3 Needs of Children

Introduction

The able bodied and children with exceptionality have the same pattern of needs. Meeting the needs of the exceptional persons will help a child to grow into a mature adult who can take decisions that are worthwhile.

Two authors have worked extensively on needs of children. Pringle (1978) propounded four basic emotional needs, which have to be met from the very beginning of life to enable a child grow from helpless infancy to mature adulthood. They are:

1. The need for love and security;
2. The need for new experiences;
3. The need for praise and recognition; and
4. The need for responsibility.

The Child Care Commandments:

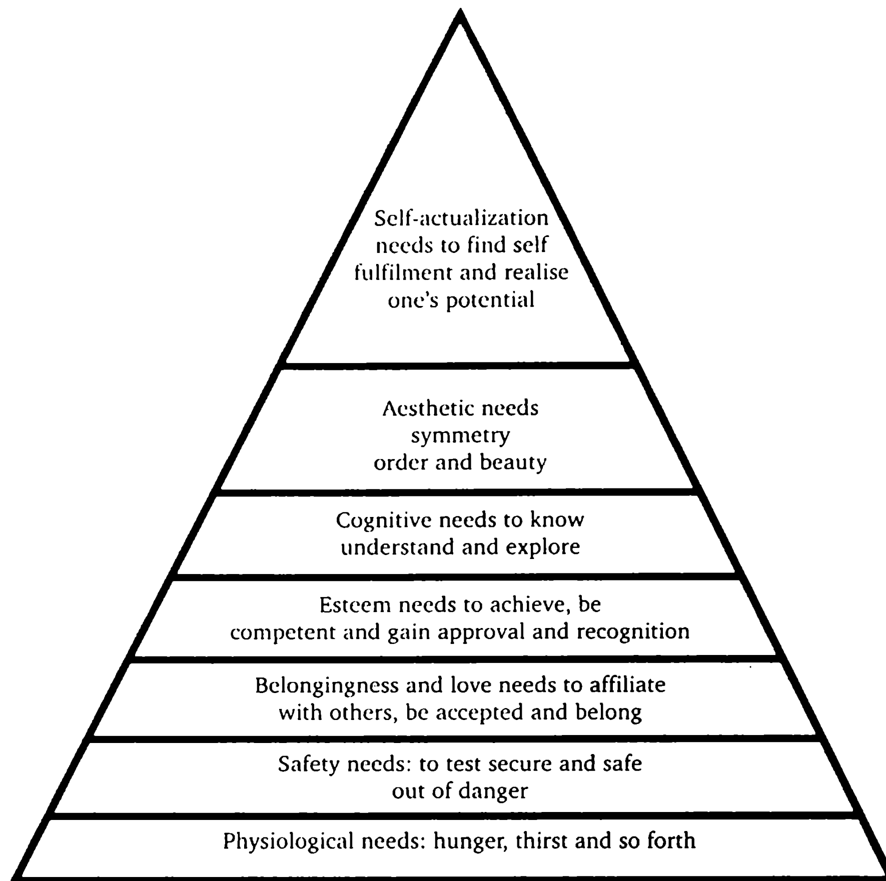
5. Give continuous, consistent, loving care - it is as essential for the mind's health, as food is for the body.
6. Give generously of your time and understanding - playing with and reading to your child matters more than a tidy smooth running home.
7. Provide new experiences and bath your child in language from birth onwards, they enrich his growing mind.
8. Encourage him to play in every way both by himself and with other children - exploring, imitating, constructing, pretending and creating.
9. Give more praise for effort than for achievement.

10. Give him ever-increasing responsibility like all skills, because they need to be practiced.
11. Remember that every child is unique and suitable handling for one may not be right for another.
12. Make the way you show disapproval fit your child's temperament, age and understanding;
13. Never threaten that you will stop loving him or give him away; you may reject his behaviour but never suggest that you might reject him.
14. Don't expect gratitude; your child did not ask to be born - the choice was yours.

