

## Comfort Measures for Invasive Procedures: A Major Paradigm Shift in Pediatric Practice



Mary Barkey, MA, CCLS

**K**nowing how many children, families and healthcare providers have benefitted from “Comfort Measures,” we asked Mary Barkey to reflect on the history of the comfort positioning techniques that she pioneered in partnership with the late Barbara Stephens.

“We’ve been very fortunate,” she says. “If you’d told me 15 years ago that I’d be traveling around the country speaking [at conferences and grand rounds], I’d have told you you were crazy!”

The comfort measures/positioning model for children having stressful procedures was initially inspired by Mary’s observations in the treatment room during her first few years as a child life specialist at Rainbow Babies and Children’s Hospital in the early 1980s. A typical approach is described in an article she coauthored, entitled “Techniques to comfort children during stressful procedures” (Stephens, Barkey and Hall, 1999):

*The child was taken into the treatment room while the parents waited outside the door. Often the child was not prepared in any way for the procedure other than being told the type of procedure to be performed—“You need an i.v.,” for example, or, “We are going to put a tube in your nose.” The child was forced to lie supine on the table with staff members pinning the child down. The number of staff were increased until the child was sufficiently immobilized to perform the procedure, at times requiring 4 to 5 adults. (p.49)*

“I remember thinking, ‘Why are we traumatizing our children like this? Isn’t there a better way to do these procedures?’” Mary recalls. So she began talking to her colleague Barbara Stephens, a nurse, and they discussed their ideas for transitioning to a team approach for procedures, which would be child- and family-centered. Thus began a period of exploration, intervention, and change at Rainbow Babies and Children’s (RB&C) that resulted in the development of the Comfort Measures model.

Mary and Barbara identified doctors who they thought might be open to something new. With the support of these doctors, they involved parents, caregivers, and children in various procedures. “It quickly became clear that the children really wanted to have their parents [or caregivers] with them, and to be able to sit up.” Mary says, “It now seems to be such common sense, but back then it was a real paradigm shift.” The Comfort Measures model includes preparation for the child and family, providing a role for everyone, positioning the child (sitting up whenever possible), creating a calm environment, and having the child choose distraction techniques.

Although this model was now commonly used at RB&C and began to generate interest from nearby programs, it was still not widely accepted. Convinced that they were onto something unique that would be helpful to the pediatric healthcare community, Mary suggested to Barbara that they submit a proposal for the 1992 conference of the Association for the Care of Children’s Health (ACCH).

Not only was the proposal accepted; it was well-received at the conference by a room filled to capacity with healthcare professionals interested in hearing more about the Comfort Measures

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## PRESIDENT'S PERSPECTIVE



### Year in Review

Barbara Gursky, MA, CCLS, Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital, New Brunswick, NJ

*"Never doubt that a small group of committed people can change the world; indeed, it is the only thing that ever has."*

— Margaret Mead, anthropologist

As I finish my term as President of the Child Life Council, I'd like to thank the CLC Executive Board, volunteer leaders, and staff for their hard work, dedication, and support. I have had the pleasure of working closely with many passionate individuals, who not only have helped further the mission of the Child Life Council, but also have demonstrated a constant desire to better the lives of the children and families we serve. It has been an exciting year of growth for the organization: we achieved record-breaking numbers with a membership high of more than 3,700; developed and implemented a new strategic plan; and unveiled a new Web site that enhanced our members' online experiences. We published two evidence-based practice statements, created a 25th Anniversary DVD, held our first online elections, conducted a new salary survey, and continued to develop new and existing committees and task forces.

I'd like to share more information about two of these initiatives.

*So, as I pass the gavel to Janet Cross, I would like to personally thank all of those individuals—CLC staff, board members, volunteer leaders and members—for allowing me to serve the Child Life Council.*

We are very excited to present the second CLC Evidence Based Practice Statement, *Therapeutic Play in Pediatric Health Care: The Essence of Child Life Practice*, which appears on *Focus* page 1. The third Evidence-Based Practice Statement, on assessment, will be available later this year. Look for the statements in printer-friendly format in the *Resource Library* section of the CLC Web

site. Many thanks to outgoing Board member Stephanie Hopkinson for her leadership on this important project.

As part of the ongoing implementation of our new strategic plan, I recently created the Bill of Rights Task Force, which is chaired by CLC Board member Cathy Humphreys. There has been much discussion and interest as to whether or not the child life profession and the families we serve would benefit from a Child Life Bill of Rights. As we all know, a great deal of information relating to the rights of children is already available, on both a national and international level. This new task force will research existing resources, explore the impact a Child Life Bill of Rights would have, and make recommendations to the Board based on their analysis.

In addition to taking part in these exciting newer initiatives, I have been privileged to experience firsthand the work that is being done to improve two of our most well-established, successful programs: Conference and Certification. Over the past year, I have had the opportunity to attend several important committee meetings, and I was impressed by the amount of time, energy and ingenuity that each participant dedicated to improving the programs. I think many of us, (myself included prior to this year's participation), are not aware of the work that goes into these programs. Those of us who attended this year's highly successful Annual Conference in San Diego certainly enjoyed the product of the Conference Planning Committees' efforts!

This has also been an extremely busy year for the Child Life Professional Certification program, which has benefited from the hard work of the Child Life Certification Committee (CLCC) and its subcommittees. In February, the Exam Assembly Committee, led by Sharon McLeod, met in San Diego to finalize upcoming exams. In addition, Certified Child Life Specialists from Southern California participated in an exam development education session and item review process.

The Practice Analysis Task Force then met in March to begin the process of evaluating and revising the exam blueprint, which defines current child life scope of practice. This process will ensure that the certification exam continues to accurately reflect the skills required of an entry level practitioner.

*continued on next page*



#### Child Life Council Bulletin/FOCUS

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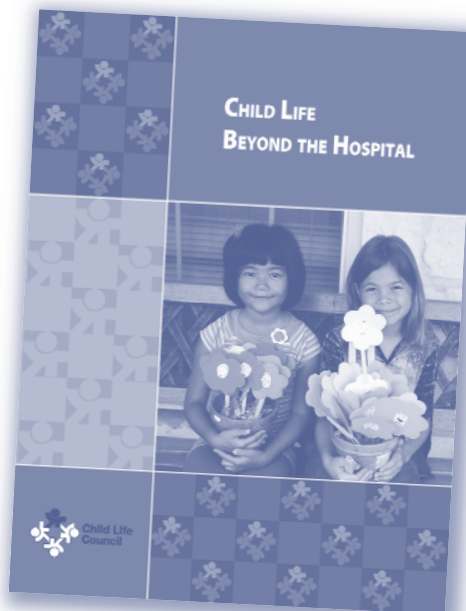
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## Child Life Beyond the Hospital Has Arrived!

The CLC Bookstore is pleased to announce the release of an exciting new publication: the eagerly-anticipated *Child Life Beyond the Hospital*, which documents the ongoing expansion of the child life profession into new practice arenas. Whether you are preparing to embark on a new career outside of the hospital, or merely keeping abreast of current trends in the field, *Child Life Beyond the Hospital* is a worthwhile addition to any child life specialist's library.

Each chapter in *Child Life Beyond the Hospital* was written by a child life specialist (or child life specialists) with experience applying child life skills in a non-traditional setting. While the intention of this new resource is not to teach the reader all of the necessary clinical skills to practice in a particular setting, each chapter can be considered a detailed introduction to the setting for those who are interested in exploring it further. For the academic reader, it also provides insight into the changing and expanding dimensions of the child life profession, as the authors discuss the ways that they have adapted their child life expertise to new environments.

