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A STUDY OF BEHAVIOR PROBLEMS IN PEDIATRIC HOSPITALS

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Introduction:

All children are problems, even the most normal varieties found in ideal home environments. For each one is faced with individual adjustments to life as he finds it.

In order to make these adjustments he must have somewhere in his surroundings both physical and emotional security, an outlet for self-expression and a feeling that he occupies an important place in the world which no one else can take. These are basic and vital needs. Without them, the elemental problems of his child world become an overwhelming tangle of questions and puzzles without any answers. Faulty adjustments and personality problems soon follow.

Groups of children coming from all types of environment and illustrating all types of adjustment are especially noticable in three institutions for children---the school, the foster home, and the Pediatric Hospital. In the school we find a majority of normal adjustments, in the foster home a majority of abnormal adjustments, and in the Pediatric Hospital a mixture of both normal and abnormal plus the all-important health problems.

It is the behavior of children in the third and most complicated group, the Pediatric Hospital, which I will consider in this paper.

At first hospitals were so concerned with the physical care of children that behavioristic aspects were disregarded. In the meantime, psychologists and educators developed the field of applied child psychology and began preaching it to parents, teachers, child welfare institutions and nurses. Although doctors and nurses became increasingly aware of the relations between behavior problems and successful treatment in the hospital, they are still a long way from utilizing its advantages to the fullest extent.

Therefore, a study of principles applied by schools and child welfare institutions will precede the study of pediatric problems in order that we may consider tackling similar hospital problems with their methods of approach. For many hospital problems are exactly the same things which teachers meet in the school room and substitute mothers meet in foster homes.

Adequate provisions for meeting problems of children in the hospital has its preventive side also. Normal adjustments with the help of understanding doctors and nurses with constructive plans for working out problems before they become serious, will prevent disagreeable adult personalities and future unhappiness for many sick children.

Part 1---Rights of Children

Because children do not ask to be born, because their present and future happiness depend on environment and adult guidance, certain inalienable rights of children have been set down for all groups interested in child welfare. The following code, set down as the "Rights of Children" by the White House Conference on Child Care, has been used as a basis for all children's programs since that time. They are as follows:

"By the present Declaration of the Rights of the Child, commonly known as the 'Declaration of Geneva' the men and women of all nations, recognizing that mankind owes to the child the best that it has to give, declare and accept it as their duty that, beyond and above all consideration of race, nationality or creed:

I The child must be given the means requisite for it normal development, both materially and spiritually.

II The child that is hungry must be fed; the child that is sick must be helped; the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succored.

III The child must be the first to receive relief in times of distress.

IV The child must be put in a position to earn a livelihood and must be protected against every form of exploitation.

V The child must be brought up in the consciousness that its talents must be devoted to the service of its fellow-men."

These rights are included here because they are usually found on the wall of every children's hospital. They represent the ideals and principles of the foremost child welfare workers in the world today, leaders in the cause of children who are too young to apply to relief offices or write stormy letters to their senators, who are too helpless to be left to their own devices.

In addition to this, Dr. James S. Plant, Director of the Juvenile Clinic of Essex County, New Jersey,lists five things in the mental field which a child needs just as he needs a certain amount of the right kind of food from a physical point of view.

I Security: Having a certain place, belonging somewhere simply because of who he is. The place a child has because of belonging to a certain family is an unassailable place, and it gives a feeling of security to a child which nothing else can.

II A certain degree of Extroversion: Reality must be made, for the time at least, a pleasant experience so that the child will not continually withdraw into his daydream, but will face and solve the problems of real life.

III Healthy Adjustment to the group: Being a follower of the group pattern and yet an individual.

IV Integration: A certain wholeness or independence, an ability to find resources within himself so that he knows how to live with himself.

V Success: Success comes to a person when he is in a situation where "nobody else will do."

In general, it could be said that everyone needs these five things in order to be happy. The importance of having them as mental backing when fighting off disease in a hospital is undeniable. If the child has been used to finding these things in his home life, then suddenly finds himself in a hospital; the nurse must help him make simple substitutions during his stay in the hospital. She must help him to draw upon the integration factor, learn to enjoy his own company and otherwise adjust himself to the hospital environment.

