapy or medical care only complicate the adolescent's adjustment to his already rapid body change. Greenspan, Shute and Tuss (1977) noted that, for some, feelings of bodily damage are aroused by their temporary or permanent loss in some body function.

Different types of illnesses and conditions illicit body image changes that Kaufman (1972, pg. 169) feels the child reflects in his drawings of his body parts. "The alteration of body image and the restitutive measures to restore self-esteem are seen as a deeply meaningful indicator of a child's reaction to illness and hospitalization." In another review of body image drawings, Kaufmann and Hersher (1971) stated that the changes in self-representation would involve the total effects of the illness on the child, as well as its meaning for the family, peer group, community and that child's

specific stage. Boyle, et. al. (1976) noted in their subjects with cystic fibrosis, that, during interviews, all of them expressed dissatisfaction with their bodies. This, Boyle and his colleagues later showed, effects in the patients' self image. Green (1976) noted that boys following emergency surgery had high frequencies of mention about body functions and appearance which gradually decreased. "Recovery was noted by a decrease in expression about body sensations, endurance, intactness and impairment and an increase in expressions about improvement." As one improves, they are more confident that they will continue to do so and will talk about it. Finally, Duran (1972) noted that the relationship a nurse has with the patient can be used to help the adolescent accept a change in body image due to surgery or a change in treatment.

Self-concept/ Self-esteem

Involved very deeply in the adolescent's body image is the issue self-concept and self-esteem. While discussing body image, it was noted that both Boyle, et. al. (1976) and Kaufmann (1972) believe that the body image changes--either negative or positive, also showed in the patient's self concepts, Korsch, et. al. (1973) also noted severe damage to the self-esteem of children belonging to the renal samples (kidney transplantation) and with a small control sample of children with cystic fibrosis. Moore, et. al. (1969) spoke in depth on the topic of self concept. He and his colleagues believe that this is an age when "belonging" is so important. "The feeling that he is not like others because of the defect that his illness represents to him produces a feeling of inferiority and loss of self esteem." They also encouraged that an adolescent patient, who has improved, be returned to prior activities as soon as possible, in order to alleviate these feelings of being different. Koegler (1957) also noted the strong

feelings of "being different" and their effect on adolescents' self concepts.

Role Definition

Another major task of the adolescent is role definition. In addition to gaining independence, the adolescent must strain to find out who he is, what his sexual identity is and what his occupational and familial roles will be (Hammar, et. al., 1976). In dealing with the issue of hospitalization, the literature centered its comments on the sexual, occupational and familial roles that may be changed or effected by the illness or treatment. The issue of who he is was briefly covered in the discussion of self-image among ill adolescents.

Sex Role

Sex role identities were mentioned frequently in the literature. Indeed, this is a central theme during adolescence for all youth. This struggle within the adolescent not only effects himself but the familial and cultural expectations as well. To build this identity and gain a role for it, the adolescent first has to contend with his rapidly changing body and new feelings (Hammar, 1976). In the hospital, these issues still remain but are added to by the additional struggles.

Little (1960) said that, in the hospital, those adolescents, who have had some question about their adequacy as male or female and who have struggled against playing very passive and dependent roles, will find themselves tempted to give in. He warned that this may produce violent counterreactions or they may just relinquish the assertive and aggressive role. Bach (1970), Hofmann (1975) and Schowalter, et. al. (1971) all noted that this is the age where strong sex roles are established and that this process can be undermined by the lack of independence and by the physical procedures done during hospitalization. Boyle, et. al. (1976) noticed, in their sample of cystic fibrosis patients,

that secondary sex characteristics were often delayed and this so severely effected these patients that they had fears of sexual inadequacy in marriages later in life. In figure drawings, 17 of 27 patients made drawings with a striking denial of sexual differences. Christopherson (1968) stressed the importance of helping the disabled male cope with the need to change his sex role to prevent the psyche from responding with the withdrawal and passive role modification that often occurred when no guidance was offered. Freeman (1970) offered another view of sexual role development in the handicapped (cerebral palsy) adolescent. He believed that the main reason these people have problems in sexual roles and identities, is that they are supervised so closely that they can't get away and experiment, as the normal adolescent can. This is a very valid possibility for some of the reaction to sex role fulfillment but other possibilities need also to be considered.

Future Roles in Occupation and Family

In dealing with a look towards the future and roles of occupation and families, the results varied, mainly due to whether the illness is chronic or not and whether it has been arrested or cured. It is important to remember that these processes of different role definitions are not separate. They all are going on at the same time and are intermingled together. If there is a change to be made in one role, then it is likely to affect the others. Freeman (1970), in the case of chronic illness, stated that this is the time when attitudes towards the future must be modified due to the fact that the adolescent (and his parents) must gradually give up the fantasy of being cured "some day". Hofmann (1975) noted that the roles of the future are looked at seriously in late adolescence and that this is when illness poses the greatest problems in role decisions. This is especially true if it affects a dating relationship, a marriage and family plan, or educational and occupa-

tional goals. On the other hand, Korsch, et. al., (1973) noted that kidney transplant patients, who are over the crisis period, had career plans, optimism in social life, school experiences and enjoyment in the future.

