

# Communicating with our Child Patient

OR

## WHY IS JOHNNY CRYING?

**EVE TILTMAN**

**Registered nurse and play worker at the Red Cross Memorial Children's Hospital.**

This article won first prize in the category for registered nurses in the 1983 Promex-Curationis writing competition. The topic of the competition was communication in nursing.

### OPSOMMING

Goeie kommunikasie is die hoeksteen van die verpleegberoep. Aan die hand van gevalle illustreer die skrywer dat die kind veral gevoelig is vir 'n gebrek aan kommunikasie en dat 'n spesiale poging dus aangewend moet word.

Hospitalisasie en veral die skeiding van sy moeder het 'n intense invloed op die kind en sy reaksies hang van verskeie faktore af. Om te voorkom dat die hospitaalervaring hom skaad is dit noodsaaklik dat sy emosionele behoeftes bevredig moet word.

Een van die beste maniere om met die kind te kommunikeer is deur met hom te speel. Ons leer daardeur om hom te verstaan en dit gee aan hom die geleentheid om aan sy gevoelens uiting te gee en sy vrese te oorbrug. Vaardige kommunikasie met die kind vereis sensitiwiteit en dat ons kennis van hom het. Al sy gedrag het betekenis alhoewel hierdie betekenis moontlik nie altyd voor die hand liggend is nie.

### JOHNNY'S STORY

Children in hospital cry. The reason for Johnny's tears is for us to interpret. Is it pain, fear, frustration, guilt, loneliness of selfconsciousness?

Johnny is 3½ years old. He was admitted for abdominal pain. The first impression one had was of a neglected, emaciated little boy. His large black eyes had a look of frozen watchfulness. There was a red scratch under his left eye and a haematoma on his forehead. His abdomen was distended and he complained of pain. He protested weakly while a nasogastric tube was passed and a drip was sited. He was kept nil per mouth.

Johnny remained ill for several days. He was apathetic and cried quietly. He appeared unresponsive to comforting and his mother did not visit him.

It became apparent that Johnny's condition might be the result of non-accidental injury. A meeting was arranged between the social worker and Johnny's parents and she reported that Johnny's father admitted abusing his child. Johnny had been kicked. An ultra-sound investigation confirmed a pseudo-cyst of the pancreas, possibly due to traumatic injury.

The role of the nurse in a child-abuse case is difficult. In communicating with these parents a noncritical, non-punitive approach is necessary. This may be difficult because of personal feelings of anger or disgust with their behaviour. In Johnny's case there was a breakdown in communication with his parents.

Johnny had been in hospital for about a week. His medical condition was improving. He was still being kept nil per mouth, on naso-gastric drainage and receiving an intravenous infusion. Johnny was now responding to emotional support. He was using crayons

and paper. We created a *boy* from clay with a *tube* going into a foot and one coming out of his nose. We discussed the need for these and the reason why he could not eat. We looked at books. Each time he came to a picture of food he would say that he likes eggs (or milk or biscuits) and I would reassure him that the time would come when he could again eat all of these. Periodically he would become frustrated and would then protest about being starved and cry loudly for food. He began to cry for his mother.

We contacted his parents and asked them to visit. They came — bringing biscuits and sweets which they gave Johnny. His parents should have been warned about his condition and treatment. We should have anticipated that, possibly operating out of guilt, they would not have come empty handed. We had to take his goodies away from Johnny. He was distraught. His parents were visibly upset and angry. They left immediately, attempts at communication now rejected. Johnny was inconsolable. We knew why he was crying but he rejected our efforts to pacify him. He fell into an exhausted sleep.

The following morning I was greeted by wails from Johnny. Why was he crying now? I took along a tray of his familiar and now favourite play materials. I sat down at his bed, getting down to his level and trying to make eye to eye contact. I spoke to him and he lashed out aggressively. I tried to interest him in making a picture. He took my box of collage materials and, with surprising force, threw it on the floor. I now realised how he felt. His cries were of anger and frustration. I told him that I knew he was angry and hurt. I made



balls of clay and invited him to throw them. I retrieved them and let him repeat his act of really getting rid of his anger. His room looked like a disaster area but Johnny was becoming calmer. At last he allowed me to pick him up and cradle him in my arms.

The next step in communication could now begin. He trusted me — I had allowed him to behave without censure in a way that would usually be considered unacceptable. I had recognised and acknowledged his feelings. From that time Johnny's emotional health improved. We established a loving relationship.