Part 2---The Child at Home

To the normal, happy child, home is the center of the universe. Like any other animal, he is tied to his parents by blood relationship and by physical needs of food, shelter and protection. In the family group, he finds the affection every child craves and a definite sense of belonging. From this point on, however, the child's growth and development depend on the individual child himself and on the personality, intelligence and financial means of his parents.

Regardless of the parent's method of approach in introducing their children to the world and teaching them how to live in it, the ideal home environment furnishes the child with the following physical and mental needs:

Physical growth: A daily routine including sleep, rest, play-time, regular habits for elimination, the common practice of personal hygiene, and a well-balanced, adequate, attractive diet---these should become as natural and automatic as breathing in order that the child may devote all his conscious effort to the more complicated business of living. He should find personal pride and enjoyment in using his healthy young body, should notice his own growth changes with intelligent curiosity, not with bewilderment or dread. The parent's part in this phase consists of establishing the health habits, building up pride in physical development, explaining fundamental physiological functions in a natural manner and guiding the child at all times by personal example.

Mental Growth: Accompanying the physical growth so that at times it seems impossible to segregate them into separate phases, is the mental growth of the child. Since the first seven years of life are the formative period of personality and behavior patterns, the mother naturally assumes the role of teacher. She is with the child a larger proportion of the time than the father and usually more closely connected with the basic needs such as food

and physical comfort. From earliest infancy innate activities and tendencies to activity are being modified by the infant's reactions to the stimuli with which it is constantly surrounded. In every situation which presents itself some reflex and random activities are selected and form the basis for habits, while other cease to function in this situation but may become habitual responses in another. This process of forming habits goes on with such rapidity that bythe time the infant is one year of age it is difficult, if not impossible, to separate the learned from the unlearned elements in the child's responses to even the simplest situations. Blanton and others tell us that the feeding habits of the young infant may be modified by nervousness in the mother. Martin gives definite evidence of a transferred fear state in an infant nine months of age.

Many of the reflex activites with which children are born can be performed more rapidly and more accurately after they have been repeated a number of times, provide the effects obtained by the repetition of the act have not been unpleasant. In all learning, the more frequently an act or a series of acts has been performed, the greater the ease of the performance and the less the degree to which conscious action is required.

Tendencies may be modified by the fact that no stimulus is presented which brings them into play. For example, the tendency to overcome obstacles may function little if at all, if during the whole pre-school period all obstacles are overcome for a child by some oversolicitious adult or older child. A child who is beginning to form the habit of taking books out of the book-case may have another activity substituted for this undesirable one, or it may, because the bookcase is kept locked at all times, stop this activity entirely. In the latter case the activity would drop out through disuse.

There are many instances in which disuse results in breaking down habits once initiated, whether these be good or bad. A child who has developed the habit of using the table utensils to feed himself may allow the habitual responses and coordinations involved in this activity to deteriorate if he is

placed in an environment in which he is fed. The habit may have to be re-acquired almost in it entirety when he returns home. Children who have learned to walk and then receive injuries which result in confining them to bed over a period of months often need long practice before they walk with the facility with which this act was performed before the injuries. Common instances of the deterioration of a habit through disuse are found in the loss of skill in golf, tennis, and other outdoor games, when practice has not been kept up. Occasionally, however, one finds that a rest period actually produces an apparent improvement in the speed and accuracy with which one performs an act.

Substitution or sublimation means merely providing an outlet for activities or emotions which were originally undesirable along lines that will be valuable to the child. Fenton[2] gives two excellent illustrations of the use of substitutions for undesirable activities where mere repression had failed to cause those activities to drop out.

" A little boy, not yet two years old, had discovered how to manipulate the stopcocks which served to turn on the gas in the gas stove, and persisted in running to turn them all on whenever her came into the kitchen. Manifestly this must be stopped, and at once, lest he asphyxiate himself some day before anyone could discover his plight. His mother argued with him earnestly and at length, explaining that it would hurt him if he turned the little knobs, and forbidding him with great solemnity and emphasis to touch them. This, however, had only the effect of enhancing his curiosity and interest. In desperation his mother slapped his hands (tactics which she hitherto not used with him), but this only made matters worse. The baby became extremely excited, and ran again and again to turn all the gas burners, crying hysterically all the while and watching his mother with a terrified face. He behaved almost as if hypnotized by the irresistible fascination of those shiny little knobs. Seeing that matters had only been made worse, his mother soothed the little fellow, and led him to the stove. Then she showed him where