The Child Life Council worked with member and former CLC president Melissa



Hicks to develop the concept and plan the production of *Child Life Beyond the Hospital*. "Over the last several years, there has been increased interest in child life practice outside of hospital settings," says Melissa. "People would often consult me — and others working in nontraditional settings — with questions about how to get started. Although the topic has been addressed in the

*Bulletin* and in discussions on the CLC Forum, I thought it merited a full-length publication."

### WHAT'S INSIDE

*Child Life Beyond the Hospital* provides readers with an introduction and conceptual framework for the topic of alternative settings. Each of the 19 chapters describes a specific setting, presenting a rationale or theoretical foundation for the application of child life in that setting, and a discussion of the potential roles and responsibilities that child life specialists might have there. The authors reflect on specific considerations for practice, as well as the challenges and rewards presented to those who choose to work in a particular environment. Some chapters also include sample forms, contracts, brochures, and other materials.

To order, please visit the CLC Bookstore at <http://www.childlife.org/BookStore/>

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## YEAR IN REVIEW

*continued from previous page*

During this meeting, task force members worked with a testing expert to review the performance domains (assessment, intervention, professional responsibility), identify tasks within each domain, and identify the knowledge and skills required for each task. In addition to this internal validation process, a survey will be sent to 1,500 practicing child life specialists, soliciting their input. The new exam content outline will be based on these findings.

I applaud all of those who over the years helped bring the certification program to such a high, professional standard. The CLC staff, in particular, Ame Enright, CLC Certification Coordinator, has done a tremendous job assisting with activities this year.

So, as I pass the gavel to Janet Cross, I would like to personally thank all of those individuals—CLC staff, board members, volunteer leaders and members—for allowing me to serve the Child Life Council. It has been a true pleasure getting to know and collaborate with so many of you, and I am proud of what we have accomplished as a team. With the development of a new strategic plan, we have implemented a dynamic process that will allow us to be responsive to a constantly evolving—and often uncertain—healthcare environment. I believe that we have laid the groundwork for enormous growth potential over the next five years, and I look forward to doing my part to help us reach an even higher level of excellence!

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## FROM THE EXECUTIVE EDITOR



### **Bulletin Transitions: CONTINUING THE TRADITION OF VISIONARY LEADERSHIP, GROWTH AND CHANGE**

Joan Turner, PhD, CCLS  
Executive Editor, CLC Bulletin and Focus

When I came on board the editorial panel of the CLC *Bulletin/Focus* in the fall of 2006, I was prepared for a great adventure and learning opportunity. The role of Associate Editor was really an apprenticeship; in the beginning, I was allowed to watch and learn from the Executive Editor, and then was introduced slowly to the challenging work of producing the *Bulletin* on a quarterly basis. Before I knew it, nearly a year had passed. The 25th Anniversary Edition was going to press, and we were planning for my transition into the role of Executive Editor.

The 25th Anniversary issue represents the culmination of child life collaboration, sharing and achievements. We owe a debt of gratitude to outgoing Executive Editor Kathleen Murphey for her visionary leadership and dedication in creating a commemorative issue to celebrate the development of the profession over the past quarter century. This important resource is a valuable addition to the child life literature base, and will continue to serve us all very well as we share the progression of our profession with families, students, administrators, and policy makers. It may also serve to inspire all of us, not only to continue to grow and achieve as a profession, but also to document the future of our good work as it unfolds.

As with all leadership positions in professional fields, the need to step up and replenish the *space* left by others is imperative. Humble as we are, we do not all see ourselves as future leaders or contributors to the field. Thus, the role of current leaders is to inspire and encourage others to step out of their comfort zones, speak up, and take on challenging opportunities. In my role as Executive Editor over the next two years, I aim to work in this spirit. The editorial panel will present a range of opportunities for more child life specialists to have a voice in the publication.

Along with a change in the *Bulletin/Focus* color scheme to mark the editorial transition, here are some of the plans for the near future:

**Writing Mentors:** In a positive effort to support and promote the aspiring writers in our profession, the program at CLC's 26th Annual Conference on Professional Issues included a writers' workshop for aspiring authors. It is our hope that the relationships and skill development initiated at the work-

shop will manifest into a series of informative new articles ready for submission to the *Bulletin* and *Focus* in the near future. Interested members who were unable to attend the workshop are encouraged to contact the Managing Editor at [bulletin@childlife.org](mailto:bulletin@childlife.org) for further information.

**New Bulletin Column:** The Child Life *Alphabet* will be a regular feature of the *Bulletin* starting in the Fall 2008 issue. Designed to encourage new writers to submit a brief composition (500 words), this column will elaborate on concepts or terms related to professional practice. To start us off in the fall will be "A is for an *Attitude of Science*." We will be seeking contributions for upcoming issues, for example, B is for Basic play materials: books, balls, blocks, babies and bubbles. Anyone with a great idea for C, D, E and so on is asked to contact the Managing Editor at [bulletin@childlife.org](mailto:bulletin@childlife.org) for information on how to proceed.

**Transformation of Conference Abstracts and Presentations into Articles:** The editorial panel encourages all members who submitted an abstract or presented at conference to consider the value of revising their ideas into an article to share with the greater membership.

**Research-Based Content:** The editorial panel would also like to encourage the submission of research-based articles. As a demonstration of our commitment to evidence-based practice, in *Focus*, we look forward to presenting an increased number of research review articles, as well as original research findings completed at the undergraduate, graduate or professional level. We aspire to creating more space in *Focus* for the presentation of research studies related to child life practice.

It is an honor and a privilege to step up into the ranks of child life leaders who have edited the *Bulletin* and nurtured its growth from a small newsletter to a vital clinical publication. I look forward to including new and emerging authors on its pages. The *Bulletin/Focus* exists to serve the interests of the membership by presenting a range of administrative, clinical and empirical information that best represents the status of the profession at a given point in time. Please contact the Managing Editor at [bulletin@childlife.org](mailto:bulletin@childlife.org) to offer your suggestions for content or features that you would like to see in the future.

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## INTRODUCTION TO THE CHILD LIFE EVIDENCE-BASED PRACTICE STATEMENTS

*The Child Life Council is very pleased to offer the second in a series of evidence-based practice statements on therapeutic play in pediatric health care. The CLC Executive Board commissioned the development of this statement, with the input of the Evidence Based Practice and Professional Resources Committees, in order to provide members with documented validation for best child life practice.*

*Child life specialists recognize that clinical care and decision-making must be grounded in research-based evidence. CLC has supported the review and analysis of outcome research that specifically addresses child life practices in order to give child life professionals the evidence they need to continually advance quality of practice and to communicate with others on the healthcare team about child life work.*

*Child Life Council will publish one more statement in 2009, and it is our hope that these will help and encourage members to contribute to the body of research necessary for professional growth and recognition in healthcare settings.*

*This statement is available in printer-friendly form on the CLC Web site. We encourage child life specialists to review the statement and consider, as individuals or teams, the implication for practice.*

**Editor's Note:** Readers of *Focus* are accustomed to seeing articles here presented in APA format. In the case of the Evidence-Based Practice Statements only, because of the nature of the material, the author has elected to use the Uniform Requirements for Manuscripts Submitted to Biomedical Journals to make for easier reading.

