



Let Me Tell You a Story . . . Kat Davitt Honored with 2014 Mary Barkey Award

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The storied career of Kathryn “Kat” Davitt, MOT, OTR, CCLS has gained her the recognition of her peers and the Child Life Council (CLC) by way of the 2014 Mary Barkey Clinical Excellence Award. The award was bestowed at the 32nd Annual Conference on Professional Issues during the Closing General Session on May 25th.

If you have ever had the pleasure to spend any time talking directly with Kat, you will know that she can tell a story and tell it well. She claims to have a story on just about any topic. For the purposes of this article, we should begin with the story of how she entered the profession of child life. Kat shares that child life chose

her, and not the other way around. It all started when Kat’s sister, an oncology nurse, encouraged her to volunteer at Arkansas Children’s Hospital during Kat’s college years. After a year and four months of volunteer work, Kat was hired as a weekend child life assistant and stayed in that role until she graduated from Hendrix College with a Bachelor’s degree in elementary education. Following graduation, Kat was hired as a child life specialist for the Burn Center, Cardiovascular ICU, and the Pediatric ICU before the days of certification by examination. At one point, Kat made a brief four-month escape into the world of teaching in a fourth grade classroom, but child life called her back to Arkansas Children’s Hospital to work in



the Surgery and Orthopedic units. After a six-year stint in Little Rock, Kat relocated to Texas and began working at Scott and White Memorial Hospital in Temple. In 1994 she transitioned again and joined the

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Child Life Alphabet

X IS FOR X-BOX: PSYCHOLOGICAL NOURISHMENT

Joan Turner, PhD, CCLS, Mount Saint Vincent University, Halifax, Nova Scotia

Premium entertainment is a mainstream phrase used to communicate the appeal of video platforms such as the X-Box to a range of audiences. First released in 2001 by Microsoft, this multimedia console represented a shift in the delivery of video entertainment to a social media platform. Just one of a variety of video gaming brands, the latest X-Box One stands as an example of the rapidly shifting landscape of video games available to children, youth, and families. But is it just entertainment? Przybylski, Rigby, and Ryan (2010) reviewed the inherent properties of the experience provided by video game activities and their effect on motivation and well-being. They referred to the qualities of competence, autonomy, and relatedness as *psychological nourishment*.

The qualities that contribute to the fun of the video game experience were examined within a framework of self-determination theory (Deci & Ryan, 2000; Ryan & Deci, 2000); that is, playing video games provides experiences that satisfy basic needs. The need for competence is met through a balance of challenge and goals; the need for autonomy through flexibility and choice; and the need for relatedness through both cooperative and competitive social interactions. Describing the majority of video game players as “wanting to versus having to play” (p. 161), the Przybylski and Ryan (2010) review of research suggests that short-term well-being is enhanced when these games are pursued with a “harmonious passion” (p. 161).

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IMMEDIATE PAST PRESIDENT'S REFLECTION



A Year of Growth and Development

Amy Bullock Morse,
MSEd, CCLS

Over the past year, it has been an honor to serve as your President, and I greatly appreciate the opportunity I've had to lead this dynamic organization. With your help, we have continued to raise the bar on the quality services we provide for children and families. Leaving the presidency is bittersweet. I have enjoyed this role immensely, but I could not be handing the gavel over to a more energetic or talented colleague: my dear friend, Carla Oliver.

The past year has been very busy. CLC's tireless volunteer leaders completed an unprecedented body of work that satisfies nearly every deliverable in the 2012-2014 Strategic Plan. Task Force 2022 and the Internship Accreditation Task Force have worked ceaselessly to deliver comprehensive standards for academic preparation and clinical training programs. The Program Standards Task Force presented the Board with a framework from which child life programs may be recognized for excellence in clinical service delivery. CLC offered program grants for a second year to promote empirical research

that contributes to our profession's body of literature. This year, CLC hosted an International Summit following the annual conference proceedings that engaged leaders of pediatric psychosocial care from over forty countries in a dialogue about global opportunities for child life. Support from CLC's partners and the director of development created the capacity for our organization to sustain resources that advance child life services for children and families.

In addition to all of the other tremendous amounts of work CLC's volunteer leaders

There are many prospects for growth, but one of the areas that appeals to me most lies in the field of literature: I would like to see us expand our body of empirical research that highlights the efficacy of play to mitigate distress in medically fragile children.

accomplished over the past year, the collaborative efforts of the Child Life Certifying Committee and Task Force 2022 also made significant contributions to the profession. CLC solicited the expertise of external consultants in credentialing and academic accreditation to explore the ways in which other associations have addressed changes in preparation standards. I'm pleased that CLC continues to benchmark with other organizations to develop pathways that will successfully advance our profession. I am also quite proud of the work of the Blue Ribbon Healthcare Task Force. Appointed in early 2014, this group continues to progressively explore the ways in which healthcare reform legislation impacts the provision of child life services across hospitals, ambulatory clinics, transitional care settings, and the community. The task force's work provides our profession with an opportunity to critically examine short- and long-term implications for new models of care delivery and reimbursement.

A colleague recently asked me how I would like to see our profession develop over the next five years. There are many prospects for growth, but one of the areas that appeals to me most lies in the field of literature: I would like to see us expand our body of empirical research that highlights the efficacy of play to mitigate distress in medically fragile children. But the question also prompted me to pause and reflect upon the major accomplishments our young profession has already attained. Not long ago, our membership decided to move forward with a certification exam, which ensures that new child life specialists have the skills necessary in order to support children and families. And today, we are building upon the expertise of our former leaders, developing and executing standards that elevate services for children and families experiencing some of life's most stressful events.

Michelangelo once said, "The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it." I'm so very proud to have had the fortune to lead an organization that is committed to providing such essential services for children and families facing challenging experiences.



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FROM THE EXECUTIVE EDITOR



Play: A Closer Examination of the Roots of Child Life

Jaime Bruce Holliman, MA, CCLS

Play. As child life specialists, we talk about it all the time. We advocate for it. We participate in it. We teach (and even preach) about the importance of it. Over the last year, we as a professional organization have engaged in many conversations about play and have committed to looking more deeply at the measureable value of play in medical settings. Play is a tool, a skill, a coping technique, a learning opportunity, and a universal language, and it is at the root of our work.

In this play-themed special issue, we invite you to return to those roots and expand your knowledge and application of play for all levels of development and ability. After reading this issue, we hope that you will feel inspired to test new ways of engaging in play with infants and that you will feel confident in articulating how play promotes their self-regulation and supports their development. We hope that you will ponder the impact of technology on play and consider how it can make a difference in your practice with school-age and adolescent patients. And we hope that you will contemplate techniques for

engaging patients who are unable to play on their own and ways to improve your skills and strengthen your interventions with children.

I think I can safely say that we all agree that play, at all ages and ability levels, is paramount, but the need for play doesn't end when you reach adulthood. In fact, I would say that it becomes even more important as other responsibilities fill our calendars. As adults we have to be purposeful in making play a part of our lives, and one of the contributors to this play-based issue encourages us to do just that as a method of professional self-care.

Play. It amazes me how something that seems so simple to the casual observer can make such a deep impact on an individual and how, when you get up close and study it, can be so complex and multi-layered.

The “Yes, and” Approach to Play

Kimberly Kow Mason, MS, CCLS, Hackensack University Medical Center, Hackensack NJ

Jon Luongo, MS, CCLS, Maimonides Infants and Children's Hospital, Brooklyn, NY; Bankstreet College of Education, New York, NY

Improvisation is the art of people playing together on stage to create theatrical pieces without preplanning the content. Everything is made up on the spot. Three strategies used to create an improvised scene are: 1. Listen; 2. Accept each scenario as proposed by your partner; and 3. Help deepen the dramatic stakes as the scene unfolds. In improv lingo these strategies together are known as a “Yes, and” approach.

Using a “Yes, and” approach to play with hospitalized children means staying flexible rather than staying in control. For example, let's say you are preparing a 6-year-old for surgery when suddenly the child pulls out a Spiderman doll to show you. The child makes Spidey do make-believe jumps and feats of strength. A traditional response such as, “Oh, do you like Spiderman?” wouldn't seem to stem from good listening, since the child clearly does. Asking questions keeps you in control and may block a moment of imaginative play from developing.

A “Yes, and” approach in this moment might be: “Whoa, thank goodness Spiderman is here. I should have known you would have such an awesome friend — I bet the two of you could go together to the operating room.” This approach shows a willingness to follow the child's lead and participate playfully without knowing exactly what will happen next.

Following your partner's lead in play can be nerve-wracking! Improv builds a healthy tolerance for uncertainty and the courage to make mistakes. These are essential qualities for reaching out empathically to an ill child. When we train ourselves to be completely present in the moment, we are better able to listen to verbal cues and attend to body language. We can inspire a child, our play partner, to engage with her own experience and come up with creative ways to cope.

Improv enthusiasts talk about play and the subtleties of communication styles with the same passion as child life specialists. In

fact the two fields share similar roots: Viola Spolin, widely considered the American “grandmother of improv,” studied with the great early 20th century Chicago sociologist and play proponent Neva Boyd. (Moffit, n.d.). Boyd had another protégé as well: child life innovator Anne Smith, who wrote the 1941 opus *Play for Convalescent Children in Hospitals and at Home*. (J. Turner, personal communication, October 19, 2012). Improv techniques and child life practices have influenced each other since their inception.

