

# Parental Ratings of Cleft Palate Infants

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By now, it is almost folklore to assume that giving birth to a child with a defect has a decided impact upon the family, particularly upon the mother. Conceptually, the source of the impact lies in the arousal of anxiety in the mother for having produced an imperfect baby. Tisza and Gumpertz (12) are excellent proponents of this viewpoint stating:

Mothers react with strong feelings of hurt, disappointment and help-less resentment to the revelation that they have a congenitally deformed child. They are in a state of acute grief because they have lost the perfect baby nurtured in their imagination and received instead a damaged child which they regard as a symbol of their own inadequacy as mothers. [p. 86]

Since anxiety and grief are the primary reactions involved, it is usually implied that the direction of the impact is almost inevitably and invariably negative and disintegrative in character.

The concept of impact is equivalent to shock. Like shock, impact is aroused whenever an event, such as giving birth to a child with an anomaly, is either physically or psychologically traumatic. Once it is aroused, impact seems to mute other behaviors and seemingly also has the capacity of reducing the mother's information processing abilities. Spriestersbach (10), for example, states that parents are in a state of shock and that the first day following the birth of a cleft palate baby is not a time for "detailed counseling". Norval, Larson and Parshall (8) point out that despite the fact that mothers of cleft palate infants were given adequate information about their babies, they were not ready to "accept explanations until they had had a chance to vent some of their own anxiety" [p. 9].

While impact is assumed to have a sudden onset, its peaking and dissipation rates have not been described. In many studies (1, 4, 5, 8) the impact is assumed to endure unabated for lengthy periods of time—months and years. Tisza and Gumpertz (12) point out that maternal anxiety gives way to feelings of compassion for the child, while Macgregor and associates (7) imply an initial shock and then a marshalling

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of forces to make the best of the situation. We still know little, however, about the arousal characteristics, dissipation qualities, and residual effects of impact.

The concept of impact implies a forcible intrusion of an event, a crisis, upon a person. Much as shock has a generalized effect, it is frequently assumed that impact affects a general class of behaviors. Thus, for example, the birth of a child with a defect is supposed to affect the mother's feelings of acceptance-rejection, her own self-concept, and her satisfaction in marriage including her sexual behavior. Not only is the mother's behavior affected, family integration may also be involved (13). Presumably these effects are unilateral in direction as they are usually seen as being generally negative in nature.

This, however, may be naive theorizing. Certainly we know that marital happiness may be affected by any crisis, but the degree to which it is affected is probably more directly a function of the pre-existing stability of the marriage. In like fashion, feelings of acceptance-rejection are more probably a function of long enduring, pre-existing personality patterns of mothers and fathers than they are of having a newborn with a defect.

Studies of the cleft lip and palate population have taken a variety of directions. Spriestersbach (11) takes the position that the adjustment of the cleft palate patient is, in part, a function of parental adjustment and the attitudes parents have toward cleft palate. Underlying the approach of Macgregor and associates (7) is the assumption that the facial appearance of the cleft lip infant is intolerable, and hence has shock value. According to them, there is a disintegrating effect on family functioning as a result of giving birth to a child with a facial anomaly. They do, however, point out the possibility of the shock giving way to integrative efforts in the sense that it leads to transitory cohesiveness among family members. Tisza and Gumpertz (12) state that the trauma is higher for parents giving birth to a baby with cleft lip compared to those giving birth to a baby with cleft palate only. They go on to stress psychodynamic factors within the mother. According to Tisza, the mother assumes the blame for, and hence the guilt of being inadequate. After an intense period of grief, however, concern for the infant takes over leading to compensatory behavior. Norval and associates (8) assume that guilt and anxiety are present when the child is born, leading to reduced information processing and perhaps increasing marital conflicts.

In our common experience we know the potentiality for crisis at birth. When things do go wrong, a crisis develops, the effects of which we call impact. To the extent that these effects interfere with ongoing processes or adjustments, we are able to demonstrate the psychological impact of a birth defect such as cleft palate. It is also assumed that this impact is selective rather than general. That is, it is thought the effects are greatest in areas of greatest psychological sensitivity.

## Procedure

This study takes as its point of departure the interviewing of mothers and fathers within a two year period after the birth of the child with a cleft. We could not, desirable as it would be, restrict the study to newborns, since there were too few newborns with clefts. We restricted the age range in order to maximize the number of available subjects while, at the same time, controlling the interval between birth and the recall of the event, since the recall of events is subject to increasing distortion with the passage of time. Even with this wide an interval, we have to wait for the relatively slow accumulation of data.