## Therapeutic Play in Pediatric Health Care: The Essence of Child Life Practice

### CHILD LIFE COUNCIL EVIDENCE-BASED PRACTICE STATEMENT

*Completed for the Child Life Council by*

*Donna Koller, PhD, Academic and Clinical Specialist in Child Life, Project Investigator, Research Institute, Hospital for Sick Children, Toronto, Ontario, Canada*

*Rebecca Mador, research assistant at the Hospital for Sick Children, is gratefully acknowledged for her contributions in the preparation of this statement.*

### PREAMBLE

The purpose of this statement is to present empirical findings regarding the value of play for children in the hospital and to assert that play constitutes an integral component of evidence-based practice in child life. This statement is based on a review of the best available research from the year 1960 to December 2006. The following search engines were used: i) PsycINFO, which records 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 “therapeutic play,” “hospitalized children,” “recreation,” and “pretend play” were used to conduct the search with the assistance of a medical librarian. (See Table 1 for a complete list of keywords used).

Searches revealed 62 articles pertaining to therapeutic play in pediatric settings. After the results were sorted to exclude repeats and non-empirical based literature, 41 articles remained, of which 26 were eliminated because their topics were beyond the scope of this review (e.g. pet therapy, music therapy, and video games). The remaining 15 articles were scored by one of two independent raters. For the quantitative studies, “The Quality of Study Rating Form”<sup>1,2</sup> was used. Articles that received a rating of at least 60 out of 100 points were selected for inclusion. Any article that scored between 55 and 65 points was re-scored by a second rater to confirm inclusion or exclusion. For the qualitative studies, the Qualitative Study Quality Form<sup>2</sup> was used.

A total of 10 studies (nine quantitative and one qualitative) is included in this statement. Children involved in these studies ranged from 3 to 12 years of age and were hospitalized for a variety of reasons, including dental surgery, cardiac catheterization and tonsillectomies. Eight quantitative studies<sup>3-10</sup> used a randomized experimental design to examine the effects of therapeutic play, while one<sup>11</sup> provided a descriptive content analysis of interviews involving play. The single qualitative study examined the process of play when children engaged in expressive arts<sup>12</sup> (see Table 2 for a list of studies included in this review).

Since evidence-based practice represents an integration of both clinical experience<sup>2</sup> and the best available research<sup>13</sup>, this statement was also 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 applications for a child and family.

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TABLE 1. LIST OF KEYWORDS USED TO CONDUCT LITERATURE SEARCH

PSYDINFO	
CATEGORY	SEARCH WORDS
Therapeutic play	Play therapy, childhood play behavior, games, recreation, toys, pretend play, anatomically detailed dolls, childhood play development, children's recreation games, doll play, role playing
Hospitalized Children	Hospitalized patients (limit to childhood and adolescence)
MEDLINE	
CATEGORY	SEARCH WORDS
Therapeutic play	Art therapy, dance therapy, music therapy, play therapy, role playing, play and playthings, illustrated books, recreation, anatomic models
Hospitalized Children	Inpatient (limited to all child), hospitalized child, hospitalized adolescent
CINAHL	
CATEGORY	SEARCH WORDS
Therapeutic play	Art therapy, dance therapy, music therapy, pet therapy, play therapy, play and playthings, games, anatomic models, recreational therapy, role playing
Hospitalized Children	Hospitalized infant, hospitalized children, hospitalized adolescent, inpatients (limit age from 0 to 18)

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### THE VALUE OF PLAY

Children from all cultures play. Even in cultures where young children are expected to assume adult work responsibilities, anthropologists cite examples of how children manage to integrate play into their daily tasks<sup>14</sup>. This suggests that play is not only universal but essential to human development. Indeed, research has repeatedly shown that the benefits associated with play are profound and wide-ranging. Following a meta-analysis of 800 studies, Fisher concluded there was cogent evidence for the positive impact of play on children's developmental outcomes<sup>15</sup>. *Play was found to significantly promote cognitive and social aspects of development and these effects were magnified when adults participated in play with children.* Accordingly, childhood play is understood to be critical to children's development for multiple reasons, including the opportunity to communicate feelings, misunderstandings and concerns in their own language using both verbal and behavioral expression<sup>9</sup>. Since play teaches children how to handle the world and the social roles in it, play is the predominant context in which children interface with their environment.

### WHAT IS THERAPEUTIC PLAY?

Play can be broadly defined as any activity in which children spontaneously engage and find pleasurable<sup>16</sup>. For children in the hospital, specific forms of play can provide an

effective venue for personal development and increased well-being. In particular, *therapeutic play* refers to specialized activities that are *developmentally supportive* and facilitate the emotional well-being of a pediatric patient.

The discourse on play acknowledges important distinctions between *therapeutic play* and *play therapy*. Although these terms are often used interchangeably, the focus of therapeutic play is on the promotion of continuing 'normal development' while enabling children to respond more effectively to difficult situations such as medical experiences<sup>17</sup>. In contrast, *play therapy* addresses basic and persistent psychological issues associated with how a child may interact with his or her world. Therefore, *therapeutic play*, in a less structured way, focuses on the process of play as a mechanism for mastering developmental milestones and critical events such as hospitalization.

Since therapeutic play comprises activities that are dependent on the developmental needs of the child as well as the environment, it can take many forms<sup>9</sup>. For example, therapeutic play can be delivered through interactive puppet shows<sup>10</sup>, creative or expressive arts<sup>12</sup>, puppet and doll play<sup>7</sup>, and other medically oriented play<sup>3-6, 8, 9, 11</sup>. It can be directive or non-directive in approach and may include re-enactments of medical situations to facilitate children's adaptation to hospitalization<sup>3, 4, 16, 17</sup>.

Regardless of the form that therapeutic play takes, the child life specialist (CLS) ensures that the play is developmentally appropriate while using language that is understandable to the child<sup>4, 5, 7</sup>. During therapeutic play children are encouraged to ask questions to clarify misconceptions and express feelings related to their fears and concerns<sup>3-9</sup>. In this way, therapeutic play acts as a vehicle for eliciting information from children while also sharing information about what to expect from medical procedures and what sensations may be experienced<sup>4</sup>.

Therapeutic play typically consists of at least one of the following types of activities: 1) the encouragement of emotional expression (e.g. re-enactment of experiences through doll play), 2) instructional play to educate children about medical experiences, and 3) physiologically enhancing play (e.g. blowing bubbles to improve breathing)<sup>16</sup>. The studies reviewed here predominantly address medically oriented play, including emotional expression and instructional play forms.

### RESEARCH ESPOUSING THE BENEFITS OF THERAPEUTIC PLAY

#### Psychological and Behavioral Outcomes

Several studies have shown that therapeutic play is effective in decreasing anxiety and fears for children from the time of admission to immediately after surgery and to the time of discharge<sup>4, 5, 8-10</sup>. In one qualitative study, Wikstrom investigated how children in the hospital experienced expressive arts through the use of clay, paint and textile. The primary finding from this study was that the children spontaneously described themselves through their art by expressing emotions such as fear and powerlessness<sup>12</sup>. Thus, a defining feature of therapeutic play is its ability to elicit emotional expression leading to greater psychological well-being for a child in the hospital<sup>4, 5</sup>. Accordingly, in studies where children were offered therapeutic play, they exhibited greater cooperation during stressful procedures<sup>4, 5</sup> and were more willing to return to the hospital for further treatment<sup>7</sup>.

In one study, Schwartz, Albino and Tedesco found that medically related therapeutic play was more effective than medically unrelated therapeutic play<sup>4</sup>. The authors examined the effects of preoperative preparation on stress reduction in 45 children aged 3 and 4 years. The children were randomly



assigned into one of three groups: a control group, a medically unrelated play therapy group, and a medically related play therapy group. The medically related play included providing information to the child and parent and a role play that resembled actual medical procedures with hospital toys. Results from the study concluded that children in this group were more cooperative and less upset than children in the other two groups, which suggests that medically related play can be more effective in alleviating stress than unrelated play.