Moore, et. al. (1969) noted that adolescents with life threatening illnesses wondered what to do about the future. Here the doctor is faced with giving honest answers without either destroying hope or encouraging false optimism. They help the patient who has adjusted well by discussing the illness with him, to help enable him to adopt a realistic outlook towards the future and to make plans, although reminding them that these plans may be disrupted for treatment and recurrent disease. Christopherson (1968) noted that, in the disabled male, often downward modifications of roles for occupation have to be made and the loss this makes the future family suffer. Christopherson noted the facilities available for vocational help and warned against the family remaining too skeptical and overprotective. The modifications need to be dealt with honesty and gently by the staff. Boyle, et. al. (1976) noted a very strong reaction of fear towards the future in cystic fibrosis patients. In addition, they would go to great lengths to avoid discussing this. They noted that the common reaction was to look back rather than ahead and to avoid any thoughts of the future. It is obvious that, in cases of chronic or recurring life threatening illnesses, the issue of the future is a hard one and that needs to be helped by a team of professionals.

Control and Self Care

Tasks, that the adolescent takes over through his new independence, are to make his own decisions and to start his own care routines, unassisted by parents. In the case of illness or a chronic condition, this is a much greater act of responsibility than in a normal adolescent. It is in the hospital that the adolescent feels dependent and as if he has lost all control

over his body and the situation he is in. Hammar (1968) and Wesseling (1965) both stressed the need for the adolescent's right to make decisions on his medical care or, at least, have an input into the process. Wesseling stressed that they are often confused in many ways but they need the love, protection and guidance of parents and adults. At the same time, they need to be permitted to make some of their own decisions and even mistakes. Hammar also stressed this need when choosing which ward to be in, if there is no adolescent area. These are ways the patient is given back some of the control he has lost in his illness and hospitalization.

Duran (1972) reported that it is the trusting relationship between adolescent and nurse that permits the adolescent to gain confidence in taking care of himself and his condition on his own. She has reminded us that turning for help at this time can also be a very difficult thing to do and that the adolescent should not be humiliated in these cases, when he does ask for help. Janeway (1973) also stated that Gallagher believes that part of the emphasis in dealing with adolescents is making them take responsibility for their own health care, rather than letting it cause problems between the generations.

Partridge, et. al. (1972) and Wesseling (1965) both noted the helpfulness of having the reasons for procedures explained to the patient and parents so that they will be less resistive in continuing the care. Partridge, et. al. (1972) made a note of the importance of the adolescents' desire to take over the care (in diabetes). They found that, in variance to the stereotype diabetic adolescents often want to take responsibility to their medical and every-day living care earlier than their normal peers. It must be stressed, in these cases, that learning to assume complete responsibility takes time and occurs gradually. Therefore, all of the care can not be left to the adolescent but rather a bit by bit turnover of the care under supervision is best.

Finally, it is helpful to mention the "learned helplessness" model and the possible intervention of the medical team's striving to increase a person's "perceived control over, and his understanding of the predictable aspects of his illness, " (Dirks, Kinsman, Jones, Spector, Davidson and Evans, 1977). Adolescents are probably less likely to fear and lose their feeling of independence if they perceive an increased control over their situation. This could be an extremely helpful technique if incorporated into an adolescent health care unit.

Hospitalization and Family Life Education

An important asset in the care of patient, either a child or an adolescent, both from a medical and emotional standpoint is the involvement of the parent. It is here that the family life educator can be of great assistance. No longer should the attention be just the patient but the family of the patient as well. The family life educator's role, by no means, begins here. There is plenty of room for them before the start of the hospital experience but the author will deal mainly with this issue. An educator of this type can deal, at least partially, with all the issues this report has covered as concerns and threats to a child or adolescent in the hospital. In this third section of this report discussion will center on some aspects of what a family life educator can do in a hospital situation.

An Unfulfilled Need

Ironically, the ones, who are in charge of the adolescent or child patient and to a great extent are responsible for their current situation, are the same people who are trained primarily, if not totally, to deal with the physical needs, rather than the totality of their patient's needs. The effort here is not to suggest a lessened importance of the medical team.

On the contrary, they are the reason for the hospitalization effort to improve the health of the patient. The point is that they are little trained to deal with the patient outside of their physical needs and yet, quite often, they have become responsible to do just this, or see that it is done. Once again, everybody's business becomes no one's and the needs are too often left unmet, as the job has been delegated to other medical personnel (nurses, etc.) equivalently untrained to handle the situation as the doctors.

Training of the Family Life Educator

The needs of the hospitalized child and adolescent, as well as their major concerns and reactions, have been adequately covered in previous section of this report. These behaviors and thoughts, to a great extent, are a function of their developmental maturity and psychological state. The family life educator is trained in the development of humans from birth to old age and is aware, not only of the general needs of these patients, but also those of their parents and siblings. Often a parent's ability to respond to the child is relative to the parents' own level of maturation. The needs of the hospitalized child and adolescent may vary somewhat, due to the effect of the illness and the hospital experience. The family life educator has usually been trained in family interaction patterns and can look at the effect of hospitalization on the entire family, as well as the individual child. These effects on the child also create changes in the family and the effects on the family create changes in the child.

