

The Impact of Symptom: A Preliminary Comparison of Cleft Lip-Palate and Asthmatic Children

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This study assumes that selective aspects of the environment acquire subjective weights or meanings as a function of previous experiences and occurrences within the environment. One such experience is the onset of a symptom (broadly conceived as a recognized clinical entity such as cleft palate or asthma) and the point in time, developmentally considered, when the symptom occurs. If the symptom occurs prenatally, it may be assumed that it is an integral and mostly an inseparable part of the self. The person, in one sense, need not accommodate to it, since it has always been a part of his structure. Should the symptom occur later in life, it can be assumed that it must be accommodated for by the person. There may, however, have been considerable antecedent psychological development highly relevant to its onset.

The degree to which a person is affected by his symptom is probably the result of the interaction of a number of important variables. Included among these are the reactions of those around him ranging from those responsible for his early care and development, to friends and casual acquaintances. The nature of the symptom itself may play a crucial role. Questions concerning symptom characteristics arise. Among them are the following: How disabling is the symptom? Is it life threatening? Does it mar appearance? Does it interfere with ongoing processes? Is the symptom remedial or capable of being altered in some way?

As part of a larger series of studies concerned with the habilitation of the cleft lip-palate individual, this study will examine two groups of children: those with cleft lip-palate, and those with asthma. Children with clefts have the onset of their symptoms *in utero* and these symptoms can be assumed to be unrelated to antecedent psychological development. Asthmatic symptoms, in contrast, develop postnatally, frequently occurring during the first two years of life. There may be considerable psy-

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chological development antecedent to the onset of asthma that may be causal to the symptom as well.

Procedure

SUBJECTS. Patients in two clinical populations were seen in the order they were processed through their respective services at Duke Hospital. Data are reported for 39 cleft lip-palate patients (26 cleft lip and palate, 10 palate only, 3 lip only), including 20 males and 19 females, and for 68 asthmatic, 44 male and 24 female, patients. The clinical diagnosis of each subject was taken from his medical record.

MEASURES. Parallel self-report interview schedules, constructed for the two populations, contain four sections. These sections and their measures are:

1. *The Impact of Symptom, I.* Based on the work of Norval, Larson, and Parshall (5), this attempts to measure reactions to having a symptom. Its purpose is to get at the current impact of the symptom in a direct manner. Titled "How I Feel About Having (Cleft Lip-Palate, Asthma)", it contains 20 questions in a multiple choice format such as,

Do you feel people stare at you because of your (cleft lip-palate, asthma)?

_____no, not at all _____sometimes _____yes, definitely

2. *The Impact of Symptom, II.* This is an attempt to measure the impact of the symptom less directly by asking each subject to indicate what changes, if any, he thinks would occur with symptom loss. Titled "If I Didn't Have (Cleft Lip-Palate, Asthma)", it contains 10 sentence completion items in a multiple choice format such as,

If I Didn't Have (cleft lip-palate, asthma)

I Would Worry

_____more than I do now

_____less than I do now

_____about the same as I do now

3. *Retrospective Perceptions of Parental Acceptance at Birth.* Titled "When I Was Born", the 16 items in this section attempt to measure the child's perception of his parents' reactions to his birth. It is assumed that there is a relationship between the child's current status and his impressions of what might have occurred when he was born. An illustrative parallel item for mothers and fathers is,

My mother wanted to show me off to everybody

My father wanted to show me off to everybody

Each item was followed by four possible alternative responses ranging from very true to very untrue.

4. *Self-Concept Measures.* Two self-concept measures, based on the work of Dickey (3) and Clifford and Clifford (2), are used. The first, the *Self-Rating Scale*, contains 15 statements about the self. The subject indicates how frequently each statement applies to himself. A reliability of .80

has been reported for this scale by Clifford and Clifford (2). The second self-concept measure, the *Self-Description Scale*, contains 20 adjectives. Each adjective is rated in terms of similarity to the self. Clifford and Clifford report a reliability of .72 for this scale (2).

Results

Two types of comparisons will be offered. The first compares 10 palate only (CP) with 26 lip and palate (CLCP) patients. Cleft lip only patients were not used in this analysis because they were too few in number. They are, however, included in the second analysis in which the combined cleft group is compared with a group of asthmatics. Sex comparisons are not reported, since with rare exception, they were not significant.