the gas pipe turned at the corner of the stove, and said, "See this nice shiny little corner? You may touch the stove right her. Here," indicating the forbidden stopcock, "is where Mother may touch the stove. Now show me the place where you may touch it." The child proudly laid his hand on the elbow of pipe, saying, "This Bobby's place." "And where may Mother touch?" "That Mother's place," said the baby. "Yes, dear, that's fine! Now you touch your place. Yes, that's right. That is Mother's good boy!" Later when the father came home, the mother suggested to the baby that he show father the nice new place he might touch the stove, which he accordingly did with evident pride and satisfaction. This particular problem now proved to be solved, for the baby showed no further desire to handle the stopcocks, except occasionally to point to them with the remark, "That Mother's place."

It will be noted in the above example that the mother tried several tactics first but succeeded by using substitution in combination with principles such as pride in ownership, repetition, pleasant experience and praise. The fact that she suggested showing the new place to the child's father indicates favorable relationships between the father and mother in training the child.

It is by applying similar psychological principles that the mother is able to help the child adjust himself to his surroundings, to learn how to cope with new situations and gain knowledge by experience. It is just as important for him to have pride and confidence in successful mental development as it is for him to be proud of his physical growth.

The rights of children as set down by Dr. Plant can not be attained unless the parents establish in early years such traits as individuality, independence, integrity and adjustment to group life. They must be basic factors in dealing with every phase of development in order to become a part of the child's mental make-up. However, every child learns them from different experiences and every parent establishes them in a different way.

Infant Behavior:

Probably the first sensations of which the child becomes vaguely aware are those which have to do with touch, temperature and Pain. During the birth process the child receives a constant train of sensations from the organs of pressure and pain. Immediately after birth he experiences a change of temperature. Children are probably more sensitive to heat, cold , pressure and pain than are adults, inasmuch as such evidence as we have points to the fact that there are the same numberoof organs for the reception of the general cutaneous sensations in the child as there are in the adult. There are therefore, more of such organs to each area in the infant than in the individual of larger size.

The organs of taste are scattered over the upper surface of the tongue and in the young child, over the inside of the cheek area as well. It is known that much of the child's early development depends upon his taste sensations, that is the sensations of sweet, salt, sour and bitter. From the time when the child can put objects in his mouth, he tastes anything which can be brought in contact with the tongue. The tendency to experiment with objects with the lips and tongueappears to be particularly prominent about the time the child is six months old.

Reactions to taste are conditioned with relative simplicity. In spite of the fact that negative reactions to sour are a part of the Kuhlman Intelligence Test at age two, children can be conditioned to enjoy soure as represented in pickles and other objects arousing taste sensations. Strong tastes of salt arouse negative reactions in early childhood, but adults react positively to objects containing strong salt solution, such as anchovy, caviar and olives. Strong tastes, that is, objects which have a strong odor will be reacted to positively or negatively by the child in terms or the general attitude of the adult, not in terms of the strength of the sensation itself.

"Two children

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"Two children, twins, had as their reward for being good during the day one spoonful of cod liver oil. When they were particularly good, the reward consisted of a second spoonful of cod liver oil. In spite of the fact that negative reactions might have been expected because of the oily consistency and strong taste, the children reacted with a high degree of positiveness to this solution."

In the young child, clear vision is extremely difficult, inasmuch as, in order to see an object clearly, one must be able to focus the eyes so that one obtains adequate binocular vison. The six eye muscles attached to the sclerotic coat of each eye do not work together in a coordinated way in the young child; his visual sensations must, therefore, be somewhat blurred, except where they are received by each eye working individually. It is not until the child reaches the age of six months, or thereabouts, that the functions of convergence and accommodation are developed to such an extent that he is able to make use of anything like the binocular vision of the adult.

The average parent is unaware that the child begins to be able to react and hear almost immediately after birth and that he reacts to differences in tone not long after this time. Loud shouts as well as loud noises of any kind, as we see in discussions of fear states, produce fears within a few days after birth.