Some of the results have been reported elsewhere (3) and will not be repeated here. The parental ratings of children have not previously been reported, and these constitute the main data in this report.

**SUBJECTS.** Sixty pairs of parents served as subjects. Mothers and fathers were simultaneously and independently interviewed, as their children were being seen at either the public or private surgical clinics at Duke University Medical Center. To be included in the study, both parents had to be present and willing to participate. Parents were not included if their child had passed his second birthday. Infants used for study were 37 males and 23 females, whose ages averaged 7.15 months at the time of the interview. The sample included parents of 30 lip and palate, 17 palate only, and 13 lip only patients.

**MEASURES.** Parallel interview schedules were constructed for separate administration to mothers and fathers. The nature of the research and the reasons for it were carefully explained to them. The interviews, described in Clifford (3), were in questionnaire form and were self-administered. Each interview contained several components. The components to be reported in this paper are as follows.

*Ratings of the Severity of the Child's Condition.* Parents rated their child's condition on a five point scale ranging from very mild to very severe.

*Activity and Halo Factor Ratings.* Haar, Welkowitz, Blau and Cohen (6) developed a personality rating scale for neonates. This scale yielded two independent factors. Items loading highest on the "activity" factor included those measuring the infant's tenseness, irritability and activity level. The second factor, called "halo", loaded highest with items measuring likeability, cuteness, and intelligence, among others. (These scales are given in Appendix A.)

*Marital Happiness.* This section contains 10 items in a multiple choice format based on the work of Schaefer and Manheimer (9) and Clifford (2), and measures the degree of expressed marital satisfaction.

*The Impact of Giving Birth to a Cleft Palate Child.* The scale containing 9 items in a multiple choice format devised by Norval and associates (8) was used. In addition, five items in the interview questionnaire measured impact.

TABLE 1. Correlation coefficients for estimating the strength of the relationship between mothers' and fathers' ratings. Coefficients which are asterisked are significant.

<i>variable</i>	<i>lip or palate</i> <i>N</i> = 30	<i>lip and palate</i> <i>N</i> = 30	<i>total sample</i> <i>N</i> = 60
marital happiness.....	.42*	.53**	.51**
severity.....	.35	.74**	.59**
activity.....	.41*	.60**	.52**
halo.....	.37*	.18	.30*
impact (Norval).....	.07	.18	.12
impact (5-item).....	.00	.12	.10

\*\*  $p < .01$ \*  $p < .05$ 

## Results

In preliminary analyses, obtained differences between the cleft lip only and the cleft palate only populations were minimal; therefore, the data for these two groups were combined in this project. This combined group is called the lip *or* palate group ( $N = 30$ ), and it is contrasted with the group having lip *and* palate involvement ( $N = 30$ ). At this point, we have no control group data, but a normal control group will be obtained and reported on at some future time.

Correlation was used to estimate the degree of correspondence between husbands and wives. These data are given in Table 1. Correspondence between husbands and wives varies with selected measures. They agree to a significant extent about their satisfaction or dissatisfaction in marriage. On two measures of generalized impact of giving birth to a child with a cleft there is little correspondence between parents; essentially no relationship is obtained. Agreement is relatively high in rating the severity of the child's condition between the parents of children with cleft lip *and* palate (.74), as contrasted with the correspondence between parents of children with lip *or* palate (.35). The trend is similar when the "activity" of the child is rated. When more subjective ratings of the child are involved, such as in the "halo" factor, the extent of agreement drops, and here the agreement is, in large measure, determined by the parents of lip only or palate only children. By inspection, with the exception of the "halo" variable, the correlations obtained are higher for the lip *and* palate symptom group.

The severity ratings, "activity" factor ratings, and "halo" factor ratings were each examined in a symptom by parent by sex analysis of variance. The  $3 \times 2 \times 2$  design compared ratings for symptom groups (lip only, palate only, lip *and* palate), parents (mother, father), and sex of the child (boy, girl). None of the interaction effects is significant. The main effects of parent or sex of the child are not significant. The only

TABLE 2. Parental ratings of Severity, Activity Factor, and Halo Factor, by mothers and fathers.