So seek out an improv theater in your region; take a workshop or drop in on a class. Improv is a bold and courageous way for a child life specialist to strengthen listening skills and become a more spontaneous, attentive, and imaginative play partner to children. “Yes, and” it's so much fun!

REFERENCE

Moffit, D.E. (n.d.). *Viola Spolin Biography*. Retrieved from <http://www.spolin.com/violabio/>

FROM THE EXECUTIVE DIRECTOR



AAP Issues New Policy Statement on Child Life Services

Dennis Reynolds, MA, CAE

The American Academy of Pediatrics (AAP) Committee on

Hospital Care has released a new version of its policy statement on child life services. The updated statement observes, among other things, that:

The provision on child life services is a quality benchmark of an integrated patient- and family-centered health care system, a recommended component of medical education, and an indicator of excellence in pediatric care (Committee on Hospital Care & Child Life Council, 2014, p. e1472).

The lead author of the statement is CLC past-president Chris Brown, MS, CCLS, Director of Child Life Services at Shands

Children's Hospital, part of University of Florida Health in Gainesville, FL. Chris has served as CLC's liaison to the AAP Committee on Hospital Care for the past eight years.

The new statement is a revision and update of earlier AAP statements on child life services issued in 2000 and 2006, and reaffirmed in 2012. In a report to the CLC Board of Directors, Chris Brown highlighted some of the major changes between previous editions and the new document:

- The 2006 statement specified that child life services should be provided by a "qualified child life specialist." This has been changed to "certified child life specialist" throughout the new version.
- The section on play is expanded, particularly regarding "the therapeutic value of play."
- A new section on pain management and coping strategies has been included, focusing specifically on the importance of non-pharmacologic techniques.

The 2006 version included a recommended ratio of 1 child life specialist to 15 or 20 inpatients, acknowledging the need for adjustment in that ratio depending upon patient age and mobility, institutional needs, and the patient or unit population. There was significant discussion during the preparation of the new version as to whether to keep or eliminate that ratio, as some felt it was not based deeply enough in evidence. In the end, the 1:15 ratio remains in the new statement as a guideline, and is accompanied by a table describing "Factors Indicating Lower Patient-to-Child Life Staff Ratios."

The new statement includes five specific recommendations regarding child life programming:

1. Child life services should be delivered as part of an integrated patient- and family-centered model of care and included

as a quality indicator of the delivery of services for children and families in health care settings.

2. Child life services should be provided directly by Certified Child Life Specialists.
3. Child life services staffing should be individualized to address the needs of specific inpatient and outpatient areas.
4. Child life services should be included in hospitals' operating budgets as an essential part of hospital-based pediatric care.
5. Additional research should be conducted to evaluate the effects of child life services on patient care outcomes.

As we are all aware, play is a cornerstone of child life – as recognized by the special theme focus in this issue of *Bulletin*– and the new AAP statement acknowledges this importance. The section on therapeutic play begins by observing that "play is an essential component of a child life program and of the child life professional's role" (Committee on Hospital Care & Child Life Council, 2014, p. e1473). The updated statement points out the value of normalizing play, as well as the importance of medical play in reducing children's emotional distress and in helping them cope with their circumstances. It makes the case that play is appropriate for infants, children, and adolescents, and points out the importance of auxiliary programs such as art, music, pet, and play therapy.

The full AAP Policy Statement on Child Life Services is available at: <http://pediatrics.aappublications.org/content/133/5/e1471.full.pdf+html>.

We are pleased that the AAP officially recognizes the importance of child life services, and we would like to thank Chris for her tireless work over the past several years in reviewing and re-casting this statement. We hope members will find the information to be incredibly valuable.

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Committee on Hospital Care & Child Life Council (2014). Child life services. *Pediatrics*, 133, e1471-e1478.

Child Life Council

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Playing for the Child Who Cannot Play

Deborah B. Vilas, MS, CCLS, LMSW
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As strong advocates for developmentally appropriate play in hospitals, child life specialists know the value of play for all children and the therapeutic benefits of play for those faced with illness, injury, and hospitalization. But what happens when a child is too scared, ill, debilitated, or developmentally delayed to engage in active play? Do we just shrug our shoulders and move on to the next patient?

None of us wants to be that person who walks away, but engaging children who cannot use their bodies to play actively can be a challenge. It is at these times that we need to dig deep into our play tool kits and our imaginations.

Two techniques come to mind that are applicable in situations when a child is unwilling or unable to play: parallel play and playing for the child. Parallel play is a technique that can be used to build rapport. It is based on the developmental stage that toddlers must master before they are ready to play cooperatively with their peers (Parten, 1932). Toddlers often play with similar toys in proximity to one another. When children play in each other's company, but not with one another, this is parallel play. They are transitioning from solitary play to more socially mature associative and cooperative play. This play provides the comfort of companionship, but does not require them to share or converse. In other words, it asks nothing of them.

Keeping this in mind, picture the child who refuses medication and retreats beneath the covers whenever medical personnel enter the room. The typical verbal meet-and-greet is not going to help you assess and connect with this avoidant child. Instead, a sure way to build trust is to ask nothing of the child, and to act like a toddler.

Enter the room with a toy; a play medical kit or any developmentally appropriate item will do. When I approached the room of a four year-old boy who had refused to eat or speak, I carried a toy garage and several small cars. Plopping myself down on the floor, I purposefully avoided eye contact. I positioned myself close enough to his bed so that he

could enter the play if he wished, but far enough away to offer no threat. Turning my back to him, I began to play with the garage, zooming the cars about, complete with sound effects. I felt silly, but my willingness to be vulnerable was effective. Within two minutes, the boy leaned over the edge of the bed, pointed to my car, and stated, "Not *that* one – the *red* one!"

I positioned myself close enough to his bed so that he could enter the play if he wished, but far enough away to offer no threat. Turning my back to him, I began to play with the garage, zooming the cars about, complete with sound effects. I felt silly, but my willingness to be vulnerable was effective.

This can be done in varying ways depending on the developmental age of the child. For school-aged kids, bringing in real medical equipment and a doll can capture their attention. Or imagine yourself making a volcano in the corner of the room; even if that child does not engage you in that moment, you have established yourself as a curiosity and the child will be more open to playing in the future.

The second technique, playing for a child, goes beyond rapport building. It allows you to assess the child's strengths and preferences, and use this knowledge to help the child enter into play. For children with little or no ability to control or move their bodies, there are two ways to approach play; they are both directive, but child-centered language and choices are woven together to allow room for control and mastery.

One approach to this is the hand-over-hand method, where you use your body and/or technical adaptations to scaffold the child's physical (and sometimes cognitive) abilities. I recall an encounter with a developmentally delayed fourteen-year-old boy who had cerebral palsy and was blind. Positioning a xylophone in his lap, I placed my hand over his so that he could grasp a mallet and guided his hand to strike the instrument. The happiness on his face when he made music is something I will never forget. Another example might be helping a child paint by assisting the child's hands or using his feet to create art. Throughout your interactions, use child-centered language and offer plenty of choice about colors and themes. This will give the child more control over the activity as you assist in moving his body.

When a child is unable to participate in assisted play, you are called upon to play *for* them. Susan Wojtasik and Sallie Sanborn

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POINT/COUNTERPOINT

Diane E. Levin, PhD, Wheelock College, Boston, MA
Anne Luebering Mohl, PhD, CCLS

POINT: Violent Play Has No Place in Medical Settings¹

As believers in and proponents of the power of play, child life specialists often see the benefits that positive and creative play can bring to the lives of children. But it can also be very upsetting to see a hospitalized child using a toy gun to shoot the “bad guys,” or a teen absorbed in a highly violent videogame. How can it be morally and ethically acceptable to allow children to pretend to hurt someone in hospital settings where we work so hard to promote children’s well-being and to help them heal? Doesn’t allowing such play teach children the harmful lesson that caring adults think violence is okay, even fun and exciting? Can’t it undermine the messages about safety, security, and helping others that child life specialists work so hard to create through play? Doesn’t it divert children’s energy away from the kind of positive and creative play they need to develop positive attitudes and understandings of their hospital experience, and to heal and grow?

While violent play can be distressing to professionals in medical settings, how does it feel to a family arriving at the hospital with a child who has been a victim of real world violence to see another patient acting out a pretend gun battle in the next bed? Can’t a hospitalized child who has been a victim of violence be further traumatized by violent play among other children in the same unit? Doesn’t allowing that child to then engage in his or her own pretend violence in the hospital teach him or her that adults think violence is an acceptable play theme? What kinds of confusing and conflicting messages does this give the child about how to deal with violence in their lives or the wider world? This juxtaposition of violent play with the consequences of real violence can feel overwhelming and damaging to patients, families, and staff.

