CHILD LIFE IN HOSPITALS

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Theory and Practice

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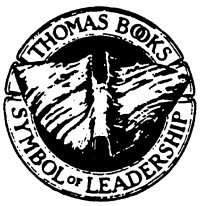

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To Our Parents

FOREWORD

The past twenty years have yielded a significant increase in the number of child life programs in North America, although there are still many pediatric settings lacking this important service for their patients. This growth and the expectation that other child life programs will be initiated underscore the need for this book.

Child Life in Hospitals presents an exciting and fresh approach to child life programming. The authors skillfully demonstrate through carefully selected case studies, pertinent bibliographical resources, and personal experience the emotional needs of the hospitalized child and his or her family, while confronting the reader with the realities of administrating a child life program.

But this book is not an activities primer, as the authors recognized that there are other resources which provide this information. They instead involve the reader in trying to understand the need for a child life program, the mechanics of establishing one, its place in the hospital hierarchy, methods of evaluating the program, and even a description of the procedure for making a cost/benefit analysis of this kind of programming. A familiarity with this knowledge increases the child life professional's political awareness of hospital administration realities.

Chapters are built on a theoretical base with thorough discussions of a variety of topics, including the elements of play, the perceptions of children, determinents of emotional upset in hospitalized children, and the importance of family involvement. The book abounds with practical aids for the child life professional. There are specific guidelines, for instance, involving the training of volunteers, the use of space, preparation techniques, effective chart notation, control of entertainment on the unit, and communication with children. Not only is this invaluable for individuals who plan to implement child life programs, but also for those eager to improve their existing programs.

It serves a greater audience than just the child life group, however. Hospital personnel of many disciplines will use this book to learn more about the field of child life as well as gather additional valuable information about the needs of hospitalized children and families. Instructors and students in the college-based programs which focus on the child life profession will find this excellent as a text for the course because of its orderly and comprehensive coverage of the subject.

Child life has made significant strides over the recent decades, not only helping children and their families experience improved care in pediatric settings but also in the evolution of the child life profession. The tools, techniques, and guidelines described by these authors make a substantial contribution to ensuring the continuation of this growth.

Jerriann Myers Wilson

CONTENTS

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CHAPTER 1

WHAT IS A CHILD LIFE PROGRAM?

DAVID: A CHILD ENTERS THE HOSPITAL

David was an active, engaging four-year-old who lived with his parents and seven-year-old brother, Phillip, in a small second-floor flat a few short blocks from downtown. David's mother had repeatedly cautioned against running in their crowded apartment, but such warnings were apt to slip from David's mind, especially when Phillip was in pursuit.

The afternoon of the accident Phillip imagined the fleeing David to be a halfback who must be stopped before reaching the goal line of the kitchen door. David was pleased by his own speed and agility. Easily avoiding the advances of his brother, he sped toward the door, flashing a victor's smile over his shoulder. The eyes of a disappointed Phillip widened with apprehension as he watched David sprint toward an inevitable collision with his mother, who was just emerging from the kitchen with a coffee pot in her hand.

David received extensive burns to his right hand and forearm. The physician at a neighborhood clinic who treated the burns determined that they were not severe enough to warrant hospitalization. David could remain at home, but he had to return daily to the clinic for treatment. He did so for several uneventful days.

Five days after the accident, David perceived something different in the way his parents were acting. They looked very worried and held hushed conferences frequently. David wondered if they were talking about him. Were they concerned about his hand? Were they mad at him?

That evening Mother and Father called Phillip and David into the kitchen. The anxious boys took seats at the table and listened to words they did not fully understand. The family had been evicted from their apartment. They would have to leave immediately and stay with friends until new accommodations could be found. David's mother had discussed their situation with the clinic doctor, who felt it best that David be treated as an inpatient until the family was settled in a new apartment.

Late that evening, accompanied by his father and his stuffed dog, David entered the unfamiliar territory of the local hospital. He watched in withdrawn bewilderment as people he had never seen before placed a name bracelet on his wrist, weighed him, stuck his finger with a needle, and dressed him in pajamas that were not his. The frightened David

submitted to this treatment without protest, for fear of making the strangers even more angry with him.