Role of the Advocate

The family life educator, with this knowledge, can help the hospitalized child or adolescent to deal with some of these issues during hospitalization. They can help the child begin to separate the fantasy from reality and can help them to work through their fear and anxiety. Very often, the child, as well as

the adolescent, finds the support of someone outside of the medical profession a great comfort. The educator is dressed in street clothes quite often. This helps to open the lines of communication, especially with the young child. The family life educator often can step into a role of advocacy for these patients. The child, it was noted earlier, is threatened by the new and strange surroundings of the hospital, often without his parents, and feels a loss of control over his body care. At the same time, the adolescents and parents are having similar feelings to an extent. The adolescent is particularly fearful of enforced dependency and loss of modesty and the parents feel a loss of their role as parents in these unfamiliar surroundings. In the role of advocate, one could take the opportunity to help gain some of the control back for both the patients and the parents. One also needs to be an advocate of the child/adolescent to their parents and vice versa. This control promotes a more active role in recovery rather than a passive role. The literature, cited in earlier parts of this report, seemed to find beneficial the effects of giving some control to the patients and their families, such as rooming in, the control of having visitors, obtaining food, etc., as well as the benefits of the activity of having control over the passivity that sets in if this is not done. These are all just small things but they give a great sense of well-being to the patients and their parents.

Role of Educator

In the role of advocate to the parent, the family life educator is in need of this parent education skills. The strongest reaction to hospitalization are, as stated earlier, a function of the child's/adolescent's developmental maturity. Perhaps, the most comforting thing a parent can hear at this stressful point, is that the child's or adolescent's present behavior is due, in a large part, to this maturity and that the current hospitalization is usually

only temporary. There is a great need for this education when a child or adolescent exhibits regression, aggression, depression, denial or anxiety. Sometimes the hospitalization is the first chance a parent gets to see their child use this behavior and it is very confusing to both of them. The family life educator can explain why this is happening and help both of them work through their feelings on it. The family life educator, at the same time, can help the child by using some simple techniques for self-awareness and understanding of the hospitalization situation. During this time, the educator can also teach the parents to use the same techniques themselves with their children. The parent often does not realize the therapeutic value of play and lets all the opportunities to help children work through the hospitalization with play slip by. This is not due to the parents lack of concern, but, rather to their lack of knowledge in helping the child deal with this.

The adolescent rarely uses play to work through their feelings but can be helped through techniques that are supportive of their needs. Once again, the parents can be trained to be of assistance to their child. This is not to suggest that the parents should expect regression in their adolescent or coddle them but rather that they be of support to them. Schowalter, et. al. (1973) stated that, too often, parents see illness in an adolescent as one more chance to "baby" them, rather than trying to give supportive care. They suggest that parent group meetings could help the parents adjust to the adolescent's varying health needs. As was mentioned earlier, Duran (1972) noted that adolescents feel more strength in dealing with their illness if the parents don't expect regression. There was other mention of parents trying to elicit dependency, long gone by, in their ill adolescent. This usually results in being an explanation or discussion group for parents about

the independence/dependence needs in adolescents.

Role of Guiding to Acceptance

In the case of a serious or chronic illness or disability, there is a lot of helpfulness in guiding the parent to develop a healthy attitude about their child's condition. Janeway (1973) stressed that, in Gallagher's view of care of the adolescent, the parents were not to be ignored, but rather listened to and dealt with in an informative manner. Kohlberg, et. al. (1970) noted that in the case of an adolescent boy with life-threatening injuries, the parents were often included in informal discussions held among house and nursing staff members. This was an excellent way to help the parents understand the patient's conditions and the needs he had for rehabilitation.

This role could be filled, to some extent with the family life educator offering to have supportive talks with the parents that are informal in order to deal with those issues involved in family life education. Armstrong (1975) found that dialysis patients differed, according to whether they had weak coalitions or strong ones with their parents. There is great possibility for parental support in the patient's concerns if there are strong coalitions. It is these patients, supported by their families, that seemed to be doing better. Wesseling (1965) noted that parents need to be encouraged to develop a healthy attitude, through education and support, so that, when their child turns to them for help, they can be a help, rather than a hinderance.

Changing Interaction Patterns

Parents can be helped to review old "bad" patterns of communication or interaction with their children, because they are frequently disrupted by the hospitalization. By this breakage of interaction patterns, it is easier for educators to start new, more productive patterns. Mason (1965) showed, in his article, that hospitalization is a crisis situation most of the time. By

the nature of the crisis situation, it is seen as a significant time of stress as well as an opportunity for learning. Mason proposes this is just the time to begin any learning that needs to take place. It is not proposed that this occur immediately upon admission to the ward but after a period of adjustment. At times, a child's behavioral response is illness or a symptom of it. Toister, Condron, Worley and Arthur (1975) showed this in a case of chronic vomiting in a 7 month old child. The mother had unknowingly conditioned the child to exhibit this behavior. This is a case where the problem turned out to be behavioral, rather than medical, and the solution was to teach the mother not only how to modify the behavior but how to exhibit better interaction with the infant was well. In this case, the mother should have been taught to give the child frequent handling and attention when the vomiting was not present.