Studies have shown that therapeutic play produces benefits not evidenced with alternative types of play or methods of preparation. Rae and colleagues compared the effects of play on the psychosocial adjustment of 46 children, aged 5 to 10 years, who were hospitalized for an acute illness. They randomly assigned the children to one of four groups: therapeutic play, diversionary play, verbal support, and no treatment. The therapeutic play consisted of playing with medical and non-medical materials as well as puppets, dolls and toy animals. During this non-directive play, the facilitator encouraged re-enactments of experiences while allowing the child to reflect and interpret feelings. Results showed that children who engaged in therapeutic, non-directive play showed a significant reduction in self-reported hospital fears in comparison with children from other groups<sup>8</sup>.

Only one study did not show a statistically significant decrease in anxiety for children following therapeutic play. Fosson, Martin and Haley<sup>6</sup> investigated the effectiveness of guided medical play in reducing anxiety in latency-age children. Fifty children, aged 5 to 9 years, were randomly assigned to either the control group, where the child watched TV with a recreational therapist for 20 minutes, or the experimental group, where a recreational therapist facilitated medically-oriented play with the child. This study found that although the mean levels of anxiety of children in the experimental group decreased more than children in the control group, the difference was not sufficient to reach statistical significance. In order to explain these findings, the authors noted that the intervention consisted of only one 30-minute play session and the control group had access to other forms of play during hospitalization.

**TABLE 2. FINAL SELECTION OF STUDIES INCLUDED IN THIS REVIEW**

- Cassell, S. (1965). Effect of brief puppet therapy upon the emotional responses of children undergoing cardiac catheterization. *Journal of Consulting Psychology*, 29(1): 1-8.
- Clatworthy, S. (1981). Therapeutic play: Effects on hospitalized children. *Journal of Association for Care of Children's Health*, 9(4):108-113.
- Ellerton, M. L., Caty, S., & Ritchie, J. A. (1985). Helping young children master intrusive procedures through play. *Children's Health Care*, 13(4):167-173.
- Fosson, A., Martin, J., & Haley, J. (1990). Anxiety among hospitalized latency-age children. *Developmental and Behavioral Pediatrics*, 11(6):324-327.
- Johnson, P. A., & Stockdale, D. F. (1975). Effects of puppet therapy on palmar sweating of hospitalized children. *The Johns Hopkins Medical Journal*, 137, 1-5.
- Rae, W. A., Worchel, F. F., Upchurch, J., Sanner, J. H., & Daniel, C. A. (1989). The psychosocial impact of play on hospitalized children. *Journal of Pediatric Psychology*, 14(4):617-627.
- Schwartz, B. H., Albino, J. E., Tedesco, L. A. (1983). Effects of psychological preparation on children hospitalized for dental operations. *Journal of Pediatrics*, 102(4):634-638.
- Wikstrom, B-M. (2005). Communicating via expressive arts: The natural medium of self-expression for hospitalized children. *Pediatric Nursing*, 31(6):480-485.
- Young, M. R., & Fu, V. R. (1988). Influence of play and temperament on the young child's response to pain. *Children's Health Care*, 16(3): 209-215.
- Zahr, L. K. (1998). Therapeutic play for hospitalized preschoolers in Lebanon. *Pediatric Nursing*, 23(5), 449-454.

### Physiological Outcomes

In addition to relieving psychological stress, therapeutic play is also effective in reducing apprehensive physiological responses, such as palm sweating, excessive body movement, escalating pulse rate and high blood pressure<sup>5</sup>. In two studies, children who were provided opportunities for therapeutic play showed less physiological distress, as indicated by lower blood pressure and pulse rate and shorter time between surgery and first voiding<sup>3</sup>. They also exhibited less palm sweating than children who did not have opportunities for therapeutic play<sup>10</sup>.

### GAPS IN CURRENT LITERATURE

Although there is considerable literature concerning play in hospitals, much of this material is anecdotal and non-empirical. From an evidence-based practice perspective, this is problematic. For instance, little is known about the process and development of therapeutic play. How does play evolve over the course of a child's hospitalization, and should more complex forms of play (i.e. medically related) be offered only after a trusting relationship has been established with the child? Also, to what extent does therapeutic play rely on non-directive approaches? In terms of timing the introduction of therapeutic play, Young and Fu found that regardless of whether needle play took

place before or after the blood test, children who received therapeutic play showed significantly lower pulse rate five minutes after the blood test when compared to those who did not<sup>3</sup>. Although the timing of medical play did not alter its effectiveness in reducing pulse rate, additional studies should be conducted in order to verify these findings across different forms of therapeutic play.

The majority of research in this area addresses the use of medically related play, while areas such as creative arts, body image activities and tension-release forms of play are understudied. Not only is the comparison of various forms of therapeutic play lacking, but also the suitability of specific types of play for particular age groups, gender types, or anxiety levels. As well, it is unclear whether group or individual therapeutic play is generally more effective for children in hospital.

Perhaps most importantly, there is a limited understanding of how children perceive therapeutic play through *their own descriptions and experiences*. The paucity of research **with children** (participatory) rather than **on children** (non-participatory) is recognized as problematic by those working in the field<sup>18-21</sup>. Inherent complexities also are associated with how play is studied and evaluated. For instance, the way in which a child life

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specialist facilitates play can determine the degree of therapeutic value and the establishment of trust with the child. Qualitative studies which are more suitable for exploring health care issues with children should address the following questions: how do children experience therapeutic play with their CLS and what types of activities are most meaningful to them?

## About the Views Expressed in *Focus*

It is the expressed intention of *Focus* to provide a venue for professional sharing on clinical issues, programs and interventions. The views presented in any article are those of the author. All submissions are reviewed for content, relevance and accuracy prior to publication.

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## SUMMARY

A central goal in pediatric health care is to facilitate the emotional and physical well-being of children in the hospital<sup>16</sup>. Research provides evidence for the effectiveness of therapeutic play in reducing psychological and physiological stress for children facing medical challenges. Therapeutic play offers long-term benefits by fostering more positive behavioral responses to future medical experiences. Since childhood play transcends cultural barriers, play opportunities should be provided for children of all ages and backgrounds.

Despite a large amount of literature purporting the value of play, research gaps exist regarding the evaluation of therapeutic play in health care settings. Future research must address the play preferences and perspectives of children if evidence-based practice is to reflect the needs of pediatric patients. Since therapeutic play embodies the essence of the child life profession, it should remain the focus of ongoing critical analysis and empirical investigation.

Approved by the Child Life Council Executive Board  
April 2008

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# Parents' Perceptions of Child Life Programs: A Survey

Heather Dubrulle, MEd, CCLS

*Heather graduated from the University of La Verne in California with a Master of Education, special emphasis in Child Life. This research was completed as a component of her graduate coursework. She is currently working in Stonington, Connecticut as a middle school special education teacher.*

Child life specialists work with children in health care settings to help promote typical development and minimize the negative effects of the medical experience on children and their families (American Academy of Pediatrics, 2006). Research specifically developed to investigate parents' perceptions of their involvement with child life specialists can serve to inform child life professional practice. The Joint Commission monitors hospital quality improvement programs, and as a result, many hospitals request feedback from the families of their patients as a method to monitor the quality of service provided (Child Life Council, 2006). The study presented here explores parents' perceptions of the child life services they received during the hospitalization of their child.

The standards for practice established by the Child Life Council (2006) serve to promote quality child life programming through defined criteria. Standards cover areas of service related to the provision of psychosocial care. Planning, administration and specific child life services described include child life activities related to patient and family care, such as play activities, preparation, support, and education, as well as administrative activities like collaboration, documentation, and research. Quality improvement research activities accessing the perceptions of parents may reveal discrepancies relative to the standards of care of the Child Life Council that can lead to improvement in the services provided to patients and families.