AGE AND GRADE COMPARISONS. The CP and CLCP subgroups were similar in age and grade placement. The total lip-palate group, at an average of 13.07 years, was significantly older than the asthmatics, who averaged 12.32 years. This is probably an artifact, however, since children above the age of 14 are not seen on this asthmatic service. Although the total lip-palate group was older, they had the same grade placement as asthmatics. When grade placement is proportioned to age, the total lip-palate group is slightly less than half a year (.43) behind the asthmatics.

IMPACT OF SYMPTOM, I. As shown in Table 1, when asked the series of questions about how they feel about having their symptom, no significant differences emerge between the CP and the CLCP groups. Differences between the total lip-palate group and asthmatics are not significant. In general, the mean scores are skewed toward the positive anchoring point, indicating relatively mild reactions to symptoms for both groups.

IMPACT OF SYMPTOM, II. Two types of scores are reported in Table 2. The first is concerned with the average number of times out of 10 the subjects indicate they thought that loss of symptom would lead to a change for the better, a change for the worse, or no change at all. No sig-

TABLE 1. Impact of symptom on cleft lip-palate and asthmatic patients, I: Reactions to having symptom. (The higher the score, the greater is the negative reaction.) Neither of the *ts* is significant.

	<i>How I feel about having (cleft lip, cleft palate, or asthma)</i>	
	<i>mean</i>	<i>t</i>
palate only.....	29.10	.571
lip and palate.....	33.27	
total lip-palate.....	31.38	.875
total asthmatic.....	28.16	

TABLE 2. Impact of symptom on cleft lip-palate and asthmatic patients, II: Mean number of changes perceived as occurring with loss of symptom. Significant *ts* at the 1% level are asterisked.

	<i>If I didn't have (cleft lip, cleft palate or asthma) I would . . .</i>				
	<i>change for better</i>	<i>change for worse</i>	<i>not change at all</i>	<i>total change (better + worse)</i>	<i>relative change (better - worse)</i>
palate only	3.80	.70	5.50	4.50	3.10
lip & palate	2.85	1.00	6.15	3.85	1.85
<i>t</i>805	.607	.496	.496	1.140
total lip-palate	3.05	.84	6.10	3.90	2.21
total asthmatic	4.20	.24	5.54	4.44	3.96
<i>t</i>	1.950	3.333**	.862	1.698	2.988**

nificant differences emerge between the CP and the CLCP groups in these comparisons. When the total lip-palate group is compared with asthmatics, a significantly greater number of responses from the lip-palate patients indicate a change in the *negative* direction. That is, things would be worse without the symptom. It should be pointed out, however, that for both groups a negative change is perceived at a rate of less than 1 in 10. There is also a slight tendency for asthmatics to perceive more of a change for the better with symptom loss.

The second type of score shown on Table 2 consists of two derived scores. The first, an absolute change score, consists of the combined positive and negative perceived changes. The other is a relative change score and it consists of positive *minus* negative perceived changes. Differences between the CP and the CLCP groups are not significant. Asthmatics, compared to the total lip-palate group, perceive a significantly greater relative change for the better. Absolute score differences are not significant. Despite the emphasis upon perceived change, however, it should be pointed out that in slightly more than half of the responses, regardless of symptom, supposed loss of symptom would result in no perceived change.

RETROSPECTIVE PERCEPTIONS OF PARENTAL ACCEPTANCE AT BIRTH. In this section, the children were asked about their perceptions of maternal and paternal acceptance of them at birth (Table 3). Differences between the CP and the CLCP groups are significant around the 5% level. Palate only patients, in retrospect, perceive a higher degree of acceptance by their mothers, by their fathers, and by both parents combined, than do patients with cleft lip and cleft palate.

When the total lip-palate group is compared with asthmatics, all differences are significant at the 5% level. Asthmatics perceive themselves, in retrospect, to have been more highly accepted by mother, by father,

TABLE 3. Perceptions of maternal and paternal acceptance at their birth for cleft lip-palate and asthmatic patients. (The higher the score, the greater the perceived parent acceptance.) *ts* which are significant at the 5% level are asterisked.

	<i>When I was born . . .</i>					
	<i>my mother</i>		<i>my father</i>		<i>total parent</i>	
	<i>mean</i>	<i>t</i>	<i>mean</i>	<i>t</i>	<i>mean</i>	<i>t</i>
palate only.....	49.10	1.974	49.00	2.195*	98.10	2.127*
lip & palate.....	44.38		44.04		88.42	
total lip-palate.....	46.00	4.655*	45.69	4.288*	91.69	4.539*
total asthmatic (N = 66).....	52.61		51.77		104.38	

TABLE 4. Self-concept ratings of cleft lip-palate and asthmatic patients. (The higher the rating, the greater the self-acceptance.)

