San Diego Conference Attendees Enjoy Opportunities for Connection, Commitment and Collaboration

Looking back at the past few years, it is amazing to see just how much the CLC Annual Conference has grown. At the recent 26th Annual Conference in San Diego, a record breaking 1,044 registered attendees flooded the meeting rooms of the Sheraton San Diego Hotel & Marina. Just three years ago, at the 23rd Annual Conference in Nashville, 2005, attendance was less than 800. That’s an increase of more than 250 participants!

Each year, CLC members consistently identify the CLC Annual Conference as an activity with the power to enlighten, empower and energize them in a way that no other event can, and the San Diego meeting was no exception. Attendees left the conference armed with fresh ideas, valuable experiences and resources, and an enhanced network of child life colleagues and friends.

When asked what they liked best about the Annual Conference in San Diego, attendees said:

“I have not been to the annual conference in over 5 years…and I loved the fact that there are so many new ideas and facets to the profession. I am realizing that I have some catching up to do!”

“I loved having the networking sessions planned for two full hours!! It was great to really be able to dive into subjects pertaining to my practice, and to get connected with others in my specialty.”

“I enjoyed [participating in sessions with] speakers that were not child life specialists. It is always good to have other disciplines present, as we have so much to learn from collaboration.”

Nearly 70% of attendees indicated that their overall conference experience was either very good or excellent, 86% said that the conference either met or exceeded their expectations.

Some of the highlights from this year’s conference were:

• The Opening Emma Plank Keynote address, *The Self Directed Healing of Young Traumatized Children* given by Sue Bratton

• The Closing General Session, *The Happiest Toddler* and professional development workshop *The Happiest Baby on the Block* given by Harvey Karp, MD

• Starlight Starbright’s giveaway of three Fun Centers and several Nintendo Wii game systems

• Exciting collaborations with speakers from outside child life, including Dr. Sue Bratton, Dr. Harvey Karp, Jody Thomas

The Child Life Alphabet

I was attending the Child Life conference in San Diego when I heard the term evidence-based practice described during a conference presentation. Although I had heard the term before and had seen it used in the *Bulletin/Focus* publication, this was a point where I really stopped to think about it. Later at the conference, I heard the related term attitude of science. Now, this one was new to me! Because my interest was piqued, I decided to find out more.

Similar to the experience of others, attending the annual conference tends to have the effect of inspiring me to learn more. However, it is not unusual for me to return home and quickly get back into the business of daily life. This time was different. While at the conference, I took the initiative to connect with someone who forwarded some resources for me to read. I wanted to research and learn more about the concept of attitude of science.
As I begin my term as president, I am thrilled to have the opportunity to work with a very talented group of association professionals in the Child Life Council office, as well as the capable individuals who make up the CLC Executive Board. We have a strong strategic plan in place to guide us through the coming year. The objectives and tasks developed in line with our plan give our leaders and the CLC staff defined outcomes for our work, which will be key in helping us to realize the bright future we envision for the child life profession.

In my view, one of the most exciting strategies coming out of the first goal of the strategic plan (“Child life specialists will be viewed as essential to quality healthcare”) is the formation of a leadership development initiative. CLC staff and the Board are working together to identify and implement leadership development strategies in several forms. Conversations and program planning for the 2009 CLC Annual Conference are well underway, and during that event we plan to include educational and networking opportunities that will promote growth in leadership skills and potential among child life specialists. Through the leadership development initiative, we will encourage child life specialists to become leaders within their own organizations, as well as get involved in a meaningful way with CLC. The continued growth and success of the organization and the profession depends significantly on contributions from our volunteer leaders, and we look forward to capitalizing on new energy, ideas and perspectives.

Related to the topic of leadership development, we have engaged a consultant from Organization Guidance Group, LLC to work with an appointed task force to review Child Life Council’s governance structure and practice. This consultant will guide us in refining our recruitment, nomination and election processes for our Board, as well as provide suggestions related to creating opportunities and encouraging development of membership leadership potential.

Another meaningful initiative is being spearheaded by the Child Life Education and Training Committee under the leadership of Anita Pumphrey, an instructor at Louisiana Tech University, and Beth Daniel, Child Life Coordinator at Huntsville Hospital for Women and Children in Alabama. The role of the committee is to promote quality and consistency of child life academic and clinical preparation programs. Anita and Beth will take the lead in helping us to examine best practices, evaluating regulatory measures for these programs in order to maintain high standards in both areas. This effort is, and will continue to be, a journey, encouraging the continued maturation and enhancement of the child life profession as we chart a course for the next generation of child life specialists.

These are only two of the remarkable things going on in the Child Life Council. I encourage you to get involved; share your thoughts and opinions with CLC Board members, committee chairs, and committee members. Or better yet, consider submitting a volunteer interest form (available in the Membership/Volunteer Opportunities section of the CLC Web site) for the chance to become a committee member yourself! Now is an exciting time to be a part of this organization; our membership continues to grow, we are maintaining a firm fiscal bottom line, and we are doing important work in identifying and developing resources grounded in evidence-based practice, which support child life specialists in their work environments. We are fortunate to be led by Susan Krug, our dynamic Executive Director, and her staff. Please join me, our Executive Board and committees, and the CLC office in contributing to professional growth and innovation as we finish 2008 and enter 2009.

This effort is, and will continue to be, a journey, encouraging the continued maturation and enhancement of the child life profession as we chart a course for the next generation of child life specialists.
Child Life Assessment: Variables Associated with a Child’s Ability to Cope with Hospitalization

CHILD LIFE COUNCIL EVIDENCE-BASED PRACTICE STATEMENT
Completed for the Child Life Council by
Donna Koller, PhD, Associate Professor, Ryerson University Early Childhood Education, Adjunct Scientist, Research Institute, Hospital for Sick Children, Toronto, Ontario, Canada
Rebecca Mador, Wendy Lee, and Michelle Gibson, research assistants at the Hospital for Sick Children, are gratefully acknowledged for their contributions in the preparation of this statement.

Preamble
The purpose of this statement is to identify key variables associated with children’s ability to cope with hospitalization. Based on the best empirical evidence, this statement can inform child life practice by serving as a guide for initial assessments of hospitalized children. The goal of an initial assessment is to determine a child’s risk for negative psychological outcomes due to hospitalization and to plan appropriate interventions.

This statement is based on an exhaustive search of the literature, which was conducted on i) PsycINFO, which records the literature from psychology and related disciplines such as medicine, psychiatry, nursing, sociology, and education; ii) MEDLINE, which focuses on biomedical literature; and iii) CINAHL, the Cumulative Index to Nursing & Allied Health Literature, which covers literature relating to nursing and allied health professions. A variety of keywords and combinations such as “hospitalized children,” “coping,” “psychological adaptation” and “stress” were used to conduct the search (See Table 1 for a list of search terms). The search was completed in March 2007 with the assistance of a medical librarian. Searches revealed approximately 150 articles regarding coping and adjustment. After the results were sorted to exclude repeats and non-empirical based literature, 39 articles remained. These articles were retrieved and evaluated based on the scoring of 2 independent raters using “The Quality of Study Rating Form”\(^1\). Articles that received a rating of at least 60 out of 100 points were selected for inclusion in this statement. Any article that scored between 55 and 65 points was scored again by a second rater to confirm inclusion or exclusion. Finally, twenty-five articles met the selection criteria (See Table 2 for a complete list of citations).

Since evidence-based practice represents an integration of the best available research along with clinical experience\(^1\), this statement was reviewed by certified child life specialists across North America in order to ensure clinical applicability. In addition, evidence-based practice acknowledges patient preferences and needs when determining the most appropriate clinical interventions for the child and family.