Child life specialists are members of the health care team responsible for providing developmental support for hospitalized children and families. Trained to apply a developmental perspective, they use their expertise to encourage typical growth and development for children in health care settings. To this end, a variety of services for hospitalized children are provided. Age appropriate activities, such as infant stimulation, developmental playgroups, arts and crafts, playing games, and computer activities help children cope with their medical treatments. Patient education is provided for patients regarding

diagnosis, treatments, or upcoming medical procedures. Child life specialists function as part of a support system for families, often offering specific programs such as sibling support groups or parent meetings.

Although the services of the child life profession are clearly described in the literature (e.g. Rollins, Bolig & Mahan, 2005), the degree to which these services are distributed and provided to patients and families may vary across programs. Quality improvement activities conducted by individual programs, such as program reviews or patient and family surveys may remain internal to the program and may not be shared beyond the specific program. However, related research activities such as the survey by Cole, Diener, Wright, and Gaynard (2001) contribute to the profession by pointing out areas where child life programs can improve the services they provide in the health care setting.

Cole et al. (2001) surveyed health care professionals, including nurses, doctors, social workers and administrators for their views of the role of child life professionals. Many health care professionals ranked child life specialists as the most important staff when it came to the psychosocial well being of hospitalized children. However, this varied relative to the level of contact the professional had with child life staff, and with the professional affiliation of the responder. Consistency was found between child life and other health care professionals in relation to the perception of child life staff providing preparation and orientation. In contrast, health care professionals reported that child life specialists *amuse and entertain* (e.g. providing services such as age appropriate activities at the bedside or in a playroom) more frequently than child life specialists themselves reported those activities. Similarly, rankings of family support, advocacy, and education (e.g. support groups, advocating for children to the medical staff, providing diagnosis or procedure education) were not consistent. The authors suggest these findings are important indicators of where child life specialists can improve in areas related to

cross-disciplinary communication and professional education. The collection and use of feedback to improve care is in line with the concept of patient- and family-centeredness as advocated by the Institute for Family-Centered Care.

Quality improvement activity conducted through the implementation of a survey for parents of hospitalized children is one way to check the consistency of perceptions and experiences between parents and the standards of child life practice. Although typically surveys are conducted and applied internally to a specific health care facility, research can be conducted in the community by accessing parents of children who had previously been hospitalized. The internet is one contemporary network that allows for the identification of potential study participants and is increasing in popularity in the field of health (Whitehead, 2007). Programs that offer parent-to-parent support such as online support groups are valid points of contact for conducting research with families (Whitehead, 2007).

One concept of patient- and family-centered care is the practice of collaboration among health care professionals, patients and families (Hollon & Palm, 2007; Institute of Family-Centered Care, nd.). The perception families have of the care they receive is a core element of the practice of family-centered care (Institute for Family-Centered Care). As such, the inclusion of parents in research studies provides a voice that should inform programs and practices. According to Hollon and Palm,

Our challenge is to continually strive to better understand and apply these elements within our daily practice to improve individual patient/ family experience, the care delivery system and organizational policy. Through concrete, and demonstrable acts we turn philosophy into quality care experience for all members of the health care partnership (2007, p. 3)

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One way to assess whether patients and families are receiving the child life services they feel they need is to ask them. Along with asking questions relative to the actual services they experienced, it is important also to request their opinions about their experience. Without ongoing access to this information, the health care system, along with child life services, will not be able to adequately attend to the real needs of the patients and families they serve (Institute for Family-Centered Care). For example, elements of the service provided, such as timeliness, accuracy, and effectiveness must be considered (CLC, 2006). When patients and families are provided a voice and their views are being heard, we are demonstrating the ability to learn through the experiences of others and improve the care we provide for future patients and families.

This research approach reflects a quality improvement method whereby stakeholders (families) are accessed and provided a voice. The purpose of the study was to review the perceptions of parents whose child had been previously hospitalized. Standard X of the Standards of Clinical Practice (CLC, 2006) emphasizes the use of evidence-based practice activities to “continually update and enhance their understanding of the children and families they serve” (CLC, 2006, p. 11). Engagement in the process of research also represents an element of ethical practice in the continuing development of the child life profession.

## OVERVIEW

Parents of previously hospitalized children were surveyed during the spring of 2006. Survey responses were analyzed using descriptive statistics and reflect the perceptions of the respondents of their experiences with child life services. Approval for the research project was granted by the course professors.

## PARTICIPANTS

Sixteen of the 196 initial respondents indicated they had not had contact with a child life specialist during their child's hospitalization. Therefore, the analysis presented includes 180 parents of a child who had previously been hospitalized and had contact with child life services.

When asked to indicate a category for

their child's diagnosis, 60% (108) of the respondents indicated a cancer diagnosis, 12.8% (23) indicated a chronic illness, and 27.2% (49) indicated other diagnosis. The child's age at diagnosis ranged from infancy through adolescence (Table 1). The majority of respondents (37.7%) were reporting about a hospitalized infant (less than 12 months of age).

**TABLE 1. DIAGNOSIS CATEGORY BY AGE GROUP**

AGE GROUPS	DIAGNOSIS CATEGORY (RAW NUMBERS)			
	Cancer	Chronic Illness	Other	Total
Infant	16	12	40	68
Toddler	40	6	6	52
Preschool	25	0	2	27
School-aged/Youth	27	5	1	33
<b>Total</b>	<b>108</b>	<b>23</b>	<b>49</b>	<b>180</b>

## PARENT SURVEY

Respondents completed a pen and pencil survey developed by the author that consisted of 12 questions. Both forced-choice and opened-ended questions were included. Participants were asked if they had received services from a child life specialist when their child was in the hospital. If they had, they were asked what kinds of services they received, which services they felt were beneficial, and how the child life specialist impacted their hospital experience.

## PROCEDURE

Participants were recruited through solicitation of a variety of Web sites related to pediatric health care support groups (i.e. Association of Online Cancer Resources, Chronic Childhood Illness Group). Additionally, some participants passed on the contact information to friends who also agreed to participate. The researcher invited parents interested in participating in the study to contact her. Interested parents subsequently received a survey to complete and a letter of consent describing the research purpose, tasks, commitment and assurance of anonymity. Surveys were returned by mail or email.

## RESULTS

### OVERVIEW

Survey data was coded and analyzed using descriptive statistics. The age at diagnosis

variable was recoded and formed four age groups for analysis: infants (0 – 1 year), toddlers (2 – 3 years), preschool (4 – 5 years) and school-aged/youth (6 to 17 years).

## FREQUENCY OF COMMON CHILD LIFE SERVICES

Respondents were asked (yes/ no) whether a child life specialist had provided a variety of child life services. Table 2 presents the results and indicates that most of the child life services were experienced by the participants. Almost 90% of the respondents indicated receiving age-appropriate activities for their child. Only school-reentry, procedure/treatment accompaniment, and grief/bereavement support were not reported to be experienced by the majority of the parents. When the school-reentry variable was examined by age group, distinctions were observed: 88% of the respondents indicating they had not received school re-entry services were parents of infants, toddlers or preschoolers.

Some respondents chose to respond to the category ‘other’ by listing services provided by child life. These included referrals to outside programs, such as Make-a-Wish Foundation, summer camps, or community support resources; goal-setting for tasks or behavioral issues; out of hospital experiences (field trips, baseball games); technology programs (use of laptop computers, use of supportive Web sites); and encouragement to attend school functions.

