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A study of the impact on ten families of illness and hospitalization of a child

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE IMPACT ON TEN FAMILIES OF ILLNESS AND
HOSPITALIZATION OF A CHILD

A thesis

Submitted by

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CHAPTER I
INTRODUCTION

This study is to explore the nature of the impact of the ill and hospitalized child in ten families. This interest relates to the current concepts of prevention as an essential function of social work.

A number of studies have been done on the illness and hospitalization of the child from the child's point of view, but little has been done with the family's reaction. The family has been considered a worthwhile area with which to be concerned, but the technical difficulties of a longitudinal study have prevented an intensive study.

Some knowledge about the causation of emotional disturbance is necessary in order to prevent disturbance. Therefore to study the family during the illness and hospitalization of a child would be in the interest of discovering if there is an impact on the family and what might be the kind of specific protection developed to cope with the effects of this impact. To be concerned with the impact on the family and how it might be dealt with coincides with the thinking that in preventive social work it is misleading and too narrow to think of the individual patient as a reference point. It is necessary rather to think of a web of forces and of the individual as being part of that web and reacting to it.¹

¹Gerald Caplan, Concepts of Mental Health and Consultation, p. 247.

This is an exploratory, descriptive study undertaken as part of a larger research project. The setting of this study and the larger project were two pediatric wards of the Boston City Hospital.

Seven of the ten families included in this study were part of the larger research project, and the other three were selected by this investigator during three weeks when no family was available from the larger project.

The data was collected from the ten families included in the study while a child of each of the ten families was hospitalized on one of the two wards of the hospital. A home visit was made and members of the family were interviewed during the home visit while the child was hospitalized.

CHAPTER II

THEORETICAL CONSIDERATIONS

The purpose of this study is to explore the nature of the impact on the family when a child is ill and hospitalized. The interest in the impact of illness and hospitalization of a child on the family stems from some of the current concepts of prevention as an essential function of social work.

This study was part of a research project which was directed by Dr. Arthur Z. Mutter, a psychiatrist at the Boston University Boston City Hospital Child Guidance Clinic.

Dr. Mutter in his study is concerned with the concept that disease is determined by many factors; that is by biological, psychological, social and physical factors. The importance of the factors vary from disease to disease. At one end of the spectrum with diseases such as measles and chicken pox the social and psychological factors are of minor importance while at the other end with the psychosomatic illnesses the psychological and social factors play a very important role. With the infectious, metabolic and other diseases in the middle of this spectrum; Dr. Mutter raises the question of what role do the psychological and social factors play.

The immediate goal is to describe the role of the factors and the long range goal is to indicate the psychological and social factors that make a person more or less susceptible to illness and in what illnesses this is true.

In regard to the study reported here the effectiveness of the measures taken in regard to the impact of the illness and hospitalization may depend on the knowledge of the factors which determine the illness.

Social welfare and social work services are considered essential and ongoing and are seen as a growth promoting type of institution. This concept makes it particularly compatible with the philosophy and efforts of prevention.¹

Prevention is described as that function which entails early discovery, control, and elimination of conditions and situations that potentially could hamper social functioning. It entails prevention of problems in the area of interaction between individuals and groups and the prevention of social ills. The latter is accomplished through the study of social infection and social contamination and through the social function of provision.²

Social work has tended to embrace the public health model of prevention. There has been some controversy in the field as to the validity of this embracement since it is relatively impossible in the realm of human behavior to describe precisely

¹Lydia Rapoport, "The Concept of Prevention in Social Work," in Social Work, vol. 6 (January, 1961), p. 4.

²Werner W. Boehm, "The Nature of Social Work," in Social Work, vol. 3 (April, 1958), p. 17.

as in public health the mediating and intervening steps in the history of a disturbance.

The public health, preventive activities are grouped under several categories. These are: primary prevention which includes health promotion, and specific protection; secondary prevention which includes early diagnosis and treatment; and last, tertiary prevention which includes disability limitation and rehabilitation.³

With this grouping one can well imagine the fuzziness of the division between one group and the other when it is applied to social work activities.

Perhaps the most clear cut preventive activity for social work is specific protection which is the activity with which the purpose of this study is concerned. Specific protection implies some knowledge about causation and in the social welfare field would consist of such activities as those of a social group worker or caseworker on the pediatric wards of a hospital. The social group worker and/or case worker who administers no medical treatment and therefore causes no pain or little resentment are able to utilize play experiences as an avenue toward a therapeutic and even educational relationship with the child and his parents.⁴

³Rapoport, op. cit., p. 4.