Loud noises, long continued, would appear to increase the general tension under which the young child lives. This does not mean that children should be protected from sounds of all sorts, but only that they should not be subjected to the strain of sound of greater intensity than those produced in the ordinary course of living. Slamming doors, shouting, dropping or throwing about metal object, and the like constitute sounds to be avoided.

Pre-school Behavior:

There are certain definite social attitudes which are observable in children of pre-school age. These attitudes may be classified as follows:

1. Treating animate objects as if they were inanimate.

2. Treating inanimate objects as if they had life.

3. Taking care of younger children and otherwise assuming an adult attitude.

4. Indulging in solitary play and resenting interference by other children or by adults.

5. Cooperating with the group.

6. Showing off and desiring to be the center of attention.

7. Imitating the activities of others

8. Seeking power over objects and persons.

9. Displaying bashfulness or timidity when first presented in a group situation.

Dewey, in his book "How We Think", outlines the five stages in the thinking process somehwat as follows: 1. The awareness of a difficulty, 2. its location and definition, 3, the suggestion of a possible solution, 4. experimentation with the bearings of the solution and 5. its rejection or acceptance. These stages, so clear as to be easily followed when the process of logical thinking at maturity is analyzed, are present in elementary form in thinking in childhood. The thinking process itself, however, shows as wide a difference from the same process in adults as do the other reactions of young children when compared with the same reactions at maturity.

The main points to be kept in mind in connection with the reasoning process are:

1. The reasoning process of children is likely to be inadequate because of lack of experience, inability to keep an end in mind, inadequate ideas, unwillingness to wait until all the facts are in, a memory process which functions neither so quickly nor so adequately as it will at maturity, and a tendency to find similariti

tendency to find similarities where none exist, and to overlook similarities apparent to the better-trained and more experienced observer.

2. Education in early childhood involves training in logical thinking, and such training should be undertaken much as is training which establishes the right motor habits and the correct social attitudes.

The sex instinct appears universally, but unlike most of the other instinctive tendencies, the period during which it functions at greatest strength is delayed. Certain manifestations of the sex instinct appear at birth in connection with the emotion that Watson calls love; that is, the infant reacts positively to stroking and petting. Between five and nine appears to be the greatest period of sex curiosity, and it is the period during which all possible information should be given in answer to the child's questions.

Certain cautions should be observed during the undifferentiated period--roughly from three to twelve years of age:

1. The child should have much outlet for activity, so that his attention may be directed away from body play.

2. He should not be allowed to sleep with other children or adults.

3. Absolute cleanliness should be insisted upon.

4. The clothing should be watched to see that it is not tight.

5. All types of excercise which produce sex excitement should be avoided.

The preceding phases of pre-school behavior are by no means complete; they are just a few of the aspects especially important from the standpoint of comparison with behavior in a pediatric hospital.

Adolescent Behavior:

The changes preceding and accompanying adolescence are not observed carefully. Consequently, the differences between childrena and adults are not clearly perceived or appraised. The child of eleven is little understood; he is thought of as a child; his true nental powers are underestimated in comparison with those of older children so that the difference between eleven and fourteen really seems greater than it is.

The youth's mental development and physical growth during adolescence are not the bizarre, saltatory affairs of popular psychology and the fiction writers. Changes do take place and they are of great importance, but life is a continuous function; the youth does not break with his past.

However, adolescene is a stage of special adjustment to physical and emotional changes. The basic habits and patterns of childhood must be strong enough to meet this test. His activities gradually branch out into more adult fields and he must learn to deal with situations in a more adult manner. This is made increasingly difficult if adults with whom he is associated persist in treating him as a child.

In fact, the child's logical question of "Why can't I do what you do?" is very well put. Every child has a right to express his opinions and demand certain rights as much as an adult---with limitations, of course, due to physical limitations and lack of experience. A wise parent will allow his child to participate in enough matters in which his choice is the important factor to satisfy this desire for adult behavior.

In general, the behavior of the child at home as surveyed here, must consist of the purely basic, fundamentals because every home and every child is different.