CHILD LIFE ASSESSMENT: WHY IS IT IMPORTANT?
Children’s negative responses to hospitalization and medical procedures are well documented in the literature\(^2\). In an effort to reduce the negative impact of hospitalization on pediatric patients, child life specialists must determine whether a child is at risk for experi-

continued on Focus page 2
Given that the quality and intensity of a child’s reaction to hospitalization can be influenced by many variables, child life specialists must consider the most significant variables when conducting assessments. Without an understanding of these variables, accurate assessments of hospitalized children are not possible and the ability to engage in evidence-based practice is thwarted.

**How Studies Identify Factors Associated with Coping**

Research in this area is complex, predominantly because several variables can be associated with children’s ability to cope with hospitalization. For the most part, this research is quantitative and correlational in design. These studies typically attempt to link results obtained through self-report scales completed by children and their parents with behavioral outcomes. It must be noted, however, that correlational designs do not allow conclusions to be drawn with respect to causality. Despite the shortcomings of correlational designs, the findings reviewed here identify key issues associated with how children cope with hospitalization. From the studies reviewed in this statement, four categories of variables emerged:

1) Child variables
2) Family variables
3) Illness variables
4) Medical experiences

**Child Variables**

**Temperament**

Temperament can be defined as an individual’s consistent and stable pattern of behavior or reaction, one that persists across time, activity, and context. Generally, an individual’s temperament consists of nine dimensions including activity level, adaptability, threshold of responsiveness, mood, intensity of reaction, distractibility, attention span and persistence, and predictability. Two studies investigated the relationship between a child’s temperament and his or her response to hospitalization. Children who responded best to hospitalization tended to be more positive in mood, more predictable, easier to distract, more approachable and adaptable while being less reactive to stimuli. In addition, McClowry found that temperament accounts for as much as 50% of the variance in children’s behavioral responses prior to and up to one month after hospitalization.

The level of anxiety exhibited by a child in hospital can reflect his or her underlying temperament and associated responses to stressful situations. In addition, distinctions need to be made between the different types of anxiety. For instance, trait anxiety, which refers to the stable and relatively constant tendency to be anxious, has a significant influence on the quality of a child’s reaction to hospitalization. Children with higher trait anxiety are significantly more likely to perceive their coping as ineffective and appraise hospitalization as a stressful experience than are children with lower trait anxiety. Trait anxiety has also been found to positively correlate with a child’s self-reported fear, indicating that highly anxious children require additional support in order to cope effectively with stressful events. In addition to trait anxiety, state anxiety refers to anxiety created as a result of a specific experience. Tiedeman and Clatworthy found that this form of anxiety dissipates from the time of admission to discharge for hospitalized children between the ages of 5 and 11.

In the event that a child life specialist is presented with an anxious child, discussions with the child and family can help determine whether the child is exhibiting a form of trait or state anxiety. For example, if the child is normally anxious in other areas of his or her life, this may be indicative of a more pervasive form of anxiety. In this case, child life interventions supplemented by a referral to psychiatry may be necessary in order to rule out an underlying anxiety disorder.

**Coping Style**

Coping is the process used to alter, manage, or tolerate a stressful situation. An individual’s preferred style of coping is a combination of his or her temperament as well as an appraisal of the stressful situation. Researchers have typically divided the coping strategies children use into two categories: avoidant and vigilant. Avoidant coping occurs when children restrict their thoughts about an upcoming event, deny their worries, and detach from a stressful stimulus. Vigilant coping strategies consist of seeking out detailed information and alertness to a stressful stimulus. LaMontagne et al., found that vigilant coping was associated with a timely return to normal activities over the course of recovery. In a related study, LaMontagne et al., classified children based on how they focused on aspects of impending surgery. Children who focused their attention on concrete aspects of the experience (i.e., details about recovery) tended to use vigilant coping and were able to return to their usual activities sooner. Children who had less information about the procedure (provided few descriptions of the experience, tended to avoid information) had the least
favorable outcome on the “activities” subscale of the Youth Self-Report and Profile which assesses the child’s usual activities (i.e., sports, chores, etc.). Similarly, Knight et al., found that children who sought information about their upcoming procedure exhibited less physiological and affective distress than children who denied the experience or avoided information19.

However, other studies suggest that the relationship between coping style and outcomes is more complex16, 19. Lowery Thompson found that children who used either information-seeking (vigilant) or information-limiting (avoidant) coping behaviors were less anxious than children using a combined approach19. Furthermore, different strategies can be associated with favorable outcomes at different time periods; while avoidant strategies were found to be more effective in reducing stress initially after surgery, children using a vigilant approach reported better long-term recovery20.

In one study, children’s baseline behavior was assessed as a predictor for how a child might behave during and after hospitalization. For instance, if a child is more likely to exhibit internalizing behaviors (i.e. anxiety, depression) prior to hospitalization, this coping style can consistently predict later internalizing behaviors following hospitalization. The same was found true for externalizing behaviors such as aggression and hyperactivity21.

Although the findings reveal complexities, children’s coping styles appear to predict psychological outcomes related to hospitalization. For the most part, avoidant characteristics appear to be less effective at ameliorating stressors associated with hospitalization. Therefore, a child’s coping style as shown by his or her willingness to seek and accept information can predict the degree of psychological risk.

**Age**

Several studies included in this review examined the relationship between a child’s chronological age and his or her likelihood of experiencing negative behavior and/or psychological sequelae in response to hospitalization13, 14, 21-24. It should be noted that these studies did not make distinctions between chronological age and developmental levels.

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**Table 2. Final Selection of Studies Included in This Review**

Twenty-five articles were evaluated using “The Quality of Study Rating Form” (Gibbs, 1989). Articles that scored between 60 and 100 points were selected for inclusion in this statement.

Despite the fact that older children (latency age) are assumed to cope better with hospitalization than younger children, the literature indicates that the relationship is more complex. For example, some studies found no link between a child’s age and his or her response to hospitalization, post-behavioral upset, anxiety or fear. Conversely, some researchers found that younger children were more likely to be anxious and fearful compared to older children. Younger children were also less likely to feel in control of their health as measured by the Children’s Health Locus of Control Scale.

The impact of age on children’s coping strategies is also unclear. Assessed by the Preoperative Mode of Coping Interview, two studies cited contradictory findings: Lowery Thompson found that age is not related to children’s coping behavior while LaMontagne et al., discovered that older children are more likely to use effective coping strategies. Given these discrepant findings, it cannot be assumed that the age of the child will accurately predict the degree of upset experienced by a hospitalized child. Hence, it is critically important to examine other variables in addition to age when making assessments regarding coping.

Gender

Many studies in this review examined the effects of gender on a child’s response to hospitalization. However, the findings from these studies are inconclusive. Tiedeman and Clatworthy found that boys tended to be more anxious than girls at admission, discharge and post-discharge, while other studies found that girls were more anxious than boys and finally some concluded that gender was unrelated to anxiety or the expression of fear. A number of studies also revealed that gender differences are not evident in behavioral upset, focus of attention, coping strategies and perception of its effectiveness and the type of events children appraised as stressful during hospitalization.

**FAMILY VARIABLES**

**Parental Anxiety and Distress**

Of all the family variables, parental anxiety is most strongly correlated with children’s adverse responses during hospitalization. Maternal anxiety not only predicts children’s emotional distress, but also correlates positively with children’s distress during invasive procedures. In one study, high levels of maternal state anxiety at first contact (6-16 hours following the child’s admission to the intensive care unit) was found to significantly increase a child’s likelihood to engage in negative behavioral responses such as hyperactivity and aggression. Maternal anxiety also mediates the positive effect of an intervention on hospitalized children’s post-hospital behavior, suggesting that it may be beneficial to provide support to highly-anxious mothers in order to enhance the psychosocial outcomes of hospitalized children.

