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The purpose of the study was to survey, by means of a questionnaire, the director and/or staff members of hospital play programs in the United States to ascertain information for developing a curriculum model for preparation of hospital playroom personnel. The questionnaire was designed to assess the educational background and training preferred for this position. Information was also collected regarding responsibilities of personnel, policies, and play activities in hospitals.

Questionnaires were mailed to hospital playroom directors listed in the directory of the Association for the Care of Children in Hospitals. Of the 172 questionnaires distributed, 122 (72%) were returned to the investigator.

Since the survey was conducted using a total population, rather than a random sample, percentage analysis was the technique used to analyze the data. The results of the data were discussed on the descriptive level.

Academic preparation of hospital play personnel was most often in the disciplines of child development, education and recreation. Included in the list of preferred training was a background in normal child growth and development, children's

reactions to illness and hospitalization, and activities that were appropriate for different age and developmental levels. A curriculum model was developed for undergraduate students majoring in child development for a career in hospital playroom programs.

A CURRICULUM MODEL FOR ACADEMIC PREPARATION OF HOSPITAL PLAYROOM PERSONNEL

by

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Approved by

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CHAPTER I

INTRODUCTION

The physical and psychological aspects of illness and hospitalization of the young child have been noted in the literature. Although many researchers have written articles concerning the hospitalization of children, in more recent years there has been a marked trend in the care of the "total" child who is part of a family unit rather than in treating the symptoms of an isolated physical being (Robertson, 1962).

Much has been written, from a variety of sources, about the effects of illness and hospitalization on children. Young children frequently develop an intense separation anxiety in a hospital environment, particularly if the hospital rules force the mother to leave the child (Haller, et al., 1967). Hospitalization has been interpreted by older children as punishment for misdeeds (Beverly, 1936), and anxiety is increased when there is fear of body mutilation resulting from intrusive procedures and surgery.

Recognized leaders (Frank, 1968; Hartley, et al., 1952; and Jolly, 1969) have pointed out the values and uses of play for both the well and the ill child. Play is purported to

decrease the child's anxiety in the hospital environment (Davidson, 1949). Play programs are believed to provide a link in maintaining the continuum of growth and development while the child is hospitalized even for a short period of time.

Various disciplines concerned with the welfare of children have become aware of the need to coordinate and provide non-medical services for the hospitalized child and the outpatient pediatric patient. Personnel involved in providing for these needs include child-life workers referred to in the present paper as hospital playroom personnel. These staff members represent diverse educational and training experiences with children. As the number of hospitals providing programs for play experiences increases, the need to develop a curriculum for students who will be involved in helping children deal with the traumatic effects of a hospital stay is of utmost importance.

According to Prugh (1953), studies that are carefully controlled have been difficult to conduct in the hospital environment. In studying the emotional distress exhibited by 14-36 month-old hospitalized children, Branstetter (1960) attributed the cause to a need deprivation resulting from a

lack of mothering care rather than from anxiety. To alleviate emotional stress, he suggested an environment which would promote interaction with others rather than one which encourages the child's tendency to withdraw.

In England during the late twenties Sir James Spence encouraged admitting mothers to the hospital along with their toddlers and infants (Robertson, 1962). He was convinced that mothers should not be regarded as "awkward appendages" to the child. Instead, he noted, parents contributed immeasurably to the child's happiness and mental health during hospitalization. The practice of mothers rooming-in with their children became well known throughout the world, but it took almost thirty years before the example was followed by other hospitals.

In a survey conducted in the United States, Hardgrove (1968) found that only 28 out of the 5,000 general hospitals responding permitted parents to spend the night with their children. In this same study 20 out of the 132 children's hospitals reported the rooming-in practice.

Heavenrich (1963) stated that

> trauma to the hospitalized child is determined by age, emotional and social maturity, security in the home, prior concept of illness, and the actions, attitudes, beliefs,

and superstitions of parents, friends and those about him including hospital personnel (p. 42).

Objectives of the Study

One objective of the present study was to gather data from the directors and/or staff of hospital play programs in the United States regarding: (a) the educational background of hospital playroom personnel, (b) the activities most often used in hospital playroom programs, (c) the responsibilities of hospital playroom staff members, and (d) the education and skills preferred and/or needed for assuming the position of a hospital play program staff member.

A second objective was to analyze guidelines and standards used in hospital play programs in the United States.

The third objective was to formulate a curriculum for students majoring in child development and preparing to assume the role of a hospital playroom staff member.

Limitations

Although many hospitals have non-medical programs for children, the target population for the present study was restricted to hospital playroom programs listed in the directory of the Association for the Care of Children in Hospitals (ACCH).

Assumptions

In establishing bases for the present study, it was assumed that academic preparation was a criterion for the playroom staff member.

Definitions

For the purpose of clarification the following terms were defined for the present study:

Play. Activity supplemental to primary care.

Hospital Play Program. An area within the hospital that is staffed and equipped to provide pediatric patients with supervised play experiences.

Child-Care Worker.

> ....is a person on the clinical team who is responsible for the children at play and at meal times, or in the hospital school, but is not involved in nursing function as such, though she may help prepare children for medical procedures or surgery through such activities as dramatic play or earnest and factual conversation in the playroom (Plank, 1971, p. 7).

CHAPTER II

REVIEW OF LITERATURE

Children's reactions to hospitalization and illness have been well documented in the literature. Preschool children react most often to maternal separation whereas school-age children fear bodily harm and mutilation. Adolescents, concerned most often with autonomy and physical appearance, are quite anxious and their self-esteem suffers a crushing blow (Schowalter, 1971).

It appears that various disciplines concerned with the welfare of children have become increasingly aware of the potential effects of illness and hospitalization on children. In the not too distant past, many persons who worked with hospitalized children appeared to believe they had done all that was necessary when they had treated children for their diseases. Little, if any, consideration was given to the child's emotional, mental, or social needs. That viewpoint has been challenged by a number of research studies.

Reactions to Illness

Children who were ill were treated at home for minor maladies. Hospitalization became necessary only for acute,

"life and death" type conditions. The ill child, described by Langford (1948), experienced many new and strange feelings which were poorly understood by the child:

> He does not feel well, understands little of why he has become sick, is irritable, and perhaps wants to be left alone. His own anxiety is often intensified by that of his parents, who may become guilty and anxious about their own part in the production of the illness and their failure to have prevented it. The usual amount of parental concern and fussing may well be increased if the illness is not a clear-cut one (p. 242).

The meaning of a specific illness to a particular child depends upon a large number of factors in his past experiences and on the attitudes of his parents. There are some things which are common to most children who become sick and which affect their attitudes and reactions toward the illness.

Beverly (1936) reported that 90 per cent of a group of children at the Children's Memorial Hospital in Chicago stated that they got sick because they were "bad". Beverly concluded that, to most children, sickness comes as punishment for their misdeeds or was caused by disobedience of parental commands.

Langford (1948), from his observations of ill children, reported regressive reactions to an earlier level of emotional and social adaptation as being part of the personality reaction

to almost any illness. "The younger the child at the time of the illness, the more quickly the regression occurs" (p. 245).

Schwartz (1971), who interviewed fifth-grade students in an elementary school in New York to determine how children perceived pain, found that fears of physical harm were quite characteristic of school-age children. Mussen and Kagan (1969) stated that "all children in middle childhood have problems with anxiety, frustration, and conflict" (p. 515). These problems would be transient and limited in severity if the child's parents provided good role models, were warm and accepting, and were consistent and flexible in their disciplinary techniques.

Reactions to Hospitalization

Hospitals are a type of institution and children requiring admission to these institutions are usually quite ill and require different tests and procedures to facilitate an accurate diagnosis. The discomforts and pain that ensue testing, and sometimes surgery, serve to compound the acute anxiety the child experiences following the separation from home and family.

When a child is hospitalized, even for a short period of time, the experience can have long-term effects on his emotional growth, especially if he is under four years old

(Millar, 1970). During this period of rapid growth and development the child has difficulty dealing with hospitalization without the possibility of damage to his growth process. Millar, a child psychiatrist, described the hospital setting as being filled with strangers, a place where the child is subjected to unusual procedures, many of which induce pain, and the child's usual routine has been terminated.