There also are the many children who have not experienced violence directly, but who have spent much time glued to screens

that contain entertainment violence. For these children, play often becomes an effort to imitate the violence they saw on screens with highly realistic toys that are linked to the violent shows. When children *imitate* screen violence, it does little to help them work on the kinds of issues hospitalized children need to work on in their play, but it does take valuable time away from the play they should be doing.

For all these reasons, doesn’t it make sense for hospitalized children’s best interests, as well as for the best interests of families and child life workers themselves, that play with violence should be banned in hospitals? Just as child life specialists are asked to limit screen time and promote more play, disallowing violent play in favor of constructive play alternatives should also be a goal. Taking away play with violence gives children more time for the positive play they need to heal their minds and bodies.

COUNTERPOINT: Violent Play Is Still Play and Should Be Allowed

Children use their play to process events or emotions, and to work on their own unique needs in ways that they can control. And although it would be ideal if play could always be wholesome and non-violent, child life specialists have long been taught to trust the voice of children in the play process. Thus, if children bring violent content and themes into their play, they are likely to have legitimate reasons for doing so. It can be their way of working through something violent or scary that they have seen, on screens or in real life. It can give them a way of expressing their anger and/or frustration at the situation they find themselves in at the hospital. It can allow them to be in control and feel powerful, at a time when it is easy to feel helpless, small, and without a voice, as we know can so easily happen with hospitalized children. Yes, violent themes in children’s play can be

disturbing, but we cannot be the final arbiters of “good” versus “bad” play; children’s voices, as expressed through their play, must be heard.

A key goal in child life work is to use play to help normalize the medical setting for children. If gun, superhero, or violent videogame play is what a child knows and plays at home, can’t having such play at the hospital bring comfort at a stressful time, even if it does happen to involve modes of play that may concern us? This will be especially true for children who spend the most time at home glued to screens that contain violence, and engaged with toys and in play that involve violent themes. Some of these children may find that what they see and do with the violence on screens at home is exciting and satisfying, so it readily becomes a coping strategy they are likely to find very helpful in the hospital as well.

Another child life goal is to help children process difficult experiences and gain control over them. For some children whose difficult

experiences involve being exposed to scary or violent things, play provides a powerful way to process them. Reenacting violent scenes children have witnessed may help them come to grips in a way that talking and drawing alone cannot, especially when they are young. Even children who do not live with violence in their lives may become overly aggressive and explore violent themes as they struggle to express the strong and/or unfamiliar emotions they may experience in the hospital. Sometimes the power that children display in their violent play is a reflection of the powerlessness they feel, and child life specialists are well aware that the lack of control in medical settings can propagate feelings of powerlessness. Banning violent play takes away an important outlet for understanding, expression, and feeling in control.

If a ban on violent play is instituted in a hospital, where should the lines be drawn? How will limits be set? Who will decide what is and is not violent play, when and where it

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1 For a more detailed discussion of these issues, see: Levin, D.E. & Carlsson-Paige, N. (2006). *The War-Play Dilemma* (2nd Ed.) New York, NY: Teachers College.



Oh the Ways We Can Play!

Jessika Boles, MEd, CCLS, Associate Editor

Afaded beige couch in the living room of a split level house in San Francisco taught me everything I know about play. There I built my first pillow fort on a rainy afternoon, got so lost in a book that I almost missed lunchtime, practiced my figure skating choreography in front of imaginary Olympic audiences, and learned to knit, crochet, and craft with my mom and grandmother. I tamed basset hound circus lions, built a snow-capped train village with my grandfather, and cared for my stuffed cat when he (and I) fell ill. I played with not one, but two, brand new baby brothers on that couch for the first time; I also played “house” there with my grandmother for the last time. It’s funny how you can ascribe such meaning to a piece of furniture, but on the play map of my life, everything emanates out from a sun-drenched compilation of fabric and wood.

Each one of us enjoyed a unique play history in our early years that we are continuing throughout our lives and work. As we grew older, through our academic training we conceptualized and theorized play in homes, communities, and healthcare settings. Our practicums, internships, and mentorship programs then gave us not only the language of play, but also the tools to play regardless of an individual’s abilities, circumstances, or background. Now, our participation in the Child Life Council, research projects, and professional development opportunities continue the evolution of our play history as individuals and as a profession.

As the incoming executive editor of *Bulletin* and *Focus*, I have been honored to be part of this issue that pays homage to the very concept of play that we hold so dear. Under the leadership and vision of outgoing editor Jaime Bruce Holliman, I have been able to “play” editor as we compiled the

articles that bring so many dimensions to play in this issue. Experimenting with topics, perspectives, and tones, this *Bulletin* issue has been a playful experience in imagination and possibility for our editorial team as our authors push the traditional boundaries of play and re-envision the foundational practices of child life. Dr. Michael Patte’s *Focus* contribution, adapted from his presentation at the 2013 CLC Annual Conference on Professional Issues and supported by the *Supporting the Field of Play for Hospitalized Children Initiative*, asks us to do the same, especially in the context of changing beliefs about play in today’s world. He argues that the days of unstructured, child-directed play are quickly disappearing, not only in hospitals, but also in neighborhoods, schools, and in all the contexts in which children develop. By sharing highlights from his own unique play history, his work reminds us that play isn’t just a developmental need for children; instead, it’s something free-flowing, healing, and entirely relevant across the lifespan for patients, families, professionals, and community members alike.

The Importance of Play on Whole Child Development

Michael Patte, PhD, Bloomsburg University, Bloomsburg, PA

ABSTRACT

This paper explores how play in America has morphed over the past decades from an unstructured, child-initiated endeavor to an adult-directed, structured enterprise and the implications that this change has on whole child (cognitive, creative, emotional, physical, and social) development. The paper concludes by offering recommendations to reestablish elements of unstructured, child-initiated play that are essential to ensure a bright future for whole child development in the 21st century.

Play scholars draw upon the memories of their subjects to capture an essence of early play experiences. These play memories are often elicited through questions and visualizations and participants often report the experience being more powerful than expected. Vast differences can be seen in play memories across generational lines (Brown & Patte, 2013).

When I ask current undergraduate college students between the ages of 18 and 22 about their early play experiences, their memories reflect adult-driven, structured play that most often took place inside, in a private space, alone, and interacting with a

screen. When I juxtapose the undergraduate student memories with memories from those 35 years and older, sharp differences can be seen in the play lives of children in this time frame in terms of play as unstructured, child-initiated, cooperative, and naturally occurring. Some argue that these changes are natural, expected, and beneficial for children while others argue that they have serious implications for whole child development. This paper explores the potential impact that a more structured and controlled play life has for children in the 21st century.

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To anecdotally highlight the changes culture of play, I would like to share a personal play memory from 45 years ago. When viewed in a present-day context, the play memory is quite astounding. It was a walk to remember—July 21st, 1969.

A WALK TO REMEMBER— JULY 21ST, 1969

I was born in April of 1967 and was just 27 months old and my brother only 44 months old when we went on the adventure of a lifetime. The spring and summer of 1969 were abuzz with stories of mankind's unthinkable journey to the moon and the Apollo 11 mission. At that time, my brother and I dreamed of becoming astronauts and exploring the planets in the Milky Way and our play episodes reflected this common theme. For starters, we settled on exploring our

local neighborhood on daily walks to the park with my mother. The landmarks guiding our way were not the brilliant constellations visible in the night sky, but the mailboxes, mom-and-pop stores, and fence posts we observed along the way. Once at the park, our Big Wheels tricycles became moon rovers and the sand piles the lunar surface perfect for unearthing moon rocks. These fantasy play episodes went on for weeks fueled by our unbridled imagination and my mother's non-interventionist approach.

During these daily trips to the park and at other times throughout the day, my brother and I were planning a most ambitious mission of our own; a secret nighttime trip to my grandmother's house to witness the lunar landing in real time. Our parents never caught wind of our plan or never believed we would carry it out, but on the evening of July 20th, 1969, all systems were go. My brother and I woke around 2:00 am, made our way to the kitchen, assembled some rations (raw egg sandwiches garnished with salt and pepper and a thermos full of orange Tang), and packed them up for the journey. Next, we headed out the door and began the roughly one-mile trek to my grandmother's house in nothing more than diapers and tee shirts. This route was well programmed in our developing brains as we followed familiar landmarks, but this was the first time we made the trek at night, in the dark, and by ourselves. The night was clear and the moon shone brightly in the quiet summer sky.

During the trip we were keenly aware of the potential dangers that stood in our way. We knew to stay on the sidewalk to avoid pointy sticks and stones that might cut our feet, we knew to be silent when passing by the houses with pet dogs to avoid raising suspicion, and we knew to duck behind trees and bushes when the glare of car lights approached to avoid being seen or abducted. How did we come to develop these basic survival skills? I would say through a little bit of biology and a whole lot of personal experience.

Once at our grandmother's house my brother and I began knocking on her door. We wanted Grandma to witness the lunar landing with us from the field behind her house. Grandma never answered the door, but the knocking did pique the interest of our uncle, a construction worker who lived just next door. Our uncle asked what my brother and I were up to, and we told him about our plan to watch the lunar landing of Apollo 11. Then came the obvious question: "Where are your parents?" We told him that our parents were still in bed at home. My brother

and I found a comfortable spot in the field to watch the lunar landing while our parents received a most unexpected anonymous tip about our ambitious plan and whereabouts. Soon after our rations were depleted, my parents arrived to reclaim my brother and me from the magical field where we witnessed Neil Armstrong take "one small step for a man and one giant leap for mankind."