⁴Dane G. Prugh, et al., "A Study of the Emotional Reactions of Children and Families to Hospitalization and Illness," in American Journal of Orthopsychiatry, vol. 23 (January, 1953), p. 72.

These activities are brought into play at a time of crises for a child to relieve the traumatic effects of such a crises.⁵

Such programs of specific protection could not be effectively developed until the effects of hospitalization on the child were systematically studied.

In addition to the services of the social worker in the interest of the child the knowledge of the effects of hospitalization on the child leads to recommendations about the timing of operations, preparation of the child, duration of the hospitalization and the hospital routine.⁶

Only by systematic study of families whose children have been hospitalized can it be determined if there is an impact and if so what kind of specific protection will be most helpful to these families. Some studies about the effects of hospitalization of the child have given some thought to the family's reaction and how it effects the child.

One such study was conducted by direct observation of parents and child together as well as by interviews with the parents. They found the child's attitude toward his bodily

⁵Tina C. Jacobs, "Casework with the Very Young Child in a Hospital," in Social Work, Vol. 3 (April, 1958), pp. 76-82.

⁶L. Jessner & S. Kaplan, "Observation of Emotional Reactions to Tonsillectomy and Adenoidectomy," in Problems of Infancy and Childhood, 1949, pp. 115-116.

defect was greatly related to the parents attitude.⁷ Several case situations were described to show how ward management of a child was changed effectively in accordance with what they learned from their observations and direct interviews with the parents. Sometimes this meant including the parents in the direct care of the child.⁸

Another article which reports on a hospital program aimed at better cooperation between the pediatric and psychiatric services of a university hospital points out how it was possible with increased cooperation for the pediatricians and ward personnel to become aware of the subtler effects of ego weakness in the hospitalized child. This lead to more sensitive handling of the child as well as more sophisticated referrals to the psychiatric department.⁹

From the above mentioned writings there is a reason to suspect that there is an impact on the family when a child is hospitalized. In thinking in preventive terms it can be misleading to think of the individual patient as the reference point. It is necessary to think of a field of forces, of a unit

⁷E. Jane Watson & A. Johnson, "The Emotional Significance of Acquired Physical Disfigurement in Children," in The American Journal of Orthopsychiatry, vol. 28 (January, 1958), p. 96.

⁸Ibid., p. 87.

⁹Elizabeth A. Bremner et al., "The Hospitalized Child," in The American Journal of Orthopsychiatry, vol. 25 (April, 1955), p. 293.

of society rather than an individual patient.¹⁰ The concept of a field of forces along with the concept of the effects of crises gives impetus to our thinking about the illness and the hospitalization of a child having an impact on the family.

In connection to crises there is another associated concept and that is the idea of equilibrium since the field of forces may become unbalanced. A state of emotional ill health is preceded at some time or another by a significant period of disturbance of previous equilibrium. Therefore in terms of a web of forces the individual is part of the web and reacting to it.¹¹ In this context to think only of the child as reacting to his hospitalization and not considering the family of which he is a part and to which he must return is being too narrow for preventive social work.

Consideration of a study made using a controlled group and an experimental group of hospitalized children to determine the emotional reactions of the children and their families to hospitalization and illness may serve to point up some of the points already made here as well as raising others to be considered.¹²

¹⁰Gerald Caplan, Concepts of Mental Health and Consultation, p. 247.

¹¹Ibid., p. 248.

¹²Prugh, op. cit., p. 70-104.

In this study the findings were that in both the controlled and experimental groups the children who showed the most successful adjustment on the ward were those who seemed to have the most satisfying relationship with their parents, and whose parents accomplished the most balanced adaptation themselves to the experience of illness and hospitalization of their child.

The children in the experimental group who were on the ward under more flexible conditions which are in line with the enlightened thinking about hospital management of hospitalized children appeared to adjust more adequately on the wards.

The two to four-year old age group had the severest reaction to illness in both the experimental and controlled group which tends to bear out some of the findings of other studies.¹³ The separation from home for the younger child causes so much trauma that they respond very little to any of the hospital procedures.¹⁴

Since there was some follow-up to this study it was possible to observe the regressive trend in these children which was quite marked in especially the younger children. It was present in the older children, but disappeared more quickly than it did in the younger ones. Other disturbances of sleep,

¹³Ibid., pp. 81-82.