Robertson and Bowlby (1959, 1960) defined three stages of reaction to hospitalization by children. The protest stage, lasting a few hours to several days, consists of loud and frequent crying by the child who is reacting to the loss of the mother. In the next stage, despair, the child becomes withdrawn and inactive. Many times his behavior is erroneously interpreted as his having become adjusted to the hospital environment. During the final stage that Robertson called denial and Bowlby termed detachment, the child appeared happy, but completely ignored the visiting parent.

Burling and Collipp (1969), using electrodes attaches to the neck and chest of patients, measured emotions of 13 children whose ages ranged from 15 months to 10 years. Pulse rates changed or increased during intrusive procedures and physical examinations. Little change in pulse rate occurred when nurses

entered the room and parents visited. The data indicated that pulse rates of children between the ages of 15 months to 4 years were affected twice as much as the pulse rates of the group from 4 to 10 years of age. This information again points out the added impact of hospitalization upon the emotions of younger children.

Spitz (1945), in a classic study, conducted a survey comparing infants in two institutional settings in England with infants residing in the parents' homes. One group of institutionalized infants fell far behind the other institutionalized group in test scores (intelligence quotients) at the end of the first year. The difference was attributed to the higher-scoring babies having had more physical contact with both the mothers and other personnel and a wider range of visual and motor stimulation. The slower group of babies had more sickness, even with excellent hygiene and prevention of contagion. Even though Spitz's research was not well controlled, it emphasized the need for something beyond genetic endowment to grow sound physically and emotionally.

Prugh and associates (1953) studied the reactions of two groups of hospitalized children regarding specific treatments or procedures. The experimental group of 50 children, ranging in age from 2 to 12 years, was exposed to a program

of daily visiting from parents, emotional preparation and support before treatments, a play program, and liberal policies regarding activity. The control group, which corresponded in age, sex, and diagnoses, did not have the benefit of the same routine. Severe reactions, consisting of crying, urinary frequency, vomiting, diarrhea, depression, and clinging behavior, were present more in the control than in the experimental group. This reaction behavior continued to be present in some of the children in the control group for as long as three months following discharge from the hospital.

Illingworth (1958) suggested that the length of hospitalization was also a determining factor of trauma and that the shorter the child's stay in the hospital, the less likely he was to suffer any lasting psychological harm.

In another study in England, Vaughan (1957) reported that children under three were more prone to eating and feeding problems, toileting difficulties, fear of the dark, thumb-sucking, aggressive behavior, and withdrawal because of their separation from the mother or primary care giver. Four to six year olds were prone to vomiting, diarrhea, and dizzy spells when their anxiety increased. As the children became older, their concern was related to pain and bodily harm. The common

finding in the Prugh (1953) and Vaughan (1957) studies was that the distress of younger patients, under four years of age, could not be alleviated if the mother was absent.

Fagin (1964) studied the effects of rooming-in and visiting mothers. In the experimental groups mothers were allowed to stay with their hospitalized children. The mothers of the children in the control group visited their children daily. Behavior of the children in the control group showed regression in behavior, emotional dependence, eating patterns, sleeping routine and toileting. The results were in favor of rooming-in as an aid to adjustment.

Fifty children, in two hospitals in the Boston area, were interviewed during the first week of hospitalization in an effort to learn more about their views of the hospital world (Adams, et al., 1965). Pictorial drawings were used to elicit feelings and beliefs from 20 boys and 20 girls between the ages of six and nine years of age. The interviewer asked the children to give reasons for being in the hospital, what happened in the hospital, and what constituted "good behavior". The children showed a marked trend toward conformity and described acceptable behavior as following the rules and not complaining. The researcher emphasized that prolonged hospitalization coupled with conforming behavior in this age

group could contribute to an interruption of normal growth and development. Adams also pointed out that these children have a normal desire "to please" and this desire could be used in a more constructive manner such as learning more about health and health practices during the hospital stay.

Schowalter and Lord (1971) suggested that adolescents were especially vulnerable to regression and feelings of depersonalization as a result of illness and hospitalization. They wrote that "when an adolescent who has just begun to make decisions for himself is hospitalized, he finds the enforced passivity and loss of autonomy very humilating" (p. 127). The loss of control and frequent and embarrassing physical examination served to undermine the adolescents' sense of pride and sexual identity.

An adolescent unit was started at Boston Children's Hospital in the early fifties with the basic approach aimed at making hospitalization a positive experience. Voluntary group meetings held daily were for the purpose of discussing a variety of subjects ranging from food preferences to death. At staff meetings observations were pooled and were used to help identify behavior characteristics that in turn facilitated approaches to management and planning after-care of the adolescent.

Following two years operation of the adolescent unit at Boston's Children's Hospital, a study of 200 semistructured interviews was conducted (Schowalter, et al., 1971). One hundred randomly selected patients and their parents were interviewed in an effort to determine reactions of parents and patients to the adolescent unit. The study emphasized the value of group meetings in determining the feelings of adolescents that were hospitalized.

Play

The values and uses of play have been cited by many recognized leaders concerned with child care and development. In play the child is involved in self-expression and self-discovery by exploring and experimenting with movements, sensations, and relationships (Hartley, et al., 1952).

Erikson (1940) suggested that children used play "to make up for defeats, sufferings and frustrations, especially those resulting from a technically and culturally limited use of the language" (p. 561). Faulty conceptions of play have often resulted in inadequate provisions for the needs of children in hospitals. Regarding play only as amusement or diversion leads to passive participation in play by the child.

There are many theories dealing with the reasons for play.

Ellis (1973) identified the theories of play and categorized them into two divisions, classical and dynamic. Classical theorists try to explain why people play, whereas dynamic theorists accept that people play, and they try to explain the process involved.

According to Ellis (1973), classical theories of play include the following: (a) surplus energy, (b) relaxation, (c) pre-exercise, (d) recapitulation, and (e) instinct. The surplus energy theory postulates that the energy of the organism is either goal directed (work) or goalless (play). Therefore, play occurs when the organism has more energy than it needs for work. The relaxation theory embraces the belief that play is used to replenish expended energy. This theory would explain better why adults play since children do no "real" work. Ellis (1973) explained the pre-exercise theory as being practice behavior in preparation for future work or adulthood. Recapitulation "play" allows children to participate in earlier stages of the cultural development of the race. According to Ellis (1973), play that is viewed as instinctive is seen as the tendency to emit behavior when none of the more powerful instincts are at work. More modern theories of play are termed dynamic. Two dynamic theories of play are derived from psycho-

analytic psychology and from Piaget. Psychoanalytic theory considers play a cathartic activity which furnishes the child the opportunity to express and master difficult situation (Ellis, 1973).

Play is a natural medium for communication in children (Senn, 1945). It permits a child to tell things about himself, about his physical abilities, and about his feelings. Diversional and occupational play should be provided for each child in keeping with his physical, intellectual, and emotional needs.

Piaget (1962) suggested that, as a result of increased cognitive complexity of the child resulting from development, the complexity of play would increase with time. "Games with rules increase in number, both absolutely and relatively, with age. They are almost the only ones that persist at the adult stage" (p. 146).

Neumann (1971) analyzed the literature on play and concluded that play could be judged by three criteria: control--internal control is play, external control is work; reality--suspending reality and pretending is play, activity tied to the real world is work; and motivation--if activity is internally motivated, it is play, as soon as

motivation is external, it stops being play.

"As play is the principal, normal medium through which children meet their emotional and social needs it continues to be most important when the child is in the hospital" (Dimock, 1960, p. 67). Even though carefully planned, not all play will provide emotional release. To be effective as a means of emotional adjustment, the play program must be formulated with the child's need as the central objective. Spodek (1974) stated that children can

> play out personally painful occurrences and by mastering pain in fantasy come to grips with it in reality. The same mastery of fantasy can allow children to cope with the affective elements of more positive life situations as well (p. 18).

The Piagetian view regards play as representation. According to Spodek (1974),

> once a child represents the outside world, the elements within it can be manipulated using the processes of assimilation and accomodation. Play then becomes an intellectual activity (p. 19).

Frank (1964) stated that "play is a universal activity, not only by children but by adults" (p. 434). He further enlarged upon this concept and explained that through play children are actually seeking to cope with the world around them.

Play as a part of early childhood education has evolved within the last fifty years. Hurlock (1934) was one of the first writers to present a survey of literature concerning play. She listed four classifications of play in the literature: (a) babyhood, (b) childhood, (c) youth, and (d) adolescence.