Parent Groups and Meetings

It was noted, by authors in several cases, that often, if an illness is chronic or a disability permanent, there was a lot of support in meeting another family who has already had this experience (Christopherson, 1968; Myers, et. al., 1970 and Wesseling, 1965). It was noted also that, in experiences of day to day adapting to a new life style, other families could be more helpful than the medical staff. This would be especially true in cases of physical disabilities or conditions. Parent groups can also be used to help the parents develop comradery among themselves to be supportive of one another. There would be advantages to having parents, at different points in the hospitalization, all together so they can share the feelings at different stages in the hospitalization, just as the children did in the groups which were discussed earlier (Sheridan, 1975).

Through these groups and the efforts of family life education, one can guard against a lot of the negative aspects of the hospitalization or, at the

very least, make others aware of them. In addition to this, the effects of hospitalization of the child or adolescent can be reduced, not only by the support methods already started in hospitals, but even by those that are just beginning to be looked at. Those that come to mind are self-esteem, post-hospital upset, the effect on the peer relationship and the effects of hospitalization and illness on the body image. These are not the medical implications of the hospital experience, but rather are the implications for the patient and their family as a whole.

Fostering Parental Support

In Myers et. al.'s (1970) study of girls in Milwaukee braces, it was mentioned that the families continued support and praise were vital in keeping the girls wearing their braces and continuing their exercises and normal activities. This support was noticed lax in those families with personality problems in the parents or marital conflicts. It seemed that they were busy dealing with these problems and didn't have time to offer support to the girls. Boyle, et. al., (1976) noted that the better adjusted patients with cystic fibrosis were those whose fathers remained involved, whose mothers allowed independence and whose families had open communication about the child and his condition. In a situation where these three things take place, the child felt secure and believed that he had the family behind him in his efforts to deal with his condition. Kohlberg, et. al., (1970) and Wesseling (1965) both noted the need for continued parental support, when their child faced difficulties in adjusting to his amputation.

Family Problem Effects on Hospitalized Child

It was noted earlier in the report, the importance for the staff to be aware of the child's/adolescent's family and some of the effects they might

have on the child's/adolescent's hospitalization. In particular, the same issue of family problems, in relation to family support of the child, was raised when there are family problems evident, when there is frequently a lessened support, or when there is a lack of support for the hospitalized child.

Hospitalization and the situations affected by it do not, by nature, reduce problems. Rather they are usually indicative of creating them. The child or adolescent, Sheridan (1975) stated, is the focus of the hospital attention, with little thought to the problems or concerns of their families'. This lack of attention to the family does not help to resolve any existing problems of the family but instead ignores them, in many cases allowing these to get worse and others to pile up. It is here that the family life educator can intervene for the family and offer support to them.

Problems of Hospitalization Effect on the Family

The effects of the problems of hospitalization on the family tend to be greater in the event of long-term hospitalization or repeated hospitalization, due to chronic illness. These are the cases who need the help of the educator to work through these concerns. Parents need help to deal with the disruption of the family, possible relocation near the hospital, farming out of siblings to relatives or friends and the stresses caused in the marital relationship (Adams, 1976). Many authors mentioned problems in dealing with siblings, usually dealing with their jealousy of the attention the ill child is receiving or what to do with them while one parent is working and the other is at the hospital, or if both need to be at the hospital (Natterson, et. al., 1960; Korsch, et. al., 1973; Adams, 1976 and Jolly, et. al., 1977). Illness in a child or adolescent can make it difficult to discipline them in that the parents get so wrapped up in the child's or adolescent's condition that they

don't realize they changed their discipline or that they feel too sorry for them to discipline them. Parents have a lot of questions, concerning the discipline of the ill children, that very often don't get answered (Korsch, et. al., 1973 and Cofer, et. al., 1975). This change in discipline frequently causes problems in the relationship with siblings.

There are the additional problems of financial strain and social life strain for the parents, which is brought on by the hospitalization (Shellhase, et. al., 1972 and Earthrowl and Stacey, 1977). Even if there is adequate insurance, there are added expenditures when a child or adolescent is hospitalized, such as gifts, meals out for parents, hospital attire and transportation to and from the hospital. Earthrowl, et. al. (1977) noted that parents, who are low income, feel the same way and feel their children have the same needs as higher income families. They simply do not have the means to meet these needs. One example they gave was in visitation. They knew that visiting the child was very important but they did not have the money to pay someone to care for the other children, pay for bus fare to the hospital and home and then pay for food while they were gone. Often, it's not that the parent doesn't know the needs of their child. They just can't meet them.

Support of Parents

When a child or adolescent is hospitalized, the parents have to deal with these real issues and problems. On top of these, they may be having to deal with feelings of guilt and blame over causing their child's illness or hospitalization (Natterson, et. al., 1960 and Sheridan, 1975) and whether they have done the proper things for their child or adolescent's condition. This is a time when the family life educator can be there to be supportive of the parents. Parental attitudes of guilt and blame can, at times, make it difficult for them to draw into their child or adolescent's care. This is a

very crucial time to deal with the parents encouraging them to be involved in the care but not forcing them to be there. Jay (1977), in dealing with the parents of children in the ICU, noted that the guilt is there and there is a process that the parent goes through to regain control of care of their child. This process is compared with Rubin's process of maternal role acquisition, and in the ICU the parents change roles and methods in helping to care for their child.