¹⁴Jessner & Kaplan, op. cit., p. 123.

hyperactivity, tantrums, and general aggressive behavior was noted.¹⁵

It was found that the relatively well integrated parent was able to take advantage of the more frequent visiting hours and to participate effectively where opportunities were made available in ward care, feeding their children, playing with them and putting them to bed. With some parents the level of denial, projection of guilt and use of the illness as punishment reached such a point that only with psychotherapeutic intervention could they accept the medical recommendations.¹⁶

Post hospitalization reaction of the parent varied with the adjustment of the parents and the seriousness of the illness. The regressive trend in the child and his disturbed behavior caused many parents confusion, resentment, guilt and anxiety.¹⁷

It is possible to assume from what had been said that with more study of families of the hospitalized child that social service activities can be directed more appropriately at determining the effects of hospitalization and alleviating them. This would be done in the interest of intervention at the time

¹⁵Ibid., pp. 95-96.

¹⁶Ibid., p. 97.

¹⁷Ibid., p. 98.

of crisis in order to prevent deleterious emotional reverberations.

Not only does a care-taking agent, meaning a person who performs certain functions which the community lays upon him in regard to other individuals, need to intervene at a time of crisis, but according to the thesis developed here and the writings on crises and prevention that intervention at the time of crisis has a far greater effect in a short time than it could before or after the crisis.¹⁸

In consideration of the hospitalization of the child as a crisis situation the family is part of the web of forces and is reacting to them. So that in this context the social worker acting as a care-taking agent during the crisis can affect the outcome of the crisis situation by direct intervention or by consultation with the ward personnel.

¹⁸Caplan, op. cit., p. 248.

CHAPTER III

METHODOLOGY

This was an exploratory, descriptive study undertaken as part of a larger research project. The project director, a psychiatrist, who is managing the larger research project is interested in the setting in which children become ill. He is considering the question of whether the child's illness is preceded by a change in the home or family.

Setting of the Study

The ten families included in this study had a child hospitalized on one of the nine pediatric wards of Boston City Hospital. This is a general hospital servicing the entire city. With its flexible plan for payment for medical care it serves many families who have marginal incomes or few economic resources.

Although the hospital provides an immense number of in-patient and out-patient services it serves as a training hospital for medical and nursing students as well as various interns and residents.

The pediatric wards where the ten children of this study were housed are characterized by medical and nursing personnel which change frequently because of the system of affiliation and training.

Social services to these pediatric wards consist of a very limited service which is restricted to help in referrals to a

child placing agency or a specialized service in the community.

The only social work service aimed at specifically coping with the problems of a hospitalized child on the ward as well as lessening the traumatic effect of such an event is a group play program under the direction of a trained group worker.

The Boston University Child Guidance Clinic which is housed in this hospital accepts referrals from the pediatric wards for diagnostic evaluation of children who are disturbed in their day to day functioning, and/or by hospital procedures. These referrals are not usually of children whose response to hospitalization or the problems of life are rather subtle.

The ward play program and the collaboration between the pediatric wards and the child guidance clinic as well as the weekly ward conference which is held to discuss the referred cases are all relatively new innovations. They are aimed primarily at increasing the ward personnel's sensitivity to the problems faced by a hospitalized child as well as to help them in developing more sensitive ways of approaching and handling the children.

Selection of the Sample

The sample was selected from two wards of the pediatric in-patient department. These wards were initially selected because of the high level of cooperation by the ward personnel with the group play program and the child guidance services. These two wards house children from four to twelve who are suffering from non-surgical illnesses.

The psychiatrist who directed the research project chose his sample as they became available and met his research criteria. When the study of one family was completed he would select the family with the first child who was admitted to the hospital on either of the two wards after midnight of the day the other family's study was completed.

All except one of the families selected in this way from the middle of November until the first of February were included in this study. The refusal of this family to be included in this study was connected to their extreme suspiciousness and apparent distrust of social workers. For two weeks during the ten weeks of this investigation no families were studied by the larger research project as no child within the six to twelve age group was admitted to the wards. Since this writer's study was not bound by this criteria, two families whose children were four years of age were included.

The director of the pediatric department of the hospital cooperated with us, and the physicians and ward personnel were helpful in giving medical information and in introducing the families to the investigators.