Davis (1965) identified and listed four types of play: random, imitative, imaginative, and reflective. He suggested that there were four elements of play which helped in the forming of a child's personality. These elements are the physical and manipulative involvement, the emotions and expressions of moods, the verbal responses, and the mental impressions. These types of play are most easily identifiable in the behavior of preschool children.

Hospital Play Programs

Plank (1971) suggested that the concept of comprehensive care of the hospitalized child has become more widespread and efforts have been made to put this theory into practice by providing programs designed to occupy and amuse children. Realization of the need for special training and skills unique to the child-care worker is not so generally realized.

Plank stated that "the success of such a program is dependent upon the caliber of people conducting it and there are presently few who are adequately prepared" (p. 5).

In the literature play programs in hospitals are described by various authors (Azarnoff, 1970; Brooks, 1969; and Tisza, 1961) from many different frames of reference. References to programs were made using such terms as these: child guidance, child life, children's activities, education, education and recreation, group guidance, occupational therapy, play, play therapy, and recreation programs. Objectives of these programs were as varied as the backgrounds of the people who directed them.

As a result of her study concerning play for the hospitalized child, Davidson (1949) suggested that an effective play program

> must be formulated with the child's need as the central objective; it must be so developed as to afford him a maximum of creative opportunity; and it must be so organized that it is available to the child at the time when he feels the need of it (p. 18).

Activity programs in the hospital environment have been created in an attempt to coordinate and provide non-medical services that contribute to the comprehensive care of the

hospitalized child. Personnel in these activity programs have diverse educational backgrounds but possess a common goal: providing an atmosphere that contributes toward a positive experience, which aids normal growth and development of those children entrusted to their care.

Most hospitals have had programs designed to occupy and amuse children and, in some instances, these programs have been quite elaborate. However, according to MacLennan

> the concept that there is need for special training and skills unique to the child-care worker is not so generally realized. The well intentioned volunteer who likes children still has her place, but it would seem that the needs are greater than she can fulfill. It is our contention that child care in the hospital should be under the direction of persons who have had experience and training in child development (both psychologic and physical), education and diversional techniques. They must also have sufficient understanding of medical matters and the administrative structure within the hospital so that they can function comfortably in the hospital environment (MacLennan, 1949, p. 209).

Although the number of hospitals and medical facilities has increased through the years, internal changes have come about slowly because of practices that have become traditionally accepted by personnel, patients, and families.

Brooks (1969) suggested that play-program personnel have a thorough knowledge of child development, have previous

training and experience in working with children both in groups and individually, have physical and emotional resilience, and have the ability to work cooperatively with other adults of many different backgrounds and levels of training. She also suggested that every effort should be made to secure people who respected the importance of play in a child's life.

Bakwin (1951) perceived the hospitalized child as needing a unique program of play designed to meet his limitation. Senn (1945), commenting on play, stated

> In children, play is a natural medium for communication. It permits a child to tell us things about himself as a person, his physical abilities, and his feelings. It enables him to try out physical energy, to experiment with newly discovered endowments, and at the same time to gain something psychotherapeutically as he related his experiences and emotions to others. It brings relaxation and rest, diverts the mind from stress, and acts as a safeguard against the development of undesireable habits such as excessive thumbsucking, masturbation, and daydreaming, through providing opportunity to express tension, anger, and resentment. Opportunities for diversional and occupational play should be provided each child in keeping with his physical, intellectual, and emotional needs (p. 28).

The value of play to the child has been equated with the achievement and expressive values of work for the adult. Kangery (1960) described the child's play as "a response to his emotional urges and needs" (p. 1749).

Azarnoff (1970), in her description of a play program in a pediatric clinic setting, explained the basic purpose of the program was to create an atmosphere that established a sense of trust in the child and his family. By-products of the pleasant surroundings included a decrease in anxiety and misbehavior. The medical staff was afforded the opportunity of observing the children and their families, an opportunity which added another dimension to the children's total care plan.

Billington (1972) described the hospitalized child and play when he stated

> The child in the hospital is a stranger in a strange world. His loneliness and apprehension, besides affecting his mental state, can also impede his medical progress. Organized play can help effect a feeling of calm, relaxation and security; ease homesickness; relieve nervous tension, and serve as an outlet for constructive ideas and activities. As the children become more relaxed, they make fewer demands on the nurses for attention and reassurance, and the entire pediatric unit takes on an atmosphere of controlled care (p. 91).

To lessen the child's adverse reaction to the hospital experience may be only part of the broader objective of assisting in the continuation of the child's normal developmental pattern. Tisza and Angoff (1961) perceived this developmental pattern as a determinant of the atmosphere of the total play

program. Basing their theory of play activity on a program established at the Boston Floating Hospital, they stated that "the freedom and activity of the playroom places the emphasis on the healthy part of the child" (p. 300).

Summary

Examination of the literature revealed special problems and needs of hospitalized children. Children's reactions to illness and hospitalization have been well documented. In the face of hospitalization, preschool children react most often to maternal separation whereas school-age children fear bodily harm and mutilation.

"The child over seven or eight loses contact, even during brief periods of hospitalization, with what seems to be the most important thing in his environment, namely school" (Haller, et al., 1967, p. 6). On the other hand, adolescents, concerned most often with autonomy and physical appearance, are quite anxious when hospitalized because their self-esteem suffers a crushing blow (Schowalter, 1971).

The value of play to the hospitalized child was also recognized (Frank, 1968). The use of play techniques in pediatric units appeared to be meeting many of these special

needs. Play programs in the hospital environment have been created in an attempt to coordinate and provide non-medical services that contribute to the comprehensive care of the hospitalized child. There were two areas of play that were considered: an input area for enrichment and an output area for expression.

In addition to in-patient play programs, other innovations have been introduced such as tutoring of school-age children, pre-hospitalization tours, provisions for outpatient playrooms, pre-operative play for children, and parent education groups.

In light of this review, there is evidence of a need for a concentration of subject matter within the child development curriculum for training hospital playroom personnel.

CHAPTER III

PROCEDURE

There were three purposes for this study: (a) to gather data from personnel in hospital play programs regarding their educational background, activities offered in hospital play programs, responsibilities of staff members, and the educational background and skills that staff members felt were necessary for their jobs; (b) to analyze the guidelines and standards used in hospital play programs; and (c) to formulate a curriculum model using the results of the data, for child development students preparing to assume the role of a hospital playroom staff member.

To achieve the purposes of this study, the investigator followed these steps: (a) selection of the target population; (b) development of the questionnaire; (c) distribution of the questionnaire; (d) analysis of the responses; and (e) suggestions for a curriculum model.

Selection and Description of the Target Population

In 1965, the Association for the Care of Children in Hospitals (ACCH) formed a group composed of professionals and non-professionals interested in the social-emotional welfare of

hospitalized children. In the years following formal organization, members have contributed in setting guidelines and standards for hospital play personnel. A directory (see Appendix C) was compiled in 1975 of hospital play programs in the United States and Canada. Since this comprehensive list was available through ACCH, it appeared that this list would be representative of the play programs throughout the country, only if all these programs (U.S.) were included. Play programs in Canada were not included because medical services are offered through National Health Services funded by the government. Since medical services of the United States operate differently, play programs of Canada were eliminated from the list.

Programs listed by this organization have as their aim to provide comprehensive child-centered care through therapeutic play and recreation.

Instrument

There was not a readily available instrument by which a survey of play activity centers could be made. A 28-item questionnaire was developed and distributed by the investigator (see Appendix A).

Development of the Questionnaire

The items included in the questionnaire resulted from the investigator's reading and experience in a play program at a local hospital. The information collected by this questionnaire concerned these areas: (a) information about the hospital, (b) information about the playroom staff members, and (c) information about hospital playroom programs.

The questionnaire was first distributed to two groups that included these people: (a) senior students who were majoring in child development and currently were enrolled in hospital play programs, and (b) faculty members who were currently teaching in the field of child development. The group was asked to determine if the directions and items contained in the questionnaire were understandable and comprehensive. No changes were recommended; thus the questionnaire was ready for distribution.

Distribution of the Questionnaire

A letter (see Appendix A) was sent to the directors of each program in the United States listed in the ACCH directory. A total of 172 letters, questionnaires, and stamped envelopes for return mailing were sent in mid-February, 1976. The

respondents were requested to complete and return the questionnaire to the investigator by March 5, 1976. A total of 122 questionnaires were returned within the time designated.

