A REVIEW OF THE ROLE OF CHILD LIFE AND PLAY IN THE HOSPITAL SETTING

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Section 1: The Problem

**Purpose of the Project**

The purpose of this creative project is to provide child life specialists with a simple tool to give to the health care team that describes the importance of child life services and the research behind why play activities and therapeutic interventions are appropriate and necessary for patients and their families in the hospital. There has been controversy in many health care settings about the validity of child life services which creates a hostile, instead of a team focused, atmosphere. This controversy presents a threat to Child Life Programs and continued financial investment. This project is not intended to take the place of in-services about child life’s role in the hospital, rather, it is meant to supplement the material for the in-services and provide a take-home tool for the health care team members that could not attend an in-service or who were in need of more information and valid research.

**Importance of the Project**

This project is a resource for child life specialists in health care settings to offer to members of the health care team who are unclear about the role of a child life specialist (CLS) and the importance of play in the health care setting. Although doctors and nurses specialize in pediatrics, they very rarely have education about child development and the stressors of hospitalization for a child and family. Misunderstandings and lack of education can cause doctors and nurses to underutilize child life services, therefore taking away the opportunity for patients and their families to cope with hospitalization in a healthy and developmentally appropriate manner.
Child life specialists are commonly known as the “play ladies” which is an acceptable term if the theory and practice behind it were understood by health care professionals. In the fast paced health care setting, it is difficult for child life specialists to find the time to educate the health care team about child life. Child life departments will occasionally set up in-services for the health care team, but attendance is not mandatory and emergencies in the hospital can cause low attendance. By having a clear, concise, and research based handbook, the child life specialist can give the handbook to as many members of the health care team as needed and have additional copies easily accessible.
Section 2: Literature Review

Abstract

For decades, researchers have studied child development and the effects hospitalization has on a child’s social, emotional, cognitive, behavioral, and physical development. Child life specialists (CLS) have been serving in health care settings since the 1920’s to promote healthy growth and development for hospitalized children. The role of a child life specialist is to help reduce stress and anxieties for children and their families when they experience illness, medical procedures, and hospitalization (Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1998). Empirical evidence has shown the effects hospitalization and illness can have on a child and how important it is for children in stressful and anxiety producing situations to have opportunities for adult directed and self directed play. Child life specialists are educated and trained in helping children and their families cope with illness, hospitalization, and medical procedures. Child life services are at risk of being underutilized, underfunded, and terminated if the perceptions of child life services are not understood by health care professionals and validated by empirical research.
A Review of the Role of Child Life and Play in the Hospital Setting

For decades, researchers have studied child development and the effects hospitalization has on a child’s social, emotional, cognitive, behavioral, and physical development. Child life specialists (CLS) have been serving in health care settings since the 1920’s to promote healthy growth and development for hospitalized children. The role of a child life specialist is to help reduce stress and anxieties for children and their families when they experience illness, medical procedures, and hospitalization (Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1998). CLS work in collaboration with other health care professionals in the hospital setting to provide holistic and developmentally appropriate care. Child life services cannot be used effectively when there are misunderstandings and misconceptions about the importance and validity of child life services. The purpose of this literature review is to educate the reader on the role of a child life specialist in the hospital setting and the importance and validity behind the play activities and therapeutic interventions child life specialists utilize.

The Importance of Play

Schafer and O’Connor (1983, p. 2) describe several elements of play behavior: “Play is pleasurable; play is intrinsically complete; play is person-dominated rather than object dominated; play is variable across situations; play is non-instrumental; play does not occur in novel or frightening situations; and play has flow,”. When children are faced with stressful situations and trauma, they use play as a way to comfort themselves, to bring meaning to their experiences, and to make sense of and bring control to nonsensical situations. The preoperational and concrete stages of development described by psychologist Jean Piaget explain that children do not have the mastery of language and abstract thinking skills to be able to communicate verbally and process their thoughts and emotions in a way that can be
communicated through conversation. Play provides an opportunity for children to communicate through activity what they are thinking and feeling (Sweeney, 1997).