Only one study found that at the time of admission to the hospital, parental anxiety did not significantly affect child’s anxiety. However, there was a significant relationship between parental anxiety and children’s anxiety following hospitalization. These inconsistent findings were partially explained by the fact that different questionnaires were used at various times during hospitalization.

**Family Characteristics**

Three studies provided an in-depth examination of family characteristics associated with post-hospitalization outcomes. The main variables included the marital status of a child’s parents, family size, and family composition. One study by Small & Melnyk (2006) found that marital status significantly predicted a child’s likelihood of displaying internalizing (focused inward, i.e. anxiety, depression) or externalizing (focused outward, i.e. aggression, hyperactivity) behaviors post-hospitalization. For example, mothers who had been married more than once had children who demonstrated more internalizing behaviors three months post-hospitalization than children whose mothers had not been married or were married for the first time. Additionally, mothers’ anxiety and level of involvement to the emotional needs of the child were primary predictors of internalizing and externalizing behaviors, as well as post-hospitalization anxiety. However, family size and composition were found to be unrelated to a child’s post-hospital adjustment.

**Socioeconomic Status**

Studies have investigated the relationship between a family’s socioeconomic status (SES) and a child’s response to hospitalization. While two studies found no association between SES and children’s responses to hospitalization, Hart & Bossert found that children with higher trait anxiety from families with a lower yearly income reported a higher amount of fear. In terms of maternal education, Rennick et al., reported that children with mothers who had higher education were more likely to feel in control of their health.

**Parental Presence and Involvement**

Studies have also sought to determine the extent to which a parent’s presence is associated with how a child responds to hospitalization. In a pediatric emergency care study, 96 children were administered a venipuncture. The children were randomly assigned to two groups; one in which a parent was present, and another in which a parent was absent. Both parents and children exhibited less distress when a parent was present during the procedure. In contrast, another study randomly assigned 20 children to either a condition with mother present during an injection and another condition where the mother was absent. Children’s behavior during and after the injection was rated as significantly more negative for the children in the mother-present condition. The authors concluded that children may feel more comfortable protesting during a procedure when a parent is present.

The level of parental involvement in the care of hospitalized children can exert significant influence on a child’s ability to cope with medical experiences. In one controlled study by Mazurek Melnyk and Feinstein, researchers found that when parents received information regarding common child behaviors during hospitalization, their participation in the care of their child increased. In turn, these children experienced less negative behaviors following hospitalization. To measure the level of maternal involvement in care, the Index of Parent Participation was used. The scale consists of a 36-item checklist of self-reported parenting behaviors during childhood hospitalization. Examples of these behaviors included playing, bathing, feeding and explaining medical procedures to the child. The authors yielded scores which reflected low, moderate and high levels of...
involvement. The study found that moderate parental involvement resulted in positive outcomes for hospitalized children while excessive or limited parental involvement was shown to result in negative outcomes. For instance, children with highly involved parents exhibited worse post-hospital adjustment, more internalized coping such as anxiety and depression, and more behavioral disturbance than children with less involved parents. Few studies have investigated whether children with chronic or acute conditions experience hospitalization differently. In one study, the degree of children’s fears was not associated with whether they had chronic or acute illnesses. However, in another study, acutely ill children were more likely to perceive their coping as effective than were chronically ill children. Bossert compared chronically ill and acutely ill children on their perceptions of what is stressful. Chronically ill children identified more intrusive events and acutely ill children identified more physical symptoms as stressful. In regards to post-hospital behavior, children from intensive care were compared with those from a general medical ward. Scores on post-hospital behavior scales revealed similar findings for the two samples.

**ILLNESS VARIABLES**

**Chronic vs. Acute Illness**

Few studies have investigated whether children with chronic or acute conditions experience hospitalization differently. In one study, the degree of children’s fears was not associated with whether they had chronic or acute illnesses. However, in another study, acutely ill children were more likely to perceive their coping as effective than were chronically ill children. Bossert compared chronically ill and acutely ill children on their perceptions of what is stressful. Chronically ill children identified more intrusive events and acutely ill children identified more physical symptoms as stressful. In regards to post-hospital behavior, children from intensive care were compared with those from a general medical ward. Scores on post-hospital behavior scales revealed similar findings for the two samples.

**Length of Hospitalization**

In two studies, the length of hospitalization was examined in regards to children’s adjustment to hospitalization. While this variable appeared to have minimal effects on children’s responses to hospitalization in one study, another study found that shorter hospital stays were associated with higher levels of anxiety by children at discharge.

**MEDICAL EXPERIENCES**

**Exposure to Invasive Procedures**

Studies reveal that the number of invasive procedures experienced by a child is positively associated with the level of stress, anxiety and fear experienced during and following hospitalization. In particular, two studies found that the number of invasive procedures was a strong predictor of children’s psychological distress, manifested in symptoms of depression, anxiety, fear and post-traumatic stress. Rennick et al., found that children subjected to a higher number of invasive procedures tended to have more intrusive thoughts and avoidance behaviors. These findings were particularly noteworthy for younger, more severely ill children who had endured many invasive procedures. Rennick et al., replicated these findings and found that children between the ages of 6 to 17 years who were exposed to high numbers of invasive procedures experienced the most psychological sequelae post discharge. Only one study did not find an association between the number of medical procedures and children’s depressive or anxious symptoms. The authors hypothesize that participants in their study had experienced frequent hospitalizations and may have learned effective coping strategies.

**Previous Hospitalizations**

The research on whether previous hospitalization has an effect on a child’s ability to cope with hospitalization is inconclusive. Some research found that previous hospitalizations are not related to the level of anxiety or coping experienced by the child while in a study by Tiedeman and Claworthy, children with no previous hospital experience were more anxious than those who had been in hospital before, alluding to the potential benefits of being familiar with the hospital setting. Support for these findings can be found in Wells and Schwebel where children with fewer previous surgeries exhibited greater disturbance and anxiety.

**Gaps in the Literature**

Since studies report mixed findings on a variety of variables (i.e. age, previous hospitalizations), additional research using randomized designs with cross-sectional samples could reveal the degree to which particular variables impact on children of various ages. For instance, there is a lack of studies that compare children of different ages with a variety of diagnoses or chronic conditions. Current research has also made no distinctions between chronological age and the developmental level of the participants. This issue may have bearing on research findings given that children sampled from pediatric settings are more likely to have a range of developmental delays which can affect their ability to cope. In addition, future research should address whether particular diagnoses and associated treatment plans place children at greater risk for negative psychological outcomes. Taken together, this information has implications for determining appropriate staff to patient ratios in specific medical areas where child life may be needed most.

According to Rodriguez and Boggs, the evaluation of emotional distress in pediatric settings is further complicated by the scarcity of measures designed specifically for the assessment of children who are hospitalized. Given that a parent’s anxiety is strongly correlated with a child’s anxiety, additional measures which address a range of family variables are also needed. Finally, the literature lacks relevant discourse on issues related to culture (i.e. values, beliefs), diversity and family background.