Many parents simply need advice, encouragement and support at these times of hospitalization. The family life educator can give these things at a time when everyone else might seem too busy to take the time (Jolly, et. al., 1977 and Leffman and Murton, 1977). Leffman, et. al. (1977) noted, in their article, that the parent often asked for advice in a waiting room for children at Charing Cross Hospital. The questions were often centered on the subject of the child's and siblings' health, physical development and emotional development. The parents often expressed fears that they and their children had about a possible or planned hospitalization and felt that talking to the child about this and about illness was very difficult. All of these issues and concerns can readily be addressed by a family life educator with some health training in his background. This waiting room was used for many services needed to support persons encountering the hospital. It is a play room for children while they wait for clinic appointments or while their parents attend a clinic or get care in the emergency room. It is a play area for siblings, while parents visit hospitalized children or friends. It provided play therapy to deal with the fear of hospitalization, a chance to see what the hospital is like before admission, a different playroom for the hospitalized children and a learning experience that hospitals don't have to be unpleasant to those not admitted.

Family Centered Care

Duran (1972, p. 70) suggested a model of family centered care in dealing with adolescents. The care entails the following:

- "1. The parent should be expected to have an understanding of the total needs of the adolescent.
2. The parent should realize that anything he shares with the nurse is confidential. This enables the relationship to be honest and respectful.
3. The parent, in discharge planning, should understand any physical or social activities that may be altered for the adolescent.
4. Whenever possible, the nurse should inform the parent that, depending on the diagnosis and medical prescription of care, the adolescent should be responsible for carrying out his own medical recommendation. Thus, the parent will see his role as a resource person rather than the responsible agent in carrying out the child's plan of care.

The above criteria indicate that any nursing intervention must be based on consistent communication between the parent and adolescent, while the nurse maintains relationship with both members of the family."

This method is used to prevent regressive behavior in the patient and also to give the parent an acceptable role, so that they also can feel security in their new situation. This model is a good one and, to an extent, can be carried out by nurses as well as family life educators. The nurses, themselves, may very well need training in the needs of the adolescent. The adolescent's sharing with the nurse and educator should be held in the same confidence as his parents. It would also be important that the adolescent understand any physical or social activities that may need to be altered and the rationale behind alterations. An educator can help the parents and adolescent work through their feelings about the illness, changes in activity that have to be made and the adolescent's self care. This model could be used in pediatric cases. It could well change the emphasis in step number four to address the child's

involvement in his self care to the level of which he is capable, being very guarded against making him take on too much, too quickly or soon and also against the child remaining too dependent on the mother's care for too long.

There is a trend, now days, to include parents in dealing with serious illness or conditions in their children or adolescents. There is beginning to be the realization, within the medical field, that the bond between children or adolescents and their parents is still strong, and can afford them with the possibility of integrating their concerns into the care and treatment procedures. The hospital staff have also realized the potential for support to the patient, if the parent is allowed to participate.

In the review of the medical literature, there was found a negative view of or desire to actually use parental support many more times than criteria was found to elicit parental support in the care of children, especially the adolescents. The dilemma seems to exist in the fact that they have seen good results in cases where parental support is used, but the medical profession team does not always know how to go beyond the initial reactions and attempts of parents and train them to be effective supports. They have a need to incorporate professionals from other fields who can help train the medical staff and the parents in effective family nursing care, and the family life educator is a prime resource for them to use.

Resistance to Innovation

Hospitals are especially resistant to change. Hall (1977) laid some of the responsibility for the lack of openness upon the notions held by doctors of professional relationships and accountability. In this article, Hall observed the innovation of play leaders into two hospitals. Overall, the hospital and the staff were resistant to change. Hall mentioned that

"resistance should not be regarded as blind or irrational response to change, but demands sociological analysis in terms of the consequences of change on established work patterns and congruence with the existing staff attitudes and values." (p. 66) A problem encountered was that the role of play leader was not, as yet, rigorously specified. The worker, at times, in attempting to make aspects of the role explicit, was creating and defining roles, as well as merely bringing them to light. The process is not "role taking" but "role making". The situation was "fluid and ripe for analysis of work...an exercise in progressive definition, negotiated through interaction with (others) staff over time." There were many mistakes made, and many opportunities lost during to the innovation of the program; learning took place by trial and error.

The role of the family life educator in the hospital today is a similar one of "role making" not "role taking". The first step in providing family life education within the hospital is to educate the medical profession and staff as to roles that the educator can take on to help meet the needs of their patients. The family life educator should not be seen as a threat to the established order or things but rather an addition to the order. Hall (1977) noted that the social position of the play leader on the ward was operating on the boundaries of the ward team. No one can judge where the family life educator will find their position, given the opportunity to work on a medical ward, but the boundary of the ward team, is somewhere between the patients/ their parents and the medical staff, an excellent place for an advocate and helper to be.