If we examine this play experience from multiple theoretical perspectives, a variety of implications can be drawn about the nature of children's play lives and how they have changed over the last 40 years. For my brother and me, a walk to remember signified one of the crowning achievements of our childhood. It demonstrated our burning desire to explore and actively participate in the world in which we live, to assess and manage risk, to devise and execute a complex plan, and to meet our growing need for autonomy and independence. All of these traits were nurtured and developed by our parents daily by providing the time, space, and freedom to daydream, explore, test boundaries, and push the limits.

From my parents' perspective, a walk to remember signified a low point in their young careers as parents. Both my mom and dad felt as if they had abdicated the primary responsibility of parenthood: to protect their children from harm. I remember my mom crying for weeks and my father installing locks high up on the doors to prevent similar excursions from taking place in the future. I don't remember the talk our parents delivered or the punishment handed down following our adventure, but I often wonder about the social stigma assigned to my parents from friends and family alike. This tension between a parent's desire for control and a child's desire for freedom has been playing out for thousands of years and will only continue to do so, but today's parents seem to be gripping a bit tighter than any time in the recent past.

THE BENEFITS OF PLAY ON WHOLE CHILD DEVELOPMENT

Today, many decisions impacting children focus exclusively on their cognitive development, or development from the neck up. However, Weissman and Hendrick (2013) endorse a whole child perspective that pictures the child as being made up of five distinct selves—cognitive, creative, emotional, physical, and social. This five-domain developmental approach underscores essential

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elements across multiple environments that children need in order to thrive. One of these essential elements is play, and recent research supports the benefits of play on whole child development:

- Interactive, exploratory experiences, both features of play in unstructured social environments, enhance cognitive understandings (Action for Healthy Kids, 2008).
- According to Pellegrini (2009), different types of play foster social competence (respect for rules, self discipline, aggression control, problem solving skills, leadership development, conflict resolution, and playing by the rules).
- When provided with frequent opportunities to play, children develop self determination, self-esteem, and the ability to self regulate; all vital elements of emotional development (Barros, Silver, & Stein, 2009).
- Active physical play builds strength, coordination, and cardiovascular fitness and moderates childhood obesity and its associated health complications (Centers for Disease Control and Prevention, 2010).
- Children engaging in pretend play exhibit a greater capacity for cognitive flexibility and creativity across the lifespan (Russ & Fiorelli, 2010).

PLAY IN THE RECENT PAST

In the recent past, children explored their communities on their own terms by walking or riding bicycles just about everywhere. They knew the safest routes and the best shortcuts for getting just about anywhere as these secrets were passed down from more experienced peers. I vividly remember the daily, adventurous walks to and from school. Each morning, rain or shine, beginning in kindergarten right up through eighth grade, I walked the three-mile round trip trek to school with a group of friends. The number of children participating in this daily ritual varied, but it was an impressive lot of characters indeed. I was reminded of these magical walks to school recently by Penny Wilson's (2012) essay, *Beyond the Gaudy Fence*. In the text, Wilson argues that children need to experience liminal spaces—places of ill-defined purpose—for it is in these liminal spaces that children enjoy the wonders of play most fully:

The walks between home and school for



me were the only valuable bits of the school day. We took the most roundabout routes home so that we could discover the miracles of a . . . snicket, the alleyways and allotments edge, the wall balancing and gate swinging, the improvised gateways of pried apart railings just wide enough to wriggle through . . . [On these adventures] there were trees and berries and flowers and wild corners where we could hide and make dens and discoveries. In this forbidden space we escaped where no parents or teachers were looking and 'learned the things that cannot be taught.' We really played here. I do not mean the formalized playground games that are often mistaken for a play experience . . . [these proved torturous] to the Dyspraxic Wilson . . . But in those marginal spaces, everything was different. The rules melted somehow. There was a sense of being drawn in and exploring, being captivated and liberated at the same time (Wilson, 2012, p. 32).

These daily excursions were private ones that happened beyond the watchful eyes of our parents. There was a sense of trust in the protective power of the group and a realization that we had to make our own way in the world, and providing the freedom to walk to school each day was the first little step in that direction.

There were also many secret places to be discovered on the walks to and from school, and we returned in the evening hours, on weekends, or whenever the chance occurred.

These places were so appealing because they were off the beaten path, secluded, and hidden from the noisy world outside. I can vividly recall making dens and tree houses and adorning them with personal artifacts to make these spaces feel like a home away from home. Here we formed secret societies, forged our own rules, and lived like kings and queens. In their seminal text, *Children's Games in Street and Playgrounds*, folklorists Iona and Peter Opie (1969) document that children prefer quiet and natural spaces to engage in play beyond the watchful eye of adults:

We forget that children's amusements are not always ones that attract attention. They are not prearranged rituals for which the players wear distinctive uniforms, freshly laundered. Unlike the obtrusive sports of grown men, for which ground has to be permanently set aside and perpetually tended, children's games are ones which the players adapt to their surroundings and time available. The peaks of a child's experience are not visits to a cinema, or even family vacations, but rather occasions when he escapes into places that are disused and overgrown and silent. To a child sport is sweetest when there are no spectators. The places they like best for play are the secret places where no one else goes. (pp. 14-15)

Just 40 to 50 years ago, roaming hoards of children were a common sight in many neighborhoods across America. At that

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time, parents provided the time, space, and freedom to play. This unstructured time was granted each day after school, on weekends, and all summer long from dawn until dusk. Space for play was wide-ranging and boundaries were always being negotiated. Pick-up games created by the group ruled the day and organized sports were more of an afterthought. Gray (2013) provides a brilliant glimpse into the long-since-forgotten era of community play:

When I was a child in the 1950s my friends and I played . . . in mixed-age neighbourhood groups almost every day after school until dark. We played all weekend and all summer long. We had time to explore in all sorts of ways, and also time to be bored and figure out how to overcome boredom, time to get into trouble and find our way out of it, time to daydream, time to immerse ourselves in hobbies, and time to read comics . . . What I learnt through my [play] has been far more valuable to my adult life than what I learnt in school . . . (p. 1)

PRESENT DAY PLAY

Fast forward to the present day, and the roaming hoards of children that once filled the local streets and neighborhoods have become virtually extinct. Children, like an endangered species, now find refuge in the safety of their houses and through participation in a variety of organized activities and sports. Sociologists have documented that in the last 50 years America has transitioned from being a 'front porch' society that values community play, to a 'back deck' society that favors organized and structured activities like play dates (Putnam, 2000). In this climate, play has morphed from an unstructured, child-initiated endeavor to an adult-directed activity (Marano, 2008). Although there are several reasons for this change, parental fear serves as the main societal barrier impeding children's unstructured play (Elkind, 2007; Gill, 2007).

Marano (2008) and Sigel (1987) identify hyper-parenting and hothousing techniques as two ways that parents attempt to create a perfect childhood and provide the optimal environment for their children to grow and develop. The authors warn that both approaches are ruled by fear and eliminate opportunities for children to face and



overcome adversity, solve real-world problems, and become self-reliant, thus creating a generation of 'tea cup' children that are fragile and inflexible.

The individualistic and competitive nature of American society creates an optimal environment for fearful adults worried about their child's ability to ascend the ladder of success and discourages its youngest members from indulging in frivolous, impractical, and unproductive activities (Patte, 2009). In this environment, many contemporary parents view play as a luxury that their children can ill afford. Research on the amount of time children spend in child-initiated play over the past thirty years supports this assertion. For example, even in schools serving our youngest children, opportunities for play are being overrun by more structured activities. Miller and Almon (2009) reported that thirty years ago, child-initiated play made up 40 percent of a typical preschool day, compared with just 25 percent today. Within this same timeframe, Elkind (2007) found that children lost 12 hours of free time per week, including eight hours of child-initiated play and outdoor activity. In stark contrast, the time children devote to organized activities like sports has risen by 50 percent from 1980 to 1998 (Hofferth, 1999).

Elkind (2007) and Gill (2007) suggest that fear causes parents to micromanage the

lives of their children through overinvesting, overprotecting, and overprogramming. One reason parents tend to overinvest today is due in part to the size of the American family. As the size of the American family continues to decline, parents have more time and resources to devote to children's schooling and extracurricular activities (Elkind, 2007). Role strain (Parsons, 1968) is another factor associated with overinvestment. Role strain holds that as society becomes more complicated, so too do the social roles of its members. Many of the parenting practices once under exclusive control of the family are now delegated to others, and parents overinvest in the practices still under their control.

Overprotection is a second barrier impeding opportunities for children's unstructured play. Generally speaking, in the early part of the twentieth century parents focused more on protecting childhood innocence and less on risks to physical wellbeing. Characteristics of this era included bigger families, smaller houses, and greater access to outdoor play spaces for children. Time for unsupervised play and for assessing and managing risk were viewed as important elements of whole child development. Today, however, parents are more concerned with protecting the physical wellbeing of their children than they are with protecting childhood innocence, even lacking any evidence claiming that children are in greater danger today than in the past.