**CONCLUSIONS**

A systematic review of the best available research revealed key variables to be considered in a child life assessment. In particular, the child’s temperament, and the level of child and parental anxiety (state or trait) are very significant factors. Small and Melnyk underscored the importance of baseline knowledge concerning a child’s usual behavior patterns, citing that this information can identify patients most in need of psychosocial interventions during and following hospitalization. Therefore, an initial assessment of the child’s temperament is an important place to start in addition to determining parental stress levels. An assessment of these key variables will help determine whether the child is experiencing state or trait anxiety. Indeed, highly anxious children may require more emotional support in order to deal with stressful events and this may be particularly significant for children who have experienced many invasive medical procedures. Finally, the research tells us that we cannot assume a child will cope poorly solely because he or she is young without considering other important variables.

The research in this area presents a complicated array of issues for child life consideration. For child life specialists who observe parents exhibiting or reporting high stress levels, collaborating with other health care professionals such as social work can make a significant difference in patient and family outcomes. Although child life specialists play an important role in children’s adaptation to hospitalization, evidence-based practice models support inter-professional collaboration as a means of strategically addressing complex
issues associated with how children and their parents cope with medical challenges.

**REFERENCES**


A Qualitative Exploration of Child Life Specialists’ Experiences Working with Hospitalized Children who have Experienced Physical Abuse

Jennifer M. Cerny, MS, CCLS, Arnold Palmer Hospital for Children, Orlando, FL
Michelle L. Toews, PhD, Associate Professor, Texas State University-San Marcos, Department of Family and Consumer Sciences, San Marcos, TX
Ani Yazedjian, PhD, Assistant Professor, Texas State University-San Marcos, Department of Family and Consumer Sciences, San Marcos, TX

ABSTRACT
The goal of this pilot study was to examine the reported behaviors of hospitalized children who have experienced physical abuse, and how child life specialists responded to these children. A total of 90 CCLs responded to a survey; 39 answered open-ended questions regarding their experiences working with this population. A qualitative analysis of their responses revealed that children who had been hospitalized as a result of physical abuse lacked trust, were fearful of the hospital, were often withdrawn, and at times exhibited aggressive behavior. The respondents also described the importance of interpreting the signs children presented in order to plan their interventions appropriately.

Key Words: child life; child abuse; hospitalized children; strategies for child life specialists

It is not uncommon for children to be admitted to the hospital as a result of physical abuse. In fact, 10% of all emergency room visits for children are the result of physical abuse (Chang, Knight, Ziegfeld, Haider, Warfield, & Paidas, 2004). In 1998, the American Academy of Pediatrics found that 57% of the 607 pediatrics surveyed had treated at least one injury resulting from child abuse. Although it is often the doctors and nurses who are the first to recognize the signs of abuse (Kaufman, 1999), child life specialists also frequently identify signs of abuse through their work with hospitalized children. Because it is their role to increase understanding of hospital experiences for children and families, child life specialists spend a significant amount of time with hospitalized children (American Academy of Pediatrics, 2006). To date no research has explored child life specialists’ experiences working specifically with hospitalized children who have been physically abused.

In order to identify how child life specialists respond to children who have experienced physical abuse, it is important to first examine the qualities that characterize this population. Although previous researchers have studied both the characteristics of children who have been abused and the psychosocial outcomes of the abuse, much of this research was completed more than 20 years ago. (e.g., Chan & Leff, 1988; In & McDermott, 1976; Kempe & Kempe, 1978; Martin & Beezley, 1976). For example, Martin and Beezley (1976) studied the characteristics of 50 children, between the ages of 2 to 13, who were physically abused. The most notable characteristic identified was children’s inability to enjoy life. In fact, these children described life as very unrewarding. This has significant implications for child life because research has shown that attitude and positive affect speed up the recovery process (Gidron, McGrath, & Goodday, 1995; Smith & Zutra, 2004). Therefore, child life specialists can play an important role in the recovery process by supporting and promoting a positive outlook for children who have been abused.

Another characteristic commonly seen among children who had experienced abuse was “frozen watchfulness” or hypervigilance (Kempe & Kempe, 1978). Kempe and Kempe used this term to describe how children who had been abused were very aware of their surroundings and would react quickly to any changes in those surroundings. Thus, it is possible that child life specialists would be more likely to observe hypervigilance among children who were physically abused because the hospital is a new environment. Hypervigilance also makes it very difficult for children who have experienced abuse to play, explore, and move spontaneously from one toy to another (Chan & Leff, 1988). This hypervigilance oftentimes presents the child with too many nervous stimuli, causing children who have been abused to have difficulty paying attention and following through with instructions (Chan & Leff). Child life specialists might need to address these issues in their interventions by working to lessen the environmental stimuli surrounding the child and perhaps providing the child with simple one-step instructions.

Researchers have also found that children who have experienced physical abuse have a tendency to withdraw (e.g., Hoffman-Plotkin & Twantyman, 1984; Kaufman & Cicchetti, 1989; Martin & Beezley, 1976; Salzinger, Feldman, Hammer, & Rosario, 1991, 1993), possibly as a defense mechanism against further punishment (Crosson-Tower 2002; Horton & Cruise 2001). Chan and Leff (1988) reported that extremely withdrawn or inhibited children who had been abused needed to learn how to play. In fact, they reported that some children who had been abused were not able to use toys purposefully and some were not even able to recognize toys (Chan & Leff). Because child life

continued on Focus page 8
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FOCUS FALL 2008

(1) What characteristics have you noticed among children who have been physically abused? Describe in detail and, if possible, provide specific examples you have encountered.

(2) How do you think these characteristics affect their hospital experience? How have you seen this in your own experience?

(3) How do these characteristics impact the way you work with these children in the hospital? If possible, provide details, examples, or personal anecdotes.

(4) What have you found to be the most effective therapeutic tool for working with children who have been physically abused? How have you seen this work with the children?

The lack of social skills exhibited by hospitalized children who have been physically abused might greatly affect their relationships with the doctors, nurses, and child life specialists who are trying to help.

The goal of this pilot study was to examine the reported behaviors of hospitalized children who have experienced physical abuse, and how child life specialists responded to these children.

Similarly, children who have experienced physical abuse might be subject to great social distortion. In other words, these children might have strong misconceptions of other people’s feelings, behaviors, or intentions (Salzinger et al., 1993). These misconceptions might affect their ability to create trusting relationships with healthcare professionals, as well as hinder their ability to differentiate between the pain caused during medical treatment and the pain inflicted on them at home. Chan and Leff (1988) found that by using simple, gentle, supportive statements frequently throughout procedures, health care professionals could help the child understand that the pain was the result of the treatment by a caring adult, rather than an abusive attack.

Furthermore, children who have been abused are very susceptible to the fear of being “bad” and tend to interpret the abuse as their own fault. Subsequently, they are likely to believe that they were hospitalized as a result of their own behaviors (Horton & Cruise, 2001). If parents leave these children at the hospital alone (a common practice), this abandonment reinforces their beliefs that they are “bad” and deserve to be in the hospital (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott, 1983). Therefore, it is important for child life specialists to help children understand the real reason for their hospitalization.

Although numerous researchers have examined the characteristics exhibited by children who have experienced physical abuse, no research to date has examined the characteristics they demonstrate while hospitalized. Moreover, given the importance of child life specialists in the hospitalization of children who have been physically abused, it is surprising that no research has explored their experiences working with this population. Therefore, the purpose of this pilot study was to examine the reported behaviors of hospitalized children who have experienced physical abuse, and how child life specialists responded to these children.

METHOD

Participants

This study was part of a larger pilot study examining Certified Child Life Specialists’ (CCLS) training, education, and experiences working with children who have experienced physical abuse. Participants consisted of CCLS who were employed by hospitals listed in the Directory of Child Life Programs (2003) at the time of the survey. Initial contact was made using the email addresses published in this directory. In programs with more than one child life specialist, whoever received the email, usually the director of the child life program, was asked to forward it to other child life specialists in the hospital. If an email was returned as invalid or undeliverable, phone calls were made to the child life department asking for contact information for child life specialists willing to participate.