In a journal article in Child’s Health Care, Rosemary Bolig (1990) describes play as voluntary, internally motivated, pleasurable, pretend present, organism rather than object dominated, unpredictable, and active. Psychologist and play researcher Mihaly Csikszentmihalyi describes the mental state children enter into when engaged in play as “flow”. Flow means that the child is in a state of forgetfulness and instead of being lost in nervous preoccupation, the child is able to be absorbed in the play experience. During this “flow” experience there is a sense of control because the child is able to influence what is happening. Children cope with illness, hospitalization, and recovery from a trauma by feeling a need and desire to escape from the situation that they are presented with. The health care environment benefits from play by:

- Maintaining an atmosphere to promote healthy child development
- Providing ways for a child to communicate their emotions and thoughts while gaining a sense of control
- Promoting feelings of positive mastery
- Encouraging adjustment
- Improving mental processing of experiences (Thompson, 2009).

**Therapeutic Play for the Hospitalized Child**

Therapeutic play and play therapy are closely related but the difference between the two determines when and how play is used. Margaret Chambers (Kelsey & McEwing, 2008) recognized the importance in distinguishing between these two avenues of therapy. She describes play therapy as a tool to diagnose children who are emotionally disturbed and too
young to verbalize and process their emotions and trauma. Play therapy is typically used by psychologist and certified play therapists with the purpose of diagnosing a child with emotional and psychological issues. Therapeutic play is the use of play as therapy to help children cope and develop coping skills when they are presented with an environmental threat, such as hospitalization and illness. Therapeutic play is the primary avenue that child life specialists use in the hospital setting to help a child cope, learn, and develop. In a research article by Bolig, Fernie, & Klein (1986), five functions of play in the hospital are described:

1. To provide diversion
2. To play out anxieties and problems
3. To restore normal aspects to life
4. To aid in understanding hospital events
5. To communicate fear (Bolig, Fernie, & Klein, 1986).

**Psychosocial Impact of Hospitalization**

The power of therapeutic play was researched by Girepy & Howe (2003) in an experimental study of young children with leukemia. In this study, two play groups were compared to see how young children with leukemia and a control group of children attending a day care play with different toys. The reoccurrence of play themes, play behaviors, and anxiety levels before and after play were observed and recorded. The children in both groups were presented with objects to play with and primarily engaged in self-directed play. Observations occurred 4 days per week for 6 weeks. The children at the hospital were observed in the waiting area of the hematology outpatient clinic and the children in the daycare were observed during free play periods. The ages of children ranged from 3-5 years old (Gariepy & Howe, 2003).
The findings show that the children in the experimental group played less than the control group, supporting the view that children who are preoccupied and anxious may have a more difficult time engaging in play activities which could deprive them of opportunities to cope and problem solve. At the beginning of every session, the children identified their mood by picking “happy”, “neither one nor the other”, or “upset” by looking at three pictures that had faces that represented these moods. The findings show that the self-reported anxiety levels correlated with the child’s play behaviors. For example, the children that reported that they were “upset” tended to engage in solitary play more than the children that reported that they were happy. There were also recurrent play themes in the experimental group that suggests that children who experience stressful situations and trauma tend to engage is recurrent play behavior to continue to process and cope with their anxieties and stressful circumstances. The conclusion from this study was focused on the importance of observing play behaviors in hospitalized children and providing them with an atmosphere that is safe and conducive to encouraging play behaviors to allow them to cope with, process, and problem solve their emotions and experiences (Gariepy & Howe, 2003).

In a case study by Runeson, Hallstrom, & Elander (2002), the needs of hospitalized boys were observed and analyzed. The purpose of the study was to show health care providers that when circumstances for children change, different needs have to be met. Patient’s were observed while in their hospital room and their needs were documented. The researchers then interpreted their needs into 10 specific categories. Six categories of needs to non-threatening situations at the hospital were identified: the need for activity, new experiences, information, participation, praise and recognition, and needs related to physical resources. Four categories of needs in threatening or painful situations in the hospital were identified: the need for control, having
parents nearby, what is familiar, and for integrity. The findings concluded that when children experience threatening and painful experiences their needs change and therefore they require different care and interventions that meet those needs (Runeson, Hallstrom, & Elander, 2002).