This writer's contact with the seven families who were on the larger research project was made through the psychiatrist who interviewed them on the ward. He either introduced this writer or the family was given the writer's name and told that they would be contacted to arrange a convenient time for a home visit.

The three families who were not on the larger research project were introduced to the writer by a physician on the ward.

In all of the ten cases the families were told briefly about the study and their permission was received for a home visit.

Data Collection

The data was collected by means of a home visit. The home visit was made on Saturday morning or in the evening in the hope that all of the family might be seen. The interviews lasted for about an hour, and they were focused on areas covered in a schedule (see Appendix I).

There were varying degrees of resistance, but in every instance it was possible to get at least superficial information in all of the areas on the schedule. The observation of the family during the home visit added to the understanding of the family's reaction to the illness and hospitalization.

The schedule in the appendix shows the five areas covered during the home visit. The first section covers the child's identifying information and reason for hospitalization. The second section covers the family's identifying information while the third section is regarding family structure.

Included under family structure is the family's economic status. The fourth section is devoted to the family's attitude toward medical care for this child in the past and present. Also this section includes how the family feels they were

treated in the past and present and their attitude toward etiology.

The impact on the household is covered in the fifth section. This is done in terms of changes in the mother since in most cases only the mother was seen even though both parents were asked to be present at the time of the home visit.

A question about the home visit might be raised now since members of the families could have been seen at the hospital. A social worker's special province it is believed is the environmental factors. It is G. Caplan who has urged that the social worker go back and study the patient in his social setting for the social worker with her special skills in assessing the environment will find the home visit adding greatly to her understanding of a situation.¹ One writer who had experience in using the home visit while working in a preventive social service program with new mothers found it extremely helpful in discussing problems, observing home atmosphere, and family interaction as well as increasing her general understanding of the family. The value derived from the home visit suggested to that writer that such visits during pregnancy would have added advantages.²

To see these families in their homes and to observe as much of their functioning as possible coincided with the purpose of this study.

¹Gerald Caplan, Concepts of Mental Health and Consultation p. 113.

²F. Cyr & S. Wattenberg, "Special Work is a Preventive Program of Maternal and Child Health," In Social Work, vol 2 (July, 1957), p. 34.

CHAPTER IV
THE FAMILIES STUDIED

The data reveals that the children of these ten families fall into three age groups: two, age four to six; four, age seven to nine; and four, age ten to twelve. Two of the ten children are female, and those that are in school tend to be making average progress. These children suffered from a wide range of diseases.

Table number 1 will deal with the identifying information of the mothers and fathers of these ten families.

TABLE 1
PARENT'S IDENTIFYING INFORMATION

		Mothers			Total	Fathers		Total
Ages	38-42	29-32	24-28		40-46	28-34		
	1111	111	111	10	111	1111		7
Occupation	Housewife	Other			Skilled	Unskilled		
	11111111	11		10	11111	11		7

The mothers of these families fell into three age groups. Four mothers were between the ages of thirty-eight and forty-two, three were between the ages of twenty-nine and thirty-two, an

and three were between twenty-four and twenty-eight. The youngest mother was twenty-five and the oldest one was forty-one.

The fathers were grouped somewhat differently in regard to age as a span of six years is covered for each age category instead of four years.

Three fathers fall into the age group of forty to forty-six, while four fathers fall into the twenty-eight to the thirty-four age group. The youngest father was twenty-eight and the oldest one was forty-five.

The information about education is not included in table number 1 since this information was incomplete. Only one mother however, had any training beyond high school and this was the youngest mother who was a registered nurse. She and seven of the mothers only occupation at the time of the study was as housewives even though at times she does work part-time. One other mother worked full-time as a nurse's aid while another worked part-time as a factory worker. The mother who worked part-time as a factory worker was listed as having an occupation other than housewife on the table.

There were only seven fathers available at the time of this study meaning that in the other three families there was a legal separation or divorce.

In two of the three families where the father was out of the home, the families were supported by public assistance. The third family was supported by mother's working as a nurse's

aid. The one mother who worked part-time said she did so to supplement father's income who was employed as a factory worker.

In those families where the father was present five of the seven fathers were considered skilled workers. Such occupations as police officer, postal clerk, and painter were considered skilled and the unskilled were factory work which consisted of no specific duties.

Since the amount of income was not available, the lack of higher education, the occupation of the persons supporting the family and the fact that all of the families spoke of a tight budget were taken to indicate that these families were in the lower socio-economic class.