The total sample of 90 child life specialists consisted of predominately White (n=80; African American, n=3; Asian American, n=2; and Hispanic/Latino, n=4) females (88 out of 90 respondents), which is consistent

TABLE 1. OPEN-ENDED SURVEY QUESTIONS

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specialists generally spend a significant amount of time with children in therapeutic play (Child Life Council and Committee on Hospital Care, 2006), they might first need to assess children’s understanding of play and then respond accordingly when working with children who have been abused.

While some researchers have found that children who have experienced physical abuse tended to be withdrawn, others found they exhibited more aggressive behaviors (Erikson & Egeland, 1987; Kaplan, Pelcovitz, & Labruna, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993). This aggression was not only demonstrated with peers, but was observable in children’s relationships with adults as well (Horton & Cruise, 2001). Aggressive behavior was often used toward adults in an attempt to determine if the children’s aggression would result in counter-aggression (Chan & Leff, 1988). Mann and McDermott (1983) suggested that caring adults, such as child life specialists, working with children who have experienced abuse should use positive guidance strategies by enforcing consistent, firm, yet non-punitive limits when addressing behavior problems and attempting to increase compliance.

Besides aggression, physical abuse impacted children’s ability to form social relationships with individuals who were trying to help them. For example, children who had been physically abused had more socially disturbed behavior, started more fights, showed less cooperation, and demonstrated less lead-

Furthermore, children who have been abused are very susceptible to the fear of being “bad” and tend to interpret the abuse as their own fault. Subsequently, they are likely to believe that they were hospitalized as a result of their own behaviors (Horton & Cruise, 2001). If parents leave these children at the hospital alone (a common practice), this abandonment reinforces their beliefs that they are “bad” and deserve to be in the hospital (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott, 1983). Therefore, it is important for child life specialists to help children understand the real reason for their hospitalization.

Although numerous researchers have examined the characteristics exhibited by children who have experienced physical abuse, no research to date has examined the characteristics they demonstrate while hospitalized. Moreover, given the importance of child life specialists in the hospitalization of children who have been physically abused, it is surprising that no research has explored their experiences working with this population. Therefore, the purpose of this pilot study was to examine the reported behaviors of hospitalized children who have experienced physical abuse, and how child life specialists responded to these children.

The lack of social skills exhibited by hospitalized children who have been physically abused might greatly affect their relationships with the doctors, nurses, and child life specialists who are trying to help.

The goal of this pilot study was to examine the reported behaviors of hospitalized children who have experienced physical abuse, and how child life specialists responded to these children.

Similarly, children who have experienced physical abuse might be subject to great social distortion. In other words, these children might have strong misconceptions of other people’s feelings, behaviors, or intentions (Salzinger et al., 1993). These misconceptions might affect their ability to create trusting relationships with healthcare professionals, as well as hinder their ability to differentiate between the pain caused during medical treatment and the pain inflicted on them at home. Chan and Leff (1988) found that by using simple, gentle, supportive statements frequently throughout procedures, health care professionals could help the child understand that the pain was the result of the treatment by a caring adult, rather than an abusive attack.
with the general demographics of those in the field. Participants had a mean age of 34.1 years. All participants had at least a bachelor’s degree and 39 held a master’s degree. Participants represented child life specialists in 27 states, with most participants responding from Texas (n=18). Additionally, there were a number of respondents from Canada (n=6). Although a total of 90 CCLS submitted a survey, only 39 responded to the open-ended questions upon which this study was based.

**DATA COLLECTION**

Participants were asked to fill out an online survey regarding their experiences working with hospitalized children who have been physically abused. For the purpose of this study, participants were also asked to respond to four open-ended questions (See Table 1).

**DATA ANALYSIS**

Despite the fact that child life specialists spend a significant amount of time with hospitalized children, there is a surprising lack of research exploring their experiences. We chose qualitative techniques because they allowed us to give voice to their unique perspectives (Patton, 1990). We conducted a content analysis to determine what characteristics child life specialists observed among hospitalized children who had experienced physical abuse and how they responded to the characteristics these children displayed. Content analysis is a technique used to systematically analyze written communication such as open-ended survey responses (Berg, 1998). This technique allowed us to examine how respondents characterized their experiences working with this population and enabled us to account for the frequency with which certain themes were reported.

Specifically, the qualitative responses were coded by two independent coders to assure a more reliable and valid analysis (Berg, 1998). Recurring commonalities among the child life specialists’ responses were identified and sorted based on similar themes (Berg). To represent these themes, initial coding categories were developed. Next, the data were examined deductively to identify more specific themes. Lastly, the primary coder examined the identified themes to determine if the findings were consistent among the coders. Any inconsistencies were discussed by the coders until consensus was reached.

**FINDINGS AND DISCUSSION**

When asked to describe the characteristics of children they had worked with in the hospital, the child life specialists reported that children who had experienced abuse tended to exhibit characteristics similar to those reported in previous research (Crosson-Tower, 2002; Salzinger, Feldman, Hammer, & Rosario, 1991). Based on the responses, four themes were identified. Specifically, the hospitalized children lacked trust, were fearful of the hospital environment, were often withdrawn, and were at times aggressive. Child life specialists also described various ways they responded to children they encountered in the hospital who had experienced physical abuse.

**TRUST**

Trust, or the lack thereof, was one of the most important themes discussed by child life specialists in this study. In fact, two-thirds of the child life specialists made some reference in their responses to either trust or the problems resulting from a lack of trust. As one child life specialist explained:

When children have developed a lack of trust with adults due to abuse, it is more of a challenge to have them "buy in" to what needs to happen. When hospitalized, they might not like what they are asked to do, but there might be no choice, such as taking medications, or walking.

Moreover, child life specialists commonly reported that children who had experienced physical abuse did not know whom they could trust, which made it difficult for them to build a trusting relationship with the hospital staff.

Because this special population often lacks the ability to trust, child life specialists reported the most important thing they could do was work to establish trust between the child and the staff at the hospital. In fact, two-thirds of the participants reported the importance of activities that built trust and rapport. One child life specialist reported:

With abuse patients, I have found that the most important thing is to attempt to establish a trusting relationship and to continue to reassure them that we are here to help them. Without accomplishing these things, it is usually very difficult, if
because children who have been abused might have strong misconceptions of other people’s feelings, behaviors, or intentions (Salzinger et al., 1993). These misconceptions might interfere with establishing a strong, trusting relationship between the children and those who are trying to help them. As a result, children’s ability to create trusting relationships with health care professionals as well as their ability to differentiate between the pain caused during medical treatment and the pain inflicted on them at home can be hindered.

One way child life specialists responded to these difficulties was by being upfront and honest about painful treatments the children were going to receive at the hospital (Child Life Council and Committee on Hospital Care, 2006). For example, one child life specialist pointed this out by stating, “I do not want the kids to think they have just ended up in another abusive relationship.” Another child life specialist mentioned, “The interventions for treatment might be considered to be like abuse to the child.” Therefore, child life specialists recognized the importance of thoroughly explaining both their role in the hospital as well as the procedures the child would encounter in the hospital. One child life specialist suggested, “You approach the child and let them know what you do and how you can help them using verbiage they understand.” Another child life specialist agreed that one must “describe all interactions with the medical staff as necessary,” and added it might be necessary for the child life specialist to explain to the child why his or her parents are not there if a separation has occurred.