Part 3 ---Foster Children

When a child's home environment shows such a lack of the rights of children as listed on pages 3 and 4 that he will be unable to develop normally, it becomes necessary to place him in one or another type of foster home, depending on the conditions. Since the purpose of foster homes is to bring to the child the same variety of experience he had in his own home, the principles in selecting foster homes and guiding foster parents consist of a series of substitutions. It should be kept in mind, however, that no child should be removed from his own home if any other solution is possible.

Children eligible for foster home care may be divided into three groups: 1. The homeless child---orphans, illegitimates and foundlings. 2. Those from unfit homes due to brutality, alcoholism, feeblemindedness, chronic neglect, sexual immorality or a serious personality defect in the parents. 3. Those requiring temporary removal from the home with the hope of returning later because of sickness, temporary incapacity for support, accident, desertion, employment of the type making home life impossible or serious misconduct on the part of the child.

Applicants for the above include childless couples, parents who desire a companion for an only child, poorly adjusted couples who think a child will solve their difficulties and people intelligently interested and fond of children.

Foster parents always inquire about the child first. They want to know: Is he sound in mind and body? Is he capable of college education? Are there any distinctly unfavorable strains in his ancestry? If his parents are living, what is their attitude toward the child? What sort of child is he--aggressive, affectionate, sensitive, independent? Does he present any behavior problems? The agency answers these question, then proceeds to interview the would-be parents from the stand-point of the child's benefit.

The visitor asks why they desire a child, what experience they have had

with children, if they are interested in both physical and mental development of the child, whether they are prepared to help the youngster enjoy all the normal satisfactions of his age, gradually releasing him to live his own life as an adult. Later she inquires further from churches, clubs, physicians, teachers, interested individuals and newspapers. Facts she must know are: financial status, make-up of family, health and temperament of its members, general housing and sleeping conditions, house-keeping and home-making standards, intelligence and information of foster parents, education and attitude toward school, moral and ethical standards, church membership and attendance, diversions and community activities and neighborhood influences.

Foster parents must sign a written agreement to treat the child in accordance with standards of the agency. They agree to:

1. Treat him kindly as a member of the family.

2. Take him to church and Sunday school

3. Provide him with a public school education.

4. Give ample clothing both for week-days and Sundays.

5. Give proper food and medical attention.

Considerations concerning both the child and his foster parents should begin with the fact that their relationship is different. After that, the foster parents should attempt to make the relation as much like the natural ones as possible. The following are differences which foster parents must face with the accompanying advantages and disadvantages:

1. No physical bond and no bond formed by nursing and care from earliest days.

2. No heredity common to two generations.

3. No responsibility for bringing the child into the world.

4. No prenatal rejection.

A new experiment in foster home selection is allowing the child himself to help choose his home. He is given a list of approved families, visits them

alone or with the visitor and reports his reactions to the agency. The result is a series of "cagey" remarks and observations on the families he visited. Usually homes chosen in this manner are much happier than those chosen so carefully and scientifically by social agencies. One reason may be that the child naturally chooses a home similar to his own in background and attitudes. This is one of the most important factors in foster home selection.

Foster homes have provided a field in which trained workers may observe and report reactions and behavior of children in various environments which are most nearly like the natural home conditions. There is a question of whether many of the difficulties encountered in foster homes might not occur many times in the normal home without being observed by the worker or considered important enough to notice by the natural parents.

At any rate the foster home relations stand mid-way between home relations and the hospital relations considered in this paper. As such, child behavior in foster homes constitutes a valuable comparison. For example, in both places there are problems of homesickness and adjustment to a new situations. Then in the foster home there is the complication of mental attitude toward dependency; in the hospital mental attitude toward sickness.

Trained social workers in foster home care take the stand that through substitution, adjustment to the foster home may be accomplished by making it as nearly like the normal home as possible. Homesickness is combated by substituting other interesting activities for the child, yet in temporary foster homes the child retains relationships with his real parents, visits them and is encouraged by the foster mother to appreciate his real parents in many ways which he has not realized before. The comparison between problems of dependency and sickness is another phase of adjustment which must be met according to the individual case. Both involve careful, sympathetic and understanding guidance by foster parents or hospital attendants.

Part 4---The Child at School

The first day at school is one of the most important days in any child's life. It is often his first experience away from home as well as an introduction to an entirely new situation and to group life. Learning, which has before that time been a natural process so interrelated with other activities that it has not been considered separately, now is presented in a formal manner in the presence of a group of other children.