A measurable example of overprotection in action is the vast number of parents using cell phones to track the whereabouts of their children at all hours of the day and night (Elkind, 2007).

A third way parental fear about unstructured play is actualized is through overprogramming the lives of children. Today's parents feel pressured to help their children develop at an accelerated pace (Elkind, 2007). We have all experienced parents who proudly share the ages at which their children utter their first words, take their first steps, read their first book, tie their shoelaces, ride a bicycle without training wheels, etc. This "sooner is better" mentality often causes parents to overenroll their children in structured activities, leaving little time for child-initiated play opportunities (Brown & Patte, 2013; Elkind, 2007; Marano, 2008).

IMPLICATIONS OF THE CHANGING CULTURE OF PLAY

Scientific evidence from multiple disciplines touts the benefits of child-initiated unstructured play for whole child development and links the absence of such experiences to negative outcomes for children:

- **Impaired social cognitive competence** – Gray (2013) documents declining opportunities to play with a corresponding decline in empathy and rise in narcissism among children with few opportunities to play socially. The National Association of Early Childhood Specialists in State Departments of Education (2002) holds that depriving children of child-initiated outdoor play impedes the development of social-emotional learning and the ability to self regulate.
- **Inability to attend and poor task completion** – The Centers for Disease Control and Prevention (2007) reports that four and a half million children between the ages of 3 and 17 are diagnosed with attention deficit hyperactivity disorder. Marano (2008) attributes the high incidence to an early childhood curriculum that requires children to sit idle for extended periods of time. There has also been a corresponding increase in the number of children being medicated to enhance their attention, with over 21 million prescriptions each year; a 400% increase over a decade.
- **Emotional fragility** – Unstructured,

child-initiated play provides children with opportunities to experience and work through challenges, discomfort, and disappointments. Lacking these experiences can impair the ability to develop coping skills and the inner resolve necessary to thrive in a changing world (Marano, 2008).

- **Health concerns** – Throughout the world children are facing an obesity epidemic, and during the past forty years in the US, the obesity rate for children aged 6 to 11 has more than quadrupled (Ogden, Carroll, Curtin, Lamb, & Flegal, 2010). Today over twenty-three million young people in the US are overweight or obese (Robert Wood Johnson Foundation, 2009).
- **Incidence of anxiety and depression** – According to Gray (2013), as opportunities for children's play have declined, mental disorders among children have increased. To highlight, anxiety disorder and major depression in young people are five to eight times what they were in the 1950s. Panksepp (2002) argues that play serves as the deepest wellspring of joy in human experience, which buffers us from anxiety and depression.
- **Void of creativity and imagination** – Kim (2011) reports that creative thinking among American children is declining. Over the last two decades "children have become less emotionally expressive, less energetic, less talkative and verbally expressive, less humorous, less imaginative, less unconventional, less lively and passionate, less perceptive, less apt to connect seemingly irrelevant things, less synthesizing, and less likely to see things from a different angle" (p. 292). Harrington et al. (1987) found psychological safety and freedom to be essential elements in home environments that produced creative potential in adolescents. In order to be creative, children need free, uninterrupted time to think and engage in reflective abstraction (Piaget, 1981).
- **Inflexibility** – Scholars argue that play serves as training for the unexpected. Bekoff and Pierce (2009) identified a 'flexibility hypothesis' in wolves that allows them to improvise behaviors more effectively through play. Further, they highlight the importance of play in developing children who are creative, flexible, and able to adapt to new environments.
- **Risk aversion** – Gill (2007) and Marano (2008) identify a present-day landscape in the UK and USA where children are "bubble wrapped" by their parents and deprived of opportunities to assess and manage risk. In this type of environment, children are incapable of adapting to a fluid world, making them risk-adverse and psychologically fragile.

RECOMMENDATIONS FOR REESTABLISHING CHILD-INITIATED PLAY

Based upon the evidence, researchers, parents, policy makers, children, and concerned citizens can play an active role in reestablishing child-initiated play. The following next steps are recommended:

- **Turn your neighborhood into a place for play** – In his play advocacy manifesto, Lanza (2012) identifies challenges to free play, offers practical strategies for fostering free play in neighborhoods across the country, and shares inspiring stories of innovative communities that are making free play a priority for children.
- **Advocate a slow parenting approach** – In her controversial text, *Free Range Kids: How to Raise Safe, Self-Reliant Children Without Going Nuts with Worry*, Skenazy (2009) advocates adopting a slow parenting approach in raising children, characterized by few organized activities and an environment where children are free to explore the world at their own pace.
- **Explore the great outdoors** – Richard Louv (2008) identified a disconnect with nature affecting the current generation of children in his book *Last Child in the Woods: Saving our Children from Nature Deficit Disorder*. Examining research across multiple disciplines, Louv argues that direct contact with nature is essential for the development of emotional and physical health in childhood and across the lifespan.
- **Join with like minded individuals** – There are many professional organizations and advocacy groups advancing the importance of play in whole child development, including The Alliance for Childhood, The American Academy of Pediatrics (AAP), The Association for Child Education International (ACEI), The Centers for Disease Control and Prevention (CDCP), The Child Life Council (CLC), The

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International Council for Children's Play (ICCP), The International Play Association (IPA), The International Playground Equipment Manufacturers Association (IPEMA), The National Recreation and Park Association (NRPA), and The US Play Coalition.

- **Explore the available resources** – There are an abundance of credible resources that examine play across various disciplines and from various perspectives including *The American Journal of Play* (www.journalof-play.org) and *The International Journal of Play* (www.tandfonline.com/loi/rijp20#.UzQ5gtx_PSE).
- **The research is on your side** – Empirical, scientific evidence documents the benefits of play on whole child development and challenges the growing trend to reduce opportunities for play at home and school (Patte, Pellegrini & Bohn-Gettler, 2013).
- **Advocate for play at home and at school** – Article 31 of the *United Nations' Convention on the Rights of the Child* (UNICEF, 1991) states in part that children have the right to relax and play and to join in a wide range of cultural, artistic, and other recreational activities. Play is a child rights and social justice issue, as under-resourced children have fewer opportunities for play than their adequately resourced counterparts (Jarrett, 2013).
- **Address the societal factors devaluing play** – Provide research-based solutions to the prominent factors in America restricting opportunities for children to play.

CONCLUSION

If there is one constant in life, it is that change is inevitable. For many, change is unsettling because it displaces us from our zones of comfort. During the past 40 years, children's play has transformed from an unstructured, child-initiated endeavor to an adult-directed, structured enterprise stressing organized activities. As the research outlined in this paper suggests, this transformation can have serious implications for whole child development. Elkind (2007) argues that striking a balance between structured and unstructured activities is the key. He recommends resisting the peer pressure to introduce children to organized sports prior to the age of five or six as doing so transforms

participation to an obligation and not actual play. Through natural play children obtain recommended amounts of exercise, prepare for future sports, choose their favorite play activities, assess and manage risk, and develop social relationships with a wide variety of children.

There are reasons to be both pessimistic and optimistic about the current state of play in America. There are a variety of societal factors marginalizing opportunities for children's play, with fear being most prominent among them. Due in part to fear and its mitigating factors, children are afforded fewer opportunities to play at home and school today than in the past. However, there are reasons for optimism as well. Many prominent professional organizations advocate for the importance of play, and current research across multiple disciplines documents the benefits of play on whole child development. In a recent essay, *What is the State of Play?*, Kuschner (2012) paints an optimistic picture about the future of children's play. He writes:

On the one hand, much has been written about how children's play is under pressure from overly structured, academic curriculum and testing; the paving over of wild spaces; and the chaos brought down upon their lives by such circumstances as family discord, poverty, and the conflicts of war. All of these forces certainly do challenge a child's ability to play. On the other hand, when considering the question I was reminded of the time I had tried to eliminate some ferns growing by the side of my house. Despite my best efforts to pull them up by their roots and poison them into nonexistence, they grew back. The pull of their nature to grow back in the very same spot was stronger than my ability to keep them out of my garden. In their insistence to live in my garden, it was almost as if those plants were mocking me. In a fundamental way, children are like those ferns; due to the pull of their nature, children will play even when the circumstances are less than ideal or when there are forces at work trying to stop them from playing altogether . . . I have faith that despite any current and future circumstances that might not be supportive of children's play, children will find ways to play and, like those ferns, at times they may even be mocking us in the process. (p. 103).

As the tension between parents' desire for control and children's desire for freedom continues to play out in the 21st century, finding a balance between child-initiated, unstructured activities and adult-directed, structured activities is the key to whole child development.

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Gaining a Larger Perspective on Play

A REVIEW OF RUSS, S. W., & NIEC, L. N. (2011). *PLAY IN CLINICAL PRACTICE: EVIDENCE-BASED APPROACHES.* NEW YORK, NY: GUILFORD PRESS.