**Child Life Directed Therapeutic Play**

Play appears to be a natural and effortless activity for children. However, it does not occur unless there is a combination of internal and external homeostasis. Children that are less threatened by external and internal demands and events tend to engage in play more rapidly than the child who is threatened. Children who are under threat of external events (hospitalization, procedures, etc.) are less likely to engage in play unless they are presented with a sense of safety and objects to engage in play with (Bolig, 1990).

The purpose of adult-directed play is to increase a young patient’s sense of predictability regarding pending medical procedures and health care experiences, increase a sense of self-control, reduce stress from unrealistic fantasies about medical procedures, increase effective coping skills, and to clear up confusions and misconceptions (Fromberg & Bergen, 1998).

In the 1980’s, hospital stays for children became shorter and illness-focused units became more prominent (oncology, intensive care, medical/surgical). The hospital playrooms were not able to be utilized by patients at the times or lengths that were needed to help a child develop a sense of safety and familiarity. The time that child life specialists had with a patient were shortened; therefore, individual and illness based play activities that were adult-directed became more desirable and successful rather than group activities and teachings (Bolig, 1990).

Empirical evidence supports the view that play, particularly pretend and symbolic play with objects or other children, promotes development of meta-cognition and self-regulation. In
an experimental research study by Whitebread and Jameson (1986), the ways children learn through playful activities was studied. Children experienced a “taught” condition and a “play” condition and were observed on their problem-solving abilities and self-regulatory processes. The children in the “taught” condition group were verbally read three different stories from picture books. The teacher then showed them the props and demonstrated the props for them. The children in the “play” condition group were read the same stories and also given props to play with that pertained to the story. The “play” condition group was given 10 minutes to play with the props after the stories were read on an individual level. Both groups were asked to write for five-minutes about each story and were given a photo-copy of the characters in the books. The results showed that the “taught” condition group recalled more correct information from the story than the “play” group communicating that the initial adult directed play activity allowed the children to recall information more clearly and provided them with direction (Whitebread, Coltman, Jameson, & Lander, 2009).

**Medical Procedure Preparation**

Therapeutic play interventions for procedure preparation can provide psychological preparation and ways to cope with stressful and confusing situations. The goal of psychological preparation is to increase the family and child’s sense of control and predictability over circumstances that are overwhelming and unpredictable. This will help with emotional adjustment and increase the likelihood of healthy growth and development. Providing support before, during, and after events in the hospital will help maintain a sense of control and familiarity throughout the hospitalization process. Therapeutic interventions are activities that encourage children to explore their environment, manipulate medical materials, and cope with being in the hospital setting and going through procedures. Child life specialists focus on the
child as whole and develop interventions that are appropriate for each individual child (Thompson, 2009).

The goal of procedural preparation is to reduce fear and anxiety that may be experienced by a patient who is experiencing a medical procedure and to promote the patient’s long term coping and adjustment to health care challenges that may be in the future. Post-traumatic stress, increased fears, and decreased cooperative behavior have been documented as negative long-term implications of medical experiences. When patients participate in preparation programs before and after procedures, there is a significant reduction in the negative psychological impact (Koller, 2007).

In an experimental study by Li & Lopez (2008), the effectiveness and appropriateness of using therapeutic play in preparing children for surgery was studied. The control group received routine preparation information prior to their surgery and the experimental group received a therapeutic play intervention prior to their surgery. In the control group, children and their parents were given routine information interventions on the preoperative assessment day. Verbal communication was used to convey information about the procedure and post-procedure recovery. A video about a patient and parent going through the procedure process from admission day to the day of surgery was also shown to the control group. The experimental group received a therapeutic play intervention that consisted of a set of structured activities designed to prepare children psychologically for their surgery. The therapeutic play included a preoperative tour to the operation room, a doll demonstration by the researcher, and a return demonstration by the children. The child’s anxiety level was measured using the Chinese version of the State Anxiety Scale for Children. The results showed that children in the experimental group reported lower state of anxiety scores in the preoperative and post-operative
periods than children in the control group. The researchers discussed that the children in the experimental group were able to regain self-control and become familiar with their environment which played a part in reducing their anxiety (Li & Lopez, 2008).