Tansley and Gulliford (1959) have identified similar areas of need with special reference to children with abnormality. These include:

a) The need for security;
b) The need for giving and receiving affection;
c) The need for acceptance' by other children;
d) Recognition and self-esteem;
e) The need for independence and responsibility;
f) The need for new experience and activity.

They agree that, the growth of personality and achievement of mental health depend upon the satisfaction of these needs at each stage from infancy to adolescence.



Maslow's Hierarchy of Needs

Albert (Abraham) Maslow has identified a hierarchy of needs which generally motivates an individual's behaviour. (See the triangle above).

The needs' are arranged in order of importance as follows. As one satisfies the lower need, the next one automatically manifest. They are:

1. Physiological needs (food, water, sleep);
2. Safety needs (security from harm);
3. Love and affection (belongingness and love);
4. Esteem needs (self-respect and status with others);
5. Self-actualization (need to fulfill one's highest personal potentialities).

The more basic needs are at the bottom and the more personal ones are at the top. Common supplies such as food, clothing and shelter needs can satisfy the lower needs (physiological). The higher needs seem to lay emphasis on the search for an inherent

sense of value and worth.

It will be seen that Maslow views human motives as arranged in an ascending hierarchy of steps extending from the basic biological needs to the most complex social and personal desires. As the needs in the lower level are fulfilled, the higher needs become stronger, active and motivate the person. For example, a starving person experiences the very strong need for food, but may feel little need to be admired by others. After the availability of food, this person may find the need to be admired a necessary one. It is imperative that these hierarchies of need are applicable-to the different nations of the world.

Special Education administrators, teachers, employers have the responsibility to help students, employees, etc. meet their needs at the lower levels and have the responsibility to enhance the people's ability to gain esteem and to strive for self-actualization as well.

The Relevance of Maslow's Hierarchy of Needs to Rehabilitation

Professionals in the field of Special Education, Rehabilitation and related fields agree that, Maslow's hierarchy of needs has relevance in many processes and settings. There is therefore, the need to examine the motivational problems involved and encountered by rehabilitation workers. This will also enable us to specify the conditions that must prevail in treatment and rehabilitation centers if we are to expect maximum progress of clients with disability and patients. Many writers (including Fink, Fentez and Zinker (1963) examined Maslow's hierarchy. Maslow describes five general levels of needs arranged in a hierarchy reflecting their developmental emergence arid prepotency. At the bottom of the hierarchy are the most basic needs, the Physiological Needs, which include hunger, thirst, vital processes, homeostatic processes, elimination, sensory pleasure, sleep, and so on. They arise as a result of some bodily deficiency (tissue deficit) and their

satisfaction is crucial to the survival of the organism.

With the satisfaction (not necessarily total) of the physiological needs, the next hierarchical level emerges, the Safety Needs. These include protection from physical danger or harm, safety from extremes of temperature, criminal assault, disease, war, social catastrophe, and so forth. Although this level of needs is not related to tissue deficit, the absence of "safe" conditions may be considered a serious deficiency in the individual's world.

At the next emergent level are the Belonginess and Love Needs. Maternal love may be considered the most basic form of love, and there is evidence that the physical and psychological health of the organism is strongly dependent upon the reception of this love during the early years of life. In later years, the need comes to involve both the giving and receiving of love. Although it has a physiological basis, sexual behaviour may become chiefly determined by love needs. While the organism can probably survive a greater deficiency in this category than it can with respect to the physiological and safety needs, excessive frustration at the love and belongingness level can be detrimental to the growth of the organism.

Although animals, below the human level, appear to experience total "contentment" with the satisfaction of the three most basic need levels, in particular physiological and safety needs, the homo sapiens seeks something more. He strives for higher level of growth. Maslow calls the next level the Esteem Needs, and points" out the increasing recognition of the central importance of the esteem needs on the part of contemporary psychologists. The satisfaction a person experiences through accomplishment, the praise and respect of others, the self-confidence of strength, worth and adequacy, are all forms of esteem-needs, they are basic to the growth of the individual and to the growth of society.