Analysis of the Responses

The summary of information derived from the present study was divided into three categories: (a) information regarding hospitals, (b) information about hospital play programs, and (c) information about the staff in play programs. Because a total target population was used instead of a random sample of hospital play programs, percentage of response was the technique used to analyze the data. The results were discussed on the descriptive level to point out trends toward agreement among respondents. Comparative analysis was not used because the sample size would have been too small for descriptive information.

Of the 172 questionnaires that were mailed to hospitals with child life programs listed in the ACCH directory, 122 questionnaires were returned in time to be included in the present study. One respondent stated that the play program was in a clinic rather than in a hospital environment; therefore the questionnaire was not applicable to this analysis, and

results were tabulated using only 121 questionnaires. Because of the excellent response, it was not necessary to send follow-up letters requesting return of the questionnaires.

Developing a Curriculum Model

A model curriculum for undergraduate students majoring in child development was developed from the survey and questionnaire data. The recommendations from directors and personnel employed in hospital play programs as well as the suggestions from the literature that was reviewed were considered in designing courses to teach techniques of comprehensive non-medical care of the hospitalized child.

CHAPTER IV

RESULTS AND DISCUSSION

Data from the 121 completed questionnaires about hospital play programs, suggestions from the literature, and observations in several hospital play programs were used as the basis for developing a curriculum model for the education of directors of hospital play programs. The results of the questionnaire will be presented first. Then the curriculum model will be presented with the supporting rationale.

The responses from the target population participating in the study were categorized and reported under several different headings. The following paragraphs contain descriptive information regarding the hospital play programs of the respondents.

Hospitals

The hospitals were divided into two categories. Thirty-nine (32.2%) were children's hospitals and 81 (66.9%) were pediatric sections in general hospitals. Forty-nine (41%) of the children's hospitals had a bed capacity of 300 or less; 64 (55.4%) of the general hospitals with pediatric units had

75, or fewer, beds per unit.

Accommodations for patients were most common in the category of semi-private and ward rooms. Ninety (74%) hospitals used semi-private (two patients per room) and ward (four patients per room) accommodations for the patients. There were only two (1.7%) hospitals with all private rooms.

Type of hospital

There were 98 (81%) teaching hospitals, 27 (22.3%) private hospitals, and 14 (11.6%) that answered "other" type of hospital. Three hospitals did not complete this question. It can therefore be assumed that the most usual type of hospital represented in the present study was the general hospital with a pediatric unit having a teaching service.

Division of patients

Ten (8.2%) hospitals did not separate patients according to age or medical service. These hospitals were centers for one specific type of patient such as orthopedic patients, burned patients, or psychiatric patients. Seventy hospitals (57.9%) divided patients according to medical services which were dependent upon the admission diagnosis. Three hospitals

did not answer the question.

Visiting hours

Over half of the hospitals responding had flexible visiting regulations. Seventy (57.9%) hospitals allowed rooming-in. Several respondents, including information about rooming-in, stated that either the mother, the father, or an older sibling could stay with the child throughout the hospitalization. Some hospitals had an additional charge for this arrangement, but usually it was indicated to be a nominal amount.

Children are no longer automatically separated from their parents upon hospital admission. There is evidence that the rigid policies of hospitals are a thing of the past. Parents are encouraged to stay with their child and even participate in care-giving. Instead of being regarded as an intruder, the parent is encouraged to participate. The importance of rooming-in is recognized (Hardgrove, et al., 1968), and provisions are made for this practice in many institutions.

Television

Sixty-nine (57%) hospitals had televisions abailable, free of charge, for their patients. Forty-nine (40.5%) hospitals

had televisions but charged for the service. There were 44 (36.4%) playrooms that had access to a television, but many respondents noted that only "special programs" were viewed by the children under supervision, and even then, not on a regular basis. One respondent stated that the playroom had a TV, but that it would "soon be removed". Television, however, has its place in the life of a hospitalized child. Familiar programs may be the link between home and hospital.

Meals

Mealtime changes have also occurred. Instead of fostering isolated eating in bed, hospitals sometimes make arrangements for children to eat together in playrooms or other areas to permit socialization with peers, hospital staff members, and parents.

Forty-three (35.5%) hospitals did not have any dining area (either in the playroom or otherwise) for patients. Meals were served on trays in the child's room. Sixty (49.6%) hospitals had other arrangements for serving meals. Some of the other arrangements were these: 15 (25%) hospitals allowed all meals to be eaten in the playroom; nine (15%) permitted children to eat in the playroom "anytime". There were 10 (16.6%)

hospitals that served noon and supper meals in the playroom and four of these indicated that meals were served family style. In six (10%) of the 60 hospitals, only the evening meal was served in the playroom. Parents were encouraged to have coffee and eat lunch in the playroom in three hospitals. One hospital respondent indicated that staff members and parents ate together. Two hospitals allowed children to eat "sometimes" in the playroom. Snack time was the only eating arrangement in the playroom for one hospital. Picnics were managed at four (6.6%) hospitals. One respondent stated that neither meals nor snacks were served outside the primary care location, but staff (playroom) members were "struggling to change this practice".

Parents were allowed to eat in the playroom with their children in 21 (17.4%) hospitals. Twenty-four (19.8%) hospitals served only the noon meal in the playroom. This meal was served family style in the playroom in 10 (8.3%) hospitals.

The hospitals represented in this study seemed to have made giant steps in providing services other than primary care. Although changes had not resulted from overnight implementation, there was evidence of trends toward understanding the psycho-social needs of children and providing the best possible environment for the hospitalized child.

Play Programs

Of the 121 hospital play programs 97 (81%) hospitals had fewer than 20 children in the playroom at any one time. Sixteen (13.2%) hospitals had between 21 and 30 children, one in each category of 31-40 and 41-50. Only three (2.5%) had over 50 children in the playroom. Two respondents did not indicate an answer to the question.

Four (3.3%) playrooms were "open" but hours of the staff were not listed. Some respondents indicated that the playroom was open all the time under the direction of either the director or volunteers.

All playrooms were open during the weekdays. Fifty (41.3%) playrooms were staffed five days a week; 11 (10%) were staffed six days a week and 56 (46.3%) were in operation seven days a week. Several respondents indicated that playrooms were available on the week-end (under supervision) with the use of volunteer help and part-time staff members. This procedure was used when the number of full-time staff members did not exceed one person. Several respondents indicated that playrooms were open on all holidays and special occasions.

Therefore, it seemed that there was more than a trend of having playrooms available and staffed at whatever time the

hospitalized child chose to avail himself of the playroom. Playroom staff members are available in evenings, on week-ends, and holidays. By providing activities for children at their convenience, the hospital again minimized separation or loneliness. Volunteers are selected and trained for playroom and outpatient auxiliary help. Their roles and responsibilities have been explained which thereby would eliminate service on an "ad hoc" basis. Volunteers contribute immeasurably to a program that is short on full-time staff members; therefore, they constitute an integral part of non-medical services.

Activities

From the choices of activities listed in the questionnaire, all of the activities were offered in over half (50%) of the programs (see Question 20, Appendix A). All 121 (100%) programs offered art activities. In one hundred eighteen, or 96.7 per cent, of the hospital play programs, games were provided for the children's use. Also among high-ranking activities were building and manipulative activities such as tinker toys and blocks in 117 (96.7%) hospitals; 116 (95.9%) provided "messy" play experiences using media such as glue, clay, and water. Ninety per cent of the hospitals offered

crafts and included active play (throwing, beating, and punching) in the list of playroom activities. Doll houses and doll play were available in 106 (87.6%) play programs.

In addition to the activities listed in the questionnaire, some programs offered a wide variety of activities that included picnics, a trip to the zoo, movies, outdoor play, and video-tape programs. The number and range of activities offered represented creative programs that were a long way from structured or ordinary. Hospitals have included many positive experiences that contribute to the normal growth and development of hospitalized children (Azarnoff, 1975). Play programs have provided a relaxed, non-structured environment where few demands are made. In a situation that closely resembles the world outside the hospital, playroom personnel have included activities and learning experiences for children in order to minimize the effects of illness and separation from familiar routines and familiar activities.

Resource people

Play programs used resource people in three areas a great deal. One hundred fourteen (94.2%) programs were aided by a classroom tutor, and 84 (69.4%) had access to a psychiatrist.