Considering the attitudes towards past and present medical care they were classified as positive, ambivalent, and negative. Positive was defined to mean all statements which indicated the family was pleased about the medical care. Negative statements were those which indicated the family was hostile or displeased; while ambivalent statements were those which indicated opposing attitudes, negative and positive.

Positive attitudes were those such as that reported by mother in the B. family. She stated that the hospital was clean, the medical personnel gave her daughter prompt attention and the ward personnel did their best for her daughter even to washing her hair which was quite a job because of its length and thickness. An example of an ambivalent attitude was the one reported by the mother in the H. family. Mother stated that

the nursing care was good, and the nurses were friendly. Also she liked the play program; however, she felt the food was poor and that the nurses aides did not properly wash her son. There were no negative attitudes expressed about the present medical care however, the attitude of the mother in the G. family toward past medical care is an example of the kind of thing that was considered negative. This mother stated that during the previous hospitalization her son did not receive proper attention. The food, nursing and the general care were poor.

The family's attitude toward past medical care was positive for most families with the attitude toward the way the family was treated scattered between positive, negative and ambivalent.

In regard to present medical care the families attitudes toward how the child was treated and how the family was treated were divided equally for the most part between positive and ambivalent.

The possibility of a relationship between past and present attitudes toward medical care was considered and will be discussed later.

There was not adequate data to categorize the families as to whether their expectations for medical care were realistic or unrealistic.

The parents attitude toward etiology was categorized in terms of external, meaning outside of their control; internal, within their control; or combination meaning some aspects of

external and internal. In the majority of the ten cases the parents believed that the etiology was external.

An example of attributing the etiology to external factors was in the E. family where the parents felt the cause of their son's illness was a fall he had while playing in the driveway. An example of the etiology being attributed to internal factors can be found in the A. family where mother was concerned that the condition was congenital. The only example of a combination of internal and external factors was found in the C. family where the mother felt he was accidentally hurt because he ran out of the house when she could not possibly be watching him, but yet she blamed herself for allowing him to get out of her sight.

In all of the families there was an impact on the household and the change from mother's point of view ranged from minimal to great.

Minimal changes were ones such as that reported by mother in the A. family who said she had less time for her household chores. Medium changes were ones like mother in the B. family reported of not having the heart to do the things her daughter did in the home. Great changes were ones like in the D. family where mother became ill and left the household chores to other members of the family.

After this general look at the data, attention was turned to more specific matters. First was whether, as in other studies, the age of the child would influence other factors.

on the schedule. To determine this a number of three fold tables were made to correlate age to attitude toward medical care.

TABLE 2
AGE OF CHILD AND ATTITUDE TOWARD PAST MEDICAL CARE

Attitude Toward Past Medical Care				
Age	Positive	Ambivalent	Negative	Total
4-6			11	2
7-9	111			3
10-12	<u>11</u>	<u>1</u>	<u>1</u>	<u>4</u>
Totals	5	1	3	9

Table number 2 shows the correlation of age to past medical care. Here it is found that for both children in the youngest age group the attitude is negative while in the seven to nine age group the attitude is positive and in the oldest group the attitude is scattered. One child did not have a past hospitalization.

According to writers¹ on the developmental stages of the child, the child is still involved to a great extent in the problems at home while the seven to nine year old is in school and has worked out some of these problems around socialization

¹Irene M. Josselyn, Psychosocial Development of Children, pp. 47-118.

and separation from home. The oldest group is again beginning to tackle the problems that are reinforced by an upsurge of impulses.

It would seem therefore that the parents' attitude toward past medical care was in part determined by the kinds of problems the child was presenting at the time of the present hospitalization.

Age correlated to present medical care posed some interesting questions. Table number 3 will show the results of this correlation.

TABLE 3

AGE OF CHILD AND ATTITUDE TOWARD PRESENT MEDICAL CARE

Age	Positive	Ambivalent	Negative	Total
4-6	1	1		2
7-9	11	11		4
10-12	<u>11</u>	<u>11</u>		<u>4</u>
Totals	5	5		10

For all age groups the attitude of the family was evenly divided between positive and ambivalent. Two reasons are noted for this split of attitudes between the positive and ambivalent columns.

One of these reasons is the ward play program which is managed by group workers which all of the families mentioned in a positive way. This is a program which was recently

started at the hospital, and the families attitude toward it took many of their responses out of the negative column, and placed them into the ambivalent one.