On the whole, no one wants to deal with the possibility of their child or adolescent needing to be hospitalized. However, with the proper environment within the hospital, the proper type of staff members, and the working together of a team of medical and helping professionals, the fearful trip

can be an effective one and a beneficial one, in more than just returned physical health. In order to make this a possibility, the hospital needs to establish a procedure that is supportive of an adolescent on an adolescent ward and a child on a pediatrics ward. The need to have all the staff trained, not only in pediatric and adolescent medicine, but also in the area of the basic tasks and needs, throughout childhood and adolescence. There is a very strong need to include the family, especially the parents in such a venture, so that, when reestablishment in the home takes place, the potential rough road is much smoother. This is needed in all cases, but is vital in extreme cases of chronic illness or permanent disability. The family life educator is someone trained to help make this objective a reality.

Bibliography

1. Abend, S. M., H. Kachalsky, and H. R. Greenberg, "Reactions of adolescents to short term hospitalization, American Journal of Psychiatry, 1968, 124:7, 109-114.
2. Adams, M. A., "A hospital play program-Helping children with serious illness", American Journal of Orthopsychiatry, 1976, 46:3, 416-424.
3. Alexander, A. S., "Psycho-social dynamics among adolescent females faced with life threatening illness: a descriptive study", Dissertation Abstracts International, 1976, No. 11-12, Vol. B, 6367B.
4. Allen, N. and B. Mondschain, "The medical role in the crisis intervention center", Adolescence, 1976, XI:42, 157-164.
5. Bach, W. G., "Teen-age patients", Hospitals, J.A.H.A., 1970, 44, 51-53.
6. Beardslee, C., "The sleep-wakefulness patterns of young hospitalized children during nap-time", Maternal and Child Nursing Journal, 1976, 5, 15-24.
7. Bodhinayake, B., "Adolescent medicine the Sri Lanka way", Impact of Science on Society, 1975, XXV:3, 225-231.
8. Boyle, I. R., P. A. di Sant'Agnese, S. Sack, F. Millican, and L. L. Kulczycki, "Emotional adjustment of adolescents and young adults with cystic fibrosis", The Journal of Pediatrics, 1976, 88:2, 318-326.
9. Brain, D. J. and I. Maclay, "Controlled study of mothers and children in hospital", British Medical Journal, 1968, 278-280.
10. Cholcher, M. and M. Burtis, "Teens together", American Journal of Nursing, 1964, 64:7, 104-105.
11. Christodoulou, G. N., A. Gangoulas, A. Papaloukas, A. Marinopoulou, and E. Sideris, "Primary peptic ulcer in childhood", Acta Psychiatrica Scandinavica, 1977, 56, 215-222.
12. Christopherson, V. A., "Role modifications of the disabled male, American Journal of Nursing, 1968, 68:2, 290-293.
13. Cofer, D. H. and Y. nir, "Theme focus group therapy on a pediatric ward", International Journal of Psychiatry in Medicine, 1975, 6:4, 541-550.
14. Conway, A., "Oedipal concerns of a 5-year-old girl during hospitalization", Maternal and Child Nursing Journal, 1973 2:1, 39-47.
15. Conway, A., "Oedipal concerns of hospitalized preschool girls", Maternal and Child Nursing Journal, 1975, 4:1, 75-81.
16. Danilowicz, D. A. and H. P. Gabriel, "Postoperative reactions in children: normal and abnormal responses after cardiac surgery", American Journal of Psychiatry, 128:2, 1971, 77-80.

17. David, N., "Play: a nursing diagnostic tool", Maternal and Child Nursing Journal, 1978, 2:1, 49-56.
18. Dirks, J. F., R. A. Kinsman, N. F. Jones, S. L. Spector, P. T. Davidson, and N. W. Evans, "Panic-fear: a personality dimension related to length of hospitalization in respiratory illness", The Journal of Asthma Research, 1977, 14:2, 61-71.
19. Drexler, C., "A four year old boy experiences surgery for a genital defect", Maternal and Child Nursing Journal, 1975, 4, 197-205.
20. Duran, M. T., "Family-centered care and the adolescent's quest for self-identity", Nursing Clinics of North America, 1972, 7:1, 65-73.
21. Earthrowl, B. and M. Stacey, "Social class and children in the hospital", Social Science and Medicine, 1977, 11, 83-88.
22. Eikeland, T. A., "A case of conditioned fear in a two year old boy after tonsillectomy", Acta Otolaryng, 1973, 76, 377-380.
23. Fleming, J. W., "Hospitalized physically disabled children focus on things not people", Perceptual and Motor Skills, 1974, 39, 1002.
24. Frank, J. L., "A weekly group meeting for children on a pediatric ward: therapeutic and practical functions", International Journal of Psychiatry in Medicine, 1977-78, 8:3, 267-283.
25. Freeman, R. D., "Psychiatric problems in adolescents with cerebral palsy", Developmental Medicine in Child Neurology, 1970, 12, 64-70.
26. Fuszard, M. B., "Acceptance of authoritarianism in the nurse by the hospitalized teen-ager", Nursing Research, 1969, 18:5, 426-431.
27. Gallagher, J. R., "Pediatrics and the adolescent, remarks on receiving the C. Anderson Aldrich Award", Pediatrics, 1973, 51:3, 458-460.
28. Green, M. M., "Adolescent boys' expressions about their body experiences following surgery", Dissertation Abstracts International, 1977, 7-8, 3350B.
29. Greenspan, B., F. Shute and C. J. Tuss, "Crises in human relations and bodily functions: reality confrontation and clarification in a residential cottage with emotionally disturbed male adolescents", Adolescence, 1977, XII:17, 345-352.
30. Hall, D. J., "Problems of innovation in a hospital setting", Sociology of Work and Occupations, 1977, 4:1, 63-85.
31. Hammar, S., Nursing Care of the Adolescent, (Revised Edition), London: William Heinemann Medical Books, Ltd., 1968.
32. Hennessey, J. A., "Toddlers' response to mother's tape recordings during brief separations", Maternal and Child Nursing Journal, 1976, 5, 69-91.
33. Hofmann, A. D., "The impact of illness in adolescence and coping behavior", Acta Paediatrica Scandinavica, 1975, Sup. 256, 29-33.