**TABLE 2. COMMON CHILD LIFE SERVICES RECEIVED**

	DID THE CHILD LIFE SPECIALIST PROVIDE ANY OF THE FOLLOWING SERVICES?	
	Yes	No
Procedure/Diagnosis teaching	108 (60%)	72 (40%)
Medical play	107 (59.4%)	73 (40.6%)
Procedure/Treatment accompaniment	82 (45.6%)	98 (54.4%)
Distraction	103 (57.2%)	77 (42.8%)
Age appropriate activities	161 (89.4%)	19 (10.6%)
School re-entry	30 (16.7%)	150 (83.3%)
Family support	120 (66.7%)	60 (33.3%)
Grief/ Bereavement support	12 (6.7%)	168 (93.3%)

## PARENT PERCEPTIONS OF CHILD LIFE SERVICES

Respondents were asked if they felt child life services were beneficial to their child. Responses indicate the majority of parents (91.7%) found the services to be beneficial. Analysis by age group indicated that of the 12 respondents indicating the services were not beneficial, 7 were parents of infants, 3 were school-aged/youth, and one parent from the toddler and preschooler group respectively. Follow-up questions were not provided.

Parents were provided a list of child life services and asked to check those services they found most and least beneficial. Additionally, a ranking of those services indicated as most beneficial was compiled (Table 3). The category age-appropriate activity was ranked first by the majority of parents (22.8%). Also presented in Table 3 are the rankings for least beneficial services. Of all the respondents, 110 parents did not respond to the question. Medical play and distraction were the highest ranked at 7.2% each. Analysis by age group indicated that of the 13 parents indicating medical play was least beneficial, five children were infant or toddler aged and three were school-aged/youth. All of the 13 parents who indicated that distraction was the least beneficial had children preschool aged or younger.

Parents were asked a series of questions about their relationship with child life specialists. The majority, 74.4%, of parents reported they felt the child life specialist was able to spend enough time with their child. Half of the parents, 51.7%, indicated they saw the same child life specialist each time they were in the hospital. Seventy percent of parents agreed that their child established a trusting relationship with the child life specialist.

Two Likert-type questions were completed by the parents. When asked about the impact of child life services on their child's hospital stay, the majority of parents, 64.4%, indicated that child life made their child's stay a lot better. In response to the question about the need for child life services, 95% indicated that child life services should be offered to all hospitalized children.

## QUALITATIVE ANALYSIS

Two open-ended questions were presented to the respondents. Parents had many comments regarding what other services could be provided by child life staff. Education

**TABLE 3. RANKING OF MOST AND LEAST BENEFICIAL SERVICES REPORTED BY PARENTS**

	Most Beneficial:	Rank	Least Beneficial:	Rank
Procedure/Diagnosis teaching	14 (7.8%)	4	10 (5.6%)	2
Medical play	14 (7.8%)	5	13 (7.2%)	1
Procedure/Treatment accompaniment	10 (5.6%)	6	10 (5.6%)	2
Distraction	19 (10.6%)	3	13 (7.2%)	1
Age appropriate activities	41 (22.8%)	1	6 (3.3%)	5
School re-entry	5 (2.8%)	7	7 (3.9%)	4
Family support	29 (16.1%)	2	8 (4.4%)	3
Grief/Bereavement support	0		1 (0.6%)	
All/multiple services selected	16 (8.9%)		1 (0.6%)	
No response	0		110 (61.1%)	
Other listed	10 (5.6%)		1 (0.6%)	
Total	180 (100.00%)		180 (100.00%)	

regarding the potential effects on a child after hospitalization/treatment was mentioned most frequently. Parents of children with rare chronic illnesses requested more education regarding their child's illness.

Alternative services, such as art therapy, pet therapy and music therapy were requested by parents. Parents also requested more organized activities, such as playgroups, teen social groups, or arts and crafts in the playroom, as well as more services for the oldest and youngest children, adolescents and infants. Finally, many comments indicated that parents wanted more time with the child life specialist, or more services to be offered to them, such as procedure support, distraction, and school re-entry.

Ninety percent of the respondents commented on their experience with child life. There were a wide range of comments, from positive experiences with an individual child life specialist and more detailed explanations of the child's hospitalization, to comments offering suggestions on ways to improve services. Frequently positive comments praised child life, including "We love child life! They not only are there to help with the children but they are great with the entire family!" and "Child life has been one of the most helpful parts of this experience for our family." Several parents commented on not knowing exactly what the role of the child life specialist was. These comments included, "I would have liked to have been more educated on what the child life specialists do and exactly what they are there for," and "I

also wish the services that are offered by child life specialists were better explained to parents." Finally, suggestions for improvement included, "Be conscious that sometimes less is more. There are times families/patients don't want any interference."

## DISCUSSION

The purpose of the study was to review the perceptions of parents whose child had a previous hospitalization. The standards of child life practice and patient- and family-centered care present child life practitioners with criteria for quality care. The questions included in the survey were developed specifically to assess areas of services that directly impact patients and families. Results offer information to child life specialists on the areas of care that parents found to be beneficial and those areas that may not be recognized by parents as valuable or appropriate for their child.

The survey response of 180 parents of hospitalized children provides for the review of a range of parent perspectives. Although the distribution of diagnosis and age was limited, some analysis provided insight into select categories of care. Most parents indicated that a variety of child life services were available for their child. Age-appropriate activities were received by most families as well as activities related to procedural preparation and support (e.g., medical play, distraction). Family support was reported by two-thirds of the parents. School-reentry and grief/ bereavement

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services would be appropriate only for certain groups to the exclusion of others; this was reflected in the data. However, the category grief/ bereavement support was experienced by few of the parents and may have been interpreted narrowly, as necessarily related to the loss of a child but not in relation to diagnosis or injury. These findings indicate that the standard of child life practice requiring the provision of a range of opportunities and services for families was met for most of the families surveyed.

The majority of parents agreed that child life services were beneficial for the child. This is a positive result indicating the services of child life are valued and recognized as important to families. However, the experience of the 12 respondents who indicated that child life services were not beneficial was not explored. As professionals, an awareness of the negative experiences of parents needs to be extended through an exploration of the details that surround the parents' perception. Giving voice to families who have perceptions contrary to our perception of services is an exercise that must be taken on in order to legitimately claim to engage in ethical and patient- and family-centered practice.

The distribution of rankings for most beneficial services was wide. Age-appropriate activities were ranked as the most beneficial with family support ranked second. These rankings highlight those services commonly associated with child life practice, play and support (family and procedural) and reinforce the understanding that these services meet a need for the entire family and not just the hospitalized child.

The least beneficial services were also ranked; however, most parents chose not to respond. Given the distribution of young children in the sample, the selection of medical play and distraction may reflect parents' opinion or the need for increased communication regarding the function and value of specific activities. Child life specialists need to consider how activities and interventions are presented to parents, how to assess parents' understanding of the value of these services, and how to respond to parents' need for education in areas related to developmental practice.

The respondents who answered the open-ended questions provide more insight into

the perceptions of parents of hospitalized children. Satisfaction with a number of child life programs that provide a unique set of services was apparent: summer camp programs, referrals to other community services, out of hospital experiences and technology programs were valued by those parents whose child had been involved. Some families who had not had these experiences mentioned them as programs they would have liked their child to experience. Additionally, parents indicated a need for more opportunities for education from the child life specialists – about child life, hospitalization, and specific diseases. Parents also suggested more alternative programs, organized activities, and services specifically targeted to the infant and adolescent populations. Finally, although three-quarters of the parents indicated they felt the child life specialist was able to spend enough time with their child, many suggested they would like more time with the child life specialist.