We were still concerned about his mother. We could not usurp her position. *Some nurses over-respond to the part they play in the emotional life of a child and tend to develop a possessive attitude. Nurses should endeavour to keep a child's affections directed towards his mother. (Pearce p 51)*

The next time Johnny's mother came to visit his condition and treatment were explained to her. While she was there we encouraged her to participate in his care. In this way she felt more accepted.

We communicated an atmosphere of warmth and understanding. A relationship was established where she could express her feelings. We felt more optimistic about her accepting counselling from the social worker.

When we have a child in our ward, we must perceive him in his totality. We therefore also care for his emotional health. Communication is the medium through which we encounter his emotional state.

Our ability to communicate is influenced by complex factors. These include our personality as well as that of the child, our experience, attitudes and the milieu in which we work. Our understanding of the process of communication increases our effectiveness.

### WHAT IS COMMUNICATION?

*Communication is fundamental to human living. It goes on virtually the whole time in ways of which we are quite unconscious. (Argyle p 4)*

With words, facial expressions, gestures and deeds we convey a message which is perceived and interpreted by another. Effective communication means that the receiver understands exactly that which we meant to convey. Like casting a stone in a pond, once an intention has been initiated, its reaction cannot be reversed.

### COMMUNICATION WITH A CHILD.

Good communication is the keystone of the nursing profession. Because the

child patient is more vulnerable to the lack of communication, a special effort is needed while caring for him.

How we communicate our feelings to the child and respond to his depends partly on his age and his stage of development. For all children eye to eye contact is an essential element.

*A nurse, understanding the value of human contact, when she feeds and changes a tiny baby will talk softly to him and caress him lovingly before replacing him in his clean cot .... This human loving touch has done far more than just feed, change and clean the infant. (Pearce p 48)*

The toddler understands more than he can verbalise. He is sensitive to verbal and non-verbal communication. He follows us with his eyes and cries when his needs are not satisfied. He is aware of whether we accept or reject him.

Once the child has words to express himself, communication is made easier. However, many of his feelings are expressed non-verbally. These are the messages which we must interpret correctly to satisfy his emotional needs.

The older child may have some starting communication skills. We need to react appropriately to foster a relationship of trust and mutual respect. Most

children cannot be fooled. The adolescent under stress may regress in behaviour but he does not like being talked down to.

### THE HOSPITALISED CHILD

Hospitalisation and particularly the separation from his mother has a profound effect upon the child.

His reaction depends on a variety of factors. These include his age, his background, previous hospital experience, but particularly on the support he gets to help him cope.

Initially he uses all the mechanisms he has developed to protest against his changed circumstances. He cries (loudly) and may fight back. He rejects many attempts to comfort him. He needs to be assured that we understand his feelings of fear, abandonment and anger. It is tempting to make rash promises in an attempt to console him.

If the period of hospitalisation is extended and depending on the support the child receives, he may reach the stage of despair. Now he cries intermittently, withdraws from his environment and mourns the loss of his familiar surroundings. At this stage the nurse needs to make an effort to encounter the

child. Through communication she attempts to discover his personality as it was before his present stressful circumstances. She establishes a relationship built on acceptance, trust and respect. She allows the child to express his real thoughts and feelings and being sensitive to him she now knows how best to respond.

When the child feels that his stay in hospital has become interminable he may progress to the stage of detachment. Now he represses his feelings of longing for his past relationships. If he has not seen his mother since his admission he makes an effort to detach himself from her and makes numerous superficial attachments to the people in his new surroundings. He may become manipulative or use attention getting tactics. He may respond with submission. He becomes dejected, apathetic and loses his spirit to fight back. In this state he makes slow medical progress. He makes few demands on the staff and is slow to express how he feels. He is called *good* and we remark how well he has *settled in*. His needs are sometimes overlooked. He may also respond with aggression. He is angry, hostile, uncooperative and disobedient. He is called *naughty*.

Meeting the emotional needs of the child in the stage of detachment requires insight, patience and good communicating skills. He needs the opportunity to express his negative feelings and the knowledge that the nurse accepts him as he is and will respond appropriately to meet his needs.

One of the best ways we can communicate with the child is by playing with him. In this time of friendly interaction we learn to understand him. With the appropriate materials he can express his feelings and master his fears. Most pre-schoolers enjoy role play and delight in *taking blood* or using a stethoscope.