Other resource people included a psychologist, a child development specialist, a recreation leader, and a health educator.

Sources of funds

Eighty-five per cent (103) of all reporting hospital play programs were financed directly by the hospital. Fifty-one (42.1%) derived funds from contributions. Hospital auxiliaries supported 38 (31.4%) programs; 15 (12.4%) programs listed "other" sources of funds such as money-making projects, grants, and endowments.

Organizational Structure

The majority of hospitals reporting, 42 (34.7%), were directly responsible to the nursing service. Twenty-nine programs (24%) answered to the chief of pediatrics; hospital administrators were in charge of 28 (23.1%) of the programs. Recreation departments controlled 12 (9.9%) of the hospital play personnel.

Being responsible to the "other" category was listed by 24 (19.8%) programs. That category included the director of social services, the hospital school, the department of occupational therapy, the director of volunteers, the director

of family services, youth development, and the department of psychology.

The general trend was for the play program to be responsible to the nursing service or the nursing service and the chief of pediatrics. One respondent added the comment that the play program was responsible to the nursing service, "Unfortunately".

Volunteers

Only two play programs, or 1.7 per cent, reported that volunteers were not needed. Most programs used volunteers, and 94 directors (77.7%) trained the volunteers that were to participate in the play program. Only 60 (49.7%) playroom directors were able to select volunteers. The average number of volunteers used in play programs was 10. It seemed that most programs used and were quite satisfied with volunteer help, although one director stated that "twenty volunteers, trained by the previous director, had been inherited".

Males in the Program

Males were reported to be part of 90 (74.4%) programs in the capacity of volunteers (47), staff members (33), and

students (10). Twenty-one programs had at least two male members involved in the program.

Playroom Staff

Most of the personnel in hospital playrooms had a child development or education background at the undergraduate level. Thirty-six (29.8%) playroom directors had backgrounds in education. Child development backgrounds were represented by 47 (38.8%) of the playroom directors. Other areas of education included 23 (19%) in psychology and 20 (16.5%) in recreation. An assortment (23 or 9%) of other backgrounds such as religious education, counseling, social service, English, recreation, child life program, and optometry were reported.

Directors with graduate degrees reported they were in child development and education. Thirty (24.8%) directors had a graduate degree in child development whereas 24 (19.8%) had a graduate degree from schools of education. The third highest group had 16 (13.2%) directors with a degree in recreation therapy. There were more directors with undergraduate degrees than directors with graduate degrees working in play programs, but the majority of playroom directors having graduate degrees were with backgrounds of child development and education.

Playroom staff members had backgrounds that included courses in normal child growth and development and experience with children of many ages and developmental levels. They were knowledgeable in age-appropriate activities and assumed responsibilities that were numerous as well as varied. It appears that in preparing for their position they have become aware of the emotional and psychosomatic disorders of childhood and methods of treatment.

Increased concentration on the emotional needs of hospitalized children has sharpened the insight of staff members and has stimulated them to devise methods of care that make possible a constructive adjustment to illness and hospitalization rather than one that results in psychic trauma.

Responsibilities

Although responsibilities of staff members varied from program to program, most programs incorporated the responsibilities in the questionnaire. Over 100 respondents included the following eight items in their programs. Selection of equipment was listed by 116 (95.9%) of respondents. Purchasing of equipment followed closely with 114 (94.2%) respondents.

The preparation of play materials in the playroom and for children in isolation was listed by 106 and 103 87.6% and 85.1%) programs, respectively. One hundred six (87.6%) staff members attended staff meetings and 105 (86.8%) directors or staff members trained and scheduled volunteers.

There were 37 responsibilities listed in addition to those included in the questionnaire. Among the responsibilities that were included in several programs were charting (10), conducting developmental testing (8), training of student teachers (7), acknowledging donations, special visitors, and favors (5), providing special activities and outings (5), and attending weekly staff conferences (4). One of the most unusual responsibilities, reported by one respondent, included home visits to parents of children who had died while hospitalized.

There was heavy emphasis on administrative duties from many aspects. Preparing budgets, participating in policy-making, and supervising volunteers were part of this breakdown.

Apparel

Ninety-four, or 77.7 per cent, of the playroom personnel wore street clothes during duty hours. Only 15 (12.4%) res-

pondents indicated that uniforms were used. Other programs (27 or 22.3%) combined street clothes with bright colored smocks or wore some identifying article of clothing that in no way resembled medical uniforms.

Training

Seventeen different types of training were listed (see Appendix A, Question 16) to determine specific kinds of training that playroom personnel had as background preparation for their present positions. Normal child growth and development was included in the background of 113 (93.4%) respondents. Only 78 (64.5%) indicated a background that included children's reactions to separation, illness, and hospitalization. Eighty-nine (73.6%) received background training in communication skills with children, parents, and families. Forty-eight (39.7%) respondents had background training in medical entities and terminology.

Serve as a Model Program

All respondents were asked if the program could serve as a "model program" and if so, in what areas. The majority of play programs, according to the respondents, could serve as

models. Sixty-eight (56.2%) listed four areas in which the present program could serve as a guide. These areas included activities (58 or 47.9%), rapport with other services (54 or 44.6%), staff members (45 or 37.2%) and playroom design (40 or 33.1%).

Suggested Curriculum

As early as 1949, MacLennan urged creation of a play program that would afford hospitalized children a maximum of creative opportunity and be available when needed. In play the child is in control of his world, and the dominant role is assumed. Play decreases the child's anxiety (Davidson, 1949), and provides a link in maintaining the continuum of normal growth and development.

Respondents in the present study were requested to indicate the types of training they believed should be included in the curriculum for play program personnel. Their suggested areas of training are listed as follows:

105	(86.8%)	Children's reactions to separation, illness, and hospitalization.
104	(86%)	Communication skills with children, parents, and families (verbal and non-verbal).
100	(82.6%)	Normal child growth and development

100	(82.6%)	Techniques of play therapy
98	(81%)	Chronic illness
98	(81%)	Acute illness
96	(79.3%)	Types, uses, and meaning of activities (recreational, physical, educational)
96	(79.3%)	Medical entities and terminology
92	(76%)	Knowledge of abnormal development and its implication
91	(75.2%)	Physical handicaps
89	(73.6%)	Emotional disturbances
88	(72.7%)	Mentally retarded children
87	(71.9%)	Environmentally deprived children
86	(71.1%)	Economically deprived children
86	(71.1%)	Minority groups
69	(57%)	Gifted children
67	(55.4%)	Techniques of testing

Many respondents listed additional areas to be included in a curriculum design. Some of these areas, listed in order of frequency, include the following:

15	Administration
12	Roles of other professionals in the hospital
10	Death and dying

8 Arts, crafts, dance, music (expressive arts)

8 Observational skills and transmitting observations to team in organized manner

7 Family variations, dynamics

6 Team concepts

6 How to cope with unpredictable crisis-ridden environments

5 Experience with normal growth and development

3 Nutrition and eating problems

3 Working with volunteers

3 Self-awareness

3 Adolescent behavior

3 Bookkeeping skills

2 Child abuse; drug abuse

2 Manual communication (deaf)

2 Staying within budget; funding

There seems to be a definite need for considering training for undergraduates majoring in child development and preparing to work in hospital playrooms. Requirements of colleges and universities in the United States that offer undergraduate child development programs have different

curriculum requirements; therefore, the proposed courses are only suggestions and could fit within the specific curriculum requirements of any college or university.

General background requirements would include a course or courses in English, physiology, psychology, social and behavioral sciences, math, health, physical education, and the humanities. An English course, or courses, would help students to organize and present observations and interpretations clearly and coherently both orally and in permanent form.

Physical science courses in physiology and anatomy are strongly recommended. Physiology would acquaint the student with normal body processes and the cause and effect of certain diseases. An anatomy course would be basic for medical terminology and would also serve as a foundation for building medical vocabulary and knowledge of specific diseases and conditions.

Behavioral and social science courses would include sociology and psychology. Sociology would provide the student with a basic knowledge of cultural patterns of the past and present. Psychology courses offer behavioral concepts and

interpretations. Both normal and abnormal conditions could be covered in this segment of background training.

Basic mathematics would contribute toward accurate record keeping of financial matters. Budgeting and bookkeeping were suggested as important for administrative skills.