Children can develop fears and anxiety while in the hospital because of the unknown pending procedures and unfamiliar environment. CLS are educated in medical procedures and medical terms that children will be exposed to while in the hospital. Fears and anxieties are greatly reduced when children understand their circumstances and are familiar with the environment and equipment. CLS explain to patients in developmentally appropriate and non-threatening language about the procedures and experiences the patients will have (Thompson & Stanford, 1981). CLS are educated in cognitive development and how children perceive certain situations. Jean Piaget’s stages of cognitive development describe how children grow to understand their environment. Having an understanding of how children perceive the environment around them greatly helps CLS to know what language to use and what therapeutic interventions will be affective for each developmental age group (Atherton, 2010).

**Health Care Professionals Perception of Child Life Services**

In a study by Gaynard, Hausslem, & DeMarsh (1989), health care professionals were asked to fill out a questionnaire that consisted of questions pertaining to perceptions of child life services. The results showed that there was a large difference in a child life specialist’s perception of child life services verses a nurse’s or doctor’s perception of child life services. CLS reported that they viewed their primary role to be a member of the health care team, whereas members of the health care team answered that the primary role of a child life specialists was to amuse and entertain patients.
A partial replication of previous study was conducted in 2001 by Cole, Diener, Wright, & Gaynard to gain a more in depth understanding. Health care professionals and child life specialists were given questionnaires to fill out to gain a better understanding of their perceptions of child life specialists and their role in the hospital setting. The questionnaire was completed by 228 health care professionals at a children’s hospital in the Intermountain West where there is a well established child life department. The questionnaires contained questions about the extent of contact with CLS, the perceptions of the primary responsibilibites of a CLS, and perceptions of power and importance of each health care professional in the health care team. There were thirteen categories to describe the primary responsibility of a child life specialist: amuse and entertain, preparation and orientation, growth and development, patient advocacy, member of health care team, patient support, family support, therapeutic or health care play, facilitate coping, play, decrease distress, make pleasant and normal, and educate staff. The participants were asked to rate the importance of each responsibility on a scale of 1-10 (1 being not very important and not very powerful to 10 being very important and very powerful. They were also asked to rate groups of health care professionals according to their overall influence, authority, and command within the health care hierarchy (Cole, Diener, Wright, & Gaynard, 2001).

The results showed that health care professionals view CLS as engaging in a wide variety of activities and responsibilities that are important for the hospitalized child and their families. The most mentioned role by health care professionals and by CLS was preparation and orientation. Health care professionals may see that a patient that is relaxed, diverted, and prepared may be more easily treated than a child who is anxious and confused. CLS may see that as their primary role because it is directly related to health care. Health care professionals also saw amusing and entertaining patients as common role for CLS; however, the CLS
infrequently mentioned this. Health care professionals observe CLS playing with the patients and may not recognize the importance or function of the play. Play is not simply for entertainment or amusement, it is the tool that children use to grow and develop. CLS do not see play solely as entertainment but as a tool for therapeutic intervention and facilitating healthy coping mechanisms (Cole, Diener, Wright, & Gaynard, 2001).

CLS mentioned children’s growth and development frequently as part of child life responsibilities whereas nurses and doctors rarely mentioned it. A CLS has training and education in child development and thus may focus on a patient’s developmental issues rather than their medical issues. Health care professionals may view child life services as distraction or entertainment rather than developmental enhancement (Cole, Diener, Wright, & Gaynard, 2001).