Although higher-level growth is strongly rooted in the satisfac-

tion of the esteem needs; it certainly does not end there. The individual finds himself impelled to seek something beyond esteem, to realize the potentialities and capacities that lie within him. He strives, as Maslow puts it, for Self-Actualization. Enjoyment of beautiful things, the satisfaction of creative expression, the wish to understand oneself and the world, the seeking of meanings, philosophical and religious, all of these are self-actualizing needs.

Our own recognition of the relevance of Maslow's hierarchy to the rehabilitation process occurred as a consequence of research project which employed the critical incident technique as its basic method; the incidents which occurred during the patient's hospitalization were classified as to whether they reflected lower level (hygience) needs or higher level (growth) needs. The patients were categorized into two groups, those who were relatively hygiene-oriented and independent in activities of daily living as the medical criterion; it was found that there were significantly more successful candidates in the growth-oriented group than in the hygiene-oriented group. This finding emphasized the importance of the level of motivation, as opposed to the amount of motivation.

The sections that follow quote many of the critical incidents report by patients in the above study, in order to illustrate how they reflect the need levels on Maslow's hierarchy. Since there were: incidents that, from the patients' point of view, helped them in some way and incidents that hindered them in some way, it will be possible to demonstrate the effects of born satisfaction and frustration of needs upon the adjustment and growth of individuals undergoing rehabilitation.

Before discussing each level of need in the context of rehabilitation, it is important to clarify a possible misconception about the overall theoretical scheme. Because the five levels show a developmental emergence we should not preconceive the process of rehabilitation as following an analogous course. The adult human being has within him needs at several, if not all,

hierarchical levels at any given time.

During acute stages of illness it may be that most of the energy of the organism is directed at one level, the physiological needs, but during most of the course of rehabilitation this is not the case. We cannot split up the treatment of the person in such a way as to focus one group of needs at a time; this violates the importance of working with the person. The processes of evaluation and planning involve consideration of all the needs operating throughout the period development. The patient's safety needs, love needs, esteem needs and self-actualization needs all require our consideration right along with the physiological needs and right from the beginning of rehabilitation. This point will become more evident in the following sections.

The Physiological Needs

A medical hospital attempts to meet the physiological needs of its patients as fully as possible. The importance of good nourishment, treatment for physical ailments, provision of all available means for maintenance of vital processes and for alleviating discomfort, require no elaboration here. Medical and nursing care are devoted essentially to problems at the physiological need level.

Satisfaction at this level is reflected in the following statement from a patient:

> "When I regained feelings in my legs and feet, and pinpricks up to my chest, it was an exciting moment".

Frustration at the physiological level is reflected by this account. 1 had trouble sleeping, couldn't sleep. There was gas in my stomach with the water. By supper, I was pretty well filled up and in misery.

In a general medical hospital the treatment most often does not go beyond the physiological level. Illnesses are acute and short term, and the situation is essentially one of temporary interruption of normal life activities for the patient. Therefore, the direct medical treatment of the illness tends to be both necessary and

sufficient for the attainment of the medical goals. In the case of chronic diseases, the same treatment may be necessary, but it is certainly not sufficient for successful rehabilitation as will become evident in the sections that follow.

The Safety Needs

Most of us are aware of the fears and feelings of insecurity, which patients develop during prolonged hospitalization. There is the fear that the treatment may not be adequate, and that the doctor or nurse will not be available during an emergency the fear of falling out of bed while sleeping, uncertainties about the disease and what the future holds, all of these play a role in the day-to-day lives of patients. Note the following satisfaction:

> Every time I've had one of those bladder or kidney infections, they've always been very prompt in their care of me. It gave me the feeling that I was being taken care of, and that my general welfare was being taken care of.

The way in which rehabilitation progress can be hindered is evidenced in the following statement:

> Well, the extremely bad situation was when I first came here. I didn't know what to expect. The first room I was put into was one with three ladies in their nineties. Two were a little confused. I spent a good deal of that day just sobbing.