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Play is a rudimentary part of children's lives that enables them to engage in new experiences and make sense of their surrounding environments (Russ, Fiorelli, & Spannagel, 2011). Play also promotes freedom of expression and creativity while facilitating physical, cognitive, social, and emotional development (Russ et al., 2011). In *Play in Clinical Practice: Evidence-Based Approaches* (2011), editors Sandra Russ and Larissa Niec feature 14 chapters written by experts in the fields of child development and play therapy. Russ and Niec further divide the chapters into four sections, (1) play in child development, (2) play in evidence-based assessment, (3) play in evidence-based intervention, and (4) play in evidence-based programs in school settings. In each section, selected authors discuss different aspects and uses of play while simultaneously emphasizing the importance of play throughout child and adolescent development. The central argument of the book is that play is a critical component of children's lives and that children with more sophisticated (i.e., flexible, creative, and dynamic) play skills are generally more emotionally and socially well adjusted than children with less developed play skills. The editors contend that children's play abilities are positively associated with their cognitive functioning.

In essence, *Play in Clinical Practice* provides a thorough overview of the necessity of play, including its origins, types, and effects, as well as information on how to conduct play assessments and interventions. *Play in Clinical Practice* also reviews child therapies that incorporate play—and describes how play can be effectively used to treat children and adolescents with various psychiatric conditions such as generalized anxiety, social phobia, posttraumatic stress, oppositional defiant disorder, disruptive behaviors, autism, Asperger's, attention-deficit hyperactivity disorder (ADHD), selective mutism, and children who have been victims of physical and sexual abuse. When discussing these treatments, Russ and Niec (2011) include real-life case studies that demonstrate the benefits and challenges of working with children who have physical and/or mental health conditions.

In addition to providing in-depth discussion on play and its uses, the editors and authors suggest numerous resources that practitioners can use to augment their work. These resources appear to be valuable and could be used by child life specialists and other individuals who serve youth. *Play in Clinical Practice* also describes numerous research studies that highlight the benefits of incorporating play into child- and



family-centered interventions. Moreover, Russ and Niec reiterate the necessity of hospital-based play programs for children coping with physical and mental illness and examine the importance of play in early childhood education and primary school settings. *Play in Clinical Practice* is an informative work that can be utilized by multiple practitioners, from child life specialists to social workers and clinical psychologists. Although some of the interventions mentioned (i.e., neurological testing and psychotherapy) are outside of the scope of practice of child life professionals, the book is a beneficial resource for individuals who desire to incorporate more play theory and techniques into their clinical practice.

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Healing With(in) Imaginative Play

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There is a rich and varied literature on the presence and value of imaginative play to contend with issues of affective and physical significance. Conceptually, developmental psychologists Jean Piaget (1962) and Erik Erikson (1976) contend that young children engage in imaginative play to illustrate mastery over experiences, including those that have affective significance. For example, children may “play out” a visit to the doctor’s office in their imaginative play to feel more comfortable than they might during a “real” visit to the doctor. Empirical work by scholars such as Cindy Dell Clark (2007) explores children’s psychological healing and stress reduction via imaginative play. Clark studies the value of imaginative play for children living with ailments such as diabetes and asthma. In her work, children who live with these physical challenges and who engage in imaginative play around themes of their illness and/or treatment are calmer and more empowered during the process. Applied work by individuals such as Patch Adams (www.patchadams.org) illustrates that children’s well-being, particularly when their health is compromised, benefits from playful interactions.

While I applaud theory, research, and applications in this area, I contend that the presence and value of imaginative play in the context of health and treatment should not be limited to young children. The play-based activities we support for children who are coping with physical and psychological stressors should be extended across the lifespan and include the multiple partners who advocate for the health and care of children. Across conceptual, empirical, and applied contexts, imaginative play is no longer “just for kids”; motivations for imaginative play and examples and benefits of it are present throughout the lifespan (e.g., Freysinger, 1998; Holzman, 2009). For example, in my interviews with adults about their life-span imaginative play (Perone, 2013; Perone & Göncü, under review), participants shared how imaginative play beyond early childhood helped them deal with issues such as feeling depressed or lonely or to contend with family issues such as domestic abuse or divorce.

For the purposes of this commentary, I would like to share the potential for imaginative play for adult health care professionals.

The value of imaginative play for these professionals not only provides them with self-care and stress reduction, but also makes them more present for, vulnerable with, and supportive of their colleagues, their patients, and their patients’ families. While there are many forms that imaginative play can take, such as young children who play dress up or adults who attend Halloween parties or Comic Con, I would like to focus on one particular example: improvisational theater activities (improv), where people engage together in imaginative and spontaneous games and scenes. Indeed, some authors (e.g., Göncü & Perone, 2005) consider improv to be an adult version of the pretend activities children do. What’s more, evidence suggests that improv is not only relevant for actors or other creative types; rather, it is a form of engagement that is invigorating, adaptive, self-caring, and relational for people of all walks of life (Holzman, 2009).

For example, Performance of a Lifetime (www.performanceofalifetime.com) conducts improv-based workshops for adults across a host of different fields and with a range of different goals: to build teams, to address workplace concerns in new ways, or to improve the health and well-being of staff. As an illustration of such goals, Performance of a Lifetime worked with members of the staff of oncology nurses at The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins University. As is often the case for health care professionals, the nurses at Johns Hopkins have found themselves stressed out or otherwise taxed by the demanding work they perform on a regular basis. As well, factors such as long hours, isolation from other professionals, and emotionally challenging work environments are often present. How might these adults contend with their work-related issues of affective significance? Might improv be a way to address these issues? The Performance of a Lifetime (POAL) team thought it might.

According to literature provided by Cathy Salit (2011), chief executive officer of POAL, the oncology nurses at Johns Hopkins engaged in improv activities over the course of eighteen months that provided them opportunities to act out the “scenes” of their work and lives, explore how they interact with each other and their patients, and experiment with new ways to perform their daily activities to become more resilient. For example, these

nurses improvised many different hospital situations such as the loss of patients with whom they had developed close connections, interactions with distressed family members, “learning the ropes” as a new nurse, and experiences with serious illness in their own lives. Taking part in these improv activities, according to Salit (2011), created play spaces for the nurses to let go of their more constrained and “scripted” performances, to have more open and honest dialogue, to be of greater support to one another, and to better handle the stressful and painful circumstances they were dealing with on a daily basis.

From this example, it seems that imaginative play can be a social and developmental activity for adults in the health care field. Imaginative play can provide opportunities to heal and co-create new experiences and new ways of relating with others. Based on the work of POAL, I encourage adults in the helping professions to perceive imaginative play as not only of benefit to the health and well-being of their patients, but also of themselves. Imaginative play, as seen in the form of improv, can be a means to contend with issues of affective experience, and in doing so, build support, create and sustain community, and develop new relationships with ourselves and others.

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POINT/COUNTERPOINT

can occur? Are only realistic-looking guns disallowed? What about colorful Nerf® guns that shoot harmless foam? Should we even ban guns that squirt water or blow bubbles? Does the ban extend to violent video games—with what ratings? What about violent television? What about therapeutic target games that many child life specialists use to help kids process negative emotions? It can get pretty heated! Would a ban on guns and violence be limited to the playroom, or would it extend to private rooms where

others are less likely to be affected? What if an 18-year-old on your unit wants to play a violent video game? A 12-year-old? What if a parent brings a toy gun as a gift for a child? What happens when a child bites his Pop-Tart into the shape of a gun (as happened in a Maryland school) and starts shooting?

Although it's nice to think that we could have an influence on a child's future choice of play materials and the lessons they learn by disallowing gun play in our hospitals, the

reality is that the nature of our relationships with most of the patients with whom we work is transient, and our influence on their lives outside of the medical realm is limited. Banning play with violence for a week while children are in the hospital may be taking away something familiar, something that allows them to feel powerful and in control, and something that they are likely to go back to once back in their usual environment, if it was present there before the hospital stay.

THE MIDDLE GROUND: All War Play Is Not the Same; Balancing Safety, Values, and Patient Needs

Yes, violent play can be difficult to watch. But the answer to dealing with violent play is less about banning or allowing it, and more about observing it, evaluating what it means to the child and how it changes over time, and making decisions about what to do, based on both what you learn from observing the child's violent play and what else you know about the patient's needs.

All play with violence is not the same. Things are going well when you find violent play that: 1. is creative (i.e., created by the child, not just imitation of something he or she saw on a screen); 2. changes over time, and is not just the same violent actions repeated over and over; 3. shows evidence of the child using his or her own imagination and special play abilities to create play unique to that child; and, 4. is open to the input of an adult, who can work with the child to tame the violent themes, and help the child bring more into the play than just the violence (e.g., making a meal and bed for the superhero to go to when he is done fighting).

Violent play that looks more like a TV script and which the child seems to exert little control or imagination over, and which does not change or evolve over time, is likely to be imitation, not child-created play, and thus, is not therapeutic. Imitative play is not creative, and a child who is merely imitating violence is not reaping the transformative benefits of play.

Some toys engender violent play by their nature: they are highly realistic replicas

of what children see on screens. They are designed for a single purpose and come with an implicit script that leaves little room for creativity. These toys encourage imitative play, and providing more open-ended toys for redirection of play is generally beneficial.