Health courses related to growth and development from conception to adulthood would provide the student with a basic understanding of individual optimal health practices for human development. Community health needs would be an expansion of basic conditions and provide expanded and interrelationships between the individual and groups.

History, art, music, and other general courses contribute toward a well-rounded cultural background for students. All of these courses contribute immeasurably toward a balanced general background for child development students.

Physical education would provide students with concepts and practices of personal physical fitness that would enhance good personal health.

Several courses in child development and family relationships would emphasize basic principles of normal growth and development from conception through adulthood. Brooks (1969)

encouraged the study of child development. Life cycle characteristics and relationships would be important in providing the student with background knowledge in assessing children and their families. A curriculum model for the preparation of a hospital playroom director justifiably could be developed within a home economics curriculum since the central focus of home economics is on the individual in a family setting.

Development of Specific Courses

The following specialized course work, incorporating suggestions obtained from the respondents of this study, and from guidelines suggested by the ACCH (Bopp, 1972), are:

1. Reactions to illness, hospitalization, and separation according to age levels, previous experiences, and family coping mechanisms. Normal versus abnormal reactions and the role of playroom personnel.

2. Medical entities and physical and emotional reactions to specific illnesses (acute, chronic, terminal) with which play personnel are most often confronted.

3. Value and meaning of play with appropriate activities as well as experience in planning activities for playroom and isolated patients. A practicuum including planning and implementing supervision for a specified length of time.

4. Communication techniques with hospitalized children, parents, and team members of allied health fields. The team concepts and contribution of the team toward the total care of the child and his family.

As part of the practicuum, the student would be expected to do these activities:

1. Observe and participate with children in other areas of the hospital (out-patient department, physical therapy, laboratory, and recovery room) in order to understand and appreciate the cause and effects of tests and procedures.

2. Observe other staff members and their roles, as they come in contact with pediatric patients and families (medical, nursing, administrator, dietetics, and social services).

3. Plan and implement activities in the playroom for a specified length of time. This experience would give the student an opportunity to improve skills in administration and management.

4. Observe parents and parent-child relationships as they affect the child's behavior before, during, and following hospitalization.

Upon completion of these courses and practicuum, the student should have a knowledge of the following areas:

1. Reactions of children and families to separation, illness, and hospitalization.

2. Medical entities and terminology; the cause and effects of acute and chronic diseases and conditions.

3. Setting up and maintaining a play/activity program incorporating administrative skills.

4. Working with special children (retarded, abused, neglected, and blind).

5. Types, meaning, and uses of activities for infants, preschoolers, school-age, and adolescents.

6. Nutritional problems of the sick child.

The suggested courses and practicuum would be based on the principles of child growth and development with special emphasis on the needs of the hospitalized child and his family.

> The kind of program for which we strive will help children cope with experiences in the hospital. Play is utilized as a primary tool because of its crucial importance to the child as a means of coping with stress. Play is the child's mode of living, learning, and working. Supportive personal relationships with the professional and with the child's peers are vital elements. The program aims to involve children in activities or personal relationships appropriate to their individual needs. It is a program for all children, not just certain ones for whom it has been prescribed (Bopp, 1971).

CHAPTER V

SUMMARY AND RECOMMENDATIONS

This study was designed to gather data regarding hospital play programs and the personnel conducting these programs throughout the United States. With this information guidelines and standards currently in use were analyzed and used to formulate a curriculum for child development students preparing to assume positions in hospital play programs.

A 28-item questionnaire was constructed by the investigator after an extensive review of literature and experience with hospitalized children. The study was limited to established programs that were listed in the directory of the ACCH; therefore, new programs that have been developed, but not yet listed by this organization, were not represented in the present study.

Percentage analysis was the technique used to analyze the data. The results were discussed on the descriptive level.

MacLennan (1949) strongly recommended that playroom staff members have background training and experience in child development, education, and diversional techniques.

The present study produced evidence that play programs were conducted by personnel with educational backgrounds at the undergraduate level in child development (47 or 38.8%) and education (36 or 29.8%). Graduate level studies of personnel were also represented by a majority of child development (30 or 24.8%) and education (24 or 19.8%) degrees.

Hospitals represented in this study were predominantly general hospitals with pediatric units that had teaching services. Pediatric units over the country have developed methods to minimize the impact of hospitalization on families. The trend toward daily visiting for flexible periods of time with opportunities for overnight stay (rooming-in) by the mother is one of these methods. Flexibility in visiting hours was very evident. Rooming-in accommodations were reportedly available in 70 (58.9%) hospitals. This practice represents a drastic change of automatic separation of the child from the parents and familiar routines reported by Hardgrove in 1968 following a survey of hospital visiting procedures in the United States.

Play in the hospital adds a new dimension to medical care by providing a protective cushion for the child and by

supplying means to understand his feelings more freely. "Play hastens the recovery of the sick child and apathy is his worst enemy" (Jolly, 1969, p. 488).

Play considered merely as diversion, "busy work", or entertainment does not seem to meet the needs of children who are facing an experience which is potentially so disturbing to them. Because of increased interest in comprehensive care for hospitalized children, many hospitals are initiating some form of play programs staffed by professionally trained workers.

As early as 1949, Davidson felt that hospital play programs should be designed with the child's needs in mind. All playrooms in this study were open at least five days a week; 50 were open only five days a week; 11 were open six days a week; and 56 programs were operating seven days a week. According to the results of this study, playrooms operated during hours that would provide children with a program available and designed with the child's needs as a primary consideration. The trend of providing coverage of play programs on a continuous basis is evident. Programs that did not have an abundance of staff members provided week-end coverage of the playrooms with part-time personnel

and with trained volunteers.

Volunteers, according to MacLennan (1949), need more than a "like of children" to work with hospitalized children. Some programs relied heavily on volunteer workers. Only two respondents (1.7%) reported that volunteer workers were not needed in their programs. Sixty (49.7%) programs selected their volunteers and 94 (77.7%) respondents reported that the program director was responsible for training volunteers. The average number of volunteers in play programs was 10.

The respondents indicated that activities in playrooms were varied as well as numerous. In addition to the activities listed in the questionnaire, respondents listed picnics, outdoor play, and trips to the zoo as other kinds of activities used in the programs.

Responsilities of the playroom staff members were quite numerous. According to the respondents, further direction was needed in administrative skills, budgeting, bookkeeping, funding, and training of volunteers. One area in which guidance was requested several times was the role of the playroom staff members to the child and to the family of the terminally ill patient.

The proposed model was basically a child development major in a home economics setting with a liberal arts background. The emphasis from the responses about the concentration for hospital playroom directors recommended courses and practicuum appropriate for the profession.

Suggestions for Further Research

Further research concerning the acceptance of a hospital play program by various hospital disciplines should be conducted. Also, studies assessing meal patterns for children during hospitalization would yield helpful guidelines for medical and non-medical personnel.

Areas of significance that should be researched are responsibilities of playroom staff members to the terminally ill child and parents and the role of staff members to the dying child and his parents.

A comparative study of academic curricula that offer preparation for playroom personnel with curriculum suggestions from personnel employed in these positions would be helpful in designing a comprehensive curriculum. The effectiveness of playroom activities that are conducted by personnel with different background training (such as child development,

recreation, and education) should be noted.

The most effective and desirable preparation for hospitalization at different age or developmental levels should be established. Attention should be focused on the adolescent. Studies should include the physical, emotional, and spiritual needs of hospitalized adolescents.

Factors that contribute toward making the hospitalization of children a positive, learning experience would be valuable to child, parents, physician, and those people working with hospitalized children.

Another area that should be researched is the needs of "special" children (blind, deaf, and mentally retarded) when they are hospitalized. The impact of hospitalization upon the parents of these children and the responsibilities of the playroom staff member to "special" children is and area that requires special consideration.

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APPENDIX A

Questionnaire

Please place check to the left of the answer.