It is difficult to ascertain whether we have established meaningful communication with our child patient. Because of his lack of life experience we get little feedback. How he has coped with his hospitalisation only becomes obvious once he returns home. If our communicating skills have been good he settles back into his routine. If not, he may be aggressive or clinging, regress or be troublesome at bed time. If he requires re-admission his behaviour makes his feelings unequivocal.

## COMMUNICATING WITH PARENTS.

We cannot treat the child in isolation. He is an intergral part of his family group. *If we really want to serve the child well we first have to communicate in an effective way with his parents, especially his mother. (Marlow p 83)*

The first message we want to communicate to the parents is that they are welcome in the ward. They receive a friendly respectful greeting. We need to convey to them that they are in control of the welfare of their child and are part of the caring team. Explaining the ward routine enables them to be useful when their help is needed. They require clear information on the condition, treatment and prognosis of their child.

While communicating with the mother we give her the emotional support she needs. A less anxious mother is better able to provide the stable responsive mothering her child requires.

The mother must be encouraged to visit as often as possible. Her presence helps the child to master experiences which, without her support, might overwhelm him. If the child rejects her after a delayed visit, she needs the nurse's help to understand the effects of prolonged hospitalisation on his behaviour.

Because the young child cries when his mother leaves, controversy about visiting may arise. However, it is better for him to see his mother regularly than to feel he has been abandoned. To retain the child's trust, the mother must be honest about her return. The nurse, by supporting both mother and child can help to make the parting less painful.

If we enquire from the mother the special words the child uses, his eating and sleeping habits, about his family and pets, we are better able to care for him while his mother is away. It helps him to retain a feeling of being an individual although he is in impersonal surroundings.

Some mothers feel guilty about their child's condition. This may make them unapproachable, over anxious or aggressive. With sensitive communication we can allow them to express their feelings and promote a better relationship.

When the child is ready for discharge the parents require clear, accurate instructions. They will want to know about medicines and follow-up clinics. We must explain about the possible behavioural problems and that loving sympathetic handling of the child can resolve them.

Caring for the family of a dying child requires our best communicating skills. They need to feel useful and not that we are taking over their nurturing functions at this difficult time. A mother expressed her feelings to Elizabeth Kübler-Ross: *.... they look at me as if to say, Are you here again They just brush past me, you know, don't talk to me. I feel like I'm invading or something, like I shouldn't be here. (Kübler-Ross p 190)*

The parents need to be reassured that everything possible is being done for their child and that he will be kept free of pain. We must justify their faith in the caring team and support them by meeting their needs.

Most parents are very appreciative of our attempts at communication while their child has been in hospital. Unfortunately isolated cases of dissatisfaction occur and these have repercussions (Refer Living & Loving, October, 1982). We must make every effort to prevent them.

## INTERPERSONNEL COMMUNICATION.

The child is at risk if there is a breakdown in communication between staff members. Unlike an adult, he does not yet have the skills to relay messages about his condition or what he hears about his treatment.

Staff tend to underestimate the ability of the child to assimilate what he hears around his bedside. We need to be careful of how and where we discuss his diagnosis, treatment and progress.

*Have you ever felt like nobody?  
Just a tiny speck of air,  
When everyone's round you,  
And you are just not there.*

*Karen Crawford aged 9 (Lewis p 163)*

At case conferences to discuss a child's treatment, it is necessary to include his emotional health. The nurse, who spends more time communicating with the child, has a valuable contribution to make.

When there has been an upsetting case or the death of a child in the ward, it is helpful for the staff to get together, perhaps with the social worker, to discuss it. This provides the opportunity to express their concerns, conflicts and coping mechanisms and helps to minimise the *burn-out* syndrome.

## COMMUNICATION AT WORK.

Putting our communication skills into practice requires a sensitive awareness and knowledge of the child. All behaviour is meaningful, although the meaning may not always be clear.

### Case 1: Belinda's awareness.

Belinda is a bright, sparkling little four year old. She is from out of town and is without her mother. She is being cared for in the oncology unit which is cheerful with posters, mobiles, small tables and chairs, toys and other play materials. She is being treated for leukemia.