Many problems developed at the safety level because the staff simply does not take the time to clarify ambiguous situations for the patient. Too much is left to his fear and fantasies; not enough reality is communicated to him to permit a more constructive desirable result. How many patients understand their own illnesses, the rationale behind much of their treatment, the problem is not so much providing safe physical conditions for the patient as it is helping him to experience safety in his own personal world, to cope with the anxiety of his crisis.

Love and Belongingness Needs

Prolonged hospitalization means prolonged separation from loved ones. As long as frequent and regular contacts are maintained between the patients and his family and friends, the patient feels relatively secured at this level of need. More often than not these relationships become strained, either because the loved ones actually fail to pay frequent visits to the hospital or because the patient feels so unfulfilled at this level that frequent enough visits are not even possible. In any event, a patient can be expected to seek friendships among staff and other patients, because the major part of his time is spent in this new social context. The ill person trusts his doctor's decisions much more when he feels that the doctor is concerned about him in a personal way. All the technical competence in the world cannot fully substitute for the personal concern of the physician for his patient. The friendship of a therapist can often act as an impetus for co-operation and effort in specific rehabilitation activities. The listening ear of a nurse, a therapist or a social worker is frequently the key to improvement. With the satisfaction of love and belongingnes5 needs we find the following kinds of statements:

> The good thing is that children can come out, and the long visiting hours here. It is nice to receive visitors. It turned out fine the first time my wife brought the baby. It helped me forget for a while that I was crippled up. I know I could see my son now and then; in the general' hospital I couldn't see him. The fact that my wife talked to me made me try harder.

The depression and worry, which can arise from unfulfilled love and belongingness needs, are quite vivid in what this patient had to say:

> I just started feeling sad because I was thinking of things on the outside. Take the job, for instance, and not being able to be around my friends as much as I would like; the lack of

> visitors; some of my friends didn't know where I was. I couldn't sleep at night, couldn't eat. Just felt like it would be the end at any time.

The acute distress of a mother separated from her children is illustrated in the following report:

> It's very difficult for a woman who has three children to be away from them as long as I have been, makes me feel lost and depressed and anxious to get home. It isn't the hospital itself that makes me feel so bad; it's just being away from the children.

This is an example of how a need at one level can supersede all other needs, to the point where rehabilitation may be impossible. Whereas the rehabilitation staff might hope for this woman to reach some maximum level of physical independence, her own desire to return to the bosom of her family might impel her to sacrifice the possible gains of a treatment programme. Rehabilitation is a family matter; we need their co-operation and help as much as they need ours.

Esteem Needs

Probably the greatest direct threat posed by severe disability is the threat to one's independence and sense of adequacy, one's feeling of confidence to meet and master the challenges of life. The mere fact of hospitalization places a person in the care of others, removes from him much of the responsibility patient's independence that self-respect and feelings of adequacy suffer a major blow. The willingness of the staff to accept the esteem needs of the patient is vital to the rebuilding of a strong coping ego; the failure to help the patient satisfy these needs, even in some vicarious fashion, can serve to defeat the overall purposes of rehabilitation:

> Progress in physical therapy has a powerful effect upon needs

at the esteem level, as shown in the following description:

> Well, I felt especially good the first time I got up in my wheelchair. I started off at one hour, then progressed to two, then four and then eight. From there I went in my braces and began to walk. I was able to maneuver on my own, go to the movies and the canteen; enjoy myself like the other fellows that were in chairs. It meant that I could do more things for myself. It made me much more independent.

It is the experience of feeling more and more independent that is important, and not just the number of things the person can be observed to do.

Frustrations at the esteem level often lead to se1f-depreciation and hostility.

> Having to wait for such a long time to get a bedpan and having to be so dependent on people for having to use bedpans. I don't like other people waiting on me, because I've always been used to doing my own work and taking care of myself. I think it's made me more quick-tempered and aggressive.

The direct effects of a disease or traumatic injury are difficult enough to cope with; the frequently child-like relearning processes required of the recovering patient add to the degrading aspects of rehabilitation. We must not remove the last vestiges of self-esteem from a patient by limiting his right to self-determination beyond that already necessitated by the circumstances.