There have been very few empirical studies that examine the perception of child life in the health care setting, and despite an increase in child life positions over the last four decades, there still is not a clear perception of child life services in health care settings. This lack of understanding could be detrimental to child life services due to the ever changing economy and budget cuts. If the importance of child life is not understood, child life services will not take priority over other health care professionals (Cole, Diener, Wright, & Gaynard, 2001).

A Brief History of Child Life and Why the “Play Lady” Legacy Needs to End

The profession of Child Life was first introduced in the 1920’s with the goal of improving the experiences children had in health care settings by providing preparation for procedures, education programs, and opportunities for play. It was around this time that researchers and health care providers began to see that emotional stability and healthy
development for hospitalized children was highly dependent on how they coped with their experiences (Child Life Council, 2010).

Many research studies were completed in the first half of the twentieth century that observed child development in a hospital setting. It became apparent that lack of stimulation, loneliness, and distress were causing delays in healing and healthy development. At that time recreation therapists and teachers were brought into the hospital to provide play activities and psychosocial support. The therapists and teachers began to provide education to health care professionals about the importance of support for the non-medical and emotional needs of the children under their care. During this time period, play was not highly considered as an effective intervention (Child Life Council, 2010).

Through time and dedication, child life workers were able to learn about the hospital culture and what types of circumstances and events caused the pediatric patients to develop fear, distress, and pain. During the 1960’s, a group of women from the child life field met in Boston to discuss their experiences and to develop hospital environment that was child and family friendly. The Association for the Care of Children’s Health (ACCH) was established. Doctors, nurses, child life specialists, parents, and other health care professionals were all about part of the multidisciplinary team that began to develop professional practices and policies for caring for children and families in health care settings (Child Life Council, 2010).

In 1982, the Child Life Council (CLC) was developed to provide professional development and standards for Child Life Specialists. By 1988 the Child Life Professional Certification Exam was established to ensure that the child life specialists were thoroughly trained in the field of child life and capable of providing high quality care. In 1983 the ACCH
received a grant to study how effective the child life theory and practice was in reducing stress and anxiety in hospitalized children. The results showed the importance of child life programs for encouraging healthy growth and development in pediatric patients. Research in the early 1990’s was required to show how the field of Child Life had grown and was going to continue to grow. The health care crisis at this time caused child life positions to be decreased, therefore, the CLC needed to prove to health care professionals how important child life specialists were as part of the multidisciplinary health care team (Child Life Council, 2010).

Presently, there are many universities and colleges across the United States and globally that teach child life theory and practice at the undergraduate and graduate level. CLS are also branching out into alternative settings. The CLC provides continuous research and education in the field of child life for prospect CLS and certified CLS. It is a growing field that is becoming respected and accepted by more and more hospitals and health care professionals (Child Life Council, 2010).

In a journal article by Rubin (1992), she describes how the “play lady” legacy has changed over the last century. Developing the “Child Life Specialist” title had been an ongoing task until it was established by the ACCH’s Child Life Position Statement in 1979 and in 1980 the profession was formally designated as child life. Child life specialists tend to avoid the “play lady” name because it comes with preconceived notions that child life specialists only provide toys and activities for pleasure with no further purpose. Professionals and parents that are not informed about psychosocial development in the hospital setting may not understand the purpose and importance of therapeutic interventions that they see as simple “play” activities to entertain a pediatric patient. Terms such as “behavioral interventionist” or “child advocate” are commonly used by CLS to describe their profession to help bring to light the deeper purpose of the
interventions that are developed based on extensive education in child development and hospitalized children (Rubin, 1992).