Furthermore, one child life specialist explained, “Many children of abuse feel at fault for the actions that have taken place.” In fact, self-blame was a theme that emerged in both the study and the literature. Because children who had been abused feared being “bad,” they often interpreted the abuse as their fault (Horton & Cruise, 2001). As a result, they might have misinterpreted the actions and intentions of the hospital staff (Salzinger et al., 1993). In other words, they might have believed the painful treatments and procedures they encountered in the hospital were a consequence of being “bad.” Thus, child life specialists must clarify misconceptions and assure children that they are not to blame.

Similar to the recommendations set forth by the Child Life Council and Committee on Hospital Care (2006), the child life specialists in this study also believed it was important to spend adequate time preparing the children for painful procedures. For example, Chan and Leff (1988) suggested using statements such as “I feel sad, too, when the needle hurts you. We care about you and want the medicine to make you better really soon” (p.172) as a way to help the child understand what was happening. Doing so could help establish trust that might have been lacking in the child’s previous relationship (Crosson-Tower, 2002), and help the child distinguish between the pain of abuse and pain that resulted from the treatment by a caring adult.

Another way the child life specialists in this study built rapport with children who had experienced physical abuse was by creating consistency. Most often, the child life specialists used this term to mean following through with things. One child life specialist explained, “Consistency is important for trust building and doing what we say we are going to do.” Child life specialists also used this term when referring to the consistency of caregivers for the child. Child life specialists suggested children who have been abused should have a primary caregiver in the hospital and limited volunteer contact as a way to reduce the number of individuals with whom they were attempting to create a trusting relationship. One child life specialist found the best way to work with these children was to provide “clustering of care to decrease the amount of contact with the patients with procedures, provide a consistent RN [nurse] and volunteer to help foster trust and reliance.” Another child life specialist found bedside work was the best way to begin establishing a trusting relationship with the child:

It has been nice that the child and the bedside work can be a very predictable environment, one where rapport can be built in little bits at a time. By the time they move to the floor, I still think continuity of staff or an introduction and overlap period of new staff is helpful.

Child life specialists also provided focused attention on the child as a way of building trusting relationships. One-third of the child life specialists mentioned the need to provide children who have experienced abuse with

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**SUMMER 2009**

**COMMENORATIVE ANNIVERSARY ISSUE OF FOCUS**

**CALL FOR PAPERS**

In recognition of the upcoming 10 year anniversary of the first issue of Focus, the Bulletin editorial panel is seeking contributions of Focus articles for a commemorative Summer 2009 issue. This Focus anniversary issue will incorporate a broad theme, Transitions, to represent the forward momentum of the child life profession. Related topics may include, but are not limited to:

- Infants transitioning from hospital to home
- Youth graduating to adult care
- Advances in clinical programming or academic training
- Child life specialists moving between the hospital and community settings
- Transitions from the role of student to professional
- Transitions from novice to leader
- Achievements in research

Those interested in submitting an abstract for consideration should contact the Managing Editor at bulletin@childlife.org for details.

Abstract submissions are due no later than Friday, December 1, 2008, and manuscript submissions will be due to the Managing Editor by March 16, 2009.
more focused attention than they might generally give to other children. When referring to one child with whom she was currently working, one child life specialist reported, “I find myself spending a lot of time with him.” Another child life specialist felt the best therapeutic tool for working with these children was simply. “Honoring them by spending time with them doing activities that are age-appropriate; something that very likely is lacking in their own lives.” Child life specialists agreed that these children required more attention than others in the hospital because their parents were not usually present. This abandonment by parents further reinforced the child’s fear that he or she was “bad” and deserved to be left alone in the new environment (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott).

Although all child life specialists agreed that children who had been abused required more specialized attention from the staff, some felt as though this could become problematic. One child life specialist explained, “I think I might tend to overfunction in some of these cases, pay more attention to that child in the playroom, maybe unknowingly create a ‘favored’ child out of it.”

Another child life specialist mentioned her frustration in not being able to spend more time with the child:

I know a lot of these children are here alone in the hospital [because their] parents are asked to have only supervised visits. This is frustrating, due to the fact that these children need someone to support them 24/7. We, as staff, do not always have someone to be in a patient’s room 24/7.

These sentiments illustrated the tension felt by child life specialists to meet the unique needs of these children while caring for other patients.

FEAR

One reason the child life specialists believed the children had difficulty trusting the staff was a fear of disclosure. Children were reported to fear activities that could possibly end in disclosure, such as befriending adults, engaging in play activities, or expressing feelings in general. One child life specialist stated, “Sometimes the patients are more scared of authority figures and take longer to open up and share how they are feeling.”

Several other child life specialists also reported the tendency for children who had been abused not to open up or express their feelings because of their loyalty to their parents. One child life specialist reported, “It can be difficult to help children open up and share how they feel with you because they do not know who to trust or may not want to say anything because they are protecting the abuser.” Another child life specialist shared, “They are scared to share any information in a situation in which they have been threatened if they do share information. They also may love the person that has abused them and do not want them to get in trouble.”

Besides the fear of disclosure, child life specialists found children were dealing with many other sources of fear. Close to half of the child life specialists (44%; n=17) made some reference to the fear exhibited by children in the hospital who had experienced abuse. It was reported that the children were afraid of the hospital staff in general, as well as interactions with the staff, a finding in line with previous research (Coyne, 2006). One child life specialist stated the children were “afraid of the simplest interaction with

continued on Focus page 12
hospital staff” and “fearful of everyone.” Another child life specialist reported the children were afraid of going home or afraid the perpetrator might come into the hospital. Another child life specialist found these children were afraid of being alone.

WITHDRAWAL

Similar to previous research studying children who have been abused (Hoffman-Plotkin & Twentyman, 1984; Kaufman & Cicchetti, 1989; Martin & Beezeley, 1976; Salzinger et al., 1991, 1993), almost half (48%; n=19) of the child life specialists surveyed specifically used the word “withdrawn” to describe the children they worked with in the hospital while others reported similar characteristics such as shy, quiet, and reserved. Although being withdrawn has been described by some as a defense mechanism to avoid future abuse (Crosson-Tower, 2002; Horton & Cruise, 2001), in this study it was also a way of avoiding disclosure. Child life specialists reported the children kept to themselves and did not open up or share their feelings. By doing this, the children protected themselves from disclosing their home situation.

AGGRESSION

While some researchers have found that children who had been physically abused tended to be withdrawn, others have found they showed more aggression (Erikson & Egeland, 1987; Kaplan, Pelcovitz, & Labruna, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993). This finding was supported by participants who reported children were “quiet and withdrawn or more provocative and aggressive or assertive.” Others described children who had been abused as “angry,” “combative,” and “violent.” They reported that some children exhibited “explosive tempers” and “self-destructive behaviors.” Participants noted that although some children were aggressive in nature, others engaged in aggressive play with toys or staff.

Previous research has found that children who had experienced abuse who demonstrated these types of aggressive behaviors were more likely to start fights and were less cooperative with others (Ammerman, Cassisi, Hersen, & Van Hasselt, 1996; Haskett & Kistner, 1991; Lane & Davis, 1987; Salzinger et al., 1993). This aggression, at times, hindered social interactions. However, the child life specialists in this study reported troubled social interactions were more the result of children resisting engaging with others and choosing to isolate themselves rather than being a result of aggression. One possible explanation for this incongruity could be the fact that because the child’s hospitalization is so closely related to the abuse, the child is withdrawing completely. On the other hand, children outside of the hospital setting might be acting aggressively as a way of disclosing their abusive situation.