Some children reenact violence that they have witnessed. They may be struggling to comprehend something that adults don't fully understand. It is important to watch how this play evolves. If the same scenes are replayed over and over with little variation, the child may not be moving forward and may need special support in interpreting the experience. And then there are the children who bring both the pretend and real violence they have seen into their play. They often need help sorting out what is pretend and what is real, both in and out of their play, as well as help bringing content other than just violence into their play.

The truth is that the children we see in hospitals today are growing up exposed to real and entertainment violence. Because children use their play to work out experience, we can expect this exposure to enter their play. We are right to be concerned about how our willingness to let children engage in such violence might affect their future relationships, problem-solving abilities, and mental health. At the same time, children need some way to work out and resolve what they see, and we can help them do that in their play. Thus, violent play should not be banned, but neither should children be left to navigate and explore violence through play without

adult support. Child life specialists, whose goal is to promote the wellbeing of children, need to find ways to balance children's needs and their own values, and at the same time influence the needs children are trying to meet and lessons they are learning.

Milestones

After a long career in child life, **Kathleen McCue**, MA, LSW, CCLS, retired in June. Widely known for her book, *How to Help Children Through a Parent's Serious Illness*, Kathleen spent much of her career as the supervisor of child life at the Cleveland Clinic Foundation (CCF), where she came to the realization that children of adult patients were impacted by the illness and hospitalization of their parents. She spent seven years developing her skills and programming for these children at CCF before founding the Children's Program at The Gathering Place, a community support center for families coping with cancer in Cleveland, OH, where she has worked for almost 15 years.

Kathleen's contributions to CLC are many: She has served on the board as secretary and president, has worked on numerous committees and task forces, and has shared her expertise in many presentations and publications. Her contributions were recognized in 2001, when she was honored with the Distinguished Service Award. We wish Kathleen a happy retirement.

Play with Infants and Toddlers: Building Coping Capacities

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At its essence, a child life specialist's role with children and families boils down to two primary goals: supporting children's optimal development and facilitating positive coping in the face of challenging circumstances.

In considering play in the first two years of life, many play activities that support specific developmental milestones readily come to mind. Some of these may support motor milestones such as tracking, reaching, grasping, rolling over, sitting, manipulating a toy with fingers and exploring it orally, pressing buttons, and crawling. Others may support language milestones like cooing, babbling,

single-word utterances, and forming word combinations. Developmental play activities that target these concrete, visible behaviors on the part of the child provide a clear path for identifying goals, choosing additional play activities that support the goals, and evaluating the outcomes of these interventions.

The connection between play and supporting coping capacities for infants and toddlers may seem less clear but it is no less important in the services that child life specialists provide. Many times, the same play activities that focus on specific developmental milestones provide opportunities to work toward enhanced coping capacity. When an infant expresses distress during play, perhaps from overstimulation or increasing fatigue, a child life specialist responds by adjusting,

or by assisting the child's parent in adjusting, the type or pace of the interaction to assist the child in returning to a calm state. As the adult recognizes and adapts to the infant's emotional needs in the play interaction, the infant experiences the ebb and flow of high arousal or excitement with a return to calm. Theory regarding the development of self-regulation points to this early experience of synchrony and attunement in relationship with caring, responsive adults as a building block for infants' growing abilities to self-regulate, with young children progressing over time from relying on more external resources for regulation to internal (Institute of Medicine, 2000).

During play interactions, the adult's ability to recognize and adjust to the infant's self-generated activity and emotional needs is a fundamental component of the play relationship. Jean Piaget highlighted the importance of self-generated play, in which the child initiates and controls actions. According to Piaget's theory, the primary mode of play in the first two years of life occurs in sensorimotor exploration and interaction with the world around them (Santrock, 2013). Vygotsky's theory of cognitive development goes a step further, proposing that children learn through hands-on activities and social interaction (Santrock, 2013). In Stanley Greenspan's model of Functional Emotional Development Levels (Greenspan, 1999), the first stage specifically identifies the importance of regulation of state and emotion as it relates to infants' abilities to focus on and attend to the sights, sounds, touches, tastes, and smells around them. In describing this stage, Greenspan also highlights the significance of infants' relationships with caring adults in the process of becoming interested and engaged with the world around them and in learning to regulate their reactions and states of arousal.

When working with infants, child life specialists have the opportunity to communicate with the family and health care team about the connection between specific developmental goals and play activities, to make what is implicit in infant play interactions explicit. Table 1 identifies several examples of common play activities that support developmental goals related to coping.

TABLE 1. IDENTIFYING PLAY GOALS AND ACTIVITIES THAT SUPPORT DEVELOPMENT OF COPING CAPACITIES IN INFANTS AND TODDLERS

GOAL	ACTIVITY
Enhancing self-regulation	<p>Playing with sound, touch, and movement in different ways to discover what is most engaging to the infant, what brings pleasure, and to learn the infant's preferences regarding type and level of stimulation</p> <p>Providing the infant with the experience of synchrony and mutual regulation by pacing play interactions to balance high arousal or excitement with a return to calm</p>
Supporting emerging concepts of self through "self-other action play" in which the infant begins to experience differentiation between self and other	<p>Engaging young infant in imitation play – a "dialogue" of action and response in facial expressions, vocalizations, or gestures</p> <p>Responding to and expanding on older infant's initiation of turn-taking games</p> <ul style="list-style-type: none"> • Give and Take, in which the infant hands you an object, and then you hand it back – "I give it to you, and you give it back to me" • The "Drop" Game, the game in which infants repeatedly drop a toy over the side of their high-chair or crib – "I drop it, and you pick it up" <p>Playing peek-a-boo</p>
Enhancing sense of mastery through "self-as-agent play"	<p>Engaging the infant in play with cause-and-effect toys or interactive games in which he controls the outcome by his actions</p> <ul style="list-style-type: none"> • For young infants, and older infants or toddlers with less strength or energy, loosely tying the string of a balloon to their wrist or ankle provides them with a way to experience cause and effect – "I move my leg, and the balloon dances" • Games in which the infant initiates an action and the adult responds contingently – for example, the familiar "Drop" game may fall into this category of "self-as-agent" play for older infants, as they often respond with such joy in the repetition of the adult response of picking up the toy and handing it back.



PUTTING THE CONCEPTS INTO ACTION: AN 18-MONTH-OLD, A CHILD LIFE SPECIALIST, AND A FLASHLIGHT

Greenspan encourages caregivers to focus on following the child's lead in play, noting that "many of our most prized and precious magic moments with our babies and toddlers" (Brazelton & Greenspan, 2000, p. 40) take place when we follow the child's lead and engage in the direct and continuous communication that results. This was certainly the case when I found myself in the room of Ty, an 18-month-old on isolation whose parents had had to step away from bedside for the afternoon. With each of my attempts to engage him in play, including separation play, he responded to each toy, song, and game with brief interest and engagement before seeming to tire and look for something else. Out of toys to try, I noticed the flashlight in its usual station at bedside and picked it up to show him how it worked. As he had been with the other toys, he responded with initial interest, figuring out how to push the button, then shining the light on his mattress, the ceiling, the wall, and then on me. When the beam of light rested on me, I acted like it was a spotlight and began to dance and sing a little bit. He grinned, then moved the light, and as the light left me, I stopped dancing and singing to talk about where the light was now shining. As he turned back to me, the light fell on me again, and again I started to dance and sing a little bit. This was the start of more than 20 minutes of joyful interaction, with Ty bouncing up and down in excitement as he moved the light around the room, always returning it to shine on me, and laughing and bouncing some more as I

danced and sang at his command.

Though the activity evolved entirely without planning on my part, I did recognize the value to Ty of a form of play that handed control to him, turning on its head the situation he had been experiencing for the several days he had already been hospitalized in which he had very little opportunity to express his autonomy, let alone to experience the sense of mastery and self-as-agent as he controlled the actions of this one adult.

Play is an especially important mode of communication with our youngest patients, and, as demonstrated, allows opportunities to build young children's sense of mastery and control, presents them with occasions to understand predictability, and offers chances to develop self-regulatory skills. By purposefully engaging in play with infants and toddlers, we can help them gain skills that enhance their coping abilities.

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X is for X-Box

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Despite concerns about their negative effects on children and youth¹, video games have become a cornerstone of play programs in hospitals across North America since the late 1980s. Often promoted as an appealing feature of hospitalization, the examination of the value of video games from a theoretical perspective can support an argument that video games also serve as an innovative tool linked to specific outcomes. I am inclined to think that the social elements of video game activity dominate a novice perspective of the possible gains to be achieved; for example, hanging out, joy of competition, peer teaching and leading, and making friends (Olson, 2010). However, perspectives can change as evidence-based theoretical models are applied to practical anecdotal cases like the one posted by Teresa Schoell, MA, CCLS on the CLC Forum (July 10, 2013). The indicators of competence, autonomy and relatedness are apparent:

As to your question about video games as a motivator ... Early in my first year of

1 Przybylski, Rigby, and Ryan (2010) also reviewed the negative influence of video games for the subset of players who are attracted by the violence and aggression of games or where an obsessive passion was a factor: perhaps that will be a topic for a future column.

practice, I received a consult for a teenage boy with mild developmental delays, admitted for cyclic vomiting syndrome. All he would do was sit in bed, clutching his basin, while rocking/moaning and frequently dry heaving. I offered every normalization play and therapeutic play option I could think of, but he turned me down because he “was too sick to play.” I had read about “play by proxy” and gave it a try. I picked a truck racing game on the Wii and started to play while he moaned and dry heaved beside me.