The other reason is connected to the limitations of the study. All of these families knew that this writer was connected in some way to Boston City Hospital and for this reason were evidently guarded about expressing negative feelings about the present hospitalization.

Ages of the children did not seem to be correlated to attitude toward etiology or the impact on the family in any significant way.

The number of children did not have any effect on the other factors studied.

Since past experiences are known to affect the present attitudes and functioning, table number 4 was used to correlate attitude toward past medical care with attitudes toward present medical care.

TABLE 4

ATTITUDE TOWARD PAST AND PRESENT MEDICAL CARE

Attitude Toward Past Medical Care	Attitude Toward Present Medical Care			Total
	Positive	Ambivalent	Negative	
Positive	IIII	1		5
Ambivalent	1	1		2
Negative	1	1		2
Total	<u>6</u>	<u>3</u>	0	<u>9</u>

Dr. Prugh in his study mentioned the effects of past hospitalizations on the family and the child.²

As is shown by table number 4, in five out of nine of the families in this study a correlation was found between the attitude toward past medical care and the attitude toward present medical care. One family had had no previous hospital experience with this child.

The effects of past experience is further considered in table number 5 where the attitude toward medical care for other family members and the attitude toward present medical care is correlated.

TABLE 5

ATTITUDE TOWARD MEDICAL CARE FOR FAMILY
AND ATTITUDE TOWARD PRESENT MEDICAL CARE

Attitude Toward Medical Care for Family	Attitude Toward Present Medical Care			Total
	Positive	Ambivalent	Negative	
Positive	111	11		5
Ambivalent	1	11		3
Negative	—	—		<u>0</u>
Total	4	4	0	8

Out of the eight families who had had experiences with the hospitalization of other members of the family the attitudes were correlated in five cases.

²Prugh op. cit., p. 74.

The results shown in tables number 4 and 5 would coincide with the thinking, about work with people, that the present attitudes of people are often similar to and influenced by their attitudes in the past.

In regard to the impact on the family only one factor on the schedule seems to correlate in any definite way to changes in the mother.

The lack of correlation between other factors on the schedule and changes in the mother may be due to the size of the sample, and the ability to appraise adequately the changes without knowing more about mother's past functioning.

The one factor that was correlated with the changes in mother was the attitude toward etiology.

TABLE 6

ETIOLOGY AND CHANGES IN MOTHER
TOWARD HOUSEHOLD CHORES

Attitude Toward Etiology	Changes in Mother Toward Household Chores			
	Great	Medium	Minimal	Total
External		1111	11	6
Combination			1	1
Internal	1	1	1	3
Total	1	5	4	10

Where the mother's attitude toward etiology was considered external the changes in her were greater.

In Table number 6 it can be seen that four out of the six mothers who attributed the etiology to external factors experienced medium changes in regard to household chores. With the three mothers who attributed the etiology to internal factors the amount of change was scattered. The mother who attributed etiology to a combination of factors experienced minimal change.

Table number 7 shows the correlation of the change in mother toward her children to attitude toward etiology.

TABLE 7

ETIOLOGY AND CHANGES IN MOTHER TOWARD THE CHILDREN

Attitude Toward Etiology	Changes in Mother Toward the Children			
	Great	Medium	Minimal	Total
External	1	1111	1	6
Combination		1		1
Internal	<u>1</u>	<u>1</u>	<u>1</u>	<u>3</u>
Total	2	6	2	10

Four of the six mothers who attributed the etiology of the illness of their child to external factors experienced medium changes in regard to the children. One mother experienced great changes and the other experienced minimal changes.

Where etiology was attributed to a combination of internal and external factors, the change was medium. With the three mothers who attributed etiology to internal factors the amount

of change was again scattered between the three degrees of change.

Table number 8 is drawn to correlate the changes in mother toward her husband to the attitude toward etiology.

TABLE 8
ETIOLOGY AND CHANGES IN MOTHER TOWARD HUSBAND

Attitude Toward Etiology	Changes in Mother Toward Husband			
	Great	Medium	Minimal	Total
External		llll		4
Combination			1	1
Internal	<u>1</u>	<u>1</u>	—	<u>2</u>
Total	1	5	1	7

Of the seven families where the father was in the home the four mothers who attributed etiology to external factors experienced medium changes toward their husbands. Where etiology was attributed to a combination of factors the change in mother was minimal, and the two mothers who attributed etiology to internal reasons the change was great and medium.