Comparison of school with pediatric hospitals involves the above factors, for hospital routines are also a new experience, a group experience and a learning experience.

The principles of learning as applied in the average school are repetition, imitation, association of ideas, the desire to excel and certain simple ceremonies designed to imprint the impressions more deeply on the patterns of the child's mind.

The advocates of progressive education go farther than this by stressing the fact that memory is dependent on the degree of pleasure gained from the experience. They strive for individuality and self expression in the child in order to develop individuals not patterns in their schools. The most natural situations, they claim, are those most conducive to learning especially if the subject is one related to means of self-expression.

The success of the child at school depends on his previous home training and on his teacher. She takes the place of his mother as a teacher and may become a sort of hero in the eyes of her pupils. Her application of the above principles and her knowledge of child behavior if correctly utilized give her an important place in the child's mental and emotional development.

In the pediatric hospital, nurses substitute in the child's mind for his mother and his teacher, too. Therefore, the nurse must have a working knowledge and understanding of psychological and educational principles in order to keep him happy and teach him the necessary health regulations .

Part 5---The Child in a Hospital

No matter where he comes from, no matter how normal his behavior at home, when a child is admitted to a hospital he comes because there is something abnormal about his physical make-up. With this physical change comes a mental change also. Therefore, it may be said that every sick child in the hospital must be adjusted to his physical ailment and to the new experience of hospital routine at the same time. The main problem of the hospital is to treat and, if possible, cure the physical condition, but they realize the importance of creating a favorable environment during hospitalization in order that the child's mental attitude may help not hinder treatment. A pediatric hospital interested in child welfare in general also takes the attitude of making the child's hospital experience a period of increased mental development, of pleasant contacts with other children and with hospital attendants.

This program, if successful, must begin the minute a child steps into the hospital. During admittance there are two problems to be faced in the child's attitude, fear of the hospital itself and homesickness. The hospital takes a positive and offensive course of action by welcoming him to the hospital as a friend and visitor, dispelling fear by gentle handling and relieving pain instead of increasing it. The parent who accompanies the child is reassured, informed of the child's condition by his doctor and invited to visit the child only during regular hospital visiting hours. If the parent feels that his child is in capable, friendly hands, his confidence and friendly attitude will be reflected in the child's attitude and the first obstacle of fear and homesickness overcome before it even appears.

Like the foster home, a pediatric hospital environment should be as much like the home environment as possible, yet the child should realize from the first that this relationship is different and that home is waiting for him as soon as he is well again.

The already existing behavior problems of the child at home must be recognized by hospital attendants and dealt with in an understanding, constructive manner. Sometimes a foreign environment and a friendly but new authority is more successful in dealing with these problems than the child's mother and the difficulties overcome permanently during his stay in the hospital.

As in the case of the child at school, temporary substitutions for normal home relations often develop. The nurse assumes the role of mother and teacher in the child's mind and the doctor stands for the wisdom and authority usually associated with a child's father. Physical security and comfort are provided by the hospital; companionship similar to the schoolroom classmates found in his hospital wardmates.

Because every child comes from a different environment and because every child is different, all must be considered as individuals and treated accordingly. Solutions of some of these problems, both general and individual, will be surveyed in the following pages.

Behavioristic Pediatric Problems

Possessions: Many times the child brings with him to the hospital a rag doll, a cotton bunny or an old blanket which he has been in the habit of taking to bed with him and which it seems impossible to take away without calling forth a burst of tears. Often these much prized possessions have become so dirty that it seems unwise for the child to keep them in the hospital. Besides, the habit if continued too long is not a healthy one for the child. Other activities should be substitued if possible to avoid this. Therefore, if the toy cannot be sent home on admission without causing an emotional upset, the child is allowed to keep it until a more favorable time. Some night after the child has gone to sleep the bunny may disappear very quietly and in the course of hospital routines and substitutions of a new game or toy be forgotten.