I'm in the ward while a medical student is making friends with Belinda. Playfully the medical student asks: *And what is wrong with you?* Without hesitation and with a toss of her head, Belinda answers: *I have leukemia.* Well, she doesn't really understand what that means. After the medical student has examined her, she returns to the table where we are busy with play activities. Belinda is going to give me a *finger prick* and squeeze my *blood* onto a *glass slide*.

But it does help me to understand why I find the normally outgoing Belinda sitting quietly in a corner one morning. Oswald had died during the night. It was common knowledge in the ward that Oswald had leukemia.

Myra Bluebond-Langner explains how children acquire this information:

*The children rely more heavily on overheard conversations between their parents and doctors; between other parents; between the staff. They know that adults tell one another things that they do not tell children; this added significance to the information gleaned from eavesdropping. The children considered information volunteered by adults to be less reliable.* (Bluebond-Lagner p 180)

When communication has been established between the nurse and the children in her care they may ask questions: *Am I going to be better?; Am I going to die?* Anna Freud suggests that the answer to give is usually: *Everything possible is being done to help you get well.* The older child may even communicate what he feels about death.

*When I die I think,  
I'll think first of brightness.  
Red lines, blue lines, yellow lines,  
Bright circles  
Spots all dashing, speeding  
Splitting across my mind.  
Pushing, pushing me back over a ledge  
of doom.  
Down, falling, falling  
Into a pit of cold black endless darkness.  
Everything goes in circles,  
It's hot but it's cold  
And then I stop,  
I stop on a rock  
A rock as cold as ice.  
But I feel that everything keeps going,  
Going forever,  
I feel at home.  
I sleep forever  
But everything just keeps going  
and going and going.*

David Short aged 11. (Lewis p 181)

Belinda didn't say anything. I sat down on a small chair and held her close for a long time. What was going on in her little mind? I reminded her that I had brought bright red ribbons for her hair. While she let me brush and plait her hair I spoke of Kevin. She remembered that he had gone home the previous week. He was looking well and cheerfully promised to send Belinda a card while he was on a holiday trip.

Belinda is going to need constant support and loving assurance in the future. Right now she is showing everyone the picture postcard she has received from Kevin.

### Case 2: Operation Enoch.

Enoch, aged eight, is lying in his cot as stiff as a ramrod. His head is hard against the top and his heels stick out at the bottom, toes pointing to the ceiling. Looking for his eyes, I see he is terrified and his mouth is crumbling. He is wearing a nightie, his stockingette cap is hanging over the top of his cot next to the *nil per mouth* sign. Clearly Enoch is going to have an operation.

I talk to him and he begins to cry with relief. Someone can speak his language (Xhosa). I ask him whether he has been in hospital before and whether he knows what is going to happen. While we talk he begins to understand — why he got no breakfast, about an anaesthetic and his operation. He makes a statement which is really a question: *I am going to wake up again.* I reassure him that when he wakes up he will be in his cot again and that I'll be there.

I keep drawing him into the conversation. Next to him Raymond, aged 12, is complaining indignantly. The doctor had told him earlier that he could have breakfast because his surgery was cancelled. Unfortunately the information did not filter down in time to overtake the food trolley. I suggest a personalised breakfast and he smiles smugly. Enoch prepares for a pillow-fight. I promise him the same another morning. Playfully they challenge one another. After his pre-medication, Enoch settles down and falls peacefully asleep.

## CONCLUSION.

It is a positive learning experience for a child to know that he can love and trust people outside his immediate family circle. In a stressful situation this lesson is more meaningful.

In the hospital situation, the staff realise this principle. By the giving and sharing of ourselves while communicating, we support our child patient, his parents and each other and achieve sound emotional health.

*A loving arm  
Shelters me  
From any harm  
The shelteredness  
Of kindness  
Flows around me.*

Mary Flett aged 9. (Lewis p 155)

## REFERENCES

1. Argyle M. Trower P. (1979) *Person to Person*. Willemshad: Multimedia Publications.
2. Bluebond-Langner M. (1978) *The private worlds of dying children*. Princeton University Press.
3. Kübler-Ross E. (1973) *On death and dying*. London: Tavistock Publications.
4. Lewis R. (1966) *Miracles* New York: Simon and Schuster.
5. Marlow DR. (1977) *Textbook of Paediatric Nursing* Philadelphia: W.B. Saunders 5th Ed.
6. Pearce EC. (1963) *Nurse and Patient* London: Faber and Faber 2nd Ed.