In addition, similar to previous research, our participants reported that children’s aggressive behaviors were not only demonstrated with peers, but were observable in their relationships with hospital staff as well (Horton & Cruise, 2001). The aggressive behavior directed toward adults might have been an attempt to determine if the children’s aggression would result in counter-aggression (Chan & Leff, 1988). Consequently, the child life specialists in this study felt it was important to provide opportunities for children who had been abused to express their angry feelings through “play, play, and more play.” Providing opportunities for play not only relieved some of the
internal tension felt by these children, but also gave them an opportunity to test the relationship with the child life specialist.

**Child Life Interventions**

Although child life specialists in this study reported characteristics they believed children who had been abused shared, almost 25% of the respondents felt it was important to recognize differences between these children and understand that they might each react differently to the hospital experience. One child life specialist explained, “Every child that I have encountered is different, each coping in their own unique way. I have had children that want to open up and say everything they have been through and others that never say a word.” As a result, the child life specialists noted the various ways they worked with hospitalized children who had been physically abused.

Many of the child life specialists reported it was extremely important to plan interventions for the particular child to increase comfort. For example, child life specialists reported the importance of providing activities for self-expression such as “art, music, or any other media that the child has interest in that they can channel their feelings into.” One child life specialist found it helpful to provide children with paper and markers because she found that “kids will draw out how they feel or what has happened.” Child life specialists reported using other expressive media such as arts/crafts, play-doh, music, and journal writing. Others discussed using dramatic play, feeling games, dollhouses, and role-playing. One child life specialist suggested, “doing an All About Me Poster because this really lets them express how they feel in a non-threatening way.” Another child life specialist found that art provided opportunities for “letting them express what they feel and remember, and talking about it.”

Similar to the information provided by the Child Life Council and Committee on Hospital Care (2006), the child life specialists’ responses indicated their beliefs that play provided a good opportunity for the children to both express what had happened and work through it.

Child life specialists also felt they needed to interpret the signs children presented in order to plan their interventions. For example, one child life specialist commented: “As a CLS, you always have to assess what happened and adapt your interventions accordingly.” Another child life specialist reported using the patients’ interactions with the hospital staff to help determine the patients’ state of mind and adjust his or her interventions. This included a child’s readiness for activity. One child life specialist explained, “Slowly move into activities the child feels comfortable doing so they can accomplish a task and feel confident. Then move into a more advanced activity and so on.”

Another child life specialist mentioned the importance of assessing the patient’s readiness to be in social situations. This is particularly relevant considering the child life specialists in this study reported children who had experienced abuse had a difficult time engaging in activities or conversations with others. Furthermore, they observed that these children often did not want to be part of a group and tended to be resistant to group activities. Therefore, the need to assess children’s readiness for social situations, such as the playroom, was pertinent. Child life specialists found listening closely to children who had been abused was a good way to assess how they were adjusting to their situation: “It is also vital to listen to and observe the patients to find out what level they are on.”

These findings are important because previous research has found that being hospitalized is a stressful experience for children in general (Coyne, 2006), and hospitalization as a result of physical abuse might exacerbate the stress children are already experiencing. In order to decrease the stress of hospitalization, child life specialists felt they needed to create a feeling of security or safety (34%; n=12). Some of the methods they reported using to create a safe environment in the hospital were speaking in a gentle voice, creating a calm environment, and ensuring the staff explained their actions to the child. Additionally, child life specialists reported using a child-directed approach with children who had experienced abuse. Examples included “I always let the child lead the way” and “I never initiate physical contact unless a child asks for it (wants a hug or a back rub).” These strategies not only provided a sense of safety for the children, but also allowed them a sense of control over their own hospitalization, a factor Coyne found to be critical in allaying the fears of hospitalized children.

Although many of these suggestions can be implemented with hospitalized children in general, Chan and Leff (1988) identified a few additional variables to consider when working with children who had been abused. Specifically, interventions must also take into account: the nature of the injury; the age of the child; previous separations and hospitalizations; the number, severity, and age of onset of past abusive episodes; and the nature of the child’s post-hospitalization environment. By accounting for these variables, child life specialists will be able to provide more developmentally appropriate care.

**Implications for Practice**

This study provides a basic understanding of what to expect when working with children who have been physically abused. It identifies characteristics to look for and provides suggestions for working with hospitalized children who have experienced abuse. Although these suggestions are given with respect to working with this particular population, they are also in line with child life specialists’ standards of clinical practice for working with all children. Our findings highlight the importance of providing trust-building activities, creating a safe

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**CALL FOR 2009 EXECUTIVE BOARD APPLICATIONS AND NOMINATIONS**

Are you interested in becoming a member of the CLC Executive Board? We invite you to consider applying for a leadership position — or nominate one of your colleagues — for the 2009 elections. The CLC Executive board represents the voice of the membership, and is responsible for keeping the organization vital and strong. Complete information on the nomination and application process is available at the following link in the Membership section of the CLC Web site:

http://www.childlife.org/Membership/NominationsandVoting.cfm

**DEADLINE: NOVEMBER 10, 2008**

Questions? Please contact 1-800-CLC-4515, ext. 15

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*continued on Focus page 14*
STRENGTHS AND LIMITATIONS

Due to the dearth of research in the field of child life, this pilot study provides valuable information regarding child life specialists’ experiences working with hospitalized children who have been abused. This study provides several important practical implications for child life specialists. Specifically, this study provides child life specialists with a basic understanding of what to expect when working with children who have been physically abused.

Despite the fact that child life specialists spend a significant amount of time with hospitalized children, there is a surprising lack of research exploring their experiences. We chose qualitative techniques because they allowed us to give voice to their unique perspectives.

Although this study provides valuable information regarding child life specialists and their experiences working with children who have experienced abuse, there are several limitations. First, the sample is extremely homogenous (88.9% white and 97.8% female). In addition, the sample size is fairly small. Although there were 90 responses, more than half of the respondents did not complete the open-ended questions on the survey. This low response rate might be due to the fact that people are less likely to write in responses on a survey because of the amount of time required to do so.

Furthermore, it is possible a large percentage of the sample might have had more education and training than other child life specialists; therefore, information might not be representative of the target population of child life specialists in general. At the same time, individuals are generally more likely to participate in research they personally find interesting or relevant to their own lives. Because participants essentially volunteered to participate in the study by choosing to complete the survey, it is possible that they might not have had the same training, education, or experiences as those who chose not to participate. This limits the generalizability of our findings because our sample might not be representative of all child life specialists.

FUTURE DIRECTIONS FOR RESEARCH

In addition to the practical implications discussed above, this study also provides several implications for research. For example, future research should attempt to obtain a larger, more diverse sample in order to validate the results of this study as well as increase the generalizability of the findings. Furthermore, conducting in-depth interviews with child life specialists who have had a significant amount of experience working with this population would add more to the current study’s findings. Additionally, although it would be difficult to conduct, a study assessing the children’s experiences of the hospital from their own point of view would provide valuable information for child life specialists and other health care professionals.

REFERENCES


Many of the child life specialists emphasized the importance of planning interventions that promote comfort. Child life specialists felt they needed to pay particular attention to the signs children presented in order to adjust their interventions based on their assessments. For example, they found it especially important to assess the patient’s readiness to handle social situations prior to sending them to the playroom where they were more likely to encounter large or rowdy groups of children. In addition to adapting interventions to each specific child depending on his or her age and developmental level, child life specialists noted the importance of using a variety of expressive play materials when working with children who had experienced abuse. For example, they suggested activities such as art, music, playdoh, journals, feeling games, dolls, dollhouses, and dramatic play as ways to accommodate children’s individual preferences and ease some of the stresses associated with hospitalization.