Homesickness: The child should not forget his home, nor lose affection for his parents during hospitalization, but if he is too dependent on his mother, for instance, the problem of homesickness becomes a major issue. Even weekly parental visits may end in fits of crying and hysteria. If this is the case, it may be wise to have the mother see the child through a window without being discovered by the child. He must be kept busy with hospital toys, make friends with other children in the ward, understand that he may go home when he is well again, that his mother will be proud of him when she sees how well he has learned to color or weave rafia mats, for instance. The subtle, temporary hospital substitutions for home relationships are of great value also in these situations.

Respect: In order to accomplish ordinary nursing procedures, treatments by the doctor and exactment of some degree of ward discipline, the nurse and doctor must be respected as well as liked by the children under their care. Respect is gained in different ways from different children. It is up to the nurse to determine the child's standards, then find some way of living up to them, thus gaining his personal respect. One twelve-year old boy, I took care of once, felt himself superior to the younger boys in the ward and to the nurses, too. Discipline by me as a nurse seemed impossible unless I could show him that I could do at least one thing better than he. Telling him did no good; he had to see for himself. One day, quite unintentionally, I gained his respect by blowing a big soap bubble in his bath water. He tried it himself and failed until I taught him how. Then it took a dozen trials until he was able to make one himself. I had done something which he couldn't do, then showed interest enough in him to teach him. This put us on an ideal basis, for I became the superior member of a soap bubble team and other nursing procedures naturally followed in the same relationship.

Hospital Clothing: Wearing a hospital nightgown all day is a constant reminder to the child that he is sick and in an abnormal situation. The substitution of light print dresses for the girls and colored overalls for the boys fnr daytime wear is one happy solution practiced by some hospitals such as the Shriner's Orthopedic Hospital in Portland.

Crying: If the cause is pain, a doctor may order sedation; if the cause is homesickness or the desire for attention, a nurse must divert the child's attention by providing toys or games, give hime an opportunity to command attention from herself or other children in the ward by excelling in some game or a constructive health activity.

Bed-Wetting: This may be a natural occurence dueto his age group, an abnormal one due to phycial ailments, or a childhood habit not yet outgrown. If it is due to his illness, this should be explained. He should realize that everyone understands he cannot help it, and does not censor or think less of him for it; that they will do all in their power to help him get well so it won't happen any more. Under the other cases, the child must realize that grown-up people don't do it; he must be encouraged to become grown-up., to develop habits which will help him lose this bad habit, and must receive recognition and praise when he is successful in controlling himself.

Feeding: Appetites are conditioned by parental tastes at home, but in the hospital the diet must be made enven more attractive in order to tempt a sick child. A ward of other children eating at the same time sometimes leads the child to go ahead and eat without question. Too much attention should not be directed to his likes and dislikes, for if he is hungry he will often eat foods he has never taken at home. Sometimes, if he isn't eating enough, he may be persuaded by the desire to excel others in his ward or to gain attention by a constructive act of finishing the tray, rather than the less desirable attention of prodding in order to induce him

induce eating. Medications also come under this heading. The Cod Liver Oil episode mentioned before is an example of parental influence. Another method is colored pills and capsules so that taking pills is a pleasant experience to be looked forward to, not dreaded.

Bed Rest: During hospitalization, one of the most important factors is rest in bed. Especially for active children this is difficult to enforce. Books, games, weaving, coloring and small toys must be made a pleasant substitute for more active recreation.

Painful treatments: Some hospital treatments are of necessity unavoidably unpleasant to any child. Preliminary explantions, absolute confidence in the doctor or nurse, a desire to get well, the belief that this treatment will make him feel better after it is over are the best aids in helping the child adjust himself to the pain.

Isolation: Contagious childhood diseases require isolation measures which mean that the child will be alone a great deal of the time and must find in himself sufficient integration to be satisfied and happy during this period. The nurse must help him adjust and find himself, must provide activities which he can enjoy alone. The child must feel that although he is alone, he is not forgotten by the nurse, his parents or his friends.

Cooperation: Treatments such as forcing fluids require the greatest cooperation possible from the child. If he can help keep track of his fluid intake , compete with others in the ward for the greatest amount, cooperation becomes a pleasant, spirited game. Other treatments and neatness of the ward in general may be accomplished in the same fashion.

Conclusion

Many other problems exist, but the preceding examples will give an idea of the principles of pediatric behavior. The subject if adequately treated would fill an entire book.

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