	<i>self-rating scale</i>		<i>self-description scale</i>	
	<i>mean</i>	<i>t</i>	<i>mean</i>	<i>t</i>
palate only.....	44.50	.434	61.60	1.545
lip & palate.....	43.61		57.46	
total lip-palate.....	43.97	1.500	59.00	.411
total asthmatic.....	45.59		59.60	

and by both parents combined. These differences, are, of course, much greater than those arising within the cleft lip-palate population.

SELF-CONCEPT MEASURES. Differences between the CP and the CLCP subgroups on the two self-concept measures are small and nonsignificant. Nor were there differences between the total lip-palate group and the asthmatics. The tendency is for all of these children to rate themselves in a rather positive, self-accepting manner.

Discussion

We do not know why these cleft lip-palate children were somewhat behind in school, as reported above. At least three explanations come to mind. a) These lip-palate patients, who are still being seen, possibly have been hospitalized more than the asthmatics, and are, therefore, behind educationally. b) Lip-palate children may not be as bright as asthmatics

and, therefore, do not do as well in school. Goodstein (4), for example, found that lip-palate IQ scores were significantly lower than those of a control group of normal children. c) While Spriestersbach, Moll, and Morris (6) point out the heterogeneous nature of the cleft palate population, in general those with lip-palate symptoms can be expected to have greater speech and communication difficulties than asthmatics. These can interfere with normal grade progression through the schools. This may be even more likely with the patients in this sample, since they are still being seen by members of the cleft palate group at Duke University.

In discussing relationships between the onset of a symptom and accommodation to the symptom, it was assumed that accommodation would be greater to the symptom occurring postnatally. The children's reactions to supposed symptom loss enables an examination of the effects of early-versus-late symptom onset. The fact that asthmatics perceive a greater change in a positive direction and less of a negative change with symptom loss supports the contention that onset of symptom is a significant variable. If accommodation to the symptom is great, then loss of symptom should result in greater effects. This seems to be borne out by the data.

The finding that lip-palate patients perceive a greater change for the worse with supposed symptom loss than asthmatics is provocative. One explanation would stress the secondary benefits that accrue from symptoms. These benefits would be lost as well. On *a priori* grounds, however, in view of psychosomatic components often associated with asthma, one might expect the reverse: that asthmatics would be more reluctant to remit the symptom. Another explanation would stress that accommodation to the symptom has been greater in lip-palate patients and that by rejecting the symptom they reject a significant part of themselves.

A noteworthy finding of this study is related to perceptions of parental acceptance at birth. Those with the greater visible anomaly at birth now perceive themselves as having been less accepted by their parents than those with a less visible symptom. In turn, those with a birth anomaly, regardless of visibility, currently perceive themselves as having been less accepted than children who were supposedly normal at birth and develop symptoms later. This finding dramatically illustrates the differential impact of differing symptoms.

Questions may arise as to whether the lip-palate perceptions regarding their acceptance at birth may be more realistic than those of asthmatics. Asthmatics may be more concerned with parental acceptance. Abramson (1), in investigating psychodynamics in asthma, points to the intensity of the relationship between parent and child as a significant etiological factor. It is possible that asthmatics need to stress parental acceptance and that current needs operate retrospectively. These relationships should be explored further, and the need for a "normal" control group is vital.

This preliminary study has pointed out several areas that merit further investigation. These include a more intensive investigation of parent-child

relationship variables, the effects of symptoms at different states of development, and the meanings symptoms have for persons within specific clinical groupings. The measures that have been most effective in this study have been those dealing with perceived effects of symptom loss and with perceived parental acceptance at birth. We see this as a beginning of a series of investigations designed to broaden our knowledge of cleft lip-palate through contrast with others having symptoms that differ in kind and in time of onset, as well as with those who are symptom-free.

Summary

Self-report measures were developed to examine the impact of the symptom on the child directly and indirectly, to examine the retrospective aspects of the symptom influencing the child's perception of his acceptance by each of his parents at his birth, and to examine possible effects of the symptom on self-concepts. Cleft palate and asthmatic children were used as subjects. Results indicate that there is a differential effect of symptom which is related both to the type of symptom and to the point in time, developmentally considered, when it occurs. In addition, palate-only children perceived a greater parental acceptance at their birth than did children with cleft lip and cleft palate. When the total lip-palate population was compared with asthmatics, the effect of the symptom was highly significant. Lip-palate patients perceived themselves as much less accepted by their parents at birth than asthmatics. Self-concept measures, on the other hand, exhibited no differential effects. Both groups rated themselves positively.

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