**Conclusion**

Research and literature on child development clearly show that children learn through play and use play as a way to process the world around them (Fromberg & Bergen, 1998). Hospitalized children experience many stressors and traumas that produce fear, anxiety, and stress. Child life specialists provide much needed support for hospitalized children by providing ways for them to cope and process the stressful, unfamiliar, and traumatic circumstances (Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1998). Health care professionals and CCLS work closely together in the hospital setting. CCLS cannot provide their services effectively if the other health care professionals are not advocating for and utilizing child life. The research shows that many health care professionals do not have a clear understanding of the role of child life in the hospital setting (Cole, Diener, Wright, & Gaynard, 2001). The studies that have been reviewed provide a brief understanding of how important play in the hospital setting is for a child’s psychosocial development, however, the field of child life is still in need of more experimental research to further confirm what observations have already shown.
References


Section 3: Procedure

**Development/Approval of Project**

This project was developed after experiences I had during a child life practicum at Children’s Hospital of Orange County in the fall of 2010. I observed many stressful conversations and circumstances that involved doctors and nurses under utilizing child life services and creating undue stress for the patient and their family. As I had conversations with other certified child life specialists and discussions in my child life classes, I realized that the field of child life is still trying to gain credibility and health care professionals are still in need of education about child life services. The idea and purpose of this project was reviewed and approved by Dr. Valerie Beltran and Dr. Leslie Young at the University of La Verne.

**How Was the Project Developed and Implemented?**

The development of this project began with research in child development and how children learn through play. The phrases “child development and play”, “play in hospitalized children”, “play and self-expression”, and “learning through play” were used to search for research studies and journal articles on the University of La Verne’s online journal database. These phrases were also used to search for books in the University of La Verne’s library. Over 20 resources were collected to write a literature review on the role of child life and play in the hospital setting.

Through writing the literature review and gaining a holistic understanding of what health care professionals need to know to understand and advocate for child life services, I was able to develop the framework for the handbook for health care professionals about child life services. I wanted to create a handbook that was clear, concise, and professional. The idea behind the
handbook was to be able to conveniently give it to health care professionals and have it be appealing to read and understand.

**Who Did You Involve in the Developmental Process and Why?**

Dr. Valerie Beltran and Dr. Leslie Young were involved in the development of this project because I trusted their knowledge about the child life profession and their opinions about the importance of child life services in the hospital setting. They reviewed the progress of the literature review and handbook two times throughout the development of this project. They provided me with constructive feedback and suggestions that I was able to implement into my project.

I also had phone conversations with two friends of mine who are in their medical residencies. One is studying to be a pediatrician and the other is studying to be a neurologist. During my conversations with them, I asked questions to gain an understanding of what their knowledge of child life was and what information should be included in the handbook. I wanted to get perspectives from health care professionals who have knowledge in child development and health care professionals who do not have knowledge of child development. My conversations with them helped in creating a handbook that was appropriate for health care professionals with a wide range of knowledge of child life and child development.
Section 4: Evaluation

**Evaluation**

The focus of my project was to educate health care professionals on the field of child life. I wanted to create a handbook that was suitable for any health care professionals who has not had any formal training in child development. I sent my project to Dr. Katelyn Smith for review and evaluation. Dr. Smith is starting her residency in neurology in St. Louis, MO and has not received any formal education about child development or the field of child life. Her perspective was vital to my project because she is the type of health care professional I want to benefit from this project. In her evaluation she was able to communicate some areas of the handbook that needed more explanation and examples to help her and other health care professionals know what they will see a child life specialist do. She also provided feedback on the words I was using like “safe environment” and asked that I elaborate on what those words meant.

Dr. Melissa Kivitz-Kransow also evaluated the handbook. She is doing her pediatric residency at the Cornell University Medical Center in New York. Her knowledge in child development and psychosocial development in the hospital setting is extensive and she works closely with child life specialists in her hospital. She provided feedback that was useful in organizing the handbook and providing information that she as a doctor would like to know more about. I was able to elaborate on the areas she felt needed more explanation and I changed the organization of the handbook according to her feedback.

Dr. Young also evaluated my project throughout the semester. She provided suggestions for topics and specific examples of child life services that should be included in the handbook. I took her suggestions by elaborating on what I already had and adding specific topics such as
defining therapeutic play, adding more information about play and development, and providing more examples of expressive therapies.
Appendix

A Guidebook to Child Life Services For Health care Professionals