34. Hofmann, A. D., R. D. Becker and H. P. Gabriel, The Hospitalized Adolescent: A Guide to Managing the Ill and Injured Youth, New York: The Free Press A Division of MacMillian Pub. Co., Inc., 1976.
35. Holmes, S., "The use of control by a hospitalized 5 year old girl", Maternal and Child Nursing Journal, 1976, 5, 189-196.
36. Janeway, C. A., "Pediatrics and the adolescent, presentation of the C. Anderson Aldrich Award to J. Roswell Gallagher, Pediatrics, 1973, 51:3, 454-457.
37. Jay, S. S., "Pediatric intensive care: involving parents in the care of their child", Maternal and Child Nursing Journal, 1977, 63, 195-204.
38. Jolly, H., N. R. Finnie, D. M. B. Hall, R. C. F. Newton and S. H. Rousounis, "The Charing Cross Hospital Child Development Centre: A description of its work and an evaluation of it's first 385 patients", Child: care, health and development, 1977, 3, 425-435.
39. Kaufman, R. V., "Body image changes in physically ill teenagers", Journal of the American Academy of Child Psychiatry, 1972, 11, 157-169.
40. Kaufman, R. V. and B. Herscher, "Body image changes in teen-age diabetics" Pediatrics, 1971, 48:1, 123-128.
41. Koegler, R. R., "Chronic illness and the adolescent", Mental Hygiene, 1960, 44, 111-114.
42. Kohlberg, I. J. and M. B. Rothenberg, "Comprehensive care following multiple life-threatening injuries", American Journal of the Disabled Child, 1970, 119, 449-451.
43. Korsch, B. M., V. F. Negrete, J. E. Gardner, C. L. Weinstock, A. S. Mercer, C. M. Grushkin and R. N. Fine, "Kidney transplantation in children: psychosocial follow-up study on child and family", The Journal of Pediatrics, 1973, 83:3, 399-408.
44. Leffman, J. and J. Murton, "The children's waiting room at Charing Cross Hospital", Child: care, health and development, 1977, 3, 241-245.
45. Leyn, R. M., "Terminally ill children and their families: a study of the variety of responses to fatal illness", Maternal and Child Nursing Journal, 1976, 5, 179-188.
46. Little, S., "Psychology of physical illness in adolescents", Pediatric Clinics of North America, 1960, 7:85, 85-96.
47. Magrab, P. R. and Z. L. Papadopoulou, "The effect of a token economy on dietary compliance for children on hemo-dialysis", Journal of Applied Behavior Analysis, 1977, 10:4 73-78.
48. Mason, E. A., "The hospitalized child- his emotional needs", The New England Journal of Medicine, 1965, 272:8, 406-413.

49. Matus, I., "A growth perspective on the care of chronically ill hospitalized children", Child Care Quarterly, 1978, 7:2 119-129.
50. Moore, D. C., C. P. Holton and G. W. Marten, "Psychologic problems in the management of adolescents with malignancy", Clinical Pediatrics, 1969, 8:8, 464-473.
51. Myers, A., S. B. Friedman and I. B. Weiner, "Coping with a chronic disability", American Journal of the Disabled Child, 1970, 120, 175-181.
52. Natterson, J. M. and A. G. Knudson, "Observations concerning fear of death in fatally ill children and their mothers", Psychosomatic Medicine, 1960, XXII:6, 456-465.
53. Neff, N. A., "Recapitulation of the separation-individuation process in a toddler during hospital and home care", Maternal and Child Nursing Journal, 1974, 3:2, 87-101.
54. Northrup, F. C., "The dying child", American Journal of Nursing, 1974, 74:6, 1066-1068.
55. Partridge, J. W., A. M. Garner, C. W. Thompson and T. Cherry, "Attitudes of adolescents towards their diabetes", American Journal of the Disabled Child, 1972, 124, 226-229.
56. Piel, J. J., F. C. Ewell, J. L. Rauh, F. C. Biehusen, J. P. Sparks, S. L. Hammar, M. Z. Dougela, W. R. Anyan, P. Benjamin, M. I. Cohen and H. Cooper, "Characteristics of an inpatient unit for adolescents", Clinical Pediatrics, 1973, 12:1 17-21.
57. Pill, R., "Health careers and competence: aspects of behavior on a children's ward", Social Science and Medicine, 1976, 10, 105-111.
58. Pless, I. B. and K. J. Roghamann, "Chronic illness and it's consequences: observations based on 3 epidemiologic surveys", Journal of Pediatrics, 1971, 79:3, 351-359.
59. Pless, I. B., B. Satterwhite and D. VanVechter, "Chronic illness in childhood: a regional survey in care", Pediatrics, 1976, 58:1, 37-46.
60. Rigg, C. A. and R. C. Fisher, "Some comments on current hospital medical services for adolescents", American Journal of the Disabled Child, 1970, 120, 193-196.
61. Schowalter, J. E. and W. R. Anyan, "Experience on an adolescent inpatient division", American Journal of the Disabled Child, 1973, 125, 212-215.
62. Schowalter, J. E. and R. D. Lord, "The hospitalized adolescent", Children, 18:4, 127-132.
63. Schwartz, A. H., "Children's concepts of research hospitalization", The New England Journal of Medicine, 1972, 287:12, 589-592.
64. Shade-Zeldow, Y., "Attachment and separation: the effects of hospitalization on pediatric patients", Dissertation Abstracts International, 1977, 37:10B, 5376B.