1. _____ Children's hospital

_____ Pediatric section in general hospital.

2. Number of beds in hospital

_____ 0-50
_____ 51-100
_____ 151-200
_____ 201-250
_____ 251-300
_____ over 300

Size of pediatric unit

_____ 0-10
_____ 11-21
_____ 21-30
_____ 31-40
_____ 41-50
_____ 51-75
_____ 76-100

3. Is your hospital:

_____ Teaching hospital
_____ Private hospital
_____ Other. Describe:

4. Are pediatric patients separated by ages?

_____ No.
_____ Infants (birth-lyr.)
_____ Toddlers
_____ Preschoolers
_____ School age
_____ Other. Describe:

Separated by medical services

_____ Medicine
_____ Surgery
_____ Psychiatry
_____ Other. Describe:

5. Usual number of patients in playroom. (Estimate)

_____ 0-10
_____ 11-20
_____ 21-30
_____ 31-40
_____ 41-50
_____ over 50

6. Hours of Playroom Director

_____ Full time (hours) _____
_____ Part time (hours) _____

7. Days and hours playroom is open. (Please fill in information).

8. Academic qualifications of Playroom Director.

-Undergraduate-

_____ Education (all levels)
_____ Nursing
_____ Child Development

-Graduate-

_____ Education
_____ Child Development
_____ Recreation Therapy
_____ Other. Describe:

_____ Psychology
_____ Recreation Therapy
_____ Other. Describe:

Experience working with children (list type and length of time)

9. Were you in a training program specifically designed for hospital play therapy?

_____ Yes _____ No

10. Hours of other playroom staff members.

_____ Full time
_____ Part time

Number on staff (not director).

_____ One
_____ Two
_____ More

11. To whom is the playroom director responsible?

_____ Nursing service
_____ Hospital administrator
_____ Chief of pediatrics
_____ Dept. of Recreation
_____ Other. Describe:

12. Check the responsibilities of the playroom director.

_____ Transport children from individual rooms to playroom.
_____ Prepare play materials in playroom.
_____ Prepare play materials for children in isolation.
_____ Select equipment.
_____ Establish and maintain equipment list.
_____ Purchase equipment.
_____ Attend staff meetings.
_____ Attend daily report (nursing).
_____ Promote parent education.
_____ Observe and supervise at noon meal.
_____ Train and schedule volunteers.
_____ Participate in policy-making.
_____ Make staff evaluation.
_____ Make self-evaluation.
_____ Prepare visual aids for students, parents, children and professionals.
_____ Speak to community groups about Play Program.
_____ Keep daily record of children while in the playroom.
_____ Others. (Please list on back page).

13. Does your program offer any of the following?

_____ Pre-admission tour of hospital
_____ Pre-admission film for parents and child.
_____ Book about hospital given to each patient.
_____ Information booklet for parents (phones, overnight accomodations, taxi, bus service, etc.).
_____ Outpatient playroom.

14. Clothing (apparel) worn by playroom staff.

_____ Uniform
_____ Street clothes
_____ Other. Describe:

15. Are there any males involved in the play program?
_____ Yes _____ No
How many? _____ In what capacity? _____

16. Place a check mark to the LEFT if you had the following training, and place a check mark to the RIGHT if you think this training should be included in the curriculum for play program personnel.

_____	Types, meaning and uses of activities (recreational, physical, educational)	_____
_____	Normal child growth and development (physical, emotional and cognitive)	_____
_____	Children's reactions to separation, illness and hospitalization.	_____
_____	Medical entities and terminology	_____
_____	Knowledge of abnormal development and it's implication.	_____
_____	Techniques of play therapy	_____
_____	Techniques of testing	_____

SPECIAL CHILDREN'S GROUPS

_____	Gifted children	_____
_____	Mentally retarded children	_____
_____	Emotional disturbances	_____
_____	Physical handicaps	_____
_____	Chronic Illnesses	_____
_____	Acute Illnesses	_____
_____	Economically deprived children	_____
_____	Environmentally deprived children	_____
_____	Minority groups	_____

17. Please list any other areas of knowledge or skills you feel are important in the training of hospital play personnel.

18. In your estimation, could your play program serve as a "model program"? _____ Yes _____ No

19. If the previous answer was "Yes," please check the following areas in which the program would be outstanding.
_____ Playroom design (physical set-up).
_____ Director
_____ Staff (qualification, experience).
_____ Curriculum design for students.
_____ Activities (valuable and extensive).
_____ Funding.
_____ Rapport with medical and nursing services.
_____ Other. List:

20. Check the following activities offered in your playroom.
_____ Children's library
_____ Art activities
_____ Teaching crafts
_____ Creative dramatics
_____ Active play (throwing, beating, punching)
_____ Musical activities
_____ Puppets
_____ Hospital play (doctor's bag and instruments)
_____ Role playing (doctor, nurse)
_____ Dress-up clothes
_____ Housekeeping corner
_____ Miniature equipment models (IV's, x-ray, heart catheterization)
_____ Doll house, doll play
_____ Playroom newspaper
_____ Messy play (glue, caly, water)
_____ Sensory experiences (feeling, smelling, tasting)
_____ Games
_____ Building, manipulation (blocks, tinker toys)
_____ Special events (cooking, hospital field trips)
_____ Animals (fish), plants
_____ Others. List:

21. Students participating in playroom program:
_____ No students participate in program
_____ Undergraduate students. Major: _____ How many? _____
_____ Graduate students. Major: _____ How many? _____

_____ Students receive all training from director.
_____ Students receive some training from director.
_____ Director does not train any students.

22. Volunteers participating in playroom program:
_____ Volunteers not needed.
_____ Volunteers are part of the program.
_____ Volunteers selected by playroom director.
_____ Volunteers trained by playroom director.
Number of volunteers (estimate) participating in program.

_____

23. Description of pediatric rooms:
_____ All private rooms
_____ Mostly private
_____ Semi-private
_____ Ward (four patients per room)
_____ Other. List:

24. TV's available:
_____ TV in all rooms (free of charge)
_____ TV in rooms (charge for service)
_____ No TV's
_____ TV in playroom

25. Meals:
_____ Only noon meal in playroom
_____ No meals in playroom
_____ Parents allowed to eat in playroom. How often? _____
_____ Noon meal served family style in playroom.
_____ Other arrangements. Please describe:

26. Play program has access to the following resource members:
_____ Social worker
_____ Recreation leader
_____ Child development specialist
_____ Psychologist
_____ Psychiatrist
_____ Tutorial service (teacher for school children)
_____ Health Educator

27. Play program financed by:
_____ Hospital (directly)
_____ Grant
_____ Hospital auxiliary
_____ Contributions
_____ Other. Explain:

28. Visiting hours in the pediatric unit:
_____ Limited visiting hours
_____ Unlimited visiting hours
_____ Rooming-in
_____ Other. Describe:

CONFIDENTIAL: This questionnaire was completed by
NAME: _____
HOSPITAL ADDRESS: _____
_____
TITLE OF POSITION YOU HOLD: _____
Do you wish a copy of the results of this survey? _____ Yes _____ No
If "Yes," please send to the following address:

APPENDIX B

Letter to the Directors of Child Life and Play Programs in the Directory of the Association for the Care of Children in Hospitals

THE UNIVERSITY OF NORTH CAROLINA
AT GREENSBORO

School of Home Economics

February 18, 1976

Dear Program Director:

As members of the Department of Child Development and Family Relations in the School of Home Economics at the University of North Carolina at Greensboro, we are conducting a survey of hospital play programs and solicit your help in this endeavor.

The enclosed questionnaire concerns play activities, director's role, policies and responsibilities of the staff. From this questionnaire, we hope to determine what factors most influence a "model play program" and design a suitable curriculum for students preparing to enter this field.

Please take a few minutes to complete the questionnaire and return it in the stamped envelope provided as soon as possible. All questionnaires must be returned by March 5, 1976.

In appreciation for your participation, when the study has been completed, we will be glad to make the results available to you. All replies will be kept confidential and there will be no identification of any specific program.

Yours truly,

Ann Rollins

Ann Rollins
Graduate student

Helen Canaday

Dr. Helen Canaday
Professor, Home Economics
Child Development

GREENSBORO, NORTH CAROLINA 27412
The University of North Carolina at Greensboro is a constituent institution of
THE UNIVERSITY OF NORTH CAROLINA

APPENDIX C

Child Life and Play Programs Listed in the Directory of Association for the Care of Children in Hospitals

Alabama	
The Children's Hospital	Birmingham
California	
Children's Hospital Medical Center	Long Beach
U.C.L.A. Hospital and Clinics	Los Angeles
Children's Hospital of L.A.	Los Angeles
Los Angeles County Medical Center	Los Angeles
Orthopaedic Hospital	Los Angeles
Cedars of Lebanon Hospital	Los Angeles
Martin Luther King Hospital	Los Angeles
East L.A. Child & Youth Clinic	Los Angeles
Children's Hospital Medical Center of Northern California	Oakland
Children's Hospital of Orange County	Orange
Children's Hospital at Stanford	Palo Alto
Mercy Hospital	San Diego
Hospitals and Clinics, University of California	San Francisco
Mount Zion Hospital	San Francisco
Stanford University Hospital	Stanford
Colorado	
Mercy Hospital	Denver
Colorado General Hospital	Denver

Colorado (cont'd.)