In no instance where etiology was attributed to internal or a combination of internal and external was there a correlation in this uniform way to changes in mother.

No table was drawn to correlate changes in mother toward other important figures with the attitude toward etiology, since there were only three families in this sample where other

important figures were present in the household. It was felt that with this small number of families no significant correlation could be found.

CHAPTER V

SUMMARY AND CONCLUSIONS

This was an exploratory, descriptive study designed to explore the nature of the impact on the family when a child is ill and hospitalized.

A survey of the literature revealed that a great many studies have been done on the illness and hospitalization of the child from the child's point of view, but little has been done on the family's reaction. Some of the technical difficulties involved in a longitudinal study have prevented any disciplined study of the family in regard to the illness and hospitalization of the child, even though it has been recognized by many writers that this might be a worthwhile area with which to be concerned.

D. Prugh's study in this instance is noteworthy since it takes in the reactions of the family and its interrelatedness to the child's reactions ~~while~~ during contact with the family while the child is in the hospital as well as some follow up contacts. The study makes note of the need of the parents for support in order to deal effectively with the inevitable regression of a child when he returns home from the hospital.¹

G. Caplan's writings about crises and the effects that can be produced by someone intervening at the time of a crisis

¹Dane G. Prugh et al., "A Study of the Emotional Reactions of Children and Families to Hospitalization and Illness," In American Journal of Orthopsychiatry, vol. 23 (January, 1953), p. 97.

was mentioned as being important in the concern expressed for the family's reaction to illness and hospitalization of a child.²

In this light data from interviews with ten families while their child was hospitalized was collected and studied.

It was found that in all of the ten families there was some impact on the family. This impact was measured in terms of changes in the mother which ranged from minimal to great.

Correlations were found to exist between age of the child and parents' attitude toward past medical care. It was speculated here based on the writings in child development that the parents' attitude was influenced by the kinds of problems the child was having which was based on the stage of development.³

Correlations were found between attitude of the parents toward present medical care for this child with attitudes towards past medical care for this child and other members of the family. They coincide with D. Prugh's concern in selecting his sample as he felt past hospital experience would have a definite affect on the child's and the family's reaction to illness and hospitalization.⁴ It also goes along with current thinking and practice that past experiences and attitudes have to be dealt with while working on current problems.

²Gerald Caplan, Concepts of Mental Health and Consultation, p. 248.

³Josselyn, op. cit., pp. 47-93.

⁴Prugh, op. cit., p. 72.

Impact on the household was found to be related in these ten families to any significant degree with only one other factor on the schedule. This factor was the attitude toward etiology.

It was concluded from these findings that the family's reactions to illness were a worthwhile area to study. It is certainly conceivable that if the family is affected by the illness this would diminish their ability to handle the child's reactions.

This sample was small so it is not possible or wise to recommend widely. Also much of the findings were not conclusive since information was available only from the family about previous modes of functioning. A study which might include some follow-up visits might lend more depth and conclusiveness to the findings.

The lack of correlation of the other factors on the schedule to impact on the household would seem to bear out the limitations of the study.

The use of a home visit during hospitalization gave indications of being an extremely helpful tool.

The findings of this study leads to hope that other such studies on the larger hospitalized child population will be done and out of this will come specific recommendations for meeting the needs of the family of an ill and hospitalized child. This would certainly coincide with aims of preventive social work.

This study further suggests that more intensive inter-

viewing of the family of a hospitalized child should be part of the services of all hospitals. The crisis nature of the hospitalization can not always be determined by casual contact, but with more scrutiny by a person trained in assessing the effect of such situations would add to the services offered to these families as well as to our knowledge of what it means to them.

The social worker in her role as expert in regard to environmental factors as well as human behavior could not only provide direct services to these families, but she could also serve as a resource person to the other hospital staff who are not trained in this way and who come in contact with the child and his family.

accepted 5/19/64
Manuel J. Schuler

SCHEDULEI. Child

Name	Age	Sex
School Grade	School Progress	
Reason for Hospitalization		

II. FamilyMother

Age	Occupation	Education
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Father

Age	Occupation	Education
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III. Family Structure

Marital Status	No. of Children
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Economic Status

IV. Attitude Toward Medical CarePast

For This Child

Family Treated

For Other Family Members

Present

For This Child

Family Treated

V. Impact on the Household

Changes in mother toward Children

Changes in mother toward Household Chores

Changes in mother toward Husband

Changes in mother toward Other Important Figures

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