	<i>severity</i>	<i>activity</i>	<i>halo</i>
<i>mothers</i>			
lip or palate.....	2.17	15.83	31.66
lip and palate.....	3.37	17.00	30.80
<i>t</i> .....	4.138***	1.612	.999
<i>fathers</i>			
lip or palate.....	2.67	15.63	31.90
lip and palate.....	3.30	16.73	29.67
<i>t</i> .....	2.330*	1.300	2.990**

\*\*\*  $p < .001$ \*\*  $p < .01$ \*  $p < .05$ 

TABLE 3. Correlations between Severity, Activity Factor, and Halo Factor Ratings of Children.

	<i>severity</i>		<i>halo</i>	
	<i>mothers</i>	<i>fathers</i>	<i>mothers</i>	<i>fathers</i>
activity.....	.41**	.31	-.36**	-.08
halo.....	-.12	-.22		

\*\*  $p < .01$ 

significant main effect, for severity and the "halo" factor, but not for the "activity" factor ratings, is the symptom status of the child.

The mean ratings given to the combined lip or palate group were compared to the ratings given to the lip and palate group. These data are given in Table 2. Severity ratings are significantly higher for the lip and palate group, with mothers making a greater distinction between the two than did fathers. The main effects of symptom on "halo" factor ratings are primarily accounted for by the fathers, who tend to rate lip or palate children more positively than the children with lip and palate. The responses of mothers are in the same direction, but the difference is not significant.

Interrelationships among severity, "activity" factor ratings, and "halo" factor ratings were obtained. These data are given for mothers and fathers in Table 3. Although the strength of the relationships is not great, ratings of severity and "activity" are positively related, significantly so for mothers. The greater the perceived severity, the greater is the rating of tenseness, irritability and activity. Ratings of severity are

negatively related, although not significantly so, to ratings of the child as likeable, cute, intelligent—the “halo” factor. For mothers, ratings of “activity” are negatively related to “halo” ratings. That is, if the child is seen as tense, irritable, and active, he is likely to be rated as less likeable, cute, and so forth.

The marital happiness scores, the impact scores of Norval, and the 5-item impact scores of the questionnaire were each subjected to a symptom by parent by sex analysis of variance. Marital happiness scores are not affected by either symptom status or sex of the child. The main effect has to do with parents. Mothers, in this sample, are less content with their marriages than are their husbands. The impact score of Norval demonstrated no main effects for symptom or sex of the child. Mothers, however, rated the impact on themselves to be greater than did fathers for all children. The 5-item impact score demonstrated a main effect only for symptom status. Impact was significantly greater for children with clefts of the lip *and* palate than for children in the lip only or palate only condition.

### **Discussion and Conclusions**

The absence of a group of parents giving birth to normal, healthy children places a limitation on the findings of this study. We do not know, for example, what the effects might be on family members and family integration of simply giving birth to a child. Despite this limitation, the data do allow for a closer examination of the cleft lip-palate population.

It has been demonstrated in a number of comparisons that differences between parents of cleft lip only and cleft palate only children were minimal. This finding itself would not support the positions taken by both Tisza (12) and Macgregor (7) that a facial defect, such as cleft lip, has more profound effects than a nonvisible anomaly, such as cleft palate.

The main effects in the analyses of variance distinguish between parents of children with combined clefts of the lip and palate as contrasted to parents whose children have clefts of the lip or palate only. The parental ratings, perceiving combined clefts to be more severe, would probably coincide with more objective ratings of physicians. In other words, it is entirely conceivable that these parents are more reality oriented than we have heretofore believed.

Since the average age of the children at the time of the interviews was slightly more than seven months, it is possible that whatever shock or impact existed at birth dissipated in the intervening time. That there are some effects on parents cannot be denied, particularly when the perceived severity of the child's condition is taken into account. For mothers, a significant correlation was obtained between severity ratings and “activity” factor ratings, indicating that children whose condition was

rated more severe also tended to be rated as more tense, irritable, and active. Furthermore, although not significant, the relationship between severity ratings and "halo" factor ratings tends to be negative. The more severe the child's symptom is rated, the less cute, less likeable, and less intelligent he seems to be. When the lip *and* palate condition is compared to the lip *or* palate condition, parents of children with the combined clefts perceive their children to be more irritable-active and less likeable-cute. These ratings may be the result or consequence of impact, since children with the more severe condition were rated less positively. These ratings may also reflect a reality orientation. Is it not possible that children whose symptoms are severe may indeed be more irritable and tense? If this be the case, would not ratings of likeableness and cuteness be affected as a result of the behavior of the child rather than a function of the stimulus value of his symptom?