The Children's Hospital	Denver

Connecticut

Bridgeport Hospital	Bridgeport
University of Connecticut Health Center	Farmington
Hartford Hospital	Hartford
Yale-New Haven Hospital	New Haven
Newington Children's Hospital	Newington
Waterbury Hospital	Waterbury

Delaware

Wilmington Medical Center	Wilmington
Alfred I. DuPont Institute	Wilmington

District of Columbia

Providence Hospital	Washington, D.C.
The Hospital for Sick Children	Washington, D.C.
Children's Hospital of D.C.	Washington, D.C.
Freedman's Hospital (Howard Univ.)	Washington, D.C.

Florida

University Hospital of Jacksonville	Jacksonville

Florida (cont'd.)	
Jacksonville Children's Hospital	Jacksonville
Jackson Memorial Hospital	Miami
All Children's Hospital	St. Petersburg
Georgia	
Athens General Hospital	Athens
Grady Memorial Hospital	Atlanta
Henrietta Eggleston Hospital	Atlanta
Eugene Talmadge Memorial Hospital	Atlanta
Hawaii	
Kauikeolani Children's Hospital	Honolulu
Illinois	
La Rabida Children's Hospital	Chicago
Children's Memorial Hospital	Chicago
Wyler's Children's Hospital	Chicago
Michael Reese Hospital	Chicago
Cook County Children's Hospital	Chicago
Rush Presbyterian-St. Luke's Hospital	Chicago
Lutheran General Hospital	Park Ridge
Swedish-American Hospital	Rockford

Indiana	
St. Francis Hospital Center	Beech Grove
St. Mary's Hospital	Evansville
Methodist Hospital	Indianapolis
Riley Hospital for Children Indiana University Medical Center	Indianapolis
St. Elizabeth Hospital Medical Center	Lafayette
Iowa	
Mercy Hospital	Council Bluffs
Kentucky	
University of Kentucky Medical Center	Lexington
Maine	
Maine Medical Center	Portland
Maryland	
The Children's Hospital, Inc.	Baltimore
John F. Kennedy Institute	Baltimore
James Lawrence Kernan Hospital	Baltimore
Sinai Hospital of Baltimore, Inc.,	Baltimore
Johns Hopkins Hospital	Baltimore
Baltimore City Hospitals	Baltimore
St. Agnes Hospital	Baltimore
University of Maryland Hospital	Baltimore

Maryland (cont'd.)

Mercy Hospital	Baltimore
Happy Hills Hospital	Baltimore
St. Joseph Hospital	Baltimore
South Baltimore General Hospital	Baltimore
National Institute of Health	Bethesda
Prince George's General Hospital	Cheverly
St. Joseph Hospital	Towson

Massachesetts

Boston City Hospital	Boston
Massachesetts General Hospital	Boston
Children's Hospital Medical Center	Boston
Boston Floating Hospital Tufts New England Medical Center	Boston
Carney Hospital	Boston
New England Deaconess Hospital	Boston
St. Elizabeth's Hospital	Brighton
Kennedy Memorial Hospital	Brighton
North Adama Regional Hospital	North Adams
North Shore Babies-Children's Hospital	Salem

Michigan

C.S. Mott Children's Hospital	Ann Arbor

Michigan (cont'd.)

St. John Hospital	Detroit
Mt. Carmel Mercy Hospital	Detroit
Mary Free Bed Hospital and Rehabilitation Complex	Grand Rapids
Blodgett Memorial Hospital	Grand Rapids
St. Mary's Hospital	Grand Rapids

Minnesota

St. Joseph's Hospital	St. Paul

Missouri

University of Missouri Medical Center	Columbia
Menorah Medical Center	Kansas City
St. Louis Children's Hospital	St. Louis

Nebraska

University of Nebraska Medical Center	Omaha

New Jersey

Children's Seashore House	Atlantic City
Clara Maas Memorial Hospital	Belleville
Elizabeth General Hospital & Dispensary	Elizabeth
Children's Hospital DHMC	Newark

New Jersey (cont'd.)

Beth Israel Medical Center	Newark
St. James Hospital	Newark
Children's Specialized Hospital	Westfield
Muhlenberg Hospital	Plainfield

New Mexico

Bernadillo County Medical Center	Albuquerque

New York

St. Mary's Hospital for Children	Bayside
Bronx Municipal Hospital Center	Bronx
Montefiore Hospital and Medical Center	Bronx
Hospital of Alber Einstein College of Medicine	Bronx
Kingsbrook Jewish Medical Center	Brooklyn
Long Island College Hospital	Brooklyn
Downstate Medical Center	Brooklyn
Children's Hospital	Buffalo
North Shore University Hospital	Manhasset
St. Claire's Hospital	N.Y.C.
St. Luke's Hospital	N.Y.C.
Lenox Hill Hospital	N.Y.C.
Metropolitan Hospital	N.Y.C.

New York (cont'd.)

Columbia-Presbyterian Babies Hosp.	N.Y.C.
Bellevue Hospital Medical Center	N.Y.C.
Roosevelt Hospital	N.Y.C.
Mt. Sinai Hospital	N.Y.C.
New York Hospital	N.Y.C.
Vassar Brothers Hospital	Poughkeepsie
Strong Memorial Hospital	Rochester
United Cerebral Palsy Treatment and Rehabilitation Center	Roosevelt
Good Samaritan Hospital	Suffern
Upstate Medical Center	Syracuse
Plythedale Children's Hospital	Valhalla

North Carolina

Memorial Mission Hospital	Asheville
North Carolina Memorial Hospital	Chapel Hill
Duke University Medical Center	Durham
North Carolina Orthopedic Hospital	Gastonia

Ohio

The Children's Hospital	Cincinnati
University of Cincinnati Medical Center	Cincinnati
Shriner's Burns Institute	Cincinnati

Ohio (cont'd.)

Cleveland Metropolitan General Hosp.	Cleveland
St. Luke's Hospital	Cleveland
Cleveland Clinic Hospital	Cleveland
Health Hill Hospital	Cleveland
Rainbow, Babies & Children's Hosp.	Cleveland
Mt. Sinai Hospital of Cleveland	Cleveland
East 35th Street Health Center	Cleveland
Children's Hospital	Columbus
Children's Medical Center	Dayton
St. Vincent Hospital Medical Ctr.	Toledo

Oregon

Doernbecker Memorial Hospital for Children	Portland

Pennsylvania

Crozer-Chester Medical Center	Upland-Chester
Harrisburg Polyclinic Hospital	Harrisburg
Milton S. Hershey Medical Center	Hershey
Children's Hospital of Philadelphia	Philadelphia
Hahnemann Hospital	Philadelphia
Thomas Jefferson Hospital	Philadelphia
St. Christopher's Hospital for Children	Philadelphia

Pennsylvania (cont'd.)	
Children's Hospital of Pittsburgh	Pittsburgh
Allegheny General Hospital	Pittsburgh
Williamsport Hospital and Rehab. Ctr.	Williamsport
York Hospital	York
Rhode Island	
Roger Williams General Hospital	Providence
Crawford Allen-Hodges Lawton Unit	Providence
Miriam Hospital	Providence
Tennessee	
East Tennessee Children's Hospital	Knoxville
Texas	
Children's Medical Center	Dallas
Shriner's Hospital for Crippled Children-Burns Institute	Galveston
Utah	
Primary Children's Hospital	Salt Lake City
Virginia	
University of Virginia Hospital	Charlottesville
Children's Rehabilitation Center	Charlottesville

Washington	
Children's Orthopedic Hospital	Seattle
West Virginia	
West Virginia University Hospital	Morgantown
St. Joseph's Hospital	Parkersburg
Ohio Valley Medical Center	Wheeling
Wisconsin	
University of Wisconsin Hospital	Madison
Madison General Hospital	Madison
Milwaukee Children's Hospital	Milwaukee