To minimize the possibility of infecting his burns, David was placed in a protective isolation room near the end of a long corridor. His father was allowed in the room, but was required to wear a yellow gown over his clothing. Anxious to return to the search for a new apartment, David's father soon left.

David sat quietly on his bed, slowly surveying the room. Its pale green walls were slick and bare, except for a sink, a closet and a small window. A silent TV was mounted high on the wall in the corner of the room, but David didn't know how to operate it.

Lonely and terribly frightened, he began to cry to himself—but very softly. Perhaps if he cried too much, these strangers would become angry, and he couldn't risk that. Why was he in this place, David wondered. Was it because he had disobeyed? Would he ever find his way to his family's new home? Would he see Phillip again? After what seemed like hours of questions and worries, David fell asleep.

Through the Eyes of a Child

Every child who enters the hospital has a story such as David's. Each must leave the familiarity and security of a home setting and endure some degree of separation from family and friends. Each must submit to various procedures, some of them painful, performed by strangers. Normal patterns and routines such as meals, school, and play must be modified or abandoned.

Despite having much in common with the stories of other children's hospitalizations, David's story was obviously unique. A number of factors such as his home situation, his previous experiences, level of development, and his personal resourcefulness influenced his reactions and adjustment to the hospital setting. The circumstances surrounding David's admission to the hospital and the cognitive immaturity of his preschool mind led David to develop many misconceptions about his treatment.

The preponderance of evidence indicated to David that the purpose of this hospital experience, with its frightening machinery and oddly garbed people inflicting pain, was to punish the young offender. The logic of his thought is undeniable. He had been injured while running through the house, an act expressly forbidden by his mother. Although briefly allowed to remain at home, David suspected that all was not well with his parents. His fears that they were displeased with him were confirmed when his father took him to the strange building. There Father stood in silent approval of the pain and humiliation inflicted upon David. Ultimately, David was placed in a solitary "cell" and was abandoned by his father. True, Father had said that Mother would come in the morning, but could he really be trusted at this point?

David and the thousands of other children who annually enter the hospital develop many secret fears and fantasies, often far too scary to share with other people. Some, such as David, fear punishment or abandonment by parents, while others are more concerned about physical limitations caused by disease, or about their own mortality. The misconceptions generated by a young mind may be so ominous that they interfere with medical treatment. For example, a child who is convinced that anesthesia is a means of inducing death rather than a benign unconsciousness will understandably fight fiercely to avoid submission.

The fantasies of other children may be incapacitating, causing them to comply in an almost unnatural way with all procedures, for fear of being subjected to even worse terrors. David was viewed by the staff as a "model patient." Although he appeared withdrawn and never smiled, he was marvelously cooperative, sitting stoically through sometimes painful procedures. Such behavior may appear preferable to the angry protests of other patients, but the anger repressed during hospitalization may surface later in less desirable forms. For example, upon returning home David frequently wet the bed, cowered at the sight of strangers, and never wandered more than a few yards from his mother's side.

CHILD LIFE INTERVENTIONS

Because of the serious and long-term consequences of children's adverse emotional reactions to hospitalization and other medical encounters, health care facilities throughout North America have developed deliberate interventions to minimize the stress and anxiety experienced by children and to assure optimal growth and development. These interventions often comprise what are called *child life programs* (but which also may carry the names children's activity programs, play therapy, pediatric recreation, and child development programs).

The importance of such programming is underscored by the fact that child life services are now mandated by the American Academy of Pediatrics (1971):

> There is a large and scientifically respectable body of literature which bears directly on this problem. Almost all of this literature supports the idea that the hospital experience is upsetting and that this upset extends into the post-hospital period. Therefore, it is mandatory that each pediatric service concern itself with this problem and institute specific programs to ameliorate or prevent psychologic upset in the child (p. 51).

Administrators of hospitals that are members of the National Association of Children's Hospitals and Related Institutions (NACHRI), when surveyed by McCue et al. (1978), also indicated the importance of child life programming. Eighty percent of the administrators said they con-