Two measures of general impact were used: the Norval (8) 9-item measure, and another 5-item measure. Generalized impact, as measured by these two sets of questions, seems to be a function of the perceived severity of the child's symptom (5-item), and of whether the mother or father is responding (Norval questions). It is of some interest to note that the Norval measure indicates greater general impact for all mothers regardless of the child's symptom. This may not be too surprising since the measure was derived from maternal interviews and therefore may not be as relevant for fathers. It is also conceivable that paternal responses are affected by cultural perceptions of sex roles. In this culture, men may be expected to greet crises and traumatic situations with overtly expressed equanimity. They may be expected to "take it" and even deny effects in order to preserve the acquired cultural norm of masculine strength in the face of adversity. It is also possible that these men respond in this fashion in order to bolster what they perceive to be the culturally expected weakness of their wives.

In this study, overt expressions of marital satisfaction do not seem to be affected by the child's symptom. Marital satisfaction differences are obtained between husbands and wives, indicating that husbands are either more content with their marriages, or perhaps more prone to deny marital dissatisfaction. Wives are significantly less content with their marriages, and at this point we do not know why.

What have these parents told us? They tell us they rate the child with cleft lip and palate more severely than a child with either a cleft of the lip or a cleft of the palate, perhaps doing so in terms of reality. They tell us that they perceive children with cleft lip and palate to be more irritable-active and, to some extent, less pleasant in personality characteristics. The parents also tell us that there is liable to be a more general impact if the child has combined lip and palate involvement and that mothers seem to be more affected than fathers. Finally, while wives may more openly express discontentment with their marriages, the fact that

they have children with clefts has not materially affected the expression of marital satisfaction.

While there are no normative controls in this study, parents indicate no adverse effects upon their marriages as a result of having a child with a cleft. Very clearly, the evidence points to a necessity of reevaluating any generalized concept of impact, making it more specific. A greater knowledge of conditions existing within families prior to the birth of a child with a defect would enable a more careful assessment of the effects of the birth of babies with clefts.

### Summary

Sixty pairs of parents of children with clefts (30 lip and palate, 17 palate only, 13 lip only) responded to several measures. All children were below the age of two and averaged 7.15 months of age at the time of the interview. Assessments of the perceived severity level of the infant's condition, ratings of the child's activity level and general attractiveness, and two estimates of the impact of giving birth to an infant with a cleft were obtained. Results indicate that husbands and wives agree with one another to a significant extent in rating their children. Parents tend to respond differentially to their children as a function of the symptom status of the child. Compared to infants with either clefts of the lip alone or clefts of the palate alone, infants with clefts of the lip and palate receive higher severity ratings, are more likely to be perceived as active-irritable, and somewhat less pleasant in personality characteristics. Generalized impact seems to be a function of the perceived severity of the child's symptom, and of whether the mother or father is responding. The evidence points to the necessity of reevaluating any generalized concept of impact. It would be particularly important to compare the effects of giving birth to a normal infant with the effects of giving birth to an infant with a defect.

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## APPENDIX A

Haar et al. (1964), Personality Rating Scale

"Activity" Factor	"Halo" Factor
<p>1. My child is usually:  very tense  tense  relaxed  very relaxed</p> <p>3. My child:  cries a great deal  cries somewhat more than other children  cries somewhat less than other children  is very quiet</p> <p>5. My child is:  very active  active  somewhat inactive  very inactive</p> <p>9. My child is:  very difficult to satisfy  fairly difficult to satisfy  fairly easily satisfied  very easily satisfied</p> <p>12. My child usually looks:  very discontented  somewhat discontented  content  very content</p> <p>13. My child is:  unusually sensitive to sound  fairly sensitive to sound  less sensitive to sound than average  not sensitive to sound</p> <p>16. My child sleeps:  little  less than average  more than average  most of the time</p>	<p>2. My child is:  very cute  cute  rather unattractive  very unattractive</p> <p>4. My child feeds:  exceptionally well  well  somewhat poorly  very poorly</p> <p>6. My child is:  very easy to take care of  rather easy to take care of  somewhat difficult to take care of  very difficult to take care of</p> <p>7. My child likes to be held or fondled:  very much  somewhat more than average  less than average  not at all</p> <p>8. My child is:  exceptionally bright  brighter than average  duller than average  very dull</p> <p>10. My child is:  very pretty  prettier than average  less attractive than most  unattractive</p> <p>11. My child is:  very strong  strong  somewhat weak  very weak</p> <p>14. My child is usually:  very easy to manage  rather easy to manage  rather difficult to manage  very difficult to manage</p> <p>15. My child in general is:  very responsive  more responsive than most  less responsive than most  not responsive</p>