Self-Actualization

Many persons at some time in their lives search for understanding of themselves and of others. These are ways of creating means of self-aggression, religious or philosophical guidelines, and some basic achievement in their own lives). It has been our experience

that the crisis of severe disability often precipitates active soul searching in patients. They suddenly are brought face to face with themselves and the world around; there comes a re-evaluation of just what is important.

Things, which previously seemed so crucial all of a sudden, appear empty. As though life has suddenly been striped down to the bare essential. Where permanent change has ensured, where reality bas imposed major obstacles to certain need satisfactions, the individual must integrate what has happened to him into the whole perspective of his life. Some patients dwell from the question of "why" it happened to them; but hopefully they grow beyond this and eventually come to be, in many respects, better human beings. The way in which this growth occurs is illustrated in the following account:

I think it's been the last ten to twelve days. It's been the best stay I ever had here. Now I've got confidence in myself, confidence in other people. Realizing my own mistakes, trying to capture and destroy them and make good out of myself. I can say, I'll never make the same mistake again. I think the hospital stay has made a better person of me all around.

Another patient reported the following experience:

> When I first got hurt, it was something so new and different to the way of life I had lived. After two years I found that I could understand things better and could see some progress. And also getting acquainted with the patients and finding out, especially with those who had been disabled longer than I, how things went and what they could do about certain things. It turned out better and not worries about things on the outside so much. It really made me feel good. Made me stronger and as if I was accomplishing something that would be good .for me in the future.

Experiences like this seem to find direct expression only in patients

who have been disabled for sometime and who have had the opportunity to work through all the struggles, which ensure into such growth. This may be why we found very few patients reporting critical incidents at the self-actualization level. We feel it is not a reflection of an absence of the need for self-actualization, but a reflection of the fact that its expression, verbally, does not come easily and even then only after a prolonged "working through" period. The fact that it can and does occur during the course of rehabilitation obligates us to do everything within our means to help patients reach what may very well be the same as success.

Integration

This is the practice of educating children with disability in regular educational setting. Integration is related to such a thing as open education, least restrictive alternative, mainstreaming, normalization, open education, and more recently inclusive education.

The main objective is to integrate exceptional children from homes and special schools into the regular school where they will receive supplementary assistance from the resource or itinerant teacher.

Advantages of Integration

1. Children are not segregated and have ties with their parents and peers.
2. It agrees with the principles of normalization. They feel normal and less handicapped by attending ordinary school and these provide incentive to cope with others.
3. The spirit of competition is encouraged and enhances learning at a faster rate.
4. It encourages the use of services of many professionals working in a team.

5. It facilitates normal learning and development of social behaviour as the special child relates to other children freely.
6. The child learns at an early age to adapt to and function among other children in the community.
7. It helps the child feel important and useful to himself.
8. Effective parent involvement in such activities is made possible, e.g. Parents/Teachers Association.

Disadvantages

1. The exceptional children frequently need special help or confidence not normally available in the ordinary school.
2. Thus, the exceptional child's special needs may not be attended to.
3. The child might not be benefiting from the programme while he will give an impression of doing so.
4. If integration is not started on time or in advance, the child may be experiencing failure instead of progress.
5. Lack of early preparation of the students towards acceptance of the exceptional child might show attitudes that will lead to rejecting the child.
6. Teachers in special schools are well trained and understand the problems of the children better.
7. Peers can isolate the person.
8. So many support services are needed.

Focus Questions

1. Explain Pringle's four basic emotional needs as they affect special needs children.
2. Explain how parents how implement any five of Pringle's ten commandments in child care of special needs children
3. Explain Abraham Maslow's hierarchy of needs in relation to exceptional children.
4. Self actualization is achievable in the life of .exceptional children.

5. In five ways justify the place of integration in the education of children with special needs.
6. Explain five areas that integration may be disadvantageous to children.
7. The needs of all children are similar and dissimilar, Explain.