Survey research that accesses participants via the internet has both advantages and disadvantages (Whitehead, 2007). In the case of the present study, one advantage was accessing a specific population which may be widely dispersed geographically. Additionally, as the researcher was not affiliated with any specific health care facility, it is assumed that feelings of anonymity may be enhanced. As well, any sense of loyalty or obligation to a specific program was reduced. Disadvantages include sampling bias, as only those parents who were active in specific support groups and had access to the internet were involved. Additionally, the questions presented to the respondents were limited in response categories and follow-up queries. Missed opportunities to explore the less than ideal or limited experiences of some of the respondents are apparent as the data is reviewed. This is an important outcome as it brings home the importance of conducting future research with consideration for the pursuit of the views of families who feel their needs were not met.

## APPLICATION

The information derived from this study has a number of implications for child life specialists. First, this study represents the standard of practice related to the importance of developing and applying research skills as a method to inform professional practice. The results of the study provide

encouraging details about the perceptions of parents of hospitalized children and encourage us to take a closer look at those families who may not have positive perceptions of their experience with child life specialists. Giving voice to parents is only one step in the process of collaboration with parents. In order to truly collaborate, the perceptions of the parents must be acknowledged and acted upon. Although the profession strives for continued quality and improvement of services to patients and families, consideration for *all* views and experiences must be welcomed. Learning from the parents about the impact of child life services on their children tells child life specialists what we may be doing right, and where we have room to improve. Reviewing results and comments from parents can inform child life specialists in the determination of how best to meet the needs of their patients. Additionally, it is hoped the results of this survey encourage others to develop a more comprehensive, in-depth study to determine parents' perceptions of child life programs.

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## Comfort Measures

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model. “We thought only a few people would be there, since we were presenting in one of the last sessions,” Mary laughs.

Mary recalls some of the lively discussions during that session about whether child life specialists belonged in the treatment room. Some attendees argued that the child life specialist should always be perceived as “the good guy,” and therefore should not be present in the treatment room during difficult procedures. “Our argument was that child life absolutely belonged there as part of an interdisciplinary team – that [child life specialists] were instrumental in helping to guide the parents/caregivers and children, and ensuring that the procedure is accomplished with the least amount of trauma to the child,” says Mary. “It was really helpful to have Barbara there to provide her perspective as a Registered Nurse. She would always say, ‘we do our job best when child life specialists are there to help us.’”

The previous thinking was that parents were the original “good guys” and should not participate in painful interventions, and that children were simply passive participants. Mary recalls that the medical staff felt that parents would be in the way or, even worse, faint. They also worried that the parents would be tainted by their association with the pain the child was experiencing. In a similar vein, children were seen as unable to actively cooperate.

Within a year, the pharmaceutical company AstraZeneca approached Mary and Barbara to collaborate on the development of educational materials about the Comfort Measures/Positioning model. Over the course of the next seven years, AstraZeneca also underwrote their travel costs to present the model at more than 100 physician and nursing grand rounds and medical and interdisciplinary conferences nationwide. Mary often used her personal vacation time to make these trips. “Helping children was important enough to me to take my own time to make sure the message got out there,” she says.

For Mary, convincing the skeptics has been one of the most rewarding aspects of

her work over the years. She keeps letters from child life specialists around the country who have thanked her for bringing Comfort Measures to their hospitals. One of her favorites is from a child life specialist who describes a nurse that had been openly skeptical about the effectiveness of having children sit upright. The letter described the nurse as a “big woman, known for her ‘holding abilities.’” Once Mary and Barbara had presented to the staff, the same nurse ended up being one of the biggest advocates for using comfort positions. “It’s that kind of feedback that kept us going,” says Mary.

Mary and Barbara went on to co-author two internationally-recognized articles on the model. The materials they produced with photographs and suggestions of positions for children in the treatment room are still used in hospitals throughout the world.



Comfort Measures pioneers Barbara Stephens, RN, MN, (left) and Mary Barkey, MA, CCLS (right)

According to CLC Executive Board member and international child life advocate Andrea Standish, CCLS, “One of the reasons the Comfort Measures are so successful throughout the world is that they require a big heart but not a big budget. Healthcare providers in countries with limited healthcare resources successfully use these child friendly techniques to improve the experience for the patient, parent and healthcare provider. I have seen excellent outcomes in Brazil, Nicaragua, China, Jordan and the Republic of Georgia.”

“In pediatrics, these techniques have been widely accepted, and they’ve had a huge impact wherever they have been implemented,” says Toni Millar, former director of the

child life program at Rainbow Babies and Children’s Hospital. “More than 90% of the invitations to present on the model came from child life specialists throughout the country, and they are the ones who single-handedly promoted Comfort Measures. The success of their [Mary’s and Barbara’s] collaborative effort has helped child life specialists continue to partner with other disciplines to provide comfort techniques that improve the patient experience.”

Andrea Standish adds that Mary Barkey has been influential in mentoring child life specialists so that they become adept at dealing with the skeptics and overcoming their objections. As a result, many more child life specialists are able to successfully integrate Comfort Measures into practice at their hospitals.

For Mary, interdisciplinary collaboration was a key factor in the development of the Comfort Measures model. “Child life specialists can’t make major changes alone,” she says, stressing the importance of Barbara’s participation, in addition to the physicians, nurses, and many other team members who were open to new ways of doing things. Embracing interdisciplinary collaboration in the *implementation* of Comfort Measures has always been equally important. After an initial learning curve, Mary and Barbara screened the requests for a presentation. “We would only present if there was an interdisciplinary team already in place [at the facility in question],” says Mary. “We knew that was the only way that there would be a chance for those changes [to be] put into practice.”

Mary considers the development of Comfort Measures to be more “a solution to a problem” than true research, but, “it gave us a great deal of satisfaction.” For child life specialists who aspire to follow Mary’s lead in developing practical approaches that will benefit children and families, she has a few pieces of concrete advice:

1. If something isn’t appropriate for family-centered care and child development, look at options to approach it differently; then speak up.
2. Reach out beyond your own discipline and collaborate with others; it will give your project added dimension and give it

*continued on page 6*

## CLC Executive Board Election Results

The CLC Nominating Committee is pleased to report the election of the following new members to the CLC Executive Board:

- President-Elect:** Ellen Good, MEd, CCLS  
*Manager, Child Life Department*  
*Yale-New Haven Children's Hospital*  
*New Haven, Connecticut*
- Secretary:** Chris Brown, MS, CCLS  
*Director, Child Life and Family Centered Care*  
*Dell Children's Medical Center*  
*Austin, Texas*
- Members-at-Large:** Patricia "Trish" Haneman Cox, MEd, CCLS  
*Adjunct Faculty*  
*University of New Hampshire, Portsmouth School District LEA*  
*Newfields, New Hampshire*
- Nicole Graham Rosburg, MS, CCLS  
*Child Life Specialist*  
*Texas Children's Hospital/St. Luke's Community Medical Center*  
*Houston, Texas*
- Child Life Certifying Committee Chair Year 1:** Kitty O'Brien, MA, CCLS  
*Child Life Clinical Manager*  
*Cincinnati Children's Hospital Medical Center*  
*Cincinnati, Ohio*

**THANK YOU TO ALL WHO VOTED IN THE FIRST-EVER ONLINE ELECTIONS IN 2008!**

## Comfort Measures

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the potential to reach a wider audience.

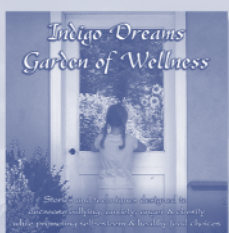
3. Making changes takes twice as long and costs twice as much as you think it will, but it's worth it.
4. When undertaking this kind of project, do research and collect hard data as you are trying out new techniques, so that you will have a basis of comparison to back up your findings.