MILESTONES

PASSING: It is with deep sorrow that CLC shares news of the loss of Mary Barkey, an innovative child life specialist best known for her pioneering work on the Comfort Measures model. Mary was a child life specialist for 26+ years at Rainbow Babies and Children’s Hospital in Cleveland, Ohio, and the focus of her work there was family-centered care. In addition to her work on the Comfort Measures model, Mary was an adjunct clinical instructor for Kent State University and the Frances Payne Bolton School of Nursing at Case Western University. She was a Member-at-Large on the CLC Executive Board from 2001-2003.

Mary passed away peacefully in her home on August 6, in the company of her husband and three daughters. She will be sorely missed, but her pioneering work and her belief in the importance of interdisciplinary collaboration will be her enduring legacy, and it will continue to enhance child life practice for years to come.

To learn more about Mary’s work, read the cover story from the Summer 2008 issue of the Bulletin: “Comfort Measures for Invasive Procedures: A major paradigm shift in Pediatric Practice.”


AWARDS: Congratulations to CLC volunteer leaders Anita Pumphrey, MS, CCLS, and Shawn Brasher, CCLS, who each were recently honored with awards from Louisiana Tech University. Anita, an instructor of human ecology at Louisiana Tech, was awarded the Tech Foundation F. Jay Taylor Undergraduate Teaching Award. Shawn, the current director of the child life program at CHRISTUS Schumpert Sutton Children’s Medical Center, was awarded the first Shirley P. Reagan Leadership Award by the School of Human Ecology. The award is given to a successful young alumnus who has demonstrated strong leadership skills through his career and service to his profession.
Professional Practice and the CLC Resource Library

Applying Child Life Resources

Child Life professional competency statements articulate that specific knowledge and skills are necessary for the education and supervision activities inherent in the responsibilities of child life specialists. With ever-increasing demands placed on individuals and programs to represent and communicate child life practice, as well as supervise child life students and volunteers, access to supportive documents and resources is imperative. Equally important is the establishment of individual or program practices that facilitate a familiarity with the Resource Library, a constantly-evolving online collection of resources and links maintained by the Professional Resources Committee.

The next time you are looking for supportive evidence to bolster your multidisciplinary presentation, grant application, annual report or academic assignment, take advantage of the reference tool designed to keep hundreds of helpful links, references, and samples at your fingertips!

Here are some examples of the hundreds of resources you will find in the updated Resource Library:

- **Evidence-Based Practice Statements** offers a series of statements commissioned by the CLC Executive Board to review and analyze outcome research that specifically addresses child life practice.
- **Direct Child & Family Services** provides resources that address a variety of topics relevant to the direct delivery of child life services to children and families, including crisis intervention, family-centered care, grief/bereavement, and many more.
- **Related Programming & Services** provides resources that address a variety of services closely associated with the delivery of direct child life services, such as art and dance therapy, recreation therapy, infant massage, pet therapy, hospital event planning, hospital-based education, and more.
- **Administration** offers resources helpful in the administration of a child life program, including child life salaries, promoting child life services, fundraising/donations, and internship programming.
- **Diagnosis Specific** presents a wealth of resources and links that pertain to specific medical conditions or diagnoses.
- **Complementary Organizations** offers a listing of organizations that provide information and services that benefit or augment child life programming.
- **Resources for Caregivers** provides information and resources meant to be shared with parents, teachers, and other caregivers. Also included is a list of activity Web sites for children and teens.
- **Annotated Bibliography** is a collection of research-related literature relevant to child life practice, developed and regularly updated by the CLC Evidence-Based Practice Committee.
- **Accessing Research** provides tips and recommended resources for accessing research, developed by the CLC Evidence-Based Practice Committee.

Do you notice a gap in the resources provided in this section, or have suggestions for potential additions? Contact resources@childlife.org to submit your ideas to the Professional Resources Committee.

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Offering Help... and Hope for the Future

When a child is diagnosed with a rare and chronic heart disease such as cardiomyopathy, it can be an overwhelming and bleak time for the family. The Children’s Cardiomyopathy Foundation can provide valuable information and a caring support network to help families cope and find hope again.

Visit our website and learn more about our free patient resources and services:

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- Fact Sheets
- Newsletters
- Resource Listings
- Family E-mail Forum
- Local Support Groups
- Physician & Center Specialty Lists

www.childrenscardiomyopathy.org
866-808-CURE

A Cause for Today... A Cure for Tomorrow
San Diego Conference

Continued from page 1

(Children’s Health Council), Joanna Kaufman (IFCC), Sue Dull (NACHRI), and Kamyar Hedayat (AromaMD)

• The first-ever Internship Forum Panel Discussion, a top rated event

CLC thanks all of the individuals whose hard work and dedication made the Annual Conference in San Diego possible; the Conference Planning Committees and volunteers, as well as all of the sponsor organizations whose generous donations allow us to offer high quality programming at affordable rates.

Next year, Boston will play host to the Child Life Council’s 27th Annual Conference on Professional Issues, and the Conference Planning Committees are already hard at work in planning a top-notch educational program worthy of the city’s rich academic tradition! The conference will take place May 21-24, 2009 at The Westin Boston Waterfront. We look forward to seeing you there!

Child Life Alphabet

Continued from page 1

An attitude of science can be shared among colleagues in a number of ways. Here are a few examples:

• Child life specialists demonstrate an attitude of science by keeping up to date with the literature. Those who subscribe to current literature, access library databases, and meet for discussions, such as in-service or journal clubs, are showing their attitude of science.

• Child life specialists can also engage in an attitude of science through documentation, collaboration, and case reviews that allow for a critical examination of interventions and outcomes.

• An attitude of science also involves engaging in writing and research that is shared with the profession. The annual conference and the Bulletin/Focus are examples of opportunities for the dissemination of information.

In short, an attitude of science is about maintaining a level of active curiosity – asking questions, seeking answers, and applying best practices that are supported by research-based evidence.

REFERENCES


* The Child Life Alphabet column A is for Attitude of Science is the first in a series of brief compositions on concepts or terms related to child life professional practice. Designed to encourage new writers, we are seeking contributions for upcoming issues. Anyone with a great idea for the letter B (or any subsequent letters) is invited to contact the Managing Editor at bulletin@childlife.org for information on how to proceed with a submission. Thank you to Roni for being the first to contribute to the column!
CLC Calendar

October
15  Deadline for written requests to withdraw from November Administration of the Child Life Professional Certification Exam

November
1   CLC 27th Annual Conference sponsorship deadline for inclusion in the conference program
8   Child Life Professional Certification Exam Administration
10  Deadline for CLC Executive Board Applications and Nominations
21-23  CLC Executive Board Meeting

January 2008
31  Child Life Professional Certification maintenance fees due

Membership Matters

CLC Membership Hits an All Time High!

What a great year 2008 has been so far — CLC membership has reached an all time high at nearly 3,800!

Each and every one of you is an integral part of creating the CLC community, the largest network of child life specialists in the world. We welcome our newest members and send a heartfelt “thank you” to the many members renewing their connection with CLC at this time of year.

Maintaining a continued membership with CLC allows us to keep our commitment to you by creating new resources for your professional development, enhancing connections with your colleagues, and collaborating to advance the child life profession. Please note that a $25 joining fee is now in effect which is automatically added to all new and re-joining membership applications. This is a one-time fee that will not be reassessed upon timely renewal of membership. If you have any questions on how to maintain your membership in this distinguished community, please contact your CLC membership team at membership@childlife.org or 301-881-7090 ext. 11.

Again, thank you for your support of CLC.