65. Sheridan, M. S., "Talk time for hospitalized children", Social Work, 1975, 20, 40-44.
66. Sides, J. P., "Emotional responses of children to physical illness and hospitalization", Dissertation Abstracts International, 1977, 38:2B, 917B.
67. Toister, R. P., C. J. Condon, L. Worley and D. Arthur, "Faradic therapy of chronic vomiting in infancy: a case study", Behavioral Therapy and Experimental Psychiatry, 1975, 6, 55-59.
68. Wesseling, E., "The adolescent facing amputation", American Journal of Nursing, 1965, 65:1, 91-94.
69. Whitehouse, F. A., "Problems of the cardiac adolescent", New York State Journal of Medicine, 1964, 64, 1108-1111.
70. Williams, T. K., "Responses of a 12 month old girl to physical restraint during hospitalization", Maternal and Child Nursing Journal, 1975, 4, 109-115.
71. Wolfer, J. A. and M. A. Visentainer, "Pediatric surgical patients' and parents' stress responses and adjustment", Nursing Research, 1975, 124:4, 244-255.

THE HOSPITALIZED CHILD OR ADOLESCENT AND THEIR PARENTS:
IMPLICATIONS FOR FAMILY LIFE EDUCATORS

by

CYNTHIA E. MAY

B. S., Kansas State University, 1978

AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Family and Child Development

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1980

The report explores the issues of concern suggested in the research as significant to children and adolescents who are hospitalized and ways that family life educators can help to meet some of the needs these children and their parents have during hospitalization. The report is broken into three major sections, the first dealing with hospitalization and children, the second dealing with hospitalization and adolescents and the last dealing with implications for family life educators to these hospitalized children and their parents.

In the first section the report discussed concerns the literature showed children had when hospitalized, some common reactions children had to the hospital experience and supportive measures that were suggested to help the children deal with these concerns and reactions. The major concerns discussed were: separation anxiety, abandonment, fantasies and distortions about hospitals, medical staff and procedures, threatening aspects of a new environment and the transfer of body control and care to strangers. Common reactions were seen as strongly dependent on the child's maturation level and past experience as well as age. Some of the reactions noted were regression, aggression, rage, anger, fear, anxiety, depression, and denial. The supportive measures discussed were those used in hospitals presently and discussed in the literature, or those recommended by authors as good possibilities for supporting hospitalized children.

The common concerns of the hospitalized adolescent are also strongly related to the developmental level they have attained. Most of the concerns mentioned in the literature are in fact developmental tasks of adolescents that become even more difficult to attain when hospitalized. One of the greatest fears of an adolescent is being different- and this relates to the issue of body image the literature discusses as important in with a sick adolescent. The self-concept and self-esteem are closely related to the body image and welfare of the patient. The adolescent is concerned also about

modesty and privacy, flirtations and crushes, independence versus dependence and finding their identity. The report mentions some of the ways hospitals have tried to support the hospitalized adolescent. These have been through maintaining the adolescent within his peer group, staff providing role models, discussion groups and helping them to continue some normal recreation and educational pursuits.

An important asset in the care of a patient, particularly a child or adolescent, both from a medical and emotional standpoint is the involvement of the family, in this case especially the parent. It is here that the family life educator can be of great assistance but their role by no means begins here- it starts by dealing with the child or adolescent who is hospitalized and helping them work through any of the above mentioned concerns or issues they have. The medical staff are trained to deal with the physical needs of the patient and often these other needs are left unmet. The family life educator can deal with these patients and their families from a developmental point of view and often help them understand their concerns and reactions from not only the patient's development, but also the parents' and siblings' development. The whole family's reaction is based on each one of their developmental levels.

The family life educator in a hospital is an advocate of the child and his family. They can be a person to express the needs and concerns of both these parties to the medical staff and can assist in meeting the needs through one to one education or counseling, or establishment of supportive programs. In fostering good relationships and interactions among the family members, a family life educator can also increase the supportive role the family plays with the patient in addition to being supportive themselves. The report discusses the various ways that the family life educator can supply these supportive roles.