The child life profession owes a great debt of gratitude to Mary, an innovative pioneer whose commitment to "making things better" has touched the work of so many child life specialists practicing today. We thank her not only for the enduring legacy of the Comfort Measures model, but also for setting an example of interdisciplinary collaboration that will continue to benefit children and families in ways yet to be realized.

### REFERENCES

- Stephens, B., Barkey, M., & Hall, H. (1999). Techniques to comfort children during stressful procedures. *Advances in Mind-Body Medicine*, 15 (1), 49-60.

### Kid's Wellness



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## CLC HQ Staff Welcomes Sharon L. Ruckdeschel

We are pleased to announce that Sharon L. Ruckdeschel has joined the headquarters staff as **Membership Database and Web Coordinator**. Sharon is responsible for managing the Child Life Council membership database and Web site integration, most commonly referred to as CLC Online. In this role, she will be the main contact for you, our valued members, in addressing issues related to your CLC User Profile, membership payments, and benefits.

Sharon has over 14 years of association and nonprofit experience. Before joining the Child Life Council, Sharon was a database manager at the American



Pharmacists Association in Washington, DC and a membership programs analyst at the World Wildlife Fund, also located in Washington, DC. Sharon has a bachelor's degree in Economics from the University of Maryland, College Park.

Sharon can be reached via email at [sruckdeschel@childlife.org](mailto:sruckdeschel@childlife.org) or at 1-800-CLC-4515, extension 11. Please help us welcome her to the child life community.



## CERTIFICATION CORNER

### PRACTICE ANALYSIS

The Child Life Certifying Committee (CLCC) is currently in the process of conducting a Practice Analysis Study, to update the current examination content outline from 2002. A 12-member task force of child life experts met earlier this year to review the current Exam Content Classification System. The resulting changes are being validated by a survey of 1,500 practicing child life specialists. The CLCC is working in collaboration with our testing agency, Castle Worldwide, to compile the information collected to create the new Exam Content Outline. Any changes will be reflected on the Child Life Professional Certification Exam, beginning with the Spring 2010 exam.

### ITEM BANK REVIEW

As a result of the Practice Analysis Study and updated Exam Content Outline, the Child Life Certifying Committee (CLCC) will be conducting a major review of the Item Bank (exam questions), and seeking a large number of volunteer CCLSs to assist in the review of all questions in the Item Bank. This process will take place in 2009, at a location yet to be determined. Please consider participating in the Item Bank review, and making a major impact on the quality of future examinations. For more information, please contact [certification@childlife.org](mailto:certification@childlife.org).

### RECERTIFICATION

Applications to recertify through Professional Development Hours were due on June 30, 2008. Applicants will be notified if more information is needed, or if their application has been randomly selected for audit. After the applications have been reviewed and the audits are complete, approved applicants will receive new certificates by mail late in the summer.

If you have not submitted an application to recertify by PDH, and your five-year certification cycle will expire on December 31, 2008, you can still recertify through PDHs, as a result of a recent CLC Board-approved policy allowing late submissions through October. Candidates who apply for recertification between June 30 and October 31 are required to pay a \$50 late fee and submit all supporting documentation (e.g. certificates of attendance) of the PDHs submitted. **Late applications cannot be completed online.**

As always, recertification candidates may also recertify by taking and passing the November 8, 2008 Certification Exam.

### FALL 2008 EXAM ADMINISTRATION

The following cities have been designated as sites for the November 8, 2008 Child Life Professional Certification Exam:

- Atlanta, Georgia
- Boston, Massachusetts
- Phoenix, Arizona
- St. Louis, Missouri
- Toronto, Ontario (Canada)

Applications for this exam are due to CLC by August 31, 2008 for anyone educated within the U.S. or Canada and by June 30, 2008 for those educated outside the U.S. and Canada.

### CERTIFICATION COMMUNICATIONS

If you have not already done so, please log in to your User Profile through the CLC Web site to ensure that your contact information is accurate. Please make sure that you have an active email address in the system that you check regularly, as we are now using email as our primary means of communication with Certified Child Life Specialists. If you do not have your username and password, please visit the following link to be emailed a reminder: [http://ams.childlife.org/members\\_online/members/password.asp](http://ams.childlife.org/members_online/members/password.asp)

Please contact Ame Enright at [certification@childlife.org](mailto:certification@childlife.org) with certification questions.

## CLC Child Life Salary Survey Results Are In!

Thank you to the more than 1,600 child life specialists who completed the 2008 Child Life Salary and Benefits Survey. We can see by the great response rate (44.8%) that this is an important topic to many professionals. Just to give our members an idea of the demographic statistics on survey participants:

### AGE

- 39% are younger than 30
- 37% are 30-39
- 24% are 40 or older

### CREDENTIALS

- 58% have bachelor's degrees
- 38% have master's degrees
- 90% have their CCLS credential

### POSITION HELD


- Child Life Specialist - 49%
- Child Life Specialist with Leadership Responsibilities - 30%
- Director/Manager/Leader of Child Life Program - 11%

A profile of the three position types, along with an outline of the salary results for each, is presented in the *Summary of the 2008 Child Life Profession Compensation Survey Results*, now available on the CLC Web site. The summary includes detailed demographic information for each group of survey respondents, breaking the information down by education, years of experience, and geographical location.

## MILESTONES

**IN THE NEWS:** Fox 19 News in Ohio recently featured CLC members Katrina Baliva and Sharon McLeod, and the Cincinnati Children's Hospital Medical Center "Josh Cares" program. The program employs Child Life Fellows like Katrina to support children whose families cannot be with them during their stay in the hospital. The story aired on May 26, and can be accessed by visiting the Press Room section of the CLC Web site.

**IN THE NEWS:** NBC Nightly News honored the life and work of Myra D. Fox, Director of Child Life Services at Children's Hospital Boston, in a feature entitled, "Hospital Worker Helps Kids in Ways Medicine Can't." The story aired on April 9, and can be viewed by searching the archives of the NBC Nightly News Web site. For a direct link, please visit the Press Room section of [www.childlife.org](http://www.childlife.org). Congratulations Myra!



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SUMMER 2008

## CLC Calendar

### JUNE

- 30 Deadline for recertifying by Professional Development Hours (PDHs)
- 30 Deadline for applications for the November administration of the Child Life Professional Certification Exam for those educated outside the U.S. or Canada

### JULY

- 15 Deadline for *Bulletin* and *Focus* articles for Fall 08 issue
- 15 Deadline for abstract proposals for the 27th Annual Conference on Professional Issues

### AUGUST

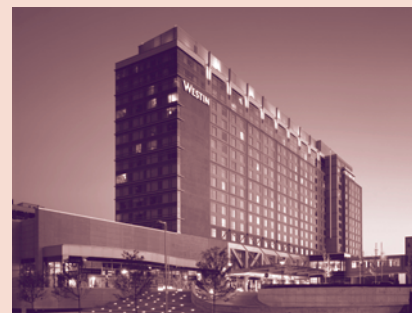
- 31 Deadline for applications for the November administration of the Child Life Professional Certification Exam for those educated within the U.S. or Canada

### OCTOBER

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

### NOVEMBER

- 8 Child Life Professional Certification Exam Administration



## 2009 Call for Papers

Interested in presenting at CLC's Annual Conference? In 2009, Child Life Council's 27th Annual Conference on Professional Issues will be held at The Westin Boston Waterfront in Boston, Massachusetts, May 21-24. CLC will accept abstracts through the online abstract submission process up until July 15, 2008. The 2009 Call for Papers information can be found under the *Annual Conference* Section of the CLC Web site.