The more I played the less he heaved! After about half an hour, we were up to a solid 8 to 10 minutes between heaves, and I started to “lose” some of my driving skill ... he started coaching me! At first just a word or two, but gradually more and more until finally, when I just kept driving through the giant mud puddle instead of jumping over it, he demanded that I hand over the control so that he could show me how to do it right. He got it right on the first try and just kept playing for almost 2 hours – He went a full 65 minutes without throwing up. By the time evening rolled around, he had asked the nurse for a tuna sandwich for dinner.

Psychological nourishment, indeed! The psychological outcomes of competence, autonomy, and relatedness demonstrated by Teresa’s case underscore the merit of the intentional use of play to influence the

well-being of children – in this case with video games. When explained through the lens of self-determination theory and supported by a program of research, the significance of child life interventions such as the use of video games can be communicated between professions as if in a shared language: “Theories are a helpful tool in the explanation of why we support and promote specific interventions and policies” (Turner, 2009, p. 34). In the case of the X-Box, self-determination theory is a useful perspective for discussions around psychologically satisfying play experiences gained through intrinsically satisfying play (Przybylski, Rigby, & Ryan, 2010).

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Playing for the Child

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presented an excellent case study in Nancy Boyd Webb’s “Play Therapy with Children in Crisis” (Webb, 1991). Their work with a boy who is paralyzed demonstrates how a specialist empowers a child to direct play verbally, by enacting whatever the child’s imagination conjures. The child takes on the role of director, narrating what the adult should draw, paint, act out, or build. Even if a child cannot verbally participate in the moment, watching an adult play provides the possibility of interaction in the future. It presupposes that the child wishes to engage in play no matter his level of physical or mental

ability. This differs from parallel play in that the intention is to encourage interaction from the onset of play.

The permissiveness and openness of the adult is essential. The specialist must use words, tone, and body language that invite, but do not demand or pressure. Check in with the nonverbal child regularly to see if he expresses a preference or wish. Child-centered language, empathic responses, and narrating or tracking (Landreth, 2012) are perfect skills to use in these situations. Narrate your own actions as you string a bead necklace, build a volcano, make oobleck out of cornstarch and water, or create and use a toilet paper target. It does not matter what you play, as long as you roll up your sleeves and enter into it wholeheartedly.

In these and all instances, child life specialists must have the courage to initiate play, as well as the humility to follow the child’s most subtle expression for preference and control. Being the perfect playmate requires you to follow your intuition and to trust the innate need of all children to be participants in play, even when their bodies cannot.

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Kat Davitt Receives Mary Barkey Award

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team at Cook Children's Medical Center in Fort Worth. This is where Kat's story plot takes a unique twist: Kat took a six-month educational leave in 2000 to obtain a Master's degree in Occupational Therapy. Just as she was about to jump tracks and follow the OT path, another great opportunity came her way which kept her rooted in child life, and she has stayed with us ever since.

At Cook Children's, Kat has engaged in a wide range of responsibilities, including several different camp programs, animal-assisted therapy, infant massage, student program management, teen support programming, community re-integration, and school re-entry. She has coordinated volunteers and special events as well as managed the hospital's in-kind donations program. Her current clinical assignment is in the neurology, palliative care, and rheumatology clinics.

This impressive list is really just a part of her story. What has earned Kat this most recent recognition is the clinical skills she employs to provide exemplary child life services. The criteria used in evaluating nominations for the Mary Barkey Clinical Excellence Award include

- collaboration,
- critical thinking with a commitment to continuous improvement,
- effective interventions,
- modeling team behavior with respect for diversity,
- demonstrating professional relationships,
- sensitivity to unique circumstances,
- family-centered care,
- incorporating evidence-based practice,
- mentoring students and new child life specialists, and
- active participation in the Child Life Council.

In all of the identified areas, Kat Davitt has significantly excelled. Her nominating peers were eloquent in vividly describing Kat's work in each of the aforementioned criteria areas.

Kat recalls two specific patient-related stories that have continued to stay with her over the years. The first begins with a ten-year-old boy with bright red hair who was preparing to have his tonsils removed the next day. He

was moving around the hospital looking very intently at his surroundings; when Kat caught up with him, he was staring at a particular mobile. When Kat asked what he was doing, the boy said, "I want to see things one last time." This was the beginning of a very earnest discussion about surgery, anesthesia, and misconceptions about "going to sleep." The other vignette that Kat holds near to her is about a neuro-rehab patient who was anxious to the point of nausea. Kat put this young patient in charge of the "Dance Party Thursday" patrol - making sure that each and every doctor, nurse, and patient demonstrated their dance moves to the song "All Star" by Smash Mouth. Almost magically, the patient's nausea abated for the whole party!

In describing the proudest accomplishments of her child life career, Kat recalls her participation in the first major strategic planning program for the CLC in 1996 called "Vision to Action."

In describing the proudest accomplishments of her child life career, Kat recalls her participation in the first major strategic planning program for the CLC in 1996 called "Vision to Action." It was a watershed event for the profession and for the CLC. Kat also describes her sense of pride and satisfaction in seeing some of her students thrive and excel in our profession, including some who were former patients.

Speaking of students, Kat has three pieces of advice for those participating in child life training. First, do not be afraid to take care of yourself. Seek balance and trust that it will make you better at your work. Second, remember to recognize the blessings of our work, as it is a privilege to have our job and do this work. Finally, don't be afraid to keep learning.

Kat has generously given of her time and skills for the benefit of the CLC. Her involvement dates back to 1986 with

membership in CLC and the Association for the Care of Children in Healthcare. She has been a remarkable leader, serving as chair of the Publications Committee, adjunct reviewer for the Conference Planning Committee, chair of the Conference Planning Committee, a member of the Leadership Development and the Education and Training committees, and was previously secretary on the Executive Board of CLC. Kat has been a presenter at numerous CLC conferences and has been the co-chair of the South Central Regional Child Life Conference. And this list is by no means the complete story.

Over the past several years, Kat has participated in a partnership program with Emanuel University in Oradea, Romania where she has provided education and training for medical, social work, and child life students as well as hospice staff. She has also served as an adjunct professor in child life at the University of North Texas.

Outside of child life, Kat enjoys hiking, travel, reading, and socializing with friends. Always one to share credit for her incredible story, Kat is very grateful to the Child Life Council and to her current supervisor, Jill Koss, MS, CCLS. Kat Davitt exemplifies the rich tradition of clinical excellence and selfless service to patients and families and Mary Barkey would be justifiably proud.



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AUGUST

- 13 CLC Webinar – Difficult Conversations Do Not Come With a Script: Adapting to the Unique Needs of Families at End of Life
- 15-30 Child Life Professional Certification Exam Administration Testing Window

SEPTEMBER

- 17 CLC Webinar – Co-Creating Meaning: Loose Parts in the 7th Dimension
- 20 Deadline for applications for the November 2014 computer-based Certification Exam Administration

OCTOBER

- 1 Deadline to submit articles for consideration for Winter 2014 issue of *Bulletin* and *Focus*
- 15 CLC Webinar – Promoting Quality Play in Medical Settings in a Media-Saturated World
- 15 Deadline to withdraw from November Administration of the Child Life Professional Certification Exam
- 31 Late Deadline to recertify with Professional Development Hours (late fee and additional paperwork required)

NOVEMBER

- 1-15 Child Life Professional Certification Exam Administration Testing Window
- 3 21st Annual Child Life of Greater New York Professional Development Conference
- 19 CLC Webinar – Teaching Child Life

Upcoming Events

SEPTEMBER 19-21, 2014

**FLORIDA ASSOCIATION OF CHILD LIFE PROFESSIONALS
23RD ANNUAL CONFERENCE
NAVIGATING UNCHARTED WATERS**

Hyatt Regency, Miami, Florida

For information, visit: www.faclp.org

SEPTEMBER 20, 2014

**MOUNTAIN WEST CHILD LIFE ASSOCIATION
2ND ANNUAL CONFERENCE
(FOR PROFESSIONALS & STUDENTS)**

CHILD LIFE ELEVATED

Salt Lake City, Utah

Contact: Stephanie Steed at stephanie.steed@imail.org or (801)285-1663

For information, visit: www.mwclassociation.wordpress.com

NOVEMBER 3, 2014

**21ST ANNUAL CHILD LIFE OF GREATER NEW YORK
PROFESSIONAL DEVELOPMENT CONFERENCE**

New York Academy of Medicine, New York, NY

Contact: Nicole Almeida at nalmeida@winthrop.org or (516) 663-2761

For information, visit: www.CLGNY.com

NOVEMBER 8 - 9, 2014

19TH ANNUAL MIDWEST CHILD LIFE CONFERENCE

Children's Hospital of Wisconsin, Milwaukee, WI

Contact: Megan Massey at mmassey@chw.org or (414) 266-8525